A District Health Board

A Report by the

Health and Disability Commissioner

(Case 08HDC08140)

Overview

Mr A (23 years) lived alone, and had recently ended a two-year relationship with his girlfriend. Mr A planned to commit suicide but aborted the attempt at the last minute. Mr A received care from his GP and the district health board (DHB) community mental health services, and was prescribed antidepressant medication. However, he was admitted to hospital ten days later following an episode of self-harm. He was discharged home alone the following day and took his own life two days later. This report considers the appropriateness of care provided to Mr A by the DHB.

Complaint and investigation

On 19 May 2008 the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by Northland DHB's mental health services to her son, Mr A. An investigation was commenced on 16 September 2008 and the following issue was investigated:

- *The appropriateness of the care provided to Mr A by Northland District Health Board in mid 2008.*

The parties involved in this case are:

Mr A	Consumer
Mrs A	Complainant / Consumer's mother
Dr B	General practitioner
Ms C	Registered nurse
Ms D	Registered nurse
Ms E	Registered nurse
Dr F	Medical officer
Dr G	Locum general practitioner
Ms H	Registered nurse

Independent expert advice was obtained from consultant psychiatrist Dr Steve Duffy and is attached as an appendix.

Information gathered during investigation

Chronology of events

In mid 2008, Mr A, aged 23 years and living alone, had recently split up with his girlfriend of two years. Although the relationship was "on and off" and his family strongly disapproved of it, when it did end it caused a great deal of distress for Mr A.

On Day 1 Mr A planned to commit suicide, but did not follow through with his plans at the last minute. The next day Mr A informed his employer of his aborted suicide attempt, and she arranged an urgent appointment with his general practitioner, Dr B at a Medical Centre.

On Day 2 Mr A attended the appointment with Dr B. Dr B noted that Mr A was co-operative and appeared generally well. He denied any current suicidal feelings, but agreed to contact Dr B or an emergency doctor if he felt suicidal again. Nevertheless Dr B referred Mr A to mental health services, writing to an unnamed doctor: "[H]e is very anxious, there is a bit of paranoic looking over his shoulder ... I suspect this is a fragile situation ... I would be most grateful if you could see him in [the next 48 hours]." Dr B prescribed an antidepressant (citalopram — 20mg daily) and a sedative (diazepam — 5mg three times daily) medication for Mr A, and arranged to see him within 48 hours or earlier if there was a problem.

Dr B reviewed Mr A again on Day 4 and considered him calmer and more relaxed but noted that he had not been contacted by the DHB's Mental Health Services (MHS). Dr B arranged another appointment in one week's time, but did not contact MHS to chase up the earlier referral.

On Day 4, Community Mental Health Team (CMHT) nurse Ms C telephoned Mr A on the number provided in Dr B's letter of referral. It was Mr A's workplace. Mr A was at work but unavailable, so Ms C left a message for Mr A to call her back. However, he did not do so.

On Day 6 Ms C visited Mr A's house, but no one was home. Ms C documented that she "left a card to call as there is no home number on referral". Ms C also noted that she had contacted Dr B in an unsuccessful attempt to obtain Mr A's home telephone number, and planned to make another home visit on Day 9, after the weekend. However, Mr A returned Ms C's message later that day and told her that he was "feeling much better". He agreed to attend an appointment with the CMHT on Day 9.

On Day 9 Mr A was assessed by CMHT nurse Ms D. She documented that his mood had been "low" for the past three months, and he had become increasingly insecure and isolated, and had trouble sleeping and dealing with distress. In addition to the aborted suicide plan that had prompted him to seek help, Ms D noted that Mr A had made some superficial cuts on his wrist "as a way of coping with distress". Although Mr A admitted to having suicidal thoughts at times, Ms D documented that he "feels unlikely to act on them" and "believes that he would not go through with any attempt". Ms D also noted that Mr A would look over his shoulder at times when voices were heard outside, and was "very anxious about confidentiality".

Ms D referred Mr A for counselling with a counsellor, and noted that he had an appointment for Day 14. As Mr A did not see a doctor after the CMHT consultation on Day 9, no formal diagnosis was made. A copy of the assessment report was not sent to Dr B.

On Day 11 Mr A was driven to hospital by his employer after making five superficial cuts to his left arm with a retractable razor blade. The wounds were cleaned and dressed by a registered nurse, who also completed an admission form and a "Suicide and Deliberate Self-Harm Evaluation" tool. The registered nurse noted Mr A's recent mental health history, which was preceded by separation from his partner of two years, and noted that he did not want his family to be informed of his depression, suicide attempt, and self-harm. Mr A stated that he had no plans to kill himself and did not want to do so. Mr A nominated his employer as his preferred emergency contact person.

Mr A was also assessed by medical officer Dr F. Dr F noted the comments made in the "Suicide and Deliberate Self-Harm Evaluation" tool, and documented that although Mr A was physically well, he needed to be reviewed by the mental health team prior to discharge. Mr A said that he felt "shame" for cutting his arm and would not do it again. He was adamant that his family not be notified. Because it was very late, a bed was available, and Mr A had no means of transport, he was admitted overnight. The dosage of his antidepressant medication (citalopram) was increased from 20mg to 40mg daily. He slept well overnight and was assessed by the DAO (duly authorised officer) and CMHT nurse Ms E on Day 12.

Ms E noted that Mr A was "feeling embarrassed re his situation" but was able to express himself freely and stated that he "definitely wants to live" and guaranteed his safety. Ms E documented a plan for Mr A's ongoing care, noting that he could be discharged as he was able to guarantee his safety. She did not complete the "DAO/Psy to complete" section of the "Suicide and Deliberate Self-Harm Evaluation" tool, which provided space to record diagnosis, suicide risk, and care plan. She noted that Ms C planned to contact Mr A the following day and had a counselling appointment for Day 14. Mr A was given the emergency contact numbers for the CMHT should he need help.

Mr A was discharged from hospital on Day 12. The discharge summary noted "patient is to see his [GP] in the next week and possibly had his citalopram increased to 40mg a day. He is also [for follow-up] with his psychologist." A copy of the discharge summary was sent to Dr B.

Later on Day 12, Mr A attended an appointment with locum GP Dr G at the Medical Centre and his dressings were changed by nurse Ms H. Dr G noted that Mr A said that he was managing well, and accepted that his relationship had ended. He said that he had no further intention or desire to self-harm, would maintain contact with the mental health nurse and had an appointment to see a counsellor. Dr G increased his antidepressant dose to 40mg daily and, although Mr A wanted to return to work, Dr G recommended light duties until his arm was healed. Mr A was advised to make a follow-up appointment with Dr B in the near future.

Ms C attempted to telephone Mr A on Day 12, but only managed to contact his workplace. As Mr A was absent, she did not leave a message.

On Day 13 Mr A paid an impromptu visit to the CMHT office and was seen by Ms C. He told Ms C that he was not suicidal and never had been, he simply "could not cope with the 'mind games his partner was playing with him'". Ms C noted that his memory was poor and he appeared distracted by noises around him. She thought he was "slightly paranoid" but he denied it, explaining that he had an underlying anger towards his ex-partner which he "feels will explode". However, Mr A denied that he would physically harm anyone. He said that he would commence counselling on Saturday and Ms C planned to call him later in the day.

That evening, Mr A telephoned his mother, who put the call on speaker phone so the rest of the family could talk to him. Mrs A said that he sounded cheery and bright, "which to us he always was".

Mr A took his own life some time between Day 13 and Day 14. Mrs A was woken on the morning of Day 14 by the Police informing her of her son's death.

Sentinel event review
Northland DHB completed a sentinel event review of Mr A's care. It identified the following "salient issues":

- Although Dr B referred Mr A for a doctor's assessment, he was not seen by a doctor. This happened for two reasons: the nurse who assessed Mr A felt his suicide risk was relatively low (although this was not documented), and urgent medical assessments were difficult to access for non-crisis patients in the area, because there was no dedicated psychiatrist.

- Some of the causes of Mr A's anxiety were noted by the CMHT nurses but not followed up. The DHB accepted that "an unrecognised psychotic process, had it been present, would have added significant risk issues".

- Dr B's referral letter was not entered directly into the nurse assessment, placed on the paper file or scanned into the electronic information management system. Because of these omissions, a key query from Dr B (the relevance of Mr A's unusual thinking) was not explored.

- Dr B did not receive any acknowledgement of his referral or a copy of the CMHT assessment because this is normally completed by the doctor following a medical assessment, and Mr A was not assessed by a doctor.

- Mr A had been clear that he did not want his family to be informed of his suicide attempt and self-harming. Since Mr A was "repeatedly adamant that he was not suicidal and would not attempt anything again", staff did not feel that breaching his confidentiality was warranted.

Changes to Mental Health Services
In response to recommendations of the sentinel event review, the following changes have been made to the Mental Health Services:

- The triage process for new referrals has been reviewed in the region. Now, if a doctor requests a medical assessment, one is either arranged or the person triaging the referral will contact the referrer to enquire as to the reason why a medical assessment is needed.
- All patients admitted to hospital following a suicide attempt now receive an urgent medical assessment.
- Important documents are now scanned into the electronic patient information management system and clinical notes are now typed into the electronic record.
- The DHB is seeking to recruit a full-time psychiatric doctor for the region, to replace two part-time medical officers. In the meantime, CMHT nurses have been encouraged to contact the on-call doctor in the main centre for urgent assessments.
- New documentation has been introduced to acknowledge receipt of referrals and advise on outcome, improve assessment and treatment planning, and provide comprehensive and explicit risk assessment and management.

Responses to provisional opinion

Mrs A
Mr A's mother believes that the delay of one week between Dr B's letter of referral to mental health services, and the CMHT's first physical contact with her son, was unacceptable. She stated that "just phoning, calling round and leaving a card is not good enough … surely they could keep ringing until they got hold of the person, so they could physically see him."

She is concerned that an accurate risk assessment was not undertaken, and she and her husband were not contacted, noting, "I want the public to know that the Privacy Act can be broken in certain circumstances such as this."

The DHB
The DHB noted that while "better communication and coordination between primary and secondary services is desirable", the responsibility for this "does not lie only with the staff of the secondary services".

Although the DHB accepts that it should have provided a copy of the initial assessment report (of Day 9) to Dr B, it noted that Dr B did not re-contact the MHS on Day 4 to express any concern that Mr A had not yet been seen. The DHB advised that

it is a "reasonable expectation by mental health services' staff that GPs are themselves competent in assessment of suicidal risk and that they will re-contact the service if they are concerned about a patient".

With respect to communication with Mr A's family, the DHB advised that "Mental Health Services staff do have a low threshold for notifying family of the risk of self-harm. They have also experienced the detrimental effects of this when it is done against the patient's wishes, but will always encourage patients to seek family support."

The DHB noted that it was very difficult to ensure timely medical review for mental health consumers in New Zealand:

> "[T]he severe, national, longstanding and ongoing shortage of psychiatrists makes it extremely difficult for any rural DHB to provide medical review within reasonable time frames for all cases likely to benefit. This in turn places huge pressure on Community Mental Health nurses to meet the expectations of GPs and the public."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

...

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

...

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

Opinion: Breach — The DHB

The death of a young person by suicide is always a tragedy. Where the suicide follows shortly after contact with mental health services, it is natural to ask whether more could have been done to prevent the death.

It cannot be known whether more intensive intervention and involvement of family could have saved Mr A's life. Until two weeks before his death, he had no history of mental health problems. With the benefit of hindsight, it can be seen that he was very unhappy and crying out for help, but he was also embarrassed by his actions, and wanted to spare his family any worry. In his last contacts with mental health services, and with a locum GP, he gave assurances that he had no intention to self-harm.

This investigation concludes that the DHB Mental Health Services did not provide Mr A with an appropriate standard of care, and failed to involve his family. However, while identifying these service failures, it is important to acknowledge that many aspects of the care Mr A received were satisfactory, and that the tragic outcome may not have been averted even if more had been done.

Risk assessment
The DHB's sentinel event review noted that "the nurse doing [Mr A's] assessment felt that his suicide risk was relatively low" and that CMHT nurses were "dissuaded" from seeking medical assessment "unless they see the client as high risk". In the report, the DHB also stated that Mr A's privacy requests were not overridden because he was not believed to be at "significant and imminent risk".

Mr A's risk was assessed as "low" without a formal risk assessment by CMHT staff. No specific reference to his level of risk was recorded in the clinical notes. My expert, Dr Duffy, criticised this aspect of the DHB's care:

> "[F]ailure to provide an appropriate standard of care lay primarily in the process of risk assessment and management by the CMHT Nurse in the ED on [Day 11] ... appropriate documentation existed for this purpose ... its use was a matter of policy ... I would conclude that this failure led to a lack of appropriate supports being sought in the community for [Mr A]. This failure was of a moderately serious nature given the presentation.
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> ...
>
> If an accurate risk assessment had been made, it is likely that disclosure [to Mr A's parents] would have been necessary."

Given that Mr A was known to have attempted to take his own life on Day 1 and had self-harmed since then, his level of risk should have been objectively assessed at the initial CMHT assessment on Day 9.

Crucially, an objective risk assessment was not completed on Day 11, by the DAO/CMHT nurse who assessed Mr A after he had been admitted to hospital following another episode of self-harm. This was despite the fact that the relevant section of the "Suicide and Deliberate Self-Harm Evaluation" tool provided space for the DAO to record suicide risk on a three-point scale (high, moderate or low).

The DHB advised that the DAO "chose instead to handwrite her assessment within the paper file ... her plan seems to indicate that she considered [Mr A's] short term suicide risk was low". This was not an adequate response. A formal, objective risk assessment was important so that a properly informed decision could be made about what support (including involvement of family) Mr A needed.

The DHB accepts that, in retrospect, there was "probably an underestimation of [Mr A's] risk", and has since reviewed its risk assessment documentation and implemented a "Comprehensive Risk Assessment and Management" tool.

By failing to objectively assess Mr A's suicide risk, the DHB did not provide mental health services with reasonable care and skill, or in a manner consistent with his needs, and breached Rights 4(1) and 4(3) of the Code of Health and Disability Services Consumers' Rights (the Code).

Communication with GP

Mr A's GP, Dr B, did not receive any communication from the CMHT to acknowledge receipt of his referral, or to update him following assessment on Day 9. He did receive a copy of the discharge summary of Day 12, from Mr A's admission to hospital. Dr Duffy advised:

> "I would have expected the outcome of this consultation [of Day 9] to have been made available to [Dr B] within a short space of time (1–2 working days) however [Dr B] ... had not received information from the CMHT ... [several days after Mr A's death]. This is below an appropriate standard but of mild concern. It would appear that no policy exists for routine communication with GPs following CMHT consultations."

The DHB stated that "[l]etters to GPs are commonly written by [d]octors after their first assessments, in this case [Mr A] did not have a [d]octor assessment". This explanation does not stack up. Referring health professionals should always be kept "in the loop" as to the outcome of their referral, regardless of who provides an initial assessment of the patient. This is especially important for a referring GP who continues to provide care to the referred patient. As the DHB acknowledged, a copy of the initial assessment report "might have given [Mr A's] GP an opportunity to reiterate any concerns about the unusual thinking [Mr A] was having".

I note that the DHB has reviewed its system for acknowledging referral letters and updating referrers. Clerical staff are now responsible for acknowledging referral letters and scanning them into the electronic patient information management system. Clerical staff also advise referrers of the outcome of their referral.

I accept the DHB's point that responsibility for improved communication between primary and secondary care services does not lie solely with the secondary service. However, I do not think that Dr B can be criticised for failing to contact NMHT again less than 48 hours after his initial referral to the DHB's mental health service.

In Mr A's case, the DHB failed to co-ordinate its care with his GP following receipt of the referral. This was especially regrettable since Mr A was isolated and had confided only in his employer and GP about his situation. A valuable opportunity was missed to identify concerns that might otherwise be overlooked (as occurred in this case). In these circumstances, the DHB breached Right 4(5) of the Code.

Communication with family

Common sense suggests what research confirms: that good working relationships between mental health staff and families/whänau usually help the recovery of people with mental illness.[1] Standard 10 of the *National Mental Health Sector Standard 2001* (NZS 8143:2001) strongly encourages family involvement and recognises their important contribution, including their role in risk management, particularly when they are involved in supporting the family member with a mental illness.

Although the DHB stated that Mr A "was 'absolutely adamant' that he did not want his family to know about his difficulties or his suicide attempts", these wishes were only documented on one occasion, on Day 12. Rule 11(2)(d)(ii) of the Health Information Privacy Code 1994 permits disclosure of health information to prevent or lessen a "serious and imminent" risk to the life or health of the individual concerned. CMHT staff "decided that given the difficulties it might create for [Mr A] and the lack of what they consider imminent risk, to go with his wishes re confidentiality".

That was no doubt an honest assessment made by mental health staff, who faced a difficult dilemma. If mental health staff override the strong wishes of a mental health consumer (and I note that Mr A was "absolutely adamant" about not involving his family), there is a risk that trust will be lost and the consumer will lose the safety net of mental health team involvement. But there is no documentation to support the DHB's claim that CMHT staff had fully explained to Mr A that his family's primary concern would be his welfare, and that they could help him face his problems. Where there have been several suicide attempts in a short period, and there is no evidence of long-standing family estrangement, there should be a low threshold for notifying family of the risk of self-harm.

As stated above, the DHB's insistence that Mr A was at low risk of suicide is dubious, since an objective risk assessment had not been undertaken. There is no evidence that disclosure to Mr A's family under the provisions of the Health Information Privacy Code was even considered. As Dr Duffy noted:

[1] Research shows the significant clinical, social, and economic advantages in providing mental health services in a family inclusive way (World Schizophrenia Fellowship, 1998).

> "If an accurate risk assessment had been made, it is likely that disclosure would have been necessary."

Given that Mr A had no other social support (apart from his employer), the DHB should have contacted his parents and advised them of his current mental health problems. I accept that, even if the assessment tool had been used, a decision may still have been made not to involve Mr A's family, in line with his wishes. However, sometimes an individual's safety should override his or her privacy, and family or caregivers should be involved to help provide a safe environment for recovery.

Recommendations

I recommend that the DHB:

- Apologise to Mr A's parents for its breaches of the Code.
- Advise HDC by **21 April 2009** of the results of audits of the use of:

  (a) comprehensive Risk Assessment documentation for all patients presenting with significant risks, suicidal ideation, or who are receiving compulsory care under the Mental Health Act

  (b) the new procedure for staff to acknowledge receipt of referrals, consult with the referrer where appropriate, and update the referrer on the outcome of any assessment undertaken.

Follow-up actions

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

Appendix A — Expert advice from psychiatrist Steve Duffy

On 13 November 2008, I asked consultant psychiatrist Dr Steve Duffy to answer the following questions:

1. Did [the] DHB CMHT respond appropriately to [Dr B's] referral, and request to have [Mr A] assessed by a Doctor?
2. Was communication between [Dr B] and [the] DHB CMHT appropriate?
3. [Mr A] did not want his family contacted. In the circumstances was it appropriate for CMHT staff to comply with his wishes?
4. Was [the] DHB's sentinel event review adequate?
5. Are there any aspects of the care provided by [the] DHB Mental Health Services that you consider warrant additional comment?

Dr Duffy provided the following advice on 16 December 2008:

"1. [The] DHB CMHT responded to [Dr B's] letter appropriately when they assigned a community mental health team mental health nurse to assess [Mr A's] presentation. He was screened appropriately for more serious presentations, his medication treatment was already appropriate and further psychosocial interventions were his primary treatment requirement.

One of the more unusual aspects of [Mr A's] presentation … was not addressed by the initial assessment. It is not clear from [Dr B's] referral or subsequent information if this represented psychotic phenomena or not. Of itself the request would not normally mandate psychiatric review, nor if such a review was indicated would it be urgent. Initial examination of this complaint is best achieved in the setting of the relationship prior to any psychiatric review of the male party.

There was also the reference to [Mr A] being distracted by noises around him and 'slightly paranoid'. For a patient presenting in distress with depression and agitation in the setting of a disturbed relationship it is easy to over interpret fleeting symptoms. If a psychosis was indeed emerging the planned contact with a [counsellor] would be more than sufficient to provide ongoing oversight and the opportunity for diagnostic review.

[Dr B] wrote a comprehensive referral to the CMHT dated [Day 3] 2008. CMHT Nurse [Ms D] saw and assessed [Mr A] on [Day 9] and wrote up this consultation. I would have expected the outcome of this consultation to have been made available to [Dr B] within a short space of time (1–2 working days) however [Dr B] states in his Coroner's letter that he had not received information from the CMHT at the time of writing his Coroner's report [several days after Mr A's death]. This is below an appropriate standard but of a mild level of concern. From [the Clinical Director,

Mental Health and Addiction Services'] letter it would appear that no policy exists for routine communication with GPs following CMHT consultations and I would recommend that this issue was addressed in favour of some routine feedback to GPs.

In addition I would have expected that a presentation and overnight stay on [Day 11] at the Emergency Department would have resulted in a report from that department and the CMHT who reviewed him to be forwarded that working day. Such a report dated [Day 11] is contained in the notes and addressed to [Dr B]. The report comments appropriately on [Mr A's] medical and psychological condition given the assessment at the time and makes recommendations for changes to his treatment. It would be worth checking if [Dr B] received this report and if not why not.

[The] DHB Sentinel event review focuses on patient management systems and provision of qualified staff and resources to meet the needs of acutely suicidal patients. Of itself it does not fully explore some of the clinical processes underlying [Mr A's] management. Taken in concert with the report from [the Clinical Director, Mental Health and Addiction Services] however the issues are substantially dealt with.

I would like to see some clarity in addressing [Dr B's] concerns regarding the lack of communication following the initial assessment by the CMHT as noted above.

Further to my preliminary opinion, I believe the failure to provide an appropriate standard of care lay primarily in the process of risk assessment and management by the CMHT Nurse in the ED on [Day 11]. It would appear from [the Clinical Director, Mental Health and Addiction Services'] letter that appropriate documentation existed for this purpose, that its use was a matter of policy and that the staff were appropriately experienced. I would conclude that this failure led to a lack of appropriate supports being sought in the community for [Mr A]. This failure was of a moderately serious nature given the presentation.

The provision of appropriate supports for [Mr A] might not have led to disclosure to his family of his condition. He might have returned to his partner or community supports such as Respite Care may have been used. As the file reads [Mr A's] parents were his main caregivers at the time of review. If an accurate risk assessment had been made, it is likely that disclosure would have been necessary."