Psychiatrist, Dr D

Social Worker, Mr C

Medical Officer Special Scale, Dr E

District Health Board

A Report by the

Health and Disability Commissioner

(Case 01HDC13687)

Parties involved

Ms A	Complainant, mother of Mrs B
Mrs B	Consumer
Mr B	Husband of Mrs B
Mr C	Social Worker, Team Leader for the Local Community Mental Health Team, Provider
Dr D	Community Consultant Psychiatrist, Provider
Dr E	Medical Officer Special Scale, Provider
Ms F	Friend of Mrs B
Dr G	Current Clinical Director at the DHB Mental Health Services

Complaint

On 22 November 2001 the Commissioner received a complaint from Ms A concerning the services provided to her daughter, Mrs B, by the District Health Board. The complaint was summarised as follows:

> *The Crisis Assessment and Treatment Team (CATT) and other staff at the District Health Board failed to provide services of an appropriate standard to Mrs B from July to September of the year Mrs B died. In particular, the CATT and other staff failed to organise appropriate follow-up after Mrs B's numerous presentations to the service with acute depression and anxiety attacks, and after suicide attempts.*

An investigation was commenced on 28 February 2002 and on 2 May 2002 was expanded to include Mr C, Team Leader for the Local Community Mental Health Team, and Dr D, Community Consultant Psychiatrist, in relation to the care they provided to Mrs B. Following independent expert advice from Dr Deborah Antcliff, psychiatrist, the investigation was extended on 14 February 2003 to include Dr E, Medical Officer Special Scale, in relation to the following allegation:

> *By prescribing Mrs B a month's supply of tricyclic antidepressant on 3 August Dr E did not provide Mrs B with services of an appropriate standard.*

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Information reviewed

- Interview with Ms A and Ms F
- Statements made to Police by Ms F and Mr B
- Mrs B's medical records from the District Health Board
- Correspondence from the District Health Board
- Correspondence from Dr D
- Mrs B's medical records held by her general practitioner
- Correspondence from Dr E
- Correspondence from Mr B
- Correspondence from the Dr G, current Clinical Director, at the District Health Board Mental Heath Services (appointed three years after Mrs B's death)
- Correspondence from Mr C

Independent expert advice was obtained from Dr Deborah Antcliff, psychiatrist and Ms Paula Nes, social worker

Information gathered during investigation

Introduction
At the time of the birth of her son, Mrs B suffered a severe episode of postnatal depression, which culminated in multiple suicide attempts. At that time, Mrs B lived in another country. Her treatment included hospitalisation. In July Mrs B had an exacerbation of symptoms of anxiety. Ms A, Mrs B's mother, advised that this arose as a result of moving house and kidney stones, and resulted in terrible depression. Following consultation with her general practitioner, Mrs B was referred to her local Community Mental Health Team (CMHT). She received treatment from staff at the CMHT and the Crisis Assessment and Treatment Team (CATT) at the District Health Board (based in a nearby city) over a period of five weeks. Mrs B committed suicide in September.

Background
Mental health services for patients in Mrs A's area that year
Until March of the previous year, the CMHT had been run by another District Health Board. The current District Health Board then took over responsibility for the service. This involved considerable changes to processes and staff in the team.

Mr C, a qualified social worker, was appointed as team leader of CMHT in May. Mr C advised me that the time when Mrs B was a patient was very much a time of change for the CMHT. He felt his team had not been considered or consulted in a sensitive way about the transfer of responsibility from the previous District Health Board to the current District Health Board and that "distractions and dynamics existing at that time" may have contributed negatively to the overall care, communication, and roles and responsibilities.

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Dr D, consultant psychiatrist, was appointed by the District Health Board to a part-time position at the CMHT early that year. Dr E, Medical Officer Special Scale (MOSS), was also employed by the District Health Board and worked two days a week for the CMHT. Prior to this, there had been one part-time psychiatrist and one part-time MOSS employed by the previous District Health Board. On 27 June Dr D and Dr E wrote to the Manager of Inpatient Services and the Manager of Outpatient Services at the current District Health Board to express their concerns about the workload they faced. They stated:

> "Since we started working with [the new District Health Board], the workload at [the] Community Mental Health has grown astronomically. We are frequently unable to see community patients at [a town in the area] as often as their conditions require because we are too busy. We only see some high risk community patients once [e]very two or three weeks. The situation poses unacceptable risks in terms of safeguarding patients and community safety. Also, there is no longer the support of a Psychiatric Registrar at [a hospital in a nearby city]. Quite simply, the psychiatrists are spread too thinly in this area. We each now need to be working full-time at [a town in the area]. [The hospital in the nearby city] needs another psychiatrist. If there is no readily available alternative, a locum may have to be found."

Dr D was appointed to a full-time role at the CMHT approximately six months after this letter was written, and was working full-time when he saw Mrs B. He remained concerned about the history of inadequate resources and the pressure being placed on him. Dr E was relocated to work in a hospital in a nearby city during August of that year and resigned to take up a new position in September.

The Clinical Leader Adult Mental Health Services at the District Health Board, advised me that mental health services at the District Health Board operated on a multidisciplinary team approach, which meant that it was expected that Mrs B's care would be arranged or provided by Mr C and Dr D working together.

Accessing mental health services and triage

The current Clinical Director of the District Health Board Mental Health Services, explained that the standard process for referral of clients to the Mental Health Service is for general practitioners to write a referral note or complete a Mental Health Service (MHS) referral form.

For more urgent referrals first contact is expected to be to the CATT, which is based in a city nearby. Once a referral to the CATT is received, the CATT staff triage the call and co-ordinate the response. When the CATT is responsible for the initial contact they are responsible for ensuring there is a safety plan, an interim management plan and a referral, if appropriate, to another level of care (such as a community mental health team or crisis respite). The CATT also manages clients for up to six weeks, if necessary, to ensure continuity of care and a baseline of treatment by either a community mental health team or GP.

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When a referral is received by a community health service (such as the CMHT), in the first instance it is expected that the referral will be triaged. This includes an assessment on safety issues, contact with the GP, information given to the client on how to contact the CATT, or referral to the CATT if urgent treatment is needed. Non-urgent referral to a community mental health team, in the normal course, is triaged according to need and people may be seen and assessed in a period of time ranging from days to weeks. During this time it is expected that the person will be encouraged to maintain contact with his or her GP and be given information on emergency contacts.

The CMHT does not operate a 24-hour crisis service, and where a patient is accepted for treatment by the CMHT, the CATT becomes an after-hours liaison team, responsible for assessing the patient when requested, completing interim management plans and notifying the CMHT of these contacts.

Dr E advised that in that year there were problems in relation to the CMHT accessing the services of the CATT for crisis situations because of "resourcing and backlog of cases".

Mrs B's initial presentation

On 27 July Mrs B consulted her general practitioner and discussed feelings of anxiety. Her doctor prescribed diazepam (which suppresses anxiety).

On 30 July Mrs B again consulted her general practitioner and presented with symptoms of extreme anxiety and insomnia. Mrs B was prescribed diazepam and midazolam (a sleeping pill).

On 31 July Mrs B and her husband, Mr B, visited her general practitioner again. Mr B said that he had noticed there was a serious problem with Mrs B and that the prescribed medication did not appear to be working. The general practitioner completed a referral letter and told Mr and Mrs B to go straight to the Mental Health Clinic. The referral letter was headed "semi urgent", addressed to the Team Leader of the CMHT, Mr C, and stated:

> "Thank you for seeing this woman with respect to extreme anxiety that has escalated dramatically in the past 3 days. Of significant note is that 14 years ago [Mrs B] had an 8 month admission with similar symptoms at that [sic] exacerbated by the birth of her son and 3 ½ years ago had a similar episode which was exacerbated by taking on the care of a dog which she later gave up.[1] This particular episode has been exacerbated by moving house. There are some major underlying issues here but her anxiety at present is so extreme that she is unable to work. She is almost catatonic [a state of psychologically induced immobility] at times and is completely unable to sleep. I have prescribed her some Diazepam tablets at night in high doses and Aurorix [an antidepressant] in the morning. I hope this helps her but I doubt it will be the end of the answer and I would value your urgent management."

[1] Ms A advised that she was not aware of any incident in which her daughter became upset over the care of a dog.

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Dr G said that the "semi urgent" referral from the general practitioner was not part of the standard referral process. He stated that there appeared to be some misunderstanding amongst general practitioners in that area at the time of Mrs B's treatment. The standard referral process was set out in a manual introduced two years prior but with the changeover of District Health Boards there was some confusion about processes.

Mr B recalled that after the consultation with the general practitioner he and his wife went straight to the local Mental Health Clinic and met with Mr C. Mr C did not make a record of this meeting, but Mr B said that Mr C organised an appointment with Dr D seven days later, on 7 August. Mr C did not advise him or his wife about the role of their general practitioner, or who to contact in an emergency. Nor did he advise Mr and Mrs B who would co-ordinate Mrs B's care.

Dr G advised me that when Mr C received the referral for Mrs B, as team leader he was responsible for assigning a co-ordinator for Mrs B's care and undertaking immediate triage – as set out in the manual. Mr C did not assign a co-ordinator and Dr G considers that Mr C's response to the general practitioner's referral was not adequate – indicating, in his view, a lack of experience. He noted that Mr C was appointed as team leader approximately four months before Mrs B was referred to the CMHT and was still new to being in charge of a community team. Accordingly, Dr G considers that the District Health Board must accept responsibility for the lack of clarity and action around the role of Team Leader. He identified the failure to clarify the role and responsibilities as a training issue.

Dr G noted that one of the regrettable side effects of the way Mrs B's referral was processed was that Mrs B and her family were left with the impression that the CMHT was responsible for a part of crisis management, which was not the case, and were distressed when Mrs B's mother made an attempt to contact the team during the weekend and found no one was available.

Dr E

Mr B advised that his wife's condition continued to deteriorate so, rather than waiting for the appointment with Dr D on 7 August, he rang the CMHT and made an earlier appointment for Mrs B to see Dr E on 3 August. Dr E described this visit as an "initial assessment" and said that it followed a discussion of Mrs B's case in a multi-disciplinary team meeting that morning. He said that the discussion meant that "I was familiar with the details of her case before I saw her" and that he had seen the referral letter from Mrs B's general practitioner, which did not mention any suicidality.

Dr E diagnosed "adjustment disorder on background of major depression with anxious features". He recalled that Mrs B denied any suicidal intent and that Mr B, who attended with her, also did not mention suicide. However, it was clear that the diazepam and midazolam had been of no assistance in helping Mrs B to sleep and Dr E prescribed a one-month supply of doxepin (a tri-cyclic antidepressant). Dr E advised that it is standard practice for the CMHT psychiatrists to prescribe a one-month supply of antidepressants after a thorough initial assessment, except in cases where patients present with any suggestion of suicidal ideation. The reasons he gave for this policy include that an

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antidepressant trial takes at least a month and there were cost considerations, relating to prescription costs. Dr E said he was also aware that Dr D was due to review Mrs B in a few days' time.

Drug overdose
On the night of 4 August, while staying with her mother, Ms A, Mrs B overdosed on diazepam and paracetamol. Ms A said she realised this when she found her daughter slumped in the toilet with empty blister packs in her handbag. Ms A called an ambulance and Mr B, who arrived shortly thereafter. Mr B said that when his wife was seen by the ambulance officers, she denied taking an overdose. Ms A stated that the ambulance officers left and told her that no damage would be done for 24 hours, but they would come again the next day if she was sure Mrs B had overdosed. Ms A said that Mrs B admitted overdosing the following morning so she rang for an ambulance again.

Mrs B was taken to a hospital in the nearby city by ambulance on 5 August and was seen at the Emergency Department. A triage note recorded that Mr B rang to say that "[Mrs B] has taken 15 diazepam and 20 Panadol. Told to call an ambulance and take to A&E. He also stated the day before she was found slumped in her chair after saying she had taken five strips of Panadol. Emergency services were called. She then revised her story saying she had taken them for menstrual pain over a period of 2 days."

Mrs B was admitted to the public hospital overnight on 5 August. She was released into the care of a friend in that city, Ms F, on 6 August. Prior to her release, a General MHS [Mental Health Services] Assessment form was completed at the hospital. This included notes about Mrs B's presentation and history and recorded that an acute appointment had been made with Dr D for 7 August. A copy of this form was faxed to the CMHT along with a cover sheet which included the statement, "It is of note that she has found counselling very helpful in the past …".

Clinical review
On 7 August, Mrs B saw Dr D with her husband. Dr D reviewed Mrs B's file before seeing her and then conducted a clinical review. Dr D recalled that Mrs B acknowledged her suicide attempt of 4 August, but said she was no longer suicidal. He decided to maintain Mrs B on her current medication and agreed to see her again on 21 August. Mr B advised that he expressed to Dr D his hope that his wife would be hospitalised for her own safety, but was told that this is "… not the way of treating people these days".

Dr D recalled that "throughout my care of [Mrs B], I was specifically assessing her in relation to the level of care (ie, hospitalisation) that she would need. She did not meet the threshold on either occasion [that he saw her]." Dr D felt constrained in that he could not admit patients directly to an inpatient unit. Any admissions had to be made through the CATT, who decided whether the patient should be admitted. He stated that it was very uncommon to be able to access crisis beds because the number of beds was limited and, in his experience, the threshold was very high.

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Mrs B had been scheduled to have her kidney stones treated by laser on 9 August, but this procedure was cancelled owing to liver damage caused by her overdose on 4 August.

On either 13 or 14 August[2] Mrs B, with Ms F's support, rang Dr D to express serious concerns over her inability to sleep and to request an earlier appointment with Dr D. Ms F was with Mrs B when the call was made. Dr D authorised an increase in Mrs B's doxepin dose and moved the appointment originally scheduled for 21 August to 17 August. Mr B advised me that someone from the CMHT later rang him to reschedule the appointment for 16 August.

Call to the public hospital

On 15 August, Ms F rang the public hospital and asked for advice. A Contact Triage Form[3] records that Ms F rang requesting advice about management of Mrs B's situation as she was "presenting in a panic but not suicidal". The form stated: "Plan – advised [Ms F] to contact the CMHT. [Has] Appoint. with Dr D 16/8 at 0900 hrs." The CATT records also record a phone call from Mr C to the CATT advising that Mr B had telephoned the CMHT from Ms F's house in the city, concerned about Mrs B's mental state. Mr B told Mr C that Mrs B was threatening to kill herself and could not sleep. Mr C requested assistance from the CATT to assess Mrs B as she was in the city. He was told that Mrs B should go to the CMHT for assessment.

Mrs B's clinical records at the CMHT note that Mr B was advised that he could bring Mrs B to see Dr E at the CMHT that afternoon if he felt that the situation could not be handled safely until the appointment with Dr D the following morning.

Assessment by Mr C and another nurse

On 16 August, Mrs B was assessed at the Mental Health clinic by Mr C and a registered nurse, in the absence of Dr D, who was unavailable owing to illness. Mr B and Ms F accompanied her. Mr C recorded in his notes that "the gist of this meeting was medication advice (discussed prior by phone with [Dr D]) and to formulate a plan, pending another appointment with the doctor". A letter from Mrs B outlining feelings of panic and despair was included in the file.

Presentation to Emergency Department

Later that day, at approximately 5.50pm, Mrs B suffered a severe panic attack at Ms F's home. Ms F recalled that this was precipitated by a visit to Mrs B's new house, a visit suggested by Mr C and the nurse at the appointment at the CMHT earlier in the day. Mrs B told Ms F that she thought she was dying and said she wanted to. Ms F tried to ring the CATT but only got through to an answer-phone. She therefore rang an ambulance. A still distressed Mrs B was taken by ambulance to the Emergency Department at the public hospital and an acute assessment was conducted by a registered nurse from the CATT. She recorded that Mrs B believed her mood to be very low after a "big panic attack earlier

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[2] Mr B and Ms F believe this call was on 13 August; Dr D on 14 August.
[3] A form on which the telephone call was recorded.

today". The nurse described her impression of Mrs B as very sad and "almost at the end of her tether".

Mrs B requested admission to hospital and noted that her support people were becoming tired and stressed with her mental health difficulties. The registered nurse discussed Mrs B's care with a psychiatric registrar and arranged for chlorpromazine 25mg to be prescribed, as well as the doxepin, and Mrs B was discharged into Ms F's care with a referral to CMHT. It was recorded: "Consider crisis respite from 17/8 (no respite available tonight). It may be useful to have Mrs B monitored overnight at respite. It will also provide her with rest and extra security and support. Support people can also have some rest and peace of mind. Mrs B in agreement with plan as is support person."

Ms F recalled that she attended this consultation with Mrs B and that in response to Mrs B's request for admission to the hospital ward, she was told that it "is not a very nice place". Mrs B was given a note with medication instructions and contact details for the CATT if she woke in the night. It stated: "We will get [Dr D] [from your area] to see you tomorrow and have your team arrange Crisis Respite for you in the morning." Mrs B stayed with Ms F that night.

Dr G confirmed that no respite beds were available on the night of 16 August. At the time the average occupancy of crisis respite beds was 60% and that night was one of the rare occasions when beds were fully occupied.

Follow-up on Emergency Department presentation
Dr G advised that the CATT were expecting Mrs B's support people to call on 17 August to discuss her state of mind and needs. However, the registered nurse's records of 16 August stated: "Both [Mrs B and Ms F] appreciate CATT not able to alter present Tx [treatment] plan and that [Dr D] and [the area's] CMHT will be responsible for any ongoing changes … copy of notes at A&E for reference and faxed to [the] CMHT." A form faxed to the CMHT included both the words "f/u [follow up] by [local CMHT] am please" and a label stuck to it which read "f/u by [local CMHT] am please". In addition an attachment to the notes stated:

> "Plan for 16/8 until 17/8 (as agreed by CATT, [Mrs B], support person and [another Dr])
> 1. D/C [discharge] home with support person
> 2. 25mg of Chlorpromazine orally added to regular prescribed drug regime
> 3. Fax to [the area's] CMHT – for f/u [follow up] on 17/8."

It was Ms F's clear expectation, after talking with the CATT staff on 16 August, that the CMHT would arrange respite care. She recalled that when she had not heard anything about the respite care by mid-afternoon on 17 August, she rang the CMHT. She was told that neither respite care nor an appointment with Dr D was being arranged. Ms F recalled that Mrs B was very angry when she found out. Mr B also recalled this phone call and said that the news had an enormously negative effect on Mrs B.

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Medication change

On 21 August, Mrs B saw Dr D, who changed her medication from doxepin to amitriptyline. Dr D made this decision because he thought the medication would be more effective and to prevent addiction to diazepam, which Mrs B reported she was taking to help her sleep after taking doxepin. Dr D prescribed a one-month prescription with automatic increases in dosage built in, starting at 150mg daily and rising to 200mg daily after five days and then 250mg daily after another five days. Dr D said he specifically told Mrs B to ring in the event of significant side effects, signs of relapse or crisis. He stated that Mrs B had severe sleeping problems necessitating a gradually increasing dose as rapidly as safe practice would allow. He said that in an ideal world it would have been possible to review Mrs B again, but there was no indication to do so. He also advised me that the therapeutic limit of 300mgs was not exceeded. I note that the *New Ethicals Catalogue* (November 2000 edition) advises that usual dosage is "initially, 75mg daily in single or divided doses. Upper range, 150mg daily. Maintenance 50–100mg daily".

Dr D believed that at the 21 August consultation he would have reviewed all the events since last he saw Mrs B, in particular the CATT assessment in relation to her potential for inpatient treatment. He did not have the resources available to him to adequately ensure the performance of a biopsychosocial formulation at the consultation. There was no psychologist available to him because the part-time psychologist, employed on a locum basis by the District Health Board, had a backlog of urgent cases and was consistently booked up three to four weeks in advance. He did not consider himself responsible for generating a more comprehensive and inclusive plan for Mrs B's treatment, as this was Mr C's role.

Dr D advised me that at all consultations he reviews with patients their depressive symptoms and observes and speaks with them about their concentration, interest, pleasure, diurnal mood variation, appetite and general functioning. He does not record negative findings for these symptoms in his notes.

Panic attack on 25 August

On Saturday 25 August, Mrs B suffered a panic attack while travelling with her mother, Ms A. Ms A drove to the Mental Health clinic and knocked on the door. No one answered, so Ms A returned home and telephoned the clinic. Again there was no answer, but an answer-machine asked her to leave a message and advised that someone would call back "in 15 minutes". Ms A left a message advising that she needed someone to call her within 15 minutes. Her call was never returned. An entry in the Mental Health team's notes records the details of Ms A's message and states "attempted to call, no answer". Ms A emphatically denies that an attempt was made to call her back. No further follow-up appears to have occurred.

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Panic attack on 27 or 28 August

The CMHT documentation records that on 27 August[4] Mrs B ran away from her mother and brother while at a local shopping mall. She was found crouching beside a main road. Ms A and her son took Mrs B to the Mental Health clinic where she saw a Community Mental Health Nurse. The nurse recorded that Mrs B had suffered a panic attack and was experiencing suicidal thoughts. He recorded in her notes that he had liaised with Dr E in Dr D's absence and included an instruction that Mrs B be reviewed "… with Dr D tomorrow by key-worker".

31 August

Mrs B had no further contact with mental health services until 31 August when Dr D documented a telephone call he received from Mr B and Mr C documented a telephone call he received from Ms F. Both Mr B and Ms F rang to express their concerns about a trip to Australia that Mrs B was considering. Later that same day Mrs B leapt from Ms A's car and ran through traffic before falling and cutting herself. An ambulance was called and Mrs B was seen at a public hospital in a nearby city before being assessed by two members of the CATT. The notes of the assessment stated that Mrs B:

> "…
>
> Is depressed, stating she wants to die. Family unable to manage.
> …
>
> Spoke to [Mr C] — ?secondary gain from being ill.
>
> …
>
> Some suicidal ideation related to feelings of hopelessness and despair. Has made two attempts recently. Remains at a low to moderate risk. Hospital not an option due to probable distress that this would cause and that this would not be beneficial (versus risk). [Mrs B] and husband aware of other options of care/support if the situation changes and have cell-phone number to use in this instance."

Mr B said that during the assessment his wife was asked several times, "Do you think taking your own life is an option?" Mrs B answered in a very confused state and was unclear in her response. Mr B recalled that she certainly did not say "no", but when pressed she indicated that she no longer saw suicide as an option. At the meeting a "safe house" was mentioned and Mr B expressed his view that Mrs B should be hospitalised. Mr B said that his wife had indicated to him several times previously that she wanted to be admitted to hospital.[5] A Risk Management Plan was completed as a result of the assessment and was faxed to the CMHT on 2 September. This plan requested that the CMHT provide follow-up on 3 September.

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[4] Ms F and Mr B stated that they recall this incident occurred on 28 August.

[5] Ms A also advised that over the period in question she, Mrs B and Mr B were all desperate for Mrs B to be admitted and that their request for admission was refused.

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On 31 August Mr C documented that Mrs B had been admitted to the public hospital in a nearby city, assessed by the CATT and discharged via the Emergency Department.

Mr B advised that on 1 September Mrs B showed some improvement, but became unsettled again after a telephone conversation with her mother.

Psychotherapist involvement

On 3 September Mrs B saw a psychotherapist in private practice. Mr B said that they sought help from him to accelerate Mrs B's progress towards recovery. Mr B said that he discussed Mrs B consulting the psychotherapist with Dr D and, at the psychotherapist's request, had asked Dr D for a note saying his wife was not suicidal. Dr D was not prepared to write such a note as he could not state categorically that Mrs B was not suicidal. In the absence of a note, the psychotherapist asked Mrs B to make a contract with him that she no longer had suicidal thoughts. Mr B said that while his wife made notes for this purpose, she did not sign a contract.

Dr D's review of the file

On 4 September a note in the CMHT written by Dr D stated "noted above for [follow-up]". Dr D advised me that this note indicated he had reviewed all entries in the notes since he had last seen the file. He did not take any action after reviewing the notes because he had ineffective and insubstantial resources available to him. He said that Mrs B had already been reviewed by the CATT, which was the agency responsible for vetting any referrals from him. He therefore did not consider inpatient care as an option.

Mrs B rang Dr D later that same day requesting extra medication to help her sleep. Dr D recorded in the notes: "Patient discussed with [indecipherable] was Rx'd [prescribed] Zoplicone [Imovane, a sedative] nocte prn [at night as required], in addition to Amitriptyline, with good result. This was requested by patient/family, as a result so see about for Rx (to be held/dispensed by mother)." Mr B advised that at this point Mrs B was at home with him and was not with Ms A.

Mr B recalled that his wife showed signs of improvement over the week beginning 3 September. On 7 September, he spoke on the telephone to Mr C about his wife's condition. Mr C recorded: "[Mrs B] is doing better, making tea and generally showing glimpses of her old self. An appointment is made for the 21.9. to see our psychologist and [Mrs B] is seeing [Dr D] on Monday the 10th [September]."

On 8 September, Mrs B committed suicide.

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Independent advice to Commissioner

Psychiatric advice
The following expert advice was obtained from Dr Deborah Antcliff, an independent psychiatrist:

> "**PURPOSE:** *I have been asked to provide independent psychiatric advice about whether [Mrs B] could or should have had anything further done for her.*
>
> *Whether the level of communication between the various staff and services involved in [Mrs B's] care was sufficient to ensure quality and continuity of services.*
>
> *Whether there are any aspects of any of the mental health staff that warrant either:*
> - *Further exploration by the investigation officer*
> - *Additional comment.*
>
> I have read all the material provided by the Office of the Health and Disability Commissioner, much of it is replicated, some is illegible, and of specific note there is no information provided by [Mrs B's] husband who was present at many of the assessments. The level of repetition of the same contacts made it difficult for me to be clear as to the exact number of them. I think she had at least 7 psychiatric (medical) assessments in the month, all, except one of these, (21 August) were acute assessments.
>
> [Mrs B] presented acutely and for the first time, to the Mental Health Team with 'severe panic and insomnia', which had not responded to 30mg of Diazepam nocte. She had also been started on Moclobemide by her GP. Her GP and husband gave a history of a very severe episode of postnatal depression, requiring hospitalisation and ECT, 14 years previously. Her husband recognised the early warning signs and sought treatment for her urgently to attempt to avoid a repeat of the earlier episode.
>
> Apart from that, it appears, she had been a competent, successful wife, mother, part-time teacher, and home-maker, right up until her referral.
>
> The appropriate diagnosis of a major depressive episode was made consistently throughout her contacts with the CMHT and CATT.
>
> Mrs B was seen multiple times by staff of the Mental Health Team and the CATT team at the public hospital from 3 August through to 31 August. In addition she made 2 emergency contacts with the Ambulance [Service] and there were several phone calls relating to her, to and from [the CMHT].
>
> Clearly there was no problem with access to services and she received thorough, comprehensive assessments repeatedly throughout her short illness.

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These assessments are well documented and appear to accurately reflect her mental state and the psychodynamic issues she was struggling with.

A different person, or pair of people did the assessments almost every time, thus there was no continuity of evaluation occurring.

She was probably disadvantaged by alternating between [the public] hospital CATT services and [the CMHT].

Each assessment appears to stand in isolation from all the information that is accumulating. Every assessment is cross-sectional, based entirely on her presentation at that point in time, uninformed by what had happened before.

[Mrs B's] husband, friend or mother were involved in every assessment, although it is unclear how much they were actively consulted for their opinion, or whether they were merely informed about decisions already made.

There was a very effective communication system between CATT and [the CMHT]. After every CATT assessment documentation was faxed through to [the CMHT] and each phone call is recorded. All attempts to call the family are noted, **although most were unsuccessful and not followed up**.

The standard of documentation is exemplary and allowed me to track the events leading to the tragic outcome relatively easily.

There are some judgements and decisions that were made that I believe are questionable in terms of best or safe practice. The comments that follow vary in significance with respect to the final outcome. I will highlight those I believe to be more contributory.

At the first assessment [Dr E] gave a patient he had never met before, presenting with acute anxiety and depression a month's supply of a tricyclic antidepressant. She proceeded to overdose the next day. She was to see the psychiatrist again 4 days later and a prescription for 4 days would have been more appropriate.

When the ambulance was called on 4 August they were persuaded not to take her to the hospital immediately because she changed her story from deliberate overdose to period pain relief. She suffered liver damage, possibly as a result of this delay, which could have been fatal if she had taken just a few more tablets. The ambulance officers should have erred on the side of safety as they were told she had probably overdosed by her mother.

On 16 August she had two separate in-depth acute assessments. This should have alerted [the CMHT].

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She saw [Mr C] and a colleague first. He identified the psychodynamic issues that were contributing to her depression. He also identified the need to formulate a more comprehensive plan. **This did not happen.**

No psychosocial interventions were offered to [Mrs B] or her family.

[Mrs B] was an articulate, insightful person, who had considerable awareness of what the issues were that had precipitated her depression. It was identified as early as 6 August that she responded well to counselling but [the CMHT] did not offer [Mrs B] anything of that nature during the month of contact. The precipitating factors were known from the outset, so this constitutes a **deficiency in service provision**.

Psychosocial interventions, eg CBT, are now recognised as equally effective as medication in the treatment of depression, and she would have been an ideal candidate.

In addition there was no work done to lessen her adverse reaction to her new home, or provide order in her day, despite the fact that she identified she was not coping with the lack of structure. No support was offered to help her deal with these issues. An occupational therapist would have been able to generate an appropriate programme.

On 16 August she provided a letter, (it is not clear to whom she gave it) which was very **despairing in content and tone. This may have resulted from her sense that nothing effective was being offered to her**.

[A registered nurse who was a member of CATT] and a CATT colleague did the second acute assessment on 16 August. This was when she **'pleaded to be admitted' according to her friend [Ms F]**. [The registered nurse], who effectively elicited the depth of [Mrs B's] depression, wrote that [Mrs B] asked for admission but gave **no reason why admission was not considered** although she did identify very clearly the reasons why **Crisis Respite should be considered** from 17 August. (She identified its unavailability for the night of 16 August.) Crisis respite was never assertively followed up.

It was also effectively dismissed as an option on 31 August, when she was again being assessed acutely, with the phrase 'they are aware it may not be available.' **No effort was put into making crisis respite a real option for [Mrs B] and her family**. …

There appears to have been **no one person at [the CMHT] responsible for recognising the significance of the multiple events, contacts and assessments and generating a single <u>proactive</u> multidisciplinary comprehensive care plan.**

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The acute assessments considered only the very immediate future, i.e. the next 12-24 hours after which there was **no active follow-up provided.**

There was far too great a reliance on the family/ friend making contact with the services on an 'as required' basis**.**

On 21 August [Dr D] assessed her for the second time. He recognised that she was not responding to the Doxepin and changed her to Amitriptyline.

He did not use this review as an opportunity to generate a biopsychosocial formulation and plan.

He does not appear to have reviewed all the events since [Mrs B] saw him last.

He does not appear to have considered himself responsible for generating a more comprehensive and inclusive plan, taking into account the precipitating factors.

He changed her medication, built in automatic increases of the new tricyclic antidepressant, to a high dose.

He gave her a month's supply and an appointment for 3 weeks hence.

Even with a 'medicate and wait' treatment approach, this is an unsafe way to practice. [Mrs B] was not responding to the treatment, that was the reason it needed changing. She was continuing to experience severe insomnia. It is not clear whether [Dr D] explored her depressive symptoms. He did not make any notes about her concentration, interest, pleasure, diurnal mood variation, appetite or general functioning. This is in contrast to the records of the assessments done by other staff, who had documented ongoing significant depressive symptoms e.g. 16 August. She therefore should have been reviewed frequently, to ensure that the new medication was effective and her symptoms were abating.

It is not usual practice to make automatic increments in dose of Tricyclic antidepressants, to higher than standard dose, **without review of the patient**. [Dr D] was, by this time, aware that her previous overdose had led to liver enzyme abnormalities, reflecting a significant overdose, **therefore to give her a month's supply of medication was not appropriate.**

On 27 and 31 August [Mrs B] behaved in a bizarre and very distressed way. It is noted on 31 August that [Mr C] queried 'the secondary gain from being ill.' This makes it sound as though he believed she was **not seriously depressed**.

The acute assessments on 27 and 31 August both documented the seriousness of her depressive symptoms and her intense distress. They also both identify suicidal ideation although not suicidal intent. On both 28 and 31 August her

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behaviour was entirely out of character and risky. I am not convinced it was responded to sufficiently assertively.

On 31 August **acute admission was considered but was dismissed** because 'Hospital is not an option due to the probable distress that this would cause and this would not be beneficial vs the risk.' The family was told that the ward was **'not very nice'**.

It is extremely serious if staff doing acute assessments believe that the full range of services and facilities that should be available actually do not provide therapeutic environments. This has the potential to **dangerously** affect their judgement.

I believe that [Mrs B] should have been admitted on 31 August.

She had been on large doses of antidepressants, and other medications, for a month by then. The notes of that day record that **'she wants to die. Family unable to manage'**. Her behaviour was becoming more desperate and risky. She could not be contained, she had not slept well for six weeks, her family had been supervising her continuously for a month and there was no sign of any improvements in her original presenting symptoms.

On 4 September it is noted that [Dr D] had read of the recent events, and that [Mrs B] was still requesting extra medication to help her sleep but **no action was taken to review her earlier than planned. She was never visited in her own environment despite the high number of crisis contacts she had made with the service by this time.**

In summary I believe more could and should have been done for [Mrs B]. She and her support people accessed the Mental Health Services appropriately and she utilised considerable resources in a short space of time.

- I do not believe these resources were appropriately applied.
- [The] Community Mental Health Team should have provided psychosocial interventions to complement medication. Psychosocial treatments must be included in Care Pathways.
- [Mrs B's] care plan should have been co-ordinated by a designated person, who should have attended to issues raised in the multiple acute assessments.
- In the absence of any other such person, [Dr D], as [Mrs B's] psychiatrist, should have ensured that the care being provided was comprehensive and appropriate.
- I do not believe he responded to the number of crisis contacts and increasingly bizarre and desperate behaviours adequately. There was information available in the later acute assessments that he did not respond to at all.
- [Mrs B] was not responding to standard treatment and therefore he should have reviewed her more frequently.

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- Her family should not have been expected to do all the help seeking and bear the entire burden of care.
- Crisis respite and acute admission should have been available, as required, and of a standard that did not cause staff to avoid accessing them.
- [Mrs B] should have been admitted at the point that it was clear her family was unable to contain her and her behaviour was unpredictable and increasingly risky."

Social worker advice
The following expert advice was obtained from Ms Paula Nes, an independent social worker working within a mental health service:

> "I have been asked to provide an opinion to the Commissioner on case number 01/13687, and have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I have a Social Work Qualification from the University of Cape Town, in South Africa. (Four Year Bachelor of Social Science, majoring in Social Work and Psychology.)
>
> I have had eighteen years experience in the social work profession, where my work has been in the field of health and disability, but the majority of which has been in the area of mental health. I have been working in health services in New Zealand since 1997.
>
> I have, over the years attended numerous training opportunities relevant to my field of practice. Most recently these have included training in Working with Grief and Loss, Cognitive Behaviour Therapy (CBT), Dual Diagnosis (Co-occurring substance abuse and Mental Illness), Differential diagnosis and mental state examination, Adult Teaching, Recovery Principles and practice and defusing and debriefing training.
>
> I have received training through Quality Health New Zealand in relation to survey and audit and have conducted audits as a member of a designated audit agency.
>
> I am currently employed as Professional Leader for social work in mental health Services at Counties Manukau DHB (CMDHB) and also have a quality and risk role within the mental health service. I am the Allied Health Representative on the Clinical Board of our DHB and the current deputy chair of the Clinical Board. I am also an active member of the Clinical Advisory Committee for the DHB.
>
> …

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Sources of Information Reviewed:

- Complaint letter from [Ms A] …
- Notes taken by [Ms A] and given to [a Dr] …
- Notes of interview with [Ms A] and [Ms F] …
- Statement made by [Ms F] to Police on 18 October …
- Statement made by [Mr B] to Police on 10 September …
- [Mrs B's] medical file, provided by [the District Health Board] …
- Mental Health notes, provided by [the District Health Board] …
- Letter and attachments provided by [the Clinical Leader, General Adult Mental Health Services at the District Health Board] …
- Letter and attachments provided by [the Clinical Practice Group Coordinator, Mental Health Service, District Health Board] Response from [Dr D], dated 21 May …
- [Ms B's General Practitioner's] medical notes …
- Response provided by [Dr E], dated 27 March …
- Expert psychiatrist advice provided by Dr Deborah Antcliff …
- Code of Health and Disability Services Consumers' Rights
- National Mental Health Standards Ministry of Health, 1997

…

Questions posed by the Commissioner:

Given the information available to [Mr C]*, could or should anything further have been done for* [Mrs B]*? If so, what?*

In my opinion, given the information available and the role of team leader it would have been expected that [Mr C] would ensure that there was a system in place for all clients to have an identified care manager/key worker appointed who would act as the key contact for each client. As the care manager [Mr C] would have, according to his job description, the role of 'ensuring all clinical and administrative steps necessary to assist clients to achieve optimal health, wellbeing and safety through the provision of, appropriate assessment, treatment and education'. [Mr C] would be expected to engage in a therapeutic relationship with this client. He would have the responsibility for effective collaboration with those professionals who had contact with [Mrs B] and her family and supports to ensure continuity of care and efforts in place to meet her changing needs. [Mr C] could have ensured better follow-up on recommendations and events that occurred, either himself, or by ensuring that systems were in place to do so. The following bullet points aim to illustrate the basis for this opinion.

- [Mr C], in his role as Team Leader arranged the first appointment for [Mrs B] for ten days from the date of receipt of the referral from her GP. The letter from her GP indicated escalation of extreme anxiety which impacted on her to the

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point that she was not able to work, 'is almost catatonic at times and is completely unable to sleep.' The GP noted medication prescribed, and ended the referral letter with '… and I would value your urgent management.' *It is of concern whether* [Mr C] *regarded* [Mrs B] *as requiring urgent assessment, given the acuteness indicated in the letter and the reason for the delay in assessment being the fact that* [Dr E] *would be leaving,* [Mr C] *made the decision to postpone the initial appointment until* [Dr D] *could see* [Mrs B]. On her presentation at [the CMHT] however, [Mr C] arranged the earlier appointment with [Dr E] and this was appropriate.

- [Mr C] was made aware of the family involvement throughout the period that [the CMHT] had contact with [Mrs B] and her family. *There does not appear to have been any attempt to seek to offer support or carer respite throughout this time or to consult with the family with regards to care-planning to the extent that they had the most experience of* [Mrs B], *at her most vulnerable, and her strengths and coping abilities during the years that she had not suffered from depression.* [Mr C] did, however support the husband when he rang on the 5th August from [the public] hospital, concerned that if [Mrs B] was discharged without a Mental State examination and then later required hospitalisation, this could be problematic. [Mr C] liaised with the C.A.T.T. and arranged for an assessment prior to discharge from the ward.

- From the notes reviewed, it appears that [Mr C] was the care manager for [Mrs B], as he was the only person in the team who had consistent contact with the family. There is little evidence to indicate that Mr C had established all the facts relating to Mrs B's initial presentation to [the CMHT]. On the 5th August when [Mrs B] was admitted to [a ward] following an overdose, [Mr B] was recommended to call [Mr C] at [the CMHT]. It would have been expected that during this call, the events leading to her admission to [the ward] would have been explored. This would have included discovery of the initial overdose the previous day where [Mrs B] was said to have 'taken 5 strips of panadol.' On arrival of the emergency services she indicated that she had taken them for menstrual pain. Again, it would have been useful to enquire whether this was a usual occurrence for [Mrs B], and the usual method of dealing with her menstrual pain, or whether she had raised this with her GP at any stage? […] GP notes indicate in a letter to the Endocrine Clinic 'an irregular menstrual cycle and no other significant past problems other than severe post-natal depression and headaches associated with her periods.' *At no time during the following weeks is the initial overdose referred to by* [Mr C] *as having been a self harm attempt. It would have been expected that Mr C would have routinely provided follow up for* [Mrs B], *after each of her other contacts with* [the CMHT] *and C.A.T.T. It would also have been* [Mr C's] *responsibility to complete a comprehensive treatment plan and the index of risk factors. Completion of these would have highlighted the escalating risk and the issues requiring attention, including the psychosocial issues that had decreased her coping skills in the past.*

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- Following the initial general mental health assessment by [a doctor] and the faxed cover sheet and notes from […C.A.T.T, (6/08)] there was clear indication that [Mrs B] required follow-up by [the CMHT] and that it was 'of note that she has found counseling very helpful in the past' [from the General MHS Assessment form]. *It would have been appropriate for* [Mr C] *to have pursued this in the treatment plan as an immediate option (particularly with the evidence base of CBT as a preferred treatment option for depression) and to have ensured that the history already gathered was used in formulating her treatment plan.*

- On the 16th August the meeting with [Mr C] made no reference to a phone call taken … the previous day, [recorded on a Contact Triage Form] which noted that [Mrs B] had been unable to be seen by C.A.T.T. The notes by [Mr C] reflected that the meeting was for 'medication advice'. In his care manager (with a social work professional base) capacity it would be expected that he would have looked to address the full psychosocial needs of [Mrs B] at any contact. This would include a mental state assessment and risk assessment, along with current issues. [Mr C] duplicated information already gathered and detailed some of the history and issues impacting on [Mrs B], but did not identify all the changes and losses as significant issues relating to her illness. No specific advice or treatment (apart from medication) or coping strategies were offered and these were instead deferred for 'discussion at the next appointment' [recorded in an Outpatient Clinic Case Sheet]. No reference is made to the letter which [Mrs B] gave to [Mr C] on the 16th August, apart from the use of the term 'red alert'. *It is of concern that* [Mr C] *did not see the significance of this letter and its content as a reflection of the distress that* [Mrs B] *was experiencing.*

- On the evening of the 16th August the interventions at A&E notes include an in-depth discussion with [a registered nurse] (C.A.T.T.) where [Mrs B] is described as 'almost at the end of her tether', on a mood scale of 0-10 [Mrs B] rated herself as a '3' and a complete mental state assessment, which indicated that [Mrs B] 'appreciates she is required to do much work around her psychological difficulties' [recorded on a Mental Status Examination form]. The Plan agreed to that night was for medication and follow-up by [the] CMHT to consider Crisis Respite from the 17th August. *It is of concern that there is no indication that this was seen or taken note of by* [Mr C]*, as the care manager for this client or team leader for the service and none of the suggested follow-up with respite or psychological therapy occurred.*

- [Mrs B] was seen by [Dr D] on the 21st August. *It would have been appropriate for* [Mr C] *to have raised some of the issues known to him on the 16th August that he noted would be deferred to the next appointment along with those issues that were noted by C.A.T.T. members on the evening of the 16th August in order for continuity of care to have been assured. The importance of this role being*

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highlighted as each time [Mrs B] *attended appointments, she was accompanied by different support people, none of whom would have had all the information that was available to the [CMHT] staff.* (It is acknowledged that this information is more clear to the advisor with the benefit of hindsight and all the notes in one place.)

- Faxed information from C.A.T.T. to [the] CMHT regarding phone call from [Ms A] on the 25th August and then notes of contact with [a staff member] at [the CMHT] on the 27th August 'review with [Dr D] tomorrow by keyworker' [recorded on a Contact Triage Form]. *As the care manager it would be expected that* [Mr C] *would have followed this up or raised the client for review in the MDT or with* [Dr D]. *There was no review the following day. As this information was faxed it is of concern that* [Mr C] *did not follow this up or ensure that there was a system in place to ensure that all faxed information from C.A.T.T. was reviewed by the team before being filed in the clinical notes.*

- On Friday the 31st August, there were two contacts detailed in the notes referring to concerns about [Mrs B] going on a trip to Australia. *It is not clear whether* [Mr C] *advised the callers to have the discussion of their concerns with* [Mrs B]. *It is apparent that* [Mr C] *did not then seek to have a direct conversation with* [Mrs B] *or call a family meeting as part of treatment planning and review and ensuring informed decision-making and informed choice on the matter.*

- In the afternoon of the 31st August when seen at hospital notes [in a Contact Triage Continuation Form] and subsequent mental status examination and risk management plan indicate severe depressive symptoms, suicidal ideation and impulsivity and heightened distress. Recorded as a low 'to moderate risk'. *It is of concern that the note relating to* [Mr C] *… queries 'secondary gain from being ill' but it is not clear whether this would have influenced treatment decisions at the time*. The faxed Risk Management Plan stipulated follow-up by [the] CMHT on Monday. *Given that* [Mr C] *was aware of the assessment by C.A.T.T. on the Friday, it would be expected that he would follow up on the Monday. There is no indication that this was followed up on the 2nd September, or indeed at all.*

Was the level of planning conducted by [Mr C] appropriate?

There is very little evidence in the documentation reviewed to indicate that [Mr C] *saw care planning as a part of his role. Of all his documentation notes only those* [recorded in the Outpatient Clinic Case Sheet for 7 September] *reflect forthcoming appointments with* [Dr D] *and* [another psychologist], *but no actual treatment plan with key areas identified and planned actions to address these. It would be an expectation that* [Mr C] *would have been the 'link' to combine all the bits of information and contact and chains of events with* [Mrs B] *and her family, into a whole picture that could be reviewed together with the family to ensure that the*

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picture was accurate. Then to plan the way forward with the family as partners in the care plan.

- ***Was the level of communication between the various staff and services involved in [Mrs B's] care sufficient to ensure quality and continuity of services?***

The level of communication from the C.A.T.T. and the various wards and departments at [the public hospital] and [the areas] Mental Health Services was of a good and effective standard.

The level of communication from [the CMHT] and the hospital and C.A.T.T. was more limited, but there is evidence in the documentation reviewed of phone calls and faxed copies of documents and information [in the Contact Triage Form for 5 August, the Contact Triage Continuation Forms for 6 August and 31 August].

The efforts of staff at [the CMHT] *to ensure continuity of care for* [Mrs B] *are not evident in the documentation reviewed.*

There does appear to have been deficiencies with the level of communication among staff within the CMHT where information that was sent via fax to the CMHT was not referred to at all times.

There are a few exceptions. [Mr C] liaises with [Dr D] on 16th August regarding medication. [Mr C] noted phone call from the police and liaison with C.A.T.T. [Dr D] then notes this information as read [in the Outpatient Clinic Case Sheet for 31 August and 4 September].

The [Contact Triage Form completed on 25 August] *indicated that C.A.T.T. would follow-up over the weekend and refer back to* [the CMHT] *on Monday. There is no documented evidence to suggest that the C.A.T.T. did follow-up over the weekend, but it is clear that the form was then faxed to* [the CMHT] *on the 26th August.*

- ***Please review the policies and procedures provided by [the District Health Board]. Were they adequate for dealing with situations like the one that arose in this case?***

- The documentation received relating to the [District Health Board's] Mental Health Services … Manual is comprehensive and clear and largely adequate for dealing with situations like the one that arose in this case. It is expected that the appropriate training of staff occurs alongside this pathway to ensure staff competency in relation to their responsibilities.

The [manual] stipulates standards, documentation requirements, rationale and responsibilities. (In line with National Mental Health Standards, Standard 7, Consumer record and documentation.)

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Standard documentation is referred to in the … manual which includes a statement where 'All clients must have current Index of Risk Factors, Risk Management Plan (if indicated), Treatment Plan and Treatment Review in their primary file'.

Throughout the documentation reviewed, reference is made to [the] CMHT and [Dr D], as the primary team responsible for the care of [Mrs B].

- The Contact Triage Form was used extensively for the contacts with [Mrs B] and her family and supports. The information on these forms was adequate in describing the issue, the urgency, the actions taken and the recommendations. Staff appear to have current knowledge on the purpose and use of these forms (in Line with National Mental Health Standards, Standard 13 and 14, access and entry to mental health services).

- The [DHB] Mental Health Service Assessment Form is clear and specific and comprehensively completed for [Mrs B] […] and was useful in identifying current risks and safety issues, initial care plan and recommendations for management including crisis strategies (in line with Standard 15 National Mental Health Standards, Consumer care treatment and support, based on a comprehensive assessment completed by a health team with appropriate knowledge and skills).

- Mental Status examination and acuity is clear with good prompts to encourage a comprehensive mental state examination. *There was an issue of the acuity score not being completed consistently on this form.* The acuity rating scale procedure is clear and user friendly but would require staff to undergo specific training to ensure usefulness and standard utilisation across the services.

6th August, MSE [Mental Status Examination] completed with no acuity score recorded. …

16th August, MSE completed with no acuity score recorded. …

31st August, MSE has an acuity score, … but with only limited information and first contact with the assessors it looks underscored and reflected lower risk and acuity scale than may otherwise have been indicated. (There is concern that the discussion with Mr C [documented in the Contact Triage Continuation Form of 31 August 2001] may have influenced the acuity rating and therefore the risk management at this time. But this is not conclusive.)

- According to the manual, the Index of Risk Factors form should generally be filled in by the clinician who has the best knowledge of the client and their history, and who has access to all of their mental health files. In the community this is usually the client's care manager/individual clinician and in an inpatient setting it will usually be the Primary Nurse. Judgement of risk is based on the clinician's knowledge of the client's past behaviour and current clinical presentation, and will take into account reports from relevant other people. It is

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expected that the clinician will discuss risk issues with relevant other people, including the multi disciplinary team, in order to make a valid judgement of level of risk. The standard stipulates that every client must have an Index of Risk Factors completed.

It appears that no such Risk Index was completed at any stage for [Mrs B]. This may have had an impact on the lack of continuity and inability to identify the whole picture with regard to [Mrs B's] *multiple presentations, increased distress and acuity. (Standard 7 of National Mental Health Standards refers to Consumer record and Documentation to assist with coordination of care.)*

- The Risk Management Plan is clear, easy to follow and pertinent to assessment of risk. It is not written in 'consumer friendly language' but has an area to identify early warning signs as well as intervention recommendations for management. There were several Risk Management plans within the documentation reviewed, but of them, only one was completed with early warning signs and clear interventions and recommendations. (31st August …). On the 6th August, Risk Management Plan incomplete, as no early warning signs identified. …. *From these examples it is unclear whether all staff have received training and are aware of the importance of discussing early warning signs with consumers and their families and support people in an effort to aid recovery (in line with National Mental Health Standards and recovery principles).*

- ***Are there any aspects of any of the mental health staff which you consider warrant either:***

- ***Further exploration by the investigation officer?***

No, it appears that the aspects of care as delivered by [Dr D] are already under investigation.

No-one else specifically stands out as warranting further exploration.

- ***Additional comment****?*

It is not known whether anything could have prevented [Mrs B] taking her life on the 9th September, as these events are not always preventable or entirely predictable.

As noted by Dr D. L. Antcliff, the documentation received was confusing in that it was not in chronological order at all times. Duplicate copies made it difficult to follow in the first instance.

The written information submitted by [Mr C] shows poor attention to detail and is inaccurate at times. This occurred both in the body of the notes and in his

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chronological list of events leading to the culmination in the death of [Mrs B]. *This may have been due to the stress / pressure at the time of having to compile this list.*

([In the Outpatient Clinic Case Sheet completed on 16 August] the age at which [Mrs B] is said to have given birth to her son is incorrect. In [Ms A's] letter, she refers to [Ms B's son] having been born approximately 15 years ago, which would put [Mrs B] at approximately 30 years of age.

Stated further down in those notes referring to the period when [Mr B] was overseas that just [Mrs B] and her mother lived together. No mention of… her son at that time at all.)

[In his memo of 10 September] [Mr C] writes Clomipramine instead of Chlorpromazine.

In the Chronological list [completed by Mr C after Mrs B's death], 07/08 is repeated and other dates are omitted.

There is little indication of the family being involved as partners in care-planning, it is unclear whether the staff had received any training in involving families at all levels of the service. There was more emphasis on 'symptom management' and less on recovery and enabling and supporting the individual, [Mrs B], to cope with the disabling effects of her illness on her life.

Thank you for the opportunity to review the notes which resulted in this tragic outcome. I hope that this review is of some use to you in coming to your decision.

Please accept my sincere condolences to the family in their time of grief.

Paula Nes
B.Soc.Sc. SW. MANZASW"

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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.*

…

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

RIGHT 6

Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —*
   …
   b) *An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …*

Opinion: Breach — the District Health Board

Overview
Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) affirms a patient's right to have services provided with reasonable care and skill. Right 4(5) affirms a patient's right to co-operation amongst providers to ensure quality and continuity of care.

The care provided to Mrs B was not of an appropriate standard. Her care was not co-ordinated, she was not admitted to hospital when she needed to be, and her (and her family's) desperate pleas for help were met with ineffectual responses. Dr D, the psychiatrist responsible for Mrs B's care, and Mr C, the team leader responsible for co-ordination of her care, must take some responsibility for this, but there were serious systems failures for which the District Health Board was responsible.

The District Health Board has acknowledged that "the quality of the services provided to [Mrs B] fell below that standard that we expect of ourselves".

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My analysis of the failures in Mrs B's care follows. In criticising the various shortcomings, I appreciate that it cannot be known whether Mrs B's tragic suicide could have been avoided. Sadly, suicide is sometimes the end point of a serious mental illness. I am also conscious of the need to guard against the inevitable hindsight that colours the judgement of agencies charged with inquiring into mental health tragedies.

Accordingly, I have sought to determine what could reasonably be expected of Mrs B's providers given what they knew at the time and the resources available to them.

Resource constraints

At the time of Mrs B's care, the District Health Board had been responsible for the provision of Mental Health Services in Mrs B's area for little over a year. Issues arose as a result of the changeover in management. This is important background to the inadequacies in Mrs B's care. Mr C commented that changes to the management of the CMHT had not been sensitively handled and that the dynamics and distractions of this may have negatively impacted on "the overall level of care and communications and roles and responsibilities". Dr G noted that there were changes in personnel, training issues and confusion about processes. Dr D was concerned that the CMHT was under-resourced and provided me with correspondence he sent management at the time about his concerns. Dr E also expressed concern about lack of resources.

Under clause 3(1) of the Code it is a defence for a provider to show that it took "reasonable actions in the circumstances to give effect to the rights" of a patient. The "circumstances" mean "all the relevant circumstances, including the provider's resource constraints" (clause 3(3)).

The resource constraints faced by mental health services at the District Health Board that year were significant and clearly impacted on Mrs B's care. The question for determination is whether the District Health Board responded reasonably given the lack of resources. For the reasons that follow, in my view the service failures in Mrs B's care can be partly explained, but not excused by the resource constraints.

Lack of co-ordination of care – breakdown in policies/procedures and training

There are numerous examples of breakdown in co-ordination of Mrs B's care. My expert social work advisor, Ms Nes, advised me that the policies and procedures in place at the District Health Board through the Mental Health Services Manual were comprehensive, clear, and largely adequate. The forms provided for the purpose of documenting Mrs B's condition and course of treatment were adequate. However, policies and procedures are only useful when staff are appropriately trained in their implementation and steps have been taken to ensure their competence in relation to their documented responsibilities. Forms are only useful when they are completed appropriately.

Dr G noted that Mrs B's first contact with the CMHT was after a "semi-urgent" referral note from her general practitioner. He advised that this is not a standard referral process set out in the manual document. Usually "non urgent" referrals are made to the CMHT and "urgent" referrals are made to the CATT. The "semi-urgent" referral was indicative of

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confusion existing in the area following the takeover of their mental health services by another District Health Board.

The failures in Mrs B's care started from the initial management of the referral. Dr G acknowledged that one of the regrettable side effects of the way that Mrs B's referral was processed was that Mrs B and her family had the impression that the CMHT staff were responsible for crisis management. As the point of first contact, it was up to the CMHT staff to advise Mrs B and her family of the services available, and to either plan and co-ordinate Mrs B's care themselves, or to make an urgent referral to the CATT. This did not occur.

While the various providers involved in Mrs B's care appear to have documented their contact with her appropriately and communicated this to other providers, no one person took responsibility for analysing these contacts, acting on them and co-ordinating Mrs B's care. The overall picture is of care provided in a haphazard and disjointed manner with no one person taking responsibility for Mrs B's well-being. The presence of a dedicated staff member with an overview of Mrs B's care and the responsibility for planning future care would have ensured more proactive, co-ordinated and effective treatment.

The Clinical Leader, General Adult Mental Health Services, advised me that mental health services at the District Health Board operate on a multi-disciplinary team approach to care and that this meant Mr C and Dr D were expected to work together to provide or arrange input into Mrs B's care. However, as my expert psychiatric advisor, Dr Antcliff, stated: "There appears to have been no one person at [the CMHT] responsible for recognising the significance of the multiple events, contacts and assessments and generating a single proactive multidisciplinary comprehensive care plan."

Dr G noted that Mr C was responsible for assigning a co-ordinator for Mrs B's care. He stated that Mr C could have delegated this role to someone else, but as Team Leader he retained responsibility to ensure good practice. This is set out in the manual document. In addition, Mr C's job description stated that he was responsible for "all clinical and administrative steps necessary to assist clients to achieve optimal health, wellbeing and safety through the provision of appropriate assessment, treatment and education". He was therefore responsible for the co-ordination of information and contact. However, Ms Nes advised me that there is very little evidence to indicate that Mr C saw care planning as part of his role.

The District Health Board has accepted that it must take responsibility for the failure to clarify with Mr C his responsibilities as a team leader, and for the fact that Mrs B was not appropriately triaged when she first presented.

Dr Antcliff advised me that in the absence of any other such person, Dr D, as Mrs B's psychiatrist, should have ensured that the care being provided was comprehensive and appropriate. Dr D's job description stated that he was "responsible for taking all clinical steps necessary to assist clients to achieve optimal health, wellbeing and safety through the provision of appropriate assessment, intervention and education". However, it appears that

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Dr D was also of the view that care planning was not part of his role. He advised me that this was the role of the care manager. Dr D added that he was already operating under a heavy workload and was under severe pressure – the implication being that even if he had wanted to, he would not have been able to take on the extra duties this would have entailed.

As neither Mr C nor Dr D appears to have seen themselves as responsible for planning Mrs B's care, there was little planning in any of her contact with the CMHT. Much of the care that was provided appears to have only looked at her presentation at that point in time, in isolation from all the information accumulating. No counselling was offered, despite it being identified early in Mrs B's presentation that she responded well to counselling; there were no psychosocial interventions arranged by the CMHT, except for an appointment made in the first week of September with a psychologist, for late September; she was not visited at home; and no plan was in place to help Mrs B with the issues precipitating her depression.

Dr G advised me that Mr C and Dr D reacted to Mrs B's individual acute presentations, and the opportunity to discuss her case at a multi-disciplinary team meeting did not arise. Treatments such as cognitive behavioural therapy and occupational therapy were not offered because normally they would be part of a comprehensive management plan. The fact that there was no such plan stemmed from the initial management of the referral.

There were serious systemic failures arising from the changeover of responsibility for provision of mental health services in the area to the new District Health Board. A key Mental Health Team staff member (Mr C) was inadequately trained in his role and responsibilities; there was lack of clarity around the processes; the full-time psychiatrist felt overworked and unsupported in terms of access and resources; and the CATT was not always able to respond to requests for crisis assistance for patients in the area.

In summary, Mrs B's care was not appropriately planned and co-ordinated from the time of her first visit to the Mental Health Team. This meant that she did not get the full range of care or continuity of care she needed. In my opinion, by failing to ensure that the roles and responsibilities of staff were clear, that processes were clearly understood by those involved, and that there was a clear system for ensuring co-operation among providers to ensure continuity of care, the District Health Board breached Rights 4(1) and 4(5) of the Code.

Failure to admit

Mrs B and her family repeatedly asked that she be admitted to hospital for treatment. The reasons why hospital admission was not considered an appropriate option for Mrs B's care are not clear, nor were they explained to Mrs B and her husband, or her mother and Ms F, who were her main caregivers. Dr D saw the CATT as gatekeepers to hospital admission and appeared to resent that he could not admit patients directly to hospital. He did not contact the CATT to discuss the possibility of hospital treatment as Mrs B's condition deteriorated. The CATT's reasons for not considering admission were not explained and

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they gave Mrs B and her family the impression that any change in the treatment plan was CMHT's responsibility.

Requests for admission were made twice to the CATT staff, as well as to the CMHT staff on a number of occasions. The first time a request was made to the CATT staff was on 16 August, when Mrs B was assessed, having been taken to the public hospital by ambulance after a severe panic attack. It was the second time she had been assessed that day (the first assessment was by the CMHT staff). She was accompanied by Ms F, who says Mrs B begged to be admitted to hospital. The CATT staff member who assessed Mrs B told her that hospital was "not very nice" but did not explain to Mrs B or document why hospital admission was not considered an option. However, the staff member did discuss the option of crisis respite care with Mrs B. Unfortunately (and according to Dr G, unusually) a crisis respite bed was not available that evening. The CATT staff member recorded "consider crisis respite from 17/08" and faxed this information to the CMHT. The CMHT did not follow up this option, despite a request from the family. Mr B recalls Mrs B's disappointment and anger that respite care was not being arranged for her.

The option of hospital admission was raised again with the CATT by Mr and Mrs B on 31 August. Mrs B had been taken to a public hospital by ambulance after leaping from a car. The notes record:

> "Hospital is not an option due to the probable distress that this would cause and this would not be beneficial (versus risk)."

Dr Antcliff advised me that Mrs B and her family accessed mental health services appropriately, and that crisis respite and acute admission should have been available, and of a standard that did not cause staff to avoid accessing them. Mrs B should have been admitted at the point when it was clear her family was unable to contain her, and her behaviour was unpredictable and increasingly risky. The family should not have been expected to do all the help seeking and bear the entire burden of care.

In response to my provisional opinion, Dr G stated that Mrs B's support people did not advise mental health staff that they were not coping. However, the CATT notes of 16 August state that Mrs B felt her support people were becoming tired and stressed and the notes of 31 August state that Mrs B advised staff that her "family [was] unable to manage". Mr B, Ms A and Ms F all cared deeply for Mrs B and were highly supportive of her. As Mr B noted, "[Mrs B's] family and friends who were her caregivers were untrained for this situation. We were emotionally involved, under extreme stress, having to cope as best we could." They repeatedly asked that she be admitted to hospital. In these circumstances I do not accept that mental health staff were not aware that Mrs B's support people were finding it difficult to cope.

Dr G also pointed out that Mrs B's support people were active participants in the decision-making about treatment options and planning. I accept this. In my view Mr B, Ms A and Ms F were all very clear in what they wanted for Mrs B — hospital admission. The

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decision not to admit Mrs B to hospital was one taken by her clinicians in the face of the ongoing requests by Mrs B and her family that she be admitted.

Dr G submitted that the apparently negative comments of clinicians about inpatient care reported by the family (in particular, that the hospital was "not very nice") should not be interpreted as being reflective of a "non therapeutic environment" in the inpatient wards. He noted that there was no evidence to suggest that Mrs B was not admitted to hospital because staff avoided accessing hospital services because a "non therapeutic environment existed". Dr G stated:

> "[Although] the family reported clinicians' comments that 'it's not very nice' [in hospital] staff did not record this or recall this comment. There may have been discussions regarding the ward as a not ideal environment for [Mrs B's] particular needs.
>
> These comments themselves do not provide any evidence of a non-therapeutic environment within the ward. The fact that it was identified that [Mrs B] would probably not find the ward 'nice', and that it would likely cause her distress, are reflective only of the nature of [Mrs B's] particular circumstances, and are in sense reflective of a general 'non-therapeutic environment' on the ward. While of course every effort is made to make an inpatient ward an easy and comfortable place to be for clients, the inevitable reality is that a public hospital acute psychiatric ward is an environment in which some people may not feel comfortable. For someone such as [Mrs B], given her circumstances and the nature of her illness, it was clearly thought by staff assessing her that the ward would not be a place where she would get the greatest benefit. Allied with this is the CATT staff's effort to preserve a client's contact with their community. Once a person is admitted to hospital these links are very often broken. For instance, on 31 August [Mrs B] reported that she had made an appointment on 2 September with a private psychotherapist with whom she had had a successful therapeutic relationship in the past. [Mrs B] reported that she was very much looking forward to having this meeting. Admitting [Mrs B] at this time might have made it more difficult for this appointment to be kept.
>
> As you know, not every person with a severe mental illness necessarily benefits from admission to an inpatient ward. In some circumstances, admission is contra-indicated, not because of a lack of therapeutic environment, but because of other factors related to the nature of the problems requiring attention."

Dr G commented that the decision not to admit Mrs B was one made by individual clinicians at the time of assessment, based on Mrs B's presentation and mental state. He stated that if a clinician had decided that it was appropriate to admit Mrs B, then she would have been admitted.

I find the Board's explanation unconvincing. It begs the question *why* the CATT staff decided it was inappropriate to admit Mrs B. The answer is set out in their notes:

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"Hospital not an option due to the probable distress that this would cause and that this would not be beneficial (versus risk)."

It defies belief that the risk of self-harm by a woman who had overdosed four weeks before, had suffered major panic attacks over previous days, had leapt from a moving car earlier that day, and who was depressed and stating she wanted to die, would be thought to be outweighed by the possible harm from a 'non-therapeutic' ward environment, missing a psychotherapy appointment, and temporary loss of community links.

In her desperate state, Mrs B needed to be in the safety of a hospital ward. I agree with Dr Antcliff's advice that Mrs B's condition on 31 August was such that she should have been admitted acutely to hospital.

Instead, the CATT staff sent Mrs B home and faxed a Risk Management Plan to the CMHT for follow-up the next day. Dr D and Mr C were both aware of the 31 August assessment. Dr D said that he did not view inpatient treatment as an option, given that the CATT did not recommend it on 31 August. The failure to have in place a system where Dr D felt that he could access inpatient services as an option for Mrs B if appropriate is an indictment on the District Health Board.

It is also of concern that an adequate explanation for the non-admission was not given to Mrs B and her family. The failure by all staff concerned to discuss and adequately explain to Mrs B and her caregivers why hospital treatment was not considered appropriate (despite her many requests for admission and her deteriorating condition) denied them the information that a reasonable consumer in her circumstances would expect – and was entitled – to receive.

These were serious systems failures. The staff who cared for Mrs B rejected hospital admission as an option, and failed to explain why they did not consider it appropriate, despite Mrs B's deteriorating condition. In these circumstances, the District Health Board breached Rights 4(1) and 6(1)(b) of the Code.

Opinion: Breach — Mr C

Although the District Health Board has accepted responsibility for failure to ensure that Mr C was clear about his responsibilities in his role as Team Leader, Mr C himself must also accept responsibility for the failings in Mrs B's care.

My independent expert social work advisor, Ms Nes, advised me that she did not consider that Mr C's care was of an appropriate standard in the following respects. Mr C:

- did not make an immediate appointment for Mrs B's initial assessment when he received the referral from Mrs B's general practitioner on 31 July, and may not have

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regarded Mrs B as requiring urgent assessment, despite the referral requesting "urgent management" and indicating escalation of her extreme anxiety

- did not appear to offer support or carer respite to Mrs B's family or to have consulted with them about her care apart from in response to Mr B's telephone call of 5 August
- did not investigate all the facts relating to Mrs B's initial presentation to the CMHT
- did not complete a comprehensive treatment plan or index of risk factors
- did not follow up on each of Mrs B's contacts with the CMHT or the CATT
- did not follow up on the fax of 6 August which advised that Mrs B had found "counselling very useful in the past" when it would have been appropriate to have pursued this treatment course as an immediate option and included it in formulating a treatment plan
- did not look to address Mrs B's full psychosocial needs at his appointment with her on 16 August, including a mental state assessment and risk assessment along with current issues. Mr C duplicated information already gathered and detailed some history and issues in relation to Mrs B, but did not identify all the changes and losses as significant issues relating to her illness, and did not offer any advice, treatment or coping strategies
- did not refer to the letter Mrs B presented to him on 16 August apart from use of the term "red alert" and did not appear to see the significance of the letter as a reflection of the distress Mrs B was experiencing
- either did not see, or did not note, the in-depth discussion between Mrs B and the CATT nurse documented in the Accident and Emergency Department notes of 16 August and did not act upon the suggestions for follow-up with respite or psychosocial therapy contained in them. These notes include four separate requests that follow-up be arranged by the CMHT
- did not advise Dr D of the issues he was aware of before Dr D met with Mrs B on 21 August, which was particularly important given that each time Mrs B attended appointments she was accompanied by a different support person, none of whom would therefore have had access to full information about her
- did not follow up an instruction by a member of the CMHT on 27 August that Mrs B be reviewed the following day with Dr D by a key worker or review the notes faxed by the CATT on 25 August
- failed to contact Mrs B or call a family meeting when telephone calls were received from both Ms F and Mr B expressing concern about a trip to Australia planned by Mrs B
- failed to act on a recommendation from the CATT faxed on 31 August which recommended that Mrs B be followed up by the CMHT on 2 September.

In my opinion, this list reflects a pattern of substandard care which is characterised by a failure to plan, a failure to liaise appropriately with Mrs B and her family, and a failure to act on the advice of other providers. Mr C does not appear to have acted as anything more than a simple administrator, filing information as it came in, without review. Mr C's job description stated that he was responsible for "ensuring all clinical and administrative steps necessary to assist clients to achieve optimal health, wellbeing and safety through the provision of appropriate assessment, treatment and education are carried out" and "to

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provide senior clinical advice, support and the setting of a vision and strategy for the community mental health team to perform its functions …". Ms Nes informed me that Mr C would therefore have been expected to have engaged in a therapeutic relationship with Mrs B. He would have been expected to collaborate effectively with other professionals who had contact with Mrs B and her family, to plan her care, to ensure continuity in her care, and to make sure efforts were in place to meet her changing needs. Ms Nes advised me that Mr C could have ensured better follow-up occurred, either himself or by ensuring that systems were in place for others to do so.

I accept my expert advice. In my opinion, Mr C did not ensure follow-up occurred when it was needed, did not plan appropriately for Mrs B's care, and did not liaise appropriately with Mrs B, her family and other providers. In these circumstances he failed to provide Mrs B with services with reasonable care and skill, and failed to ensure that individual providers co-operated to ensure quality and continuity of care. Although the District Health Board has accepted the training issues in relation to Mr C, this does not excuse Mr C's failure to provide services to Mrs B of an appropriate standard. In these circumstances, Mr C breached Rights 4(1) and 4(5) of the Code.

Opinion: Breach — Dr D

Dr D, the community consultant psychiatrist, must also accept responsibility for the failings in Mrs B's care.

Dr D first saw Mrs B on 7 August, after Mr C had arranged an appointment following a referral from her general practitioner. This was three days after a serious drug overdose that damaged her liver. At the consultation Dr D decided to maintain Mrs B on her current medication and to review her again in two weeks' time.

Dr D next saw Mrs B two weeks later, on 21 August. In the meantime she had suffered a severe panic attack (on 16 August) and been taken by ambulance to the Emergency Department, but discharged. Yet Dr D changed Mrs B's medication from doxepin to amitriptyline and prescribed her a month's dosage with automatic increases of dosage included in the prescription. I wholly endorse Dr Antcliff's advice that it was not appropriate for Dr D to prescribe a month's supply of medication when he was aware Mrs B had recently overdosed, and that this had led to liver enzyme abnormalities.

Although Dr D advised me that his prescribing was within therapeutic limits, it exceeded the usual dosage levels outlined in the *New Ethicals Catalogue*. Dr Antcliff advised me that this was an unsafe way to practise. It is not usual to prescribe for automatic increments in tricyclic antidepressants to a higher than standard dose, without reviewing the patient. Dr D responded that although reviewing Mrs B might have been possible in an ideal world where he could see patients once a week, it was not indicated in this case.

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Dr Antcliff highlighted a number of shortcomings at the appointment of 21 August. Dr D:

- did not use the review as an opportunity to generate a biopsychosocial formulation and plan
- does not appear to have considered himself responsible for generating a more comprehensive and inclusive plan, taking into account the precipitating factors
- does not appear to have reviewed all the events since last he saw Mrs B
- did not make notes about Mrs B's concentration, interest, pleasure, diurnal mood variation, appetite or general functioning, nor is it clear whether he explored her depressive symptoms
- changed her medication inappropriately, giving her a month's supply of medication.

Dr D responded that he would have reviewed all the events since last he saw Mrs B, in particular the CATT's assessment of her potential for inpatient treatment. He did not have the resources available to him to adequately ensure the performance of a biopsychosocial formulation at the 21 August consultation. There was no psychologist available to him; a psychologist was employed part-time on a locum basis by the District Health Board, but it was practically impossible to refer cases to her given the backlog of urgent cases and because she was consistently booked up three to four weeks in advance. Dr D was also aware that Mrs B had sought advice from a private psychotherapist independently of the CMHT. He did not consider himself responsible for generating a more comprehensive and inclusive plan for Mrs B's treatment, as this was Mr C's role.

Dr D advised me that at all consultations he reviews with patients their depressive symptoms and observes and discusses their concentration, interest, pleasure, diurnal mood variation, appetite and general functioning. He does not record negative findings for these symptoms in his notes.

On 4 September a note in the records indicates that Dr D had read recent entries about Mrs B's care, but no action was taken.

Dr Antcliff commented that Dr D did not respond adequately to the number of crisis contacts and Mrs B's increasingly bizarre and desperate behaviours. There was information available in the later acute assessments that he did not respond to at all. Since Mrs B was not responding to standard treatment, Dr D should have reviewed her more frequently.

Dr D submitted that he did not take any action on 4 September because he had ineffective and insubstantial resources available to him. He said that Mrs B had already been reviewed by the CATT, which was the agency responsible for vetting any referrals from him. He therefore did not consider inpatient care an option. I do not accept that this justified not contacting the CATT to arrange further assessment or consider respite care. The CATT had previously clearly indicated that Mrs B should be considered for crisis respite care and asked the CMHT to follow up this suggestion. Dr D failed to act on this advice.

HDC

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Dr Antcliff considered that Mrs B's care plan should have been co-ordinated by a designated person who should have attended to issues raised in the multiple acute assessments. In the absence of any other such person, Dr D, as Mrs B's psychiatrist, should have ensured that the care being provided was comprehensive and appropriate.

While Dr D considered that generating a more comprehensive and inclusive plan for Mrs B's treatment was Mr C's responsibility, there is no evidence that he raised this with Mr C. From his reviews of the clinical records it was, or ought to have been, clear to him that no such plan existed and care was not being co-ordinated. Dr D advised me that he reviewed files before seeing patients, and that on 21 August he would have reviewed all events since the last time he saw Mrs B. Having done this, Dr D should have been aware of the note from Mrs B included on the file on 16 August outlining feelings of panic and despair; the note from the CATT the same day, which recommended that admission for respite care be considered; and the requests from the CATT for follow-up faxed to the CMHT on 17 August. In the circumstances, Dr D should have taken steps to ensure that the care provided was comprehensive and appropriate.

I accept that Dr D was acting under resource constraints. He was unable to arrange an inpatient admission except by referral to the CATT. However, I do not consider that the lack of resources excuses his failure to assess Mrs B's condition adequately, respond appropriately to a number of crisis contacts and her increasingly bizarre and desperate behaviours, or to prescribe appropriate medication. In a recent District Court decision, Hubble J stated: [6]

> "There can be no doubt that the test [for a doctor's duty of care] is harsh on medical practitioners who are working under-resourced and under-staffed and often extreme hours. The expected standard in relation to medical practitioners must be high, because unlike with lawyers and psychologists, errors can be life threatening or fatal. Only the practitioner himself or herself can assess their personal capacity when confronted with a problem, it is right therefore that they alone can decide whether it is desirable to call on further assistance or advice, or at least invite greater participation from those assisting who might otherwise be reluctant to intervene."

In my opinion, Dr D failed to provide services to Mrs B with reasonable care and skill and did not ensure that her care was properly co-ordinated. In these circumstances, Dr D breached Rights 4(1) and 4(5) of the Code.

[6] *Perera v MPDT* (Whangarei District Court, MA94102, 10 June 2004).

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Opinion: No breach — Dr E

On 4 August Dr E prescribed Mrs B a month's supply of tricyclic antidepressants. Dr Antcliff advised me that given that Dr E had never seen Mrs B before and was aware she was due to see Dr D in four days' time, a four-day prescription would have been more appropriate. Dr E informed me that it was current practice at the time he prescribed the medication for doctors at the Mental Health Team to prescribe antidepressants in a one-month prescription unless the patient presented with any type of suicidal ideation. This was because of the cost to patients in filling more than one prescription, and because an antidepressant trial takes at least a month.

I accept that in making his prescription Dr E was following the Mental Health Team protocols. I also note that he had undertaken an assessment of Mrs B and questioned her about her suicidal ideation and was satisfied by her assurance that she had no desire to kill herself. In the circumstances, Dr E provided services with reasonable care and skill and did not breach Right 4(1) of the Code.

Actions taken by the District Health Board

Dr G advised me that in the time since Mrs B had died considerable work has been done by the District Health Board to minimise the chance of similar deficiencies in community mental health care in the future. The following changes have been made to mental health services provided by the District Health Board:

- All team leaders have participated in education and training sessions.
- There has been education and liaison with general practitioners in the region.
- A Home Based Treatment Team managed by the CATT has been introduced.
- An electronic reporting system has been introduced that identifies who has the primary responsibility for each patient.
- There is an active multidisciplinary team working within the Community Mental Health Team.
- The Manual was reviewed in 2003 and is currently being reviewed again, with specific regard to Risk Management documentation. A staff education programme is implemented at the end of each review.
- There has been an increase in the number of crisis respite beds.
- A day hospital has been opened in a nearby city's hospital.

Mr C advised me that since the year of Mrs B's death the following systems have been put in place:

- If a referrer states that a client is in crisis and the client is not known to the service, then the first point of contact is the CATT.

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- If the CATT assesses a client and decides that follow-up by a community team is appropriate, it will retain the care of the client until an appointment with the community team has been made.
- Formal reviews now take place on a daily basis. The whole team meets to discuss all triage correspondence, new referrals and clients of concern. In addition a half day per week is dedicated to a multi-disciplinary meeting, which examines all aspects of the work.
- A Trainer has been established from within the team and has been provided the necessary authority and support to co-ordinate and audit client pathways.
- Education and supervision sessions by speciality services are now an ongoing part of team culture.
- A second consultant psychiatrist has been employed along with a clinical psychologist and a part-time occupational therapist.

I commend the District Health Board on the changes to mental health services since that time.

Recommendations

I recommend that:

- Dr D review his practice in light of this report.
- Mr C review his practice in light of this report.
- The District Health Board review and take further steps to improve the quality of frontline mental health services in light of this report. In particular, the review should include consideration of all the points made by my expert advisor, the co-ordination of a patient's care by a designated staff member, the interface between the Crisis Assessment and Treatment Team and the Community Mental Health Team, the use of psychosocial interventions, and the development of prescription protocols for antidepressants.

Follow-up actions

- Copies of this report will be sent to the Coroner, the Medical Council of New Zealand, the Royal Australian and New Zealand College of Psychiatrists, and the Social Workers Registration Board.
- Copies of this report will be sent to the Mental Health Commission and to the Director-General of Health with a request that the Ministry audit the steps taken by the District

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Health Board to improve the quality of frontline mental health services, and report to me on the audit by 30 November 2004.

- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.
- A copy of this report, with all details identifying the parties removed, will be placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings considered this matter and decided not to issue proceedings before the Health Practitioners Disciplinary Tribunal or the Human Rights Review Tribunal.

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