Nelson Marlborough District Health Board

A Report by the

Mental Health Commissioner

(Case 15HDC00563)

Table of contents

Executive summary

1. Mrs A complained to HDC about the services provided to her late husband, Mr A, by Nelson Marlborough District Health Board (NMDHB). Mr A was on long-term[1] opioid substitution treatment (OST)[2] under the care of the Addictions Service at NMDHB.

2. On 14 Month1[3] 2015, Mr A presented to the Emergency Department (ED) at Hospital 1 in Town 1 after a fall. Following this presentation Mr A was found to have multiple tiny nodules on his lungs and a lesion on his liver. Consultant physician Dr E[4] reviewed Mr A and recorded her impression of chronic liver disease, hypoxia[5] with suspicions of malignancy, and abdominal lesions and nodes. Further investigations were ordered.

3. On 17 Month1 Mr A contacted Mr C, an addiction clinician at the Addictions Service, and told him that he had been diagnosed with cancer of the liver. Mr C emailed Ms D, the Addictions Service's Manager, and told her that he would keep her updated on Mr A's progress. The minutes from the Addictions Service's weekly meeting of 18 Month1 noted that Mr A was being investigated for liver cancer and was requesting to have his methadone increased when discharged from hospital.

4. The discharge summary prepared on Mr A's departure from hospital referred to discussion about Mr A's "possible poor prognosis" and included a plan for outpatient follow-up and GP review of Mr A's abdominal pain and pain relief.

5. Mr A presented at Hospital 1 again on 5 Month2, reporting shortness of breath and high levels of abdominal pain. He was admitted to the medical ward and provided with morphine. Mr A's admission, and pain, were reported to Ms D. Ms D replied to Mr C that she had spoken to Dr B, an addiction specialist, and that they "should be looking at reducing [Mr A's] methadone not increasing it". Dr B told HDC that he was on leave at this time, and did not discuss Mr A with Ms D on this occasion.

6. Mr A was discharged on 8 Month2 by Dr H, with a prescription for increased methadone intended for acute pain relief. Mr A was noted at the time to be in severe pain with a deteriorating clinical condition.

7. Mr A presented Dr H's prescription to a pharmacy on 8 Month2. Because of the change in methadone dose, the pharmacy called the Addictions Service. Dr B called Dr H to clarify the prescription, and was advised that the methadone was prescribed to help with abdominal pain. Dr B told HDC that Dr H was unaware of Mr A's current

[1] At the time of these events, Mr A had been on the opioid substitution treatment programme for over 25 years.
[2] Opioid substitution treatment, provided to people with opioid dependence, involves replacing an illegal opioid, such as heroin, with a legal, longer acting, but less euphoric, opioid, such as methadone.
[3] Relevant months are referred to as Month 1-2 to protect privacy.
[4] Dr E has been vocationally registered in internal medicine since 2010.
[5] Hypoxia is a deficiency in the amount of oxygen reaching the tissues.

script and the NMDHB policy on prescribing methadone for Addictions Service's clients on discharge. Dr H cancelled the script.

8. Dr B did not follow up on the prescription when he returned to work on 9 Month2.

9. Mrs A told HDC that over this period Mr A was in pain, and his condition was deteriorating rapidly. Mr C continued to see Mr A regularly, but there is no documentation of these visits.

10. Mr A was discussed at the OST meeting on 16 Month2, at which time it was noted that Mr A was having an MRI that afternoon. The minutes note that Dr B was "reluctant to increase [Mr A's] methadone, due to concern he is drug-seeking".

11. On the afternoon of 16 Month2, Mr A underwent an MRI, but it could not be completed because he was unable to lie still owing to pain. This information was relayed by Mr C to Dr B. Dr B told HDC that this was the first indication he had had that Mr A could be requiring methadone for clinical reasons rather than addiction. Responsibility for Mr A's methadone prescribing was passed over to Dr F on 16 Month2.

12. Mr A was transferred to hospice care on 20 Month2, and passed away shortly afterward.

Findings

13. There were a number of missed opportunities for communication about Mr A's situation, his condition, and his pain relief requirements, as a result of service-based failures attributable to NMDHB. Mr A did not receive the pain relief he should have been able to access. As a result, it was found that NMDHB failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[6]

Recommendations

14. It is recommended that NMDHB:

a) Develop a process for formal handover of Addictions Service clients when they move from outpatient to inpatient services and vice versa; conduct an audit to ensure that all interactions with clients are recorded in Addictions Service records and/or, if relevant, clinical records; and review and revise, as necessary, the position descriptions for Addictions Service staff referred to within this report, to ensure clarity of role expectations, professional development, and support.

b) Conduct a random audit of Hospital 1 discharge summaries over a one-month period to assess compliance with the requirement that hospital discharge summaries be sent to relevant GPs.

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

c) Provide refresher training for all Hospital 1 staff on the "Methadone/Buprenorphine (with Naloxone) — Opioid Substitution Therapy for Treatment of Dependence (Addiction)" and "Pain Management — Adults" guidelines.

d) Provide a written apology to Mr A's family.

Complaint and investigation

15. The Commissioner received a complaint from Mrs A about the services provided to her late husband, Mr A, by NMDHB. The following issues were identified for investigation:

- *Whether Nelson Marlborough District Health Board provided Mr A with care of an appropriate standard between 14 Month1 and his death in Month2.*
- *Whether Dr B provided Mr A with care of an appropriate standard between 14 Month1 and his death in Month2.*
- *Whether Mr C provided Mr A with care of an appropriate standard between 14 Month1 and his death in Month2.*
- *Whether Ms D provided Mr A with care of an appropriate standard between 14 Month1 and his death in Month2.*

16. The parties directly involved in the investigation were:

Mrs A	Complainant
Nelson Marlborough DHB	Provider
Dr B	Addiction specialist
Mr C	Addiction clinician/case manager
Ms D	Addictions Service manager

Also mentioned in this report:

Dr J	Psychiatrist
Dr L	Consultant psychiatrist

17. Information was also reviewed from:

Dr E	Consultant general physician
Dr F	Palliative care/pain specialist
Dr G	Consultant general physician
Dr H	House officer
Mr I	Pharmacist
Pharmacy	

Dr K	General practitioner
Medical centre	General practice

18. Independent expert advice was obtained from general physician and addiction specialist Dr Geoffrey Robinson (**Appendix A**).

19. Independent expert advice was obtained from addiction practitioner Ian MacEwan (**Appendix B**).

Information gathered during investigation

Background

20. Mr A, aged 64 years, was on long-term OST under the care of the Addictions Service at NMDHB. He was prescribed 200mg per day of methadone,[7] which was gradually reduced, over several months, to 155mg per day by Month1. On Monday through to Saturday, Mr A took his daily dose of methadone on site at a pharmacy. On Sundays, he took his methadone dose on site at a second pharmacy, as his usual pharmacy was closed. Mr A also had Hepatitis C.[8]

21. This report addresses the care provided to Mr A by the Addictions Service and Hospital 1 (NMDHB) between 14 Month1 and his death in Month2.

Addictions Service

22. The Addictions Service is responsible for managing the prescription of opioids to opioid-dependent clients, pursuant to the Misuse of Drugs Act 1975, for the purpose of treating their dependency.[9] Addictions Service medical staff can prescribe opioids, or can delegate this to other prescribers, such as a GP. Prescription of opioids for the purpose of pain relief is not restricted under the Misuse of Drugs Act 1975.

23. At the time of these events, the Addictions Service had two medical staff: addiction specialist Dr B,[10] and psychiatrist Dr J,[11] both based in Town 2. NMDHB told HDC that usual Addictions Service medical cover for Town 1 consisted of Dr B being in Town 1 on Wednesdays, Dr J being in Town 1 on Thursdays, and both being available via telephone on other days. However, Dr B was on leave from 16 Month1, returning to on-call duties on 7 Month2, and to work on 9 Month2. At the same time, Dr J was

[7] Methadone is an opioid medication and a controlled drug. It is used as a substitute drug in the treatment of opioid dependence, and is also a powerful analgesic.
[8] Hepatitis C is a liver disease resulting from infection with the Hepatitis C virus.
[9] Opioid substitution treatment programmes must be specified by the Minister under section 24 of the Misuse of Drugs Act 1975. Section 24 of the Misuse of Drugs Act 1975 states: "(1) Every medical practitioner commits an offence who prescribes, administers, or supplies a controlled drug for or to a person who the practitioner has reason to believe is dependent on that or any other controlled drug, — (a) in the course or for the purpose of the treatment of the person for dependency. …".
[10] Dr B has held a general scope of practice in New Zealand since 2012.
[11] Dr J has been vocationally registered in psychiatry since 2014.

on reduced on-site hours, but was available for advice via telephone, for emergency consultations in Town 2, and for prescriptions across the service.

24. Dr B stated that it was his role to oversee the prescribing of Mr A's methadone and his overall addiction treatment. The Addictions Service Manager, Ms D,[12] told HDC that her role was to liaise with Dr B and Mr A's case manager, addiction clinician Mr C,[13] in the capacity of after-hours manager, and to provide input into multidisciplinary team (MDT) discussions.

25. Mr C told HDC:

> "[M]y role was to liaise with [Mr A] and the [Addictions Service] team. … All liaisons regarding [Mr A] was with [Ms D], [Dr B] and/or presented at the multi disciplinary meetings."

Hospital 1 (14–20 Month1)

26. On 14 Month1, Mr A presented to the ED at Hospital 1 in Town 1 after a fall. He reported haematuria,[14] a bruised right lower leg, and pain in his right knee. Mr A was given morphine[15] for analgesia, and oxygen via a nasal prong for his low oxygen saturation levels. He was discharged home at 12.40am the next day, with a plan in place for him to return at 9.30am for a computed tomography (CT) scan.[16] The discharge summary, which was copied to Mr A's general practitioner (GP), Dr K[17] at the medical centre, noted Mr A's presenting complaint and queried intra-abdominal injury or nephrolithiasis.[18]

27. Shortly after discharge, a consultant general surgeon requested that Mr A return to hospital, so that he could be monitored. Mr A was called and asked to return, and he arrived at 1.49am on 15 Month1. A house officer reviewed him at 4.30am, documenting that, if Mr A remained in hospital, a telephone call would need to be made to his pharmacy to confirm his methadone dose. Nonetheless, Mr A was administered 155mg of methadone at 10.00am, without the dose having been confirmed.

[12] Ms D is a registered addiction practitioner with the Addiction Practitioners Association Aotearoa New Zealand. She trained as a nurse and has worked in Addictions for many years. She is not able to prescribe medication.
[13] Mr C is a registered addiction practitioner with the Addiction Practitioners Association Aotearoa New Zealand. He holds a graduate diploma in Addiction Studies. He is not able to prescribe medication.
[14] Haematuria is the presence of blood in the urine.
[15] Morphine is a potent analgesic opioid medication, and is a controlled drug.
[16] Computed tomography is an imaging procedure that uses special X-ray equipment to produce cross-sectional images.
[17] Dr K has been vocationally registered in general practice since 1987.
[18] Nephrolithiasis is the presence of stones in the kidney.

28. Later on 15 Month1, an abdominal CT scan was completed and reported no renal injury, but multiple enlarged lymph nodes[19] within the abdomen, and multiple tiny nodules on his lung[20] (differential diagnoses lymphoma,[21] metastatic disease[22] and infection), hepatic cirrhosis[23] with portal venous hypertension,[24] and a lesion on his liver[25] (differential diagnoses metastatic disease and hepatocellular carcinoma[26]).

29. At 10.00am on 16 Month1, Mr A was administered a further 155mg of methadone, without the dose having been confirmed. A hospital pharmacist confirmed the dose with the pharmacy at 12.05pm.

30. Later on 16 Month1, consultant physician Dr E[27] reviewed Mr A. Her impression was of chronic liver disease, hypoxia[28] with suspicions of malignancy, and abdominal lesions and nodes. Dr E's plan included further investigations and consultation with a respiratory specialist and a haematologist. She noted that the Urology team was planning to undertake an outpatient flexi-sigmoidoscopy,[29] if needed. Mr A was transferred from the surgical ward to the medical ward that night.

31. On 17 Month1, Mr A contacted Mr C, who recorded:

> "[Mr A] phoned the clinic this morning quite emotional, he is in hospital and said that he has been diagnosed with cancer of the liver … [Mr A] asked if I could come see him at the hospital which I was able to do. … [Mr A] has asked if his methadone can be increased back up to 200mg, I have advised that given his condition I could not advise whether this would be advisable but would discuss it with [Ms D] as our medical officer [Dr B] was on leave. … I have advised I will drop in and see him each day when able and would talk with [Ms D] about his request and any decision would need to be in collaboration with medical staff."

32. Mr C emailed Ms D, relaying this information and stating that he would keep her and the Addictions Service updated on Mr A's progress.

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[19] Lymph nodes are small swellings in the lymphatic system (part of the circulatory system and the immune system) where lymph (fluid formed when the fluid in body tissue is collected through lymph capillaries) is filtered and lymphocytes (a subtype of white blood cell) are formed.
[20] Pulmonary nodules.
[21] Lymphoma is a malignant tumour of the lymph nodes (see footnote 15).
[22] Metastatic disease is the distant spread of disease (usually a malignant tumour) from its site of origin.
[23] Hepatic cirrhosis is a condition in which the liver responds to injury or death of some of its cells by producing interlacing strands of fibrous tissue between which there are nodules of regenerating cells. Complications include portal venous hypertension (see footnote 24).
[24] Portal venous hypertension is a state in which the pressure within the hepatic portal vein (a blood vessel that conducts blood from the gastrointestinal tract and spleen to the liver) is increased, causing enlargement of the spleen and ascites (the accumulation of peritoneal fluid (a liquid made in the abdominal cavity which lubricates the surface of tissue that lines the abdominal wall and pelvic cavity)).
[25] A hepatic lesion.
[26] Cancer of the liver.
[27] Dr E has been vocationally registered in internal medicine since 2010.
[28] Hypoxia is a deficiency in the amount of oxygen reaching the tissues.
[29] A flexi-sigmoidoscopy is a procedure used to evaluate the lower part of the large intestine.

33. On 18 Month1, Mr A was discussed at the Addictions Service's weekly OST meeting. No medical officer was present, but Mr C and Ms D were in attendance. The minutes state:

> "Currently an inpatient following [a fall]. … [Mr A] now being investigated for [liver cancer] as scans have shown he has lesions on his liver and he is passing blood in his urine. … [Mr A] requesting to have his methadone increased back up to 200mg and 2 days [takeaway] when he is discharged. [Mr C] to follow up need for increase with [Mr A's] physician. Any changes to his current dispensing regime to be held off until he is reviewed by [Dr B]."

34. The same day, Dr K was informed of Mr A's hospital admission and nodules in his lungs and abdomen.

35. Also on 18 Month1, Dr E reviewed Mr A again. Her documented management plan included discussion with the Addictions Service regarding Mr A's methadone dose.[30] On 19 Month1, Mr A's methadone was increased from 155mg to 160mg by a house officer. NMDHB was asked by HDC whether this increase was for addiction or pain, and NMDHB responded that it had no further comment.

36. Later on 19 Month1, the Addictions Service OST co-ordinator emailed Dr J (copied to Mr C and Ms D), stating that Mr A was going to be discharged from the hospital the next day and needed new prescriptions for his increased methadone dose. Dr J completed the prescriptions, and Mr C sent a fax to both pharmacies, informing them that Mr A had had his methadone dose increased to 160mg by request of a doctor at the hospital.

37. On 20 Month1, Dr E reviewed Mr A again, documenting that her management plan included liaising with the Addictions Service about Mr A's methadone dose.[31] Mr A was discharged that day, with a prescription for 12x 20mg tablets of morphine (four days' worth) and a copy of his discharge summary. The discharge summary, which is not listed as copied to Dr K, sets out Mr A's clinical issues as chronic liver disease with portal hypertension, coagulopathy,[32] widespread pulmonary nodules and lymphadenopathy[33] in his chest and abdomen, ongoing low oxygen saturation levels, a new liver lesion, and abdominal pain likely related to his fall. Malignancy, inflammation, and sarcoidosis[34] were queried as the cause of the pulmonary nodules and lymphadenopathy. The discharge summary also refers to discussion with Mr A about "possible poor prognosis" and his wishes about end of life care. The discharge plan included outpatient follow-up and GP review of Mr A's abdominal pain and pain relief.

[30] When asked for information about what discussion was held, NMDHB stated that it had no further comment.
[31] When asked for information about what discussion was held, NMDHB stated that it had no further comment.
[32] Coagulopathy is a bleeding disorder in which the blood's ability to form clots is impaired.
[33] Lymphadenopathy is a disease affecting the lymph nodes.
[34] Sarcoidosis is a disease involving abnormal collections of inflammatory cells that form lumps.

38. Mr C told HDC that he visited Mr A every day during this admission, but documented only his 17 Month1 visit.

Community care (20 Month1–5 Month2)

Consultation with Dr K 23–25 Month1

39. On 23 Month1, Mr A presented to Dr K. Dr K told HDC that he was aware that Mr A had been in hospital with multiple injuries after a fall, and that, during the investigation of those injuries, a chest X-ray had suggested some unusual lung appearances, which might be sinister medically. Dr K was not aware that Mr A was for GP follow-up of his abdominal pain, as a copy of the hospital discharge summary from 20 Month1 was not sent to him. Dr K recorded:

> "Is to … slowly increase the Methadone. … The investigations continue for the cause of his altered [chest X-ray] and lymphadenopathy. He looks a complete wreck physically — this may be due to injuries but may also be methadone withdrawal or the new diagnosed illness. … I need to speak to [Ms D] about the control of his opiates as dosage needs to be controlled. … Unable to contact [Ms D] but will try again tomorrow."

40. Dr K told HDC that Mr A did not specifically ask for any extra analgesia, but he (Dr K) felt that Mr A required it. The next day, Dr K recorded the following note: "Rang [Ms D] at 0845 answer phone … left a message I would like to increase the methadone by 5mg/day back to 200mg and forgo [morphine] as the potential for abuse is significant." He told HDC that he informed the Addictions Service that Mr A had been injured and that they needed to reassess his analgesia requirements.

41. Also on 24 Month1, Dr E sent Dr K a letter advising that she had discussed Mr A's management with a liver specialist and a haematologist. It was stated that his hypoxia was most likely hepatopulmonary syndrome,[35] the lesion on his liver could be hepatocellular carcinoma, and his bleeding and coagulopathy could be disseminated intravascular coagulation[36] of a chronic nature (for which malignancy is usually the cause) or a disseminated malignancy. Dr E noted that further investigations were planned.

42. On 25 Month1, Dr K contacted the pharmacy and prescribed Mr A six 20mg morphine tablets, to take as needed up to every four hours. Dr K recorded:

> "[No] contact from [Ms D] … Responsibility for methadone and analgesia is with [Addictions Service] but they have no [Town 1] [Medical] Officer. [Dr B] is [on leave] so await [Ms D]. … NO FURTHER SHORT ACTING OPIATES OR METHADONE DOSE CHANGES unless [Addictions Service] advises."

[35] Hepatopulmonary syndrome is shortness of breath and low oxygen levels in the blood caused by the broadening of blood vessels in the lungs of patients with liver disease.
[36] Disseminated intravascular coagulation is a condition in which small blood clots develop throughout the bloodstream.

43. Dr K told HDC that he considered both the difficulty in contacting Ms D and Mr A's acute situation, and decided to supply him with six morphine tablets for his current breakthrough pain. Dr K stated that he explained to Mr A (over the telephone) that any further opiates would have to be sourced through the Addictions Service.

44. In contrast to Dr K's records and recollection, Ms D documented a telephone call with Dr K on 25 Month1, stating:

> "[Mr A] was discharged from hospital after [a fall] and he was given an increase in his methadone to 160mgs plus 12 [morphine] tablets. He has used them all and now presented to [Dr K] stating he was in further pain and needed more pain relief. [Dr K] reluctantly [provided] a script for an extra six tablets of [morphine] and has made it [quite] clear to the pharmacy and [Mr A] that he will not be prescribing any more.
>
> [Dr K] does not believe that the pain is the result of liver issues that are still [being] investigated. [Mr A] was told it could be one of three things and he has just taken on board that it could be cancer. There is no indication that further pain medication is required. [Dr K] has requested that we continue with the prescribing and keep him informed of any change. … I have informed [Dr K] that when [Dr B] returns from leave he will be seeing and assessing [Mr A] and will liaise back with him."

45. Ms D told HDC that her only recollection of contact from Dr K is the documented telephone call. She said that Dr K told her that Mr A's leg injury did not require the amount of analgesia he was seeking. Ms D did not read Mr A's discharge summary of 20 Month1, which was not sent to the Addictions Service, but was viewable on Mr A's electronic clinical records.

46. At 10.30am on 25 Month1, Mr A was discussed at the OST meeting. Mr C and Ms D were present, but there was no medical officer in attendance. The minutes state: "Discharged from Hospital on Friday. Awaiting test results ?Sarcoids. Physician has increased his dose to 160mg."

Ongoing pain 27 Month1 –5 Month2

47. On 27 Month1, Mr A's wife, Mrs A, called Mr C. Mr C documented:

> "Phone call from [Mrs A] wanting clarification regarding pain medication for [Mr A] as he is still experiencing significant pain and not sleeping. I advised [Mrs A] of the conversation that [Ms D] had with [Dr K] … I advised [Mrs A] that an appointment has been made for [Mr A] to see [Dr B] here at [Addictions Service] on the 16th of [Month2] at 2.30pm and could not be seen earlier than this due to [Dr B] being on leave. I advised that [Mr A] see his GP again if he is in significant pain and that [Dr K] could phone [Ms D] for further advice if needed."

48. There is no record of Mr C communicating with Ms D or Dr J about this telephone call at the time. The same day, Dr J renewed Mr A's Monday to Saturday methadone prescription. This was a routine prescription.

49. At 10.33am on 27 Month1, Mr A presented to ED at Hospital 1. The triage nurse recorded that he had worsening shortness of breath and epigastric[37] pain. Mr A was placed on a high flow nasal cannula[38] and given morphine. He was offered admission, but declined. The Medical Record, which is not listed as being copied to Dr K or provided to the Addictions Service, states:

> "Patient on chronic methadone 160mg a day and has been on [morphine] 40mg[39] [three times daily] which he has run out. Cannot get more until [11 Month2] when [Addictions Service] provider will be back. [Complained of] some intermittent band like lower abdominal pain which he has been having. … **Follow up and Advice:** [Morphine] 20mg #40 tablets prescribed."

50. On 2 Month2, Mr A underwent a flexible cystoscopy.[40] The findings were of a normal urethra and a normal bladder. Also on 2 Month2, Dr J routinely renewed Mr A's Sunday methadone prescription.

51. On 4 Month2, Mr A was discussed at the weekly OST meeting. Mr C and Ms D were present, but no medical officer was present. The minutes state: "Called looking for pain relief.[41] Advised to contact his GP re this. Appears [Mr A] was prescribed further [morphine] by ED [medical officer]."

52. On 5 Month2, an Addictions Service methadone takeaway/transfer request form was completed for Mr A. It stated: "Would like any [takeaways] the team can give him. Would like increase in dose (160) currently. [Magnetic resonance imaging (MRI)][42] on 16 [Month2] in [Town 2]." "Declined" was circled on the form. There is no documentation of Mr A making this request, who completed the form, or the reason for it being declined. NMDHB was asked for this information and told HDC that it had no further comment.

53. Mr C told HDC that he visited Mr A most days between 20 Month1 and 5 Month2, but there is no documentation of these visits.

Hospital 1 (5–8 Month2)

54. On Thursday 5 Month2, Mr A again presented to ED at Hospital 1. He was reviewed by an ED doctor, who recorded:

> "Patient progressively more [short of breath] over last few days to the point of being unable to cope at home. … Finding it difficult to walk around house. Both patient and wife in tears. In addition [complains of] epigastric pain and left flank pain — usual pain around 8/10 on pain scale not relieved by [morphine]/other

[37] Epigastric means the upper central region of the abdomen.
[38] A high flow nasal cannula is a nose tube that delivers oxygen at a high rate.
[39] Mr A had actually been prescribed 20mg tablets of morphine, not 40mg.
[40] Cystoscopy is an examination of the bladder via a cystoscope inserted in the urethra.
[41] Mrs A had called on 27 Month1 regarding Mr A's pain medication.
[42] Magnetic resonance imaging (MRI) is a type of imaging procedure used to view internal body structures.

> analgesia, pain radiates around back, pain is crampy in nature. Vomited x2 per day. Reduced appetite."

55. Mr A was admitted to the medical ward and provided with morphine. A hospital pharmacist called Mr C to confirm Mr A's methadone dose.

56. The next morning, 6 Month2, Mr A was reviewed by consultant physician Dr G.[43] Dr G noted that, in addition to abdominal pain, Mr A also had bilateral lumbar back pain radiating to his chest and making it hard to breathe. Dr G's management plan included review by palliative care/pain specialist Dr F,[44] and he queried increasing Mr A's methadone dose.

57. The same day, Mr C emailed Ms D, stating:

> "[Mr A] was readmitted to hospital yesterday, shortness of breath and abdominal pain, he is being given [morphine] for pain and at this stage looks like he will remain in hospital over the weekend. [Mr A] mentioned that the doctor wanted to increase his methadone, I haven't been able to clarify this but [Mr A] said the doctor would phone you to discuss this, so you may receive a call sometime."

58. Ms D replied to Mr C's email, stating: "I have talked to [Dr B] about this and with his shortness of breath we should be looking at reducing his methadone not increasing it." Dr B told HDC that Ms D did not discuss increasing Mr A's methadone dose with him on 6 Month2, and that her comment in the email referred to a clinical discussion held prior to Mr A's first admission, in relation to Mr A's shortness of breath over the preceding 12 months. Ms D told HDC that she was not contacted by hospital doctors, so did not take any further action.

59. Also on 6 Month2, Dr F increased Mr A's methadone dose from 160mg to 180mg per day. Dr F also prescribed 30mg methadone to be given up to four times a day (up to a maximum dose of 120mg per day), for breakthrough pain. Dr F told HDC: "I was aware that Mr A was on Methadone supervised by [Addictions Service], but the acute issues were more palliative management of an obviously terminal situation." It was documented by nursing staff that methadone was given with good effect and that Mr A felt much better after his analgesia had been increased.

60. At the morning ward round on 8 Month2, Dr G recorded: "[Plan]: 1. [Discharge] today. 2. GP [review] in 2/52 for [regular] analgesia dispensing." Mr A was later discharged with a two-week prescription for methadone 180mg per day plus 30mg up to four times daily, written by house officer Dr H.[45] The prescription was not annotated as being for pain. Neither Dr G nor Dr H contacted the Addictions Service about Mr A's discharge. Dr G told HDC that he recognised that there was probably a breakdown in communication between the hospital and the Addictions Service, and

[43] Dr G has been vocationally registered in internal medicine since 2010.
[44] Dr F has been vocationally registered in general practice since 1990 and in rural hospital medicine since 2011.
[45] At the time of these events, Dr H was registered with a provisional scope of practice. He now holds a general scope of practice.

stated that Mr A being discharged on a Sunday by a junior doctor probably contributed to this.

61. Dr G told HDC:

> "The discharge plan was for [Mr A] to go home on his usual dose of Methadone with extra doses as required, and to have follow up with [Dr E] (as previously planned) and also his GP, both of whom would be able to evaluate his pain control. The Palliative care team were also going to assist with his ongoing management. … This seemed to be a reasonable short term plan regarding his pain management and followed usual practice for a patient with severe pain due to a likely malignancy. … To my mind the additional Methadone was part of an acute pain management strategy for a new condition as opposed to regular Methadone as part of the Methadone programme. … At the time [Mr A] was clearly extremely ill with severe pain and a deteriorating clinical condition … and our focus was on providing effective pain relief, confirming the diagnosis and managing the malignancy."

62. Dr H stated that he discharged Mr A as per Dr G's instructions. Dr H said: "As the methadone dose had changed while he was in hospital, I provided him a prescription for this. I was unaware that [Mr A] was on daily dispensing of methadone or that it was usually prescribed by [the Addictions Service]."

63. The discharge summary, which was issued on 10 Month2 and copied to Dr K, stated that Mr A had presented because his pain and shortness of breath were getting on top of him. The discharge summary listed Mr A's diagnoses of presumed hepatopulmonary syndrome, queried hepatocellular carcinoma, abnormal coagulation possibly due to an underlying malignancy, possible sarcoidosis, and chronic Hepatitis C. The discharge summary stated: "Regular methadone dose increased to 180mg daily + methadone 30mg Q4H/PRN for breakthrough pain. Trialled on this new regimen to good effect." The discharge plan included an outpatient MRI, outpatient review, and GP review in two weeks' time for "further methadone/pain relief".

Community care (8–16 Month2)

Dispensing of methadone prescription 8 Month2

64. On the afternoon of 8 Month2, Mr A presented Dr H's prescription to pharmacist Mr I at the pharmacy. Mr I told HDC that, given Mr A's long and significant history of opioid substance abuse, he was concerned that the methadone dose had been increased and that the new prescription was for up to 300mg of methadone per day. Mr I stated that Mr A was not able to provide him with reasons for the change of dose. Mr I said that Mr A was not in pain when he discussed the prescription with him, was mobile, and did not seem to be in any distress. Mr I stated that, as he was aware that Mr A was under the care of the Addictions Service, and that the NMDHB methadone guidelines required prescriptions to be approved by the Addictions Service, he called Ms D to discuss Mr A's new methadone prescription.

65. Ms D then called Dr B. Dr B told HDC:

> "[A]s the [Addictions Service] had no prior notice of any additional dosage or prescription by any other clinician, I telephoned [Hospital 1] straightaway to clarify the prescription. The prescriber, [Dr H], advised me that methadone was prescribed to help [Mr A] with abdomen pain and that there was no clear diagnosis or cause for the pain. [Dr H] was unaware of the script that [Mr A] already had for methadone (or the restrictive nature of it) or the NMDHB's policy on prescribing methadone for [Addictions Service] clients on hospital discharge. In addition, [Dr H] also advised me that [Mr A] had already been dispensed with a quantity of methadone from the hospital stock that morning. We agreed that the new script from the hospital should be cancelled."

66. Dr B stated that he considered that the prescription was a mistake, as no Addictions Service client would ever be approved to be dispensed all at once 14 days' worth of up to 300mg methadone per day, with no controls. He told HDC that he understood from his telephone call with Dr H that the methadone prescription had been issued in error. Dr B said: "It was therefore agreed with [Dr H] that [Addictions Service] would follow up the script." Dr B stated that he does not recall Dr H telling him to contact Dr G.

67. Dr H told HDC:

> "I recall explaining clearly that the methadone was for the purposes of pain relief, not addiction. I explained that [Dr B] could contact the on call physician for an opinion for any uncertainties. … As a [newly graduated doctor], getting a call from a senior doctor who is a specialist in [Addictions Service], I did not question [Dr B's] decision and advice. [Dr B] said [Addictions Service] would be responsible for the dispensing of methadone. I stated that I was unfamiliar with the methadone policy and hence I followed [Dr B's] instructions and cancelled the script and documented the plan on the clinical notes."

68. Dr H told HDC that his understanding was that, if there were any problems, Dr B would communicate directly with Dr G. After the telephone call, Dr H contacted the pharmacy and cancelled the script. Dr H recorded in the hospital clinical records: "[Addictions Service] to take over methadone dispensing NOT GP. → Prescription script cancelled." Dr H acknowledged that, in hindsight, it would have been better for him to have reported the cancelled prescription of 8 Month2 back to Dr G.

69. Ms D wrote on a copy of the cancelled script: "[Dr H] does not have the authority to prescribe opiates/methadone for Addiction (see [Misuse of Drugs Act]). Script withheld." In a joint response to HDC, Ms D and Dr B told HDC that Dr H's prescription was not dispensed at the pharmacy under their direction, as it was outside NMDHB policy and "the spirit of the Misuse of Drugs Act".

70. Mr I told HDC that, after he was instructed not to dispense the prescription, he advised Mr A of this and told him to return to ED immediately if he needed pain relief.

Follow-up of methadone prescription 9–16 Month2

71. Dr B did not follow up the methadone prescription when he returned to work on 9 Month2. He told HDC that he became aware that Mr C had been keeping in contact with Mr A and the hospital daily, and there was no indication from Mr C that Mr A might require methadone for analgesia. Dr B stated that usual practice is for the hospital team to liaise with Addiction Services at the time of admission, and he would have expected that any prescription changes had been discussed, and that any important information would be relayed to him. He told HDC that the Addictions Service should have been involved in the hospital discharge plan on 8 Month2, and that it has been the Addictions Service's practice for case managers to facilitate this communication, as part of their role is to act as a liaison between other NMDHB departments.

72. Dr B told HDC:

> "I was not alerted to any reason for me to change [the] view [that the hospital prescription was a mistake]. Because there was no indication I did not feel that re-checking the situation with the hospital was necessary. Indeed, I feel it would be unreasonable to expect that I would go back and re-check or follow up on prescriptions that were issued in error."

73. Dr B told HDC that the Addictions Service did not receive a copy of Mr A's discharge summary issued on 10 Month2. The discharge summary was viewable on Mr A's electronic clinical records. Dr B stated that there was no reason for the team to be concerned about Mr A's admission and that, if there had been a concern raised, he would have contacted Mr A and arranged to see him on 11 Month2, as he was in Town 1 that day.

74. On 11 Month2, Mr A was discussed at the weekly OST meeting. Mr C and Dr B were present. The minutes state:

> "Has an [appointment] to see [Dr B] next week. Seems fixated on having his dose increased to 200mg and obtaining [takeaway] [medications]. Team expressed concern that [Mr A] was prescribed 2 weeks worth of methadone tablets to [takeaway], at the weekend, by a House Surgeon at the Hospital. Fortunately, [Mr I], at [the pharmacy], refused to dispense this to [Mr A]. [Dr B] has contacted the House Surgeon to discuss our concerns around this as [Mr A] has talked about overdosing. [Mr A's] GP does not believe [Mr A] will be in as much pain as he is claiming. Team feel his request for increase and [takeaways] is more about drug seeking. [Mr A] to continue [on site] daily for time being."

75. Mrs A told HDC that, over this period, Mr A was in pain, and his condition was deteriorating quickly. Mr C told HDC that he continued to see Mr A most days between 9 and 16 Month2, but there is no documentation of these visits. Mr I stated that he saw Mr A once more after 8 Month2 and that, when Mr A indicated that he was in pain, he advised him to go to his GP or ED immediately.

76. Mr A was discussed again at the next OST meeting, at 10.45am on 16 Month2. Mr C and Dr B were present. It was recorded in the meeting minutes:

> "Still requesting to have his methadone increased to 200mg for pain. Is having an MRI in [Town 2] this afternoon. ? [Cancer] or Sarcoids. Has an [appointment] to see [Dr B] this week. [Dr B] is reluctant to increase his methadone, due to concern he is drug-seeking."

77. Dr B told HDC that it was agreed at the OST meeting that, as Mr A would be unable to attend the appointment with Dr B because of the MRI, Dr B would call him the next day to arrange another appointment time.

78. In the afternoon on 16 Month2, Mr A underwent an MRI. This could not be completed because he was unable to lie still, owing to pain. Mr A subsequently called Mr C to advise him of this. Mr C then emailed Dr B, relaying the information and stating:

> "[Mr A] said he is in great pain and needs an increase in his methadone. I advised him that you were intending to speak with him again and that nothing could be done for him today. He's just arrived back in [Town 1] and said he was going up to the hospital now to see if they could help him. I recommended he be seen at the hospital if he was not coping with his pain and they could assess him."

79. Dr B told HDC that this was the first indication he had that Mr A could be requiring methadone for clinical reasons, rather than the usual OST programme. Dr B stated that, until 16 Month2, he was not provided with any additional information about Mr A's medical condition that would affect his management of Mr A's methadone treatment.

Hospital 1 – from 16 Month2

80. At 4.48pm on 16 Month2, Mr A presented to ED at Hospital 1. The triage nurse documented that he was gasping for breath and that he and Mrs A both appeared very angry, "referring to lack of care at all the places where they asked for help". Mr A's pain scale score was 10/10.

81. Dr H reviewed Mr A and recorded:

> "[Patient] for MRI today but severe pain stopped this. Came to ED after unable to reach [Addictions Service doctor]. [Bilateral] spine pain [and] generalised [abdominal] pain. … Weight [decreased] 10–15kg last month. … More early [shortness of breath]. … Achy [abdominal] pain, constantly there. Feels can't get comfortable."

82. Dr H prescribed Mr A 180mg methadone per day, as well as 30mg up to every four hours, at a maximum of 120mg per day. Mr A reported improved pain control after the increase in methadone, but continued to experience pain.

83. Dr E told HDC:

> "[Mr A] and his family reported to me on their return [to hospital] that they were very unhappy with how and why his higher dose methadone had been declined at the pharmacy, and by how they had been treated by [Addictions Service] since that time. … [Mr A] was in a lot of pain on his return on 16 [Month2] and clearly now at the very end of his life. His analgesic requirements were high … system failures had led to [Mr A] not getting adequate analgesia, as had been intended and prescribed by his clinicians, between the period of discharge 8 [Month2], and readmission 16 [Month2]. I did express remorse to them and apologise at the system failings that had led to his suffering and their disappointment. I also said I regretted that [the family] had not contacted the hospital staff about this matter until 16 [Month2], choosing to only liaise with [Addictions Service], as we were unable to advocate for him when we were unaware of the problem."

84. On the morning of 17 Month2, Mr A called the Addictions Service and advised that he had been readmitted to hospital. Dr B later called Mr A and discussed his admission.

85. On 18 Month2, Mr A's condition deteriorated. Dr E reviewed him and advised him of his very poor prognosis, and that his care was to be taken over by palliative services. She increased his analgesia to 100mg of methadone twice a day, with 30mg up to every three hours for breakthrough pain. Mr A was referred to hospice, but no bed was available.

86. Also on 18 Month2, Dr F spoke to Dr B about Mr A. Dr B documented:

> "[Mr A's] condition has deteriorated quickly, and his prognosis is now looking poor. … it has been agreed that the opioid prescribing, including methadone, will now be guided and taken over by [Dr F], and [Addictions Service] will cease his [Addictions Service] methadone script."

87. A note was added to the OST meeting minutes from 16 Month2, stating: "MRI incomplete due to pain. Prognosis poor. Readmitted to Hospital and pain management handed over to his Physician."

88. Dr B told HDC that, until his telephone call with Dr F, he was not aware that there was a possible cancer diagnosis or a palliative care approach to treatment. Dr B stated:

> "Until I was aware of the need for [Mr A's] prescribing arrangements to change, my view was that [Addictions Service] was the appropriate prescriber for his methadone, given that [Addictions Service] was fully aware of [Mr A's] risks, […]. The hospital's physicians may not be aware of [Addictions Service] clients' issues such as these. It was not until 18 [Month2] when I became fully aware of [Mr A's] clinical situation that I believed [Mr A] should be discharged from [Addictions Service]."

89. Mr A was transferred to hospice on 20 Month2 and passed away shortly afterward. His death certificate listed the cause of death as hepatopulmonary syndrome, hepatoma with metastatic spread to lungs and peritoneum, and Hepatitis C.

Further information

Mrs A

90. Mrs A stated:

> "[Mr A's] family watched as this poor man limped around like a wounded dog in unbearable pain. We'll never forget. … [Mr A] suffered more than anyone could imagine, this being witnessed by his [family] and friends, most of whom have said, like myself, [that] those [images] are hard to deal with. In fact [I] have looked into [counselling] — as it's hard to move on from those unforgettable sights we had to witness."

Mr C

91. Mr C told HDC:

> "[Mr A] did indicate very early in his time in hospital that he did not want to talk about the 'department' and this was evident on a couple of occasions when family were present and they wanted to ask questions about [Addictions Service], [Mr A] told them '[Mr C's] not here for that, I asked him to come here as my friend'. … Over the years of being [Mr A's] clinician we had established a close therapeutic relationship … I did not record on [Mr A's] file a number of conversations we had as these were usually of a personal nature."

92. Mr C stated that he was not formally given information on Mr A's condition by hospital staff, but was present at times when hospital staff would update Mr A on his condition. Mr C stated that, in future, he will make a point of closer clinical liaison, and will draw his manager's attention to his case notes.

Dr B

93. Dr B told HDC that Mr A's history on the OST programme presented some risks of instability, which resulted in the Addictions Service being cautious regarding his prescriptions and dispensing. Dr B stated that, since September 2014, all of Mr A's methadone was prescribed to be consumed on site, with close control.

94. Dr B acknowledged that there was a regrettable breakdown in the expected sharing of clinical information between Hospital 1 and the Addictions Service. He stated that the Addictions Service relies on case managers to respond to clients' changing needs in the first instance. Dr B said:

> "This [breakdown in communication] may in part have been due to lack of clarity around the role of case manager in liaising with the hospital team regards their client, and then advocating and representing the client's needs to the [Addictions Service] multidisciplinary team, for action and response."

Dr H

95. Dr H expressed his condolences to Mr A's family. Dr H stated: "As a result of this case I am now aware of the methadone prescribing policy and am more vigilant in terms of understanding my patients dispensing details in regards to their methadone." Dr H said that he has learnt from these events and changed his practice accordingly.

Dr E

96. Dr E told HDC that she saw Mr C on many occasions during Mr A's admissions to Hospital 1. She stated: "It seemed reasonable then to assume [Mr C] was reporting back and keeping his [Addictions Service] colleagues up to date with [Mr A's] medical care."

97. Dr E told HDC that, in her view, there were a number of contributing factors in this case, including:

- It was hard to predict Mr A's analgesic requirements, as his conditions were numerous, rare, complex, rapidly progressing and not fully diagnosed, and it is uncommon for the same patient to have methadone for addiction and then palliation.
- It is usual practice for pharmacies to contact the prescriber to clarify scripts, rather than the Addictions Service.
- An opportunity to clarify that the purpose of the methadone prescription had changed from addiction to palliation of pre-terminal pain was missed during Dr H and Dr B's phone call. Addiction Services then did not access Mr A's discharge summary dated 10 Month2, which clarifies the prescribing intentions, or call any senior hospital clinicians for clarification.

98. Dr E stated that, in retrospect, this problem would have been avoided outright with a conversation at a senior clinician level at discharge, or anytime thereafter, between the Addictions Service or even between the pharmacy involved and Medical Services. She said:

> "On behalf of the Medical services, I apologise again to [the family] that [Mr A] and his family had a distressing experience under the DHB's care, and apologise that our systems allowed this to happen."

NMDHB

99. NMDHB told HDC that, over Mr A's time on the OST programme, there were numerous concerns. NMDHB stated that, as a result, decisions about Mr A's care were always made in consultation with the OST multidisciplinary team, and from a position of caution.

100. NMDHB also told HDC that, if a patient's GP is in the hospital system, the discharge summary should be sent to the GP automatically as an electronic copy. The Addictions Service would not routinely get a copy of discharge summaries.

101. NMDHB told HDC that, as a result of these events, it has made the following changes:

- All Addictions Service staff are now required to make notes in the hospital clinical records when visiting clients in the hospital, as well as make file notes for the Addictions Service file.
- Updates of clients in hospital are discussed weekly at OST meetings.

— A weekly meeting has been developed for Addictions Service medical and Addictions Service hospital liaison staff (including the Hospital 1 liaison nurse) to discuss clients in Hospital 2 and Hospital 1.
— Case managers in Town 1 have had their roles clarified regarding responsibility when their clients are admitted to hospital.
— Hospital staff have been reminded of the methadone policy for OST clients being admitted to, and discharged from, hospital.
— All verbal contact between Services regarding clinical care is documented in NMDHB's new electronic record system.
— Hospital staff have been reminded to inform Addictions Service staff when Addictions Service clients are admitted to hospital, and this is now incorporated into routine training.
— The electronic record system unifies record-keeping and discharge summary access across the DHB.
— Addictions Service staff have been reminded of protocols regarding lines of communication, and this is being monitored by senior staff.
— Work on handover of clients from outpatient to inpatient services and vice versa is ongoing, with the electronic record system streamlining handover, and the Addictions Service having a staff member on call to discuss patients out of hours.

Dr K

102. Dr K told HDC that Mr A's care was extremely complicated. Dr K stated that Mr A had a life-long history of opiate abuse and had been on methadone for many years. Dr K said that the Addictions Service took over his methadone and opiate analgesia prescribing, as he was considered unsuitable for supervision in general practice. Dr K stated that he was specifically requested by the Addictions Service not to supply Mr A with further opiates.

103. Dr K said that, other than on 23 Month1, Mr A did not request analgesia from him. Dr K stated that he never heard back from the Addictions Service following his voicemail message on 24 Month1, but was not worried because he was aware that Mr A was being investigated at Hospital 1.

Mr I and the pharmacy

104. Mr I stated that he is confident that he followed appropriate processes in the circumstances, and that Mr A was not without the option of obtaining pain relief through the correct channels. Mr I said that he followed local protocols for dispensing opioids to opioid-dependent clients.

105. The pharmacy's Standard Operating Procedure (SOP) "Methadone Dispensing"[46] states: "Check all the [prescription] details are correct and in accordance with legal requirements." The SOP also refers to NMDHB's clinical guideline "Methadone/Buprenorphine (with Naloxone) — Opioid Substitution Therapy for Treatment of Dependence (Addiction)".

[46] Issued 10 October 2007. Reviewed 30 November 2011 and 24 November 2014.

NMDHB clinical guidelines

106. NMDHB's clinical guideline "Methadone/Buprenorphine (with Naloxone) — Opioid Substitution Therapy for Treatment of Dependence (Addiction)"[47] states:

> "**On Admission**
> - Patients being prescribed Methadone, Suboxone (Buprenorphine/Nalaxone) or other opioids for dependence are not to receive their medications in a NMDHB hospital until their daily dose (in mg) has been confirmed with their Addiction Services case manager. This can be done by the doctor, pharmacist, or nurse, and should be documented in the patient's notes. Do not call the patient's community pharmacy unless the Addiction Service is unavailable to provide the information in a timely manner. When contacting Addiction Services, highlight you are calling from the hospital …
> - Medical Practitioners prescribing need to ensure that:
>   - The potential for overdose is minimised
>   - The patient is not unsafely intoxicated with other drugs (urine drug screen on admission is good practice) and
>   - The potential for diversion is limited.
> - It is the responsibility of Addiction Services to liaise with the community pharmacy to advise that the patient has been admitted to an NMDHB hospital. This is so extra supplies of methadone, buprenorphine (with naloxone) and any other medications prescribed by the Addictions Service, cannot be collected by the patient or a third party while the patient is admitted. Once they have confirmed details of medications prescribed through the Addictions Service, they will then contact the hospital prescriber. …
> - Patients receiving opioid substitution therapy should be prescribed analgesia for pain as for other patients. See NMDHB pain guideline or contact the on-call Addiction Medicine doctor (via the Operator) or an Anaesthetist for advice. …
>
> **On Discharge**
> - At discharge, contact the Addiction Service case manager or duty worker (if after hours ask switchboard to contact the after hours person as above), to advise of the discharge date and arrangements, and of changes to any medications prescribed by the Addictions Service. The Addiction Service will then arrange reinstatement supply in the community pharmacy from the day of discharge, in accordance with the updated medication regime."

107. NMDHB's clinical guideline "Pain Management — Adults"[48] states:

> "**For Advice** … If patient on methadone program, always discuss all admissions and extra analgesia requirements with [Addictions Service]. …
> **Acute Pain** … **Opioids** … Consult [Addictions Service] if methadone user. …

[47] Issued 1 February 2013. Reviewed September 2014.
[48] Issued 1 February 2013. Reviewed 1 July 2013.

> **Chronic Cancer Pain** … Opioids … Morphine first choice but in some situations use oxycodone[49] …, transdermal fentanyl,[50] methadone (not pethidine).”[51]

NMDHB position descriptions

108. NMDHB’s position description for the role of addictions clinician includes the following responsibilities:

> “**[A]ssess and counsel individuals … referring to inpatient treatment or other agencies as appropriate** … Ongoing professional counselling for clients … presenting client cases at weekly team meetings, conducting client evaluation, … up to date and appropriate case notes are maintained with a clear treatment plan …
>
> **Maintain Opioid Substitution caseload in accordance with the national and local Opioid Substitution Treatment protocols.** … Accurate up to date notes are kept of all interactions with clients.
>
> **Ensure proactive multi-disciplinary liaison with a range of agencies, … and maintain accurate documentation of clinical practice …** Ongoing liaison is maintained with a range of agencies in relation to mutual clients … Keep accurate up to date clear records in client files according to clinic procedures and protocol …”

109. NMDHB’s position description for the role of Addictions Service manager includes the following:

> “**Objectives:** …
> To ensure that the Alcohol and Drug Services delivered by Nelson Marlborough Health Services provide a range of options and choices for clients and their families, based on a comprehensive assessment of consumer need. …
>
> **2. Resource Management** …
> *Expected Results*
> — Effective management of staff …”

110. NMDHB’s position description for the role of addiction medicine specialist includes the following liaison responsibilities:

> “• Undertakes consultation and liaison services with other Mental Health Services and other Services within Nelson-Marlborough Health. Providing advice on management and/or participating in joint assessment and management of individuals having co-existing disorders and requiring care from other Services in addition to Alcohol and Drug Service.

[49] An opioid pain reliever.
[50] An opioid pain reliever in the form of a patch.
[51] An opioid pain reliever.

- Provides consultation and advice for general practitioners concerning assessment, diagnosis and management of individuals with substance use disorders."

Other relevant standards

111. The Ministry of Health's *New Zealand Practice Guidelines for Opioid Substitution Treatment* (2014) states:

> "**6.6 Management of acute and chronic pain**
> **6.6.1 Management of acute and surgical pain and the peri operative period**
> Addiction may precipitate neurophysiologic, behavioural and social responses that increase a person's experience of pain and complicate provision of adequate analgesia … These responses are heightened for clients receiving OST, for whom the neural responses of tolerance or hyperalgesia may increase their experience of pain. As a consequence, opioid analgesics are often less effective for these clients, and they require higher doses administered at shortened intervals. …
>
> Specialist services and primary care providers need to implement a clear policy or memoranda of understanding with hospitals in their region that outlines the protocols for planned and emergency admissions of clients on OST. …
>
> The OST provider can then liaise with the health professionals involved to advise them of the client's current OST and pain management. Service providers should ensure the client's medication, dose and dispensing details are correctly documented, in order to avoid dose error or double dosing. …
>
> In the case of an emergency admission where a client's OST provider is unavailable, hospital staff should contact the client's pharmacy when the client is next due to consume on the premises. Hospital staff should not dispense any doses of OST medication until they have confirmed both the current dose and the last dose dispensed with the pharmacy.
>
> If a client requires a prescription for opioid analgesia on discharge from hospital, hospital staff should liaise with the client's specialist service or primary care provider, and the medication should reduce in a timely manner. Discharge planning should ensure a smooth transition back to the previous OST regime.
>
> Note: Any medical practitioner can prescribe a controlled drug for a person with a substance dependence who requires opioids for reasons other than treating opioid dependence. Such prescribing must take into account the risk of aberrant behaviour, so controlled dispensing (eg, dispensing daily or three times a week) should be considered the norm.

Analgesia for clients on methadone
Opioid substitution medications provide little, if any, analgesia for acute pain because of clients' increased opioid tolerance. Most clients receiving methadone treatment cannot achieve effective pain relief through conventional doses of opioids."

Responses to provisional opinion

112. The parties were provided with the relevant sections of the provisional opinion for comment.

NMDHB

113. In response to the provisional opinion, NMDHB stated:

> "… [NMDHB agrees that] this is a fair finding and acknowledge that at numerous points along the journey of care [Mr A] suffered from disconnected services that did not secure adequate communication to address his needs …
>
> [E]ach service did their best to manage the need they saw, pain, investigations or substance abuse; unfortunately his needs across the three domains were not met together … These challenges arose from a whole variety of causes related to our systems of care and work has already been going on for some time to improve the communication, particularly between the drug and alcohol services and other clinical services with shared health records. As with most system issues, a large number of people were involved in the services that did not support [Mr A] adequately."

114. NMDHB noted that the person who was due to cover Dr B's role while he was on leave was not present, owing to an accident, "so other staff members were left with a multi-disciplinary team not supported by appropriate medical input". NMDHB stated that on return from leave Dr B continued care, basing his decision on "information that turned out to be inaccurate or incomplete".

115. NMDHB acknowledged that each of the services involved in Mr A's care responded only to the parts of the problem they saw. NMDHB submitted that the root of the problems outlined in the report was the "significant challenges within the systems of care across services within [NMDHB] for which it is appropriate you find [NMDHB] in breach".

The Addictions Service

116. The Addictions Service stated that it regrets the issues that arose in the care of Mr A, and would like to "extend a full apology to [Mr A's] family for the unnecessary pain [Mr A] was subjected to in his final weeks".

117. In responding to the provisional opinion, the Addictions Service stated:

> "[The Addictions Service] failed to provide the individual clinicians involved with [Mr A] with adequate information to assist the team to identify who the clinical lead was for [Mr A] as his clinical presentation, diagnosis, symptoms and medical needs changed over time. The system was not flexible so was not able to respond to needs of [Mr A] as they changed."

118. The Addictions Service outlined a number of system changes that have been put in place, including:

- Addictions Service notes now on the same patient management system as clinical services;
- Clear communication points and protocols with Charge Nurse Managers in inpatient and addictions services; and
- Ensuring that all clinicians contribute to clinical notes when they see a patient in the clinical services setting.

119. In the provisional opinion it was recommended that NMDHB implement a weekly meeting for Addictions Service medical and Addictions Service hospital liaison staff to discuss clients in Hospital 1, as occurs for Hospital 2. In response to the provisional opinion, the Addictions Service advised that this is now occurring in both hospitals.

Dr B

120. Dr B provided the following submissions:

- The hospital failed to adequately liaise with the Addictions Service regarding Mr A's ongoing care and pain management;
- Whatever knowledge was conveyed to the Addiction Service was held by Mr C or Ms D, neither of whom relayed an accurate clinical picture to Dr B. Dr B understood Mr A was likely to be drug seeking and had been told to see his GP or ED for pain relief; and
- The Addictions Service was not responsible for pain management.

121. In relation to his conversation with Dr H, Dr B stated that he was left with the impression that the prescription issued was a mistake, and that "there was nothing serious going on with [Mr A] at that stage". While Dr H advised that the prescription was for pain, Dr B told HDC that what was conveyed was a "vague reference to an unspecified abdominal pain", with no clear diagnosis. Dr B submitted that it is very common for patients such as Mr A "to complain about pain, as pain is a typical medical symptom of opioid withdrawal in opioid dependent patients. The initial clinical consideration in that scenario … is to consider whether their tolerance to opioids has changed for some reason".

122. Dr B also stated that when he told Dr H that the Addictions Service would follow up on the script, he meant that the Addictions Service would take responsibility for OST prescribing, not for pain.

123. Dr B noted that there was no formal liaison with the hospital at that time, and that "there must be a threshold before the Addiction[s] Service is required to make further enquiries". He noted that the information available to him at the time "was insufficient to put him on notice of any serious clinical situation that [Mr A] may have been facing".

124. In relation to Mr A's discharge from hospital on 10 Month2, Dr B submitted that it was relevant that Mr A's discharge was not communicated directly to the Addictions Service. While Dr B accepts that the discharge summary was available electronically, in his view it was "neither practice nor an achievable expectation" that he review discharge summaries routinely.

125. Dr B also provided a report from consultant psychiatrist Dr L in response to the expert advice provided to the HDC. Dr L stated that, in his view, careful management of methadone is important and caution necessary in patients with a "past history of, or likelihood of, misuse of their methadone".

126. Dr L also observed that the primary role of addiction specialists is to manage addiction. He noted that there is no clear record that Mr C made Dr B aware of Mr A's possible diagnosis, and expressed the view that Dr B provided Mr A with the "appropriate standard of addictions care up until this became obsolete …"

127. Dr L noted that improved communication between the medical parties, including Dr B, would have potentially improved Mr A's care. However, Dr L noted that the responsibility for this communication did not lie solely with one practitioner.

Opinion: Introduction

128. Mr A was a long-term OST patient under the care of the Addictions Service at NMDHB. Mr A was experiencing pain after a fall, and due to other complications including possible cancer. During Month1 and Month2, Mr A presented to his GP and the ED at Hospital 1 seeking pain relief. After being discharged from Hospital 1 on 8 Month2, he was prescribed an increase in his methadone by physicians at Hospital 1. Mr A presented his prescription to pharmacist Mr I, who declined to dispense it after discussion with the Addictions Service. On 16 Month2, Mr A was unable to complete an MRI owing to severe pain, and was readmitted to Hospital 1. Subsequently, Mr A was transferred into hospice care, and died shortly afterward.

129. This opinion considers the care provided to Mr A in Month1 and Month2, including the breakdown in communication between the Addictions Service and Hospital 1. During the course of this investigation, no concerns were identified regarding the care provided by Dr K or Mr I.

Opinion: Nelson Marlborough District Health Board — breach

130. District health boards are responsible for the operation of the clinical services they provide, and can be held responsible for any service-level failures.[52] While individual Addictions Service and Hospital 1 staff hold a degree of responsibility for their individual failings, taking into account the number of staff involved in the inadequate care provided to Mr A, I consider that NMDHB holds responsibility at a systems level for the suboptimal co-operation among providers.

131. NMDHB acknowledges its responsibility in that regard, and has accepted the criticism about NMDHB contained in this report.

Confirmation of methadone dose 15–16 Month1

132. On 15 and 16 Month1, Mr A was administered 155mg of methadone by Hospital 1 staff, without the dose having been confirmed. Later on 16 Month1, a hospital pharmacist confirmed the dose with the pharmacy.

133. NMDHB's OST clinical guideline states that OST patients are not to receive their medication in hospital until their daily dose has been confirmed with their Addictions Service case manager, and that the patient's community pharmacy should not be called unless the Addictions Service is unavailable.

134. The Ministry of Health's OST guideline states that specialist services need to have a clear policy with hospitals in regard to emergency admissions of clients on OST, to enable the OST provider to advise hospital staff of the client's current OST management. It also states that, when a client's OST provider is unavailable, hospital staff should contact the client's pharmacy, and that no doses of OST medication should be dispensed until the dose has been confirmed.

135. I am concerned that Mr A was administered two doses of 155mg methadone (on 15 and 16 Month1), before this dose was confirmed. Further, the dose should have been confirmed with Mr C in the first instance, rather than with the pharmacy. This also would have served to inform Mr C that his client was in hospital, rather than relying on Mr A to inform him.

Liaison between Hospital 1, the Addictions Service, and Dr K, 14–20 Month1

136. Mr A contacted Mr C on 17 Month1 and informed him that he had been admitted to hospital. Mr C visited Mr A daily during the remainder of his admission, but told HDC that he was never formally given information on Mr A's condition by hospital staff, but was present at times when hospital staff would update Mr A on his condition.

137. Dr E's documented management plan from 18 Month1 included discussion with the Addictions Service regarding Mr A's methadone dose, but it is unclear what discussion, if any, occurred.

[52] See 14HDC00766.

138. On 17 and 18 Month1, Mr C informed Ms D of Mr A's admission, investigations for liver cancer, and request for his methadone to increase back up to 200mg. The OST meeting minutes from 18 Month1 state that Mr C was to follow up the need for an increase with a hospital physician. There is no record of this occurring, but Mr A's methadone was increased from 155mg to 160mg by a house officer on 19 Month1.

139. The OST Coordinator informed Dr J that Mr A was to be discharged the next day, and Dr J wrote a new community prescription for Mr A for the increased dose.

140. Mr A's discharge summary stated that there were suspicions of malignancy, and also that Mr A had abdominal pain, likely related to his fall, and that his GP should follow this up. However, the discharge summary was not sent to Dr K. Dr K told HDC that he was therefore not aware that Mr A was for GP follow-up. Mr C updated Ms D about Mr A's increased prescription for methadone and discharge at the OST meeting on 25 Month1.

141. I am critical that Mr A's discharge summary was not sent to Dr K, particularly as it requests GP follow-up.

Liaison between Addictions Service and Dr K, 23–25 Month1

142. Dr K stated that, on 23 Month1, Mr A did not specifically ask for any extra analgesia, but he (Dr K) felt that Mr A required it. The next day, Dr K recorded that he had called Ms D and left a message stating that he wanted to increase Mr A's methadone by 5mg per day back to 200mg, rather than prescribe morphine, owing to the potential for abuse. Dr K told HDC that he informed the Addictions Service that Mr A had been injured, and that they needed to reassess his analgesia requirements. On 25 Month1, Dr K prescribed Mr A six morphine tablets for breakthrough pain. Dr K recorded that he had had no contact from Ms D.

143. Ms D was aware from Mr C that Mr A had been admitted to hospital, was being investigated for liver cancer, was requesting an increase in methadone back to 200mg, and had received an increase from the hospital from 155mg to 160mg. Ms D documented a telephone call with Dr K on 25 Month1, stating that Mr A had presented to Dr K stating that he needed more pain relief, that Dr K had reluctantly prescribed six tablets of morphine, that Dr K did not believe Mr A's pain was the result of liver issues, and that there was no indication that further pain medication was required. Ms D told HDC that Dr K told her that Mr A's leg injury did not require the amount of analgesia he was seeking.

144. Ms D did not read Mr A's discharge summary of 20 Month1, which was viewable electronically. Mr A's discharge summary sets out his clinical issues, including queried malignancy, and that end-of-life care had been discussed. The discharge plan included GP review of Mr A's abdominal pain and pain relief.

145. My expert advisor, general physician and addiction specialist Dr Geoffrey Robinson, advised that, if Dr K had requested a management plan to increase Mr A's methadone in light of possible disseminated cancer, he would have expected a more urgent

response from the Addictions Service (such as review by Dr J or a case conference between the hospital, Dr K, and the Addictions Service).

146. I am concerned that Dr K and Ms D have such different records and recollections of their contact between 23 and 25 Month1. Given the different versions of events, I am unable to make a finding as to what occurred. I consider that it would have been prudent for Ms D to have read Mr A's discharge summary, before liaising about his pain management.

Liaison between Hospital 1, Dr K, and Addictions Service, 27 Month1

147. On 27 Month1, Mrs A called Mr C to advise that Mr A was still experiencing significant pain. Mr C documented that he advised Mrs A of Ms D's conversation with Dr K, and that an appointment had been made for Mr A to be reviewed by Dr B on 16 Month2. Mr C recorded that he advised Mr A to see Dr K again if he was in significant pain. Mr C did not communicate with Ms D or Dr J about this telephone call at the time, but updated Ms D at the OST meeting on 4 Month2.

148. Also on 27 Month1, Mr A presented to ED at Hospital 1 in pain. He was given morphine, but declined the offer of admission. The medical record, which was not sent to Dr K or the Addictions Service, stated that Mr A had been having lower abdominal pain. Mr A was prescribed a further 40x 20mg tablets of morphine on discharge.

149. In regard to Mrs A's telephone call of 27 Month1, my expert advisor, addiction practitioner Ian MacEwan, advised:

> "Given that [Mr C's] manager had been in contact with the GP about the level of medication, two days earlier, [Mr C's] response to [Mrs A] seems appropriate. As the presenting problem from [Mrs A] was about levels of medication, this would be outside of [Mr C's] scope and any new clinical assessment would be appropriate for a medical officer. … Given his manager's involvement, it would have been better had [Mr C] drawn her attention to his file note."

150. Mr MacEwan stated that Mr C failing to inform Ms D of the telephone call was not a significant departure from the standard of care, but reiterates the importance of clinical liaison. I accept Mr MacEwan's advice that Mr C's response to Mrs A's telephone call of 27 Month1 was appropriate, although it would have been better if he had informed Ms D of it at the time. I note that Ms D was made aware at the OST meeting on 4 Month2.

151. With regard to Mr A's presentation to ED, I am concerned that the medical record was not sent to Dr K or to the Addictions Service. Information sharing is important for coordination of care and, in this case, would have alerted both Mr A's GP and the Addictions Service to the level of pain Mr A was experiencing, and the fact that he had been prescribed morphine for pain. I consider this a missed opportunity.

Methadone takeaway/transfer request form, 5 Month2

152. On 5 Month2, an Addictions Service methadone takeaway/transfer request form was completed for Mr A, requesting takeaways and an increase in dose. "Declined" was circled on the form. There is no documentation of Mr A making this request, who completed the form, or the reason for it being declined. NMDHB was asked for this information and responded that it had no further comment.

153. I am critical that there is no documentation of the reasons for Mr A's request being declined, and that NMDHB was unable to provide this information. Thorough contemporaneous documentation is important, including to inform other providers involved in a consumer's care.

Liaison between Hospital 1 and the Addictions Service, 5–8 Month2

154. On 5 Month2, a hospital pharmacist contacted Mr C to confirm Mr A's methadone dose. The next day, Mr C emailed Ms D, stating that Mr A had been readmitted to hospital with pain, and that a doctor wanted to increase his methadone and would call her to discuss this. Ms D replied, stating: "I have talked to [Dr B] about this and with his shortness of breath we should be looking at reducing his methadone not increasing it." Dr B told HDC that Ms D did not discuss increasing Mr A's methadone dose with him on 6 Month2, and that her comment in the email referred to a clinical discussion held prior to Mr A's first admission, in relation to Mr A's shortness of breath over the preceding 12 months. She told HDC that she was not contacted by hospital doctors, so did not take any further action. On 6 Month2, Dr F increased Mr A's methadone dose from 160mg per day to 180mg per day. Dr F also prescribed 30mg methadone to be given up to four times a day (up to a maximum dose of 120mg per day), for breakthrough pain. Dr F told HDC that the increased methadone dose was for palliative care.

155. At the morning ward round on 8 Month2, Dr G recorded: "[Plan]: 1. [Discharge] today. 2. GP [review] in 2/52 for [regular] analgesia dispensing." Mr A was later discharged with a two-week prescription for methadone 180mg per day plus 30mg up to four times daily, written by Dr H. The prescription was not annotated as being for pain. Neither Dr G nor Dr H contacted the Addictions Service about Mr A's discharge. Dr G acknowledged that there was a breakdown in communication between the hospital and the Addictions Service, and stated that Mr A being discharged on a Sunday by a junior doctor probably contributed to this.

156. Dr G told HDC:

> "The discharge plan was for him to go home on his usual dose of Methadone with extra doses as required, and to have follow up with [Dr E] (as previously planned) and also his GP, both of whom would be able to evaluate his pain control. The Palliative care team were also going to assist with his ongoing management. … This seemed to be a reasonable short term plan regarding his pain management and followed usual practice for a patient with severe pain due to a likely malignancy."

157. Dr H stated that he discharged Mr A as per Dr G's instructions. Dr H said: "As the methadone dose had changed while he was in hospital, I provided him a prescription for this. I was unaware that [Mr A] was on daily dispensing of methadone or that it was usually prescribed by [the Addictions Service]."

158. NMDHB's OST clinical guideline states that, for OST patients admitted to hospital, the Addictions Service is to be advised of the discharge date and arrangements, and of any changes to medications prescribed by the Addictions Service, for the Addictions Service to reinstate a community prescription. NMDHB's clinical guideline "Pain Management — Adults" states that, for OST patients, all admissions and extra analgesia requirements should be discussed with the Addictions Service.

159. The Ministry of Health's OST guideline states that any medical practitioner can prescribe a controlled drug for a person with a substance dependence who requires opioids for reasons other than treating opioid dependence, but that such prescribing must take into account the risk of aberrant behaviour, so controlled dispensing should be considered the norm.

160. Dr Robinson advised: "[T]he optimal way to achieve analgesia in methadone maintenance patients is to use increased doses of methadone." However, he also stated that the discharge planning in terms of liaison with the Addictions Service around the methadone prescribed on 8 Month2 was inadequate. Dr Robinson concluded that the lack of communication between the hospital and the Addictions Service about Mr A's changing clinical situation and pain relief needs constituted a moderate departure from accepted standards.

161. Furthermore, Dr Robinson advised that Mr A's discharge prescription needed to clearly identify the indication for additional opioids and that it was replacing the usual Addictions Service prescription. Dr Robinson stated: "Clearly a prescription for 14 days single supply is inappropriate for a patient already on methadone for long-standing drug dependency where frequent dispensing is the norm."

162. Nonetheless, Dr Robinson concluded that the care provided by Dr H was reasonable, given his position and experience. Dr Robinson stated:

> "[Dr G] appears to have given [Dr H] less than adequate support and supervision over a complex controlled drug discharge prescription situation. My experience is that such early stage interns are not yet fully familiar with opioid and controlled drug regulations and requirements. [Mr A] was not one of [Dr H's] usual patients, and he would not likely have known of the [Addictions Service's] role in opioid management as a weekend house surgeon."

163. However, Dr Robinson also concluded that the care provided by Dr G was reasonable, taking into account his explanation about the planned follow-up.

164. I accept Dr Robinson's advice, and consider that it was appropriate for Mr A to have been prescribed increased methadone, for analgesia. I consider that Dr H should have annotated his prescription as being for pain and as replacing the existing Addictions

Service script. Furthermore, I agree that it was inappropriate to prescribe 14 days' worth of the increased dose to be dispensed all at once, given Mr A's history and the Ministry of Health guidelines that controlled dispensing should be considered the norm. In this respect, I consider that Dr G should have provided closer supervision to Dr H in regard to Mr A's discharge.

165. Furthermore, Hospital 1 staff should have contacted the Addictions Service to discuss the increase in methadone on 6 Month2 and the discharge arrangements for 8 Month2 in accordance with NMDHB's and the Ministry of Health's guidelines.

166. Nonetheless, I am also concerned at Ms D's lack of follow-up and escalation, after she was informed on 6 Month2 that Mr A had been readmitted to hospital with pain and that a doctor might call her to discuss increasing his methadone. I acknowledge that hospital staff did not liaise with the Addictions Service adequately, but I consider that Ms D should have been more proactive and contacted the hospital when she did not receive a telephone call from them.

167. Discounting the possibility of increase to Mr A's dose in her communication with Mr C without escalating the issue to an Addictions Service doctor — for the doctor to make decisions about Mr A's methadone prescription — was inappropriate.

168. While I note that the Addictions Service has acknowledged that its failure to arrange adequate leave cover for Dr B contributed to the issues identified in this report, my concern in this matter remains.

Cancellation of discharge prescription, 8 Month2

169. Dr B called Dr H to discuss Mr A's discharge prescription. According to Dr B, Dr H advised that the methadone was to help with Mr A's abdominal pain, for which there was no clear diagnosis. Dr B submitted that it is very common for patients such as Mr A "to complain about pain, as pain is a typical medical symptom of opioid withdrawal in opioid dependent patients. The initial clinical consideration in that scenario … is to consider whether their tolerance to opioids has changed for some reason."

170. Dr H was unaware of Mr A's existing script or NMDHB policy on prescribing methadone, and it was agreed that the discharge prescription should be cancelled. Dr B stated that he considered that the prescription was a mistake, as no Addictions Service client would ever be approved to be dispensed 14 days' worth of up to 300mg methadone per day, with no controls. He stated that it was agreed with Dr H that the Addictions Service would follow up the prescription. In response to the provisional opinion, Dr B stated that he meant that the Addictions Service would take responsibility for OST prescribing, not for pain management. Dr B told HDC that he does not recall Dr H telling him to contact Dr G.

171. Dr H told HDC that he recalls stating that the methadone was for pain relief, not addiction, that Dr B could contact the on-call physician if he had any concerns, and that he (Dr H) was unfamiliar with NMDHB's methadone policy. Dr H stated that Dr B advised that the Addictions Service would be responsible for Mr A's methadone. Dr

H recorded in the hospital clinical records: "[Addictions Service] to take over methadone dispensing NOT GP. → Prescription script cancelled."

172. Dr Robinson advised that it was appropriate to cancel Mr A's discharge prescription, given the lack of control over the dispensing. Dr Robinson stated that, while the care provided by Dr H was reasonable, given his position and experience, he should have informed Dr G or Dr F that the prescription had been cancelled, so that they were aware that Mr A's methadone had not been increased as intended.

173. Dr Robinson also stated that the discussion between Dr H and Dr B presented an opportunity for analgesia discussion between the hospital and the Addictions Service.

174. I accept Dr Robinson's advice that it was appropriate in the circumstances for Dr H to cancel Mr A's discharge prescription. However, I consider it suboptimal that this resulted in Mr A not receiving adequate analgesia between 9 and 16 Month2. I also consider that Dr B and Dr H's communication on 8 Month2 was a missed opportunity for discussion about Mr A's condition, his pain, and the pain relief he required, which in turn resulted in Mr A not receiving adequate analgesia between 9 and 16 Month2. This is a further example of the suboptimal communication between Hospital 1 staff and Addictions Service staff.

175. Further, I consider that it would have been prudent for Dr H to have informed Dr G or Dr F of the cancelled prescription (although I acknowledge that he did document in the clinical records that the prescription had been cancelled).

176. I also note Dr Robinson's advice that "[n]otwithstanding the importance and good stewardship over prescribed controlled drugs, there appears to be possible issues relating to accessibility and responsiveness, somewhat autocratic process, and communication".

177. On the afternoon of 8 Month2, Mr A presented his discharge prescription to the pharmacy, who contacted Ms D. Ms D was aware from Mr C that Mr A had been prescribed further morphine for pain, and that he had been admitted to hospital recently, and had stated that a doctor wanted to increase his methadone. Ms D called Dr B, who called Dr H. Following discussion with Dr B, Dr H cancelled the prescription.

178. Ms D wrote on a copy of the cancelled script: "[Dr H] does not have the authority to prescribe opiates/methadone for Addiction (see [Misuse of Drugs Act]). Script withheld." In a joint response to HDC, Ms D and Dr B told HDC that Dr H's prescription was not dispensed at the pharmacy under their direction, as it was outside NMDHB policy and the spirit of the Misuse of Drugs Act.

179. I am concerned that Ms D's annotation on the prescription, as well as Ms D's and Dr B's explanation for it, demonstrate their failure to consider that Dr H's prescription was for pain relief, rather than for addiction. The Addictions Service's clinical records, the OST meeting minutes, and the Addictions Service's responses to HDC indicate a firmly held assumption that Mr A did not require additional methadone for

pain, and in asking for this was drug-seeking, despite evidence against this. I acknowledge that Mr A's history mandated a need for caution in prescribing and dispensing to him; however, in my view, the Addictions Service's actions were overly cautious. There was a demonstrable lack of clear, unbiased consideration of Mr A's condition, and, as a result, Mr A was unable to address his need for pain relief adequately.

Follow-up of discharge prescription, 9–16 Month2

180. Dr B told HDC that, when he returned to work on 9 Month2, he became aware that Mr C had been keeping in contact with Mr A and the hospital daily, and there was no indication from Mr C that Mr A might require methadone for analgesia. Dr B stated that he was not alerted to any reason for him to change the view that the hospital prescription was a mistake, so he did not feel that re-checking the situation with the hospital was necessary.

181. Dr B told HDC that the Addictions Service did not receive a copy of Mr A's discharge summary issued on 10 Month2. The discharge summary was viewable on Mr A's electronic clinical records. In response to the provisional opinion, Dr B accepted that the discharge summary was available electronically, but stated that it was "neither practice nor an achievable expectation" that he review discharge summaries routinely. Dr B also noted that Mr A's discharge was not communicated directly to the Addictions Service.

182. On 11 Month2, Mr A was discussed at the weekly OST meeting. The minutes state: "Team feel his request for increase and [takeaways] is more about drug seeking." Mr A was discussed again at the next OST meeting, at 10.45am on 16 Month2. It was recorded in the meeting minutes: "Still requesting to have his methadone increased to 200mg for pain. … [Dr B] is reluctant to increase his methadone, due to concern he is drug-seeking."

183. In the afternoon on 16 Month2, Mr C emailed Dr B, stating that Mr A's MRI had been unable to be completed owing to pain, and that Mr A needed an increase in methadone, and that Mr C had recommended that Mr A present to ED if he was not coping with his pain. Dr B told HDC that this was the first indication he had that Mr A could be requiring methadone for clinical reasons, rather than the usual OST programme.

184. With regard to Mr C, Mr MacEwan stated that it is not easy to form a view as to the adequacy of Mr C's liaison after 5 Month2, given the lack of documentation. Mr MacEwan advised that case managers are expected to provide liaison with other professionals involved with the client. He stated:

> "It appears that information was passing between medical staff and may have been bypassing [Mr C], especially in relation to the deterioration in [Mr A's] health. It is not clear whether [Mr C] attempted to make sure that he fully understood [Mr A's] condition."

185. Mr MacEwan further stated that while it was understandable that notifying his manager about proposed changes in medication might have been seen as sufficient, it would have been better if Mr C had ensured that Dr B, on his return to work, was given the information relating to Mr A.

186. In regard to Mr A's telephone call of 16 Month2, Mr MacEwan advised that informing Dr B of developments and advising Mr A of a reasonable course of action if he had concerns was consistent with accepted practice.

187. With regard to Dr B, Dr Robinson advised:

> "[Dr B] had a duty of care and ethical responsibility to follow up on the issue of the increased dosage which he had cancelled and potentially jeopardised pain control. … I would judge his failure to follow up on this issue as a mild–moderate departure from the standard of care, which should be to ensure terminally ill patients in pain have successful analgesia, or arrange for other medical practitioners to assume such oversight."

188. In response, Dr B reiterated that he was not aware of the level of Mr A's pain prior to 16 Month2. Dr B stated that the Addictions Service was not responsible for Mr A's pain management. Dr L gave an opinion that improved communication between the medical parties would have potentially improved Mr A's care, and acknowledged that the responsibility for this communication did not lie solely with one practitioner.

189. I acknowledge that Dr B had discussed the prescription with Dr H and was satisfied that the prescription was issued in error; and that he was not informed by Mr C or Ms D that Mr A required additional methadone for analgesia.

190. I accept Mr MacEwan's advice that Mr C's response to Mr A's telephone call of 16 Month2 was appropriate. I am concerned that Dr B did not take any action to follow up or enquire about Mr A's condition prior to 16 Month2. Dr B was aware of the request for an increased dose of methadone on 11 Month2, which was consistent with the prescription previously issued by Dr H. I am also concerned at Mr C's lack of effective communication with other Addictions Service staff and with Hospital 1 staff. I consider that he should have been more proactive in liaising between the hospital and the Addictions Service, particularly after Mr A's discharge prescription was cancelled. Mr C was aware that Mr A was experiencing pain, and that hospital staff had wanted to increase Mr A's methadone for analgesia, but did not convey this information to the Addictions Service adequately (although he discussed Mr A's case at weekly OST meetings and emailed Ms D on 6 Month2), or liaise with hospital staff.

191. However, despite these concerns, I note the DHB's statement that Mr A suffered from disconnected services that did not secure adequate communication to address his needs, and acknowledge Dr L comments that improved communication between the medical parties would have potentially improved Mr A's care. In this respect, I also accept that responsibility for this did not lie solely with one practitioner.

192. I note the improvements that have been put in place by the Addictions Service, and trust that in the future these changes will mitigate against the concerns identified in this case.

Documentation

193. Few of Mr C's interactions with Mr A between 14 Month1 and 20 Month2 are documented. Mr C told HDC that these conversations were not recorded because they were of a personal nature.

194. Mr MacEwan advised that it is essential practice to record fully all actions relating to client contact. He also stated:

> "[It appears] an element of informality had entered the client–practitioner relationship, which though not unethical can have unintended consequences such as happened here with unrecorded conversations and, potentially, a more relaxed regard to developments. The point being made is the importance of maintaining the therapeutic and case management focus between practitioner and client."

195. I accept Mr MacEwan's advice. I am concerned that an element of informality had entered Mr C's relationship with Mr A. In this case, the informal nature of Mr C's relationship with Mr A meant that Mr C did not record a number of interactions. This had the unintended consequence that important information was not passed on to other providers involved in Mr A's care. Thorough contemporaneous documentation is important, including in order to inform other providers involved in a consumer's care. Again, I note that the Addictions Service has made improvements in this area through the use of electronic systems.

Conclusion

196. In my view, there were a number of ways in which NMDHB failed to provide services to Mr A with reasonable care and skill. A number of staff were involved in these failures and, accordingly, I find them to be service-level failures directly attributable to NMDHB.

197. NMDHB failed to ensure documentation of communication when it did occur, or to document adequately crucial bases for decision-making in relation to Mr A; and it failed to identify and/or address an overly cautious approach being taken to the management of interactions with Mr A. There were a number of missed opportunities for communication about Mr A's situation, his condition, and his pain relief requirements, as a result of the system-based failures attributable to NMDHB, including through the failure to ensure that discharge information was provided to the relevant parties. Central to this is the fact that Mr A did not receive the pain relief that he should have been able to access. As a result of all of these factors, I find that NMDHB breached Right 4(1) of the Code.

Recommendations

198. I recommend that NMDHB undertake the following actions and report back to HDC on each action, within three months of the date of this report:

a) Develop a process for formal handover of Addictions Service clients when they move from outpatient to inpatient services and vice versa.

b) Develop, as part of the process above, a policy requiring hospital discharge summaries for Addictions Service clients to be emailed to the Addictions Service on discharge; and for all related contact between the Addictions Service and other services to be documented.

c) Conduct an audit over a one-month period to ensure that all interactions with clients are recorded in Addictions Service records and/or, if relevant, clinical records.

d) Review and revise, as necessary, the position descriptions for Addictions Service staff referred to within this report, to ensure clarity of role expectations, professional development, and support.

199. In addition, I recommend that NMDHB:

e) Conduct a random audit of Hospital 1 discharge summaries over a one-month period to assess compliance with the requirement that hospital discharge summaries be sent to relevant GPs, and report back to HDC on the outcome of this audit within three months of the date of this report.

f) Provide refresher training for all Hospital 1 staff on the "Methadone/Buprenorphine (with Naloxone) — Opioid Substitution Therapy for Treatment of Dependence (Addiction)" and "Pain Management — Adults" guidelines, and provide evidence to HDC, within six months of the date of this report, that this has occurred.

g) Provide a written apology to Mr A's family. The apology should be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

Follow-up actions

200. A copy of this report with details identifying the parties removed, except the experts who advised on this case and NMDHB, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name in covering correspondence.

201. A copy of this report with details identifying the parties removed, except the experts who advised on this case and NMDHB, will be sent to the Australasian Chapter of Addiction Medicine (Royal Australasian College of Physicians) and the Addiction Practitioners Association Aotearoa New Zealand, the Director of Mental Health, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent general physician and addiction specialist advice to the Commissioner

The following expert advice was obtained from general physician and addiction specialist Dr Geoffrey Robinson:

> "Thank you for asking for my opinion as an Independent Advisor on matters raised by the Investigation of this complaint.
>
> My name is Geoffrey Robinson and I am a registered medical practitioner (Medical Council 7585). I have been asked to provide independent advice to the HDC on several other cases in the past, and I am familiar with the HDC 'Guidelines for Independent Advisors'.
>
> My qualifications are Fellow of the Royal Australasian College of Physicians (FRACP), and Fellow of the Chapter of Addiction Medicine of this College, (FAChAM). I trained in General Internal Medicine and Addiction Medicine, the latter initially by way of a two year residency programme in Addiction Medicine offered by the Addiction Research Foundation Clinic Institute, Toronto, Canada 1978–1980. On return I practised General Medicine and Addiction Medicine at Capital and Coast DHB (CCDHB) as a specialist physician. Since 2005 I have been the Chief Medical Officer at CCDHB. Since this time my addiction practice has been in the Medical Detoxification Service. Prior to that, I worked half time in the Outpatient Alcohol & Drug Service. I am familiar with opioid substitution treatment and the legal and protocol frameworks, and continue to be involved in regular peer review group for addiction doctors.
>
> I have been asked to review provided documents relevant to the Investigation and in particular: '*Provide your opinion on whether the care provided to [Mr A] by the Nelson Marlborough District Health Board as a whole was reasonable in the situation. In particular, please comment on:*
>
> *Whether or not it would be reasonable for a patient in similar circumstances to wait one month for review by Alcohol and Other Drugs Service (AOD)s;*
>
> *Whether the level of staff cover appears reasonable, given the difficulties other clinicians reported in discussing [Mr A's] case with Alcohol and Other Drugs Service (AOD)s;*
>
> *Whether the level of communication between Alcohol and Other Drugs Service (AOD)s and other DHB Departments appears adequate;*
>
> *Whether it is reasonable to expect Alcohol and Other Drugs Service (AOD)s to have been more responsive to [Mr A's] changing needs;*
>
> *Whether you believe Alcohol and Other Drugs Service (AOD)s acted reasonably and not discharging [Mr A] from their care sooner;*
>
> *Whether more could or should have been done by other Departments to help ease [Mr A's] pain;*

Whether facing the issues surrounding [Mr A's] pain relief and the apparent inability to contact Alcohol and Other Drugs Service (AOD)s, [Mr A] should have been admitted as an inpatient earlier;

Whether [Mr A's] status is an addict or drug seeker, and the consequent restrictions on prescribing and dispensing medication should have been reviewed after this cancer diagnosis.

Any changes to the NMDHB policies that you consider may help them prevent recurrence of this situation.

I would also appreciate receiving any further comments you may have regarding the care provided to [Mr A].'

The documents provided to me are:-

Letter of complaint

File note of telephone call between complainant and [HDC] providing context and further information to the complaint

Responses from Alcohol and Other Drugs Service (AOD)s

A response from [Mr A's] general physician, [Dr E]

Comment from the Hospice which provided end of life care

A response from [Dr K], [Mr A's] GP

Clinical Records from NMDHB covering the period 1 [Month1]– [Mr A's death in Month2]

Clinical Records from Alcohol and Other Drugs Service (AOD)s covering the period [to Mr A's death in Month2]

Clinical Records from [Dr K] covering the period 18–25th [Month1]

Relevant internal policies from NMDHB

A time line of events as understood by this Office.

Case Summary/Timeline:

[Mr A] was a patient on long-term opioid substitution treatment (OST) with prescribed methadone. This had previously been prescribed under authority from the Alcohol & Drug (A&D) service of the Nelson Marlborough District Health Board (NMDHB) by his General Practitioner (GP) at a dose of 200 mg per day which is in the high range. Following some altercation, with another patient, his prescribing was taken back to the A&D Service. Subsequently the methadone dose was gradually reduced, as possibly requested by the patient, and he was down to 155 mg in [Month1].

On the 14th [Month1] [Mr A] reports to the ED at [Hospital 1] reporting having [had a fall] on the 12th [Month1]. He reported blood in the urine (confirmed by an ED urine sample) and some pain in the right leg from the fall. He was given morphine in ED and sent home to return the next day for a scan because of the

blood in the urine. The scan did not find kidney pathology but there was significant incidental findings including multiple enlarged lymph nodes in the abdomen, liver cirrhosis (attributed to Hepatitis C infection), an enlarged spleen, a 19x30 mm liver mass, and multiple pulmonary nodules at the lung bases. His oxygen levels were low.

The diagnosis was uncertain as made clear in a letter from [Dr E] on 27 [Month1] to the Respiratory Service in [another centre]. Possible diagnoses included disseminated cancer, a hepato-pulmonary syndrome causing the low oxygen levels, and other possibilities such as sarcoidosis or tuberculosis.

The hospital admission was from the 15th to the 20th [Month1] during which time the patient was made aware of a possible poor prognosis. During the admission the patient was attended by his A&D case worker, [Mr C]. There was liaison with the A&D Service and the methadone was increased to 160 mg, and he was also prescribed four days of additional morphine tablets on discharge by the hospital with subsequent General Practitioner review as needed.

23 [Month1]: The patient was reviewed by his GP who noted the patient was 'a complete physical wreck', but did not mention pain specifically. He wanted the methadone to go back up to 200 mg by 5 mg/day increments as allowable per protocol. The GP attempted without initial success to contact the A&D Service for advice around an opioid management plan. The A&D file note noted the GP had prescribed six more morphine tablets but the GP was not going to dispense any more. A review by [Dr B] on either the 11th or the 16th [Month2] was considered necessary before any change of the opioid (methadone) management plan.

27 [Month1]: The A&D file note from [Mr C] reported a phone call from the patient's wife and the response was that there was no indication for further analgesia and to wait [Dr B's] review or see the GP.

27 [Month1]: [Mr A] attended ED with shortness of breath and abdominal pain. Low oxygen levels were noted and a chest x-ray showed more numerous lung nodules. The patient was offered admission to manage the oxygen but he declined, he was prescribed forty 20 mg morphine tablets.

02 [Month2]: Bladder investigation (cystoscopy) for blood in the urine was normal.

05–08 [Month2] (Admission): [Mr A] was admitted via ED with symptoms of abdominal pain, shortness of breath and weight loss to the Medical Service under [Dr G]. At that time there was consultation with [Dr F] (Pain/Palliative Care) noted in the discharge summary. During the admission the methadone dose was increased with 'good effect' to 180 mg methadone a day as baseline together with additional doses of 30 mg up to three times a day. A prescription for two weeks at this dosage was presented to the Pharmacy on the 8th [Month2] (a Sunday) but was declined to be dispensed after the Pharmacy contacted [Dr B] of the A&D Service.

[16 Month2]: Patient presents with a planned MRI imaging at which time he was found to (Admission) be in severe pain and was subsequently readmitted to [Hospital 1] for palliative care and it was noted pain relief was difficult to achieve. Alcohol & Drug Service hands over the prescribing to [Dr F] of the Palliative Care Service, on the 18 [Month2].

[Patient deceased.]

Opinion:

As a preamble, I would wish to comment that when patients on opioid substitution treatment develop pain, the principle of having one nominated prescriber, an a co-ordinated agreed treatment is a worthy ideal, and should minimise risks associated with multiple prescribers.

Secondly, I am prompted to comment on the phrase in [the A&D letter], that the prescription of (presumably the 8th [Month2]) was not honoured under the A&D Clinic's direction as 'Outside of the spirit of the Misuse of Drugs Act'. Section 24 of this Act makes it clear that prescribing for dependency per se is not lawful. However prescribing for the indication of pain is allowable indeed occurred from the GP and the ED on other occasions. [Mr A] was not a restricted person within the context of Section 25 of the Misuse of Drugs Act.

Thus there needs to be clear identification of the indication for additional prescribed opioids on such prescriptions, and was not annotated as such on [Dr H's] methadone discharge prescription of 08 [Month2].

[Mr A] would be highly tolerant of opioids having been on methadone for so many years. In my experience, the optimal way to achieve analgesia in methadone maintenance patients is to use increased doses of methadone, as suggested by [Dr K] on the 24th [Month1], and undertaken by [Dr G]/[Dr F] on 08 [Month2].

Comment on Clinical Processes:

There was adequate communication between the hospital (Junior doctor), [Mr C] (A&D liaison) and the A&D Clinic during the time of the first admission. At that time it was not particularly clear how much pain [Mr A] was experiencing but additional morphine was prescribed. The A&D Clinic would have been aware of the alarming possible diagnosis of extensive cancer (liver, abdomen and lungs).

The increased methadone by 5 mg to 160 mg a day would have minimal added analgesia in this patient.

The A&D Service appeared to have not agreed to the GP's request, about 23 [Month1], for a revised 'opioid control and treatment' plan, and deemed no change was needed until [Dr B's] review planned for the 16th [Month2].

The ED felt the clinical situation on the 27th [Month1] merited further morphine and prescribed 40 tablets.

There were in retrospect lost opportunities to improve analgesia following the 5th to the 8th [Month2] admission. I am not aware of any input from the case worker [Mr C] at this admission and he may not have known about it.

The discharge planning for Sunday 08 [Month2]appears less than adequate in terms of liaison with A&D Services around the intended much increased dose of methadone (for analgesia).

I have read [Dr E's] [letter which] summarises these discharge events and I agree with her observations and commentary.

The prescription for methadone 180 mg plus 30 mg three times per day for breakthrough pain was not annotated for pain or indicating that it should have been attempting to replace the usual prescription (160 mg) from the A&D Service. There should have been prior liaison with A&D as per the NMDHB 'clinical guidelines (for admissions)'. I note within these Page 2 'on discharge' that this should have occurred, and there is also an after-hours A&D contact possible. It is noted in this document that discharge supplies should not be given and this may have prompted [Dr B's] advice not to honour the discharge prescription from [Dr H]. It is difficult to understand why the A&D Service did not follow up on the next day (Monday) as to the reasons for the much higher dose of methadone, which would have been for analgesia (palliative). Such an enquiry would have brought to light [Mr A's] deteriorating condition and palliative care needs. I note the A&D Team meeting of 16 [Month2] (attended by [Mr C] and [Dr B]) documents concern about drug seeking, which could relate to the patient's past history at the clinic, but seems out of context if the updated clinical picture had been appreciated.

Specific HDC questions:

Whether or not it would be reasonable for a patient in similar circumstances to wait one month for review by Alcohol and Other Drugs Service (AOD)s.

The decision for this A&D Clinical review on the 11th or 16th [Month2] was made on the 25th [Month1], despite requests from [Dr K] for an earlier management plan in a setting of possible disseminated cancer diagnosis. I would have expected a more urgent response which could have been a consultation with [Dr J] who was available for emergency situations. Alternatively some form of case conference with hospital physicians, [Mr C], [Dr J] and the GP could have engendered a more responsive treatment plan. This is particularly so after 08 [Month2] discharge. I would have thought that sooner A&D assessment should have been prompted in the circumstances. I believe this is a departure from the usual standard of care viewed of moderate severity.

Whether the level of staff cover appears reasonable given the difficulties other clinicians reported in discussing [Mr A's] case with Alcohol and Other Drugs Service (AOD)s.

It is not possible for me to answer this question from the information available. It appears there was limited but available medical staffing from [Dr J] whilst [Dr B] was on leave. In addition, there was a designated case worker for the patient.

Whether the level of communication between Alcohol and Other Drugs Service (AOD)s and other DHB departments appears adequate.

As above, I believe the lack of communication between the hospital and A&D following the declined prescription of 08 [Month2] was inadequate. The hospital should have been proactive in contacting A&D about the changing clinical situation and pain relief needs; and that [Dr B] should have followed up on 09 [Month2]. This likely resulted in [Mr A] having inadequate analgesia from the 9th to the 16th of [Month2]. I believe this is a departure from usual standards of care of moderate severity.

Whether it is reasonable to expect Alcohol and Other Drugs Service (AOD)s to have been more responsive to [Mr A's] changing needs.

This is partially covered in my response to questions 1 and 3 above.

From the information available to me I have wondered about the role of the case worker whom I presume is based in Town 1. I do not see any clinical assessments or attempts to bring [Mr A's] deteriorating state to the attention of the A&D services. The last note of the 27th [Month1] from him is to advise [Mrs A] of no indication for increased analgesia until the 16 [Month2] appointment.

As it appears, the Alcohol & Drug Service had a mechanism to proactively keep [Mr A] under review and liaise with other professionals but I do not find evidence of clinical assessments in a patient who should have merited such reviews.

Again I believe the Alcohol and Other Drugs Service (AOD) should have been more responsive in assessing the clinical situation and liaising as necessary. This is a mild to moderate departure from adequate care in my opinion.

Whether you believe Alcohol and Other Drugs Service (AOD)s acted reasonably in not discharging [Mr A] from their care sooner.

I would say in retrospect the handover of care should have likely been after the second admission (5th to 8th [Month2]). This was a lost opportunity consequent to the failure of various clinicians to communicate the clinical situation as covered in Question 3 above.

Whether more could or should have been done by other departments to help ease [Mr A's] pain.

No. I was impressed by the care provided by **ED** from the notes of the presentations there on the 14th and 27th [Month1].

The hospital appears to have managed analgesia adequately during the admissions. This was an acceptable standard of care.

I have discussed the intent of the hospital to increase the methadone post discharge on 08 [Month2] in previous paragraphs above.

Whether, facing the issues surrounding [Mr A's] pain relief and the apparent inability to contact Alcohol and Other Drugs Service (AOD)s, [Mr A] should have been admitted as an inpatient earlier.

Probably not. This would primarily have been arranged by his GP but it appears that [Mr A] did not utilise his GP after he had been advised by him that he would not be prescribing further opioids after 25 [Month1].

[Mr A] attended ED on 27 [Month1] and was offered admission at that time which he declined. ED advised [Mr A] he could return there if he deteriorated. I believe this was an acceptable standard of care.

Whether [Mr A's] status is an addict or drug seeker, and the consequent restrictions on prescribing and dispensing medication, should have been reviewed after this cancer diagnosis.

This is similar to Question 5 above. I would say not as the initial diagnosis was complex and uncertain but did include the possibility of metastatic cancer which remained of unknown type. Also the prognosis was uncertain and I suspect the rapidity of his decline was perhaps not anticipated.

I think it was acceptable for [Mr A] to initially stay with the A&D Service, probably up to the time of the 5th to the 8th [Month2] admission as discussed above. I believe this was acceptable practice for the period after his first admission and it was only subsequently found that the A&D Service was seemingly unable or unwilling to provide further clinical assessment and consider analgesic requirements.

Any changes to NMDHB policies that you consider may prevent recurrence of the situation.

I have no suggested changes. I thought the clinical guidelines were excellent and note on the top of Page 2 'the need for OST patients in hospital to be prescribed analgesia as for other patients and liaise with an Addiction Medicine doctor'. These are important sentiments with regard to this case. Like all policies, these are only useful if available and read by hospital clinicians. I wonder if the liaison case worker had brought them to the attention of the [Hospital 1] physicians? My recommendation is around the A&D Service ensuring such policies are brought to the attention of hospital doctors especially those needing to prescribe additional opioids to patients on opioid substitution for dependency via the A&D Service.

Additional Comment:

Having read all the provided documents and the time line relevant to the complaint I have some subjective disquiet about some aspects of the Nelson Marlborough District Health Board's A&D Service. Notwithstanding the

importance and good stewardship over prescribed controlled drugs, there appears to be possible issues relating to accessibility and responsiveness, somewhat autocratic process, and communication.

Given the nature of the work and patients, it is possible for a culture of 'an embattled castle' to unwittingly emerge with OST clinics, with adverse effects on a patient-centred comprehensive approach (which [Mr A] was requiring, at least in retrospect). I would also have some questions on the clarity of roles of staff, eg. Case-workers, inter-clinician reporting, and teamwork.

I am also very aware that I have no clinical details about [Mr A's] previous long period as an A&D patient, compliance with OST treatment, and to what degree he remained a 'drug-seeker', which could have influenced certain processes and decision making in the period relevant to this complaint.

I trust this report is helpful."

Dr Robinson provided the following further advice on 17 June 2016:

"Thank you for your letter of the 19th May 16 seeking further advice, and enclosing additional relevant documents:

1. NMDHB response 10/3/16
2. NMDHB response 19/4/16
3. Dr H's response 21/4/16
4. Mr I's responses 11/6/15 and 2/3/16.

Having been through these, I do not find reasons to amend my previous advice of the 16/1/16 on the broader issues related to this case.

However I offer some comments on specific issues:
1. It appears there was an important missed opportunity for improved analgesia on the 8 [Month2] DISCHARGE prescription as in Item 3, page 9 of my previous report.

It is not so much the cancellation of this prescription per se, but rather the opportunities for analgesia discussion that should have been provoked between hospital and A&D.

Clearly a prescription for 14 days single supply is inappropriate for a patient already on methadone for long-standing drug dependency where frequent dispensing is the norm. It has now emerged that [Mr A] had a complex past history with A&D services generating a need for 'caution' as [Dr B] reports. As previously stated the hospital should have contacted A&D, as per protocol via the after hours A&D phone that Sunday.

[Dr G] appears to have given [Dr H] less than adequate support and supervision over a complex controlled drug discharge prescription situation. My experience is that such early stage Interns are not yet fully familiar with opioid and controlled drug regulations and requirements. [Mr A] was not one of [Dr H's] usual patients,

and he would not likely have known of the A&D role in opioid management as a weekend house surgeon.

I also note that [Dr H] states 21/4/16 that he advised [Dr B] to contact the on call physician [Dr G] for clarification of the clinical and prescription situation but this did not happen.

In addition, [Dr H], although documenting the cancellation of the prescription in the case notes, did not appear to have appraised [Dr G] or [Dr F] who would thus not have been aware that the methadone dose had not been increased in the community post discharge as intended by these physicians.

2. I note in the material forwarded to me that various A&D clinician job descriptions include LIAISON functions within teams, and with other NMDHB departments. This area remains as a concern.

For example, both [Mr C] and Ms D knew of the admission 5 [Month2] as per email of 6 [Month2], as did [Dr B] via phone calls 8 [Month2]. Yet none of these individuals appear to follow up with hospital physicians, or initiate some form of case conference.

[Dr B] alludes on page 6 of his response of 9/3/16 that these might be Case Manager responsibilities.

He has not explained why he himself did not follow up the discharge prescription issue on return to work 9 [Month2].

I have made comment in my previous report page 12 on the roles of Case Workers and others.

I note the Professional Responsibilities in [Mr C's] Job Description and wonder if these were performed at the expected standard.

I was interested in [Mr C's] response of the 12/4/16 which notes that he was in near daily weekday contact with [Mr A] and his family and no doubt had a significant support role.

[Mr C] would have been well placed to liaise with his A&D clinic or hospital clinicians or GP around pain issues or the hospital's failed analgesic plan. He refers to himself as the Case Manager, but this perspective or scope appeared to be limited or peculiarly constrained.

One notes [Mrs A] complains of inadequate analgesia, yet the Case Manager of the service responsible for opioid prescribing was visiting him daily.

Thus, as in my previous reports, I have concerns about aspects of [Mr A's] care over his final illness period and much of these relate to communication issues and probably clarity of clinicians' roles.

In addition you have sought my views on, in the circumstances, the 'reasonableness of the care provided by …'

1. [Dr H]
I believe this was reasonable given his position and experience. He should have reported the cancelled prescription back to [Dr G].

2. [Dr G]
I believe this too was reasonable noting the intentions and explanations in his letter of 7/4/16.

Clearly he now recognises the A&D policies on discharge prescribing to their patients.

3. [Dr B]
As above, I believe the cancellation of the near double dose and 14 days of methadone was appropriate.

Follow up on the analgesia situation was also indicated. [Dr B] himself states that [Dr H] mentioned the abdominal pain issue, as does [Dr H] in his response of 21/4/16. [Dr B] says page 3 in his response of 9/3/16 'and leave for A&D to follow up'.

He appears to not provide an explanation for not doing this himself. It may be that he was relying on the Case Manager to investigate and advise; or was awaiting a call from a [Hospital 1] physician on the presumption that they knew their methadone prescription had been cancelled. Clearly there were multiple other individuals potentially involved with following up this situation including the patient who appears not to have contacted the hospital, GP, or engaged the case manager in the analgesia needs. Nevertheless, I would say [Dr B] had a duty of care and ethical responsibility to follow up on the issue of the increased dosage which he had cancelled and potentially jeopardised pain control.

Considering all the circumstances and various communication issues I would judge his failure to follow up on this issue as a mild–moderate departure from the standard of care, which should be to ensure terminally ill patients in pain have successful analgesia, or arrange for other medical practitioners to assume such oversight."

On 23 June 2017, Dr Robinson was asked to provide further advice following receipt of Dr B's response to the provisional opinion and the report authored by Dr L. Dr Robinson advised that he did not wish to amend his report, noting: "I believe doctors need to be able to respond to more comprehensive issues whatever their usual scope."

Appendix B: Independent addiction practitioner advice to the Commissioner

The following expert advice was obtained from addiction practitioner Ian MacEwan:

"**1.** I have been asked to provide an opinion to the Commissioner on case number 15/563, and I have read and agree to follow the Commissioner's Guidelines for independent advisors.

2. My relevant qualifications are a Diploma in Social Work, a Certificate of Qualification in Social Work, a Master's degree in Community and Social Studies (Addiction) and a Certificate in Clinical Supervision. I have 46 years' experience in addiction treatment which includes dozens of skill-based workshops and training seminars principally in addiction treatment. I have taught on the University of Otago, Christchurch School of Medicine PSMX422 Case Management from 2003-14.

3. I have been asked to review the enclosed documentation and advise whether I consider the care provided to [Mr A] by [Mr C] was reasonable in the circumstances, and why. In particular (and without limiting the scope of this request), I have been asked to comment on:

1. Whether [Mr C] should have taken any further action on 27 [Month1], following [Mrs A's] phone call;
2. The reasonableness of the care provided by [Mr C] between 5 and 16 [Month2], including in relation to liaising with hospital staff and AODS staff in regard to [Mr A's] pain management; and
3. The appropriateness of the actions taken by [Mr C] on 16 [Month2], following [Mr A's] phone call.

I have also been asked to comment on any other aspects of the Addictions Clinician care provided to [Mr A] that I consider warrant such comment.

For each issue listed above, it would be helpful if I would advise:

1. What the standard of care/accepted practice is;

2. If there has been a departure from the standard of care or accepted practice, how significant a departure you consider it is; and

3. How the care provided would be viewed by my peers.

If I note a conflict in the evidence, please provide my advice in the alternative. For example: whether the care was appropriate based on scenario (a) and whether it was appropriate based on scenario (b).

I note the Commissioner has obtained separate advice about the Addictions Specialist and medical care provided to [Mr A]. I am to limit my advice to the Addictions Clinician care provided to [Mr A], from the perspective of a peer case worker, taking into account that [Mr C] has undertaken training in Addiction Studies, but has no other clinical qualifications or experience.

4. I have reviewed the documents supplied by the Commissioner.

5. Background

[Mr A] was a long-term opioid substitution treatment (OST) patient under the care of the Alcohol and Other Drug Service (AODS) at NMDHB. He was prescribed 200mg per day of methadone, which was gradually reduced [over a period of several months] to 155mg per day by [Month1].

On 14 [Month1], [Mr A] presented to the Emergency Department (ED) at [Hospital 1] after a fall. He reported blood in his urine and pain in his leg, and had low oxygen levels. The next day, a computed tomography scan of his abdomen found multiple enlarged lymph nodes in the abdomen, liver cirrhosis, an enlarged spleen, a liver mass and multiple pulmonary nodules at the lung bases. Possible diagnoses included disseminated cancer, a hepato-pulmonary syndrome and sarcoidosis.

On 17 [Month1], [Mr A] asked his AODS case worker, Addictions Clinician [Mr C], if his methadone could be increased back up to 200mg. [Mr C] agreed to discuss this with Ms D, the AODS manager, as AODS medical officer [Dr B] was on leave until 7 [Month2]. [Mr A's] methadone was increased to 160mg per day on 20 [Month1], approved by [Dr J] at AODS. He was discharged from hospital that day and prescribed four days of morphine. His discharge summary stated 'Abdominal pain — likely relating to fall. For GP [follow-up]' and 'Severdol [morphine] on [discharge] for 4/7 with GP review'.

On 23 [Month1], [Mr A] presented to his general practitioner (GP), [Dr K] at the medical centre, requesting his methadone dosage return to 200 mg per day. [Dr K] told HDC that he left a message for [Ms D] stating that he would like to increase the methadone by 5mg per day back to 200mg per day and forgo morphine, due to the potential for abuse. He stated that he had not heard back from her by 25 [Month1], so prescribed a further six morphine tablets, with the caveat that he would not prescribe any further short-acting opiates or methadone dose changes unless AODS advised.

In contrast, [Ms D] documented a phone call with [Dr K] on 25 [Month1], with him stating that he did not believe [Mr A's] pain was the result of liver issues. She felt there was no indication for further pain medication and documented that she told [Dr K] that, on his return from leave, [Dr B] would review [Mr A]. In his response to HDC, [Dr B] stated that [Dr K] told AODS that [Mr A] may have been engaging in drug-seeking behaviour and that no further analgesia for his leg problem was envisaged. Following consultation with [Dr J], it was agreed there would be no further increase in [Mr A's] methadone dose, prior to him being seen face to face.

On 27 [Month1], [Mr A's] wife, [Mrs A], called AODS to advise that [Mr A] was still experiencing significant pain. [Mr C] told her that there was no indication for further analgesia, as per [Ms D's] documented conversation with [Dr K], and to

wait for his scheduled review with [Dr B] on 16 [Month2]. He stated that [Mr A] could not be seen earlier as [Dr B] was on leave, but he could see [Dr K] again, who could call [Ms D]. [Mr A] instead attended ED, with shortness of breath and abdominal pain. He was offered admission but declined and was prescribed 40 morphine tablets.

On 5 [Month2], [Mr A] was admitted to hospital via ED with abdominal pain, shortness of breath and weight loss. It was apparent his health had deteriorated substantially and his prognosis was poor. On 7 [Month2], [Dr F], pain specialist, increased his methadone to 180mg per day with additional doses of 30mg up to four times a day, in a palliative capacity. On discharge the next day, [Dr H] (first year house surgeon) wrote a prescription for two weeks at this dosage. The script was not meant to be treating addiction, but treating pre-terminal pain. It was intended to replace any pre-existing methadone scripts, not be in addition to them.

The prescription was presented by [Mr A] to the pharmacy. Pharmacist [Mr I] had concerns about it because the dose had been increased and he knew [Mr A] was under the care of AODS. [Mr I] contacted [Dr B] and was instructed not to dispense the prescription. [Dr B] then called [Dr H] and told him that AODS would assume the responsibility for [Mr A's] methadone. [Dr H] did not realise that AODS would not give [Mr A] the higher doses needed for adequate analgesia. [Dr B] told HDC that he understood the script had been written in error.

An OST clinic meeting was held on 16 [Month2], during which it was noted that [Mr A] would not be able to attend his appointment that afternoon, because he had an MRI scheduled. It was documented that [Dr B] was reluctant to increase [Mr A's] methadone, due to concern he was drug-seeking, but it was agreed that [Dr B] would phone him the next day to arrange another appointment. [Mr C] received a call from [Mr A] later that afternoon, stating that he had not been able to complete his MRI due to pain, was still in great pain and needed an increase in methadone. [Mr C] emailed [Dr B] about this, who called [Mr A] the next morning to learn that he had been admitted to hospital the previous evening for palliative care. On 18 [Month2], AODS handed over the prescribing of his methadone to [Dr F]. [Mr A] passed away [shortly afterward] in hospice.

6. Whether [Mr C] should have taken any further action on 27 [Month1], following [Mrs A's] phone call:

[Mr C] reports that he did not carry out a clinical assessment as [Mrs A] was seeking clarification regarding pain medication. There was an appointment in place for [Mr A] to see the addiction specialist, [Dr B] two weeks later. He advised that [Mr A] should see his GP if he is in significant pain. This was noted on file but he did not pass the information on to his manager.

Given that [Mr C's] manager had been in contact with the GP about the level of medication, two days earlier, [Mr C's] response to [Mrs A] seems appropriate. As the presenting problem from [Mrs A] was about levels of medication, this would be outside of [Mr C's] scope and any new clinical assessment would be

appropriate for a medical officer. No other changes are stated that would indicate that [Mr C] should conduct a new assessment.

Given his manager's involvement, it would have been better had [Mr C] drawn her attention to his file note.

- **What the standard of care/accepted practice is:** The practitioner would receive the information, note it on the client's file, give advice to address the concern and notify other professionals involved with the client.

- **If there has been a departure from the standard of care or accepted practice, how significant a departure you consider it is:** Given his manager's involvement, it would have been better had [Mr C] drawn her attention to his file note. Not a significant departure but a lesson to be learnt about the importance of clinical liaison.

- **How the care provided would be viewed by your peers:** in the context of needing to know in this case, it would be seen as a heads-up to ensure good liaison. Similar case reviews have shown considerable negative consequences from this sort of failure, though in those cases the need to know context was more critical. Apart from the moderate level need to know, [Mr C's] actions would have seemed reasonable.

7. The reasonableness of the care provided by [Mr C] between 5 and 16 [Month2], including in relation to liaising with hospital staff and AODS staff in regard to [Mr A's] pain management:

[Dr E] reports that [Mr C] was seen with [Mr A] during ward rounds on many occasions though she was not doing ward rounds during the 5–8th [Month2] admission. On the 6th, [Mr C] emailed his manager with an update on [Mr A's] current medication, the proposal to increase his methadone and to expect a call from the hospital doctor to discuss the proposed increase. It appears from [Dr B's] notes that contrary to his expectation, [Mr C] was not sufficiently made aware of the rapidly deteriorating state of [Mr A's] health. [Dr B], in his letter to [HDC] suggests that the responsibility for keeping him informed of 'necessary discussion and prescription adjustments' lay with [Mr C]. It is noted that [Dr B] was on leave at this time, but that on his return to work on the 9th, he had not been notified. It is not clear from [Mr C's] accounts but it seems possible that notifying his manager on 6th [Month2] was felt by him to be sufficient notification.

- **What the standard of care/accepted practice is:** the practitioner attends the OST meetings, maintains appropriate therapeutic contact with the client, providing case management liaison with other professionals and significant others involved with the client. The practitioner keeps clear and current notes on the client's file.

- **If there has been a departure from the standard of care or accepted practice, how significant a departure you consider it is:** it is not easy to form a view as the provided notes do not address [Mr C's] intentions in

ensuring good liaison; nor do the records describe how much importance the hospital staff gave to [Mr C's] role as case manager. It appears that information was passing between medical staff and may have been bypassing him, especially in relation to the deterioration in [Mr A's] health. It is not clear whether [Mr C] attempted to make sure that he fully understood [Mr A's] condition. It is understandable that notifying his manager about proposed changes in medication might have been seen as sufficient. It would have been better if he had ensured that [Dr B] was given the information relating to [Mr A] on his return to work.

- **How the care provided would be viewed by your peers:** There is an often expressed frustration with medical staff bypassing and/or ignoring the roles played by allied staff such as [Mr C]. Some would hold the view that he should have ensured [Dr B] would have that information upon his return. Others would be content that he had contacted his manager who was directly involved and they would be aware that [Mr C] had apparently been left unaware of the seriousness of [Mr A's] condition.

8. The appropriateness of the actions taken by [Mr C] on 16 [Month2], following [Mr A's] phone call:

On the 16th [Month2], [Mr C] informed the addiction specialist, [Dr B], of developments relating to [Mr A] and of his request for an increase in methadone. He advised [Mr A] to attend ED if there was an acute medical need. [Mr C] would have expected [Dr B] to telephone [Mr A] on the 17th [Month2] as agreed at the OST meeting.

- **What the standard of care/accepted practice is:** To inform [Dr B] of developments when he ([Mr C]) became aware of them and to advise [Mr A] of a reasonable course of action to take should matters deteriorate.
- **If there has been a departure from the standard of care or accepted** practice**, how significant a departure you consider it is:** in my view there is no apparent departure from standard care or accepted practice.
- **How** the **care provided would be viewed by your peers:** I believe it would be seen as acceptable.

9. General comments:

[Mr C's] responsibility was the development and implementation of the non-medical aspects of a treatment plan for [Mr A]. Accountability for this would rest with his manager and with the OST weekly meetings. [Mr C] is a registered addictions practitioner, so Dapaanz expectations of practitioners at [Mr C's] level of addiction training and registration, would be that he is able to meet the requirements as set out in the Dapaanz Addiction Intervention Competency Framework (2011).

[Dr B's] report on improvements already implemented reinforce the importance of fully recording all actions relating to client contact and this is essential practice.

[Mr C's letter to] [the] Patient Relations Co-ordinator/Clinical Governance Support Administrator suggests an element of informality had entered the client–practitioner relationship, which though not unethical can have unintended consequences such as happened here with unrecorded conversations and, potentially, a more relaxed regard to developments. The point being made is the importance of maintaining the therapeutic and case management focus between practitioner and client."