Care provided by community mental health services immediately prior to patient's suicide (08HDC08140, 27 February 2009)

District health board ~ General practitioner ~ Mental health ~ Self-harm ~ Depression ~ Suicide ~ Sentinel event review ~ Risk assessment ~ Communication with GP and family ~ Rights 4(1), 4(3), 4(5)

The family of a 23-year-old man complained about the care provided by a district health board's (DHB's) community mental health services. The man had recently ended a two-year relationship with his girlfriend, and had planned to commit suicide but aborted the attempt at the last minute. Following this attempt he received care from his general practitioner and the community mental health services, and was prescribed antidepressant medication. However, he was admitted to hospital 10 days later following an episode of self-harm. He was discharged home alone the following day and took his own life two days later.

It was held that by failing to objectively assess the man'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).

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

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 the family of a mental health consumer of the risk of self-harm.