Southland District

Health Board

Mental Health Services

February–March 2001

A Report by the

Health and Disability

Commissioner

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INTRODUCTION

In late September 2001, Southland District Health Board (Southland DHB), formerly Southern Health Limited,[1] publicly released the conclusions from a clinical audit of the care provided to Mr Mark Burton (Mr Burton) by Southland DHB's mental health services. The audit was conducted by Wellington psychiatrist Dr Bridget Taumoepeau. Southland DHB commissioned the audit after Mr Burton killed his mother, Mrs Paddy Burton, on 31 March 2001, one day after being discharged from Ward 12, Southland Hospital, Southland DHB's inpatient mental health unit.

Mr Burton was charged with the murder of his mother but was found not guilty by reason of insanity.

Mr Burton had been a client of Southland DHB's mental health services since July 1998. He had received care from the Queenstown Community Mental Health Team (CMHT) and had twice been hospitalised as a voluntary patient in Ward 12. He was an inpatient of Ward 12 between 10 February 2001 and 30 March 2001.

Dr Taumoepeau's report raised issues about the appropriateness of the care that Mr Burton received from Southland DHB's inpatient mental health services in February and March 2001.[2] At the time the results of Dr Taumoepeau's audit were made public, the Director of Mental Health, Dr David Chaplow, stated publicly that Dr Taumoepeau's report highlighted problems with Southland DHB's mental health services that needed to be addressed.

TERMS OF REFERENCE

On 4 October 2001 I announced the following terms of reference for an inquiry into the quality of care provided to Mr Burton by Southland DHB's inpatient mental health services.

> "**THE HEALTH AND DISABILITY COMMISSIONER'S OWN INITIATIVE INQUIRY INTO QUALITY OF CARE PROVIDED TO MR MARK BURTON**
> As a result of concerns about the quality of care provided to Mr Mark Burton by Southland District Health Board, the Health and Disability Commissioner, Ron Paterson, is to commence an independent inquiry under section 35(2) of the Health and Disability Commissioner Act 1994.
>
> The following matters will be investigated:
>
> The quality of care provided to Mr Mark Burton from 10 February 2001 until 30 March 2001 by Southland District Health Board's inpatient mental health services.
>
> In particular, the following matters will be investigated to determine whether any acts or omissions by Southland District Health Board, or any individual health care

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[1] References to Southland DHB in this report include references to its predecessors.
[2] References to Dr Taumoepeau's conclusions are made throughout this report.

providers employed by Southland District Health Board, have breached Mr Burton's rights under the Code of Health and Disability Services Consumers' Rights:

- Contact and co-ordination with Mr Burton's family
- Discharge planning, including formulation, implementation and review of discharge plans
- Appropriateness of Mr Burton's discharge
- Co-ordination with the Community Mental Health Team."

The terms of reference require me to consider the quality of care provided to Mr Burton during the relevant period.

INDIVIDUALS UNDER INVESTIGATION

In accordance with the terms of reference, and the requirements of section 36(2) of the Health and Disability Commissioner Act, in addition to notifying Southland DHB of my investigation, I notified the following employees of Southland DHB[3] that I had decided to investigate their involvement in Mr Burton's care to enable me to form an opinion on whether they had breached the Code of Health and Disability Services Consumers' Rights.

- Mental Health Needs Assessor
- MOSS Psychiatry, Inpatient Mental Health Unit
- Patient Services Manager, Mental Health
- Acting Team Leader, Inpatient Mental Health Unit
- Enrolled Nurse, Inpatient Mental Health Unit
- Social Worker, Inpatient Mental Health Unit
- Staff Nurse, Inpatient Mental Health Unit
- Clinical Director, Mental Health
- Alcohol and Drug Services Counsellor, Rhanna Clinic

The Mental Health Needs Assessor, the Medical Officer Special Scale (MOSS), Enrolled Nurse A, Staff Nurse A, Social Worker A and the Alcohol and Drug Services Counsellor were all directly involved in Mr Burton's clinical care. The Patient Services Manager, the Team Leader and the Clinical Director each had management responsibility for the standard of care in the inpatient mental health unit and/or supervisory responsibility for staff involved in Mr Burton's care.

[3] I have not identified the names of the individual providers under investigation in this report. I do not believe that it is in the public interest that they be named at this stage. The processes and reports of the Health and Disability Commissioner are confidential. Although this report is being publicly released, I see no reason to depart from my standard practice, which seeks to rehabilitate rather than punish individual providers. My report attributes individual and corporate responsibility for shortcomings in the care of Mr Burton. Individual providers will be held accountable and publicly identified in any professional disciplinary proceedings that ensue from this report.

COMPLAINT FROM MR TREVOR BURTON

On 5 October 2001, I received a letter from Mr Trevor Burton, Mr Burton's father, complaining about the care provided to Mr Burton while he was an inpatient at Southland Hospital's Mental Health Unit in February and March 2001. The complaint included the period from 22 March to 30 March while Mr Burton was on trial leave from the inpatient unit.

Mr Trevor Burton complained, in particular, about the standard of care provided to his son by the doctor responsible for his care, the MOSS, and the lack of supervision of the MOSS by Southland DHB's Clinical Director of Mental Health Services.

Mr Trevor Burton asked that I consider the issues raised in Dr Taumoepeau's audit about the quality of Southland DHB's mental health inpatient services. These matters fall within the terms of reference for my investigation.

Mr Trevor Burton also complained of matters that have caused him and his family further anguish since Mrs Paddy Burton died, but that are outside my jurisdiction. These matters relate to comments made by Southland DHB staff (in particular, the General Manager, and the Clinical Director) following the release of Dr Taumoepeau's report.

Mr Trevor Burton expressed his strong desire to see the individual health providers, whom he considers failed to provide his son with an adequate standard of care, held accountable.

Mr Trevor Burton and his family have suffered a terrible tragedy, for which I express my deepest sympathy. However, under the Health and Disability Commissioner Act I am required to be impartial and independent in forming my own opinion as to whether Southland DHB, or any of the individual providers under investigation, breached the Code of Health and Disability Services Consumers' Rights.

THE INVESTIGATION TEAM

I appointed an investigation team of five independent advisors and a project manager:

Dr Murray Patton, Psychiatrist, MB ChB (Otago) FRANZCP (Chairperson)
Ms Kate Prebble, Mental Health Nurse, RCompN BA MHSc FANZCMHN
Ms Paula Nes, Social Worker, B.Soc Sc (SW) UCT
Ms Linda Simson, Consumer Advisor
Ms Maxine Gay, Family Advisor
Ms Alyson Howell, Project Manager, MPhil, BA

The investigation was overseen by Assistant Commissioner Katharine Greig.

HOW THE INVESTIGATION WAS CONDUCTED

A Coroner's inquest was held between 26 November 2001 and 4 December 2001. At the request of Southland DHB, and counsel for one of the doctors, my investigation team did not visit Southland Hospital or interview staff until after the inquest.

Evidence from the inquest was made available to the investigation team.[4] Southland DHB also provided considerable documentation.

The investigation team visited Invercargill from 8 to 10 December 2001 and, over this three-day period, interviewed all staff notified that they were under investigation, and a number of other key individuals, including Mr Trevor Burton.

Interviews were conducted face to face and tape-recorded. The interviews were transcribed and returned to the interviewees for checking and signing.

Face-to-face interviews with Mr Burton and Mrs Paddy Burton's sister were held on separate dates. They were not tape-recorded. Southland DHB's Director of Nursing and Midwifery provided information by telephone.

The interviews, together with evidence from the inquest, Mr Burton's clinical records, and other documents and information provided by Southland DHB were used as the source material for this report.[5]

Provisional opinion

Having reviewed all the evidence and my expert advice, I formed a provisional view on the quality of care provided to Mr Burton. As required by section 67 of the Health and Disability Commissioner Act 1994, in June 2002 I sent a copy of my provisional opinion to each of the providers adversely commented upon, to give them a reasonable opportunity to respond. Their responses have been carefully weighed in forming my final opinion as set out in this report.

Multiple inquiries and stress on parties

Following Mrs Paddy Burton's death there has been considerable scrutiny of Southland DHB's mental health services by external agencies. A number of the staff interviewed by the investigation team gave statements to the Police, as well as to Dr Taumoepeau, and gave evidence at the criminal proceedings and the Coroner's inquest. In the course of this scrutiny, the inpatient staff most directly involved clearly discussed the period of Mr Burton's hospitalisation and, not surprisingly, developed a common view of what had occurred while Mr Burton was in hospital. In forming my own view, I have placed

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[4] The Coroner's Findings were released on 12 April 2002. References to evidence from the inquest and to the Coroner's conclusions are made throughout this report.

[5] In its response to my provisional opinion Southland DHB submitted that the investigation team did not seek input from those who knew about Mr Burton's life in Queenstown, and therefore had an incomplete view. This is not correct. The investigation team read the detailed clinical notes made by the Queenstown CMHT and the visiting psychiatrists who cared for Mr Burton when he lived in Queenstown. They interviewed Mr Burton's associate key worker in the Queenstown CMHT, who had cared for him since March 2000; Mr Burton's father; one of Mrs Paddy Burton's sisters; and a Central Otago Schizophrenia Fellowship field worker who provided support and resources for Mr Burton's family while he was living in Queenstown. Mr Burton's most recent key worker in the Queenstown CMHT was not available, having left New Zealand before Mr Burton was admitted to hospital.

particular weight on clinical notes made contemporaneously, without the benefit of hindsight.

I acknowledge the considerable stress that the staff involved in Mr Burton's care have experienced since Mrs Paddy Burton's death. Many have been subject to the external scrutiny. I am aware that many of those directly involved, and those supporting them, have found this scrutiny "arduous, lengthy, stressful and emotional".[6]

However, following the release of the results of Dr Taumoepeau's audit, I considered it necessary to commence an investigation because of public safety concerns. Mr Trevor Burton also exercised his right to make a complaint to me about the standard of care his son received. As Health and Disability Commissioner, I am charged with promoting and protecting the rights of health and disability services consumers. By law, the Commissioner is the gatekeeper for possible disciplinary or other action against providers, where I am of the opinion there have been serious breaches of the Code of Health and Disability Services Consumers' Rights.

Clearly, until I investigated this matter, I could not form an independent opinion on whether any acts or omissions by Southland DHB, or any individual provider employed by Southland DHB, breached Mr Burton's rights under the Code and, if so, whether referral to the Director of Proceedings was appropriate.

Hindsight bias

In their responses to my provisional opinion a number of providers raised concerns that my investigation team were affected by "hindsight bias" because they knew that there had been an adverse outcome and were aware of Dr Taumoepeau's report, and that this affected their judgement.

As noted above, it is my responsibility to form an opinion on whether Mr Burton received care of an appropriate standard. In doing so, I readily accept that I should be wary of "hindsight bias". It is inevitable that most matters I investigate fall to be judged with the benefit of hindsight. The avoidance of hindsight bias requires, in the context of this case, that the death of Mrs Paddy Burton does not influence my assessment of whether the care provided to Mr Burton between 10 February and 30 March 2001 was of an appropriate standard, having regard to Mr Burton's presentation and the information available (or which the providers should have obtained) at the time.

To assist in forming my opinion I sought the advice of independent advisors.[7] I have been guided by the report from my advisors, but I have taken care to review all the evidence, and to consider the responses to my provisional opinion before forming my final opinion. The opinion that follows is my own.

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[6] During the course of my investigation a number of staff interviewed used language that my advisors considered paternalistic and stigmatising. As my advisors noted, this is an aspect of practice that requires little time to correct, but which can have an important effect on the attitudes and values of staff. Right 1 of the Code provides that every consumer has the right to be treated with respect. Use of appropriate language is an essential element of respect and is not merely a matter of semantics or political correctness. Several responses to my provisional opinion submitted that it was unfair to judge staff on the basis of language used in an interview with my advisors. I accept that my advisors saw staff in a stressful situation, and that the language used during the interviews may not be representative of their standard use of language.

[7] I note that the opening paragraphs of my expert advisors' report make clear that they were aware of the need to take care when evaluating the care provided to Mr Burton, and not to fall into the trap of assuming that Mrs Paddy Burton's tragic death was the inevitable result of poor care provided to Mr Burton.

Conduct of interviews

There was criticism that some interviewees found the questions asked by my investigation team confusing. I do not accept that the criticism is valid. With one exception, all staff interviewed were accompanied by a lawyer. The person without a lawyer was accompanied by a support person. During the course of the interviews staff were able to, and did, ask for clarification where they did not understand a question. Their lawyers were available to assist, object, and seek clarification, if necessary. There was an opportunity during all interviews for staff to speak privately with their lawyer.

Some staff found their interview stressful, particularly where it touched upon questions of consistency with sworn evidence given during the Coroner's inquest (which reminded them of the stressful experience of cross-examination at the inquest). It is naturally stressful for individuals to be interviewed during an investigation. The purpose of holding interviews in private, with a lawyer and/or support person present, was to minimise the stress on interviewees.

Southland DHB raised concerns about the timing of the interviews. It stated that a number of interviewees complained about the times their interviews were held and cited as examples that the interview with the Patient Services Manager was held at the end of her working day, that the Clinical Director's interview was scheduled between patient clinical sessions, and that most others had their interviews on the weekend. The Team Leader also noted that staff gave up their time during a weekend and that it was stressful for those who had to wait until the end of the weekend to be interviewed.

The interviews were in fact delayed at the express request of Southland DHB. The Chief Executive Officer requested that my investigation team reschedule their visit (planned for the week of 19 November 2001), so that Southland DHB staff would have more time to prepare for the Coroner's inquest into Mrs Paddy Burton's death, and would not be put under undue pressure prior to the inquest. The Chief Executive Officer expressed the view that having the interviews after the inquest was sensible so that my investigators did not "duplicate the inquest to be conducted", and so that the evidence from the inquest could be taken into account by my investigators, as "the inquest will generate a considerable amount of material relevant to your inquiry".

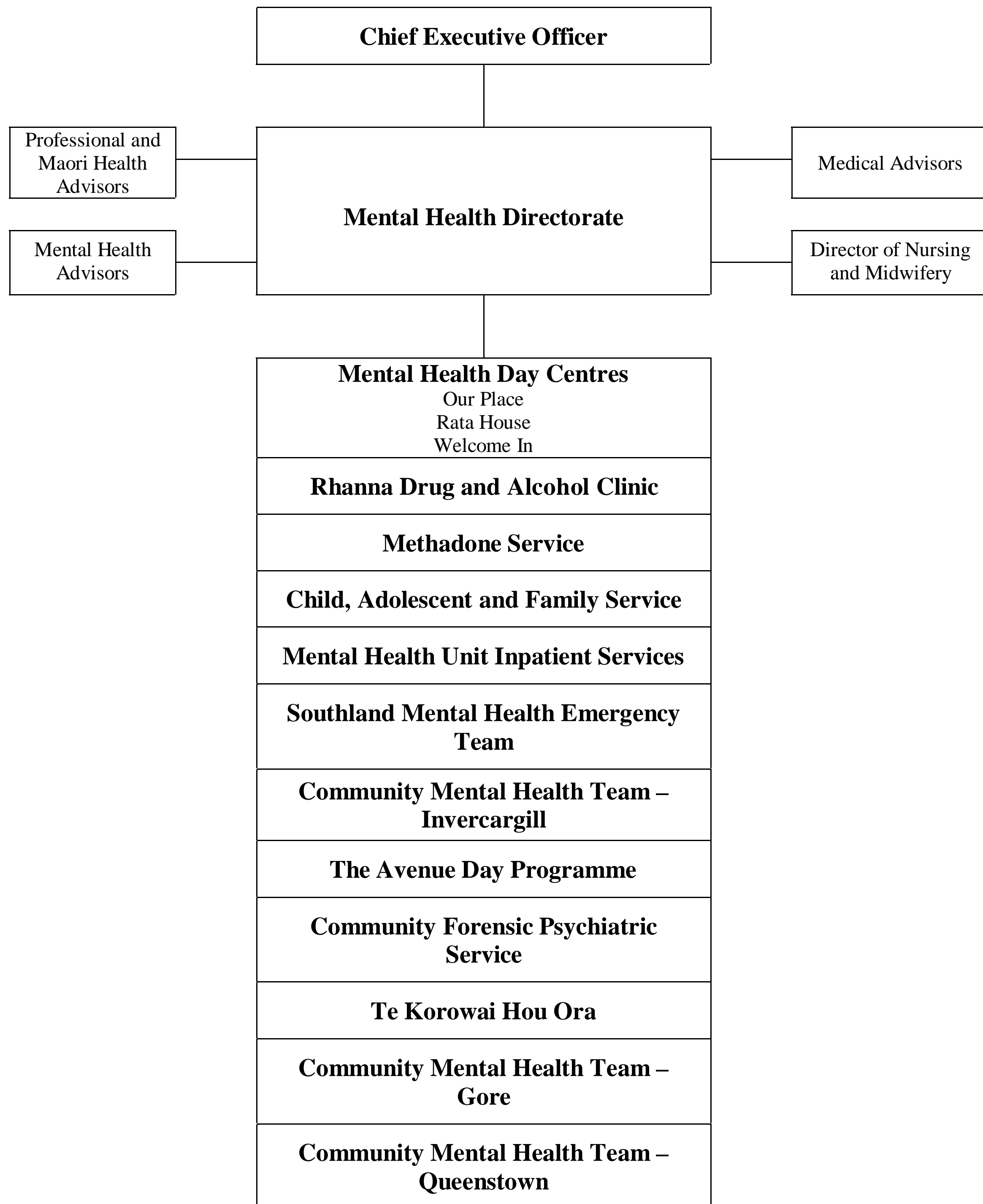
I agreed to Southland DHB's request to postpone the investigation, and Southland DHB was given an option of dates when the investigation team was available. It chose the dates of 8 to 10 December 2001 and undertook that all staff would be available on those dates. Interviews were arranged through Southland DHB's Legal/Risk Advisor, who was very helpful. Through the Legal/Risk Advisor, interviewees were asked for their preferred times, and considerable effort was taken to meet the various requirements of those interviewed. For example, interviews with nurses represented by the New Zealand Nurses Organisation (NZNO) needed to be scheduled to match the availability of the NZNO representative who, not unreasonably, was available for only part of the three-day period my investigation team was in Invercargill. The Clinical Director and the MOSS initially advised that they wished to have legal representatives from out of town present, so their interviews were arranged to take this into account. Convenient times also had to be made for others who had to travel from out of town to be interviewed. Some staff who were not subject to such constraints co-operated by agreeing to interviews later in the day. I note that it was in Southland DHB's control to ensure that staff were able to attend their interview

without having worked a full day and with sufficient time to prepare for, attend, and debrief after the interview.

BACKGROUND TO THE REPORT

Southland DHB's mental health services

The structure of Southland DHB's mental health services in February and March 2001 is depicted below.



Inpatient Unit – Ward 12

Southland DHB's adult inpatient mental health services are provided at Ward 12, Southland Hospital, Invercargill. Ward 12 accepts all people requiring inpatient care, except some forensic clients requiring a higher level of security. In February/March 2001, Ward 12 was a 23 bed unit, with 2 beds classified as intensive care beds, 12 as acute beds and 9 as sub-acute beds.[8]

Staffing

Inpatient staff over the relevant period included:

- Team Leader
  - .75 position, which reported to the Patient Services Manager, Mental Health

- Nursing Staff:
  - 13 full-time registered comprehensive nurses working rostered shifts (including one newly registered comprehensive nurse)
  - 6 part-time staff nurses
  - 2 part-time enrolled nurses
  - a pool of casual registered and enrolled nurses, rostered when required.

  Nursing staff reported to the Team Leader.[9]

- Medical Staff:
  - Clinical Director
  - 1 full-time psychiatrist – (Psychiatrist A)
  - 1 Medical Officer Special Scale – (the MOSS)

  Medical staff reported to the Clinical Director.[10]

- Allied Staff:
  - social worker .5 position (20 hours per week)
  - recreation co-ordinator .5 position (20 hours per week)
  - occupational therapist .2 position (8 hours per week – incumbent on parental leave)

  Allied staff reported to the Team Leader.

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[8] In its response to my provisional opinion Southland DHB questioned why my investigation team did not carry out a review of how staff worked in the inpatient setting and noted that as Dr Taumoepeau had spent several days on the ward observing staff during her audit, the team should have contacted her for input on this and other issues. I do not accept this submission. The terms of reference required me to examine the quality of care provided to Mr Burton between 10 February and 30 March 2001. How staff worked on the ward while Dr Taumoepeau was present, or in November 2001 when my investigation team was in Invercargill, is not relevant to my investigation. The investigation team was taken on a tour of the ward by the Team Leader and, as already noted, considered Dr Taumoepeau's report and her evidence at the Coroner's inquest as part of this investigation.

[9] The Director of Nursing and Midwifery noted that in Southland, as well as nationally, mental health nursing is an area where it has been difficult to recruit and retain staff, and that few inpatient registered nurses at Southland DHB have more than five years' experience. The Team Leader stated that over 40% of inpatient nursing staff have under two years' mental health nursing experience.

[10] Southland DHB has a shortage of psychiatrists. In February/March 2001 its mental health services were funded for 7.2 medical staff. It had 3 consultant psychiatrists and 3 Medical Officers Special Scale.

Responsibility for patient care – medical staff

The Clinical Director explained that ad hoc arrangements determined which doctor was allocated responsibility for a newly admitted patient. The MOSS, who admitted Mr Burton and remained the doctor responsible for his care, said that on-call entry was the only criterion for determining whether he or the consultant psychiatrist on the ward would be responsible for a newly admitted patient. The Admission Procedure required the admitting doctor to document his or her assessment of the patient on the Admission Assessment Form and, with an inpatient nurse, complete a risk alert sheet. The Admission Procedure stipulated that patients could expect to be seen by their doctor twice a week.

Responsibility for patient care – nursing staff

Ward 12 operated a system of primary nursing. The Entry Policy required that within 24 hours of a patient's admission a nurse be allocated to be the primary nurse responsible for the patient's care. The primary nurse was required to be a registered nurse. An associate nurse was also assigned to assist the primary nurse and carry through things the primary nurse was not able to do, and ensure some continuity of care. An associate nurse could be an enrolled nurse.

There is some confusion as to whether Mr Burton did in fact have a primary nurse during the first weeks of his admission (discussed later).

A senior registered nurse (known as the "red dot" nurse) co-ordinated day shifts. This nurse was responsible for allocation of patients to staff on the shift, acted as a resource person for other staff on the shift, and was the contact person for the emergency team, and medical and allied staff.

Care planning

The Consumer Assessment Policy required that on admission all patients be diagnosed by a consultant psychiatrist. The Quality Care and Treatment Policy provided that a patient's treatment, support and medication plans were to be developed collaboratively and reviewed regularly with the patient and the patient's family. Expected outcomes were to be identified and special needs, including dual diagnosis, recognised.

Discharge planning

The Admission Procedure and Discharge Policy required that discharge planning commence on admission and be developed collaboratively with other professionals involved in caring for the patient. The patient's family, whanau and significant others were to be involved if the patient consented. The Family and Carer Participation Policy provided that a family meeting format would be utilised to develop a treatment plan in partnership with the patient, family and carer.

The principal aims of discharge planning were identified as:

- continuity and co-ordination of care and treatment
- provision and mobilisation of a level of support that corresponded with the assessed needs of the patient for community living
- early intervention during crisis and relapses of illness
- optimal health and wellbeing for the patient/consumer.

The Discharge Policy envisaged that a patient's individual care plan would include a discharge plan with:

- client details
- needs assessment
- service arrangements
- information on medication, illness, community resources
- signs of becoming unwell and a crisis plan
- confirmation that the patient had a good understanding of his or her illness, and treatment and community resources available
- check list of necessary patient-related and administrative actions to be taken to ensure a well-managed discharge.

The policy stated that discharge planning would be reflected in the clinical notes.

Both the Discharge Policy and Exit Policy required that, prior to discharge, a patient's mental health status must be checked by the consultant psychiatrist in consultation with the patient's key worker and primary nurse/associate nurse and other team members involved with the patient.

The Exit Policy required a review of outcomes of treatment, support and follow-up arrangements, including crisis plan and re-entry plan, before a patient was discharged. It also required that a discharge planning meeting be held prior to discharge, and include those persons involved with the patient and family and/or carers. This meeting was to be recorded in the patient's clinical record. A discharge check list was also required to be completed prior to discharge.

The Exit Policy required that a crisis plan and list of signs of becoming unwell be developed in partnership with the patient and his or her family/caregiver.

Weekly team reviews

A weekly multi-disciplinary team review was held at which each inpatient's case was presented by the nurse looking after the patient that day (not necessarily the primary or associate nurse). Treatment issues were discussed and the Quality Care and Treatment Policy required that patients' individual treatment plans be reviewed. The Follow-Up Policy required that progress towards discharge planning also be reviewed.

The review was attended by available medical staff (including a community psychiatrist), a selection of nursing staff, the Team Leader, and usually a needs assessor representative, a CMHT representative, the ward social worker, and representatives from other teams from time to time. A weekly review form was in use on which the nurse presenting the patient was expected to record information for the meeting, such as the patient's diagnosis, mood/affect, thought patterns, safety/risk management and medications. There was also a section entitled "leave" where the outcome of the meeting, discharge planning, supports and key worker input was to be recorded.[11]

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[11] Dr Taumoepeau noted in her conclusions that the review form does not adequately direct the team towards goals for the week, so there is little indication from the review form what direction the treatment team is taking. Incidents and risk assessment were not included in the weekly review.

Roles and background of individual staff members under investigation

Medical Officer Special Scale

The MOSS was employed by Southland DHB as a Medical Officer Special Scale in psychiatry. He obtained general registration as a medical practitioner in New Zealand in March 1993. He does not have a specialist qualification as a psychiatrist.

The MOSS registered as a medical practitioner in England in 1985. He then spent three years in England training for general practice, followed by a year working in hospital management before working in a psychiatric department for one year.

In 1989 the MOSS applied to train as a psychiatrist and, after a year working as a registrar in psychiatry, entered the four-year training scheme for psychiatrists. After two years he left and came to New Zealand, where he took up a position in the mental health unit at Southland Hospital in December 1992, which he left in 1997. The MOSS then worked at Seaview Hospital (on the West Coast) from October 1997 until May 2000, before again taking up a position in the mental health services at Southland Hospital in October 2000 as a MOSS.

The MOSS was on call for the weekend of 10/11 February 2001 and was the doctor who assessed and admitted Mr Burton. He continued as the doctor responsible for Mr Burton's care during the period 10 February to 30 March 2001.

The Clinical Director was the MOSS's line manager. He stated that MOSSs have been employed by Southland DHB (and in other places in New Zealand) to act as independent psychiatrists. His view, in February/March 2001, was that the MOSS was Mr Burton's psychiatrist.

Under section 20 of the Medical Practitioners Act 1995, doctors holding general registration (such as the MOSS) are entitled to practise any branch or sub-branch of medicine, but only while they are subject to the general oversight of a person who holds vocational registration in the branch or sub-branch of medicine concerned.

Following Dr Taumoepeau's audit, the MOSS agreed to voluntarily undertake a review by the Medical Council of his competence to practise medicine, in accordance with the competence review provisions of the Medical Practitioners Act. In August 2002 the Medical Council, having undertaken this review, resolved that the following condition be placed on the MOSS's registration under section 61(3)(b) of the Medical Practitioners Act:

> "That [the MOSS] may practise only under structured and intensive supervision by a vocationally registered medical practitioner working in the same branch as him."

The Medical Council advised that its reasons for imposing the condition were that there was an identified need for regular dedicated meeting time to discuss patients' cases and to monitor professional skills, competence and attitude by both direct personal observation and in consultation with other colleagues with whom the MOSS is working. The Medical Council agreed that for the protection of patient safety the MOSS must have supervision if he resumes practice as a Medical Officer Special Scale.

The MOSS is currently overseas and not practising in New Zealand.

Enrolled Nurse A

Enrolled Nurse A had worked in the inpatient mental health unit at Southland Hospital since 1976, apart from two periods between 1980-1982 and 1984-1985. In February/March 2001 she held a .9 position.

Enrolled Nurse A assisted the MOSS with Mr Burton's admission on 10 February 2001. She had previously cared for Mr Burton during his admission to Ward 12 in 2000.

Enrolled Nurse A was allocated as Mr Burton's associate nurse and, except for two duties, was assigned to care for Mr Burton every time she was on a morning or afternoon shift until Mr Burton was discharged. Over the period of Mr Burton's hospitalisation, Enrolled Nurse A cared for him on 17 duties (specifically on 11-13, 17-19, and 24-26 February and 2-3 and 15-19 March). She was away from the ward, on leave, from 5-12 March. Enrolled Nurse A attended Mr Burton's discharge meeting on 30 March 2001.

Enrolled Nurse A described her role as associate nurse as "working alongside a primary nurse. If the primary nurse isn't on duty we automatically pick up the patient and we do all the cares that patient needs." The Team Leader's description of the role of the associate nurse was consistent with this. She added that the associate nurse is expected to carry through things the primary nurse is unable to do, to enable some consistency of care "or try to, depending on rosters".

Staff Nurse A

Staff Nurse A registered as a comprehensive nurse in 1997. She commenced as a staff nurse in Ward 12 at Southland Hospital in mid-1999.

Staff Nurse A had some contact with Mr Burton during his first admission to Ward 12 in 2000. She first cared for Mr Burton during his February/March 2001 admission on 14 February 2001. Staff Nurse A, in sworn evidence at the inquest, stated she was Mr Burton's primary nurse from 14 February. In her subsequent interview with my investigation team, she amended her view and said that "I need to make it clear at this point that I was the primary nurse but it was only for the last two weeks of [Mr Burton's] admission. [Mr Burton] didn't have a primary nurse prior to that time. [Mr Burton] had an associate nurse but wasn't assigned a primary nurse, so that was the role I took in the last couple of weeks of his admission. … What actually happened was that [Enrolled Nurse A] was on holiday. [Staff Nurse B] had a lot of involvement with [Mr Burton]. She was also going on study leave and another week's holiday and so what happened was no one had allocated themselves as [Mr Burton's] primary nurse. There seemed to be a void there and [Enrolled Nurse A] and I discussed that I would pick him up in the last few weeks due to the absence of herself and [Staff Nurse B]."

The responsibilities of the primary nurse included:

- facilitating referral to the CMHT and requesting that a key worker from the CMHT be allocated and/or advising the key worker when a client of theirs was admitted
- liaising with other service providers such as needs assessors
- involving the service to be responsible for the care of the patient after discharge in discharge planning
- consulting and involving the patient's family in determining the needs of the patient on discharge (with the patient's permission)

- referral to, and involvement of, professional support services applicable, eg community mental health team, Rhanna Clinic, and discharge planning
- mental/physical health
- ensuring the patient understood his/her medication, side effects, etc
- identifying signs of becoming unwell and developing a crisis plan in partnership with the patient and his or her caregiver and documenting this on the discharge plan
- ensuring that a discharge meeting was held prior to discharge
- ensuring the patient had follow-up telephone numbers for the mental health unit, the crisis team and the community mental health team provided on the discharge plan
- completing a discharge check list
- making a follow-up phone call to the patient within one working day of discharge to ensure that all services arranged had been implemented
- accountability for planning, implementation and evaluation of care.

Staff Nurse A said that when she was Mr Burton's primary nurse she did not care for him very often because "I had my own set of patients which I looked after. [Mr Burton's] mental state appeared more settled than other patients who were acutely unwell so I guess my role was looking after some of the more unwell patients at that time."

Staff Nurse A cared for Mr Burton on 14, 15 and 21 February (on night shift), and 5, 21 and 22 March. From 5 March, when Staff Nurse A agrees that she was Mr Burton's primary nurse, she was on morning duty on 5-9, 17-18 and 21-23 March; not on duty 10-16 and 19-20 March; and on night duty from 24-30 March.

Staff Nurse A reported to the Team Leader.

Social Worker A

In February/March 2001, Social Worker A held a .5 position (20 hours per week) as a social worker in the inpatient mental health unit. He commenced at Southland DHB in January 2000. During the first year of his employment he worked as a social worker in the Invercargill CMHT before moving to Ward 12 as a social worker. Social Worker A worked on Monday to Friday mornings for four hours each day. Prior to commencing at Southland DHB he had worked as a social worker for approximately eight years. Over this period he had not worked in mental health services.

Social Worker A has a postgraduate Diploma in Social Work from Victoria University and a Diploma in Child and Adolescent Guidance Counselling from the Central Institute of Technology. He is a member of the Aotearoa New Zealand Association of Social Workers.

As well as assisting Mr Burton to find a flat in Invercargill, Social Worker A was asked by the MOSS to follow up Mr Burton during his week of trial leave from 23-30 March. Mr Burton attended a car maintenance group run by Social Worker A.

The Team Leader was Social Worker A's line manager.

Mental Health Needs Assessor

The Mental Health Needs Assessor commenced her position in June 2000. Prior to this she was the co-ordinator of a level 3 home run by PACT (Patients Aid Community Trust) Southland (an organisation that provides a range of community support for people with intellectual and psychiatric disability). She is one of three needs assessors (2.5 full-time

equivalents) who are based in the Social Work Department at Southland Hospital. She has no formal qualifications. Needs assessors report to the Co-ordinator of Social Work Services.

The primary objective of a needs assessor is described in the Mental Health Needs Assessor's position description as being "to facilitate support needs assessment and co-ordination for people with mental health disabilities, enabling them to identify and explore their needs so they can enjoy a fulfilling lifestyle within their own capabilities".

Needs assessments for patients in Ward 12 are triggered by a referral from inpatient medical or nursing staff who identify that a patient has a need for extra support in the community. Referrals are reviewed and prioritised by the needs assessors at a weekly meeting.

A referral was made by Ward 12 staff on 12 February 2001 for a needs assessment for Mr Burton. The Mental Health Needs Assessor was the needs assessor assigned to undertake Mr Burton's assessment.

Alcohol and Drug Services Counsellor

The Alcohol and Drug Services Counsellor commenced at Rhanna Clinic in 1996. He reported to the team leader of the Clinic. Rhanna Clinic, which is part of Southland DHB's mental health services, provides counselling, group therapy, rehabilitation programmes, follow-up and education and information for consumers. Counsellors are expected to work closely with family/whanau, and community groups.

The Alcohol and Drug Services Counsellor has a certificate of alcohol and drug counselling from the Central Institute of Technology. He also has a Diploma Oranga Hingeraro (Mental Health) and Diploma Rorohiko (Computer Studies), both obtained at Te Wananga O Raukawa since 1996.

A referral to Rhanna Clinic for Mr Burton was made by Ward 12 staff in March 2001 and the Alcohol and Drug Services Counsellor was assigned the referral. He met with Mr Burton on 12 March and made an initial assessment of his drug and alcohol use. Mr Burton advised the Alcohol and Drug Services Counsellor that he did not wish to address his alcohol/cannabis use at that time. The Alcohol and Drug Services Counsellor ensured Mr Burton understood that he could talk with a Rhanna Clinic counsellor at any time, and had nothing further to do with Mr Burton or his care.

Clinical Director

The Clinical Director of Mental Health Services has been employed as a psychiatrist at Southland Hospital since 1998, and as Clinical Director since mid-1999. He is also the Director of Area Mental Health Services (DAMHS). The Clinical Director's line manager at the relevant time was the Chief Executive Officer.

The Clinical Director has vocational registration as a psychiatrist. He has an MBChB from the National University of Ireland, and gained membership to the Royal College of Psychiatrists in 1984.

The primary objectives of the Clinical Director's position include:
- ensuring the effective provision of clinical services
- ensuring training and development of medical staff as appropriate
- providing quality leadership.

Key responsibilities in relation to workforce include:
- assessing performance of medical staff quarterly and annually
- ensuring development and delivery of medical staff orientation package
- ensuring CME and peer review meetings are well attended.

Key responsibilities in relation to quality include:
- ensuring all medical staff including locums are properly credentialled
- ensuring all medical staff attend clinical audit and peer review meetings
- ensuring clinical protocols and pathways are produced and maintained
- co-ordinating the implementation of all medical aspects of the service including ensuring recognised standards of clinical practice are met including peer review, clinical audit and quality assurance activities
- ensuring clinical notes are adequately maintained by random peer review and other modalities.

The Clinical Director did not have direct involvement with Mr Burton's care but, with the Patient Services Manager, did have overall responsibility for the inpatient mental health unit. He had line management responsibility for all medical staff.

Patient Services Manager

The Patient Services Manager for Southland DHB's mental health services formed the Mental Health Directorate with the Clinical Director, Mental Health. The Patient Services Manager was a member of Southland DHB's senior management team and in February/March 2001 reported to the Chief Executive Officer.

The primary objectives in the Patient Services Manager's job description were to:
- develop, provide and monitor the delivery of high quality patient focused, effective clinical services in mental health services, which meet patient requirements, and contractual obligations, within financial targets, and within the overall strategic direction of Southern Health;
- develop a style of leadership, and management systems and processes, which reflect Southern Health's values, and enable the people within mental health services to actively contribute to the continuous improvement of health services and their delivery, to the benefit of the people of Southland.

The Patient Services Manager was not directly involved in Mr Burton's care but, with the Clinical Director, had overall responsibility for the inpatient mental health unit and line management responsibility for the Team Leader.

Team Leader

In February 2001, the Team Leader had been the acting team leader in the mental health inpatient unit for approximately one year.[12] She had worked for Southland DHB's mental health services for four years prior to that. Her position was .75 (30 hours a week).

The Team Leader was required to have a tertiary level nursing qualification, preferably in mental health care, and extensive experience in mental health service provision.

The Team Leader is a registered comprehensive nurse. She gained registration first as a psychiatric nurse and then completed a bridging course in 1985 to obtain comprehensive registration.

The primary objectives of the Team Leader's position description were to take:

- overall responsibility for the management and leadership of the Mental Health Inpatient Unit both operationally and clinically;
- primary responsibility for clinical aspects of the team.

In relation to service delivery, the Team Leader was responsible for:

- ensuring that policies and procedures related to episodes of care were established and implemented for each individual accessing the service. This included ensuring that individual treatment and discharge plans were developed in consultation with the patients, family/whanau and caregivers.

The Team Leader was responsible for employing staff, managing the inpatient budget, and establishing an inservice education programme for all staff, covering all aspects of mental health delivery.

The Team Leader did not have direct involvement in Mr Burton's care, but had line management responsibility for nursing and allied staff in Ward 12 and overall responsibility for management and leadership of the inpatient mental health unit. She reported to the Patient Services Manager.

MR BURTON'S MENTAL HEALTH HISTORY

Mr Burton was a patient of Southland DHB's mental health services from 1998. He was first referred to the mental health service of Southland DHB in July of that year when his mother, Mrs Paddy Burton, contacted the Queenstown CMHT concerned about his mental health.[13] Mr Burton had withdrawn from work, was unable to sleep, was expressing beliefs about being on a "higher plane" and believed the radio and television were referring to him.

[12] She was appointed as Team Leader shortly thereafter.

[13] Mr Burton and his family lived in Queenstown.

On assessment, Mr Burton was noted to have features consistent with a psychotic illness (a serious mental disorder where a person loses touch with reality and is unable to distinguish what is real from what is not). A history of alcohol and cannabis use was noted.[14]

Mr Burton received outpatient follow-up and a moderately high level of contact was maintained between the Queenstown CMHT, Mr Burton and his parents. Over time a diagnosis of paranoid schizophrenia was made. He was trialled on an antipsychotic medication (trifluoperazine), and was recorded as having only a partial response. Concerns regarding adherence to medication and use of alcohol and cannabis continued to be noted. There were fluctuations in his mental state that appeared related to alcohol use and stresses.[15] He was trialled on the anti-psychotic medication risperidone from September 1998.

In early 1999, Mr Burton was working part-time and being monitored by the Queenstown CMHT. Alcohol use was still noted to be a concern. His medication was increased but some adverse effects were noted by mid-year. Mr Burton was fired from his job in July. He commenced seeing a drug and alcohol counsellor but alcohol use continued to be a problem throughout the year. Mr Burton continued to have a high level of contact with the Queenstown CMHT.

Mr Burton was admitted to Ward 12, Southland Hospital, in June 2000, with a diagnosis of paranoid schizophrenia, having been found agitated and threatening to harm himself and others. Prior to admission he had been inconsistent with taking his medication. Mr Burton was in hospital for approximately four weeks. During this time there was an improvement in his mental state.

Mr Burton returned to his parents' home in Queenstown and continued to have a high level of contact with the Queenstown CMHT. In mid-August, his parents noted a period of deterioration, which they associated with alcohol use. In September, a management plan was developed in conjunction with Mr Burton and his family, and a number of issues for attention were identified. These included taking of medication, alcohol use and rules about living at home. Early warning signs of a relapse were identified and a crisis plan developed.

Concerns about Mr Burton's use of alcohol continued, as did concerns about Mr Burton not taking medication. Features consistent with early relapse were noted in November and Mr Burton was monitored closely by the Queenstown CMHT.

In mid-January, Mr Burton changed medication to the anti-psychotic drug olanzapine. Soon after, Mrs Paddy Burton reported that Mr Burton had had a bad experience the previous night and was angry towards her with bizarre conversation.

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[14] Drug and alcohol abuse is a major exacerbating factor for people with acute and semi-acute mental disorders. *The Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley under section 47 of the Health and Disability Services Act 1993 in respect of Certain Mental Health Services* (May 1996) reported that "although there is no hard evidence as to the number of dual-diagnosis patients in New Zealand, the problem is substantial and estimates range between 35% and 85% of psychiatric patients also having alcohol and other drug problems".

[15] The risk of violence from those with severe mental illness, such as schizophrenia, is increased when active psychotic symptoms are present. It is further increased when drugs or alcohol are misused when active symptoms are present – *Guidelines for Clinical Risk Assessment and Management in Mental Health Services* (Ministry of Health in Partnership with the Health Funding Authority, July 1998).

During the remainder of January and into February, the Queenstown CMHT provided frequent home visits. Mr Trevor Burton and Mrs Paddy Burton reported in early February that they were concerned about Mr Burton's use of cannabis and alcohol and that he was aggressive and agitated and being unco-operative at times.

On Saturday 10 February 2001 Mr Burton's parents contacted the Southland Mental Health Emergency Team, which is based in Invercargill, for assistance. Mr Trevor Burton described the reasons for calling the emergency team as follows:

> "I suppose it would be fair to say that I felt more at risk that morning at home than [I had during] what was until then, 28 years in the Police. Mark was extremely agitated and aggressive. His mother just went to his room to enquire after him because he had been out the previous evening and Paddy wanted to ensure that Mark got home as mothers do. She went to his room and returned very shortly thereafter to the bedroom where she spoke to me. She was in tears. Mark had threatened her by shaping up as if he was going to belt her, and he had threatened her using a number of obscenities. I immediately went down the hallway but I couldn't get in because Mark had barricaded his door. I demanded that he remove the barricade from the door, which he did. By the time I had opened the door, Mark was standing up on his bed in a state of extreme anger and he told me that he had to barricade his door to prevent his mother and brother from entering because they were interfering with him during the night and essentially he told me that if it continued he would kill them for it. This was not a calm conversation. It was fraught with potential for Mark to launch himself off the bed at me, and in fact I anticipated that was going to occur. My conversation with Mark was not a calm one. I told him he was not going to threaten his mother in that manner in our house and he should pack his bags and leave. I then returned to Paddy while Mark was effectively throwing various items into his bag and I told her to go downstairs and contact the Southland Mental Health Emergency Team from Invercargill and get them rolling to our place. I believe it was at that time Mark came down, or it was within a short period of this. I wasn't in the kitchen at that stage but Paddy told me that he came quickly through the kitchen, said he was sorry then he walked into the lounge area where I was present. He went rapidly round and around the lounge clenching and unclenching his fists and at that point I decided to sit down and try and remove any threat that I might have posed to him and after some further communication Mark went up into his room, and I think he lay down for 15 minutes or so, perhaps less, and then he came down again and in a brief moment of insight, he said that he thought that he needed to go to hospital."

Mr Trevor Burton also advised that he removed a knife from his son's room that morning.

The emergency team recorded that Mrs Paddy Burton and Mr Trevor Burton telephoned on 10 February voicing concern about the deterioration in Mr Burton's mental state:

> "… acting bizarre, threatening to harm family. Had been smoking 'pot' and drinking yesterday. Father states [Mr Burton] getting progressively worse past 2-3 weeks. Has been accusing family of 'sexual abuse' and voicing bizarre statements. Threatening to kill 14 year old brother. Father feels no longer able to contain the situation and feels he should be in hospital."

The emergency team also recorded that Mr Trevor Burton telephoned later in the morning to advise that Mr Burton was requesting to come in to hospital and that he would be able to bring him.

Mr Trevor Burton drove Mr Burton to Invercargill from Queenstown. Mr Trevor Burton said he and his son travelled mostly in silence, but that Mr Burton said angrily at one stage that his father and mother had stolen millions of dollars from him. Mr Burton also referred to his mother and brother molesting him and, as they got closer to the hospital, he said words to the effect that "the matrix is watching now, there are cameras all around here".

ASSESSMENT AND ADMISSION TO WARD 12, 10 FEBRUARY 2001

On arrival at the unit, Mr Burton was assessed by the on-call doctor, the MOSS, and Enrolled Nurse A. The MOSS and Enrolled Nurse A had been given a summary of Mr Burton's condition and prior mental history by the emergency team nurse. Mr Trevor Burton was present at the MOSS's assessment and explained to the MOSS the events that led him to bring his son to the ward. The MOSS recorded:

> "Psych assessment
> First psych contact at 17 years
> Grandiose thinking – thought he was JC
> + ideas of saving people
> ± [possible] paranoid thoughts including being put on cross/references from radio
> At the time working in kitchen
> Alcohol +
> Cannabis ++
> Flatting
> Saw GP + psychiatrist
> Started on risperidone – good compliance
> Last year – relapse. Using THC [cannabis]
> Came to ward 12 – winter for 3 weeks
> Discharged on risperidone – 6mgs
> Went home to parents
> Work for short periods – alt days at best
> Finds radio disrupting
> From father – school apparently OK, not great scholar, left to join joinery but firm folded
> At the time deterioration in mental state noted, parents aware of THC use, doesn't return to normality when off THC
> Saw […] 6/2
> EPS ++[16]
> Poor motivation
> Risperidone changed to olanzapine 10mgs
> Since then alcohol ++, cannabis ++ not recently
> No work lately

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[16] EPS – Extra-pyramidal symptoms (which are a side effect of antipsychotic medication and involve Parkinson's-like symptoms).

Kitchen sparehand job organised by friend/boss aware of [Mr Burton's] condition
Now – threatening behaviour – especially towards mother
Deluded regarding parents having a quantity of his money
(There is no money in fact)
MSE [mental state examination] – reasonably calm and co-operative, some anxiety
A little pre-occupied
Believes being disturbed at night
Ideas of reference
Paranoid thinking
Vivid negative dreams
Cognitively unimpaired
Some insight – knows things are not right but probably doesn't accept illness, agrees to hospital
IMP [impression] schizophrenia (no family history – brother and sister well)
Plan – admit ward 12, increase olanzapine to 15mgs daily use CPZ [chlorpromazine] as required (CMHT in Queenstown […])"

The MOSS admitted Mr Burton to Ward 12 as a voluntary patient. A risk alert sheet was completed by the MOSS and signed by Enrolled Nurse A. It recorded Mr Burton as being of no increased risk of harm to others, or of suicide, self harm, sexual or AWOL [absent without leave] risk.[17] Enrolled Nurse A completed a standard form patient history and nursing assessment and a generic care plan.

Mr Burton signed a Southland DHB "Disclosure of Information" form giving consent for information relating to his current condition to be released to his father while he was an inpatient of the mental health services.

Mr Burton remained an inpatient until 30 March 2001 when he was discharged to a flat on his own following eight days' trial leave.

CHRONOLOGY OF INPATIENT ADMISSION, 10 FEBRUARY 2001 TO 30 MARCH 2001

The following detailed chronology covers the 40 days while Mr Burton was an inpatient (from 10 February 2001) and eight days of trial leave (from 22 March) before Mr Burton was discharged on 30 March 2001.[18, 19]

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[17] At the inquest, and during interviews with my advisors, the MOSS (and other staff) said that they believed the risk alert sheet related to the risk of harm to others on the ward at that time and in that environment. As Dr Taumoepeau stated at the inquest, the documentation does not reflect in any way that on the day of admission Mr Burton was an unknown quantity and one of the risks might be that as a voluntary patient he could leave the unit. She noted that if that happened then the possible risk to his family would be increased.

[18] Mr Burton was a voluntary patient and could leave the inpatient mental health unit at any time. Nonetheless, the term "discharge" is commonly used to describe a patient's leaving an inpatient facility, and being "discharged" from inpatient care. It was used in Southland DHB's inpatient mental health unit policies and documentation. Accordingly, it is used in this report.

[19] In the main, Mr Burton's nights appear from the clinical record to have been uneventful, with the nursing staff recording that he slept well. This chronology records episodes only where there is a significant departure from "slept well".

Saturday 10 February

Once admitted, Mr Burton was noted during the afternoon/evening to be preoccupied and making occasional inappropriate comments and smiling inappropriately. He denied any auditory or unusual hallucinations or unusual thoughts. He was given chlorpromazine 100mgs at his request after the staff nurse caring for him (Staff Nurse B)[20] explained what chlorpromazine was for.

Sunday 11 February

Mr Burton was cared for during the morning shift by Enrolled Nurse A. He got up after midday. The notes recorded that he "appears guarded during conversation but not as pre-occupied as yesterday".

Enrolled Nurse A faxed a referral to the Queenstown CMHT to notify that service that Mr Burton had been admitted to the unit. The referral noted that "Mr Burton to remain on unit → 14 days for assessment and be established on olanzapine". It also noted that Mr Burton might look at living in Invercargill on discharge.

Mr Burton was cared for during the afternoon shift by Staff Nurse B. He requested, and was given, 100mgs of chlorpromazine. Staff Nurse B recorded that Mr Burton had no irritability or inappropriate smiling but was guarded in conversation, especially when discussing mental state.

Monday 12 February

Enrolled Nurse A cared for Mr Burton on the morning shift. She recorded that he refused to get out of bed during the morning and that he appeared sedated. She noted that the MOSS had requested that chlorpromazine not be used that evening "unless absolutely necessary". Although it is not documented, the MOSS has stated that he was contacted by an experienced nurse (Enrolled Nurse A) who told him Mr Burton appeared sedated – hence his instructions.

Enrolled Nurse A prepared a referral for Support Needs and Care Needs level assessment (needs assessment). The service requested was "? supported accommodation". Under a comments section on the form was recorded: "It has been suggested to [Mr Burton] that living in supported accommodation in Invercargill may be beneficial for him so he can be closer to our services."

Mr Trevor Burton delivered to the Queenstown CMHT a letter that he had written to the inpatient mental health unit at Southland the previous day. The letter commences: "These are just a few notes to hopefully assist you in your understanding/treatment of Mark from our observations as his parents." It then sets out in some detail the concerns Mr Trevor Burton and Mrs Paddy Burton had experienced since Mr Burton changed medication from risperidone to olanzapine, and the events of Saturday 10 February that precipitated Mr Burton's admission to hospital. The letter states:

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[20] The Team Leader believes Staff Nurse B may have been Mr Burton's primary nurse for the first few days of his admission.

> "OUR MAJOR CONCERN;
> Mark has a paranoia about 1. His parents robbing him of vast sums of money. and 2. of being molested by his mother and brother (and perhaps myself, I am not sure.) This causes great rage and apparent hatred.
>
> I believe that Mark is a real danger should he be discharged from this hospital while still holding such views and that he could cause serious injury/death within the family home. I base this on my observations of him as a parent and also a considerable amount of experience over 28 years observing violent behaviour as a front line policeman.
>
> Mark seems to be able, most of the time, to keep his thoughts to himself or disguise what he is thinking. I WOULD THEREFORE ASK THAT PARTICULAR NOTE IS TAKEN OF MY CONCERN AS TO THE SAFETY OF MARK'S MOTHER AND YOUNGER BROTHER SHOULD HE RETURN TO THE FAMILY HOME.
>
> Having said that, Mark needs security and some sort of supervision and we believe that the home is the best place he can get it. If he is to find lodgings in the community he would need quite constant monitoring by a mental health worker as to his medication and his involvement with drugs/alcohol. He would also need assistance to finance a 'life in the community' beyond the amount of money presently paid on his sickness benefit.
>
> Mark will be welcome back here at home should he so desire and provided there is an assurance as far as is able, regarding his paranoia of his parents and family being under control.
>
> I may be contacted at any time at home or at work. [Contact details given.]
>
> Thank you for taking the above into consideration and good luck with Mark. We appreciate any help that can be given him.
>
> TREVOR and PADDY BURTON.
> 11/2/2001."

Mr Burton's community key worker in Queenstown read the letter and immediately forwarded it and the community notes to the inpatient unit. She completed an updated risk management plan, in light of the information in Mr Trevor Burton's letter, which she also forwarded.

Tuesday 13 February

Mr Burton was cared for again by Enrolled Nurse A on both the morning and afternoon shifts. She recorded that he was up early for breakfast and a routine blood test and then returned to bed until lunchtime. Although woken several times, he refused to get out of bed during the morning. He was noted to be slightly guarded during conversation and preferred to listen to music via headphones. He commented that the radio related to him. During the afternoon he was noted to be reasonably settled and appeared to have good concentration.

Mr Burton's clinical notes from the Queenstown CMHT and the letter from Mr Trevor Burton arrived in Ward 12. The Team Leader discussed the letter with the MOSS and Enrolled Nurse A.

Wednesday 14 February

The MOSS recorded in the notes: "Reviewed. Settled mentally. May have day leave as required." The risk alert sheet commenced on admission was updated by the MOSS who recorded that Mr Burton was "no increased risk".

Staff Nurse A cared for Mr Burton on morning duty. She recorded that [Mr Burton] went swimming with the recreation co-ordinator[21] and that she would discuss an exercise programme for Mr Burton with the recreation co-ordinator the following day. Mr Burton's mental state was recorded as "settled" and it was noted that he did not appear pre-occupied. The Team Leader discussed Mr Trevor Burton's letter with Staff Nurse A.

The weekly review meeting was held. Mr Burton's review form recorded his diagnosis as drug-induced schizophrenia.[22] Under "leave arrangements" is recorded "for day leave, referral sent to needs assessor last week".

Mr Burton was described as "settled" on afternoon duty.

Thursday 15 February

Staff Nurse A cared for Mr Burton on morning duty. She recorded his mood as "bright" and that she did not observe any pre-occupied behaviour. She noted that she had spoken to Mr Burton about the possibility of shifting to Invercargill but that Mr Burton was hesitant about this. Staff Nurse A sent a referral to the Invercargill CMHT. The referral noted "pt considering moving to Ingill – hence will require key worker [from the Invercargill CMHT]" and that a referral had been sent to the needs assessor for "? supported accommodation".

Staff Nurse B cared for Mr Burton on the afternoon shift, and recorded that Mr Burton's father had telephoned to let staff know that he had rung Mr Burton earlier in the day and his discussions with his son showed that Mr Burton was "still ruminating about past sexual allegations [Mr Burton] has made of his mother and brother having interfered with him".

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[21] The recreation co-ordinator provided a weekly programme for patients on Ward 12. She described her role as setting up programmes – usually physical activities such as walk groups, golf, horse riding, swimming – to help patients fill their days with "healthy lifestyles" and develop interests they could carry into the community. Mr Burton undertook a number of activities with the recreation co-ordinator. At the relevant time the recreation co-ordinator did not document her interactions with patients in the clinical notes. All feedback was verbal, to nursing staff.

[22] The MOSS said that paranoid schizophrenia was the correct diagnosis for Mr Burton, and that he had not picked up that nursing staff had recorded Mr Burton's diagnosis as drug-induced schizophrenia on several occasions, and thus had not corrected this misapprehension.

Friday 16 February

The enrolled nurse who cared for Mr Burton on the morning duty noted that he had a "settled duty, mood appearing bright" and that Mr Burton had slept late and gone out with the recreation co-ordinator. During the afternoon he was described as "quiet but pleasant and appropriate when spoken to".

A key worker (a registered nurse) and an associate key worker (an occupational therapist) in the Invercargill CMHT were allocated following the referral from the inpatient unit. The inpatient unit was advised.

Saturday 17 February

Enrolled Nurse A cared for Mr Burton on the morning duty. She noted that Mr Burton had a settled duty and got up in time for lunch and that his mood appeared bright. Her notes recorded: "Doesn't want to see his family, especially his mother and brother – thinks they are trying to twist his mind, but wouldn't elaborate." Enrolled Nurse A also recorded that Mr Burton didn't want to live in Invercargill as he knew no one there. Her notes stated: "Adamant doesn't want to live at home again, doesn't trust his mother and brother and if his father finds him accommodation he will be changing the locks." Mr Burton requested to see the MOSS after the weekend.

Staff Nurse B, who cared for Mr Burton on the afternoon shift, gave him 50mgs chlorpromazine for "previously stated paranoid thoughts" and noted that he was "not openly admitting to experiencing same this duty". Mr Burton was noted to be "irritable when abused by another patient". The staff nurse who cared for Mr Burton on night duty noted that he "became involved in verbal altercation with fellow pt, [Mr Burton] able to be redirected by nursing staff". No incident form was written.

Sunday 18 February

Mr Burton woke at 11.30am, had lunch and went out for a walk. Enrolled Nurse A cared for him on the afternoon shift. She recorded: "Admits to feeling improved today but after spending 1:1 time with [Mr Burton] he is still paranoid towards mother and brother and expressed a lot of hate towards his sister. Still has no intentions of staying in Invercargill – the only people he knows here are old drug friends who he'd prefer not to reacquaint with."

Monday 19 February

Mr Burton was seen by the MOSS, at Mr Burton's request, and recorded: "Review – seems pretty settled. Olanzapine not too sedating although [Mr Burton] still complains about EPS [extra-pyramidal symptoms] – not much sign of it objectively. [Mr Burton] now keen to return to Q'town. Plan – suggest [Mr Burton] rings Dad to arrange meeting with family."

Enrolled Nurse A cared for Mr Burton on morning duty. Her notes recorded: "[Mr Burton] to contact his father for him to arrange a time to see the MOSS later this week." She noted that Mr Burton went on a ward outing.

Staff Nurse B cared for Mr Burton in the afternoon. She recorded that Mr Burton "denied any bothersome thoughts" and did not voice paranoid ideation in conversation.

Mr Trevor Burton telephoned the unit and advised that the family would be happy to have Mr Burton living at home once his paranoid ideation had ceased. He noted his concern about risk to family members in the meantime. He stated that he would prefer his son to remain in supported accommodation in Invercargill but was aware Mr Burton did not wish to do so. He also told the staff that he would be happy to attend a meeting with the MOSS the next day, but would prefer to discuss the matter by telephone, if possible.

Tuesday 20 February

Mr Trevor Burton telephoned the unit and spoke to his son. He questioned him about his thoughts concerning his mother and brother coming into his room during the night. Mr Trevor Burton advised the staff nurse caring for Mr Burton on the morning shift that his son told him he still thought this had happened, and Mr Trevor Burton expressed concern to the nurse about the safety of his wife and son if Mr Burton returned home.

Mr Burton denied any unusual thoughts to the staff nurse, but acknowledged he had had them in the past.

The notes record that the MOSS tried unsuccessfully to telephone Mr Trevor Burton.

Staff Nurse B cared for Mr Burton on the afternoon shift and reported him to be "settled".

Wednesday 21 February

Mr Burton got up for breakfast but returned to bed until lunchtime. He was reported as having a settled duty and not voicing paranoid ideation.

Mr Trevor Burton telephoned to speak to the MOSS and left telephone contact details when he was unable to do so.

Staff Nurse B looked after Mr Burton on the afternoon shift. She recorded: "Remains settled in mental state. Pleasant and appropriate in superficial reactions. Continues to be guarded re paranoid thoughts."

Thursday 22 February

Mr Burton was discussed at the weekly ward review. The review form recorded that he was "guarded re paranoid thoughts". It also stated: "? need for early intervention, intensive input. Need for follow-up of needs assessment. ? polytech course Southland Academy. Need to involve parents."

The staff nurse who cared for Mr Burton on morning duty recorded: "From ward round to look into possible employment or short courses at Polytechnic or Southland Academy ie woodwork/mechanics to be followed up by S/N."

The clinical notes record that Mr Burton did not voice any paranoid thoughts on 22 February.

Friday 23 February

Mr Burton was cared for on the morning shift by a staff nurse who had not previously cared for him. She noted that he was reluctant to get up in the morning and that he stated

that this was his usual morning routine. She noted that he was only willing to converse on a superficial level, but denied any bothersome thoughts. Mr Burton requested to see the MOSS.

The MOSS saw Mr Burton and recorded that he remained settled and noted in his plan: "Continue to encourage [Mr Burton] to stay in Invercargill. Awaiting needs assessment. Need to develop OT [occupational therapy] programme for [Mr Burton]."

He also recorded that Mr Trevor Burton had telephoned and said that Mr Burton's mother and siblings were very concerned at the proposal for Mr Burton to return to Queenstown and that there was no suitable accommodation in Queenstown.

On the afternoon shift Mr Burton was cared for by another staff nurse who had not previously cared for him. She recorded a suspicion that Mr Burton may have been planning to go on an outing with another patient to use drugs. He was discouraged from doing this and informed he might have to produce a urine specimen on his return. Mr Burton did not go on the outing.

Saturday 24 February

Mr Burton was cared for by Enrolled Nurse A. She recorded that he did not get up until lunchtime, and that Mr Burton was adamant he was not staying in Invercargill. He told Enrolled Nurse A he had spoken to his father about staying in a tent in the camping ground in Queenstown. Enrolled Nurse A also recorded that Mr Burton said that he felt he was not ready for work yet and that he refused to speak about his mother and brother, saying they were no longer in his life.

At about 5.00pm Mr Burton asked to leave the ward to get some food. He returned about 20 minutes later. A staff member reported that she had seen Mr Burton going into a bar. Mr Burton was questioned about this but denied using alcohol. About 9.00pm Mr Burton's behaviour changed. He became aggressive, punching his fist into the palm of his hand. He also punched the wall and said that he wanted to hit somebody and was going to hit the security man. This aggressive behaviour lasted for about an hour. Mr Burton was given chlorpromazine 200mg and went to sleep. No incident form was completed.

The night staff recorded that Mr Burton discarded a sheet with a large amount of vomit in the toilet.

Sunday 25 February

Enrolled Nurse A cared for Mr Burton on the morning shift. She recorded that he slept late and that when he got up he had to be shown that he was covered in vomit. She recorded that there was vomit on the walls, windows and under the bed in his room. Staff suggested to Mr Burton that the vomiting was due to alcohol and pizza. Mr Burton did not deny this.

During the afternoon Mr Burton was overheard telling another patient about his experiences with illicit drugs.

Monday 26 February

Enrolled Nurse A cared for Mr Burton on the morning shift. She recorded that he was "settled" and had visited the Day Centre with the recreation co-ordinator.

Mr Burton was reviewed by the MOSS at the request of nursing staff following the apparent drinking episode in the weekend, "although they did not have any particular concerns". He recorded: "Review – Discussion about discharge plans. [Mr Burton] keen to return to Q'town. Told father not happy with this idea. Suggest look at In'gill possibilities for accommodation and occupation and leave thoughts of Q'town until down track."

The afternoon nurse contacted Mr Trevor Burton and arranged for him to meet with Mr Burton and the MOSS later in the week. She reported that Mr Burton was bored and frustrated about not being able to return to Queenstown and that the MOSS had given him "a clear message of looking for accommodation and employment locally".

Tuesday 27 February

Mr Burton stayed in bed until lunchtime, despite encouragement to get up, and told the nurse caring for him that he was not interested in seeking accommodation as he wished to return to Queenstown. During the afternoon he was reported as tired. He was observed leaving the ward in pyjama pants after being encouraged to go out with the staff for a drive. He advised the afternoon nurse he wanted to return to Queenstown.

Mr Burton also advised his key worker from Invercargill CMHT, who spoke to him when she was on the ward, that he did not wish to stay in Invercargill. Because of this the key worker decided not to go ahead with a visit to Mr Burton with the associate key worker planned for 28 February, as the Invercargill CMHT only cares for clients living in Invercargill. She also made an undocumented request to a member of the inpatient nursing staff that she be advised once Mr Burton had decided where he wanted to live.

Wednesday 28 February

Mr Burton arose late and went to the bank with the recreation co-ordinator. Although not documented, the recreation co-ordinator advised that while she was with Mr Burton in the bank, one of the other patients ran off. The recreation co-ordinator went to look for this patient. Consequently, she did not ask Mr Burton about how much money he had withdrawn. Usually she would have enquired, so that she could advise staff how much money he had. She thought that normally he withdrew only small amounts.

Shortly after arriving back from the bank Mr Burton left the ward with another patient and was later found by staff with one dozen beer and a 750ml bottle of whisky. He was reported as reluctant to return to the ward and initially refused, saying that he wanted to consume the alcohol. The MOSS was notified and Mr Burton returned to the ward smelling of alcohol, after Police action was suggested. He had no alcohol with him. An incident form was completed.

A letter was sent to Mr Burton by a needs assessment facilitator advising that a referral had been received and a needs assessor would contact him within two weeks.

Thursday 1 March

Mr Burton advised the enrolled nurse caring for him on the morning shift that he wished to be discharged as he realised he was a voluntary patient. The weekly ward review was held and the ward review form records "paranoid towards mother and brother" and noted that a family meeting was scheduled for 4.00pm that day.

The clinical notes, written by the enrolled nurse on the morning shift, recorded that at the ward review the MOSS suggested that Mr Burton go to Odyssey House in Christchurch where there was currently a bed available. No detail was recorded as to why this suggestion was made.

The notes for the morning shift also recorded: "Apparently [Mr Burton] punched another patient as witnessed by a female patient." No incident form was completed.

Staff Nurse B cared for Mr Burton on the afternoon shift. She recorded a meeting at which she, Mr Burton, the MOSS and Mr Trevor Burton were present. The key worker from the Invercargill CMHT was invited to attend but was unable to do so because of other commitments. At the meeting Mr Burton stated that he wanted to be discharged and to return to Queenstown. The MOSS and Mr Trevor Burton advised him that this was not an appropriate option at that time because of accommodation problems. The option of attending a rehabilitation programme at Odyssey House in Christchurch was discussed. The staff nurse's notes recorded: "After much discussion [Mr Burton] agreed to same although would like further information. Is to remain in unit until this option available/organised." She also recorded that the MOSS had instructed that Mr Burton was only to have leave when escorted by staff.

Friday 2 March

Mr Burton stayed in bed until lunchtime.

The enrolled nurse caring for Mr Burton on the morning shift recorded that the MOSS would prefer a mental health rehabilitation unit with drug and alcohol input. The nurse recorded that she had contacted a staff member from the Children and Family Service who suggested Odyssey House in Auckland, which had a dual diagnosis programme, or Odyssey House in Christchurch, which had a residential programme, with youth specialty service input from the Canterbury mental health services.

Mr Burton remained on escorted leave only, and went on an outing with the recreation co-ordinator. He was looked after by Enrolled Nurse A on the afternoon duty. She recorded that he was settled and showed no signs of irritability, although Mr Burton was expressing frustration at being in the unit.

Saturday 3 March

Mr Burton was cared for by Enrolled Nurse A on the morning shift. He slept late and he was reported as remaining frustrated at still being an inpatient. Mr Burton spoke to Enrolled Nurse A about his mother and brother going into his room at home and stealing a large amount of money. Enrolled Nurse A questioned him about where the money came from and he terminated the conversation. This is not documented in the clinical notes. Staff Nurse B who cared for Mr Burton on the afternoon shift, recorded that Mr Burton was settled, but that he continued to display limited insight into the detrimental effects of drugs and alcohol on his mental state.

The night nurse recorded that Mr Burton requested, and was given, extra food before settling. She also recorded: "? if [Mr Burton] invited another pt to share above food, as another pt found in his darkened room."

Sunday 4 March

Mr Burton got up late. In the afternoon he was looked after by Staff Nurse B. She recorded a verbal conflict with another patient which was settled with minimal intervention from staff. She also recorded that Mr Burton was "voicing concern about believing someone is 'f---ing with him' at night. Suspicions that people are entering unit and his room."

Mr Burton advised Staff Nurse B that he no longer wanted to go to Christchurch but would like to go to the Homestead, a respite facility in Dunedin. Staff Nurse B considered this request was made because Mr Burton knew another patient was going to the Homestead. Mr Burton also said that he wanted to get back to Queenstown as he wanted some "dope" and that work "messed with his mind" and "dope and alcohol straightened him out".

Monday 5 March

Mr Burton was cared for by Staff Nurse A. He got up at noon and again talked about going to Dunedin. Mr Burton asked to see the MOSS. Staff Nurse A recorded advice from the Mental Health Needs Assessor that the needs assessment was due to occur on 8 March and reported that Mr Burton was settled. He spent much of the afternoon and evening in his room. His mood was described as pleasant. He said that he wanted to go to the Homestead.

Tuesday 6 March

Mr Burton was described on the morning shift as having periods of irritability when his needs were not met immediately. He again expressed a desire to go to the Homestead. No irritability was recorded on the afternoon shift.

Wednesday 7 March

Mr Burton remained in bed until lunchtime and then went on an outing with the recreation co-ordinator. He was described as settled.

Thursday 8 March

Mr Burton slept late. He was cared for by an enrolled nurse who attended the weekly ward review and recorded in the clinical notes: "Ward meeting: Because [Mr Burton] is feeling he has a drug and alcohol problem – a referral to Rhanna Clinic would be beneficial." The weekly review record does not record this decision, but notes under the thought patterns section of the form recorded "paranoid at times (4/03/01)". His diagnosis was again recorded as drug-induced schizophrenia.

A formal mental health services referral form was sent to Rhanna Clinic by the enrolled nurse. The date is difficult to read but it is likely to have been sent on 8 March as it states that Mr Burton had been an inpatient for 26 days. The diagnosis on the referral is noted as "drug induced schizophrenia". The referral advised that Mr Burton had a past history of drug and alcohol abuse, had been quite settled as an inpatient and now realised he had a drug and alcohol problem. It also noted that Mr Burton's father was keen for Mr Burton to seek assistance.

An appointment was made for Mr Burton to attend Rhanna Clinic the following Monday, but later in the duty Mr Burton stated that he was not prepared to go to Rhanna Clinic, but was prepared for a Rhanna Clinic counsellor to visit him on the ward. Mr Burton also told

the enrolled nurse that he felt he did not have a drug and alcohol problem and was certainly not going "to be a good boy on discharge".

The enrolled nurse recorded in the clinical notes that Mr Burton's needs assessment had been done and that the Mental Health Needs Assessor would contact the MOSS and Mr Trevor Burton about Mr Burton's future. This record is not correct. In fact, the Mental Health Needs Assessor commenced the needs assessment but did not complete it.

The enrolled nurse who was allocated to care for Mr Burton on that shift (and who subsequently recorded in the clinical records that the assessment had been done) attended the needs assessment as a support person for Mr Burton. During the meeting Mr Burton advised the Mental Health Needs Assessor that living at home was not an option but did not explain why. He told the Mental Health Needs Assessor that he planned to go back to Queenstown because that was where his friends were. He spoke of the possibility of joining a friend from Ward 12 in Dunedin at The Homestead. The Mental Health Needs Assessor explained that this was not an option as the Homestead was a respite facility and Mr Burton was not eligible to go there.

The Mental Health Needs Assessor said that after being initially reluctant to talk about his relationship with his family, Mr Burton began to talk about his mother and sister. He said he did not want anything to do with them because they would come into his room and touch him. The Mental Health Needs Assessor noticed a change in his demeanour when talking about his mother and sister, which concerned her, and she decided to terminate the interview.

The Mental Health Needs Assessor gained Mr Burton's agreement to talk to his family so that she could obtain their views on ways to support Mr Burton, and finished the interview without completing the assessment – which she intended to return to after speaking with Mr Burton's parents. She documented the part of the assessment she had completed.

After the interview the Mental Health Needs Assessor raised with the enrolled nurse Mr Burton's changed behaviour when he talked about his mother and sister. The enrolled nurse told the Mental Health Needs Assessor that it had happened before. This information is not documented in the clinical records.[23]

Nursing staff reported that Mr Burton was not irritable and that his conversation was superficial and limited.

Friday 9 March

Mr Burton was reported to be pleasant and settled and interacting well with patients and staff. His conversation was recorded as superficial. Mr Trevor Burton rang to see how his son was and what progress had been made with discharge plans. He was advised to call again the following week when the needs assessment results might be available.

Saturday 10 March

Mr Burton remained in bed until late in the morning. He went out with staff for two outings, one of which was to McDonald's. He was described as "pleasant and appropriate

[23] At that time, needs assessors did not document in patients' daily clinical notes, and needs assessment documentation and file notes of client contacts were kept in the social work department.

on all interactions" and "settled". He talked to the afternoon nurse of returning to Queenstown following discharge, and of working part-time.

Sunday 11 March

Mr Burton got up late in the morning and went out with staff for two outings. He was again described as "pleasant and appropriate in all interactions" and "settled".

Monday 12 March

The morning nurse recorded that Mr Burton was seen by the MOSS, although there was no clinical record made by him. The nurse recorded that the MOSS reinforced that returning to Queenstown at that time was not an option and encouraged Mr Burton to consider flatting in Invercargill or Dunedin and having input from early intervention. It is recorded that he was "not receptive to same".

The MOSS returned a call made to him by the Mental Health Needs Assessor on 9 March following the commencement of the needs assessment. He advised her that he had spoken to Odyssey House, Christchurch about the possibility of Mr Burton transferring there but that it was not suitable as it was a facility for alcohol and drug rehabilitation only and Mr Burton had a dual diagnosis. At the MOSS's request the Mental Health Needs Assessor agreed to check other options.

Although not documented in the daily clinical records, Mr Burton was visited by the Drug and Alcohol Counsellor from Rhanna Clinic on 12 March and a drug and alcohol assessment was carried out and documented using the Southland DHB standard health services initial assessment form.[24]

The Drug and Alcohol Counsellor also administered a number of diagnostic and screening tools for establishing the presence/absence or degree of severity of drug and alcohol abuse. Mr Burton disclosed intermittent heavy alcohol use since his mid-teens, with physical sequelae, such as vomiting and minor withdrawal symptoms, and cannabis use since approximately the same time.

Mr Burton also told the Drug and Alcohol Counsellor that he had been arrested for fighting on three occasions and for minor shoplifting on one occasion. This was information that had not been elicited on Mr Burton's admission, or subsequently.

The Drug and Alcohol Counsellor documented that Mr Burton expected to "just play the game until released and will return to drinking". Under the heading "Discharge Planning", the Drug and Alcohol Counsellor noted that he would leave this up to the mental health unit as Mr Burton had stated that he knew what was wrong and was not yet ready to address his cannabis/alcohol use and understood he could talk with a counsellor any time.

The Alcohol and Drug Services Counsellor said that his usual practice after an assessment was to find out who was looking after the patient and let them know "the position" and give the nurse the documentation he had completed to integrate into the patient's file. He said that he would have told the nurse that Mr Burton did not want to use Rhanna Clinic's services at that time and was "just playing the game" until discharge. The Alcohol and

[24] At that time Rhanna Clinic staff did not document in patients' daily clinical records, but their assessments were included in the integrated clinical records.

Drug Services Counsellor gave the documentation he had completed to a nurse to put in the clinical records before leaving the unit.

On the afternoon shift, Mr Burton became violent towards another male patient who surprised him by "sneaking up behind him and kissing him". Mr Burton chased the patient and hit him in the eye. He stopped when interrupted by staff and was recorded as not being remorseful. An incident form was completed.[25]

Tuesday 13 March

Mr Burton remained in bed until lunchtime. He went out with staff and purchased McDonald's. On direct questioning by the staff nurse caring for him on the afternoon shift, he denied auditory hallucinations, but then said he heard people talking at a distance but could not make out any of the voices. He also said he enjoyed taking drugs. The nurse recorded that Mr Burton had made no definite decisions about where he might settle on discharge and she spoke to him about looking at what accommodation might be available.

Wednesday 14 March

Mr Burton had a meeting with the MOSS, the unit social worker (Social Worker A), and the enrolled nurse caring for Mr Burton on that duty, about "[Mr Burton's] future". There is nothing documented about the meeting by the MOSS. The nurse recorded that Social Worker A and Mr Burton were to look for a flat the next day and to access the Day Centre (for Mr Burton to do woodwork, in which he had expressed an interest), and that Mr Burton was unwilling to seek information himself and became angry when told that nursing staff would not assist.

Mr Trevor Burton phoned and was reported as "reasonably happy for [Mr Burton] to go flatting but would have preferred supervised accommodation". The MOSS spoke to Mr Burton, although this is not recorded in the clinical notes.

An entry by Social Worker A records that he contacted the Day Centre and discovered that it was not set up for woodwork.

On the afternoon shift, Mr Burton requested to see the District Inspector of Mental Health to discuss his rights, as he wanted to go back to Queenstown. He agreed with the nurse that he would still look at flats the next day, as well as arrange to see the District Inspector.

Thursday 15 March

Mr Burton was cared for by Enrolled Nurse A on the morning shift. She left him to get up and organise himself to go flat hunting with Social Worker A that morning. Mr Burton got up at lunchtime and said that he would not go flat hunting until he had spoken to the District Inspector. An appointment was made with the District Inspector for the following day.

Enrolled Nurse A recorded: "Denies any hallucinations but paranoia still evident about his mother and brother although [Mr Burton] unwilling to speak about same."

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[25] In February/March 2001 incident forms were kept separate from the clinical records.

The weekly ward review was held. Nothing about the outcome of the meeting was recorded in the clinical notes. The weekly review form recorded under the heading "Thought Patterns", "paranoia still evident". His mood was recorded as "irritable due to being in unit". No outcome of the meeting was recorded.

On the afternoon shift, Mr Burton stated that he still wanted to go back to Queenstown.

Friday 16 March

Mr Burton met with the District Inspector. It was recorded by the nursing staff that Mr Burton's rights as a voluntary patient were explained to him by the District Inspector, who encouraged Mr Burton to co-operate with staff in organising his discharge destination. The General Manager advised that Mr Burton and the District Inspector discussed his options for leave and going flatting.

Social Worker A spoke to Mr Burton and arranged to go flat hunting with him. He recorded that Mr Burton rang WINZ (Work and Income New Zealand) himself to get information. Enrolled Nurse A looked after Mr Burton on the afternoon shift and reported that he was "pleasant and appropriate on all interactions".

Saturday 17 March

Mr Burton and Social Worker A found a one-bedroom flat in Invercargill, available from 22 March.

Enrolled Nurse A looked after Mr Burton on the morning shift and recorded that after he returned from flat hunting he was overheard talking to another patient about drugs. Enrolled Nurse A recorded that this patient "may be supplying [Mr Burton] with drugs, ? while in unit or on his discharge".

On the afternoon shift Mr Burton went to McDonald's with a nurse. He spoke to his father in the evening and told him he wanted his car when he moved into his flat. Mr Burton was reported as being very angry with his father as his father said he could not have the car. Mr Trevor Burton asked where the flat was, but Mr Burton told staff he did not want his father to know the address of his flat.

Sunday 18 March

Enrolled Nurse A cared for Mr Burton on the morning shift. She recorded that he remained angry with his father for not allowing him access to his car and stated that if he did not get his car he would go back to Queenstown and take it and live with his friends there.

On the afternoon shift one of the other patients overheard a conversation that suggested Mr Burton might be meeting another patient's visitor in the unit's toilets, to obtain drugs. Mr Burton was recorded as being "really upset" when staff intervened. Cannabis utensils were found in his room. An incident form was completed.

During the night Mr Burton asked staff if they "treated pain". There is no record of any further explanation or discussion about this query.

Monday 19 March

Enrolled Nurse A cared for Mr Burton on morning duty. She recorded that Mr Burton had a cassette tape on the door handle of his room that morning. Mr Burton told her that the reason for this was so that no one could come in while he was asleep without him being aware. Although it is not documented in Mr Burton's clinical notes, there is evidence from other nurses that prior to this date Mr Burton had used a towel at nights as a warning mechanism to alert him to others entering his room.

Enrolled Nurse A took Mr Burton to WINZ to organise his benefit prior to discharge. She recorded that the MOSS was going to contact Mr Burton's father that afternoon to organise his car and belongings and that Mr Burton wanted to see the MOSS after that.

Tuesday 20 March

The MOSS recorded in the clinical records: "Discharge Plan. In discussion with [Mr Burton's] father, [Mr Burton] may move into his new flat on Thursday (or as soon as convenient afterwards). His father will bring [Mr Burton's] requirements down from Queenstown and take him back so that he can collect his car."

Mr Trevor Burton said that although he and Mrs Paddy Burton had been opposed to Mr Burton having the car, the MOSS recommended that Mr Burton have it. After discussion, he agreed to let Mr Burton have it.

The MOSS's recollection differs. He said that he contacted Mr Trevor Burton and told him that his son wanted his car, but that he did not suggest that Mr Burton should be given the car. Rather, after discussion with Mr Trevor Burton it was agreed that Mr Burton should be allowed to use the car, because it would give him something to do, as the car was his hobby.

During the afternoon, Mr Burton was described as "slightly irritable" when staff were not free to take him to get take-aways. He was reported to be harassing a female patient to get the name and address of her boyfriend who had contacts with drug suppliers. He was challenged about this by the nurse caring for him and did not deny it. He said that "other people shouldn't stick their nose into things". He was also reported as exhibiting paranoia about his mother and family members.

Wednesday 21 March

The weekly ward review was held. Nothing was recorded on the review form under the heading "Thought Patterns". Under the heading "Leave" it was recorded: "Flat found. WINZ. Seek work part time. Doesn't want parents to know his address – 1 weeks leave meds – contact K/W … tomorrow."

Staff Nurse A, who cared for Mr Burton on morning duty, recorded that Mr Burton was settled and queried whether he was to have trial leave prior to discharge. She was to discuss this with the MOSS and the community key worker the next day.

The afternoon nurse recorded that Mr Burton's father was due to arrive with Mr Burton's belongings the following morning and then take Mr Burton back to Queenstown to collect his car.

Thursday 22 March

On Thursday 22 March, Staff Nurse A cared for Mr Burton on the morning duty. She recorded at 11.50am that Mr Burton had been placed on one week's leave and that he had been given leave medications and instructed to ring the inpatient unit if he had any problems. She recorded: "Discouraged from using any illicit substances/alcohol. Instructions on taking medications each night. [Social Worker A] to f/u [follow up] each day. I will contact k/w [key worker] [the Community Mental Health Nurse] tomorrow to inform her of leave."

Social Worker A recorded that he took Mr Burton to WINZ on the morning of 22 March and met Mr Trevor Burton, when he brought down some of Mr Burton's belongings and at the same time delivered Mr Burton's car. Mr Trevor Burton asked Social Worker A to contact him if his son needed anything.

Mr Burton moved into his flat without assistance. Social Worker A said that he had hoped to assist Mr Burton, but as he only worked in the mornings, was unable to do so.

Friday 23 March

Social Worker A visited Mr Burton in his flat. He documented his visit in Mr Burton's clinical notes on Monday 26 March. He reported that Mr Burton had settled into his flat and that he had had a good first night but woke twice. He reported that Mr Burton had some tinned food and a "brick" of beer in the fridge. He also had a small flask of whisky. He reported that Mr Burton had consumed six stubbies on his first night in the flat.

Mr Burton asked Social Worker A to contact his parents and ask for some supplies (including a knife, fork, plate, cooking pot and frying pan). Mr Burton also expressed interest in the recreation co-ordinator's activities programme.

Social Worker A arranged for Mr Burton to bring his car to the mental health unit the following week to do some work on it, as a project for the home maintenance group run by Social Worker A.

Although it was not documented in the clinical records, Social Worker A was suspicious that Mr Burton may have been smoking cannabis because he saw what looked like cannabis butts in the bottom of one of the empty beer bottles. Social Worker A questioned Mr Burton, who denied that he had been smoking cannabis. Social Worker A could not smell cannabis in the house and did not document or report this, because he was not sure that Mr Burton had been using cannabis.

Staff Nurse A left a message on Mr Burton's community key worker's answerphone advising that Mr Burton was on leave and that a discharge meeting was planned for 30 March. Staff Nurse A told the investigation team that she did so because it was her expectation that Mr Burton would be visited at home by the key worker while Mr Burton was on leave. She said that Social Worker A was to visit to make observations, not to assess mental state; that was why the key worker needed to visit. She said she was aware

that key workers did not work on weekends but would have expected the key worker to visit on Monday or Tuesday.[26]

Staff Nurse A said that the clinical team was aware that there were risk factors relating to Mr Burton's drinking and use of drugs "and that is why it was important we monitored his leave".

The Mental Health Needs Assessor contacted Ward 12 to pass on information she had obtained about drug and alcohol treatment options and was told Mr Burton had gone on trial leave and was living in a flat. Until this conversation the Mental Health Needs Assessor did not know Mr Burton was on leave.

The Mental Health Needs Assessor attempted to contact Mr Trevor Burton and Mrs Paddy Burton to arrange a meeting with them in Queenstown on 26 March as she was planning a visit to other clients in Queenstown that day.

Saturday/Sunday 24/25 March

No one from Southland DHB's mental health services visited Mr Burton.

Monday 26 March

Social Worker A visited Mr Burton in his flat. Mr Burton is recorded as saying he had had a good weekend and had walked to the shops several times. He told Social Worker A he had not been sleeping well during the weekend, going to bed in the early mornings, but waking often. He had consumed the remainder of the beer and half the small flask of whisky. Social Worker A recorded this in the clinical notes. Social Worker A also saw, but did not record, that Mr Burton had a large bottle of whisky which was full.

The Mental Health Needs Assessor visited Queenstown. She tried unsuccessfully to contact Mr Burton's parents. She and Mrs Paddy Burton left telephone messages but missed each other. The Mental Health Needs Assessor telephoned and spoke to Mrs Paddy Burton that evening to apologise for not having been able to meet. Mrs Paddy Burton expressed concern to her about her son being able to cope with cooking and cleaning in a flat and said she doubted whether he would eat properly. She asked about the possibility of PACT (supported) accommodation in Invercargill. The Mental Health Needs Assessor told her that she did not think PACT accommodation would be suitable as Mr Burton appeared "anti-establishment". The Mental Health Needs Assessor told Mrs Paddy Burton she would meet her and Mr Trevor Burton next time she came to Queenstown and in the meantime would complete the needs assessment and let Mrs Paddy Burton know the outcome.

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[26] During the course of my investigation my investigators were provided with the following statement from the Invercargill CMHT:

> "5 December 2001
> TO WHOM IT MAY CONCERN
> As a result of information from the Coroner's hearing relating to [Mrs] Paddy Burton, we as members of the Invercargill Community Mental Health Team wish to state that it has been our custom and practice and understanding that the responsibility of care for clients on leave from the Invercargill Mental Health Unit remains with Mental Health Unit staff until discharge/transfer has been completed. If specifically requested and agreed to, Community staff may have contact and input while a client is on leave from the unit. Signed by Invercargill CMHT"

Tuesday 27 March

Mr Burton met with Social Worker A at the mental health unit to work on his car radio as arranged. He arrived early and made himself a cup of tea and played pool. Staff Nurse A, who was on night duty, saw him and spoke to him briefly. Staff Nurse A said that his mental state appeared normal. She did not record this. Mr Burton is recorded as being very active in helping with the car radio. Mr Burton reported to Social Worker A that he went to bed the night before at 2.00am and woke twice. Social Worker A noted that "everything seems to be going well at the flat, no issues or concerns raised".

Wednesday 28 March

Social Worker A visited Mr Burton at his flat. Mr Burton reported that he had had his best sleep so far, from 11.00pm-4.00am. He was noted to be eating well and that his mood was good, but that he was consuming whisky in large quantities.

Enrolled Nurse A recorded in the clinical notes that a discharge meeting was planned for Friday 30 March at 11.00am and that Social Worker A was to collect Mr Burton from his flat to attend the meeting.

Thursday 29 March

Social Worker A visited Mr Burton and delivered a box that the Mental Health Needs Assessor had collected from Mr Burton's parents in Queenstown. Social Worker A recorded that Mr Burton was fine and required a WINZ medical certificate and a medication script. Social Worker A arranged for Mr Burton to collect the script from the inpatient unit at 9.30am the following day.

Mr Trevor Burton rang the MOSS to "touch base". Although it is not documented, the MOSS stated that he confirmed to Mr Trevor Burton that the week on leave had been uneventful and that Mr Burton would be discharged the next day.

Staff Nurse A, who was on night duty, rewrote a discharge plan that had been commenced by an unidentified staff member, because it "was old and tatty and because it needed to be updated with more accurate information".

The rewritten plan recorded under the heading "Progress to Date": "Settled on admission. Expressing paranoia to mother and brother, found flat in town, applied for job [in a tavern] …" Under the heading "Goals on Discharge" is recorded: "Short term accommodation found – yet to find long term. Look at employment options, has interview for job on 23/3/01. Attend [Day Centre]." Under the heading "Signs of Becoming unwell/Crisis Plan" is recorded: "Becomes aggressive. ↑ delusional thinking, references from radio. ↓ sleep. Smiles inappropriately."

There is no reference in the clinical records to the job interview referred to on the above discharge plan as scheduled for 23 March.

Friday 30 March

Enrolled Nurse A recorded that a discharge planning meeting was held on Friday 30 March and attended by Mr Burton, the MOSS, Social Worker A and Enrolled Nurse A. This meeting was scheduled for 11.00am, but Mr Burton arrived at 9.30am, as arranged by

Social Worker A, and did not want to stay until 11.00am. The MOSS agreed to hold the meeting early. The key worker from the CMHT was to attend the meeting at the scheduled time of 11.00am. She was in the building at 9.30am but was not advised of the change of time, and so did not attend.

The MOSS documented: "Review – week at home – no major problems – drinking a bit but taking medication. No talk of returning to Queenstown. Plan for discharge, Olanzapine 75mg nocte."

Enrolled Nurse A recorded that Mr Burton was "to continue meeting with Social Worker A for social work group on Tuesdays" and to have a follow-up meeting with the MOSS, his key worker from the Invercargill CMHT, and the recreation co-ordinator to discuss an exercise programme and future employment. Mr Burton was given a script for three months' supply of olanzapine.

The MOSS advised that he would have preferred to give Mr Burton a weekly script but Mr Burton wanted a three-month prescription.

A client discharge form from the inpatient unit was completed noting Mr Burton's diagnosis as paranoid schizophrenia.

Enrolled Nurse A sent the key worker a note advising that Mr Burton had been discharged and that a further meeting was to be held on 6 April 2001 with the key worker and associate key worker. A discharge letter written by the MOSS recorded that Mr Burton was to see him in one week's time, on 6 April 2001. The appointment was not recorded in the clinical records.

Social Worker A recorded in the notes on 31 March that he had advised Mr Burton's associate key worker that he would see Mr Burton for another week and would then arrange an introduction meeting and hand-over to the community mental health staff.

THE DEATH OF MRS PADDY BURTON

The Coroner's Findings record the circumstances leading to the death of Mrs Paddy Burton:

> "[After he was formally discharged on 30 March 2001, Mr Burton] went to his flat where that night he drank Bourbon and beer.
>
> In the early hours of Saturday [31] March he drove himself from Invercargill to his family address at Kelvin Heights, Queenstown, taking with him a knife, a plastic container of petrol and a change of clothing. He arrived at the family home between 3.00am and 3.30am.
>
> [Mr Burton] broke into the property and confronted his mother. He stabbed her some 56 times, resulting in her death. The wounds were inflicted with two separate weapons being the small knife purchased in Invercargill and a large kitchen knife located by [Mr Burton] at home. Using the petrol as an accelerant [Mr Burton] then set fire to the house and his mother's body."

In the High Court in August 2001, Mr Burton was found not guilty of the murder of his mother, on the grounds of insanity. He was committed as a special patient under section 115(1) of the Criminal Justice Act 1985.

MR TREVOR BURTON'S PERSPECTIVE

Mr Trevor Burton told the investigation team that he and Mrs Paddy Burton made the assumption that their son would be getting intensive psychiatric assessment and care while he was an inpatient. They assumed that when Mr Burton was discharged a psychiatrist would have addressed the issues that led to Mr Burton's admission – in particular, his son's paranoia. He said that he now believes that his son had a roof over his head while he was in hospital and very little else in the way of effective treatment. He also said that he considers that Mr Burton was "essentially kicked out into a flat to look after himself". His son had not received appropriate care or had a needs assessment and had received inadequate care from the psychiatric team at Ward 12 while he was on leave.

Mr Trevor Burton said that he recognised his son could be difficult and that he would not just throw his cards on the table and tell the medical staff his secrets, but he did not consider that medical staff persevered sufficiently. They had allowed his son to dictate his care.

Mr Trevor Burton said that contact with Ward 12 was largely left up to the Burtons. There was no proactive effort by the hospital to contact them. He told the MOSS, who he assumed to be a psychiatrist, that he would like to be the point of contact with the family as his wife was tired. Mr Trevor Burton was the person who made contact with the ward and who was contacted by the MOSS. However, Mr Trevor Burton considered that his contact with the MOSS was superficial. He was not given the name of a primary nurse to act as a regular contact person.

Mr Trevor Burton said that he was not told about several key facts: the suspicion that Mr Burton had been drug-seeking while an inpatient; discovery of cannabis utensils; the incident where Mr Burton vomited after being suspected of drinking; the incident of aggressive behaviour; and the evidence of paranoia at the time he went on trial leave, and the content of that paranoia, which had altered to include Mr Burton's sister. Nor was Mr Trevor Burton told of Mr Burton's drinking while he was on leave. He said that if he and Mrs Paddy Burton had had all that information, "I'd like to think we would have protested long and hard about him being discharged."

Mr Burton was clear that he and his wife were not invited to a meeting that involved all members of the family, or to a meeting to discuss Mr Burton's progress, plans for discharge or community support, although Mr Burton attended one meeting on the ward, requested by the MOSS, at which the idea of Mr Burton going to a drug and alcohol treatment centre was discussed.

INDEPENDENT ADVISORS' REPORT

My independent advisors prepared a detailed report on the quality of services provided to Mr Burton between 10 February 2001 and 30 March 2001 while he was under the care of Southland DHB's inpatient mental health services. A full copy of their advice is attached as Appendix I to this report. Their advice provides context and detail for my opinion. [27, 28]

I take this opportunity to publicly acknowledge the hard work and professionalism of my advisors, and to thank them. At short notice I requested that my advisors – all of whom have demanding work commitments as well as family commitments – travel to Invercargill to interview relevant people, review the large amount of documentation and provide a report in a short time frame. I am aware that it required long hours of work, some of it over the Christmas break, to produce their report.

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[27] In its response to my provisional opinion Southland DHB raised concerns that it was inappropriate that I had a forensic psychiatrist providing expert advice on staff operating in a general psychiatric setting. Its concerns in this regard are unfounded. Dr Patton is not a forensic psychiatrist. He is a Clinical Director of a DHB mental health service and a Director of Area Mental Health Services.

Some responses to my provisional opinion also raised concerns that another member of the investigation team, Ms Gay, the family advisor, could not be considered impartial because she has a son with schizophrenia. I reject this submission. Ms Gay was appointed because of her expertise as a family advisor. She has extensive experience in this area – gained in part because she has a child with a mental illness. She is a former Chair of the Schizophrenia Fellowship, Wellington; a member of the Mental Health Commission Advisory Board, as a family advisor; chair of the Schizophrenia Fellowship National Conference in 2000; speaker at the Themes Conference 500 in 2001; a panel member at the Paradox of Rights Conference in 2002; and editor of the 1999 Schizophrenia Fellowship publication *The Sun Will Shine Again*, which contains stories of families with mental illness.

The Patient Services Manager and Southland DHB noted that the investigation team did not include someone with expertise and experience in management. Although none of the independent advisors was appointed as a "management advisor", as a group the investigation team had considerable experience and expertise in management. At the time of the investigation, three of my advisors were on the management teams of the mental health services of their respective DHBs.

[28] Some matters raised in response to my provisional opinion refer to views expressed by my advisors in their report but which are not included in my opinion. I have not invariably commented on these responses, and do not consider myself obliged to do so. Pursuant to the Health and Disability Commissioner Act, what is of significance is my opinion on whether there has been a breach of the Code of Health and Disability Services Consumers' Rights.

CODE OF HEALTH AND DISABILITY SERVICES CONSUMERS' RIGHTS

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

RIGHT 4
Right to Services of an Appropriate Standard

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

…

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

SUMMARY OF COMMISSIONER'S OPINION

While he was under the care of Southland DHB's inpatient mental health service between 10 February 2001 and 30 March 2001, Mr Burton had the right to have services provided that complied with the Code of Health and Disability Services Consumers' Rights.

In my opinion, Mr Burton did not receive services of an appropriate standard. There were acts and omissions by individuals and by Southland DHB that breached Mr Burton's rights under the Code.

As noted by my advisors, there were "numerous 'holes' in this cheese,[29] so many and some of such proportion that they lined up to create large gaps through the substance of the service. Although each deficit singularly may not have been responsible for the outcome, the substance or quality of the service appears in this case to have been so compromised that the risk of occurrence of adverse events was not managed at all effectively."

The terms of reference of my inquiry have focused on the quality of care provided to Mr Burton. My conclusion is that the care he received was of poor quality. There were inadequate monitoring and control mechanisms to ensure that staff practised safely, that incident and risk management strategies were in place, and that policies and procedures were followed.

In relation to each of the specific terms of reference, practice was substandard. Contact and co-ordination with Mr Burton's family was patchy and inadequate; much of the time the family was left in the dark about what was going on. Discharge planning was scanty, ineffective and poorly co-ordinated; it is not hard to see why Mr Trevor Burton considers that his son was "essentially kicked out into a flat to look after himself". The discharge itself was dubious. The inpatient mental health service failed to piece together the available information about Mr Burton's disturbed sleep patterns, alcohol abuse, psychotic

[29] This is a reference to the Swiss cheese model of system accidents in which successive holes in the layers of defences, barriers and safeguards line up. See Reason, J, "Human Error Models and Management", *BMJ* 2000, 320:768.

behaviours and lack of support in Invercargill. Finally, there was a notable lack of co-ordination with the Queenstown Community Mental Health Team (which had considerable previous contact with Mr Burton) or the Invercargill Community Mental Health Team, whose involvement should have been pivotal to ensuring Mr Burton's successful discharge into the community.

There was a sense of complacency throughout Southland DHB's inpatient mental health service. The overall picture is one of sloppy care that was lax and laissez-faire. Mr Trevor Burton and his family have every right to feel that the health system failed them.

MEDICAL CARE

Medical Officer Special Scale

Introduction

The MOSS was, for all practical purposes, Mr Burton's psychiatrist in the period under review. In my opinion, the MOSS did not provide services of an appropriate standard to Mr Burton.

My advisors made a number of criticisms relating to the quality of care provided by the MOSS. Their report details their concerns and should be read in conjunction with this section of my opinion. Overall, my advisors considered that in many aspects of Mr Burton's care, the MOSS failed to provide services that complied with Southland DHB's policies and other relevant standards and that he did not perform to a standard expected of an unsupervised MOSS. The specific deficits in the MOSS's practice are considered below.

Medical Officer Special Scale not a psychiatrist

The MOSS was not a trained psychiatrist, although Southland DHB's expectation was that, while Mr Burton was an inpatient, the MOSS was acting as a psychiatrist. In some matters, specifically consideration of the use of the Mental Health Act and medication, my advisors considered discussion with more experienced staff would have been helpful. The MOSS said that he understood that as a MOSS he was not vocationally trained as a psychiatrist and that he believed that his contract with Southland DHB required him to work under supervision. Although there was no regular dedicated time for support and advice from a senior colleague, the MOSS felt that where necessary he could discuss a case with the Clinical Director. However, he did not consider that he needed to discuss issues relating to Mr Burton's care with the Clinical Director; Mr Burton's behaviour was uncontroversial while on the ward and, as he was "co-operative with management", the MOSS felt that he did not need advice from the Clinical Director. My advisors considered that the MOSS paid inadequate attention to his own needs for supervision. Although he was accepting of the notion of supervision, he did not avail himself of it or seek it out.

In response to my provisional opinion, the MOSS said that he considered that my expert advisors did not accurately reflect the excellent opportunity the weekly ward review provided for the responsible clinician to discuss individual patients with both nursing staff and consultant psychiatrists. The MOSS's counsel advised that "from the MOSS's point of view, this was the weekly forum to discuss patient management and all involved felt

comfortable to air any concerns they had about a particular patient. The MOSS does not believe he misjudged the general lack of concern expressed by others; however as a result of these discussions there was a general acceptance that [Mr Burton's] management was uncontroversial and there were not major problems perceived by staff."

My psychiatric advisor agreed that ward reviews may be an excellent opportunity for input. However, he advised that the records available do not support the MOSS's assertion, and do not demonstrate how the input of others contributed to Mr Burton's management. At one of the five weekly meetings while Mr Burton was a patient, no consultant psychiatrist was present. As my advisors noted in their report, records of attendance suggest that, as a forum for supervisory input on a regular basis from a more experienced member of the medical staff, the meetings would have been of limited value.

Assessment and care planning

My advisors considered that the MOSS did not meet the standards of assessment and care planning set out in Southland DHB's Consumer Assessment policy in the following respects:

- He did not record his admission assessment on a standardised assessment form.[30]
- He did not record an adequate history on admission. For example:
  - there was no detail about the nature of threatening behaviour or precipitating factors
  - there was no reference to the nature or content of the discussion between Mr Burton and his father on 10 February, including on the journey to Invercargill
  - key concerns of the family were not detailed
  - there was scanty developmental history
  - there was brief reference only to psychiatric history
  - there was limited reference to social circumstances and no detailed reference regarding stresses, finances or relationships
  - there was no medical history
  - there was no record of quantity or frequency of use of alcohol and cannabis, circumstances of use, features of dependence or withdrawal, physical or psychological consequences of use or other relevant factors.
- His treatment and support was not based on a comprehensive assessment and at no point during Mr Burton's admission is there documentation of thorough and systematic review of Mr Burton.
- None of the MOSS's file entries offer any detail in regard to Mr Burton's mental state.
- He did not review Mr Burton's assessment regularly.

[30] There is evidence that a copy of this form was not available when the assessment was commenced. In response to my provisional opinion, the MOSS submitted that Mr Burton's admission should be seen and considered in the context of it being an admission during which Mr Trevor Burton gave most of the answers to the MOSS's questions; the usual admission form was not available as it was a Saturday; and Mr Burton's file had not yet been received from Queenstown CMHT. He submitted that he therefore fully expected that he would be able to obtain a fuller history once he had seen Mr Burton's previous notes and during his ongoing contact with Mr Burton throughout his admission. I accept that on the Saturday Mr Burton was admitted, for some reason there was not a standardised admission form available, nor were Mr Burton's notes from Queenstown available. However, even when both became available, the MOSS did not complete an adequate assessment or attempt to complete the standardised assessment form.

- He did not develop and document a sufficiently broadly based treatment plan. For example:
  - the focus in his records is on the location of domicile
  - he did not identify important matters, such as effective understanding by the clinical team of the nature of Mr Burton's psychotic experiences and provision for effective treatment and management of the risks of psychotic phenomena.
- He did not give systematic and adequate attention to matters he said he identified as priorities, in particular, addressing Mr Burton's drug and alcohol use and helping Mr Burton to come to terms with his illness. For example:
  - although documentation from an assessment of Mr Burton's drug and alcohol use by a counsellor from Rhanna Clinic was incorporated in Mr Burton's file, the MOSS did not study this assessment and accordingly missed key information
  - there is no record of the MOSS discussing drug and alcohol use with Mr Burton, although the MOSS says he did. However, when the MOSS reviewed Mr Burton after his period of leave there is no indication that the MOSS discussed with Mr Burton the amount of alcohol he had consumed while on leave and that this was of concern, and the treatment plan was not reviewed or the discharge plan reconsidered
  - the documented use of alcohol was substantial, but appears to have been minimised by the MOSS
  - there is no evidence of systematic attempts to find a residential facility that would address substance abuse, although this was at one stage suggested by the MOSS
  - there is no evidence that consideration was given to whether improvement in Mr Burton's sociability might have been due to reduced alcohol use but that his underlying psychiatric symptoms were unchanged
  - the records reflect no systematic attempt to help Mr Burton come to terms with his illness.[31]
- He did not give adequate attention to Mr Burton's mental state and did not adequately assess whether there was an improvement in Mr Burton's psychotic symptoms.

[31] Dr Taumoepeau also concluded that Mr Burton's diagnosis of alcohol and drug (predominantly cannabis) abuse was not formally recorded, either at admission or on discharge, and that this aspect of Mr Burton's diagnosis appears to have been minimised.

- Possible indicators of persisting psychotic persecutory delusions were not explored or taken into account in a more cautious approach to treatment.[32, 33]
- Although there was clear evidence of Mr Burton's persisting use of alcohol while on trial leave, the MOSS gave insufficient attention to consideration of options for more assertive interventions, even though he had no evidence of being able to work effectively to engage with Mr Burton to access his thoughts or change his intention in regard to alcohol use.
- He did not give adequate attention to Mr Burton's medication once the dose of olanzapine was increased on admission, with no evidence of regular systematic review of the effectiveness of the treatment or Mr Burton's tolerance of it.
- He did not seek consultative or supervisory support to assist with clinical decision-making, for example, in relation to possible use of the Mental Health (Compulsory Assessment and Treatment) Act, and Mr Burton's response to medication.
- He did not sufficiently specify the circumstances in which the "as required" medication (which he prescribed for Mr Burton on admission) was to be used.

Clinical risk assessment and management

My advisors considered that in the following respects the MOSS did not meet the criteria in Southland DHB's Clinical Risk Assessment and Management policy:

- He did not complete a comprehensive assessment of the risks associated with Mr Burton's illness and presentation, including completing the assessment of risk document that the policy required be filled in. The information from the Queenstown CMHT, including a recently completed risk assessment and the letter from Mr Trevor Burton dated 11 February 2000 and historical information available in old notes, was not used to add to the detail known on admission to formalise and document an overall view of risk.
- He undertook no documented review of Mr Burton's assessed level of risk following incidents such as Mr Burton returning to the ward apparently intoxicated and behaving in a threatening manner, or after discovering that Mr Burton had placed an object on the door handle of his room.

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[32] Dr Taumoepeau also concluded that during admission, details of Mr Burton's symptomatology, particularly the extent of paranoid delusional ideas, were not adequately explored or recorded in a formal way. She noted no evidence, or sense, of a formulation of the pattern and evolution of Mr Burton's psychiatric problems from a diagnostic point of view. She considered this particularly significant in that new and disturbing features of Mr Burton's illness were emerging while he was in hospital. The Coroner noted that Mr Burton was not challenged about his delusions and concluded that until Mr Burton's delusions were understood, his treatment as an inpatient was incomplete.

[33] My advisors noted in their report that the clinical team "failed to address Mr Burton's delusions". Southland DHB sought clarification of this expression. My psychiatric advisor clarified as follows:

> "Delusions are by definition false fixed beliefs. They are not amenable to reason and to logic. In good practice it is important to get a clear idea of the nature of someone's delusions, in order to get a clear idea of their type and extent and to get a foundation from which any change can be measured over time as treatment (in the form of antipsychotic medication) takes effect. If, for example, we do not explore the nature of the delusions, or indeed identify so little of the content of someone's mental state to know whether there are delusions at all, or whether they are simply unusual ideas of another sort, we have no way of knowing whether things that become apparent over time are a reflection that treatment is not helping, whether the mental state is deteriorating, or whether any risks associated with the delusions are changing. What we mean [in our report] by 'failure to address' was that the clinical team failed to explore these in any way that allowed clear understanding as to whether there were delusions, whether there may have been risk factors that related to the delusions (for example, whether, if Mr Burton believed he was being interfered with, he also then felt he needed to take any action to respond to these ideas) and whether the delusions persisted over time. There is no evidence in the file of detailed exploration of these matters – that is what we meant by 'address'."

- He undertook no documented review of risk prior to the decision that Mr Burton would have a week of trial leave.
- He did not complete a comprehensive assessment of risk before Mr Burton left the inpatient setting – which was the point at which the MOSS said he understood a comprehensive risk assessment was required.

In response to my provisional opinion, the MOSS said that he and Mr Trevor Burton agreed, after discussion, that Mr Burton should have his car in Invercargill, "as it would at least give him something to do". The car was delivered the day Mr Burton went on trial leave. My advisors noted that the MOSS did not review Mr Burton's risk once this decision was taken and considered that he should have done so.

My advisors also considered that the MOSS did not reach the standards set out in the *Guidelines for Clinical Risk Assessment and Management in Mental Health Services* (Ministry of Health in partnership with the Health Funding Authority, 1998). In particular:

- there was no evidence that the MOSS incorporated ongoing events in Mr Burton's care into a review of risk status
- there was little documented evidence that details of events were explored by the MOSS in sufficient detail to enable a comprehensive understanding of their significance and the circumstances in which risks may increase
- there was no documented formulation of risk data leading to comprehensive plans to reduce risk
- there was evidence that an early sign of relapse was noted, but no evidence of actions to closely monitor any change in mental state.[34]

Leave planning

My advisors considered that the MOSS did not meet the standards required by Southland DHB's Authorisation of Leave for Inpatients policy in the following respects:

- The MOSS authorised day leave for Mr Burton on 14 February but there was no reference to Mr Burton's mental state, the intentions for the leave, or any conditions attached to the leave.
- There is no documented consideration of leave privileges after Mr Burton was seen going into a bar on 24 February and later vomiting. A review of leave status was only documented 24 hours after an occasion on 28 February when Mr Burton left the ward and was found in possession of a large quantity of alcohol.
- There were inadequate arrangements for review of Mr Burton's mental state during the week of trial leave authorised by the MOSS.
- There was clear evidence of behaviour during trial leave that ought to have led to concern by the MOSS, but did not result in any change in the leave provisions.

[34] Dr Taumoepeau also concluded that the assessment of needs and risks was inadequate during Mr Burton's inpatient stay and did not meet the minimum standards laid out in the *Guidelines for Clinical Risk Assessment and Management in Mental Health Services*. She concluded that there was little evidence that risks were assessed, recorded or understood and that the medical notes, in particular, did not record exploration of symptoms that could have clarified risks and safety issues. The Coroner also concluded that there was lack of effective risk management.

Discharge planning and continuity of care

Southland DHB's expectations for discharge planning are set out in their Consumer Assessment and Discharge policies. My advisors considered that those responsibilities that are specifically identified as medical responsibilities in these policies were incompletely or inadequately implemented by the MOSS. In particular:

- the MOSS prescribed a three-month supply of medication without evidence of discussion of the need to adhere to the prescribed dose, or of strategies to monitor adherence, or to restrict supply[35]
- there is no evidence of a comprehensive review of Mr Burton's mental state on March 30, when the plan to discharge was confirmed
- no attempt to undertake a mental state examination was documented
- no review of risk factors was documented
- no discussion of Mr Burton's substantial use of alcohol in the week of trial leave, or the implications for his mental state, was documented.

The Clinical Director's view was that the responsibility of the primary psychiatrist of a patient was the assessment, diagnosis and treatment. He included in this the responsibility for medication and discharge. This suggests that the doctor has responsibility for elements of the discharge other than medication and mental state. My advisors considered that on this wider view of the responsibilities of the doctor, other aspects of the MOSS's attention to discharge were not of an appropriate standard. They noted that the MOSS was to continue to be involved in Mr Burton's care, in conjunction with the community key worker, and that this reduced the extent of documentation and communication necessary to ensure continuity of care, but nevertheless considered that the MOSS did not perform to an appropriate standard. In particular, the MOSS discharged Mr Burton:

- without the community key worker attending the discharge meeting (after the MOSS changed the meeting time without advising her)
- without a formal needs assessment
- without ensuring sufficient arrangements to adequately monitor Mr Burton in the days following his discharge to a flat in Invercargill where he had little personal support and minimal financial resources, and where he had not engaged with the professional supports potentially available for his ongoing assistance.

Under Right 4(5) of the Code, consumers have the right to co-operation among providers to ensure quality and continuity of care. Standard 18 of the *National Mental Health Standards* requires that consumers be assisted to plan for their exit from mental health services to ensure that ongoing follow-up is available if required. Criterion 18.5 provides that the mental health service should ensure that consumers referred to other service providers have established contact with that provider and that the arrangements made for ongoing follow-up are satisfactory to the consumer, their family and carers, and the other service providers, before the consumer exits the service.

A discharge meeting was planned for 11.00am on 30 March. Mr Burton, the MOSS, Enrolled Nurse A, Social Worker A and Mr Burton's community key worker were to attend the meeting. Mr Burton arrived early at the inpatient unit and did not want to stay until the arranged time, so the MOSS agreed to bring the meeting forward without advising

[35] Dr Taumoepeau also noted that while comments were made that Mr Burton was taking his medication while on leave, no plans were in place for supervision of this – for example, blister packing of medication, or daily or weekly dispensing.

the key worker or ensuring that she could attend. The meeting was held without her, and Mr Burton was discharged without arrangements in place for follow-up care by the key worker, or an opportunity for her to provide input into the wisdom of discharging Mr Burton at that time.

In my opinion, by agreeing to hold the meeting early without ensuring that Mr Burton's key worker could be present to provide input into the discussion about discharge and community support arrangements, the MOSS failed to ensure continuity of care for Mr Burton.

Discharge into flat

In response to my provisional opinion, the MOSS and Southland DHB expressed disagreement with my proposed endorsement of Mr Trevor Burton's statement that Mr Burton was "essentially kicked out into a flat to look after himself". The MOSS's counsel stated:

> "[Mr Burton] was a voluntary patient in the Mental Health unit, where he remained for a period of six weeks while staff used their very best efforts to find a solution to conflicts between [Mr Burton's] wishes, the family's requests and the clinical judgement about [Mr Burton's] illness. [The MOSS] is unequivocal that no-one, either in March 2001 or since thought that a flat was an ideal situation, but they had little choice and decisions were made to best support [Mr Burton] upon discharge. During his admission, numerous discussions were held with [Mr Burton] about placement in supervised accommodation on discharge. In addition, the possibility of PACT housing and placement at Odyssey House was discussed with [Mr Burton]. Because of [Mr Burton's] dual diagnosis, Odyssey House was likely to be the only practical placement. This was because PACT had a policy that if a client was caught with drugs and/or alcohol they would be asked to leave. In [Mr Burton's] case, because he would not agree to desist from using drugs or alcohol, PACT accommodation would be 'setting him up to fail'. … [Mr Burton] was also refusing to consider living in a residential setting … In any event, at the time [Mr Burton] was discharged there was a waiting list for PACT accommodation and no beds were available. As it was not considered appropriate to use the Mental Health (Compulsory Assessment and Treatment) Act, [Mr Burton] was discharged into a flat so the Community Mental Health Team could continue to work with him, and he could continue to see [the MOSS] as an outpatient. The level of supervision put in place for [Mr Burton] was greater than usual … as [Mr Burton] was to have daily visits to monitor and support him. It should not be overlooked that [Mr Burton] managed his seven-day trial discharge without any dramatic difficulty. The problem was, and still is, that appropriate places do not exist, particularly for dual diagnosis patients who will not comply with the requirement to cease use of drugs and/or alcohol while in supervised residential accommodation."

Southland DHB also expressed concern at my provisional endorsement of Mr Trevor Burton's statement and echoed the MOSS's submission that PACT was not an option for Mr Burton because of his refusal to maintain an alcohol- and drug-free lifestyle.

Comment needs to be made on some of the factual matters asserted in the MOSS's response. Although the MOSS has said that "numerous discussions were held with Mr Burton about placement in supervision on discharge", there is no reflection of this in the

daily clinical record or in the records of the weekly ward reviews, and it is not clear what was discussed with Mr Burton, or by whom.

Evidence was given at the inquest by the Chief Executive Officer of the PACT Trust that at the time Mr Burton went on trial leave there were beds available in its level 4 housing (level 4 being the most intensive support) – one of which was in a 24-hour staffed house – and that no approach was made to PACT Southland to enquire as to the resources or options it had to offer Mr Burton at that time. The Chief Executive Officer of the PACT Trust also gave evidence that the process of accessing PACT services is through a referral from Needs Assessment and Service Co-ordination services. The Mental Health Needs Assessor advised that she did not discuss PACT accommodation with Mr Burton or the MOSS as she had not completed her assessment.

The Chief Executive Officer of the PACT Trust did confirm at the inquest that PACT's residential facilities are drug and alcohol free, and that a person needs to agree to its facilities and rules in this regard. She said that PACT does accept people who, in addition to their mental disorders, have drug and/or alcohol use/abuse issues.

I accept that PACT may have been ruled out because of substance abuse, but note my psychiatric advisor's comments that there is little evidence of concerted efforts to find a flat or of any effort to ensure that Mr Burton was prepared, or able, to flat on his own. My advisor noted that there seems to have been a low threshold to dismiss the PACT option without any discussion with PACT about whether it could be attempted, with support. This may have been appropriate had the clinical team believed it to be the only suitable option.

Southland DHB also stated in its response to the provisional opinion that "as a result of previous searches we were well aware that there was no alternative community facility for someone like Mr Burton. There was little point in embarking on a futile search …"

This comment is not consistent with the evidence. Attempts were commenced to find other suitable accommodation. In early March the MOSS requested an enrolled nurse to find out whether there was space available for Mr Burton in Odyssey House, Christchurch – a facility for drug and alcohol rehabilitation. There was a bed available but this appears to have been discounted as an option as it was not a dual diagnosis centre.

The nurse recorded that she had been advised that Odyssey House, Auckland may have been a suitable option as it had a dual diagnosis programme. This was not pursued. The MOSS said in evidence at the inquest that this was because Mr Burton had made it clear that he was not prepared to follow a drug and alcohol programme.

On 12 March the MOSS advised the Mental Health Needs Assessor that Odyssey House, Christchurch was not suitable as it was not a dual diagnosis facility and the Mental Health Needs Assessor agreed to check for other suitable facilities. She had commenced enquiries in Christchurch but had not completed her enquiries or reported back to the MOSS at the time Mr Burton went on trial leave.

My psychiatric advisor's comments on the MOSS's response to my provisional opinion are as follows:

> "At the time of trial leave, at least 2 important initiatives that would have been helpful, and which were in my view necessary to explore reasonable options for

ongoing care, had not been completed. Both were matters of which [the MOSS] was, or should have been, aware.

One was the seeking of information about residential programmes to address drug and/or alcohol use. A preliminary search was made for a suitable programme and more information was anticipated, but no follow-up of this took place. [The MOSS] had identified substance abuse however as a top priority for attention.

The other aspect was the incomplete needs assessment. A complete needs assessment would address those aspects of support necessary for improving the success of tenure in the community, and is of particular importance if discharge (or leave) is to an independent and/or unsupported (no in-house supervision) domicile. Referral was made for needs assessment, but [the MOSS] did not follow through to find the outcome, or whether information of use in planning care had been obtained.

In my view, a reasonable and competent clinician would have recognised the importance of these elements of information and followed through to obtain the information necessary to assist planning care. The results of these activities, had they been completed, may possibly have left the clinical team in the same position of there being few options available. Careful thought could then have been given to how risk could be minimised in the only available alternative. There is no evidence that this occurred, and the arrangement for supervision by a social worker, poorly qualified for the task required, reflects this lack of careful planning to minimise risk.

Mr Burton had evidence of a mental disorder as defined by the Mental Health (Compulsory Assessment and Treatment) Act. On admission he satisfied criteria for the first limb of the definition and the evidence available suggests that there were clear risks, sufficient to meet the criteria of the second limb of the definition, at that time.

The evidence suggests that he continued to experience psychotic symptoms through his admission, with signs suggestive of persecutory ideas at least evident at times through to shortly before the trial leave. There were incidents suggestive of risk, although the relationship of these to psychotic symptoms, or to alcohol use, was never explored by [the MOSS] (or if so, was not documented). Mr Burton was reluctant to engage in full and open discussion of his symptoms. There was evidence of historical concerns about his concordance with a prescribed medication regimen. He had clear ideas for his future that were not fully in accord with matters that [the MOSS] felt appropriate for his ongoing care, and much effort was expended on trying to encourage Mr Burton to accept the plans of the clinical team.

In my view, a reasonable clinician when confronted with someone with evidence of mental disorder, a history of problems with medication concordance, and reluctant engagement with treatment plans, would consider use of the Mental Health Act, especially where there were concerns that assessment was compromised by limited access to mental state phenomena and where risk concerns were high in the context of incompletely treated symptoms. In my view this applied to Mr Burton.

> Adequate voluntary engagement in a treatment plan and minimisation of risks would mitigate against the need for a compulsory process. There was little evidence of this with Mr Burton, who clearly and quickly demonstrated behaviour (in the form of alcohol abuse) that markedly increased risks of deterioration in mental state and other adverse events. Such a pattern would have prompted a reasonable clinician to consider use of compulsion.
>
> There may be an argument that use of the Mental Health Act was not appropriate in this circumstance, as the particular concern was of alcohol use. Normally alcohol use alone is one of the exclusion criteria for use of the Act, although there is debate about how in a situation like this that should be applied. Given that debate and alcohol use being a precipitant, a reasonable clinician, who was not a specialist psychiatrist and perhaps unsure of criteria for compulsion (using Mental Health Act or any other authority) and how they should be applied, would have been prudent to discuss this specifically with a senior colleague. That did not occur."

My advisor also noted that during Mr Burton's leave he drank copiously and that the comment by the MOSS, in his response, that "[Mr Burton] managed his seven-day trial leave without any dramatic difficulty or incident" seems an under-response to this serious aspect of Mr Burton's presentation – and one that the MOSS in retrospect identified as a major focus of attention ("at the top of the list of things to address").

Involvement of family

Southland DHB's expectations of family involvement are set out in the Quality Care and Treatment and Family Carer and Participation policies. In addition, Standard 10 of the *National Mental Health Standards* provides that "families and carers are involved in the planning, implementation and evaluation of the mental health service".

Mr Burton had a loving family who were interested in being involved in his assessment, care and review of his progress. My advisors considered that there is little evidence that the inpatient team, including the MOSS, responded positively to the clear evidence of a family concerned about Mr Burton's welfare.

The MOSS had several discussions with Mr Trevor Burton regarding plans for Mr Burton. However, Mr Trevor Burton expressed concern to my advisors that he had little information about some aspects of inpatient care. He felt that he had to initiate most of the contact with the clinical team, and even then not a great deal of information was forthcoming. My advisors considered the family were provided with insufficient information to enable them to participate meaningfully in decisions about plans and that systematic attention was not given to ensuring appropriate involvement of the family in the treatment process.

There is no record of whether Mr Burton was asked if he wanted his family involved in a family meeting. At his interview with my advisors Mr Burton seemed clear that there was no discussion with him about this. Mr Trevor Burton is clear that the family were not invited to any meeting. The MOSS did not know whether the family were invited to attend the discharge meeting. He said he "hoped" they were.

The MOSS told my advisors that the Burton family (other than Mr Trevor Burton) gave the impression that they did not want to be involved in Mr Burton's care any more. In response to my provisional opinion, the MOSS stated: "Mr Trevor Burton … insisted that all

discussions be with him alone, and he also eventually let it be known that Mrs [Paddy] Burton would not be attending Ward 12, although no reason was given for this decision." The MOSS also said that he had on several occasions sought a family meeting, but Mr Trevor Burton "conveyed the wish that he be the only point of contact with [Mr Burton's] family".

It is clear that Mr Trevor Burton presented himself as the main point of contact for the family. There is ample evidence that he made himself available to be contacted at any time, made contact with the ward (and his son) on several occasions and travelled to Invercargill to a meeting and to drop off his son's car. He also advised the inpatient team, in writing, that he and his wife both considered that home was the best place for their son to get security and some sort of supervision and that he was welcome back home once proper arrangements had been made.

I am not persuaded that the idea of a family meeting was proposed to Mr Trevor Burton (as the point of contact for the family) and refused. I note that this is nowhere documented in the clinical records; that Mr Burton was clear when interviewed by my advisors that there was no discussion with him about whether his family would be involved in a family meeting (although I note my expert advisors' comments that it is hard to know what weight to put on Mr Burton's comments); and that Mr Trevor Burton advised my expert advisors that the family were not invited or asked to come to a family meeting by the MOSS, or anyone else.

My advisors did not consider that the MOSS worked sufficiently to involve the family, to discuss their concerns, to outline the likely course of treatment and proposed plans, or to ensure appropriate involvement of the family in the treatment process. I agree.[36]

Documentation standards

My advisors considered that the MOSS did not meet the standards in his position description (that he "provide for comprehensive and appropriate records of patients seen"), the *Recommended Standards for Case Notes* (Ministry of Health, 1992), or the criteria for comprehensiveness of consumer record and documentation in Standard 7 of the *National Mental Health Standards* (Ministry of Health, 1997). In particular:

- after admission, the MOSS made only six file entries over the whole period of Mr Burton's admission and none offered any detail in regard to Mr Burton's mental state
- the MOSS did not document contacts he had with Mr Burton that formed part of his ongoing assessment
- the entries the MOSS made in the clinical notes were scanty
- the MOSS did not document a treatment plan[37]

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[36] Dr Taumoepeau also noted that there did not appear to have been any in-depth discussion with the family regarding ongoing treatment options, the role of alcohol and drug treatment, or involving the family in treatment plans. She noted that in light of the events that led to the admission, Mr Trevor Burton's letter outlining safety issues and the family's considerable input and difficulties in managing Mr Burton previously, an in-depth family meeting would have been advisable.

[37] The Coroner and Dr Taumoepeau noted the lack of a formal written care plan. Dr Taumoepeau noted that in the absence of any sort of treatment plan in the medical notes there was no feeling that treatment was being directed towards goals on a day-to-day, or week-to-week basis, for example, symptom control, exploration of aspects of mental status examination, response to medication, and goals for discharge.

- the MOSS did not document the rationale for leave, or any special conditions. The MOSS's records were not sufficient to enable care to be provided by other clinicians in a satisfactory manner.

The MOSS has admitted that his clinical records did not meet an appropriate standard, and acknowledged that it would be "hard to justify that amount of documentation".

Other matters

My advisors considered that the MOSS lacked sufficient clinical scepticism to ensure that enough consideration was given to the most clinically significant possibilities for the basis of Mr Burton's presentation. For example, possible indicators of persisting psychotic persecutory delusions, such as the tape on the door handle, or comments that his mother was not in his life anymore, were not explored or taken into account in a more cautious approach to treatment. Sleep disturbance was attributed to alcohol use without evidence of systematic attention to other possible factors suggestive of a relapse of his illness.[38] Mr Burton's assurance that he was continuing with medication while on leave was accepted, despite the clear history of need for close attention to this while previously out of hospital, on the basis that he had been compliant on the ward. Triggers for review of risk alert status (for example, incidents of aggressiveness) were not acted upon.

My advisors also considered that the MOSS was not sufficiently assertive with Mr Burton, who was often allowed to determine the course of events himself. For example, Mr Burton was allowed to limit exchanges to passing conversations in corridors, to determine where the alcohol and drug assessment was to occur, to receive a supply of medication much greater than the MOSS recommended on discharge, and to dictate the timing of a discharge meeting to such a degree that a key participant was absent. My advisors noted that giving weight to Mr Burton's own preferences was consistent with Criterion 16.8 of the *National Mental Health Standards*, which provides that the mental health service provides the least restrictive and least intrusive treatment and support possible to the consumer. However, this was not necessarily in Mr Burton's best interests and more consideration ought to have been given to a more assertive approach, determined by the service itself, or in conjunction with Mr Burton's family.

My advisors concluded that the MOSS did not follow through intentions and plans with sufficient rigour. For example, the MOSS noted that the needs assessment should be followed up, but did not ensure that occurred. He did not take notice of the content of the assessment notes by the Alcohol and Drug Counsellor. There was little follow-up of efforts to find residential rehabilitation with a drug and alcohol focus.

Conclusion

I accept my expert advice that there were serious deficits in the MOSS's performance and that he did not provide services to Mr Burton of a standard that would be expected of a Medical Officer Special Scale, or in accordance with relevant policies.

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[38] Dr Taumoepeau also concluded that Mr Burton should have been much more specifically challenged in relation to exploration of symptoms that could have clarified risks and safety issues, and it made plain to him that they must be explored before discharge.

In my opinion, the MOSS did not provide Mr Burton with services of an appropriate standard in relation to documentation, assessment and care planning, clinical risk assessment and management, discharge planning, involvement of family, leave planning and overall management of Mr Burton's care, and breached Rights 4(1), 4(2) and 4(5) of the Code.

NURSING CARE

Enrolled Nurse A

Enrolled Nurse A was Mr Burton's associate nurse from the day he was admitted. She assisted with his admission, prepared his nursing care plan and looked after him on more duties than any other nurse. She also co-ordinated aspects of his care.

Although the Team Leader and Enrolled Nurse A believe that at all times the name of a primary nurse was written beside Mr Burton's name on a whiteboard in the office (which was where the primary and associate nurse allocations were recorded) they are not clear which registered nurse had this responsibility for the first weeks of Mr Burton's admission. Nor could other nurses, or the MOSS, recall who was his primary nurse. Staff Nurse A considered that Mr Burton did not have a primary nurse before she took on that role. The Team Leader admitted that it was possible that Enrolled Nurse A was Mr Burton's de facto primary nurse before Staff Nurse A took on the role.

On the evidence available, I am satisfied that Enrolled Nurse A took overall nursing responsibility for Mr Burton's care by default and acted as his de facto primary nurse from his admission until she went on leave on 5 March – even if there was a person nominally allocated to that role (which is not clear). Even when she returned from leave, and Staff Nurse A was assigned as Mr Burton's primary nurse, Enrolled Nurse A was still considered by Staff Nurse A to have responsibility for assessment and decision-making in relation to Mr Burton's care.

Section 53A of the Nurses Act 1977 provides that it is an offence for an enrolled nurse to practise other than under the direction and supervision of a registered nurse or medical practitioner. The Nurses Act does not define "direction and supervision". The Nursing Council's *Guidelines on Direction and Supervision* differentiate between direct and indirect supervision. Direct supervision is provided when the registered nurse is actually present, observes, works with and directs the person who is being supervised. Indirect supervision is provided where the registered nurse works in the same facility as the supervised person, but does not constantly observe his or her activities. The extent of the direct or indirect supervision depends on the complexity of nursing skills and judgement involved.

Southland DHB's Scope of Practice of Enrolled Nurses policy notes that an enrolled nurse provides nursing care to a person with relatively predictable needs that require uncomplicated nursing skills and judgements. However, in situations involving more complex skills and judgements, the policy provides that the enrolled nurse may assist the registered nurse under his or her direct guidance and supervision.

The policy also provides that in relation to primary nursing:

- the initial assessment must be carried out in conjunction with the registered nurse
- the registered nurse may not delegate the planning, implementation and evaluation of care to the enrolled nurse, and accountability for such care remains with the registered nurse.

At all times when Enrolled Nurse A was on duty there were also registered nurses on duty in the mental health unit, from whom she could seek direction and assistance. However, as already noted, there was not always an identifiable primary (registered) nurse accountable for planning, implementing and evaluating Mr Burton's care, under whose direction Enrolled Nurse A could provide ongoing care.

I accept my expert advice that Enrolled Nurse A provided sound care within her level of training and qualification. I also accept that Enrolled Nurse A perceived herself as being under the direction and supervision of registered nurses at all times.

Registered nurses are expected to exercise professional judgement regarding the degree of direction and supervision in the delegation of responsibilities to enrolled nurses. It appears that, from the time of his admission, Mr Burton was considered by the registered nurses on the inpatient unit to be a person with relatively predictable needs that required uncomplicated nursing skills and judgement. Mr Burton was therefore seen as a suitable patient for Enrolled Nurse A to care for without the direct supervision of a registered nurse. Although my advisors question whether Mr Burton could be so categorised, Enrolled Nurse A cannot be held accountable for the professional judgement of the registered nurses who allocated him to her care on a regular basis. Nor should she be held accountable for the failure by registered nurses to have a comprehensive and updated nursing care plan, or to clearly allocate a primary nurse responsible for overseeing and co-ordinating Mr Burton's care.

Accordingly, in my opinion, Enrolled Nurse A did not breach Right 4(2) of the Code.

Staff Nurse A

Introduction

Staff Nurse A was Mr Burton's primary nurse for at least some of the time he was in hospital. In my opinion, Staff Nurse A did not provide services of an appropriate standard to Mr Burton.

My advisors identified the following key areas in which they considered Staff Nurse A's performance did not meet appropriate standards:

- assessing/planning and evaluating Mr Burton's care
- co-ordinating Mr Burton's care while on trial leave
- discharge planning
- directing and supervising Enrolled Nurse A
- consistency in quality of care.

Each of these aspects of Staff Nurse A's performance is considered in detail, after an initial discussion of the role of the primary nurse and the allocation of a primary nurse for Mr Burton.

The role of the primary nurse

Staff Nurse A gave evidence to the Coroner that she was Mr Burton's primary nurse from 14 February 2001. She amended that date when interviewed by my advisors and said that she was Mr Burton's primary nurse for two weeks prior to his discharge – although she was vague on the specific dates.

Staff Nurse A said that confusion arose because she had to provide evidence to the inquest on short notice, without having previously been interviewed by the Police or giving evidence, and that as matters had happened so long ago it was very difficult to pull her statement together in a matter of hours. In fact, Staff Nurse A had been given opportunities and time to think about matters well before the inquest. She had provided Dr Taumoepeau with a written statement, in response to specific questions, in May 2001, during Dr Taumoepeau's audit. She had also provided my investigation team with a written statement, prepared for this investigation, on 30 November 2001, four days before she gave evidence to the inquest. She used this statement at the inquest.

On the information available to me, I consider that Staff Nurse A was Mr Burton's primary nurse from, at the latest, 5 March 2001, when Enrolled Nurse A went on holiday. From that time, she was responsible for meeting all the obligations associated with being Mr Burton's primary nurse.

I am concerned that there is confusion about such an important matter as the identity of Mr Burton's primary nurse. Although the role of the primary nurse is not specified clearly in one document, various Southland DHB policies make it clear that the primary nurse is accountable for planning, implementing and evaluating a mental health inpatient's care. The primary nurse also has particular responsibilities in relation to discharge planning. The Team Leader told my advisors that the role of the primary nurse is to check and co-ordinate care of a patient. It does not seem credible that staff are unable to recall who played this important role in Mr Burton's care for several weeks – unless there was not, in fact, a primary nurse.

As a registered comprehensive nurse, relevant standards against which to measure Staff Nurse A's care include the Nursing Council of New Zealand *Code of Conduct for Nurses and Midwives*, the Nursing Council of New Zealand *Competencies for Entry to the Register of Comprehensive Nurses*, the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) *Standards of Practice for Mental Health Nursing in New Zealand*, as well as Southland DHB's own policies.

In her response to my provisional opinion, Staff Nurse A accepted that Southland DHB's policies prescribed the scope of her duties as primary nurse – which she acknowledged included responsibility for planning, implementing and evaluating the care of patients for whom she was primary nurse, and particular responsibilities in relation to discharge planning. However, she emphasised that the policies were not consistent with the practice operating at the time in the inpatient mental health unit and said that she was in fact unaware of the extent of her responsibilities as contained in the policies.

It is apparent to me, based on the information obtained during the investigation, and the responses to my provisional opinion, that the system of primary nursing in the inpatient mental health unit was not working well, and that there was a gulf between the policies of the District Health Board and their practical implementation. I can therefore accept to a degree that Staff Nurse A was constrained by the deficiencies of the system within which she was working.

However, health professionals working within a poorly functioning system cannot abdicate all responsibility for maintaining appropriate professional standards. There are aspects of Staff Nurse A's practice in the present case that cannot be excused by limitations imposed on her by the system. Aspects of her practice indicate a failure to exercise the independent professional responsibility reasonably expected of a registered comprehensive nurse in the circumstances at the time.

Assessment and care planning

Staff Nurse A did not undertake a comprehensive nursing assessment when she became Mr Burton's primary nurse, nor did she update his existing care plan. My advisors noted that there is little evidence to show that Staff Nurse A co-ordinated the clinical team or involved Mr Burton or his family, or other interested parties, in planning, implementing and evaluating Mr Burton's care.

Staff Nurse A made no effort to encourage contact with Mr Burton's family or to ensure that there was appropriate involvement of the family in the treatment process. The only contact she had with the Burton family was the day Mr Burton went on trial leave, when Mr Trevor Burton delivered his son's car and some of his belongings to the hospital.

There is little evidence to show that Staff Nurse A established an effective nurse–patient relationship with Mr Burton. She did not complete mental health assessments on the shifts when she cared for Mr Burton.

Staff Nurse A appeared not to be aware that the needs assessment had not been completed and did not follow up with the Mental Health Needs Assessor to obtain information from the assessment.

My advisors considered that the lack of comprehensive nursing assessment – for example, of mental state and family and social issues – undermined the ability of the clinical team to make safe and effective decisions on Mr Burton's discharge.

In her response to my provisional opinion, Staff Nurse A informed me that she did not perform a comprehensive nursing assessment when she became the primary nurse because she considered that comprehensive assessments were undertaken by the doctors, rather than by the nurses. Staff Nurse A noted that she had never been advised that it was the role of the primary nurse to carry out such an assessment. She also noted that she did not update Mr Burton's nursing care plan because there had been no change in the level of risk assessed by the doctors.

I do not consider that Staff Nurse A's omissions can be excused by the limitations of the primary nursing system. My nursing advisor noted her surprise that Staff Nurse A did not understand the need to carry out a nursing assessment and have a care plan. As a matter of basic nursing practice, someone newly allocated as a patient's primary nurse should check the nursing assessment and nursing care plan and update it as required. I accept this advice.

In my opinion the lack of attention to these matters was not so much reflective of a deficient system, as of substandard nursing practice for someone in Staff Nurse A's position.

My advisors considered that, by not adequately assessing, planning and evaluating Mr Burton's care, Staff Nurse A did not meet a number of relevant standards. In particular:

- criteria 2.4 of Principle Two of the *Code of Conduct for Nurses and Midwives*, which requires registered nurses to demonstrate expected competencies in the area in which they are currently engaged
- the mental health performance criteria for Competency 4 (management of nursing care) or Competency 9 (inter-professional health care) of the *Competencies for Entry to the Register of Comprehensive Nurses*
- standards II and III of the *Standards for Practice for Mental Health Nursing in New Zealand*
- standard 10 of the *National Mental Health Standards* (Family and Carer Participation).

Competency 4 of the *Competencies for Entry to the Register of Comprehensive Nurses* provides that the nurse manages nursing care in a manner that is responsive to the client's needs, and which is supported by nursing knowledge.

The mental health performance criteria include:

- carrying out a mental assessment status as part of a broader nursing assessment
- incorporating into mental health nursing practice a knowledge of the commonly used assessment frameworks, for example, DSM-IV
- implementing mental health nursing in a manner that facilitates independence, self-esteem and safety of the patient/consumer
- using a nursing framework to assess, plan and implement nursing care with patients/consumers, their family and whanau
- implementing mental health nursing care that demonstrates an understanding of psychotherapeutic and partnership principles
- evaluating the effectiveness of mental health nursing in partnership with patients/consumers, their family and whanau.

Competency 9 provides that a nurse promotes a nursing perspective within the inter-professional activities of the mental health team.

The mental health performance criteria include:

- identifying the role of the mental health nurse within the mental health team
- providing input from nursing assessments to participate in the decision-making process of the mental health team
- promoting the delivery of integrated and co-ordinated mental health care.

The *Standards for Practice for Mental Health Nursing in New Zealand* are set out as Attachment 4 of my advisors' report (Appendix I). Standard II requires that the mental health nurse establishes partnerships as the basis of therapeutic relationships with clients. Standard III requires that the mental health nurse provides nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan.

Co-ordination of care during trial leave

Mr Burton was sent on trial leave to a flat by himself while Staff Nurse A was his primary nurse. Staff Nurse A stated that she knew that when Mr Burton went on trial leave his mental state had to be followed up. She also said that she did not consider that the purpose of visits by the social worker (Social Worker A) was to assess Mr Burton's mental state. Staff Nurse A said that she expected the key worker from the Invercargill CMHT to visit Mr Burton to monitor his mental state. She considered that she made arrangements for such follow-up to occur, as she left a telephone message for the community key worker the day after Mr Burton went on leave. Staff Nurse A said that the message she left was that Mr Burton was on leave and that a discharge meeting was to be held at 11.00am on 30 March.

Staff Nurse A did not follow up this message. She told my investigation team that she did not consider that she had a responsibility to ensure that the key worker had received her message and was indeed going to monitor Mr Burton while he was on leave. She said she saw that as the role of the community team.

The key worker (and other members of the Invercargill CMHT) provided a statement to my investigation team that the community mental health team did not expect to be involved in a monitoring role while an inpatient was on leave, unless a specific request for assistance was made. The key worker did, however, expect to be involved in the discharge meeting and, on receipt of the message, diarised the meeting planned for 30 March.

Even if Staff Nurse A's intention was for the key worker from the community mental health team to monitor Mr Burton's mental state while he was on leave, I am satisfied that Staff Nurse A did not consult with the key worker about Mr Burton's arrangements while he was on leave, or make a specific request that the key worker monitor Mr Burton.

My advisors considered that Staff Nurse A demonstrated a lack of professional judgement by not adequately assessing Mr Burton's fitness for trial leave (having regard to the safety of Mr Burton and others) and not ensuring that a nursing response was available during that week to closely monitor Mr Burton's mental state.

My advisors considered that, in failing to exercise adequate professional judgement about these matters, Staff Nurse A did not meet the mental health performance criteria for Competency 3 (professional judgement) of the *Competencies for Entry to the Register of Comprehensive Nurses*.

In response to my provisional opinion, Staff Nurse A submitted that she did not know it was her role as primary nurse to co-ordinate Mr Burton's care while he was on leave. Staff Nurse A noted that the usual practice was that co-ordination of care was done by the "whole clinical team". She also said that the practice was that the primary nurse was never solely responsible for co-ordination and it was the nurse who was allocated to care for a patient, Monday to Friday, who co-ordinated the care. I appreciate that this lack of clarity on Staff Nurse A's part is at least partially reflective of the wider problem of the lack of demarcation of areas of responsibility within the inpatient mental health unit. Indeed, her Team Leader said that she considered Staff Nurse A's expectation – that whoever was allocated to care for Mr Burton, Monday to Friday, would be fulfilling the responsibilities of the primary nurse – was reasonable at that time. I note, however, that in May 2001 Staff Nurse A provided a written statement to Dr Taumoepeau in which she described her role as a primary nurse as being "to initiate and co-ordinate care amongst the service".

Whatever her understanding, aspects of Staff Nurse A's actions fell below what could reasonably be expected of her in circumstances where she was not only Mr Burton's primary nurse, but also the nurse who cared for him on morning duty the day before he went on trial leave (a Wednesday) and on the day he went on trial leave (a Thursday).

As Mr Burton's primary nurse, Staff Nurse A could reasonably be expected to ensure that, even if she herself did not do it, appropriate liaison and co-ordination with the community team had been undertaken so that plans were in place for monitoring and caring for Mr Burton while he was on trial leave. Even if I were to accept that Staff Nurse A could reasonably rely on the liaison and co-ordination for monitoring of Mr Burton's leave being undertaken by the weekday nurse allocated to his care before he went on trial leave, Staff Nurse A was that nurse.

Accordingly, I consider that Staff Nurse A did not meet the standard reasonably expected of a nurse in her position. She should have recognised the need to co-ordinate Mr Burton's care while he was on trial leave.

Discharge planning and continuity of care

As primary nurse, Staff Nurse A had a number of responsibilities related to discharge planning. The principal aims of discharge planning, as set out in Southland DHB's Discharge Policy, included continuity and co-ordination of care and treatment, optimal health and wellbeing for the patient/consumer, early intervention during crises and relapses of illness, and mobilisation of a level of support that corresponded with the assessed needs of the patient for community living. Specific responsibilities identified for the primary nurse included involvement of the service to be responsible for the care of the patient after discharge; consultation with relevant patients in regard to the needs of the patient after discharge; referral to applicable professional support services; development and documentation of a crisis plan; and signing, with the patient, the discharge plan.

As noted above, one of the responsibilities of the primary nurse was to develop a crisis plan in partnership with the patient and his or her caregiver, and document this on the patient's discharge plan. Mr Burton's discharge plan documented signs of his becoming unwell, but did not document a crisis plan. There is no evidence of any attempt to develop a crisis plan in consultation with Mr Burton and his community key worker.

Other aspects of the discharge plan were also inadequate. No information from the needs assessment, or from the alcohol or drug assessment, was used to inform planning, and Mr Burton's family were not involved in discharge planning. Lack of co-ordination and communication with the community key worker has been discussed earlier.

Another responsibility of the primary nurse set out in the Discharge Policy was that prior to discharge the mental state of all patients was to be assessed by various people, including the primary nurse. My advisors considered it appropriate that this standard should apply to a period of trial leave.

Staff Nurse A stated she was aware that, the day before Mr Burton's trial leave, he had shown signs of irritability and paranoia, and claimed that she took care to look for further signs of paranoia. If she did so, it is not evident from her clinical records. My advisors consider her clinical records were on the whole inadequate to allow for informed decision-making by the clinical team – which they considered indicated that she was either not undertaking sufficient assessment or was relying on verbal communication.

My advisors considered that by not completing an adequate discharge plan, not consulting with Mr Burton's family and other health professionals, and not ensuring that Mr Burton's mental state was assessed and that the service to be responsible for him after discharge was involved, Staff Nurse A did not adequately meet the primary nurse's responsibilities for discharge planning set out in Southland DHB's Discharge Policy.[39]

In my provisional opinion, I criticised Staff Nurse A for a perceived lack of consultation when she began to draw up Mr Burton's discharge plan. In her response, Staff Nurse A informed me that she was not in fact responsible for creating the discharge plan; she had simply rewritten what had been previously documented. Staff Nurse A informed me that the night prior to the discharge meeting (when she was on night duty) she noticed that the existing discharge plan was "old and tatty", and accordingly she rewrote it, leaving the rest of the form to be filled in by Enrolled Nurse A following the discharge meeting the next day.

Staff Nurse A also commented that the "principal aims of discharge planning as set out in the Southland DHB's Discharge Policy have never been the primary nurse's responsibility since I have been at the Southland DHB". Staff Nurse A understood the "inpatient clinical team collectively" to be responsible for discharge planning. As primary nurse, Staff Nurse A expected that she would document the plans for discharge "whenever possible", but the Monday to Friday daytime staff member would also be expected to do this. Staff Nurse A noted that her expectations were based on the practice in place at the time within the inpatient mental health unit. She stated:

> "Discharge planning to me was documentation of what had been planned, not to actually plan it. … To me it was simply documenting what had been planned by other people."

Having considered Staff Nurse A's response, my nursing advisor acknowledged the difficulty of establishing effective continuity of care in a ward where 24-hour nursing care is being provided. I accept that the demands of rostering staff in a 24-hour care environment mean that it is unrealistic for the primary nurse always to be personally involved in discharge planning meetings. I note in this regard that Staff Nurse A was on night duty on the day the discharge planning meeting was held and Mr Burton was discharged.

However, Southland DHB's Discharge Policy required discharge planning to commence on admission, and Staff Nurse A's response indicates that she had no involvement at all in the process of discharge planning, and that she did not recognise that she had any responsibilities associated with discharge planning.

I find Staff Nurse A's limited view of her role in relation to discharge planning unimpressive. First, I do not accept that it is appropriate for a registered nurse to limit her involvement, in such a critical aspect of a patient's care as discharge planning, to that of note-taker, especially where the policies of the organisation specifically dictate otherwise. My nursing advisor noted that Staff Nurse A's response minimises the need for nurses to

[39] Dr Taumoepeau also noted that the discharge plan did not include a review of symptoms, possible risks, details of follow-up or early warning signs, nor did it outline the details for community care. Rather, it focused on accommodation which, Dr Taumoepeau commented, was particularly worrying in view of the fact that at the time of arranging the flat, Mr Burton was reported to be seeking drugs in the ward and talking about paranoid ideas.

display independent professional responsibility and judgement in their work. I concur with this view. Registered nurses are trained health professionals with independent professional responsibilities. This view is reinforced by Southland DHB's Discharge Policy; it expects considerable input into discharge planning from the primary nurse.

Secondly, as Mr Burton's primary nurse, if Staff Nurse A could not personally be available at discharge planning meetings because of the rostering system, she should have communicated and co-ordinated with the weekday daytime staff to ensure that an adequate nursing perspective was incorporated into discharge planning.

Consumers have the right to co-operation amongst providers to ensure quality and continuity of care. As noted in relation to the MOSS, Standard 18 of the *National Mental Health Standards* requires that consumers be assisted to plan for their exit from the mental health service to ensure that ongoing follow-up is available, if required.

There were large gaps in the continuity of Mr Burton's care which, as primary nurse, Staff Nurse A was responsible for co-ordinating. Staff Nurse A did not follow up on information from the needs assessment or ensure that this assessment, which was necessary for determining what Mr Burton needed to achieve independence, had been completed and was available to inform discussions on discharge. She did not ensure that appropriate arrangements were in place to monitor Mr Burton while he was on leave, and did not ensure that the community mental health team was involved in his discharge planning.

Accordingly, I consider that Staff Nurse A did not take appropriate action in her position as primary nurse to ensure that Mr Burton's discharge was properly planned.

Direction and supervision of care

Staff Nurse A left much of the responsibility for co-ordination of Mr Burton's care with an enrolled nurse. Enrolled Nurse A was expected to complete the discharge plan, assess the outcome of Mr Burton's trial leave, and (with the MOSS and Social Worker A) make plans for Mr Burton's community follow-up. My advisors considered that as Mr Burton's primary nurse, Staff Nurse A should have provided direction and supervision for Enrolled Nurse A in carrying out care of this complexity. They considered that Staff Nurse A took a laissez-faire approach to Mr Burton's care, leaving assessment and decision-making inappropriately to a social worker and enrolled nurse, neither of whom was qualified for implementing complex mental health care.

In response to my provisional opinion, Staff Nurse A informed me that she was not aware that it was her responsibility to direct and supervise Enrolled Nurse A. Staff Nurse A noted that the mental health unit operated a "red dot nurse" system, whereby the senior nurse on the ward at the time had responsibility for direction and supervision of the other nurses.

Staff Nurse A's response missed the point of my criticism, which was not directed at the fact that Staff Nurse A did not exercise general supervision over Enrolled Nurse A. I accept that general nursing supervision was managed through the red dot nurse system operating within the unit.

My criticism was directed at the relationship between Staff Nurse A, as Mr Burton's primary nurse, and Enrolled Nurse A, officially Mr Burton's associate nurse, but who seems to have performed many of the functions that would normally be associated with the primary nurse. Staff Nurse A stated that she and Enrolled Nurse A communicated "a great

deal" about Mr Burton's care and worked closely together. However, from the information available to me, it appears that Staff Nurse A was content to leave a number of the key duties in relation to Mr Burton's care to Enrolled Nurse A. There is little evidence that Staff Nurse A familiarised herself with the nursing actions taken in respect of Mr Burton or critically analysed them to determine whether further action needed to be taken. That was her responsibility as primary nurse.

I acknowledge that general supervision of a nurse with Enrolled Nurse A's years of experience by a nurse of Staff Nurse A's more limited experience could, as Staff Nurse A pointed out, present some difficulty. However, in relation to Mr Burton, the direction and supervision was in the context of a patient for whom Staff Nurse A was designated as primary nurse. In this situation it was incumbent on her to ensure that Mr Burton's nursing care was being appropriately directed.

I therefore remain of the view that Staff Nurse A did not adequately direct and supervise Enrolled Nurse A in caring for Mr Burton, and accordingly failed to meet the standard expected of the primary nurse in Southland DHB's Scope of the Enrolled Nurse policy.

Consistency and quality of care

One of the areas of responsibility in Staff Nurse A's position description was "to ensure consistency and quality of nursing care". Performance measures included "demonstrating and utilising the following aspects in nursing practice:

- individualised patient care
- effective nursing documentation inclusive of discharge planning
- current nursing theory and practice."

My advisors considered that Staff Nurse A did not provide consistency and quality of nursing care and did not meet a number of the performance measures for this key responsibility. In particular, Staff Nurse A:

- spent very little time with Mr Burton
- did not perform or co-ordinate a comprehensive nursing assessment
- did not update his nursing care plan
- viewed co-ordination of his care as waiting for other staff to tell her if there were problems
- did not ensure that arrangements were in place for nursing follow-up when Mr Burton went on trial leave
- did not ensure adequate nursing involvement in the discharge plan
- did not follow up to ensure her role as primary nurse had been properly discharged by ensuring that discharge documentation was completed adequately by other staff.

In her response to my provisional opinion, Staff Nurse A stated that she was unable to spend more time with Mr Burton because of the competing demands of other patients on the ward who were acutely unwell and who required someone of her relative experience to care for them. I accept that acutely unwell patients require more intensive nursing intervention and that on occasions Staff Nurse A, as a more senior nurse on duty, may have been required to care for such patients. Staff Nurse A considered that Mr Burton required less active nursing intervention, given the MOSS's assessment that he was low risk, his status as a voluntary patient, and his general recovery.

This concerns me for two reasons. First, I am concerned that Mr Burton was seen as requiring less active nursing intervention because he was not a compulsory patient under the Mental Health Act. My nursing advisor noted that this is an inappropriate means by which to prioritise allocation of nursing resources. Not all acutely unwell patients are made the subject of compulsory treatment orders and it is inappropriate to assume that those who remain as voluntary patients require less active nursing intervention. There are a host of reasons why someone who is acutely unwell may remain as a voluntary patient.

Secondly, I would expect – and this was confirmed by my expert nursing advisor – that a decision by nursing staff that a patient required less focused nursing attention would be made only on the basis of a comprehensive assessment of that patient (including risk assessment as a component of the assessment) by nursing staff. It is clear in the present case that such an assessment was not completed.

Nevertheless, I accept that the operational reality of the ward at that time may have required that on some of her duties Staff Nurse A was not able to look after Mr Burton. She had, however, accepted responsibility as his primary nurse. In her statement to Dr Taumoepeau, Staff Nurse A said that she expected there would be liaison between the primary nurse and any other nurse who cared for the patient when the primary nurse was not available. There is no evidence of such liaison, nor that she raised with her Team Leader her inability to continue as Mr Burton's primary nurse because of her responsibilities elsewhere.

Self appraisal

My advisors were concerned that Staff Nurse A did not appear to demonstrate an understanding of professional accountability or critical appraisal of her own practice or that of her peers. There were inconsistencies between her evidence at the inquest and the information she gave my advisors during her interview only days after giving evidence at the inquest. This was particularly in relation to the period for which she was Mr Burton's primary nurse. Other inconsistencies in the information Staff Nurse A gave to my advisors also appeared to my advisors to demonstrate a lack of critical reflection.

In response to my provisional opinion, Staff Nurse A's lawyer submitted that my advisors were "overly critical" of her because of a perceived defensiveness in her attitude during her interview with them. She advised that Staff Nurse A's defensive demeanour during her interview with my expert advisors "was a cloak to cover terror".

I do not accept that my advisors' detailed and reasoned assessment of Staff Nurse A's professional responsibilities in caring for Mr Burton was influenced by an overly critical response to her manner at interview. Staff Nurse A did not appear to have critically appraised of her own practice. However, in response to my provisional opinion she advised that she has now spent considerable time reflecting on her practice and has learnt a great deal from being involved in the process of investigation. She advised that she has made the following changes to her practice:

- She now documents everything – especially what she observes and concludes when carrying out a mental state examination and also if symptoms she has looked for are not present.
- She is currently studying towards a postgraduate certificate in mental health nursing, to advance her knowledge in this field.

- She is working to try to find ways to implement best practice in her dealings with her clients in order to provide a higher quality of care to them and their families.

Conclusion

I have considered Staff Nurse A's submissions about the difficult position in which she was placed because of the inherent deficiencies of the operation of the primary nursing system. This submission was reinforced by Staff Nurse A's lawyer, who suggested that my provisional opinion expected "gold standard" primary nursing in a system that did not allow for it, and that insufficient weight was given to the deficient system within which Staff Nurse A was operating. However, taking into account the system deficiencies, I remain of the view that a registered nurse, having been designated as primary nurse, should have recognised the need to take a more proactive, less passive approach to ensuring that Mr Burton's nursing needs were being appropriately met and co-ordinated. Health professionals must be expected to demonstrate independent judgement and assume professional responsibility within their area of expertise.

My expert advisors stated that Staff Nurse A did not provide Mr Burton with services that met professional and other relevant standards (identified above) by:

- not adequately assessing Mr Burton, or planning, implementing or evaluating his care when his primary nurse
- not ensuring that adequate arrangements were in place to monitor Mr Burton's mental state while he was on trial leave
- not undertaking adequate discharge planning
- not assuming full responsibility as Mr Burton's primary nurse and leaving assessment and decision-making inappropriately to Enrolled Nurse A
- not ensuring consistency and quality of nursing care.

I am guided by my advisors' view that there were serious deficits in aspects of Staff Nurse A's performance. I consider that Staff Nurse A's practice fell below the standard expected of a registered nurse in such circumstances, and breached Rights 4(1), 4(2) and 4(5) of the Code.

SOCIAL WORK

Social Worker A

Introduction

Social Worker A was Mr Burton's social worker in the inpatient mental health unit. In my opinion, Social Worker A did not provide services of an appropriate standard to Mr Burton.

Social Worker A's first documentation in Mr Burton's clinical records is on 14 March 2001 after he attended a meeting with the MOSS, an enrolled nurse, and Mr Burton, to discuss Mr Burton's future. Prior to this meeting he had attended the weekly review meetings where Mr Burton was discussed, and had had a number of casual encounters with Mr Burton around the ward.

At the 14 March meeting it was agreed that Mr Burton would find a flat in Invercargill, which Social Worker A thought was a good idea. The MOSS asked Social Worker A to assist Mr Burton. Three days later Mr Burton and Social Worker A found a flat that Mr Burton could move into on 22 March.

On 22 March, Mr Burton commenced one week's leave from hospital, living in the flat alone. Social Worker A was asked to "follow up" Mr Burton each day while he was on leave.

My advisors stated that aspects of Social Worker A's care of Mr Burton were not of a standard that could reasonably be expected of a social worker in an inpatient mental health unit. The specific deficiencies in his care are considered below. However, it is first necessary to deal with jurisdictional and process issues raised by Social Worker A's lawyer.

Jurisdiction and process

In response to my provisional opinion, Social Worker A's lawyer submitted that the jurisdiction of the Health and Disability Commissioner does not extend to social workers. I do not accept that submission for the following reasons.

Health care providers subject to the duties in the Code are not limited to registered health professionals. Any person who provides "health services" is covered (HDC Act, s 3(k)). "Health services" include any services to promote health (HDC Act, s 2). Social workers operating within a multi-disciplinary mental health team are, in my opinion, providing such a service. Mental health social work is a health service aimed at promoting and maintaining a client's mental health. Accordingly, in this context, social workers are health care providers subject to the Health and Disability Commissioner's jurisdiction.

Social Worker A's lawyer also raised a process concern that Social Worker A was not advised of his right to legal representation, prior to his interview. Social Worker A was not compelled to attend the interview with the investigation panel. The interview was a voluntary one, arranged in advance. Social Worker A was not a person under arrest or detention to whom the right to consult a lawyer (and to be informed of that right) applies (New Zealand Bill of Rights Act 1990, s 23(1)(b)).

Social Worker A's lawyer also complained about the lack of cultural support for her client. I note that Social Worker A raised concerns to the investigation panel about his voice being recorded on the tapes made of the interview. He confirmed that his concerns would be allayed if the tapes were returned to him once no longer required by my Office, and he was assured that this will be done. Had Social Worker A indicated any other concerns relating to the cultural safety of the interviewing process, those concerns would have been addressed so far as reasonably practicable.

Performance measures for clinical competency

My advisors considered that in relation to care, Social Worker A did not meet the performance measures for clinical competency set out in his position description. In particular, Social Worker A:

- did not consider that attention to history and clinical phenomena was necessary, so did not read the notes relating to Mr Burton's past care

- demonstrated limited understanding of Mr Burton's mental illness, and this impacted adversely on the care he provided
- demonstrated limited attempts to assess Mr Burton systematically and had no knowledge or skills to assess Mr Burton's mental state
- inappropriately viewed Mr Burton and his problems in the light of his personal experiences and drew conclusions based on this comparison
- did not make effective care plans or recommendations, or document any conclusions reached from his involvement with Mr Burton.

My advisors considered that a social worker in an acute mental health unit should be familiar with assessment of mental state and be aware of key symptoms for any individual with whom they are involved, and have a broad understanding of mental illness and its impact.

Social Worker A demonstrated limited understanding of mental illness and its impact and noted that he was not "psychiatrically trained", so his practice was oriented towards tasks and he relied on his colleagues for psychiatric input. My advisors considered that Social Worker A's lack of understanding adversely affected his ability to provide Mr Burton with care of an appropriate standard.

Social Worker A's lawyer made the following submissions in response to criticisms of her client's practice (as set out in my provisional opinion):

- The expectations of Social Worker A were unrealistic and do not accord with standards of social work practice generally throughout New Zealand.
- The comments display a lack of understanding about the role of the social worker in the mental health environment.
- Generally, Social Worker A was not deficient in his performance but was hampered by the lack of leadership and systems of communication within the mental health service; any lack of continuity of care was not an issue for which Social Worker A could be held responsible.
- It is inappropriate to "blame" the social worker when the team as a whole was dysfunctional.
- Insufficient allowance was made for the constraints under which Social Worker A was working, for example that he was only in a half-time position.

There is no doubt that Social Worker A was working within a dysfunctional system. The role he should have played within the team caring for Mr Burton was ill-defined and not fully understood by other members of that team. It is also clear that Social Worker A's managers and indeed the Southland DHB must accept some responsibility for the fact that Social Worker A was in a position that he was not professionally equipped to fill. Nevertheless, Social Worker A's lawyer informed me that he is indeed a "highly experienced social worker who takes his professional responsibilities very seriously". Social Worker A, prior to joining Southland DHB, had approximately eight years' social work experience, and postgraduate qualifications in social work. Even allowing for the limitations placed upon him, aspects of his practice fell below the standard reasonably expected of a competent and experienced social worker.

My social worker advisor set out her view of the role of the social worker in the mental health environment:

"This role would have the responsibility of understanding the person within his 'social context' and the impact of his mental illness on the client and his family. Furthermore, to recognise the 'social consequences' of the mental illness on the consumer and his family.

To do this, the social worker would be expected to:

– Work as a member of the multi-disciplinary team within the unit, and as such follow up on identified areas of concern or social issues following the establishment of the consumer's care plan.
– Actively seek to establish, develop and maintain a supportive relationship with the consumer and also with his family and support networks.
– Undertake psychosocial assessment with the consumer, establishing relevant historical information and identifying current issues of concern as identified by the consumer and his family/whanau. Discussing strategies for attaining the goals that pertain to these issues. (This would entail looking at old notes and earlier risk plans and relapse plans, looking for patterns of behaviour and precipitating factors to admission as well as giving useful information regarding interests, support networks, physical wellbeing, social needs, rehabilitation needs etc. Any gaps could then be filled through interviews with the consumer and their family/whanau).
– Work in partnership with the consumer/family/whanau/other health care professionals, to assess, plan, deliver and evaluate outcomes of care.
– Take on the role of advocate on behalf of the consumer where necessary in matters relating to consumer rights, benefits and accommodation issues, issues of employment/training.
– Promote the concept of self-care and inclusion of the family/whanau in provision of care.
– Take responsibility for effective collaboration with other professionals internally and externally, liaising with the consumer's key supports to ensure continuity of care and that the consumer's changing needs are met.
– Communicate clearly and effectively with the consumer, his family, and other health professionals in the multi-disciplinary team.
– Provide education and information in a way that is understood, to consumers and their families/whanau. To do this, the social worker would be required to know and understand the major mental illnesses and be able to educate the families about these and their usual presentation and progression. It is possible that some units would not expect their in-patient social workers to be able to assess mental state of a patient by doing a formal mental state examination, but would expect social workers to be able to recognise early warning signs and escalating risk. The social worker would be expected to be able to recognise early warning signs of relapse and identified risk areas or issues and to discuss this with the consumer and their families. Through this discussion, efforts would be made in order to encourage them to consider these as well as strategies for preventing relapse or being able to recognise early symptoms of relapse or identified risk.
– All interventions would be required to be documented and participation at multi-disciplinary team review meetings would be expected.

The role of the social worker in a community setting would include all of the above. The social worker would be deemed to have a case manager role (known as

> keyworker role in some areas) and would be expected to drive the care plan or at the very least be supporting that process, as well as review this in conjunction with the responsible clinician or team. All those social workers working autonomously with clients in the community would be expected to be able to assess mental state and identify whether this was deteriorating, and act on that by arranging for a mental state review by the treating doctor or a crisis team doctor or DAO [Duly Authorised Officer]. They would be expected to liaise with non-government organisations (NGOs) as appropriate with regard to the consumer's recovery and care plan."

Taking into account my expert advice as to the appropriate role of a social worker in the mental health environment, I consider that in the following respects Social Worker A failed to achieve the competencies reasonably to be expected in the circumstances.

– Attention to history and clinical phenomena

Social Worker A submitted that it would have been unrealistic for him to read previous notes relating to Mr Burton's care, given the limitations of his half-time position. I do not accept this. In their initial report my advisors were critical of Social Worker A's failure to read the notes and take into account Mr Burton's history and clinical phenomena. My social work advisor noted that familiarity with a client's file is part of compiling a comprehensive psychosocial assessment of that client.

In the circumstances, I do not think a basic professional failing can be excused by the limitations of a part-time position. Regardless of whether a health professional works on a part- or full-time basis, there is an expectation that that person will act competently and in accordance with appropriate standards. In the present case, Social Worker A failed to do so.

– Limited understanding of mental illness

Social Worker A submitted in response to my provisional opinion that he was employed as a "generic social worker in a mental health hospital", not as a mental health social worker. It was noted that his position description does not require knowledge of mental illness.

It is true that Social Worker A's position description does not spell out a requirement for knowledge of mental illness. The position description sets out the purpose of Social Worker A's position as follows:

> "The Mental Health Inpatient Unit is a component of the comprehensive Mental Health Service. The unit provides comprehensive assessment, treatment, rehabilitation and monitoring of clients identified as having moderate to severe mental health problems. Team members are expected to work closely with consumers/family/whanau and community groups in a supportive, educational and clinical role. The social worker will provide social work service into the team as required through consultation and advice, individual assessment and treatment, community education and development …"

The position description then sets out areas of responsibility that make clear that the social worker is part of Southland DHB's inpatient mental health team. It requires the inpatient mental health worker, amongst other things, to work autonomously with consumers within the policies and procedures of the mental health team, Southland DHB, and Mental Health

Standards, and to have a working knowledge of "the Mental Health Act 1992 and all other legal requirements of the Ministry of Health pertaining to mental health". The person specification that accompanies the position description requires that the incumbent has mental health assessment skills, a sound knowledge of intervention options and an ability to implement these.

I acknowledge that prior to working at Southern Health, Social Worker A had no experience in the mental health field; that is not a matter for which he could be held accountable. But over the year that he was with the District Health Board prior to meeting Mr Burton, there is little evidence that Social Worker A developed his understanding of key concepts and issues surrounding clients with a mental illness. To a degree, responsibility for this situation must rest with the District Health Board, as it undoubtedly had a responsibility to ensure that staff had the skills required to fulfil their professional responsibilities. I note in this regard that the Patient Services Manager advised me that there was a dedicated Education and Training Officer for the mental health service whose task was to organise and facilitate education opportunities for all mental health staff. This person ran a variety of in-service educational opportunities, including a course on mental illness for mental health staff. The Patient Services Manager said that such educational opportunities were widely advertised.

In my view, a qualified and experienced social worker in Social Worker A's position should have appreciated the necessity to undertake further development of his understanding of key issues in working with clients with a mental illness. His position description required that he "actively pursue" appropriate educational opportunities. Without such ongoing development, I fail to see how Social Worker A could provide a safe and appropriate service to his clients.

– Limited assessment of Mr Burton

In his response, Social Worker A denied that assessment of Mr Burton was his responsibility. He characterised assessment of Mr Burton as a medical and nursing responsibility. My social worker advisor did not accept this. As noted above, one of the key roles of the social worker is to undertake a comprehensive psychosocial assessment of the client. A social worker in an inpatient setting has an ongoing responsibility to recognise early warning signs of relapse and identified risk areas; to be watchful for factors associated with risk.

There is little evidence that Social Worker A's interactions with Mr Burton involved any degree of assessment. His involvement appears to have been simply task oriented. In my view this does not accord with the standard of practice reasonably expected of a social worker in Social Worker A's position.

– Lack of recommendations or documentation of conclusions

Social Worker A submitted that he "was not responsible for ongoing needs assessment and involvement. That was the Mental Health Needs Assessor's job." He also submitted that this amounted to confusing the medical and social work model, as assessment documentation is the responsibility of medically trained personnel.

There is no suggestion that Social Worker A was responsible for needs assessment. However, my social worker advisor informed me that it is a requirement of providing social work services of an appropriate standard that the social worker reach and document

conclusions based on the involvement with the client. These should then be shared with the rest of the team. Social Worker A should have analysed the information obtained from his interactions with Mr Burton, reached conclusions based on such analysis, documented them, and raised them with the other team members. There is no evidence that he did so.

Involvement of family

Southland DHB's Family and Carer Participation policy states that family and carers are to be involved in discharge planning, and that a family meeting format is to be utilised to develop a treatment plan in partnership with the patient, family and carer. However, my advisors noted that although Social Worker A stated that for him as a social worker "a family is everything … It's the most important context that anyone could possibly be in", Social Worker A did not attempt to engage Mr Burton's family in his care or pursue the possibility of a family meeting or family input into Mr Burton's discharge plan.[40]

The evidence is that on two occasions Social Worker A did speak to Mr Trevor Burton – once fairly briefly when Mr Trevor Burton rang the ward and Social Worker A handed him over to the MOSS, and once when Mr Trevor Burton delivered his son's car to the ward. Neither conversation was aimed at seeking input for Mr Burton's discharge plan.

Matters relating to discharge planning should have been squarely in Social Worker A's mind. However, he did not raise with the clinical team the possibility of seeking family input into Mr Burton's discharge plan or of a family meeting prior to discharge. Not raising the possibility of family involvement was contrary to the DHB's policy and was surprising in light of Social Worker A's expressed view of the importance of family.

My advisors also noted that the Discharge Policy aimed to achieve continuity and co-ordination of care. Social Worker A was at the meeting with the MOSS and an enrolled nurse on 14 March, where it was decided that Mr Burton would seek a suitable flat to live in following discharge. At that time no information was available about the outcome of the needs assessment. My advisors concluded that consideration of a flat as a suitable accommodation option without assessing Mr Burton's support needs was contrary to the Discharge Policy. They considered that, as a social worker, Social Worker A should have raised this issue and ensured that the assessment necessary for placement recommendation had been completed by the needs assessor before decisions were made.

In response to my provisional opinion, Social Worker A submitted that he did not make key decisions, such as the decision for Mr Burton to move into a flat on trial leave, and the decision to discharge him from inpatient care. Accordingly, he said that he was simply following instructions in relation to decisions already made.

He submitted that it was an unrealistic expectation that he could have any degree of control over the completion of the needs assessment; he should not be held responsible for the non-completion of the report in time for the meeting at which it was decided that Mr Burton would go on trial leave; and it was "incredible" that he should be considered to have any

[40] In response to my provisional opinion, Social Worker A and Southland DHB pointed out that in her report Dr Taumoepeau stated that there was "considerable contact" with Mr Burton's family while he was an inpatient. However, I note that Dr Taumoepeau's report also stated that on the ward there appeared to be no in-depth discussion with the family or involvement with the family in treatment plans.

responsibility for raising at the meeting the issue that the needs assessment was not available for consideration.

My social worker advisor expressed concern that Social Worker A did not see himself as part of the treatment team that made the decisions that Mr Burton would go on trial leave and be discharged. She noted that he attended both meetings and stated at his interview with my advisors that he thought trial leave to a flat was a "good idea" and that he agreed with it. She advised:

> "It would most certainly be expected that if the social worker recognised issues of concern, it would be reasonable to expect him/her to raise them with the team, or at the very least, document these concerns in the client notes. This would be most useful, especially if they felt the team was not taking heed of their concerns. I would also have expected him to have explicitly raised these [issues of concern] with the team and the client, as an advocate for the client, bringing with him a patient focus and requesting specialist additional information in the form of the needs assessment that was never completed."

I agree with my expert advisor that, as a social worker, Social Worker A should have flagged at the meeting where trial leave was discussed that a needs assessment had not been completed, and was an important piece of information the clinical team should take into account when considering trial leave. I reject the submission that it was "incredible" that Social Worker A should have considered and raised this issue. I note that Social Worker A's first documentation in Mr Burton's notes is on 14 March, following the meeting at which trial leave was approved, and Social Worker A says that he had only had casual encounters with Mr Burton prior to the meeting.

On balance, I am satisfied that Social Worker A may not have had sufficient time to consider issues and concerns relating to Mr Burton's potential move to a flat before attending the meeting. The situation can be distinguished from Social Worker A's failure to raise with the clinical team the possibility of involvement of Mr Burton's family in discharge planning, or of a family meeting prior to Mr Burton's discharge. That failure occurred over a period when Social Worker A was clearly involved in Mr Burton's care.

Performance measures for personal development

My advisors also considered that Social Worker A's lack of attention to the performance measures required for personal development set out in his position description impacted on his ability to provide services of an appropriate standard to Mr Burton.

Of particular concern to my advisors was that Social Worker A appeared to view Mr Burton in light of experiences in his own life and drew conclusions based on this comparison. Social Worker A's position description required that he receive peer supervision and clinical supervision in accordance with the Aotearoa New Zealand Association of Social Workers standards. Standard 6 requires that social workers be accountable for their practice through supervision or some other form of oversight.

One purpose of supervision is to ensure that one's own life experiences do not lead to patterns of understanding and response that distort the clinical reality. My advisors considered that Social Worker A's own life experiences did have that effect, yet Social Worker A did not see that he needed supervision. My advisors also considered that Social Worker A did not understand the purpose and importance of supervision. They were

concerned that Social Worker A did not appear to be receiving supervision when Mr Burton was in hospital.

In response to my provisional opinion, Social Worker A stated that he was in fact receiving supervision. When requested to supply details of his supervision, Social Worker A did not respond. However, Southland DHB did provide details. It advised that in 2000 and early 2001 Social Worker A received peer supervision on an ad hoc basis from a drug and alcohol counsellor on staff. This person does not have social work qualifications and cannot recall whether he and Social Worker A met during the period Mr Burton was an inpatient.

Social Worker A met once for clinical supervision with a Southland DHB approved supervisor during the relevant period and missed one appointment. He also attended a supervision session in December 2000 and one in early February 2001. Prior to that, Social Worker A had not attended clinical supervision with the clinical supervisor approved by Southland DHB for some months. This matter was raised formally with Social Worker A in late 2000 by his Team Leader and the Professional Advisor, Social Work, and the requirement that he receive supervision was made clear to him. The Patient Services Manager advised that she had directed that if Social Worker A did not make himself available for clinical supervision, it would develop into a serious performance issue.

It is clear from this information that Social Worker A had received very little clinical supervision from the Southland DHB approved supervisor in the months leading up to Mr Burton's admission and that reasonably regular supervision appointments with this person commenced only shortly prior to Mr Burton's admission, at the express direction of Southland DHB.

ANZASW standards

Social Worker A is a member of the Aotearoa New Zealand Association of Social Workers (ANZASW). My advisors considered that some aspects of his care of Mr Burton did not meet ANZASW standards.

– Standard 1
Standard 1 requires that a social worker establish an appropriate and purposeful relationship with his clients. My advisors considered that Social Worker A did not meet this standard. Social Worker A described his interventions as being largely "task orientated". My advisors noted that Social Worker A was largely unable to explain the purpose of his interventions, and that his role was simply one of an observer, rather than an "active seeker of new information and internal phenomena". I am satisfied that Social Worker A did not meet this standard.

– Standard 2
My advisors also considered that there was limited evidence to suggest that – apart from looking for a suitable flat and working on Mr Burton's car at his car maintenance group – Social Worker A's interventions were goal-oriented, as expected by Standard 2 of the ANZASW standards. Social Worker A did not recognise the importance of creating opportunities for Mr Burton to participate in discussion regarding issues, decision-making and future goals.

Social Worker A pointed to the dysfunctional nature of the team as a whole to explain his lack of compliance with this standard. But, at least for the period when Mr Burton was an

inpatient, Social Worker A appears not to have realised that goal-oriented interventions were required.

In relation to the period when Mr Burton was on leave, my advisors considered that it was not surprising that Social Worker A was unsure of his role, in view of the differing expectations of the clinical team, and Social Worker A's lack of mental health experience. Social Worker A told my advisors that while Mr Burton was on leave he did not see himself as having a role in assessing Mr Burton's mental state – rather he expected to report back what he observed so that the nurses and the MOSS could make assessments. The Team Leader's expectation was that Social Worker A would report back any change in Mr Burton's mental state. Staff Nurse A recorded in Mr Burton's clinical records that Social Worker A was to "follow up" each day, but did not record the purpose of the follow-up. She told my advisors that Social Worker A was not assessing mental state, but was visiting Mr Burton and documenting his observations.

– Standard 8
My advisors also considered that Social Worker A did not meet Standard 8 of the ANZASW standards, which requires that the social worker act to ensure the client's access to resources and opportunities. They noted that this was, in part, because of his lack of knowledge about mental health. However, he also did not identify gaps in Mr Burton's care in the flatting situation, such as the fact that Mr Burton had no support during the weekend, and only Social Worker A visiting during the week. Nor did Social Worker A recognise the contributions of others (such as the needs assessor) in addressing Mr Burton's needs.

This does not amount to a criticism of Social Worker A for any lack of resources available to Mr Burton, as Social Worker A suggested in his response to my provisional opinion. It is instead directed to Social Worker A's insufficient identification of important issues such as the factors that were potentially impeding Mr Burton's access to resources.

Conclusion

I accept the advice of my advisors that there were deficits in aspects of Social Worker A's performance, within the realm of intervention for which he should have had sufficient experience and training, over the period when Mr Burton was an inpatient.

In my opinion, Social Worker A did not meet the performance measures for clinical competency or personal development in his position description, ANZASW standards or Southland DHB policies. I do not accept that his failings are excused by external limiting factors. Accordingly, Social Worker A breached Rights 4(1) and 4(2) of the Code in relation to these matters.

However, in relation to the period when Mr Burton was on trial leave, I consider that Social Worker A cannot fairly be held accountable for any shortcomings. Social Worker A was carrying out a task for which he was poorly equipped. He was not given any clear guidance by the MOSS, or Staff Nurse A, about what the clinical team expected him to "monitor" while Mr Burton was on leave, nor was he told that Mr Burton was someone to be concerned about. It would have been prudent for Social Worker A, as the team member designated to "follow up" Mr Burton during the week of trial leave, to insist that a crisis plan was in place before Mr Burton went on leave. Nevertheless, in all the circumstances, I do not consider that Social Worker A breached the Code in relation to his monitoring of Mr Burton on leave.

NEEDS ASSESSMENT

Mental Health Needs Assessor

Introduction

The Mental Health Needs Assessor was assigned to undertake an assessment of Mr Burton while he was in the inpatient mental health unit.

Needs assessment is a process of determining the current abilities, resources, goals and needs of a person with a disability and which of those needs are the most important. The purpose of the assessment is to decide what a person needs to achieve independence and participate fully in society, in accordance with his or her abilities, resources and goals.

Needs assessment should have been an integral part of Mr Burton's discharge planning. Ward 12 staff made a referral for Mr Burton to have a needs assessment. However, he was discharged before the assessment was completed.

Mr Burton's discharge without a needs assessment having been completed is of very real concern. However, I accept the advice of my advisors that the Mental Health Needs Assessor carried out her activities generally in accordance with her position description and the service specifications for the Needs Assessment and Service Co-ordinator role. She documented the partially completed needs assessment on the approved assessment form and made an effort to involve Mr Burton and his parents in the process.

In my opinion, the Mental Health Needs Assessor generally met the standard expected of a mental health needs assessor, but failed to take sufficient steps to ensure continuity of care for Mr Burton, as explained below.

Continuity of care

The Mental Health Needs Assessor was surprised and, not unnaturally, disappointed when she learned that Mr Burton had been sent on trial leave to a flat before she had finished her needs assessment and identified the support arrangements Mr Burton required in the community. Nevertheless, she continued gathering information to complete the assessment. She intended to work with the key worker from the community mental health team once Mr Burton was discharged, to add some domestic support to Mr Burton's living arrangements.

While Mr Burton was still on trial leave, the Mental Health Needs Assessor spoke to Mrs Paddy Burton, who expressed concern about her son's ability to manage alone in a flat and, in particular, to cook and clean. The Mental Health Needs Assessor did not contact the inpatient unit staff and pass on this information to add to the information available at the discharge meeting. The Mental Health Needs Assessor said that she did not do so because she understood that one of the purposes of Mr Burton's trial leave was to see whether he could manage alone in a flat, including whether he could manage to cook and clean. She said that had her conversation with Mrs Paddy Burton taken place prior to the trial leave she would definitely have brought the information to the attention of the inpatient clinical team.

I acknowledge that the Mental Health Needs Assessor had been sent a strong signal that the inpatient clinical team caring for Mr Burton did not consider that it was necessary to have

information from the needs assessment before Mr Burton went on trial leave to a flat on his own. She made a not unreasonable assumption that the reason for the trial leave was to assess whether Mr Burton was able to live in a flat on his own, and that this assessment would include consideration of the very matters Mrs Paddy Burton had expressed concern about. However, consumers have the right to co-operation among providers to ensure quality and continuity of care, and the Mental Health Needs Assessor had directly relevant information that was not available to others in the clinical team. This information should have been available to be taken into account as part of discharge planning. My advisors were critical of the Mental Health Needs Assessor's lack of assertiveness in her interaction with the clinical team once she had gathered information that she considered important to the discharge plan.

In my opinion, by not passing on relevant information to the inpatient clinical team, for consideration prior to making any decision about Mr Burton's discharge, the Mental Health Needs Assessor breached Right 4(5) of the Code.

Timeliness

A referral to the needs assessment service was made two days after Mr Burton was admitted (12 February). The Mental Health Needs Assessor did not commence the needs assessment until three and a half weeks later and did not complete the assessment before Mr Burton was discharged, although she had planned to do so.

Such a delay in commencing and completing this very important step in discharge planning is not appropriate. However, as far as the Mental Health Needs Assessor is concerned, there are some mitigating factors. Southland DHB had no policy that specified a time frame within which needs assessments must be commenced and completed. It is unclear when the Mental Health Needs Assessor was allocated the referral. A letter to Mr Burton from a Needs Assessment Facilitator (not the Mental Health Needs Assessor), acknowledging receipt of the referral and advising that contact would be made in the next two weeks, was sent on 28 February. The Mental Health Needs Assessor commenced the assessment eight days later. The inpatient unit staff did not request that Mr Burton's needs assessment be done urgently, nor did anyone from the unit follow up on the assessment, despite reference in the clinical notes to the need for this to be done. The Mental Health Needs Assessor learned, by chance, that Mr Burton was on trial leave in a flat. Mr Burton was discharged without the needs assessment information being requested. The MOSS also requested that the Mental Health Needs Assessor assume a service co-ordination role before the assessment was completed, and this may have impacted on the timeliness of her intervention.

I am satisfied that in circumstances where Southland DHB had no policy about the time frame in which a needs assessment was required to be completed, and where there were failures in communication and co-ordination on the part of other members of the clinical team, the Mental Health Needs Assessor was not aware of the need for greater urgency. Accordingly, in my opinion the Mental Health Needs Assessor did not breach relevant standards in relation to the lack of timeliness of the needs assessment.

Adequacy of information gathering

The Mental Health Needs Assessor briefly looked at Mr Burton's clinical file before commencing the needs assessment. My advisors considered that the Mental Health Needs Assessor should have done a more thorough review of Mr Burton's clinical notes to gain a

comprehensive understanding of past presentation and concerns about his function. They also considered that she should have paid attention to risk assessment as part of the needs assessment process (although, as they note, it would have been difficult to do so for Mr Burton as the risk assessment had not been completed).

The Mental Health Needs Assessor advised that it was not her usual practice to do a detailed review of notes; usually she worked with staff on the unit, who would notify areas of concern in relation to risk. No such areas of concern were identified to the Mental Health Needs Assessor. When she raised Mr Burton's change in demeanour to the nurse who sat in on the needs assessment, the Mental Health Needs Assessor's observations were not taken sufficiently seriously to even be documented by the nurse.[41]

I accept my expert advice that reviewing clinical records and paying attention to risk assessment is an important part of the needs assessment process that did not occur. However, I also note that my advisors considered that the Mental Health Needs Assessor was required to carry out tasks for which she needed further training and supervision.

Under Clause 3 of the Code, a provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, of the Code. The onus is on the provider to prove this.

In my opinion, in circumstances where the Mental Health Needs Assessor was carrying out activities in accordance with her position description and service specifications, and where there was no expectation by Southland DHB that a review of clinical records be undertaken as part of the needs assessment, the Mental Health Needs Assessor did not breach relevant standards in relation to the adequacy of the information gathered.

Conclusion

Having reviewed the Mental Health Needs Asessor's involvement with Mr Burton while he was a patient in the inpatient mental health unit, I am satisfied that she generally met the standard expected of a mental health needs assessor, but failed to take sufficient steps to ensure continuity of care for Mr Burton. Accordingly, the Mental Health Needs Assessor breached Right 4(5) of the Code.

Changes to practice

In response to my provisional opinion, the Mental Health Needs Assessor advised that she has reflected on her practice, and she and Southland DHB have implemented the following changes:

- Needs assessments are now put into the integrated clinical notes.
- The Mental Health Needs Assessor has a timeline for study.
- The Mental Health Needs Assessor ensures that needs assessments are completed in a timely manner and if there is to be any delay the inpatient clinical team is advised.
- The Mental Health Needs Assessor has re-evaluated her workload within the team.
- The Mental Health Needs Assessor is continuing to receive supervision from a qualified social worker.
- The Mental Health Needs Assessor now ensures that she passes on to the inpatient clinical team all information given to her by a client.

[41] As noted in the chronology, at that time there was not an expectation that needs assessors would document in the clinical records.

ALCOHOL AND DRUG ASSESSMENT

Alcohol and Drug Services Counsellor

Introduction

The Alcohol and Drug Services Counsellor worked at Rhanna Clinic. Rhanna Clinic is part of Southland DHB's mental health services and is described by Southland DHB as a comprehensive alcohol and drug service which provides counselling, group therapy, rehabilitation programmes, follow-up, and education and information for consumers.

Mr Burton was referred to Rhanna Clinic by Ward 12 staff almost a month after he was admitted to hospital. The Alcohol and Drug Services Counsellor was assigned the referral and undertook an alcohol and drug assessment of Mr Burton.

In my opinion, the Alcohol and Drug Services Counsellor did not provide services of an appropriate standard to Mr Burton in one respect – his failure to document any overall conclusions or recommendations after he completed his assessment – but other deficits in his practice can be excused in all the circumstances.

No conclusions or recommendations documented

One aspect of the Alcohol and Drug Services Counsellor's performance caused my advisors particular concern. The Alcohol and Drug Services Counsellor did not document any overall conclusions or recommendations after he completed his assessment. This surprised my advisors, as one purpose of a specialised assessment is to provide a more expert perspective than is available from a general clinician. Such an assessment should be followed by some conclusion in relation to its findings. My advisors considered that the Alcohol and Drug Services Counsellor's failure to document conclusions or recommendations indicated he did not appreciate the important role of a specialist service in the spectrum of care.

The Alcohol and Drug Services Counsellor noted in response to my provisional opinion that he did include in his report the client's expectations and a discharge plan, and thus it should have been apparent that Mr Burton was unwilling to address his alcohol and drug problem.[42] Nonetheless, the Alcohol and Drug Services Counsellor failed to document conclusions that might have enabled the other members of the clinical team to gain a more in-depth insight from the specialised assessment.

I accept my expert advice that, by not documenting recommendations or conclusions, the Alcohol and Drug Services Counsellor did not meet the standard expected of a specialist advisor. Accordingly, in my opinion, the Alcohol and Drug Services Counsellor breached Right 4(2) of the Code.

Assessment of Mr Burton

As noted above, the Alcohol and Drug Services Counsellor undertook an alcohol and drug assessment of Mr Burton after Ward 12 staff sent a referral to Rhanna Clinic. The referral

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[42] The discharge planning section of the document stated: "I'll leave this up to the M.H.U. [mental health unit] for [Mr Burton] states he knows what's wrong and yet not ready to address his cannabis/alcohol use, also understands that he can talk with a counsellor at any time." Mr Burton's expectations were recorded as: "Just play the game until released and will return to smoking and drinking – also to fill these forms out and if I want to talk about [sic] I'll talk."

noted that Mr Burton now realised he had a problem with drugs and alcohol that he wished to address and that his father was also keen for this to occur.

My advisors describe the Alcohol and Drug Services Counsellor's assessment as "fairly extensive". He engaged Mr Burton in a manner that allowed identification of aspects of his history not documented elsewhere in his clinical records, for example, involvement with the Police.[43] During the assessment, the Alcohol and Drug Services Counsellor administered some questionnaires designed to assist with rating the severity of any drug and alcohol abuse.

My advisors considered that the Alcohol and Drug Services Counsellor's limited understanding of psychiatric problems impacted on his ability to provide services of an appropriate standard to Mr Burton. They identified two areas where this was particularly evident – his lack of appreciation of the need for ongoing intervention, and his lack of understanding of the effects of mental illness – and raised some concerns about his follow-up of his assessment.

Lack of appreciation of need for ongoing intervention

Mr Burton's lack of enthusiasm or motivation to address his use of drugs and alcohol presented a difficult problem for staff. Mr Burton clearly told the Alcohol and Drug Services Counsellor that he had no wish to address these issues. The Alcohol and Drug Services Counsellor respected Mr Burton's wishes, but he did not appreciate the need for ongoing active intervention, for example by counselling or group involvement, in order to motivate Mr Burton to contemplate changing. The Alcohol and Drug Services Counsellor informed me in response to my provisional opinion that he did appreciate the need for ongoing intervention but felt that his hands were tied, as he was unable to compel Mr Burton to accept treatment. I accept that the Alcohol and Drug Services Counsellor was unable to compel Mr Burton to accept treatment, but this did not rule out the possibility of more active attempts to motivate Mr Burton.[44]

Lack of understanding of effects of mental illness

My advisors were concerned that the Alcohol and Drug Services Counsellor inappropriately normalised Mr Burton's alcohol use and overlooked his mental illness and the evidence that use of alcohol contributed to an increase in risk of aggressive actions. However, in respect of both these matters it was my advisors' view that in being asked to undertake a drug and alcohol assessment for Mr Burton, the Alcohol and Drug Services Counsellor was expected to carry out a task for which he had insufficient training and experience. They noted that the Alcohol and Drug Services Counsellor's position description did not indicate knowledge of mental illness or dual diagnosis as a requirement.

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[43] My advisors commented that the Alcohol and Drug Services Counsellor did not gather information from other sources or involve Mr Burton's family in the assessment. The Alcohol and Drug Services Counsellor noted in his response to my provisional opinion that he spoke to Mr Burton about his parents during the assessment and at that time felt no need to involve them in the assessment.

[44] Rhanna Clinic and the mental health unit now have an agreement to increase inter-service agreement and access for clients. It provides that when a client in the mental health unit has been identified as having a drug and/or alcohol problem, Rhanna Clinic will be notified and a Clinic key worker will be allocated to liaise with the mental health unit staff and client, and a care plan appropriate to the patient's needs will be put in place. The Clinic key worker will visit the mental health unit twice weekly and/or maintain daily contact through support group meetings held every morning at Rhanna Clinic. The agreement also provides for liaison/communication between the two units and that the Clinic key worker will be involved in the patient's ongoing care plan as well as discharge planning.

Southland DHB's Quality Care and Treatment Policy, issued in August 1999, states that consumers admitted to the inpatient mental health unit with dual diagnosis "are catered for by dual management with other service providers, eg Rhanna Clinic". The Clinical Director advised that the psychiatric services and the drug and alcohol services "do their best to work together" but Southland DHB does not have an expectation that the drug and alcohol services staff provide services for people who have a mental illness, without liaising with the mental health team around issues relating to mental illness. He also acknowledged that the drug and alcohol services staff were not particularly well trained in psychiatric issues and mental state examination.

There is evidence that the Alcohol and Drug Services Counsellor and other Rhanna Clinic staff sought to attend a course on dual diagnosis provided for other mental health staff at Southland Hospital, but that their request was declined by the Patient Services Manager. The Patient Services Manager confirmed that she declined the request because she did not consider the course suitable for Rhanna Clinic staff as it was not aimed at drug and alcohol counsellors. It was a dual diagnosis course designed "for mental health staff so that they could understand more fully drug and alcohol issues". The Patient Services Manager also advised that Southland DHB has a working party looking at the issues around managing dual diagnosis so that all mental health unit staff are trained in baseline assessments.

I accept my expert advisors' advice that the Alcohol and Drug Services Counsellor's lack of understanding of mental illness impacted on his ability to provide services to Mr Burton of an appropriate standard. He did not appreciate the need for ongoing intervention, or have an understanding of Mr Burton's psychiatric disorder, or of comorbid substance abuse potentially impacting on his mental state in an adverse fashion. The Alcohol and Drug Services Counsellor was expected by Southland DHB to carry out a task – assessment and counselling of clients with mental illness as well as substance abuse issues – for which he had insufficient skill and training. The deficits of the Alcohol and Drug Services Counsellor's services noted above are excused by Southland DHB's failure to provide him with adequate support.

Follow-up of assessment

My advisors considered that the Alcohol and Drug Services Counsellor did not adequately follow up his assessment with Ward 12 staff. The Alcohol and Drug Services Counsellor gave a nurse (whose name he can no longer remember) his assessment documents to include in Mr Burton's integrated clinical records before he left the ward. He said he would have told her "the position" (ie, that Mr Burton would play the game until discharged). He stated: "I would usually write to them [the inpatient staff] I suppose, I just didn't that day."

There is no reference to the alcohol and drug assessment having been completed in the clinical notes and there is no discussion of the Alcohol and Drug Services Counsellor's assessment in the notes, including the notes of the weekly review meeting following the assessment. In fact, there is no information to suggest that the Alcohol and Drug Services Counsellor's assessment documentation was accessed at all as part of the treatment or discharge planning process. The MOSS did not see it until after Mr Burton was discharged.

In response to criticism in my provisional opinion that he had not been sufficiently proactive in ensuring that Ward 12 clinical staff were aware of his assessment and the outcomes of that assessment, the Alcohol and Drug Services Counsellor informed me that he followed the procedure expected by Southland DHB at the time. Alcohol and drug

services counsellors were expected to complete and provide assessment documentation to the inpatient staff for inclusion in the integrated clinical records. They were not expected to document in the inpatient daily clinical records, nor was there an expectation that they would attend weekly review meetings.

I have revised my earlier opinion. The Alcohol and Drug Services Counsellor did complete assessment documentation, informed nursing staff immediately it was completed and passed on a copy of his assessment to be included as part of the integrated notes. The nurse he spoke to should have recorded in the clinical notes that the Alcohol and Drug Services Counsellor had visited, that the assessment had been filed and that Mr Burton had declined assistance. While I consider that the Alcohol and Drug Services Counsellor's handover in this case was less than optimal, it was reasonable for him to assume that the information he had passed to the nursing staff would be incorporated and acted upon appropriately.

Conclusion

Having reviewed the Alcohol and Drug Services Counsellor's involvement with Mr Burton during the period under review, I am satisfied that in one respect – his failure to document any overall conclusions or recommendations after he completed his assessment – he did not provide services of an appropriate standard to Mr Burton. The Alcohol and Drug Services Counsellor breached Right 4(2) of the Code by his documentation failure. However, the other deficits in his practice can be excused in all the circumstances.

MANAGEMENT AND LEADERSHIP

There were three people with management and leadership responsibilities for Southland DHB's inpatient mental health services: the Clinical Director, the Patient Services Manager, and the Team Leader. In a number of respects they failed to fulfil their management and leadership responsibilities.

Clinical Director

Introduction

The Clinical Director is Southland DHB's senior psychiatrist. The primary objectives in the position description for Clinical Director include:

- ensuring the effective provision of clinical services
- ensuring the training and development of medical staff as appropriate
- providing quality leadership.

The key responsibilities include assessing the performance of medical staff, establishing and monitoring clinical standards of practice (including peer review, clinical audit and quality assurance activities), and ensuring that clinical notes are adequately maintained. The Clinical Director had line management responsibilities for all mental health services medical staff.

Leadership is critical for safe health care.[45] Clinical leadership (leadership of clinicians, by clinicians) is increasingly recognised as a key factor in promoting clinical quality.[46] My advisors point to several important areas where a lack of clinical leadership by the Clinical Director is evident. The Clinical Director did not realise that monitoring and reviewing the standards of practice of medical staff was required by his position description. He did not recognise that this responsibility is standard practice for the clinical leader of a service. Nor did he assume responsibility for establishing the roles and responsibilities of medical staff in Southland DHB's mental health services.

In my opinion, these were serious failings by the Clinical Director and are not excused by the constraints – a shortage of skilled staff, a heavy workload and time pressures – that he faced.

Monitoring and reviewing of the Medical Officer Special Scale

The Clinical Director was responsible for reviewing the MOSS's performance and ensuring that he met recognised standards of clinical practice. The Clinical Director failed to fulfil this responsibility. He did not ensure any systematic review of the MOSS's performance or that there was effective monitoring of his practice.

The Clinical Director regarded the MOSS as a psychiatrist even though he had no specialist qualification in psychiatry and limited formal training in psychiatry. Significantly, the Clinical Director failed to determine the MOSS's scope of unsupervised practice or take into account that, as the MOSS held only general registration, he was not permitted by law to practise psychiatry without mandatory general oversight by a doctor holding vocational registration in psychiatry (s 20, Medical Practitioners Act 1995).

The Clinical Director said that he thought it would be "ungentlemanly" to review the MOSS's standard of practice and that he was not aware of the necessity to be looking over the MOSS's shoulder or to be checking on him. His assumption was that a qualified and responsible physician would bring his concerns to a colleague if he felt he was not managing.[47]

The Clincial Director submitted, in response to my provisional opinion, that my expert advisors seemed unable to distinguish between "supervision" and "oversight" and that "what they seem to deem appropriate would be more accurately described as "surveillance". He stated that comments about the legal requirements for oversight not being met were incorrect and referred me to "the guidelines for general oversight pertaining at the time published by the Medical Council".

In *General Oversight – Guidance for doctors providing and receiving oversight* (January 2000) the Medical Council makes it clear that general oversight is mandatory for MOSSs and gives guidance on the Council's expectations of general oversight. It notes that oversight is not supervision, but that sometimes a supervisory role may be necessary. The

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[45] Berwick DM, Leape LL, "Safe Health Care: are we up to it?", *BMJ* 2000, 320:725.

[46] Malcolm L, Wright L, Barnett, P, Hendry C, *Clinical Leadership and Quality in District Health Boards in New Zealand*, Clinical Leaders Association of New Zealand (2002).

[47] In its response to my provisional opinion, Southland DHB commented that the Clinical Director's cultural background is inextricably linked to his use of language and that my advisors did not understand or incorrectly or unfairly interpreted language or phrases he used – in particular his use of "ungentlemanly" and "this famous letter".

brochure states that "general oversight is a key tool in the [Medical Practitioners] Act to ensure doctors' ongoing competence, which in turn helps protect the public".

There is clearly a difference between "supervision" and "oversight". However, neither oversight (as required by law) nor supervision was undertaken in relation to the MOSS. There was no discussion between the Clinical Director and the MOSS setting out the parameters of the required oversight, nor were areas of particular need for support and assistance agreed. Although the Clinical Director has stated that he was available to all staff, my psychiatric advisor noted that this was not sufficient – he should have had a closer relationship with the MOSS, who was a key staff member taking responsibilities beyond his expertise. This did not happen. I have no doubt that there were pressures on the Clinical Director's time in terms of setting up regular oversight sessions, but he had a responsibility to ensure that there was a reasonable system in place for the MOSS's oversight and, where necessary, supervision.[48]

Position description

My advisors noted that the Clinical Director appeared to have no knowledge of what was in his position description.

The Chief Executive Officer of Southland DHB responded that the Clinical Director's "lack of in-depth familiarity with a generic job description is both trivial and understandable". He advised:

> "All staff are aware of the generic content of their positions, but a staff member's 'position' is not a static concept and may change over time. Consequently the day to day activities and duties carried out by staff may differ from the precise content of their position description. In common with other staff members, [the Clinical Director] had a moral obligation to address the clinical issues first, as a priority, regardless of the scope of practice envisaged by his position description. This moral obligation is reinforced by Southland DHB's expectation that the treatment of patients is the highest priority."

This submission misses the point that the Clinical Director had some key responsibilities in his position description that he ought to have been aware of in order to carry out his responsibilities as a Clinical Director to an appropriate standard. He did not need to be aware of "the fine print" of his position description, but as Clinical Director of Mental Health Services, with line management responsibilities for all mental health services medical staff, the Clinical Director ought to have been aware that monitoring and reviewing the standards of practice of medical staff was a key responsibility in his position description.

Resource constraints

My advisors, in their report, and the Clinical Director and his counsel, noted the considerable constraints on the Clinical Director's time. In response to my provisional opinion, the Clinical Director stated:

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[48] The Coroner concluded that it would have been appropriate for Mr Burton's risk assessment and management to have been reviewed by a qualified psychiatrist on a regular basis and no decision made on his release or discharge without the direct and informed authorisation of a qualified psychiatrist.

> "I cannot hope to describe to you the complexity and multiplicity of decisions and actions required as the Clinical Director, in an under-resourced area on a day to day basis. The Advisor on the Panel made no effort to understand this beyond the reading of a generic job description which bears little relationship to operational reality …
>
> The Panel did not acknowledge twice-weekly meetings, many informal meetings, ward rounds and my 24-hour per day, 7 days per week availability by telephone for support and consultation, with 150 staff.
>
> They did not acknowledge my role as DAMHS, in itself a time consuming role, or that my jobs as Clinical Director and DAMHS have a combined allocation of 0.2 of my work time (hence the necessity of the level of availability by telephone)."

The Clinical Director's counsel submitted that "Southland District Health Board's mental health services were, and are, severely affected by lack of resources and more particularly lack of experienced personnel … [The Clinical Director] … had to take on additional duties and workloads in order to compensate for lack of resource and trained personnel."

The Clinical Director's job – in an environment that is geographically isolated and short of psychiatrists and other skilled staff – was obviously complex and demanding and, at times, lonely. The Clinical Director had to shoulder a heavy workload in part because of shortage of psychiatrists.

At the time of the interview with my advisors, the Clinical Director was under pressure, which his counsel advised was because of preparing for and attending the Coroner's inquest while trying to maintain his normal workload. Some of the Clinical Director's responses to my investigation indicate that he has continued to find investigation of this matter stressful. As I have noted earlier, I am aware that staff have found the investigations that have occurred since Mrs Paddy Burton died, stressful. I have taken that into account.

I do not, however, accept that my expert advisors have failed to understand the complexity of the Clinical Director's role, or how busy he was. My psychiatric advisor is a Clinical Director of a DHB mental health service and a DAMHS. He advised me that his own service has significant shortages of staff, and many MOSS employees, and that he is well aware of the constant need to prioritise. My advisors' report is clear that the demands on the Clinical Director's time must be taken into account in evaluating his performance.

Conclusion

I accept that the Clinical Director was stretched in his ability to perform the tasks of Clinical Director in addition to his clinical responsibilities, and that he was working in an environment of constant time pressures. However, taking into account these constraints, the Clinical Director has not demonstrated that he took reasonable actions to ensure that the MOSS was operating within an appropriate scope of practice, and that his legal requirements for general oversight were met and his standards of practice were monitored and reviewed.

In my opinion, the Clinical Director failed in several respects to fulfil his responsibilities as Clinical Director. The Clinical Director:

- failed to recognise that it was inappropriate to consider the MOSS as a psychiatrist
- failed to define the scope of the MOSS's unsupervised practice

- failed to ensure that, at a minimum, the legal requirements for general oversight for the MOSS were met
- failed to monitor and review the MOSS to ensure, as far as he was able, that the MOSS met appropriate standards in his care of Mr Burton.

These failures constitute a serious departure from the responsibilities of a Clinical Director. The Clinical Director did not meet the standard expected of a Clinical Director, and accordingly breached Right 4(2) of the Code.

Patient Services Manager

Introduction

The Patient Services Manager – Mental Health[49] and the Clinical Director formed the Mental Health Directorate for Southland DHB's mental health services. The Patient Services Manager was a member of Southland DHB's senior management team. At the time of Mr Burton's admission, the Patient Services Manager reported directly to the Chief Executive.

The primary objectives set out in the Patient Services Manager's position description were to:

- develop, provide and monitor the delivery of high quality, patient focused, effective clinical services
- develop a style of leadership, and management systems and processes, that reflect Southern Health's values, and enable the people within mental health services to actively contribute to the continuous improvement of health services and their delivery.

The key responsibilities identified in the position description include:

- delivering clinical services that are efficient, effective and to a high clinical standard
- leading and managing the staffing resources within the area to ensure optimum contribution of all employees
- developing effective systems and processes for monitoring and improving the quality of services provided.

In my opinion, the Patient Services Manager generally met the standard expected of a manager of a mental health service. However, in the specific respects identified below, she did not meet that standard.

Jurisdiction

In response to my provisional opinion the Patient Services Manager submitted that she was not a "health care provider" under the Health and Disability Commissioner Act and accordingly that the Commissioner does not have jurisdiction to investigate her role as Patient Services Manager. I do not accept that submission for the following reasons.

Although the Patient Services Manager had no direct clinical involvement with patients, she was responsible for ensuring that Mr Burton and other patients receiving mental health

[49] The Patient Services Manager is no longer working for Southland DHB, having accepted a position in another health service.

services received care of an appropriate standard. The position description for the Patient Services Manager stated, as a primary objective:

> "6.1 Deliver, *provide* and mentor the delivery of *high quality patient focused, effective clinical services in Mental Health Services*, which meet patient requirements, and contractual obligations, within financial targets, and within the overall strategic direction of Southern Health." (italics added)

The Patient Services Manager accepted this position. Although she could not be expected personally to provide mental health services, she was responsible for ensuring that appropriate systems were in place to deliver safe and effective mental health services for the people of Southland. As stated by the Privy Council in 1999: "The philosophy which seeks to divorce the administration from the medical care so as to leave the administrator free from any responsibility for deficiences in the care of the sick cannot be sound. The care, treatment and safety of the patient must be the principal concern of everyone engaged in the hospital service."[50] Their Lordships also stated that if the interest of the patient is to remain paramount, the enterprise must be one of "co-operative endeavour" between clinical staff and administrators. The Patient Services Manager was in the key managerial/administrative role within Southland DHB's mental health services.

Section 5(1) of the Interpretation Act 1999 states that the "meaning of an enactment must be ascertained from its text and in light of its purpose". The stated purpose of the Health and Disability Commissioner Act 1994 is "to promote and protect the rights of health consumers and disability services consumers" (s 6). To the extent that there is any ambiguity over whether managers within a clinical service are "health care providers" for the purposes of the Act, I consider that the consumer protection purpose of the statute points towards an inclusive definition. This must especially be the case if the manager is (in theory, if not in practice) in a partnership relationship with the Clinical Director.[51] In such a case, the manager is (for the purposes of the HDC Act, s 3(k)) a "person who provides, or holds himself or herself … out as providing, health services to the public".

Management of staffing resources

The Patient Services Manager was required to lead and manage the staffing resources within mental health services to ensure optimal contribution of all employees. She was also required to ensure the delivery of efficient, clinically effective services of a high standard and to develop effective systems and processes for monitoring and improving the quality of care.

The Patient Services Manager had responsibility for ensuring that staffing levels and clinical cover were appropriate to clinical requirements; that staff with appropriate skills were employed; that staff were able to develop knowledge and skills within the context of their job; that work performance was managed and monitored; and that there was an appropriate skill mix within a team.

My advisors were concerned that a team leader was employed part-time for an onerous, full-time role, and two staff members who lacked relevant background and training were expected to undertake roles in which knowledge of mental health problems in general, and

[50] *Roylance v General Medical Council* [1999] 3 WLR 541, 559.

[51] The lack of an effective partnership between the Patient Services Manager and the Clinical Director is discussed under 'Corporate Responsibility' later in this report.

psychiatric illness in particular, was essential. These issues are discussed in more detail below.

– Team Leader

My advisors considered that the Team Leader was employed in a role too big to be carried out within her .75 appointment.

The Patient Services Manager was the Team Leader's line manager. She was also, as Patient Services Manager, responsible for developing, providing and monitoring the delivery of high quality, patient focused, clinically effective mental health services. A key area of responsibility identified in her position description was leading and managing the staffing resources to ensure optimum contribution of all employees. One of the performance measures for this responsibility was reviewing all positions to ensure jobs were designed to deliver optimum care.

The Patient Services Manager should have been aware that with the Team Leader's competing demands she could not effectively discharge all her responsibilities. My advisors were given no evidence that measures had been put in place to assist the Team Leader or to lighten her load, or to increase the hours required for the Team Leader's position.

In response to my provisional opinion, the Patient Services Manager advised that she had put in place measures to assist the Team Leader and to lighten her load, and that while she was aware of the Team Leader's workload, at no time had the Team Leader indicated to her that she could not effectively discharge all her responsibilities. The Patient Services Manager stated:

> "All staff were fully extended by their workloads, it was the nature of the service and organisation as a whole. In recognition of the size of the Team Leader's and other Team Leaders' workloads I employed a full time Management Support Officer whose job it was to carry out the more laborious and time consuming functions of the Team Leader's role – for example ordering supplies, arranging for the use of vehicles and collating incident reports. Some of the Team Leaders were better than others at using the services of the Management Support Officer …"

The Patient Services Manager advised that she held regular meetings with all team leaders – the purpose of which was to discuss any areas of concern and to assess workload demands. Further, her door was always open to any staff to discuss work pressures. She stated that the Director of Nursing and Midwifery "set the budgeted nursing staff establishment at that time" and had not raised with her the issue of the size of the Team Leader's position.

While it is commendable that the Patient Services Manager had taken steps to ensure that team leaders were not burdened with unnecessary clerical tasks, her response indicates that she relied on the Team Leader and/or the professional nursing advisor to tell her if the Team Leader was overburdened or that she could not effectively discharge all her responsibilities.

The Team Leader's role is a key position, having overall management responsibility for the inpatient unit, both operationally and clinically. There is evidence that at the time Mr Burton was a patient, alterations were being undertaken in the unit, which added to the

Team Leader's load. She was working in an acting capacity and coping with trying to introduce change because she had identified areas of risk in nursing practice. In my opinion the Patient Services Manager should have been more proactive in satisfying herself that the Team Leader, with all her competing demands, was effectively discharging all her responsibilities. She should have brought any concerns about the size of the Team Leader's role to the attention of the Director of Nursing and Midwifery.

– Social Worker A

Social Worker A was employed in the inpatient mental health service, but he had no prior experience of mental health. His position description did not spell out knowledge of mental illness as a requirement, yet it required him to work autonomously with patients with mental illness. The person specification accompanying the position description required mental health assessment skills. My advisors considered that it would have been sensible to make a requirement for knowledge of mental illness explicit. Social Worker A's limited understanding of mental illness and its impact affected his ability to provide Mr Burton with care of an appropriate standard. Social Worker A could not point to any educational opportunities offered while he was working on the inpatient unit.

Social Worker A's position description required that he receive clinical supervision in accordance with Aotearoa New Zealand Association of Social Workers guidelines and be prepared to receive peer supervision. My investigation team was concerned that there appeared to be no arrangements for Social Worker A to receive clinical or peer supervision during the period Mr Burton was in hospital.

In response to my provisional opinion, the Patient Services Manager advised that it was the role of the Professional Advisor, Social Work, to set the position description for Social Worker A. The Patient Services Manager said she was well aware that Social Worker A's position description required that he receive clinical supervision and be prepared to receive peer supervision. She understood at the time that Social Worker A was receiving peer supervision from another social worker, but that there had been issues with Social Worker A not undertaking clinical supervision as required by Southland DHB during 2000. Following several requests from Social Worker A's Team Leader and the Professional Advisor, Social Work, the Patient Services Manager had directed "that if Social Worker A did not make himself available for clinical supervision it would develop into a serious performance issue". She was advised soon afterwards that the issue had been resolved and that he was in fact receiving clinical supervision.

The Patient Services Manager commented: "The impasse over [Social Worker A's] supervision occurred prior to and over the time Mr Burton was in hospital. Over this period I was supporting the Professional Advisor and Team Leader in their attempts to persuade [Social Worker A] to accept clinical supervision." The issue of what clinical supervision Social Worker A was receiving is discussed earlier in this report, but information provided by Southland DHB largely accords with the Patient Services Manager's response.

The Patient Services Manager also advised that there were educational opportunities available to Social Worker A and other mental health staff. She said that she established the position of Education and Training Officer for the mental health service. This person was charged with organising and facilitating educational opportunities for all staff. The Patient Services Manager said that the Education Officer had run a course on mental illness for staff within the mental health service and for staff in various community agencies, such

as PACT, and that there were also other in-service educational opportunities. All such opportunities were widely advertised.

I am persuaded by the Patient Services Manager's response that her management of issues relating to Social Worker A's position description, supervision and the provision of educational opportunities was of an appropriate standard.

– Alcohol and Drug Services Counsellor

Southland DHB's Quality Care and Treatment Policy, issued in August 1999, provided that consumers admitted to the inpatient mental health unit with dual diagnosis "are catered for by dual management with other service providers eg Rhanna Clinic". As noted earlier, Rhanna Clinic is part of Southland DHB's mental health service.

The Alcohol and Drug Services Counsellor's position description did not indicate knowledge of mental illness or dual diagnosis as a requirement, yet he was expected to provide a specialist assessment of a patient with a mental illness. The drug and alcohol service is located within the mental health service, and Southland DHB does not have a specialist dual diagnosis service. My advisors considered that the lack of a requirement for knowledge of mental illness or dual diagnosis in the position description for drug and alcohol services counsellors expected to "cater for consumers with dual diagnosis" reflects a gap in the range of skills that should be represented in the service.

In response to my provisional opinion, the Patient Services Manager advised that Southland DHB's mental health services did not purport to provide a specialist dual diagnosis service. She noted that specialist substance abuse services are funded out of Christchurch and that there are only two specialist dual diagnosis services in New Zealand, both in the North Island. She stated:

> "There is no dual diagnosis service funded within Southland DHB's Mental Health Service, although such a service does exist as required by [Southland DHB's] Quality Care and Treatment Policy issued in August 1999. The dual diagnosis service takes the form of a working party of experts, that is to say staff who had completed specific study and who had worked in the area of dual diagnosis. To criticise the lack of dual diagnosis expertise fails to recognise that no central government funding is available for the provision of this service."

It is not in dispute that Southland DHB does not have a specialist dual diagnosis service. The situation in Southland, where dealing with patients with a dual diagnosis is common, highlights the need for the drug and alcohol service to work closely with the mental health team in relation to clients. Indeed, the Quality Care and Treatment Policy is explicit that dual management is required.

In Mr Burton's case, the inpatient mental health staff considered it appropriate to refer him to Rhanna Clinic. Yet there is no evidence of dual management or of a framework that facilitated it. An assessment by the Alcohol and Drug Services Counsellor, without any conclusions, was simply entered on the file and apparently not discussed with anyone within the mental health team. There is no evidence of the drug and alcohol service and the inpatient mental health unit working together. It is clear that neither the Alcohol and Drug Services Counsellor, nor the inpatient staff, had an expectation of working together, and

there was no policy or procedure in place setting out the expectations of dual management.[52]

In her response to my provisional opinion, the Patient Services Manager provided some information on steps she has instigated to provide educational opportunities to mental health staff, via the Education and Training Officer. She advised that she had specifically raised with the Team Leader of Rhanna Clinic the need for Rhanna Clinic staff to have knowledge of mental health issues and received assurances that staff were taking training in this area. She also noted that the Alcohol and Drug Services Counsellor had completed a Maori Mental Health Diploma. However, it remains the case that the Alcohol and Drug Services Counsellor had insufficient training and support to provide Mr Burton with services of an appropriate standard.

Response to staffing shortages

At the time Mr Burton was a patient there was no occupational therapist in the inpatient unit as the incumbent (who holds a 0.2 FTE position) was on parental leave and had not been replaced. Without an occupational therapist, aspects of Mr Burton's assessment (such as assessment of function or using activity-based interventions to facilitate access to thought content and perceptions) did not occur. The Patient Services Manager told my advisors that it was difficult to fill such a part-time position. The Patient Services Manager noted that "despite lengthy advertising" there were no applicants for the 0.2 FTE position, and she had made a proposal to the Chief Executive Officer to increase the position, which was declined. I am satisfied that the Patient Services Manager took reasonable steps in the circumstances to try to ensure this vacancy was filled.

Shortage of psychiatrists was also a chronic problem. Like many other services of a similar size in New Zealand, Southland is vulnerable to problems of recruitment and retention of adequate numbers of staff. Southland DHB has lacked a critical mass of psychiatrists for some time.

My advisors were critical that the Patient Services Manager missed an opportunity to employ a forensic psychiatrist full-time. The Patient Services Manager explained that Southland DHB had a position for a part-time forensic psychiatrist as there was only a part-time forensic workload and therefore funding for only a part-time position. A forensic psychiatrist who applied for this position was not prepared to do anything other than forensic psychiatry. Accordingly, Southland DHB did not employ him. Instead, the Patient Services Manager arranged for a forensic psychiatrist from Christchurch to make regular visits to provide clinical services in Invercargill and to undertake case review and supervision with the community forensic team each week by video. This arrangement is still in place.

I am satisfied that ongoing attempts were made to fill vacant positions and that the Patient Services Manager put considerable thought into covering gaps in the service, and developed proposals to use the surplus in mental health funding to fill such gaps. She took

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[52] Since Mrs Paddy Burton's death the drug and alcohol service and the inpatient mental health unit have reached an agreement on how they will work together to ensure appropriate management of a patient who has a dual diagnosis. Southland DHB currently has a working party examining issues around managing dual diagnosis so that all mental health unit staff are trained in baseline assessments. In its response to my provisional opinion, Southland DHB noted that Christchurch School of Medicine's National Centre for Treatment Development has suggested that dual diagnosis services not be delivered from specialist centres.

steps on at least one occasion to enlist the support of a psychiatrist from a bigger centre to fill a gap.

Conclusion

The Patient Services Manager was placed in an unenviable position, for which Southland DHB must accept corporate responsibility. In the difficult circumstances she faced, she generally met the standard expected of a manager of a mental health service. [53] However, in my opinion, some aspects of her management of staffing resources did not meet that standard. Accordingly, the Patient Services Manager breached Right 4(2) of the Code.

Team Leader

Introduction

The Team Leader had overall responsibility for the management and leadership of the inpatient mental health unit, both operationally and clinically. She had primary responsibility for clinical aspects of the team and she was responsible for ensuring that policies and procedures were established and implemented, including ensuring that individual treatment and discharge plans were developed in consultation with patients, family/whanau and caregivers. She was also responsible for the budget. The nursing staff, recreation co-ordinator, social worker and occupational therapist reported to the Team Leader. The medical staff did not. The Team Leader's position was .75 (30 hours per week).

My advisors noted that generally the Team Leader ran a cohesive team with a high degree of loyalty and commitment to the work, and that her management of the ward seems to have resulted in a relatively stable nursing workforce in the face of national mental health staff shortages. They also noted the difficulties of fulfilling the Team Leader's role in 30 hours per week.

However, aspects of the Team Leader's leadership were identified by my advisors as being of concern. In my opinion, the Team Leader did not meet the standard expected of a team leader of an inpatient mental health service (even in a .75 position) in the areas highlighted below.

Allocation of primary nurses

Primary nursing was in place in Ward 12 when Mr Burton was a patient. The Team Leader could not point to one policy document that set out the role of the primary nurse, but referred to several policies that set out the responsibilities of the primary nurse. She told my advisors that a key responsibility of the primary nurse was to oversee and co-ordinate the care of an individual patient.

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[53] Although the matter is not within the specific terms of my investigation, I consider that it was a departure from the standard expected of the person with overall responsibility for managing the service (ie, the Patient Services Manager) not to follow up formally with the Clinical Director what had occurred at the clinical review of Mr Burton's care, and to ensure that the terms of reference for the external review would allow for comprehensive investigation of all issues, including any issues not addressed adequately at the review. This issue is discussed under 'Corporate Responsibility' later in this report.

My advisors were given no evidence of a consistent method of allocating a primary nurse. Nor was there a reliable, enduring record kept of who the primary nurse was, although the Team Leader advised that it should have been recorded in the clinical records. The Team Leader said that the primary nurse would often be the nurse who had been involved in admitting the patient, or at the next handover there would be discussion about who would be appropriate to take this role. The Team Leader said that staff tended to be allocated according to interest and who was working at the time, and she would sometimes steer the process.

Although primary nursing was officially in place in Ward 12, the Team Leader was aware at the time that primary nursing "wasn't working like a primary nurse system should do" largely because of a system of self-rostering which was in place when she became acting team leader. She said that this meant that continuity of care was difficult in a ward where nurses had to provide 24-hour coverage, and other staffing issues such as sick leave, annual leave and study leave had to be taken into account.

In her response to my provisional opinion, the Team Leader stated that primary nursing as described by my advisors was an ideal, something to strive for, and reinforced the point that the primary nursing system was not working in the manner described in the DHB policies. The Team Leader stated that that was "unrealistic and unattainable at the time". The Team Leader reiterated that primary nursing responsibilities in the inpatient mental health unit at the time were "shared between the primary nurse, the associate nurse and whoever was allocated to the patient Monday to Friday. This was the system I inherited when I became Acting Team Leader."

The Team Leader informed me:

> "The culture of the unit at the time was that it was not one nurse's responsibility to do things that a primary nurse should, in your advisors' view, undertake. It was a shared responsibility. The system in place at the time did provide for continuity and co-ordination of patient care for a large number of patients."

The Team Leader outlined her attempts to try to improve the primary nursing system. She noted that the matter had been discussed with staff and a meeting on the issue was held prior to Mr Burton's admission. At the meeting the processes were reviewed and there was discussion about how nurses could provide some continuity of care given that the primary nurse was not always rostered to a patient during the day and, even if they were, they were not always able to care for that patient because of other competing demands on their time. The Team Leader noted that since that meeting – and subsequent to Mr Burton's discharge – changes have been implemented so that two or three nurses are identified as a patient's primary nurse.

The Team Leader explained that at the time Mr Burton was a patient the ward was busy and there were building alterations being undertaken, which made it disruptive for staff. There were also some new staff and some fairly inexperienced nurses having to take responsibility for senior positions. The Team Leader noted that associate nurses were allocated for the purpose of continuity of care and that Enrolled Nurse A provided continuity of care for Mr Burton.

I accept that the deficiencies in the primary nursing system were being followed up by the Team Leader, and that she was taking steps to address the need for a system that allowed

for continuity of care for patients. While recognition needs to be given to the Team Leader for her efforts to improve the nursing system, an equally critical part of her role as team leader was to ensure that current patients received appropriate nursing care while she consulted with nursing staff about changes to the system. In the interim, it was important that measures were put in place to ensure co-ordination of care and a satisfactory system for allocation of an appropriate primary (registered) nurse.

As discussed earlier, no one can identify who was Mr Burton's primary nurse for some of the time he was in hospital. The Team Leader said it was possible, although it would not be usual, that Enrolled Nurse A, officially Mr Burton's associate nurse, was his de facto primary nurse.

In Mr Burton's case, nobody took overall responsibility for co-ordination and continuity of his care. This resulted in incomplete assessment and treatment planning and poor implementation and review of plans. Aspects of Mr Burton's care were not followed up, and his family and other health professionals were not involved in treatment and discharge planning.

The Team Leader responded:

> "I did not know at the time who was co-ordinating [Mr] Burton's care as the ward was very busy and I did not read his notes. … However, I did assume that his care was being co-ordinated because he seemed to be making progress. This is what I heard from the weekly review meetings and the Monday meetings."

The steps the Team Leader was taking to improve the primary nursing system came too late for Mr Burton. In my opinion, the Team Leader failed to exert sufficient leadership to ensure that primary nurses took overall responsibility for the co-ordination of patients' care. In Mr Burton's case, this led to decisions being made without comprehensive nursing assessment and planning and with no one checking that important processes had been undertaken.

Scope of practice of enrolled nurses

The Team Leader agreed that it was possible that Enrolled Nurse A was working as Mr Burton's de facto primary nurse, even though that was not permitted by Southland DHB's Scope of Practice of Enrolled Nurses policy.

Enrolled Nurse A had over 20 years' experience in the inpatient mental health unit. Comments from Staff Nurse A and other staff suggest that there may have been a lack of understanding, in practice, about the limitations of the enrolled nurse's role. For example, once Staff Nurse A became primary nurse she left Enrolled Nurse A with discharge documentation and expected Enrolled Nurse A to approach her about the care of Mr Burton "if there were any problems".

The Team Leader was responsible for ensuring that patient care was adequately covered, that registered nurses exercised sufficient judgement regarding the degree of direction and supervision of enrolled nurses, and that Southland DHB's Scope of Practice of Enrolled Nurses policy and the Nurses Act were complied with in relation to the limitations of the enrolled nurse's role.

My advisors considered that the Team Leader did not provide sufficient direction to ensure that Enrolled Nurse A did not assume an inappropriate level of responsibility for planning, implementing and co-ordinating Mr Burton's care.

In response to my provisional opinion, the Team Leader acknowledged that she should have provided more direction to ensure that Enrolled Nurse A did not assume an inappropriate level of care. However, the Team Leader detailed a number of mitigating factors. She explained that in the system operating at the time, it was unavoidable in some cases to have a senior enrolled nurse allocated to a patient as associate nurse. As the MOSS had not indicated that Mr Burton was a high-risk patient, the Team Leader considered it appropriate for Enrolled Nurse A to fill the associate nurse role. The Team Leader noted that senior enrolled nurses have traditionally held significant roles in the team. As with the issue of primary nursing, the Team Leader recognised the need for change so that enrolled nurses were not placed in a de facto registered nurse role, but felt that she had to "tread very carefully" in implementing effective change to ensure that staff were appropriately consulted.

The Team Leader also stated that she believed Enrolled Nurse A was aware of the limitations of her practice and was sufficiently experienced to seek guidance where necessary. The Team Leader also noted that the red dot nurse would have been supervising Enrolled Nurse A.

I accept that the Team Leader faced challenges in changing the existing system, and that to a certain extent it was inevitable that there would be some reliance on the experience of senior enrolled nurses such as Enrolled Nurse A. I also accept that Enrolled Nurse A was supervised in a general sense, in that there was always a registered nurse on duty. Nevertheless, the Team Leader had recognised the problems with the primary nursing system, and was aware that in some cases associate nurses were assuming a de facto primary nurse role. In these circumstances, I consider that she should have taken steps to ensure that Enrolled Nurse A did not assume an inappropriate level of responsibility for planning, implementing and co-ordinating Mr Burton's care.

Nursing care plans

Standard III of the Australian and New Zealand College of Mental Health Nurses *Standards for Practice for Mental Health Nursing in New Zealand* requires that the mental health nurse provides nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan. The Team Leader's position description specifies that she was responsible for ensuring that individual treatment plans were developed in consultation with patients, family/whanau and caregivers.

Nursing care planning for Mr Burton was restricted to a computer-based plan that the Team Leader said was used throughout the hospital but was not useful for care planning in the mental health setting. She said that the plans were "not exactly ideal" and that it was difficult to get staff to use them and "they were working toward" changing the plans.

The Team Leader also advised that the inadequacy of the plans had been highlighted by an investigation following the death of a patient late in 2000. As a consequence, a project was under way at the time Mr Burton was an inpatient to "format new nursing care plans". Although the project was not completed while Mr Burton was a patient, the Team Leader

had been "addressing the issue since the previous investigation's recommendations and was encouraging staff to involve patients in care planning".

Nurses interviewed by my advisors appeared to consider the nursing care plan largely irrelevant. Mr Burton's care plan was drawn up by an enrolled nurse (Enrolled Nurse A) and was not checked, updated or amended during Mr Burton's time in hospital.

Clearly the Team Leader was addressing the need for improved nursing care plans. I commend her for this and acknowledge that change takes time. However, for the entire period that Mr Burton was an inpatient in 2001, he did not have a nursing care plan checked, updated or amended by a registered nurse. In a situation where the Team Leader was on notice that the existing care plans were inadequate and therefore posed a risk, her "encouragement" to staff was an inadequate response to ensure appropriate nursing care planning in the interim. For Mr Burton, this meant that there was no nursing care planned by a registered nurse.

Clinical risk assessment

The Team Leader accepted that nurses were not likely to formally assess risk and that they would have difficulty with formulation. The Team Leader told my advisors that risk assessment is the responsibility of the doctor. Her response to my provisional opinion indicates that she was referring to full assessment of mental state and risk on admission. However, Southland DHB's Clinical Risk Assessment and Management procedure states that the risk assessment form is completed on admission by the doctor and nurse. The Team Leader said that the nurse who is present at admission "will maybe" participate and that if nurses have background knowledge of the patient then they will contribute. There was no indication from the Team Leader that she would expect the nurse actively to solicit new information or clarification as part of a comprehensive assessment, including assessment of risk.

The Team Leader also noted that risk is part of someone's mental state and that nurses on the mental health unit do look at risk as part of mental state, but may have trouble formulating or verbalising the risk. She expressed concern that nurses have seen risk as "coming out as a separate form", instead of being seen as part of mental status. She said that she would expect nurses to assess mental status routinely. The Team Leader noted that failure by nurses to document mental state examinations was a difficulty "we're trying to work on, getting people to see it's important".

My advisors considered that, notwithstanding her reasonable comment that assessment of risk is part of assessing someone's mental state, the Team Leader did not provide the necessary standard of leadership to the nursing staff and perpetuated an expectation that risk assessment was solely a medical responsibility, rather than a joint responsibility.

In response to my provisional opinion, the Team Leader emphasised her view that risk assessment is primarily the medical clinician's responsibility:

> "I consider that it is the medical clinician's responsibility to carefully take historical information and carefully discern precipitating circumstances that could lead to harm and then estimate if and what type of harm is possible. … In [Mr] Burton's case the nurses were not alerted to the possibility that [Mr] Burton was at risk of harm to others. …

> It is the risk management role that involves nursing staff and this involves assessing whether or when a risk already identified will occur. In [Mr Burton's] case there was a risk identified by his father but not identified as significant by his treating medical clinicians, even after the letter was received. Nursing staff should be guided by the doctor as to the type of risk that could eventuate so as to be on the look-out for it. Once identified I fully expected that this type of risk assessment was a nursing responsibility and I did expect nurses would document it."

My nursing advisor considered that the Team Leader demonstrated an under-appreciation of the need for nursing staff to be actively involved in the process of risk assessment, rather than simply following the doctor's lead. The Team Leader's response, in my advisor's opinion, indicated that she expected a passive role of the nurses.

My advisor noted that it is the registered nurse's responsibility to be appraised of the client's history and current health status, and to assess both immediate and potential risk. For registered nurses to narrow their area of assessment to that indicated by a doctor is at odds with Standard VI of the Australian and New Zealand College of Mental Health Nurses *Standards of Practice for Mental Health Nursing in New Zealand*, which require that "the Mental Health Nurse is a health professional who demonstrates the qualities of identity, independence, authority and partnership". While there should not be an undue focus solely on risk assessment and risk management to the detriment of other aspects of nursing care, risk assessment should form part of a comprehensive nursing assessment.

Conclusion

I accept that the Team Leader carried a heavy load in a part-time position and that at the time Mr Burton was a patient she had recognised many of the areas identified by my advisors as being of concern. She had inherited a system with a number of flaws which she had begun to address in what was, inevitably, going to be a slow process. The Team Leader emphasised the importance of changes being made only following appropriate consultation with staff, explaining that she "wanted staff to buy into the changes" rather than imposing change on them. There is force in her submission that she was taking steps to address areas of concern and that consultation and "buy in" from staff was important for long-term success.

The fact remains that there were gaps in policies and procedures, and in the implementation of existing policies and procedures, which Mr Burton slipped through. Even taking into account her significant responsibilities and time constraints, and the commendable efforts she made, the Team Leader has not demonstrated that she took reasonable actions to ensure that Mr Burton received care of an appropriate standard.

I have formed the view that, in all the circumstances, the Team Leader did not meet the standard expected of a team leader of an inpatient mental health service (even in a .75 position), and therefore breached Right 4(2) of the Code.

Finally, I note that in her response to my provisional opinion, the Team Leader advised that there has been a great deal of reflection and looking at the way things could have been done better in relation to Mr Burton's care, and that she has "encouraged people and supported people to look and reflect on their practice and to make changes and to fill gaps". She has also reflected greatly on her own clinical practice and style of management and continues to work on ways of improving herself. She commented that the whole focus

of the staff has been "to try to develop systems to enhance performance and to learn from this tragedy".

CORPORATE RESPONSIBILITY

Southland DHB

Introduction

Southland DHB was subject to a legal duty to provide mental health services at the level of care and skill reasonably expected of a District Health Board. The evidence, and my expert advice, indicates that in numerous respects, Southland DHB fell well short of its corporate responsibility as a provider of publicly funded mental health services.

Gaps between policy and practice

My advisors considered that the standards for the mental health service set out in Southland DHB's position descriptions and in policy and procedure documentation were reasonably sound. However, some staff were not aware of the content of their position descriptions and had little awareness of the existence and content of policy and procedure requirements. A number of policies and procedures were not satisfactorily implemented. There was a substantial gap between the policies and procedures and their actual implementation.

A widespread failure to follow policies and procedures contributed to and facilitated mistakes by individual clinicians. My advisors considered that the Team Leader and the Clinical Director did not exert sufficient leadership to ensure that policies and procedures were followed, and that the Patient Services Manager did not have sufficiently good systems in place to monitor the quality of clinical practice.

These shortcomings were symptomatic of an endemic lack of monitoring and control mechanisms in Southland DHB's mental health service, which allowed gaps between policy and practice to continue unchecked. The gaps were especially evident in the areas identified below.

Clinical records

Standard 7 of the *National Mental Health Standards* (Ministry of Health, 1997) sets out criteria for consumer records and documentation. Southland DHB's Consumer Record and Documentation policy required co-ordinated, accurate records for all mental health consumers.

The MOSS's failure to keep adequate records is discussed earlier in this report. However, many of the other staff involved in Mr Burton's care did not meet the criteria of comprehensiveness established by Standard 7 of the Consumer Record and Documentation policy.

Of particular concern to my advisors was the frequent use of the term "settled" to describe Mr Burton's mental state. As noted by my advisors, the term is relatively meaningless: "It conveys a sense that there were no behavioural problems observed, but gives no idea as to whether clinical phenomena such as delusions, hallucinations, or even negative symptoms

of schizophrenia (such as anergia, amotivation, withdrawal) or of mood disorder were evident, or sought after and unable to be assessed. These details are the essential criteria against which clinical progress can be measured …"

My advisors considered that, in general, documentation of Mr Burton's symptoms was so inadequate that an observer uninvolved in his care would not be able to determine accurately whether Mr Burton was really ill in any way, or what progress he had made.[54]

In February/March 2001 Southland DHB was operating an integrated clinical notes system that had been in place for at least two and a half years. The Integrated Notes Policy required that all clinical records for a patient be kept together to promote continuity of care throughout the mental health service. The Integrated Notes Policy also required that each member of the multi-disciplinary team document patient care, variances, progress and treatment in the integrated record using the Clinical Notes page.

There were, however, some notable omissions in Mr Burton's clinical records. Needs assessors kept their records, including records of contacts with other people such as family members, separately in the social work department until the needs assessment was completed. Copies of incident forms were not kept in the clinical records. This meant that important information was not in the clinical records.

The Mental Health Needs Assessor, Recreation Co-ordinator and the Alcohol and Drug Services Counsellor involved in Mr Burton's care did not expect to make any entries of their assessment or intervention with Mr Burton in the daily clinical record. It appears to have been left to nurses to record such events. The result was that important information was not recorded (for example, the fact that Mr Burton's drug and alcohol assessment had occurred, and that during his needs assessment he described psychotic experiences) or was recorded incorrectly (for example, that the needs assessment had been completed).

Use of standardised forms

My advisors noted that Southland DHB had a variety of standardised documents available that represented reasonable approaches to developing a structured and consistent clinical record. However, many of the documents were not completed adequately for Mr Burton. For example, the MOSS did not complete the Assessment of Risk Form or the Initial Assessment Form as required by the Clinical Risk Assessment and Management Procedure and the Admission Procedure. The weekly review forms were not completed adequately. The Discharge Plan was not completed as required by the Discharge Policy.

Incident reporting

At the time Mr Burton was in hospital, Southland DHB had a Mental Health Services Incident Reporting and Management Policy (July 2000) and a Mental Health Services Incident Reporting and Management Procedure (September 2000).

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[54] In response to my provisional opinion, the Team Leader noted that the people who were reading Mr Burton's clinical records at the time were people involved in his care, and that nurses only documented changes. She submitted: "It was also clear from the nursing notes that when there were symptoms displayed by Mr Burton, these were documented." Yet the evidence suggests that Mr Burton sometimes displayed symptoms that were not documented by nursing staff, and while some nurses were clearly documenting symptoms when they occurred, others gave very little information on mental state, leaving the reader unable to tell whether symptoms had been assessed. Not everyone who read Mr Burton's clinical records at the time would have been familiar with him. Over the period he was in hospital, 20 different nurses cared for him on morning and afternoon shifts – eight of them for one shift only.

The Incident Reporting and Management Policy states that the primary intent of incident management is the improvement of systems and processes within the mental health service resulting in a safer environment for patients, employees and others.

My advisors were concerned that on at least two occasions while Mr Burton was in hospital, and possibly one other, an incident form was not completed by nursing staff when it should have been (for example, on 1 March the clinical notes record that Mr Burton hit another patient but an incident form was not completed).

The Incident Reporting and Management Procedure set out guidelines for incident investigation for the purpose of ensuring that appropriate action is taken to minimise or eliminate the risk of the incident recurring in the future. However, where incident forms were completed in relation to Mr Burton, there is little evidence that the incidents were investigated to any degree.

There is no evidence that any of the incidents were discussed at weekly review meetings, nor that any of the incidents, whether documented in the clinical notes or on an incident form, resulted in changes in treatment.

Incidents that impacted, or had the potential to impact, on Mr Burton's safety and the quality of his care, were not reported or adequately followed up. This meant that attention was not given to factors contributing to the incidents or how future events might be prevented.

There appeared to be lack of clarity and "buy in" by nurses about when an incident form should be completed. The standard set by the Southland DHB policy for reporting an incident was not met on at least two occasions. Nor was the procedure for investigation followed.

Clinical risk assessment

The *Guidelines for Clinical Risk Assessment and Management in Mental Health Services* (Ministry of Health in Partnership with the Health Funding Authority, 1998) (the Guidelines) note that it is the responsibility of every mental health service to ensure appropriate strategies, protocols, teaching programmes and audit tools are developed and used.

As noted in the Guidelines, the most important way to minimise risk is good clinical management. Good clinical management should be underpinned by comprehensive assessment, including assessment of risk. Risk assessment is not a "one-off" event, and should be part of every clinical observation.

My advisors considered that Southland DHB's risk assessment policy was reasonably consistent with the Guidelines, but that practical operation of the policy was not consistent with the policy itself, or the Guidelines. The MOSS, many nursing staff, and Social Worker A did not meet the standard of the policy in their assessment of Mr Burton.

The MOSS said that he"did not see risk assessment as being a 'one-off' event, but that it should be monitored in each interaction with a patient".

Nursing staff distanced themselves from responsibility by saying that they were unable to assess risk because they had not received training. This is somewhat at odds with evidence

from the Director of Nursing and Midwifery at the inquest, which suggests that some training at least had been made available. The Team Leader's view of the limited role of nurses in clinical risk assessment has been discussed above.

Social Worker A said that as he was not psychiatrically trained he relied on other staff. The Alcohol and Drug Services Counsellor and the Mental Health Needs Assessor said they did not undertake risk assessment. Southland DHB appears to have had very little organisational expectation that social workers, drug and alcohol services counsellors, or needs assessors needed to contribute to risk assessment of mental health clients.

Many staff held the view that risk assessment is something special, to be undertaken by particular staff. The Clinical Director's view, which my advisors considered appropriate, is that risk assessment is part of every assessment, rather than something special and distinct.

In its response to my provisional opinion, Southland DHB commented as follows:

> "There appears to have been a huge misunderstanding in relation to risk assessments. All of Southland DHB's staff have indicated to [the CEO] that they do as a matter of practice undertake risk assessments on a daily basis. They thought that the Investigation Team, when asking staff whether they undertook risk assessments, were asking whether they did something in the nature of a formal clinical risk assessment (including filling out the necessary forms) and answered accordingly. Therefore we submit that it is unfair and incorrect to make adverse findings against our staff on this issue."

I agree that there was confusion on the part of Southland DHB staff about risk assessment, the purpose of the risk assessment form, and how it should be completed. However, I do not accept that they were confused by their interviews. Having reviewed the evidence, it is clear that some staff seemed not to understand that risk assessment should be part of every clinical assessment, and did think that risk assessment was something special.

There appears to have been no sustained attempt to address the commonly held misunderstanding that risk assessment is something special, or to clarify the standards expected of staff. The training offered appears to have been inadequate, notwithstanding the requirement in Criteria 12.11 of Standard 12 of the *National Mental Health Standards*, which provides that "the mental health service regularly identifies education/training and development needs of its staff and ensures that the necessary skill mix is evident to deliver on the core functions of the service".

There is no evidence that skill development in clinical risk assessment was systematically addressed at Southland DHB's inpatient mental health service under the leadership of the Clinical Director, the Patient Services Manager and the Team Leader.

I find it remarkable that at the time Mr Burton was in hospital, staff thought so little about the concept of risk assessment that they considered the risk alert sheet related solely to "risk of harm to others on the ward and in that environment". This was despite the fact that Mr Burton was a voluntary patient and, as staff were quick to point out to my investigation team, was able to come and go from the ward freely. Notwithstanding Mr Trevor Burton's clear and compelling letter, nobody turned their mind to the fact that if Mr Burton left the ward the possible risk to his family would be increased. There is little, if any, evidence that further assessments were undertaken, even after events while he was an inpatient that ought

to have triggered a thorough review. Nor was Mr Burton's risk further assessed once he had access to a vehicle, before he went on trial leave or before he was discharged.

Weekly team reviews

The weekly team reviews were the only opportunity for medical staff to review the practice of colleagues and to offer support and guidance. They were also an opportunity for the multi-disciplinary team to meet and, as required by the Quality Care and Treatment Policy and the Discharge Policy, review individual patients' treatment plans and progress towards discharge planning. However, the documentation from the reviews undertaken in relation to Mr Burton suggests that significant information was not discussed. For example, attention does not appear to have been given to Mr Burton's persisting psychotic symptoms, to untoward incidents that occurred during his inpatient care, or to possible use of the Mental Health (Compulsory Assessment and Treatment) Act. Documentation of outcomes of the review was scanty and of limited use.

The Team Leader attended all the review meetings where Mr Burton was discussed. The Clinical Director attended two of the five meetings. There is no evidence that the Clinical Director or the Team Leader established and implemented clear expectations about the standard of presentation required, or the standard of documentation of outcomes required. My advisors also considered that it was a failure of clinical leadership that the Clinical Director did not issue a clear directive that senior medical staff should attend the review meetings.

Clinical Director role

Clinical leaders have clinical leadership and management responsibilities. Clinicians taking up such responsibilities require training and development and time to recognise and respond to problems in their area of responsibility.[55] Yet there was no reduction in the Clinical Director's clinical workload when he was appointed as Clinical Director.

The accountabilities in the Clinical Director's position description are significant and demanding. However, the General Manager of Hospital Services at Southland DHB said that there was no formal guidance or direction given to the Clinical Director about how to manage, or what his priorities as Clinical Director should be. The General Manager said that, in a service that is short of psychiatrists, prioritisation is necessary to ensure that clinical need is met. He acknowledged that "some of the clinical leadership role in terms of governance, and workforce planning and some other clinical interrelationship, communication issues and rules take a back bench and are only managed when they can be managed".

While Mr Burton was a patient, Southland DHB's inpatient mental health service suffered from a lack of clinical leadership by the Clinical Director. My advisors were provided with no information to suggest that the Clinical Director had been given any assistance to acquire the necessary leadership or managerial skills or to manage his competing demands so that he could provide effective clinical leadership. Nor was information provided to demonstrate that proactive steps had been taken by Southland DHB to manage the risk presented by having a Clinical Director who juggled a number of responsibilities, including filling clinical gaps, or that this risk had been drawn to the attention of the Health Funding

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[55] See footnote 46 and *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol* (2001), pp 197-198.

Authority. In fact, there appeared to be an acceptance by Southland DHB that clinical leadership had to take a back seat.

Southland DHB appointed the Clinical Director into that role on top of his other responsibilities in an area that was short of specialists. In my opinion, it was inevitable that without considerable support the Clinical Director would not be able to provide effective clinical leadership and discharge his responsibilities. Sadly, this proved to be the case while Mr Burton was a patient.

Management and leadership

Inevitably, the Clinical Director's lack of time had consequences, not only for his own performance, but also for the effective functioning of the Mental Health Directorate. The Patient Services Manager wanted to work in partnership with the Clinical Director, and initially said that she felt she did. On reflection, she amended her assessment of the relationship to one of "co-operative endeavour". The evidence shows that the Patient Services Manager and the Clinical Director did not always work together effectively, which is hardly surprising, given the constraints on the Clinical Director.

A successful partnership requires a willingness to build a partnership on both sides based on common goals, and a commitment to clinical and financial accountability and to better health outcomes for patients. Developing a partnership between clinical leaders and management is a key factor in building a quality culture within the New Zealand health system.[56]

My advisors were concerned that in practice they saw little evidence of the mental health services operating as a partnership. For example, the Patient Services Manager considered that the Clinical Director had an important role in the monitoring of standards. The Clinical Director did not share this view. The Patient Services Manager and the Clinical Director identified different training priorities for the service. There was no evidence to suggest they had discussed training issues.[57]

The evidence is that, at least in some matters important for the management of the service, the Patient Services Manager and the Clinical Director did not have common goals. Rather, it appears that they developed a modus operandi which the Patient Services Manager believed kept the service "on track" while allowing the Clinical Director to get on with his clinical responsibilities.

My advisors identified the differing responses of the Patient Services Manager and the Clinical Director, about whether an internal clinical review occurred after Mrs Paddy Burton died, as a serious indication of their lack of partnership. The Patient Services Manager said that following an incident there is generally a process of debriefing, followed within a few days by a clinical review, generally led by the Clinical Director. For the most serious incidents involving suicide or serious harm, an external review is also commenced.

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[56] Malcolm L, Wright L, "Important Progress in Building a Quality Culture in our Health System", *Health and Hospital*, March-April 2002, pp 12-13.

[57] In its response to my provisional opinion, Southland DHB submitted that it was a generalisation for my advisors to suggest that "a disagreement between [the Clinical Director] and [the Patient Services Manager] with regard to a matter of training" was evidence of a lack of partnership. I do not accept this. As discussed above, this was one of several examples that suggested to my advisors that the Clinical Director and the Patient Services Manager were not working in a partnership – which was how the Patient Services Manager described the relationship.

The Patient Services Manager understood that a clinical review did occur after Mrs Paddy Burton died and that is was a "difficult and somewhat defensive meeting". She did not discuss it with the Clinical Director or receive any documentation about the findings of the meeting. The Patient Services Manager preferred to seek information from someone other than the Clinical Director, "suspected" that there may have been a conflict of interest at the meeting, "understood" that a number of issues had not been addressed as one would expect, but did not raise this with the Clinical Director and "expected" that many of the issues would come to light when Dr Taumoepeau did her audit. Despite the absence of minutes, the Patient Services Manager provided no evidence that she took steps to ensure that "unaddressed issues" would be considered as part of the external audit, so that contributing factors and underlying systemic issues could be identified and addressed.

The Clinical Director told my advisors that an internal review did not occur. Southland DHB's Legal/Risk Advisor said that he had attended an internal clinical review two or three days after Mrs Paddy Burton died, at which nothing was documented. Southland DHB confirmed that what was intended to be a clinical review did take place, "but due to the stress levels of staff ended up being a team debrief which is probably why no notes were taken".

The evidence about the internal clinical review and lack of any documented outcomes or follow-up highlights the management and leadership problems that existed within the Southland DHB mental health service.

Another problem was that the two clinical leaders with responsibility for ensuring provision of clinically effective services in the inpatient mental health unit (the Team Leader and the Clinical Director) were both over-stretched: the Team Leader, because of her wide range of responsibilities and part-time position; the Clinical Director, because he held the role on top of his full-time clinical responsibilities.

My advisors also noted that there was no nursing leadership for mental health. Although the Director of Nursing and Midwifery has experience as a manager in a mental health service, she is not qualified as a mental health nurse. It appears that senior managers looked to her to ensure that nursing standards were maintained within the mental health service, even though she was not properly equipped to provide clinical leadership for mental health nurses.

The Patient Services Manager confirmed that the Director of Nursing and Midwifery had considerable input into the quality of care provided to mental health patients. The Patient Services Manager advised that she had recommended that the position of Director of Mental Nursing be established "as previous reviews had indicated the need for such a position", but that this proposal was declined.

Staffing deficits

Like other mental health services in provincial New Zealand, Southland DHB's mental health service suffered from a shortage of qualified staff. There was a chronic shortage of psychiatrists, which resulted in the MOSS in effect practising as a psychiatrist without adequate supervision. My advisors were concerned that there was little evidence that options to increase the availability of psychiatric expertise were pursued as rigorously or comprehensively as might have been expected in the circumstances. My advisors noted that there was in fact an underspend in the budget over the relevant period.

Southland DHB responded that the underspend in its mental health budget is primarily due to an inability to fill vacant positions. As a small geographically isolated centre, it has difficulty in attracting and retaining experienced and well-trained staff in a workplace where opportunities for promotion and professional development are limited. Southland DHB stated that it had made strenuous attempts to fill vacant positions.

It is clear that the shortage of psychiatrists was a matter that Southland DHB was well aware of, and properly concerned about. Its Mental Health Workforce Development Strategy Plan (June 2000) highlighted the difficulty of recruiting and retaining skilled staff, and pointed to an acute shortage of psychiatrists. The current Chief Executive Officer advised that many positions are difficult to fill – and take some time to fill as the successful appointee usually has to relocate to Invercargill – and that "vigorous" attempts had been made to attract psychiatrists.

My advisors noted that "overall, there is an impression of staff having roles beyond the skills they bring to those positions, without sufficient oversight and support, and sometimes without meeting the qualification requirements of those positions".

In addition to the MOSS, other examples included Enrolled Nurse A, who was permitted to function beyond her scope of practice; Social Worker A, who had little experience or qualification for mental health work, yet was in sole charge of monitoring Mr Burton when he remained ill in an unsupervised environment in a flat on his own; the Mental Health Needs Assessor, who was required to carry out tasks for which she needed further training and supervision; and the Alcohol and Drug Services Counsellor, who was expected to work with clients with mental illness as well as substance abuse issues, despite his lack of skill and training for such work.

Needs assessment

Standard 1.2 of the Ministry of Health *Standards for Needs Assessment for People with Disabilities* (1994) requires that the assessment service action all referrals and assessments promptly and appropriately. Standard 2.1 requires that the assessment service have written policies and procedures followed by all staff which reflect current knowledge and principles of assessment.

Southland DHB's Service Type Description for Needs Assessment and Services Co-ordination for Community Mental Health Services expressly recognises that the assessment process should meet the Ministry of Health *Standards for Needs Assessment for People with Disabilities*.

My investigation team was not provided with any information about expected time frames for actioning referrals and assessments, or written policies and procedures on assessment. Such policies would have provided important guidance for the Mental Health Needs Assessor in her dealings with Mr Burton.

Standard 5.8 of the *Standards for Needs Assessment for People with Disabilities* deals with qualifications and professional development of assessment staff. Performance indicators for the standard include ensuring that all assessment staff hold recognised and relevant qualifications in their field of assessment, ensuring that staff are encouraged to maintain and develop their professional skills in their field of assessment, and ensuring that professional development is available.

Southland DHB's Service Type Description for Needs Assessment and Services Coordination for Community Mental Health Services states that assessment services will be provided by staff with appropriate qualifications, competencies, skills and experience in meeting the support needs of people with serious mental health problems/disorders.

The Mental Health Needs Assessor had experience in working with people with mental health disabilities but did not have a relevant tertiary qualification, even though it was listed as "essential" in her job description. My advisors considered that the Mental Health Needs Assessor was hampered in her ability to provide services of an appropriate standard to Mr Burton by lack of experience and training, including lack of knowledge of mental illness, and that she required more supervision.

Southland DHB was aware, when it employed the Mental Health Needs Assessor, that she did not have a relevant tertiary qualification which was regarded as essential. In such circumstances, particular attention should have been paid to ensuring that, in accordance with Standard 5.8 of the *Standards for Needs Assessment for People with Disabilities*, she had careful supervision and training so that she could perform her job to an appropriate standard.

Alcohol and drug service

Rhanna Clinic is an alcohol and drug service that forms part of Southland DHB's mental health services. Southland DHB does not have a specialist dual diagnosis service. However, it is commonplace for people with mental illness to present with alcohol and drug abuse problems. In light of the well-established evidence that comorbid substance abuse adversely affects mental state, it is essential that mental health services are properly equipped to assess and treat clients with dual diagnoses.

Although Southland DHB had a policy that states that patients admitted to the inpatient mental health unit with dual diagnosis "are catered for by dual management with other service providers, eg Rhanna Clinic", it appears to have taken no steps to ensure that its mental health staff were properly equipped to assess and treat clients with dual diagnosis. The Alcohol and Drug Services Counsellor and other Rhanna Clinic staff were given no specific training in mental illness or dual diagnosis. Instead, alcohol and drug services staff were simply expected to undertake assessment and counselling of clients with mental illness as well as substance abuse issues, without adequate training or support.

Resource constraints

In response to my provisional opinion, Southland DHB criticised the application of "idealised" standards and submitted that financial constraints, staffing constraints and the unsuitable design of its inpatient mental health unit restricted its ability to provide "the ideal standard of service to mental health consumers". While Southland DHB always tried to provide the best possible service for its mental health consumers, it was constrained in its ability to do so by these constraints. Southland DHB concluded:

> "The effects of these constraints combined with 'idealised standards' may leave us with effectively only one choice between the two detailed below.
>
> The **first option** presented to us is to provide a service which, while at the best level we can possibly achieve, cannot meet the ideal standard you demand of us. This option leaves us vulnerable to future investigations and findings of liability.

> Our difficulties in attracting and retaining staff will be greatly magnified, increasing the detrimental effect of this constraint on our service. This is a problem that Southland DHB does not suffer alone.
>
> The **second option** facing us is a defensive one. It is to shut down our mental health service completely in order to avoid possible exposure to the risk of future investigations and findings of liability for failure to meet the ideal standard. If we are forced to take this option, the real sufferers will be mental health consumers and their families in the Southland DHB area, who will be denied a service for which there is an obvious need."

I do not accept that Southland DHB is being held to "idealised" standards. My opinion is based on an assessment of reasonable and appropriate standards (including professional standards, standards set in Southland DHB's own policies, and national standards) for a mental health service subject to the very real constraints Southland DHB experienced.[58] The question for determination is whether Southland DHB fulfilled its duty to provide a mental health service at the level of care and skill expected of a District Health Board in such circumstances.

I acknowledge that ensuring that consumers receive services of an appropriate standard when faced with the sort of constraints experienced by Southland DHB – although not unique to Southland – presents significant challenges. However, I do not accept Southland DHB's submission that it must either close its mental health service or provide a service that is not of an appropriate standard.

Conclusion

The overall impression of Southland DHB's inpatient mental health service, at the time Mr Burton was a patient, is of a service marked by a sense of complacency; a pattern of sloppy care that was lax and laissez-faire. There were so many organisational shortcomings that quality of care for mental health patients was inevitably compromised. The risk of adverse events was not managed effectively.

In relation to each of the specific terms of reference, practice was substandard. Contact and co-ordination with Mr Burton's family was patchy and inadequate; much of the time the family was left in the dark about what was going on. Discharge planning was scanty, ineffective and poorly co-ordinated; it is not hard to see why Mr Trevor Burton felt that his son was "essentially kicked out into a flat to look after himself". The discharge itself was dubious. The inpatient mental health service failed to piece together the available information about Mr Burton's disturbed sleep patterns, alcohol abuse, psychotic behaviours and lack of support in Invercargill. Finally, there was a notable lack of co-ordination with the Queenstown Community Mental Health Team (which had had considerable previous contact with Mr Burton) or the Invercargill Community Health Team, whose involvement should have been pivotal to ensuring Mr Burton's successful discharge into the community.

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[58] I do not regard the design of Ward 12 as having particular relevance to the care Mr Burton received. Although the design of Ward 12 made it unsuitable for close supervision – patients could easily leave the ward and the seclusion rooms were inadequate – Mr Burton did not require seclusion and, as a voluntary patient, was entitled to leave the ward.

Southland DHB must accept corporate responsibility for its failure to provide a mental health service at the level of care and skill expected of a District Health Board. In all the circumstances, Southland DHB failed to fulfil its organisational duty of care and skill, and breached Right 4(1) of the Code.

The way forward

Southland DHB has provided considerable detail about the steps it is taking to improve its mental health service. The Chief Executive Officer has advised that the mental health service "is substantially different to the operation that existed in February/March 2001" and expresses optimism that the clinical team, operating in an improved environment, is able to provide quality health care. A number of individual staff subject to my investigation have reflected on their own practice and are making changes as a result. These are heartening developments.

Southland DHB's mental health services will remain vulnerable to problems of recruitment and retention of its staff because of its size and isolation. Training and support for staff will continue to be essential. These challenges are not insurmountable, if larger DHBs and smaller DHBs become involved in regional collaboration and form alliances to improve service quality and access for consumers. Such formal alliances would allow psychiatrists and other professionals to become part of a wider peer group and provide opportunities for continuing education and collegial support, oversight and supervision.

There is scope for a regional group of DHBs to employ specific staff (for example, psychiatrists) and assume joint responsibility for their deployment. Regional co-ordination of oversight and supervision of health professionals employed by a number of different DHBs could occur. Secondment of staff to cover temporary service gaps is also a possibility.

I encourage Southland DHB and other South Island DHBs to explore these possibilities to address current (and forseeable) mental health workforce shortages, and the difficulties posed by geographical isolation.

RECOMMENDATIONS

Apologies

A number of individuals employed by Southland DHB did not provide care of an appropriate standard. They were all members of the multi-disciplinary team which should have provided Mr Burton care of an appropriate standard. In the circumstances, I recommend that letters of apology, signed by the Clinical Director, the MOSS, the Patient Services Manager, the Team Leader, Staff Nurse A, the Mental Health Needs Assessor, Social Worker A, and the Alcohol and Drug Services Counsellor be offered to Mr Trevor Burton and his family, and to Mr Burton. These letters are to be sent to my Office and will be forwarded to Mr Trevor Burton and to Mr Burton (via his psychiatrist) respectively.

In making this recommendation I am aware that some staff have already expressed their sorrow and regret to Mr Trevor Burton and his family about the death of Mrs Paddy Burton. Indeed, some may have apologised if their care of Mr Burton contributed in any

way. However, I have specifically formed the opinion that some Southland DHB staff did not provide Mr Burton with care of an appropriate standard. It is for their breaches of the Code of Health and Disability Services Consumers' Rights that I recommend the named providers apologise.

There were also breaches of the Code by Southland DHB. I recommend that Southland DHB also offer letters of apology to Mr Trevor Burton and his family, and to Mr Burton. These letters are to be sent to my Office and will be forwarded to Mr Trevor Burton and to Mr Burton (via his psychiatrist) respectively.

Review of practice

I recommend that the Clinical Director, the MOSS, the Patient Services Manager, the Team Leader, Staff Nurse A, the Mental Health Needs Assessor, Social Worker A, and the Alcohol and Drug Services Counsellor review their practice in light of this report.

Competence reviews

I note that the Medical Council of New Zealand has undertaken a review of the MOSS's competence to practise medicine and placed a condition on his registration as a result of the outcome of the review.

I recommend that the Medical Council of New Zealand review the Clinical Director's competence in light of the areas of deficit in his practice identified in this report.

Southland District Health Board

I recommend that Southland DHB take the following actions:

Clinical Director

1. Ensure supervision and audit of the Clinical Director's practice, with particular attention to standards of practice and training needs in relation to:
   - capacity to critically appraise and monitor systems of care, and to develop practice improvement strategies
   - *National Mental Health Standards.*

2. Develop clear performance criteria for the Clinical Director's practice, with particular attention to implementation of standards, policies and procedures and development of an effective partnership with the Patient Services Manager.

Medical Officer Special Scale

3. In the event that the MOSS returns to work for Southland DHB, ensure supervision and audit of the MOSS's practice by a vocationally registered psychiatrist, with particular attention to standards of practice and training needs in relation to:
   - comprehensive assessment and treatment planning, implementation and review
   - assertiveness of follow-through of plans
   - documentation
   - comprehensive assessment of risk and development of risk management plan
   - family and carer participation
   - comorbid substance abuse and mental illness.

Patient Services Manager[59]

4. Ensure supervision and audit of the Patient Services Manager's practice, with particular attention to standards of practice and training needs in relation to:
   - capacity to critically appraise and monitor systems of care, and to develop practice improvement strategies
   - *National Mental Health Standards*.

5. Develop clear performance criteria for the Patient Services Manager's practice, with particular attention to implementation of standards, policies and procedures and development of an effective partnership with the Clinical Director.

Team Leader

6. Develop clear performance criteria for the Team Leader's practice in light of any revisions to her position description, with particular attention to implementation of standards, policies and procedures.

Staff Nurse A

7. Review the competence of the incumbent against the standards of the Australian and New Zealand College of Mental Health Nurses and the Nursing Council of New Zealand Code of Conduct.

8. Ensure supervision and audit of Staff Nurse A's practice, with particular attention to standards of practice and training needs in relation to:
   - comprehensive assessment and care planning
   - comprehensive assessment of risk and development of risk management plans
   - co-ordination of care
   - family and carer participation
   - capacity to critically appraise and reflect upon her own practice.

9. Develop and implement a professional development plan for Staff Nurse A, with a clear time frame for review of progress.

Mental Health Needs Assessor

10. Review the qualifications, skills and experience of the incumbent in light of any revisions to her position description.

11. Ensure supervision for the Mental Health Needs Assessor with particular attention to:
    - timeliness and completion of assessment and service co-ordination processes
    - full gathering of information, including old records
    - professional development
    - adequate communication with clinical staff.

12. Develop and implement a professional development plan for the Mental Health Needs Assessor, with a clear time frame for review of progress.

[59] I note that the incumbent in this position was not the Patient Services Manager at the time of the events under investigation. However, the recommendations apply to the position rather than to its current holder.

Social Worker A

13. Ensure arrangements are made for assessment of the competence of the incumbent in accordance with the requirements for full membership of the Aotearoa New Zealand Association of Social Workers.

14. Ensure supervision and audit of Social Worker A's practice, with particular attention to standards of practice and training needs in relation to:
    – assessment and treatment of mental disorders
    – assessment of risk and development of risk management plans, in accordance with the role of the social worker
    – family and carer participation
    – substance abuse in mental illness.

15. Specify, in writing, arrangements for clinical and peer supervision for Social Worker A.

16. Develop and implement a professional development plan for Social Worker A, with a clear time frame for review of progress.

Alcohol and Drug Services Counsellor

17. Review the qualifications, skills and experience of the incumbent in light of any revisions to his position description.

18. Ensure supervision for the Alcohol and Drug Services Counsellor, with particular attention to:
    – professional development to assist with familiarisation with aspects of disorders of mental health
    – formulation of expert opinion and provision of advice to clinical staff of the mental health service
    – assessment and management of risk
    – process of communication and co-ordination between the drug and alcohol service and clinical mental health staff.

19. Develop and implement a professional development plan for the Alcohol and Drug Services Counsellor, with a clear time frame for review of progress.

Mental Health Service Development

20. Develop internal audit and monitoring processes to audit compliance with policies and procedure documents, with immediate attention to consumer assessment, consumer record and documentation, incident reporting, risk assessment and management, quality care and treatment, discharge, supervision, and family and carer participation.

21. Review policy and procedure implementation mechanisms to ensure adequate attention to these documents in orientation of new staff.

22. Assess training needs across the service in relation to recovery competencies, comorbid mental illness and substance abuse, family and carer participation, comprehensive assessment and treatment planning, risk assessment and management, and the *National Mental Health Standards*.

23. Develop a culture of critical appraisal and reflection by all inpatient (Ward 12) staff and by senior medical staff. Initial priorities should be to review impact of changes in inpatient team weekly review processes (attendance and active participation of all senior medical staff, presentation of cases, documentation of outcomes, communication of decisions) to ensure desired effects of system changes are achieved.

24. Develop a mental health service quality improvement strategy in response to *National Mental Health Standards*, and monitor progress against the strategy.

25. Review, confirm and demonstrate its commitment to development of nursing standards for mental health nursing.

26. Identify specific areas of skill for acute inpatient nurses (for example, nursing and risk assessment, presentation skills and goal-directed therapeutic engagement), and develop, implement and monitor performance measures/indicators for mental health nursing standards of practice.

27. Develop a mental health nursing structure across the DHB to provide professional support for nurses, formal links with education providers, the setting of standards, and a process for provision of advice to management on mental health nursing issues.

28. Develop a comprehensive mental health nursing clinical career pathway.

29. Develop a model of nursing that allows for a "named nurse", co-ordination by experienced, skilled nurses, and proficient nursing input into multi-disciplinary review.

30. Undertake a training needs analysis of skills for mental health nurses based on their active contribution to patient outcomes.

31. Review the employment of enrolled nurses in the acute psychiatric setting, including consideration of whether there is a place for enrolled nurses and, if so, ensure implementation and audit of policy with regard to scope of practice.

32. Ensure sufficient supervision and staffing support so that the practice of enrolled nurses remains within enrolled nursing scope of practice.

33. Develop strategies for increased input of senior medical staff to the service, including clear action plan for recruitment, increased use of teleconferencing, and relationships with other centres.

34. Develop clear criteria for supervision of MOSS staff, including, as a minimum, attention to new cases, cases of concern, and use of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

35. Ensure that appropriate oversight is in place for doctors with general registration working in the mental health service.

36. Ensure clear criteria and process for review of performance of medical staff, including use of external reviewers, and for attention to performance problems.

37. Ensure the weekly ward review becomes a priority for senior medical staff attendance. In circumstances of limited psychiatrist presence within the service, develop teleconferencing links with other centres to ensure psychiatrist participation.

38. Review the position description and the necessary skills and qualifications for:
    - the Clinical Director's role and job size, with reference to the need for clear clinical leadership and for monitoring and developing clinical standards of practice
    - the Inpatient Team Leader role and job size, with reference to the need for clear clinical leadership and for monitoring and developing nursing standards of practice
    - the Needs Assessor and Service Co-ordinator role
    - the role of drug and alcohol counsellors
    - the role of inpatient service social workers.

39. Review position descriptions and person specifications to ensure skills and experience for roles are clearly identified.

40. Review developmental needs of current staff to address skill gaps, where review shows skills required are not already present.

41. Develop policies and procedures to ensure effective involvement of services such as Needs Assessment and Service Coordination, and drug and alcohol services, into the routine activities of the inpatient team to ensure effective integration of those specialist assessments and processes into care planning and implementation.

42. Develop systems to improve processes of communication and co-ordination between Drug and Alcohol Service and clinical team.

43. Develop systems to improve processes of communication and co-ordination between Needs Assessment Service and clinical team.

44. Ensure adequate attention to substance abuse within mental health services, through development of skills of mental health staff and drug and alcohol service staff, development of appropriate documentation for use by specialist services, and approaches to intervention that are not reliant upon readiness of the consumer to cease substance misuse.

45. Develop clear criteria for clinical supervision (including for social workers working in the mental health service).

46. Develop formal alliances on a regional basis with other DHB mental health services, to improve service quality and access for consumers.

47. Continue with progress towards achieving accreditation of the mental health service by 31 December 2002, ensuring that action is taken to make any improvements that may be identified by Quality Health New Zealand as necessary to obtain accreditation.[60]

48. Obtain certification against the National Mental Health Standard under the Health and Disability Services (Safety) Act 2001, by 31 October 2003.

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[60] This process has already begun with Quality Health New Zealand.

In conjunction with other DHBs throughout the South Island Regional Mental Health Network,[61] *or by other means regionally or nationally:*

49. Review contracts for provision of and access arrangements to:
    - dual diagnosis (mental illness and substance abuse disorders) services
    - inpatient rehabilitation services
    - supported accommodation that tolerates substance abuse and that works with consumers to address substance abuse problems.

In conjunction with other DHBs throughout the South Island Regional Mental Health Network, or by other means regionally or nationally, and the Ministry of Health:

50. Review whether, with limited senior medical staff, services can safely continue to be provided solely by Southland DHB, and what core service provision is necessary and can be safely maintained within the District.

Ministry of Health

I recommend that the Ministry of Health audit the Southland DHB mental health services and report to me on progress in meeting the above recommendations, at intervals of six months and twelve months from the date of this report (ie, reports by 30 April 2003 and 31 October 2003).

REFERRAL TO DIRECTOR OF PROCEEDINGS

I am referring this matter to the Director of Proceedings pursuant to section 45(f) of the Health and Disability Commissioner Act 1994, for the purpose of deciding whether further action should be taken.

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[61] Regional Mental Health Networks represent national mental health stakeholder groups, including DHB funders and planners, DHB providers, NGOs, consumers and families.

APPENDIX I

Expert Advisors' Report

Health and Disability Commissioner's own initiative inquiry into quality of care provided to Mark Burton

Report of Review Panel
Maxine Gay
Paula Nes
Murray Patton (chairperson)
Kate Prebble
Linda Simson

March 2002

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A: SUMMARY

In October 2001 you announced to the Southland District Health Board, in a letter to the Chief Executive Officer, your intention to commence an inquiry into the quality of care provided to Mark Burton [Mr Burton] by Southern Health.[62] The focus of the investigation, as outlined in this letter, is outlined in Attachment 1 to this report. Following your decision to commence an inquiry a Review Panel was convened to provide expert assistance in this matter. Substantial written material was provided to members of the Panel. A database of this material has been maintained by staff of the office of the Health and Disability Commissioner.

A number of employees of Southland District Health Board were notified that they were under investigation. They were:

[• Mental Health Needs Assessor
- Medical Officer Special Scale
- Acting Team Leader, Inpatient Mental Health Unit (Team Leader)
- Patient Services Manager, Mental Health
- Social Worker, Inpatient Mental Health Unit (Social Worker A)
- Enrolled Nurse, Impatient Mental Health Unit (Enrolled Nurse A)
- Staff Nurse, Inpatient Mental Health Unit (Staff Nurse A)
- Clinical Director, Mental Health Services
- Alcohol and Drug Services Counsellor.]

The members of the Panel visited Invercargill and over the 3-day period December 8, 9 and 10 interviewed a number of people in relation to this investigation. The list of interviewees is attached in Attachment 2.

Two members of the Panel also met with Mr Mark Burton, in his hospital ward. Four members of the Panel met with [Mrs Paddy Burton's sister] in Auckland.

Counsel for Southland District Health Board, in his opening statement to the Coroner's inquest into the death of Mrs Paddy Burton, commented that care must be taken to avoid the trap that the tragic outcome was inevitable and that care must be taken when evaluating cause and effect.

The Panel is aware of this as an area for caution. The Panel was not asked to determine the cause of this tragedy, but to address matters in relation to the quality of care provided to Mr Mark Burton and to investigate whether any acts or omissions by Southland District Health Board or of any individual employees have breached Mr Burton's rights under the Code of Health and Disability Consumers' Rights. This report identifies findings in relation to each of these employees of Southland District Health Board then provides specific comment in relation to the matters that are the focus of the investigation. The report does not attempt to reach final conclusions in regard to a causal connection between these findings and the death of Mrs [Paddy] Burton.

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[62] Southern Health was the Hospital and Health Service providing services to the Southland region in the period of interest in the care of Mr Burton. This entity is now known as Southland District Health Board. In this report, unless otherwise specified, any references to Southland District Health Board should be read to include the entity formerly known as Southern Health.

The Panel notes however the comment made by [the General Manager] of Hospital Services of the Southland District Health Board. [The General Manager], in response to a question of what went wrong, said that in his view it was a systems failure. He commented that it was "a classic cheese effect", indicating that issues along the whole spectrum of care probably lined up to result in a tragic outcome.

In brief, the Panel agrees. There are numerous 'holes' in this 'cheese', so many and some of such proportion that it is not surprising that they lined up to create large gaps through the substance of the service. Although each deficit singularly may not have been responsible for the outcome, the substance or quality of the service appears in this case to have been so compromised that the risk of occurrence of adverse events was not managed at all effectively.

Southland District Health Board made a great deal of material available to the Panel. Much of this material identifies standards to be achieved by the service, outlined in position descriptions and in policy and procedure documentation. These documents are fairly comprehensive although some of the position descriptions do not outline the competencies or pre-requisite qualifications and experience required for the roles. Apart from that omission the documents in themselves set the scene for delivery of a reasonably sound service. The Panel was told that the service has achieved the standards required by the National Mental Health Standards, based apparently on its own assessment of progress against these standards.

In practice, however, the Panel finds that in relation to many of the staff interviewed there is a substantial gap between the policies and procedures and their actual implementation. The Panel found evidence that some staff were not aware of the contents of their position descriptions and had little awareness of the existence or content of policy and procedure statements. Some staff appeared aware of their roles and the standards required of them, whether set out in Southland DHB documents or elsewhere, but in practice did not exercise their professional responsibilities to a reasonable standard. Deficits are evident in a number of aspects of practice, including assessment (including assessment of a range of elements of history, mental state, needs and risks); comprehensive approach to treatment planning; documentation; coordination and communication between staff and services; incident reporting and review; involvement of families; supervision processes; and in leadership of the service.

There are some notable exceptions to these comments. Evidence available to the Panel suggests that staff of the Queenstown Community Mental Health Team offered a service to Mr Burton and his family that was sensitive to the needs of both Mr Burton and his family and where there was reasonable compliance with appropriate standards of practice. The relatively limited contact the Panel had with staff of the Invercargill [Community Mental Health Team] does not reveal substantial deficit in their practice, although it might be argued that there should have been greater assertiveness in expression of concerns about the process of discharge planning and in the suitability of the plan for Mr Burton to flat on his own.

Some deficiencies in aspects of the wider set of services also appear relevant to the quality and comprehensiveness of services available to Mr Burton.

There appears little doubt that psychiatric manpower is in short supply in Invercargill. There is not a great deal of evidence that options for increasing availability of psychiatric

expertise have been pursued as rigorously or comprehensively as might be expected in these circumstances.

There appears little attention within the organisation to ensuring that standards of mental health nursing practice are maintained. Developments under way within the rest of the organisation aimed to improve nursing standards and leadership have been only partially and belatedly applied to mental health nurses. Although the Director of Nursing and Midwifery has experience as a manager in a mental health service, she is not qualified in mental health nursing. The Team Leader of the acute psychiatric inpatient unit, who has responsibility within that unit for provision of clinical leadership, is employed on a part-time basis and has many responsibilities that limit her ability to focus on nursing practice standards.

There appears to have been a degree of difficulty in finding a suitable residential facility for ongoing rehabilitation of Mr Burton, although there did not appear to be any sustained effort to this end. Tentative exploration of a facility with some orientation toward addressing substance abuse yielded little information about a facility that was readily available, although this appears not to have been rigorously pursued. The supported accommodation in Invercargill appears to have been quickly dismissed as being available to Mr Burton because of the view that that organisation would not accept people with substance abuse disorders. Although that organisation reports that people with comorbid problems of substance abuse and mental illness can reside in its facilities, it also notes that the facilities are drug and alcohol free. There appears to be an absence of a facility that will tolerate drug and alcohol use in the context of ongoing efforts to reduce substance abuse.

There is a sense of complacency about aspects of the function of the organisation. The Clinical Director [of Mental Health Services] thought it was ungentlemanly to be reviewing aspects of practice of other staff. He tolerated a liberal attitude by the doctor primarily responsible for Mr Burton, [the Medical Officer Special Scale (MOSS)], toward use of the Mental Health Act. He waited for [the MOSS] to bring concerns to him, rather than setting criteria for supervision or establishing useful structures for that to occur. There seemed to be no sense of urgency, for example in giving clear direction with respect to a key aspect of service coordination.

Complacency appears evident in other aspects of performance of the organisation, at all levels. Identification by staff of deficits in fundamental aspects of practice such as documentation did not result in any clear effort to change the standard. Staff without significant experience in mental health work were given important responsibilities beyond their scope of expertise. There was little follow up of referrals for important components of the care process to ensure that they were completed or provided additional assistance in treatment planning. Incidents occurred without evidence of the matter being addressed in any meaningful way. Comments made by Mr Burton and aspects of his behaviour that may well have indicated bizarre and continuing psychotic symptoms were not rigorously followed up. Much emphasis was placed upon him not creating a problem within the ward, and therefore it seemed not to be of concern to follow through whether he actually was still unwell. Substantial alcohol use was neglected, at least in regard changing plans for his discharge from hospital.

There appears also to be complacency represented in the lack of rigour to analysis of incidents. The Patient Services Manager was not aware of findings of any internal review of the care of Mr Burton, and indeed there seems confusion as to whether one took place at

all. The General Manager of Hospital Services appears to have publicly accepted, without reservation, the competence of his staff, but appears not to have noticed the confusion about whether an internal incident review took place.

There appears also to be an acceptance of people being employed without the skills and experience necessary to effectively meet the requirements of their positions, and of people being so overloaded with many responsibilities that important clinical leadership roles were unable to be performed.

B: BACKGROUND TO THIS REPORT

Mr Mark Burton was discharged from ward 12 of Southland Hospital on 30 March 2001 to a flat in Invercargill. The following day he was taken into police custody following the death of his mother in Queenstown. The Health and Disability Commissioner decided to commence an "own initiative" inquiry into aspects of the care provided to Mr Burton by Southern Health.

Mr Burton was first referred to the mental health service of Southern Health in July 1998 when his mother, Paddy Burton, contacted the Queenstown Community Mental Health Team concerned about his mental health.

On assessment Mr Burton was noted to have features consistent with a psychotic illness. A history of alcohol and cannabis use was obtained. His parents expressed concerns about his aggressiveness and excessive use of alcohol. Treatment was commenced with medication that was supervised by his parents, even though he was not living at home, because of concern about his adherence to the medication regimen. Mr Burton's parents kept detailed records.

Over the period through to late 1998 a moderately high level of contact was maintained between the community mental health team, Mr Burton and his parents. There were fluctuations in mental state that appeared related to alcohol use and to stresses. Concerns regarding adherence to medication and in regard to alcohol and cannabis use continued to be noted.

By early 1999 there appeared to have been some improvement in Mr Burton's condition and he was working as well as seeing a counsellor for alcohol and drug use problems. Alcohol use was still noted to be a concern in April 1999. In May 1999, the occupational therapist from the community mental health team became involved in Mr Burton's care.

Medication was increased at this time but some adverse effects were noted by mid-year. Mr Burton had obtained employment by June but was fired from that job in July. A high level of contact with the occupational therapist continued. Continued alcohol use and expenditure of $40 per week on alcohol was noted. In August consumption of a 24-pack of beer each week was recorded. Through the remainder of that year alcohol use continued to be a concern, even though Mr Burton continued to have some contact with an alcohol counsellor.

Contact with the community mental health team continued through early 2000, with a fairly high level of contact with Mr Burton and his family. In the middle of the year some

fluctuation in mental state was noted. After a period living away from home, Mr Burton had returned home again in large part because of financial problems.

In a home visit in June 2000 concerns were expressed by his parents regarding safety of Mr Burton and his siblings. Mr Burton was noted to be agitated and angry with prominent psychotic symptoms. Admission to the inpatient mental health unit was arranged.

Over the course of this admission of approximately 4 weeks, there was an improvement in Mr Burton's mental state. His father was involved in meetings in which plans regarding discharge were discussed. Discharge back to Queenstown occurred in the latter part of July.

Contact with the community mental health team resumed. Some changes in medication were made because of what were felt to be adverse effects of the then current treatment of risperidone. In mid-August however his parents noted a period of deterioration that they associated with alcohol use. In September a management plan was revised in conjunction with Mr Burton and his family, and a number of issues for attention were identified, including medication concordance, exercise, work roster, alcohol use, and rules about living at home. Early warning signs of relapse were identified and a crisis plan developed.

Parental concerns regarding excess drinking continued through September and problems with motivation and medication concordance were addressed. Visits by community staff continued, often involving discussion with one or other of Mr Burton's parents.

In November features consistent with early relapse were noted and visits were adjusted to monitor closely. There still remained some concerns about his taking medication reliably in December and that month a change in medication, to olanzapine 10 mg daily, was made, which Mr Burton commenced in mid-January 2001.

In mid-January 2001 Mrs [Paddy] Burton was concerned about angry episodes directed toward her by [Mr Burton], with restlessness and bizarre conversation and disturbed sleep.

Early in February there continued concern regarding bullying and threatening behaviour toward Mr Burton's mother and brother. Alcohol use continued to be a concern, and cannabis use was noted.

On February 10 Mr Trevor Burton contacted the emergency service in Invercargill and noted his son to be acting bizarrely and threatening to harm his family. Trevor Burton drove his son to Invercargill for admission, noting bizarre content to thoughts on the journey. This information was conveyed to the inpatient staff on admission.

An admission assessment was carried out by the MOSS on duty that day [the MOSS]. This admission note is scanty. There is little detail of phenomenology, substance abuse, precipitants for admission, or of prior response to or adverse effects of treatment. The management plan is brief and a risk assessment was not completed. An increase in the dose of olanzapine was prescribed, to be given regularly. A brief nursing assessment and a very brief generic care plan were documented by an enrolled nurse. These were not subsequently updated.

Various staff made referrals to several services over the next few days, including a referral to the Queenstown Community Mental Health Team, the Invercargill Community Mental

Health Team, and the Needs Assessment and Service Coordination service. A detailed letter was received from Mr Trevor Burton, Mark Burton's father, outlining concerns. His community notes and a risk assessment completed by the Queenstown service were also received at Ward 12.

Over the following week Mr Burton presented little difficulty in respect of his behaviour, although features suggesting psychotic symptoms were noted. This pattern continued through his entire stay in hospital, punctuated by occasional incidents including episodes of alcohol abuse, aggressive behaviour and the finding in his room of materials for marijuana use.

The main focus for discussion with Mr Burton was the location of his ongoing domicile, with views expressed by his family, through Trevor Burton, about him not returning to Queenstown. Exploration of a facility for residential rehabilitation and treatment of substance abuse commenced but was not completely followed through. A needs assessment was commenced but was not completed. A referral for assessment by the alcohol and drug service resulted in a prompt assessment by that service, but no conclusions or recommendations were made and there appears to have been no impact of that intervention on ongoing clinical management.

After some 5 weeks in hospital plans were in place for Mr Burton to live in a flat in Invercargill. There was only little involvement of family in this decision. With the assistance of the ward social worker a flat was located and Mr Burton commenced a week of leave. No arrangements were made for review of his mental state during that period, although the social worker, [Social Worker A], visited frequently. In the course of those visits, substantial use of alcohol was noted, along with possible use of marijuana. Sleep disturbance, identified as a possible early indicator of deterioration in Mr Burton's mental state, was noted.

At the end of the week of leave Mr Burton attended the ward for a meeting to discuss possible discharge. The community key-worker to be involved in his care was not involved in this meeting, nor were Mr Burton's parents. Discharge was confirmed. A discharge plan form was partially completed. A risk assessment was not completed. A prescription for a 3-month supply of medication was provided. Follow up by the social worker for a further week was to occur, and arrangements were planned for ongoing contact with a community key worker with medical review by [the MOSS].

C: SOUTHERN HEALTH STAFF

This section of the report covers aspects of the performance of the staff of the service who were notified they were under investigation. Where possible, performance is rated against identified standards as defined by documents produced by Southern Health/Southland DHB, Ministry of Health, or other bodies or organisations.

C1 [Mental Health Needs Assessor]

[The Mental Health Needs Assessor] is employed as a Needs Assessor and Service Coordinator. That role involves carrying out needs assessments on people referred to the service through a number of routes, but who have in common the feature of having a

disorder of their mental health. Criteria for referral to the service include someone having a diagnosis under the DSM 4[63] diagnosis that is likely to be ongoing for 6 months or more.

C1 (a): Service type description for community mental health services – needs assessment and service coordination. *(National Service Specification, February 2001)*

This document supplied by Southland District Health Board identifies that the nature of this service is a full appraisal and evaluation of an individual's needs in regard to ongoing assistance with conduct of their role. The function of the service is to facilitate the provision of comprehensive services to individuals through comprehensive assessment and coordination of a range of services and supports to meet the needs identified.

This role therefore has potentially significant value, in assisting with identification of need in a systematic manner through the use of an approved assessment tool. This information could be used to inform treatment planning by supplementing other assessment information already available.

The service description document does not itself identify a time period following referral in which the process of assessment and coordination should be completed. [The Mental Health Needs Assessor] was of the view that service coordination was required to be completed within 14 days of the needs assessment being completed. Criteria for time to initiate or to complete the needs assessment component of the process were not identified in the material received by the Panel.

For Mr Burton, a referral was made to the service on 12 February, according to the entry in the clinical record that day. [The Mental Health Needs Assessor] first saw him on 8 March. Reasons for this delay are not clear, although 2 days of training did occur in that period.

The Panel was advised that referrals are received at the Social Work department where they are placed in an incoming referrals folder. A weekly discussion takes place in regard to these referrals and they are prioritised for response.

At the time of Mr Burton's care, referrals were not date-stamped upon arrival. That now occurs. It is therefore not clear when Mr Burton's referral was received, and the Panel was advised that it sometimes takes some time for referrals to arrive in the internal mail, although the Social Work Department is located on the same hospital campus as Ward 12.

Urgent referrals can be responded to within 48 hours. There is no indication that Mr Burton's referral was considered to be urgent by the staff in Ward 12 making the referral. There is no evidence that the clinical team were concerned that there had been no response to the referral despite a lapse of approximately 4 weeks from the date of referral.

An entry in the weekly review summary on 22 February notes "need for follow up of needs assessment", and the following day [the MOSS] noted "awaiting needs assessment". There is no indication however of action to expedite the needs assessment, even though over the next two weeks there were further references in the notes to possible arrangements for accommodation after discharge. There was no further discussion of this aspect of assessment recorded in the notes of the weekly review meetings.

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[63] The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, a guide to classification of psychiatric disorders, widely used in New Zealand.

The process of needs assessment was not completed by the time of Mr Burton's discharge.

The service type description notes that services will be provided by staff with appropriate qualifications, competencies, skills and experience in meeting the support needs of people with serious mental health problems/disorders. This is expanded in the position description for this role, although this document does not set out necessary prior training and experience for the role. No other document summarising these specifications was made available to the Panel.

C1 (b): Position Description – Needs Assessment Facilitator/Service Co-ordinator *(Southland District Health Board July 2000)*

The position description for a Needs Assessment and Service Coordinator establishes key characteristics of the role. This job description for [the Mental Health Needs Assessor] notes the primary objective of the position is to facilitate support needs assessment and service co-ordination for people with mental health disabilities, enabling them to identify and explore their needs.

Needs assessment reports are to be developed in partnership with the consumer and their family/caregivers.

[The Mental Health Needs Assessor] began a process of assessment by briefly looking over the clinical file. The purpose of this was to get an overview of some of the clinical issues faced, as well as to obtain information about Mr Burton's ability to look after himself, including matters such as need for prompts over matters such as showers, medication, and washing clothes.

In fact little of that sort of detail would have been available to [the Mental Health Needs Assessor] from the file. As noted later in this report, notes with regard to history and function are scanty. [The Mental Health Needs Assessor] is clear that she did not look at the risk assessment for Mr Burton and noted that usually the needs assessors work with staff in the unit who would notify the assessors if there were issues of concern.

How this might have happened then with Mr Burton is unclear. A risk assessment was not completed, and nursing staff repeatedly told the Panel that the risk assessment is the doctors' responsibility. The doctor said it would be done at discharge. This is expanded upon elsewhere in this report. This clearly puts the assessor in a position however, at least for Mr Burton, of having incomplete information in an important matter that ought to be incorporated into decisions about provision of ongoing support.

[The Mental Health Needs Assessor] continued the process of assessment by meeting with Mr Burton on 8 March with [Enrolled Nurse B] who had been allocated to care for him during that shift. That assessment proceeded in an unremarkable fashion until the conversation focussed on Mr Burton's relationship with his family. [The Mental Health Needs Assessor] noticed that Mr Burton's demeanour changed and he made some comments about what appeared to be psychotic experiences. [The Mental Health Needs Assessor] continued, subsequently advising Mr Burton of her wish to discuss things further with his parents, and why this was important. Although Mr Burton was reluctant, [The Mental Health Needs Assessor] did obtain his consent for that to occur. The interview ended with [the Mental Health Needs Assessor] planning to make contact with Mr

Burton's parents when she was next in Queenstown, although she was not sure when that would be.

Little more happened, other than some telephone contact a few days later (12 March) between [the MOSS] and [the Mental Health Needs Assessor] in which there was some discussion of drug and alcohol treatment facilities and difficulties that substance abuse created in finding residential places. [The Mental Health Needs Assessor] agreed to check options for Mr Burton's ongoing support.

On 23 March [the Mental Health Needs Assessor] contacted Ward 12 to provide some information about Christchurch alcohol and drug treatment options. In this conversation she was advised that Mr Burton had commenced a week of trial leave to a flat on his own. As she perceived needs assessment to be an important part of the discharge planning process she was disappointed not to have been involved in this decision.

Following this, [the Mental Health Needs Assessor] attempted to make contact with Mr Burton's parents by telephone. After several missed attempts to make contact a telephone conversation took place on 26 March between [the Mental Health Needs Assessor] and Mrs [Paddy] Burton in which Mrs [Paddy] Burton expressed concerns about her son's ability to look after himself properly, and about him taking his medication properly. [The Mental Health Needs Assessor] assured Mrs Burton that she would contact Mr Burton and ensure the areas of concern she had identified were addressed.

[The Mental Health Needs Assessor] advised Mrs [Paddy] Burton she would meet with Mr [Trevor] and Mrs [Paddy] Burton following [Mr Burton's] discharge.

Mr Burton was discharged on 30 March without [the Mental Health Needs Assessor] having any further contact with the family, Mr Burton, or the clinical team.

***C1 (c): Adequacy of performance of* [the Mental Health Needs Assessor]**

It appears that [the Mental Health Needs Assessor] was attempting to follow the processes ordinarily required of the Needs Assessment and Service Coordination service. Her statement to the Panel outlined an understanding of processes that seems in accord with the service specifications. An effort was made to involve Mr Burton and his parents in the process, although there was only limited success in this. Clear concerns from his mother were noted however, in her own separate notes.

Plans were made by the clinical team without benefit of the information obtained in the process of assessment. This appears to reflect a failure on the part of the clinical team to follow through assertively with [the Mental Health Needs Assessor] in expediting the assessment, but also in proceeding with discharge arrangements without knowing what arrangements were required by Mr Burton to ensure adequate tenure in a flat on his own.

Clearly however there were some inadequacies on the part of [the Mental Health Needs Assessor]. There was considerable delay in starting the process of assessment. Brief review of the notes is inadequate to gain a comprehensive understanding of past presentation and concerns about function, or about strengths. There was some detail in the old notes that would have been helpful in this regard. It could be argued that such in-depth review of the notes might best occur after the initial discussion with the patient, but this did not occur either.

Detailed attention to clinical features may have helped [the Mental Health Needs Assessor] understand the reaction she noted when discussing family with Mr Burton. [The Mental Health Needs Assessor] does not have a clinical qualification however and on her own might not be expected to understand the phenomena observed, but a connection might have been made with Mr Burton's unusual ideas about his family that could then have been discussed with the clinical team.

To her credit [the Mental Health Needs Assessor] did notice a reaction and what appeared to be persisting psychotic beliefs, but discussion with the enrolled nurse attending the interview did not result in this signal that he may still be unwell being transmitted back for closer attention by the clinical staff. The nurse, in her own discussion with the Panel, downplayed an event that, had the nurse exercised more clinical scepticism, might have told the clinical team that this relationship between Mr Burton and his family required much more active attention. The nurse made no reference to the event in her file entry.

Attention to risk assessment (and therefore what needed to be taken into account in developing a support package) seems a critical part of the needs assessment process, but did not occur. Mr Burton's record would not have been helpful anyway as the whole assessment was not completed, but [the Mental Health Needs Assessor] should not have left attention to risk assessment incomplete as part of her assessment.

Having commenced the assessment process, [the Mental Health Needs Assessor] encouraged Mr Burton to allow her to contact his family. This was in accord with the usual process of assessment, and was certainly a sound approach even though Mr Burton was reluctant. [The Mental Health Needs Assessor] seems to have been thorough in her attempts to engage with Mr Burton in a cooperative manner in this regard. Having his agreement though, [the Mental Health Needs Assessor] then took some considerable time to actually initiate contact with the family. Meantime the clinical team was proceeding with plans that appear to have taken no account of the needs assessment being incomplete. It would have been appropriate for [the Mental Health Needs Assessor], on discovering that plans were afoot for Mr Burton to live in a flat on his own, to have initiated contact with the clinical team and become more actively involved in decisions regarding discharge and ongoing care plans.

It is possible that some of this delay was due to [the Mental Health Needs Assessor] being distracted from the usual process of assessment and subsequent service coordination by beginning a service coordination role before Mr Burton's assessment was completed. The documentation in the contacts sheet of the Needs Assessment Service indicates that she was involved in seeking information in regard to drug and alcohol treatment facilities, before she had completed her own assessment. This action seems to have been precipitated by the direction of the clinical team. Some days were spent awaiting information regarding these options, rather than being spent continuing the assessment process.

[The Mental Health Needs Assessor] did not make entries in the clinical file. Needs Assessment and Service Coordination files were at this time kept separately to clinical files. As a consequence however, the final entry she made in which she documented Mrs [Paddy] Burton's concerns regarding Mr Burton's ability to care adequately for himself was not available to the clinical team. This information was not in any other way conveyed to the clinical team. Although [the Mental Health Needs Assessor] expected that she would work with the clinical team to add some domestic support to Mr Burton's living arrangements, these plans were not confirmed at the point of discharge. It would have been

helpful for this concern to be actively taken into consideration at the final discharge meeting. This would have provided an opportunity for reconsideration of the plan and perhaps the timing of discharge pending other support arrangements being in place.

In summary, [the Mental Health Needs Assessor] carried out activities generally in accord with the position description of her role and with the service specifications for this service. She demonstrated skills in engaging sufficiently with Mr Burton to notice a change in his demeanour that was probably of clinical significance, and noted that change even without clinical training. She engaged sufficiently to gain Mr Burton's consent to contact his parents, even in the face of his reluctance.

A problem however lies in the thoroughness and timeliness with which information was gathered and the assertiveness of her interaction with the clinical team once she had gathered information that she considered important to the discharge plan. Once she learned of the trial leave [the Mental Health Needs Assessor] did make more active attempts to contact the family, but by this time it appears a course of action had already been charted by the clinical team.

It would have been helpful for her notes to be incorporated in the clinical file, although in making separate notes [the Mental Health Needs Assessor] appears simply to have been following standard procedure for her service. It is noted that this practice has subsequently changed and that notes are now integrated.

It would have been helpful too for [the Mental Health Needs Assessor] to have known of the plans for Mr Burton to go flatting prior to him having the week of leave, and for her to have been informed in a planned manner rather than through a chance telephone conversation. It appears that the attendance of Needs Assessors at the weekly ward meetings had been insufficient for this information to be passed to her, and thus another opportunity to note that the assessment had not been completed, and that the decision might need to be revisited, was lost.

Finally, [the Mental Health Needs Assessor] in her discussion with the Panel, was one of only two staff who spontaneously offered reflections upon their practice and had clearly given consideration to how her own conduct may have contributed to failings in the care of Mr Burton. She was clearly open to the possibilities for learning from the event, and was eager to be part of processes to improve communication and other aspects of service delivery.

C2 [Medical Officer Special Scale]

[The MOSS] was the doctor responsible for Mark Burton's inpatient care during the period 10 February to 30 March 2001. Southland District Health Board was asked to provide a copy of [the MOSS's] job description. The document provided does not clearly identify itself as relating to [the MOSS]. It is a position description that begins "The Psychiatrist shall …" then included a paragraph that includes specific reference to "MOSS Psychiatrist." No other references are made specifically to the role of MOSS Psychiatrist.

Assuming however that this description refers to [the MOSS], some of the responsibilities include:

- "provide for comprehensive and appropriate records of patients seen. …"

- "ensure that the standard of service is commensurate with Southern Health duties and intentions and Southern Health's business plan. …"
- "actively participate in processes regulating performance and accountability which will include quality assurance measures, medical audit and medical peer review."
- "ensure junior staff are adequately supervised. …"

[The MOSS] described to the Panel that his role in the ward was "coverage". He noted that he had been employed the previous year to help out in the outpatient service as a medical officer. Over the period of Christmas and the New Year one of the inpatient doctors took an extended period of leave and [the MOSS] began to spend part of his time in the inpatient setting, eventually working about half time in each place by February 2001. He recalls having responsibility for at most 6 inpatients at any time.

A number of policies and procedure documents also refer to responsibilities related to inpatient care and assessment. These include:

- Consumer assessment
- Clinical Risk Assessment and Management
- Consumer Record and Documentation
- Discharge Policy
- Quality Care and Treatment
- Admission policy.

Other documents are also in existence which identify parameters of practice of medical staff within SDHB [Southland DHB]:

- Documentation standards (Ministry of Health)
- Guidelines for clinical risk assessment and management (Ministry of Health)
- Clinical supervision for Mental Health Services (SDHB Policy)
- Family and Carer Participation (SDHB policy)
- Leave planning (SDHB policy).

Comment can be made about [the MOSS's] practice in respect of each of these aspects of his job description, guidelines and policies.

C2 (a): Position description

Provide for comprehensive and appropriate records of patients seen

[The MOSS] did not achieve this standard. [The MOSS] told the Panel that he spent lots of small amounts of time with Mr Burton. He found it useful to chat with Mr Burton for short periods of time. That might happen in one of the social areas of the ward, or even the corridor or the car park. Not all contact he had with Mr Burton was documented. This is probably in itself not unusual, as often in inpatient units staff will have a casual exchange with a patient in passing in a corridor or outside of a formal interview setting. In circumstances however where such exchanges form a substantial part of the ongoing assessment (as they did with Mr Burton because of the difficulty engaging in more "formal" discussion) then such informal discussions upon which some weight is put should form part of the documented record.

Entries that have been made by [the MOSS] are scanty. [The MOSS] accepts that his documentation falls below acceptable standards of practice. It is the view of the Panel that the standard demonstrated by [the MOSS] falls below that of generally accepted standards of practice. A common medico-legal truism is that if it is not documented, it did not happen. While the Panel accepts that there were interactions not reflected in the clinical record it is the record itself which must be sufficient to enable care to be provided by other clinicians in a satisfactory manner. A medical practitioner unfamiliar with Mr Burton would not, on the basis of [the MOSS's] notes, be able to satisfactorily take over care without substantial effort to repeat work (e.g. assessments) reported to have already been done. Comment is made elsewhere in this report in regard standards of documentation by other staff.

Ensure that the standard of service is commensurate with Southern Health's duties and intentions, and Southern Health's business plan.

Although not specified in the position description, the Panel assumes that the policy and procedure documents of Southern Health illustrate the standards of the organisation's duties and intentions. The section below (section C2 (b)) expands further upon achievement of those standards.

Actively participate in processes regulating performance and accountability, which will include quality assurance measures, medical audit and medical peer reviews.

Supervision is not specifically referred to in this element of the position description. Supervision would appear however to be one of the processes compatible with regulating performance and accountability. [The MOSS] did not engage regularly in supervision. This matter is expanded below (section C2 (b)).

There was no evidence presented to the Panel that [the MOSS] participated in any other formal review of his practice, whether by regular audit or by peer review or formal periodic review of performance. Participation in the weekly ward round was the only opportunity used in relation to Mr Burton for contribution from other senior medical staff. This was of limited value as is discussed later in this report.

C2 (b): Policy and procedure documents

Consumer Assessment

The Southern Health Mental Health Unit procedure document titled "Consumer Assessment" (dated 11 August 99) notes that a comprehensive assessment is ensured by the service and that care, treatment and support is based upon that assessment. The assessment is to be completed by a health team with appropriate knowledge and skills, and the assessment is to be documented using an assessment form. The assessment is to be regularly reviewed.

The admission assessment completed by [the MOSS] was not recorded on the standardised assessment sheet. The admission took place at the weekend and apparently these forms were not available. There is no evidence of a subsequent attempt to complete the standardised structure document.

The history as recorded on admission is scanty. The circumstances precipitating admission are outlined in 20 words only ("Threatening behaviour especially towards mother. Deluded regarding parents having a quantity of his money. (There is no money in fact.)")

There is no detail of the nature of the threatening behaviour or of any precipitating factors. There is no reference to the nature of the content of the discussion between Mark Burton and his father that day in which clear delusional thoughts were evident. There is no reference to further delusional thoughts evident during transport to Invercargill. The key concerns of the family are not detailed.

The Panel heard that the scanty entries in the file are not reflective of the nature of the interactions that took place between [the MOSS] and Mr Burton. There is no evidence however that if any of these critical elements of the history and presentation were actually obtained they were used in any way to guide further assessment or other intervention.

The admission assessment documentation records a scanty developmental history, refers briefly to the past psychiatric history, and makes no reference to presence or absence of any forensic history. Social circumstances are referred to in an extremely limited manner and there is no detailed information regarding stresses, finances or relationships. Medical history, another standard part of a comprehensive assessment, is not noted at all.

Substance abuse, which [the MOSS] in discussion with the Panel noted to be one of the top of the list of things to address, is referred to extremely briefly. The entry notes "Alcohol + Cannabis ++". There is no record of quantity or frequency of use, circumstances of use, features of dependence or withdrawal, physical or psychological consequences of use, or other factors that should be considered in someone in whom substance abuse is thought to be a significant part of their presentation.

It may be that this was to be addressed elsewhere, and indeed an assessment by the Rhanna Clinic was arranged. This Rhanna Clinic assessment was entered into the file, but [the MOSS] appears to have over-looked it. Information about past episodes of involvement with the police by Mr Burton was documented by the Rhanna Clinic assessor but was not apparently seen or noted by [the MOSS] until well after Mr Burton's discharge. It did not feature in review of risk and the assessment by the Rhanna Clinic staff member appears not to have influenced Mr Burton's treatment in any way.

At no point is there documentation of thorough and systematic review of Mr Burton. Further file entries (after admission) by [the MOSS] number only 6. None of these offer any detail in regard to Mr Burton's mental state.

On 14 February he is noted by [the MOSS] to be "settled mentally".

On 19 February [the MOSS's] file note comments that Mr Burton "seems pretty settled".

On 23 February [the MOSS] records Mr Burton "Remains settled".

The file entry on 28 February makes no reference at all to Mr Burton's presentation other than noting he was keen to return to Queenstown.

A meeting took place on 1 March involving Mr Burton, his father and [the MOSS]. The file note was made by the nurse present in the meeting and makes no reference to [Mr] Burton's mental state.

A file entry made by a nurse on 12 March reflects that [the MOSS] saw Mr Burton. There is no reference to Mr Burton's presentation at that time, other than "Mood settled", and "pleasant and appropriate". Such comments as "settled" and "pleasant and appropriate" feature regularly through the file.

The next entry made by [the MOSS] himself appears to be March 20. There is no reference to an assessment of [Mr Burton] but the entry briefly records discussion of proposed discharge arrangements.

The final file entry by [the MOSS] on 30 March makes scant comment in regard Mr Burton's mental state ("No talk of returning to Queenstown"). The decision to discharge is confirmed. The plans regarding ongoing treatment are limited to "olanzapine 15 mg nocte". [The MOSS] makes no reference to follow-up, or to attention to other domains of need. The nursing note does however refer to follow-up and to exercise, employment and a group programme.

It is clear that the records do not document a comprehensive assessment of Mr Burton by [the MOSS], nor do they document a broadly based approach to treatment plans. The focus in [the MOSS's] notes is exclusively on location of his domicile. One entry within 5 days of admission also refers to allowing Mr Burton to have leave, but makes no reference to justification for this decision (and there is no evidence of any exploration of change in mental state or consideration of risk elements) or any conditions of leave.

[The MOSS] advised the Panel that Mr Burton's drug and alcohol use was at the top of the list of things to address. Helping him come to terms with his illness was a close second. It is not clear where effective understanding by the clinical team of the nature of the psychotic experiences and providing effective treatment, or managing the significant risks associated with the psychotic phenomena, featured on the list of priorities.

However, given these stated priorities it is possible to examine what systematic attention was given to each of those.

A referral was made to Rhanna Clinic, the drug and alcohol service. Elsewhere in this report follows further discussion of the connection between Rhanna Clinic and processes of assessment and intervention. The documentation of the assessment by Rhanna Clinic was incorporated in the clinical file at Ward 12. The assessment appears not to have been studied by [the MOSS]. He told the Panel that this information had only come to light (to him) subsequent to Mr Burton's discharge, despite the assessment notes being entered in the ward file. [The MOSS] did not therefore notice at least one piece of key information – an element of history of prior arrests for fighting and for shoplifting – until after discharge. There is no clear evidence that this assessment contributed in any meaningful way to ongoing treatment.

The assessment records substantial alcohol consumption with features suggestive of dependence. [The MOSS] advises that the matter of drug and alcohol use was discussed with Mr Burton by him and by other staff. There is no evidence of this in [the MOSS's] notes. Indeed upon reviewing Mr Burton after the period of leave, during which very substantial quantities of alcohol were consumed by Mr Burton, the record simply reflects [the MOSS] noting that Mr Burton had been "drinking a bit". Although this is understood to reflect Mr Burton's account of the quantity, there was clear information available to [the MOSS] regarding the actual amount being used. There is no indication of discussion that

this was a concern. There is no evidence in the file that [the MOSS] viewed the quantity as being of concern. There is no evidence that the treatment plan was reviewed or that the plan to discharge was reconsidered, despite alcohol use being a priority in the list of things to address.

During the admission there had been some attempts to find a residential facility that would address substance abuse. [The MOSS] is recorded on March 1st to have suggested Odyssey House. Some exploration of options is considered in the notes but there was no evidence of a systematic attempt to identify the range of possible treatment options, nor of [the MOSS] attempting to contact the identified facilities to argue for Mr Burton being a priority for admission. When a referral was eventually made to the drug and alcohol service, the idea being reflected in a nursing file entry on 8 March nearly one month after admission, no specific assistance was sought in investigating residential treatment facilities. Once the assessment had been completed there was still no joint effort between the ward team and the drug and alcohol treatment service to try to engage a residential treatment programme.

[The MOSS] was of the view that reduction in alcohol use was the main factor contributing to improvement in Mr Burton's mental state. It clearly can be questioned however whether there had been in fact a substantial improvement in positive psychotic phenomena.

The evidence presented to the Panel about how much improvement was understood by [the MOSS] to have been made by Mr Burton is however somewhat contradictory. At one point [the MOSS] told the Panel that "within a couple of weeks, I'd say three weeks, by the end of February he was able to function essentially normally …". Behaving "essentially normally" presumably therefore includes the occasional episodes of alcohol use and acts of aggressive behaviour and evidence of suspiciousness that occurred in March.

[The MOSS] also told the Panel "we all felt that olanzapine was effective". He continued by noting that comparisons were made to Mr Burton's prior presentation, noting him to be warmer, less isolative and more prepared to join other patients. This comment in regard olanzapine being effective is hard to reconcile with a later remark to the Panel, [the MOSS] commenting that "He was fairly guarded and his delusions were fairly evident on the ward, so clearly his illness was very much present".

It appears to the Panel that a great deal of weight was placed upon the improvement in Mr Burton's sociability. There were however occasional reports of persisting features suggestive of continuing delusional ideas documented through the entire admission. [The MOSS] commented that he was unable to gain sufficient access to Mr Burton to explore those phenomena, but there is no indication of how these ongoing reports of these features were taken into account in reaching the view that there was an improvement in the psychosis. The possibility that the improvement in sociability might have been due to reduced alcohol use and that underlying psychotic symptoms were unchanged seems not to have been considered.

[The MOSS] commented to the Panel that on admission it was clear that Mr Burton was actively psychotic. As noted above he felt there had been an improvement by the end of February, adding that it was "only when you talked to him" that you would discover he was psychotic. There is little documentation of evidence of medical or nursing staff trying to talk to Mr Burton much at all about his symptoms. Notes contain references to there being no symptoms observed, but there are only few accounts of active efforts by only a

few staff to explore for specific symptoms, and few reports of Mr Burton's responses to such efforts, or of specific denial of identified positive symptoms.

Mr Burton made it very clear that he had no intention to change his alcohol use, both in his statements and in his behaviour. [The MOSS] maintained a hope however that he would find a way of working with Mr Burton. Even with the clear evidence of persisting use of alcohol, and with the thought that improved mental state was due to reduced alcohol use, and with no evidence of being able to work effectively to engage with Mr Burton to access thoughts or change intentions in regard to alcohol use, no more assertive intervention was made.

Options were available. These included not continuing with discharge plans, active seeking of residential treatment facilities, and use of the Mental Health Act.

[The MOSS] commented to the Panel that he was striving to find ways of working with Mr Burton. He did not want Mr Burton to feel that the Act was "hanging over his head" but he noted that whenever he did make a firm decision Mr Burton accepted it.

In the view of the Panel, [the MOSS's] continued striving to work with Mr Burton in this way, and his willingness (as he stated to the Panel) to compromise on everything else as long as Mr Burton did not return to Queenstown is inconsistent with alcohol use being regarded as a priority and suggests an error of clinical judgement.

Such decisions are difficult however, and are the type that should be assisted by consultation and support of experienced colleagues. In retrospect, [the MOSS] thinks he would have used the Mental Health Act. This was however not a matter he raised in supervision with colleagues at the time. Consultative or supervisory support with this decision was not provided.

Another matter that could have been brought to supervisory attention was in relation to Mr Burton's response to medication. Having told the Panel that "clearly the illness was very much present", [the MOSS] went on to say that he felt that as much as could probably be done at that time in modifying the illness with chemical interventions was being done. But that is open for discussion. The dose of olanzapine was unchanged at the end of the admission from the dose to which it was increased on admission (15 mg). The usual dose range of this medication is usually considered to be 5 to 20 mg per day, so even within that range there was room for increase to attempt to reduce persisting symptoms, and in an inpatient setting, in an environment in which close attention can be paid to tolerance of the drug, higher doses still could be considered. Decisions such as this would reasonably be discussed with more experienced senior staff, but this does not appear to have been considered.

Rather than further increment in medication though, [the MOSS] felt that "what we really needed to do was to establish the other aspects of the treatment …". This comment referred to discussion with the Panel regarding areas of need other than pharmacological management, including alcohol use, coming to terms with his illness, and other matters related to Mr Burton's stage of life.

Attention to alcohol use has been discussed above. The lack of an occupational therapist on the ward precluded in [the MOSS's] view attention to ADLs (activities of daily living), as did refusal by Mr Burton to be involved in a day centre. The other priority for intervention,

according to [the MOSS's] statement to the Panel, was helping Mr Burton come to terms with his illness. The records reflect no systematic attempt to do this.

Overall then, attention to other aspects of the treatment was limited.

An attempt was commenced to obtain a structured assessment of Mr Burton's needs. This appears to have been arranged in order to assist with finding accommodation. Such an objective assessment can often also be a basis for planning interventions in a range of domains. [The MOSS] stated to the Panel however that all a formal Needs Assessment does in Southland is assist with gate keeping to PACT [Patients Aid Community Trust] (supported housing). The potential value of such structured assessment in identifying a range of needs, and therefore serving as a basis for a comprehensive treatment plan, seems to have been unrecognised by [the MOSS].

A referral had been made for Needs Assessment as early as 12 February. The assessment did not commence until March 8. No other structured assessment of need took place in the meantime. The Panel was advised that the absence of an occupational therapist in the ward limited the capacity to undertake comprehensive assessment. Given therefore the availability of the Needs Assessment Service as potentially providing such a structured guidance to needs, it is of concern that there is no evidence of attempts to engage that assessment earlier or to highlight the need as urgent.

[The MOSS] did make an adjustment to Mr Burton's pharmacological treatment on admission, increasing the dose of olanzapine to 15mg. There is comment elsewhere in this report upon the lack of documented evidence of any attempt to explore the effects of this change on psychotic experiences. There is no evidence of exploration of adverse effects by [the MOSS]. An entry in the nursing note on 30 March reflects some indication that an exercise programme was being considered although rationale for this is not evident. It may be reasonable to expect that this was to assist with weight gain commonly associated with use of olanzapine, but there is no evidence that there was any other ongoing systematic attempt to address this aspect of care, or to prevent that problem of weight gain. Instead, on a number of occasions there is reference to his consumption of 'McDonalds' (on occasion even being taken there by staff) without evidence to suggest alternative approaches to diet and health maintenance.

It is the view of the Panel that [the MOSS] did not meet the standards of assessment and care planning expected by the SDHB procedure statement. It is also the view of the Panel that the evidence of the clinical notes as well of [the MOSS] in his statements to the Panel indicates he did not meet a standard that could be reasonably expected of an unsupervised senior medical practitioner.

Clinical Risk Assessment and Management

The Southern Health Mental Health Unit procedure titled "Clinical Risk Assessment and Management" (dated December 2000) notes that the Assessment of Risk Sheet should be completed upon admission for all patients by the admitting doctor and nurse and thereafter daily by responsible clinician/psychiatrist and assigned nurse, until routine observation level is reached. This document, the Assessment of Risk, was struck through by [the MOSS] at the time of Mr Burton's admission and no further copy was completed.

A comprehensive assessment of the risks associated with Mr Burton's illness and presentation was not completed. [The MOSS] commented to the Review Panel that he accepted the responsibility for completing the risk assessment documentation. In his understanding, in the ward the risk assessment was purely a medical decision. [The MOSS's] view however was that while Mr Burton was on the ward there was not any risk and that a comprehensive risk assessment was not required until Mr Burton left the inpatient setting.

Another document related to risk was partially completed, in accord with the Clinical Risk Assessment and Management procedure. This document, the Risk Alert Sheet is understood to be required to be completed upon admission by the admitting doctor and nurse and thereafter daily by the responsible clinician/psychiatrist and assigned nurse. It is required to be accompanied by the 'Assessment of Risk' document.

The Risk Alert Sheet was completed 10 February upon admission and identifies Mr Burton as no increased risk. A further entry was made on 14 February with the same assessment of no increased risk. No further entries were made. Incidents such as Mr Burton returning to the ward apparently intoxicated and behaving in a threatening manner did not result in documented review of his assessed level of risk. No documented review of the assessed level of risk, or of level of observation required, followed discovery of him placing objects on the door handles of his room.

[The MOSS] understood that he had a major role in the process of risk management. The question must be considered then as to whether he completed this task adequately, in respect of SDHB procedures.

It is the view of the Panel that he did not. The Risk Assessment Sheet was not completed upon admission. [The MOSS] commented to the Panel that completion of this document should be done in conjunction with the community team, but information available to him from the community in the form of a completed risk assessment (dated 9 February 2001) was not utilised as the basis of further documentation. Such further documentation would also include information obtained upon admission with more specific reference to threatening behaviour toward his mother.

[The MOSS] was of the view that the Assessment of Risk would be completed at the time of leaving the ward. This is not in accord with the documented procedure, but even despite [the MOSS's] view this did still not occur at that point of departure.

Consumer Record and Documentation

The Southland District Health Board procedure document titled "Consumer Record and Documentation" (dated 25 November 1999) notes that clinical activities are to be documented to assist in the coordinated delivery of care. Any treatment or intervention is to be documented in the clinical notes. Each health professional making an entry must clearly identify themselves, their designation, and time of entry. Each entry must be legible. Notes should be comprehensive. Each consumer should have an individual care plan, nursing care plan and discharge plan.

As noted already, entries that are made by [the MOSS] are scanty. They are signed and indicate his designation as "MO". His name is not printed at each entry but his signature

does appear on a list of names and signatures of people making entries in the record. Legibility is satisfactory, although with some difficulty.

It is the view of the Panel that the standard demonstrated by [the MOSS] falls well below that of this SDHB procedural statement.

Discharge Policy

The procedure for Consumer Assessment and Documentation already identified refers to each record containing a discharge plan. A further statement in relation to discharge is found in the Southern Health Mental Unit policy titled "Discharge Policy" (dated 18 January 2001). This document notes that discharge planning must commence on admission, be developed collaboratively with other professionals involved in care (e.g. CMHT [Community Mental Health Team]) and must include a variety of components, including needs assessment, signs of becoming unwell and a crisis plan. All patients are to have an assessment prior to discharge in conjunction with, amongst others, the community team. No specific responsibilities of the responsible doctor are identified other than in relation to medication, and in relation to assessment of mental health status.

[The MOSS] did address prescription of medication. He gave Mr Burton a prescription for a 3-month supply of olanzapine that would have been dispensed monthly. He would have preferred him to have it every week, but Mr Burton wanted it monthly as he had always had it that way. There is no documentation of comprehensive review of mental state prior to discharge.

[The Clinical Director], in his brief of evidence to the Coroner notes however a broader view of the role of the doctor in discharge than the policy appears to suggest, noting that "The responsibility of the primary psychiatrist of a patient is the assessment, diagnosis and treatment. This includes medication and discharge". This suggests the doctor has much more responsibility for other elements of the discharge than just review of medication and mental state.

The clinical record on 20 March reflects discussion regarding plans of a move into a flat. This entry by [the MOSS] is headed "Discharge Plan". This discussion included Mr Trevor Burton although the record reflects little of the conversation. The record seems to reflect discharge plans that were made, at least as far as accommodation was concerned, some days previously. A meeting on 4 March involving Mr Trevor Burton is documented, and a subsequent telephone conversation, noting that Trevor Burton was "reasonably happy for [Mr Burton] to go flatting although would have preferred supervised accommodation".

A further entry by [the MOSS] on 30 March reflects what is described (by the nurse who was also present) as a discharge plan meeting. It had been planned that a community team member would attend but the meeting was held approximately 90 minutes earlier than planned. No contact was made with the community worker, who at the time was in the building, to see if she could attend. A follow-up meeting with the community worker was planned, but the discharge was confirmed.

A "Client Discharge from Ora*Care" document was completed. This document appears to be an administrative form rather than being very useful clinically. A standardised discharge plan clinical document was completed also, although the document is slightly confusing. In brief, it notes that the needs assessment process had been completed (it had not), that a

discharge planning meeting had occurred on 1 March (it was not clear whether this was a discharge planning meeting in fact), makes no reference to the outcomes of the discharge meeting on 30 March, and notes "has a job interview on 23 March".

Signs of relapse are noted but there is no reference to a crisis plan.

It is evident that the process of discharge planning was deficient in a number of ways. These matters, according to the policy, appear to largely have been the responsibility of the primary nurse. Another section of this report addresses primary nursing matters more fully. Those responsibilities that are specifically identified as medical appear also to have been incompletely or inadequately implemented.

There is no evidence of a comprehensive review of Mr Burton's mental state on March 30, when the plan to discharge was confirmed. No attempt at mental state examination is documented. No review of risk factors is documented. No discussion of the substantial use of alcohol or implications for mental state is documented.

Prescription of a substantial supply of medication, without evidence of discussion of the need to adhere to the prescribed dose, or of strategies to monitor adherence, or to restrict supply, seems at best unusual for a man for whom adherence to a medication regimen had been of such concern in the past that special attention had been paid to that element of a treatment plan.

A draft discharge letter dated 3 April 2001 appears in the file. It is in error in some respects, noting the date of admission as 15 February, and date of discharge as 39 March. This appears to be a typed version of an undated handwritten and poorly legible note by [the MOSS]. It notes that close community follow-up was instituted and the intention that [the MOSS] would review Mr Burton on 6 April. Evidence from [the Community Mental Health Nurse (Invercargill)], the community key worker, is that she would not be able to see Mr Burton until the fourth day after discharge. [Social Worker A], who had seen Mr Burton during the period of trial leave, was to continue to see Mr Burton for a further week after discharge. In light of [Social Worker A's] limited capacity to assess mental state, and in light of persisting alcohol abuse, these arrangements do not seem sufficient to adequately monitor Mr Burton.

With reference to the specific responsibilities outlined by the SDHB Discharge Policy, [the MOSS] seems not [to] have performed to a reasonable standard. He was however to continue to be involved in care in conjunction with the community key-worker. Such ongoing involvement to a degree reduces the extent of documentation and communication necessary to ensure continuity of care. It does not however reduce the risk associated with limited contact by people able to undertake mental state examination, or who are sufficiently concerned about alcohol use to attempt to intervene in it, or the risk associated with apparently relatively uncontrolled availability of alcohol.

Evidence was available in the history (even without the Needs Assessment being completed) of poor success while in flatting situations – yet this was not incorporated clearly in arrangements for discharge.

Quality Care and Treatment

The Southern Health Mental Health Unit policy document titled "Quality Care and Treatment" (dated 1 August 1999) notes that treatment, support and medication plans are developed collaboratively and reviewed regularly with the consumer and their family. Expected outcomes should be identified and plans should recognise special needs, including dual diagnosis.

This report has already noted matters in relation to extent of care plans and attention to substance abuse.

[The MOSS] did on a number of occasions have discussion with [Mr Trevor Burton] in regard to plans. In retrospect he commented to the Panel that he would work harder to involve the family. Mr Trevor Burton certainly expressed concern that he had little information in regard to some aspects of inpatient care, notably the episode of vomiting after drinking, the incident in which his son hit another patient, and the apparent persistence of psychotic symptoms. He commented that he felt that it was he who had had to initiate most of the contact with the clinical team, and that even then there was not a great deal of information provided.

By his own account, [the MOSS] was working to engage Mr Burton in a collaborative process in regard [to] assessment and treatment. This would certainly accord with the policy on quality care and treatment. As noted earlier however it is not evident that Mr Burton was likely to actually engage in such a collaborative process, certainly in regard [to] alcohol abuse.

Admission Policy

The Southern Health Mental Health Unit procedure titled "Admission Procedure" (dated 19 May 1999) notes that the admitting doctor is responsible for documenting his/her assessment on the Admission Assessment Form. [The MOSS] did not do this. It seems unusual that such forms are not available at the weekend, but nonetheless the form of [the MOSS's] notes broadly followed the structure of the standardised document. Notable exceptions to the information that would usually be included in the assessment have been identified already.

The Admission Policy notes that the admitting doctor and inpatient nurse complete the Risk Alert Sheet. This sheet was completed. This policy also sets out that patients can expect to be seen by their doctor twice a week. [The MOSS] was not aware of this standard. He feels he would certainly expect to see inpatients twice a week, and feels that he probably saw Mr Burton most days. He feels a more in-depth conversation took place about weekly. The clinical file does not reflect such frequency of in depth conversations.

Documentation standards

The Ministry of Health produced a set of standards for case notes in 1992 (*Recommended Standards for Case Notes – Ministry of Health, 1992*). The content is unremarkable and is generally in accord with commonly understood standards of practice and with the Southern Health Consumer Record and Documentation procedure. The document notes that clinical information has to be distilled, organised and recorded before it forms a reliable reference source for other members of the team involved with the patient.

This publication notes that there may not be a correlation between the completeness and quality of case notes and clinical outcome. However the importance of the notes as a vehicle for communication with people involved in care who do not have opportunity for other interactions to obtain information is without question. In Mr Burton's case, the notes made by [the MOSS] were inadequate to provide much information.

Guidelines for Clinical Risk Assessment and Management

The Ministry of Health, in partnership with the Health Funding Authority, published a document titled "*Guidelines for Clinical Risk Assessment and Management in Mental Health Services*" in 1998.

This document and standards of risk assessment and management are discussed in more detail later in this report.

It is evident however that the attention paid to risk management by [the MOSS] did not reach the standards established by this document. There is little to suggest that [the MOSS] incorporated ongoing events in Mr Burton's care into a review of risk status. There is little documented evidence that details of events were explored in sufficient detail to enable a comprehensive understanding of their significance or of future circumstances in which risks may increase. There is no documented formulation of risk data that leads to comprehensive plans to reduce risk. There is evidence that a possible early sign of relapse was noted, but no evidence of actions to closely monitor any change in mental state.

Clinical Supervision

Members of the Review Panel were supplied with a copy of a policy document titled "Clinical Supervision for Mental Health Services" (dated 14 February 2001). Clinical supervision in this document is described as a method of supporting and developing competence by providing practitioners with an opportunity to meet with an experienced colleague, in order to discuss their own work and reflect on and learn from that actual clinical experience under discussion. The policy is intended to cover all staff engaged in direct client contact. The policy notes that supervision, amongst other things, will be regular (at a frequency of fortnightly at a minimum) and provides for specialist knowledge for appropriate consultation when required. It is to provide assistance with consideration of ethical issues.

The policy notes that clinical supervision is not provided by line management relationships. [The Clinical Director] has a specific responsibility (according to his position description) to manage medical staff resources, but [the Clinical Director] was also regarded by [the MOSS] as his supervisor. Perhaps the supervision relationship was to encompass matters therefore that were different to those outlined by the policy document, although the matters outlined in the document appear sensible and congruent with generally accepted principles of supervision, aside perhaps from the reference to line management relationships.

Certainly [the MOSS] understood that his contract required him to take clinical matters to [the Clinical Director]. He notes that he would have seen [the Clinical Director] as his supervisor. There was no formal supervisory system in place (as might be evidenced by regular time to discuss cases individually, or defined criteria for cases or problems to discuss). [The MOSS] had however had prior experience of working in settings in which

he was supervised. In those settings case discussion was commonly a basis for the supervision.

A significant difference from those prior experiences of supervision and [the MOSS's] experience in the Southern Health setting was that there was no regular time for him in Southland set aside for supervision. It is [the MOSS's] view that pressure of work prevented that regular time from being established. Despite that absence of regular dedicated time for this support and advice from a senior colleague [the MOSS] felt that had there been a case that needed discussing he would have taken it to [the Clinical Director]. [The MOSS] noted to the Panel that there was plenty of input from nurses and others on the ward.

One forum for such input was the ward round attended by a variety of staff, including other senior medical staff. At the time of Mr Burton's care there were at least 3 other senior medical staff members who were available to attend those meetings, of whom at least 2 were vocationally registered Psychiatrists. Records of attendance for 5 of those ward rounds in the period suggest that on these dates the following numbers of medical staff were present:

22 February	**2** (1 MOSS – [the Medical Officer Special Scale]; 1 Psychiatrist – […])
1 March	**4** (2 MOSS – [the Medical Officer Special Scale], […]; 2 Psychiatrists – [the Clinical Director], [Psychiatrist A])
8 March	**4** (2 MOSS – [the Medical Officer Special Scale], […]; 2 Psychiatrists – [the Clinical Director], [Psychiatrist A])
15 March	**2** (2 MOSS – [the Medical Officer Special Scale], […])
22 March	**3** (2 MOSS – [the Medical Officer Special Scale], […]; 1 Psychiatrist – [Psychiatrist A])

Notes of those meetings do not allow the nature of the contribution from each of these staff to be identified. It is evident though that as a forum for consistent supervisory input on a regular basis from a more experienced member of the medical staff group, it would have been of limited value. On one of the occasions during the period of Mr Burton's care, no psychiatrist at all was present.

Family participation

A Southern Health Mental Health Unit procedure document titled "Family and Carer Participation" (dated 27 September 2000) identifies that families and carers are involved in discharge planning with the patient's permission. A family meeting format is to be utilised to develop a treatment plan in partnership with the patient, family and carer.

The clinical record does not clearly show whether Mr Burton was specifically asked if he wanted his family involved in such discussion. There were however a number of occasions on which information was obtained from family and on which there was some discussion of proposed plans. As noted elsewhere however, [Mr Trevor Burton] does not feel he was sufficiently informed regarding aspects of his son's condition.

[The MOSS] did report that he hoped to have done some work about reintegrating Mr Burton with his family. His view was that a meeting between Mr Burton and his mother

was a priority to assess where the problems were, and to provide an opportunity for Mr Burton and his mother to start talking through their difficulties in a safe environment.

This aim may well have been reasonable, although it might be questioned whether the assumption that there was a problem other than a psychotic illness was reasonable and on what basis this view was reached. Assuming though that this was a reasonable approach, it is hard to know why this was not pursued while Mr Burton was an inpatient, in a setting far more "safe" than when he was away from the ward, and where monitoring of the impact on him of any interaction was much more possible than when he was an outpatient. [The MOSS] talked of learning from Mr Trevor Burton of a reluctance by Mrs [Paddy] Burton to be engaged in such process, and that the family decided that Trevor Burton only would be involved. Mr Trevor Burton can recall no suggestion from the clinical team that there be any meeting aimed at reintegration, and says there was no invitation to attend a meeting with all members of the family.

The Panel can not know whether such invitation was made and was not understood or heard, or whether such invitation was intended but did not happen, or whether some other breakdown in communication occurred. What does seem apparent however is that there was insufficient closeness in the working relationship between the clinical team and the family for each party to know what the plans and hopes of the others were and how they were intending them to be addressed.

Leave planning

A Southern Health Mental Health Unit procedure document titled "Authorisation of Leave for Inpatients" (dated 27 September 2000) notes that the multidisciplinary team makes recommendations regarding leave after consideration of the patient's mental health, potential risks and requests from the patient and their family. The psychiatrist authorises leave which is to be documented on the team review form. Subsequent changes are to be highlighted in the clinical notes.

Approval of day leave is recorded on the weekly review summary of 14 February. No other reference to leave occurs in these summaries until the record of 21 March, which notes "1 weeks leave meds. Contact K/W [Community Mental Health Nurse] tomorrow".

A file entry by [the MOSS] on 14 February confirms his permission for Mr Burton to have day leave. There is no reference to Mr Burton's mental state, to his intentions for the leave, or to any particular conditions attached to the leave. No risk assessment had been completed. A subsequent nursing file entry suggests the leave was to go swimming with the activities coordinator. Further nursing file entries reflect other periods of leave to attend activity programmes on other occasions.

Nursing notes record at least 2 episodes in which Mr Burton left the ward for reasons other than to attend an activity programme. On one he returned after having been seen going into a bar (24 February) and that evening vomited in his room. There appears not to have been any consideration of leave privileges following that event. On another occasion (28 February) he left the ward with another patient and was found in possession of a large quantity of alcohol. It is not until the end of the nursing shift 24 hours later that a file entry records a review of leave status and that he was to have escorted leave only with staff.

A further, longer period of leave occurred toward the end of March. Mr Burton had been assisted in finding a flat and was to have a week of leave. Arrangements were made for [Social Worker A] to make contact with Mr Burton during that period. This arrangement is further discussed in detail in other sections of this report. In brief however, the arrangements made for review of Mr Burton's mental state were inadequate during this period. Clear evidence of behaviour that ought to have led to concern by [the MOSS], especially given his statement that attention to alcohol abuse was "top of the list of things to address", did not result in any change in the leave provisions.

C2 (c): Adequacy of performance of **[the Medical Officer Special Scale]**

Overall, [the MOSS] did not perform to a standard that would be expected of an unsupervised MOSS. He was largely left to function as a psychiatrist, but did not have the training or skill to do so. In general he lacked sufficient clinical scepticism to ensure that enough consideration was given to the most clinically significant possibilities for the basis of Mr Burton's presentation.

For example possible indicators of persisting psychotic persecutory delusions, such as a tape on the door handle, or comments that his mother was not in his life any more, were not explored or taken into account in a more cautious approach to treatment. Sleep disturbance was attributed to alcohol use without evidence of systematic attention to other possible factors suggestive of relapse of illness. Mr Burton's assurance that he was continuing with medication was accepted, despite the clear history of need for considerable attention to this while previously out of hospital, because he had been compliant on the ward. Triggers for review of risk alert status (e.g. incidents of aggressiveness) were not evidently acted upon.

There is little evidence of attention to medication once the dose of olanzapine was increased on admission. Regular systematic review of the effectiveness of the treatment, or of tolerance of it, is not evident. There was a prescription for 'prn'[64] medication on admission, but the indications for this were only vaguely specified (for agitation). The file entry notes it was to be used as required, with no indication of in what circumstances it was to be used. Such specificity is good practice, as omission risks inappropriate over or under use of medication. Two days later the nursing file note reflects [the MOSS's] view that the prn medication was not to be used "unless absolutely necessary", but again what such necessity might include is absent from the chart.

Insufficient assertiveness was taken with Mr Burton, who was often allowed to determine the course of events himself. He was allowed to limit exchanges to passing conversations in corridors, he was allowed to determine where the alcohol and drug assessment was to occur, he was provided with a supply of medication much greater than [the MOSS] preferred on discharge, he was allowed to decline attendance in a day program, and he was allowed to dictate the timing of a discharge meeting to such a degree that a key participant was absent.

Excess concern was placed upon developing a therapeutic relationship with Mr Burton, even in the face of clear evidence that this was not likely to occur. [The MOSS] hoped for example that if he could come to an agreement with Mr Burton where Mr Burton would drink less then he would work on that rather than using the Mental Health Act and then

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[64] As required

having no therapeutic relationship. There is no evidence that Mr Burton did resolve to drink less, yet that approach by [the MOSS] persisted.

There was insufficient rigour in following through with intentions and plans. [The MOSS] noted that the needs assessment should be followed up, but did not ensure that occurred. He did not take notice of the content of the assessment notes by the drug and alcohol counsellor. There was little follow through of efforts that commenced to explore residential rehabilitation with a drug and alcohol focus. A suggestion in the nursing notes on 12 March, after discussion apparently between Mr Burton, the nurse and [the MOSS] records an intention to encourage flatting in Invercargill or Dunedin with input from early intervention. This appears not to have been pursued further.

Insufficient attention was paid to alcohol usage, despite this being a top priority to address. No attention seems to have been paid to the documented assessment from Rhanna Clinic (certainly not enough to notice elements of the history noted) and there was no follow through on plans that were initiated, but not completed, such as the needs assessment and search for residential treatment options, with or without attention to drug and alcohol use. The risk assessment was also not completed.

Major deficits in [the MOSS's] documentation have been identified, along with inadequate attention to his own needs for supervision.

C3 [Patient Services Manager]

["Patient Services Manager" refers to] the Patient Services Manager – Mental Health. She now reports directly to [the General Manager of Hospital Services], but at the time of Mr Burton's care the reporting relationship was to the [Chief Executive Officer].

C3 (a): Position description

Primary objectives of this position include the development, provision and monitoring of high quality patient focussed effective clinical services, as well as the development of a style of leadership, and management systems and processes, which reflect Southern Health's values and which enable people in the service to contribute to continuous improvement in services.

A variety of areas of responsibility are outlined, with a cluster of performance measures associated with each of these areas.

Delivery of clinical services of a high standard

Much of this report addresses matters where there appear to be problems associated with achievement in this area of responsibility. In particular two performance measures from this area of responsibility are especially relevant to findings of the Panel. These performance measures are

- Services are delivered through effective co-ordination of medical, nursing and other professional inputs
- Staffing levels and clinical cover are appropriate to clinical requirements.

The Panel found significant problems in each of these areas. These are detailed in other sections of this report and will not be expanded upon here. Briefly however there is

evidence that staff did not work in an effectively coordinated way to ensure that activities were completed (such as needs assessment) before further plans were made, and that staff did not communicate effectively to ensure that key personnel were present at important meetings (such as the community key worker being present at discharge meeting), nor that there was an adequate understanding of important elements of a job description (such as the Clinical Director not knowing he had a responsibility to assess performance of medical staff).

There is evidence that staffing levels were insufficient to meet demands. An occupational therapy position in the acute unit was only a small part-time position and had not been filled since the incumbent took maternity leave. Senior medical staff numbers were low. Skills of staff employed in particular roles seemed insufficient to meet the demands of the tasks they were allocated (e.g. [Social Worker A, the MOSS]).

Clinical records were scanty and provided little information detailing mental state. Elements of required documentation, such as risk assessment, were not completed for Mr Burton.

Leading and managing the staffing resources to ensure optimum contribution from all employees

This responsibility includes as a performance measure new staff receiving an appropriate orientation. There is evidence that at least one staff member, [the MOSS], was not introduced satisfactorily to policies directly relevant to his role. He was simply shown the policy manual and told to read it. [The Clinical Director] clearly did not know the contents of his position description. Senior medical staff had not had reviews of performance. There is evidence that suggests that supervision was not provided to key staff involved in the care of Mr Burton ([the MOSS and Social Worker A]) during the period of their involvement in his care.

Develop effective systems for monitoring and improving the quality of services

An important deficit in this area of performance is in relation to incident reporting. There is little evidence of reflection by staff on critical incidents. Some incidents in the course of Mr Burton's care do not appear to have resulted in incident forms being completed. Those that were completed reveal little analysis. The incident documentation shows action taken as a response, but gives no attention to factors contributing to the incident or how future events of a similar nature might be prevented.

Reflection on the incident leading to this inquiry seemed an area of difficulty for [the Patient Services Manager] herself.

[The Patient Services Manager] was asked when meeting with the Panel whether she had a view on the key issues from the period in focus in relation to the care of Mr Burton. Initially she noted that she saw nothing really significant about that period, but that there had been a lot of activity and work since then. When asked more specifically of the period in question and the opportunity to review that time she appeared unclear what was sought with regard to key issues. When finally asked specifically as manager what her analysis was of the problems identified in relation to the care of Mr Burton, [the Patient Services Manager's] response suggested that the major problems related to the lack of options for someone "with a complex set of issues". She noted briefly "issues identified in [Dr

Taumoepeau's] report", but went on to discuss lack of services and resource levels below blueprint benchmarks.

[The Legal/Risk Advisor] for the District Health Board noted that [the Patient Services Manager] was not a clinician. The Panel accepts that. It is clear however that the position description expects the Patient Services Manager to monitor and improve the quality of the service, and familiarity with systems of delivery of care must be part of the role of that person. In the view of the Panel, that does not require the incumbent to be a mental health clinician.

Lead on planning for future service developments

It must be asked whether [the Patient Services Manager's] comment in regards Mr Burton having "a complex set of issues" is accurate. Mr Burton had a psychotic illness, complicated by substance abuse. Relationships with his family were strained for reasons that nobody understood fully. Such a cluster of features is not remarkable in public sector mental health services. [The Clinical Director] agreed that such problems of psychosis and substance abuse were not rare. In fact he told the Panel "… schizophrenic boys of that age who abuse substances are extremely common …".

Given the common presentation, it is a responsibility of the service to prepare to deal with the problems. Some preparation was evident, and [the Patient Services Manager] had supported some training for staff to better prepare them for assisting with substance abuse problems. An area of important need for Mr Burton seemed not to have been addressed in planning and service development and delivery however. This is the matter of residential care for people with mental illness who also use drugs and/or alcohol.

The Panel was told by several staff that PACT houses, offering supported accommodation and residential rehabilitation, exclude from residence people with such a cluster of problems. Review of the copy of the Mental Health Service component of the District Annual Plan 2001-2002 provided to the Panel reveals only brief reference to attention to the problem of such comorbidity, in the form of reference to an initiative to develop a strategy for the service in the provision of services to people with comorbid substance abuse and mental illness, by July 2001. No one the Panel spoke to understood whether this initiative, if completed, had resulted in any change in the practice of the PACT homes.

The Gap Analysis paper prepared by [the Patient Services Manager] in December 2001 identifies a gap in provision of inpatient rehabilitation services, but it is unlikely that all individuals with substance abuse and mental illness would require to be, or could be, accommodated in inpatient rehabilitation services, and attention to the PACT criteria seems a necessary part of the focus of the Patient Services Manager.

Attention is paid in the Gap Analysis paper to the need for an alcohol and drug counsellor within the inpatient unit, and to the need to increase the size of the Occupational Therapy position. These aspects of service development seem very appropriate in light of the problems identified in this review.

Financial management

As noted above, a primary objective for the position includes development and provision of services within financial targets. The Panel was told that there is a sizeable underspend in

the mental health budget, due in large part according to [the Patient Services Manager] to difficulty filling staff positions. [The Patient Services Manager] seemed to have a pragmatic approach to management of the service budget apparently recognizing the priority of clinical demands, over tight management of a budget, and told the Panel it was "best to meet the clinical need first and worry about the financial issues later".

There are examples however of this approach not actually being followed through. [The Patient Services Manager] spoke of a candidate for a Forensic psychiatrist appointment who wanted a full-time role but where there was funding for only a part time post. This candidate was lost to the service because there seemed to be an inflexible approach to the size of the position, despite a critical and ongoing shortage of senior medical staff. Possibilities would exist for this person, who might be expected to have skills in assessing and managing risk, to provide a part-time role in "pure" forensic psychiatry as a specialist clinical area, but also offering clinical service to other people with substantial risk elements in their presentation, and offering teaching and supervision to other staff in this area of risk management about which there seems poor general understanding in the service.

Despite the evident clinical need no decision was made to increase the size of the occupational therapy position in the acute ward.

In another example, assistance was sought from a community trust to fund part of a joint clinical and academic position with the University. Why money should be sought from a community resource rather than the service accepting the responsibility entirely, especially at a time when there were many posts unfilled and money available, is unclear.[65]

Each of these examples appear to point well away from 'clinical need first, money later' approach.

C3 (b): Relationship with Clinical Director

The Patient Service Manager position description notes amongst the internal functional relationships a connection with "Clinical Directors". The reference to plural Directors suggests no specific relationship with the Clinical Director of the Mental Health Service.

[The Patient Services Manager] accepted however that she is charged with the responsibility of jointly managing the service with the Clinical Director, and the Panel understood this comment to refer to the Clinical Director of the Mental Health Service. She referred to a relationship that was seen by her "very much as a partnership" with [the Clinical Director].

[The Patient Services Manager] identified a long list of people and processes used to assist her in monitoring clinical quality across the service. [The Patient Services Manager] did not however refer to the Clinical Director in these mechanisms until specifically prompted about his role. When asked whether she saw monitoring of standards as an important part of his role, she replied affirmatively. She thought he understood that, but added that because of staffing levels he was often caught wanting to do more than he was able to do.

In fact however [the Clinical Director] did not see monitoring of standards of care as part of his role. When the Panel advised [the Patient Services Manager] that [the Clinical Director] did not know the content of his position description, she commented that she

[65] Southland DHB advised it could not properly fund the academic component of this position.

assumed he had signed off on it. For whatever reason [the Clinical Director] did not know his position description and responsibilities, it would appear that he was not actively involved in monitoring standards, and presumably not therefore in a position to assist [the Patient Services Manager] in that aspect of her role. That might help explain why she did not initially list him in her usual sources of this advice. Even if that is not the explanation, it would appear there is insufficient relationship with the Clinical Director to have noticed that he was not aware of that aspect of his role.

A further question about the partnership is raised by the responses of both [the Patient Services Manager] and [the Clinical Director] as to the training priorities for the service. [The Clinical Director] told the Panel that currently a training priority was matters around risk, “because the service was stumbling from one investigation to another”. This rationale was felt by the Panel to be slightly curious, noting that the rationale was not that this is an important area of practice and one that needed some attention because of inconsistent practice. Training in supervision was also seen as a priority. A further priority was training in psychotherapy.

[The Patient Services Manager] noted that training in Maori mental health, advanced nursing, new graduate nursing, child and youth, management and support for team leaders were the important training priorities. She noted that training priorities were developed as a Team, including the Clinical Director and Team Leaders. Interestingly then these priorities did not match closely with those of [the Clinical Director].

The most serious indicator of a lack of partnership between the Clinical Director and Patient Services Manager arose in discussion of the process of incident review however.

[The Patient Services Manager] was clear that following an incident there is a process of debriefing followed within a few days by a clinical review, generally led by the Clinical Director. For the most serious incidents involving suicide or serious harm an external review is also commissioned.

The Panel had understood from [the Clinical Director] that an internal review did not occur in relation to the death of Mrs [Paddy] Burton and the care provided to Mark Burton and commented to [the Patient Services Manager] that this seemed a variation from her statement about the usual process. [The Legal/Risk Advisor] attempted to clarify some matters for the Panel at this point in the discussion.

[The Legal/Risk Advisor] noted that that was indeed what [the Clinical Director] had said, but added that he had himself attended a review on a Tuesday or Wednesday following “the incident”. [The Patient Services Manager] appeared to confirm this event having taken place. [The Legal/Risk Advisor] added that the findings were not documented, but should have been. He was sure that this was a clinical review, not a debriefing.

The incident form (number 29996) referring to the death of Mrs [Paddy] Burton notes the intention to conduct debriefings on several days, including one on Monday 2 April and another on Friday 6 April.

[The Patient Services Manager] was not aware, as the person with overall responsibility for the service, of the findings of this internal review apparently led by [the Clinical Director], if indeed that is what it was. If that is not what it was, it should have been evident that a review had not occurred, and the reasons for the non-occurrence understood.

C3 (c): Adequacy of performance of **[the Patient Services Manager]**

Review of the documents provided to the Panel reveals that there has been reasonable attention to a range of matters that should contribute to the development of a satisfactory mental health service. Elsewhere in this report however evidence is outlined that suggests that there is a considerable gap between policy and practice. The Patient Services Manager seems unaware of the size of this gap, at least in some areas.

There is an impression that there is a great deal of attention to ensuring that the Mental Health Service dollars are strongly protected, which is commendable, but this appears to be to an extreme degree to the point that community trust funds are used to support a clinical post even when unspent medical salaries are available. With respect to the element of her position description in relation to financial management, [the Patient Services Manager] would appear to be performing satisfactorily. She has been active in developing proposals for bridging gaps in service provision. Of concern however is whether the budget surplus in the mental health service has been developed at the expense of effective delivery of clinical services, with decisions based upon financial prudence rather than meeting clinical need.

There is evidence of failings in systems of coordination of care, a key requirement of the position description. There is evidence that staff are appointed to positions for which they are insufficiently skilled. Even if not directly involved with or responsible for these appointments, [the Patient Services Manager] should have systems in place to monitor that the appropriate mix of skills are employed, and that practice development strategies are in place. There seems to have been little attention to such strategies, and other parts of the organisation are considerably more advanced in development of positions to increase nursing practice standards.

There is a strong impression that there is no real partnership between the Clinical Director and Patient Services Manager. This is an important area of concern.

C4 [Team Leader]

[The Team Leader] is the [Acting] Team Leader of the Mental Health Inpatient Unit, Ward 12. At the time of Mr Burton's admission to that unit she worked 30 hours per week. [The Team Leader's] responsibilities by her own account include employing staff, running the unit to ensure adequate staffing levels, and to review and develop policies and procedures. In addition [the Team Leader] noted she was involved in medical staff issues and concerns.

C4 (a): Position description

According to the Position Description one of the primary objectives of the role of Team Leader is to take overall responsibility for the management and leadership of the inpatient unit, both operationally and clinically. This document also notes that the Team Leader takes primary responsibility for the clinical aspects of the team.

A number of areas of responsibility are defined by the position description. These include to "ensure that policies and procedures related to episodes of care are established and implemented for each individual accessing the service."

Although not specified in the performance measures for this area of responsibility, it seems to the Panel that establishing and maintaining satisfactory systems for allocation of patients to staff might be a key element of performance. Certainly such systems would seem to be part of ensuring smooth clinical function of the unit. The role of the primary nurse appears central in such practices.

It does not appear that there is a consistent method of ensuring that there is a primary nurse allocated. The Panel noted comments such as "I agreed to put myself down as primary nurse" ([Staff Nurse A]), and noted that for Mr Burton a primary nurse was allocated almost immediately prior to that nurse being rostered on to night duty. For the greatest part of Mr Burton's care no one can identify who actually was primary nurse, nor is there any record of allocation that can now allow that person to be identified.

[The Team Leader] told the Panel that at the time of Mr Burton's care the primary nurse would often be the nurse who had been involved in admitting the patient, or it may be that at the next hand-over there would be discussion of who was the appropriate person to take this role. [The Team Leader] noted that she would "look over" the allocation to check the mix but added that staff tended to allocate according to interest. [The Team Leader] at times would steer the process.

It is not clear whether such steering was exercised in relation to Mr Burton.

There is no system for documenting who is the primary nurse other than on the white-board in the nursing office. No enduring record is kept.

The roles of staff appear to be determined by designated responsibilities (such as primary nurse, or allocated nurse), but also by whoever is working at any time.

[The Team Leader] referred to some policy and procedure statements that clarify the role of primary nurse. In the absence of a specific description of the role, those documents appear to be the only formal written outline to guide practice of that nurse. [The Team Leader] also was clear, as was another staff member who appears to have accepted primary nurse responsibility ([Staff Nurse A]), that a key responsibility of the primary nurse was to oversee and co-ordinate care of an individual client.

When asked specifically however if the primary nurse was responsible for coordinating patient care, or was it someone else in the clinical team, [the Team Leader] responded by qualifying "If the primary nurse was around Monday to Friday. It is usually the nurse who is allocated to the patient Monday to Friday who will pick up on the coordinating of care." For further clarification she was asked if it would still be the primary nurse responsibility, though they may not be able to do these things themselves; [the Team Leader] responded "Yes, or often the associate nurse will pick it up. Or the other person who may pick up some of these things is the nurse who has been involved in sitting in on an interview …".

So it is evident that a variety of people were seen to be responsible for coordinating care. There appear to be various possibilities for people who might see themselves as having a responsibility for oversight and implementation of plans.

"Steering of the mix" of nursing skills and allocation of the primary nurse role alone may therefore not be sufficient to ensure that there is actually anyone who will ensure that assessments are completed and plans are implemented.

For Mr Burton, the apparent lack of a clearly identified individual with oversight of his nursing care resulted in incomplete assessment and treatment planning and poor implementation and review of plans.

Since the time of Mr Burton's care at Ward 12, Team Nursing has been proposed as the way to address difficulties with the primary nursing model such as the discontinuities arising from shift patterns and rosters. Team Nursing will shift the responsibility from a designated primary nurse to a team of nurses, who then collectively oversee the care. This may assist with the supervision of junior staff but it does not guarantee consistency of care or clear lines of responsibility. It is important that the model of nursing care allows for a 'named nurse' who the client and family can identify, and who will coordinate care and have consistent and knowledgeable input into client reviews.

For Team Nursing to work better than the current arrangement, where in fact a variety of people potentially and actually already contribute to elements of the process of assessment and treatment, there must be clear leadership to ensure that the collective responsibility does not simply allow everyone to avoid any individual responsibility and whereby even more gaps in care are not created.

C4 (b): Clinical leadership

Clinical leadership was necessary to overcome the problem referred to above, but appears not to have been consistently available. Such leadership is identified as being a core responsibility of [the Team Leader].

[The Team Leader] told the Panel that the primary nurse should be able to coordinate care. With Mr Burton, it appears that there was no such capacity. The single nurse who actually did identify herself as his primary nurse for a period of time stated to the Panel that it was not her job to make sure others were doing their work. There was no clear indication from this nurse that she had been instructed that such oversight was part of her role or that the Team Leader ensured that this occurred.

Lack of nursing assessment and care planning by both [Staff Nurse B], who [the Team Leader] thought may have been Mr Burton's primary nurse when he was first admitted, and [Staff Nurse A] suggest that [the Team Leader] did not ensure that the primary nursing responsibilities were being carried out effectively. She also allowed an enrolled nurse ([Enrolled Nurse A]) to take undue responsibility, and in doing so allowed her to work outside her scope of practice.

In discussing the tendency of nurses to leave admission assessments to doctors, even though present during the admission process, [the Team Leader] commented that it was perhaps because "we're still in part of the medical model …". She noted that only more recently with arrival of more junior medical staff have nurses felt able to be more assertive. [The Team Leader] has not been able to effectively provide the mandate and support for nurses to take an active role in assessment processes with doctors, whether or not they

knew the patient. There was no indication to the Panel of attempts by [the Team Leader] in her senior capacity to try to adjust the apparently doctor driven "medical model".[66]

[The Team Leader] seems unclear of the responsibility for risk assessment. She told the Panel that it is the responsibility of the doctor to complete the risk assessment. The policy document says that it is completed by doctor and nurse. [The Team Leader] commented that the nurse who is there "will maybe" participate and that if the nurse has background knowledge of the patient then they will contribute to the assessment. There was no indication though that the nurse was expected to actively solicit new information or clarification in this or other aspects of assessment.

The computer based nursing care plan completed for Mr Burton is based upon the system in place over the rest of the hospital. It was apparently recognised that this system was not well suited for psychiatric care, but the Panel were not told of vigorous attempts to resist implementation of a poor system in that service, or of efforts to change it, or direction to staff about how best to use it. Rather the Panel was told by [the Team Leader] that the plans "are not exactly ideal", "they weren't developed for us", "it's difficult to get people to use them", and that they are "working toward" changing them.

With regard to documentation [the Team Leader] noted that failure by nurses to undertake and document mental state examinations daily was a difficulty "we're trying to work on, getting people to see that it's important".

[The Team Leader's] job description does not say anything specific in regard to nursing leadership. No one explicitly appears to have had a role in modelling standards of practice for nurses in particular within the ward.

Although [the Team Leader] recognised that the skill level overall of the nurses on the ward was not high, commenting "… Basically we are a training ground …", there were no nurses on the ward with a mandate to be role models for or to mentor nurses, other than for those on the nursing New Graduate Programme. Despite the presence of Practice Development Nurses in other parts of the hospital there were until very recently no such positions in mental health. It is unclear whether there had been any efforts by [the Team Leader] to address this lack of nursing leadership. The responsibility for this also lies with the Patient Services Manager and the Director of Nursing.

[The Team Leader's] job description encompasses a large number of different areas of responsibility yet she only worked part-time, 30 hours per week. She herself was unable to model good clinical practice because of the other demands upon her time.

In some important aspects [the Team Leader's] approach and understanding does seem to have provided a model for other staff.

[The Team Leader] noted to the Panel in relation to the risk assessment of Mr Burton that once the letter from [Mr Trevor Burton] was received, [the MOSS] reassessed Mr Burton and was happy with his progress. As Mr Burton had settled in the ward and because "we

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[66] Within psychiatry the term "Medical model" is often used by staff especially those other than psychiatrists – to describe a limited biologically oriented approach to assessment and treatment. Within psychiatry though the "medical model" explicitly recognises the contribution of much more than the biological domain, including attention to aspects of function to which nurses and other disciplines can contribute a great deal.

did not have any indications to the contrary" nothing further was done. [The Team Leader] was satisfied that risk would be reassessed on discharge and therefore that further close attention to risk at that point was not required. She noted that Mr Burton's paranoia was not intruding upon the ward environment and was not intruding upon anyone else at that point.

This focus on whether there was simply a risk in the ward environment is echoed by statements from other staff.

But in fact there were indications that there may have been some intrusion onto the ward of the impact of his psychotic symptoms and substance abuse. As recently as a few days prior to the period of leave there were indications there were persisting persecutory ideas (19 March) and that review of risk may be warranted. He was noted to be harassing a female patient for the name of her boyfriend to assist with supply of drugs, on 20 March. On 18 March "cannabis utensils" had been found in his room. There was an incident in the ward that involved threats toward a staff member and punching a wall (24 February) that ought to have triggered a review of risk assessment, but did not. Another incident in which Mr Burton hit another patient (12 March) similarly did not result in formal review of risk. Notes reflect another incident (4 March) in which Mr Burton was in verbal conflict with another patient. That also appears not to have resulted in closer assessment, despite the same entry reflecting some apparent persecutory ideas.

Despite these several indicators of concern, and despite evidence that there was an impact of risk factors on the ward, no thorough review of risk was completed.

Another area in which [the Team Leader] had an opportunity to model a positive approach, but where her failure to do so appears to have been echoed by other staff, was in her brief telephone interaction with Mrs [Paddy] Burton. [The Team Leader] was answering the telephones one day. She answered a call from Mrs [Paddy] Burton who had rung to leave a message. [The Team Leader], discussing this brief interaction, noted that she just took the message because that is what her role was, and commented that she does not tend to become involved in care unless the patient or family seek that.

This seems to have been an opportunity to involve Mrs [Paddy] Burton. [The Team Leader] was aware that Trevor Burton had had contact with [the MOSS] and felt that Trevor Burton was the "first port of call". The telephone call seemed to signal however that Mrs [Paddy] Burton was at least interested to some degree, and even if [the Team Leader] was too busy to spend time engaging Mrs [Paddy] Burton on that occasion, there may have been a chance to have other members of the team return the call and continue a process of engagement. Other staff however appear to have followed this approach of very limited interventions, dealing with only the matter immediately at hand.

C4 (c): Adequacy of performance of **[the Team Leader]**

It is difficult to make an overall judgement about the performance of [the Team Leader]. An over-riding impression of the Panel is that a huge set of responsibilities is carried by [the Team Leader] in a part-time position, and it appears that she is stretched so thinly that many of the modelling and coordinating functions associated with her role are unable to be satisfactorily performed. There seems to be no shortfall in awareness of key matters in regard to the function of the ward, and to many of the systems and standards that should be applied, but the time to implement and maintain these appears limited.

Generally it appears that [the Team Leader] has led a cohesive team in which there is a high degree of loyalty and commitment to the work. Her management of the ward seems to have resulted in a relatively stable nursing workforce in the face of national mental health shortages.

There are however areas of her leadership which were less than satisfactory in terms of ensuring that the team provided consistent, accountable care of a high standard. The “hands off” approach to nurse allocation left a situation in which the responsibility for Mr Burton’s care was unclear and the lack of clinical leadership resulted in aspects of nursing and other care being inadequate or incomplete. [The Team Leader’s] own practice provided a poor role model in terms of family engagement and attitude to risk assessment.

There are some areas in which [the Team Leader] could have performed differently, even in the face of constraints of time. She appears to have a view that risk assessment is a medical responsibility, rather than a joint one as suggested by the service policy. That seems to be an issue of knowledge rather than availability of time. Somewhat at variance with this view of the responsibility regarding risk assessment is another view she expressed to the Panel, that risk is part of someone’s mental state. [The Team Leader] indicated that she thought that nurses are often assessing for risk but may have trouble verbalising that. There was little evidence in the actions of other nurses to support the validity of this proposition, but there was also little evidence that [the Team Leader] encouraged nurses to see this as a standard part of their approach. Most were of the clear view that they were not responsible for that aspect of assessment.

Use of language is another area of practice that demands little time to correct yet which can have an important effect on other staff attitudes and values. [The Team Leader] demonstrated some examples of language in her meeting with the Panel that are not consistent with efforts to enhance understanding that people are more than any mental illness they may experience. Examples noted included “… a schizophrenic mother …”, “… any young paranoid person …”, “… a sub-acute person …”, and “… all these young dual diagnosis gentlemen …”.

Another area where [the Team Leader] might have taken a lead following the period of care of Mr Burton is that of critical analysis on her own and her team’s performance. There is little if any evidence of encouragement of staff to reflect on events, to learn from incidents, and to use that process to develop systems to enhance individual performance.

C5 [Social Worker A]

… At the time of Mr Burton’s care [Social Worker A] was employed for a total of 0.5 FTE (half time) all of which was attached to a role in the acute inpatient service.

Standards against which his practice can be measured are contained in his job description, the National Mental Health Standards and the Social Work Standards of Practice for the Aotearoa New Zealand Association of Social Workers, as well as Southern Health organisational policies and procedure documents.

C5 (a): Position description

[Social Worker A's] job description identifies his position as being a part of the Mental Health Inpatient Unit. Team members are to work closely with 'consumers/family/whanau' in a supportive educational and clinical role.

Amongst the areas of responsibility defined by the job description is an item 'clinical competency'. A number of performance measures are defined against this area of responsibility. These include conduct of assessments, although the nature of these assessments is not identified. There is reference to working autonomously with referred consumers within various policies and procedures, utilising other team members' expertise and support where appropriate. The social worker is to ensure effective treatment plans and/or recommendations are made.

In his interview with the Panel, [Social Worker A] commented that he did not normally do needs assessments as "that's been taken over by our needs assessors". He then commented however that "we can do assessments". He continued with an account of psychosocial assessment being an ongoing process, and that the more involvement there is of family and friends the more information comes to light. Following this reasonable comment in regard assessment as a process, [Social Worker A] then said however that with respect to documentation of his assessment he would leave it to nurses to take a lead role, as he had not come from a mental health background.

There is in fact no documentation of any conclusions [Social Worker A] reached from his ongoing assessment and involvement with Mr Burton. Entries in the file are largely descriptions of events with little if any analysis. There is no evidence that he made effective treatment plans or recommendations as expected by the description of his role.

[Social Worker A's] involvement in the care of Mr Burton was most evident in the period of trial leave from ward 12 in the period from 22 March to 30 March.

In or about that period of time [Social Worker A] documented contact with Mr Burton on the following days:

22 March	(Thursday) – accompanied to WINZ that day.
23 March	(documented on 26 March) – noting possession and use of quantities of alcohol. Left phone message for parents regarding possessions requested by Mr Burton.
26 March	Discussion with […] about Mr Burton not being interested in activity group.
26 March	Visit to Mr Burton. Notes use of further quantities of alcohol. Notes Mr Burton "… kept waking up".
27 March	Mr Burton visited [Social Worker A]. Notes disturbance of sleep. No apparent inquiry into alcohol use.
28 March	Visit. Notes consumption of whisky in large quantities.
29 March	Visit. File notes "consulted [the MOSS]".
30 March	Participation in discharge meeting. File note by [Social Worker A] on 31 March records his intention to see Mr Burton for a further week. Planned to arrange "intro meeting" and hand over to community staff.

It seems that [Social Worker A] himself recognised that he could not assess Mr Burton's mental state and that his role therefore was of monitoring in some other capacity. He seems to have operated in accord with his job description, that is seeing himself as working with other people, notably nurses, to monitor mental state. As is noted elsewhere in this report however, there was actually no other arrangement in place for monitoring of Mr Burton's mental state.

[Social Worker A's] approach to attempting to engage with Mr Burton, through casual exchanges, seems similar to the approach taken by other staff. Again however there appears to have been a great deal of casual contact, with little attention to more systematic attempts to assess, and to document this, in a more comprehensive manner. [Social Worker A] was clear to the Panel though that he did not feel he had engaged to the point of gaining Mr Burton's confidence or trust.

[Social Worker A] did not read the old notes relating to Mr Burton's past care. He told the Panel that he was not psychiatrically trained so his practice was oriented toward tasks. This appeared to be a rationale to justify that attention to history and clinical phenomena was not necessary. This does not appear to be compatible with the expectation of his position description that notes (within the specific skills and personal qualities) that the incumbent "possess mental health assessment skills, a sound knowledge of intervention options and an ability to implement these".

It would appear appropriate for a social worker in an acute inpatient unit to have familiarity with assessment of mental state and an awareness of key symptoms for any individual with whom they are involved, and a broad understanding of mental illness and its impact. This appears to be supported by the position description for the social worker.

This appears not to have been expected of [Social Worker A], yet such knowledge and skill is especially important if he is expected to have a role in monitoring the mental state of a patient on leave, without the support of other clinical staff. This was the arrangement with Mr Burton, without involvement of other staff in assessments.

[Social Worker A's] limited understanding of mental illness and its impact is evident in aspects of his practice.

There appears, for example, to have been limited consideration of possible causes for certain aspects of Mr Burton's behaviour. [Social Worker A] noted at one point, in commenting upon Mr Burton not getting out of bed in time, that Mr Burton "chose" to remain in bed. Possibilities such as excess sedation from medication, or significant negative symptoms of a psychotic illness leading to lethargy and amotivation, were not considered as possible causes of this aspect of behaviour.

[Social Worker A] had an "instinct" that there was much to the relationship between Mr Burton and his family that he was not seeing, which may have been accurate, but a key element – that Mr Burton had delusional ideas about his family that led him to want to distance himself from them – does not appear to have been understood. He told the Panel "… there were a lot of issues I was not aware of …". This important issue for Mr Burton, of delusions regarding his family, might have become evident to [Social Worker A] had a standard part of his practice been to pay more attention himself to the contents of the files.

These examples are not unexpected perhaps if there has been limited training in psychiatric illness, although these appear to be common enough problems in an acute setting to expect that they may have been encountered before, and might be the subject of discussion in a clinical context or in supervision.

Another area of responsibility defined by the job description is Professional and Personal Development. Amongst the performance measures appear receiving peer supervision, actively pursuing educational opportunities appropriate to social work, and receiving clinical supervision in accordance with ANZASW guidelines.

[Social Worker A] appears to have viewed Mr Burton and his problems in the light of his own experiences in his personal life. On a number of occasions [Social Worker A] commented on matters that directly related to his own life, comparing them with Mr Burton's life, and drawing conclusions based upon this comparison. This included matters such as alcohol and marijuana use, "what it's like to be alone", and perceived family problems. These would normally be important matters to be attending to in supervision. One purpose of supervision is to ensure that one's own life experiences do not lead to patterns of understanding and response that distort the clinical reality.

[Social Worker A] told the Panel that he did engage in a peer supervisory relationship with another social worker, [Social Worker B]. [Social Worker B] had been involved in Mr Burton's care in Queenstown, but [Social Worker A] told the Panel that he felt it would not have been appropriate to raise his case with her, apparently precisely because of her involvement.

[Social Worker B] however told the Panel that she and [Social Worker A] had only met for peer supervision on three occasions, all since Mr Burton's discharge from Ward 12 in March 2001.

Evidence available to the Panel regarding the supervisory relationships for [Social Worker A] is confusing.

The discussion with [Social Worker A] led the Panel to the view that he was seeing [Social Worker B] in a peer supervisory relationship at the time of Mr Burton's care. [Social Worker B's] comments contradict that. The Panel may have misunderstood [Social Worker A's] comments about the timing of this supervision with [Social Worker B], believing it was concurrent with care of Mr Burton. This appears not to have been the case. Alternatively, the Panel was misled by [Social Worker A's] comments, to believe that this was a concurrent process. Although he had said that this was occurring "at the moment", other questions in relation to the content of that supervision and whether Mr Burton was discussed did not result in a response that that was not a concurrent relationship, but (as noted above) because "she's intricately a part of that case, so I wouldn't have discussed that with her".

[Social Worker A] did not indicate any other supervisory relationship prior to that with [Social Worker B].

[Social Worker A] told the Panel that outside supervision had been arranged, to occur with [another social worker].

Subsequent to these interviews, the Panel sought further information from Southland DHB Panel regarding supervision of [Social Worker A]. Southland DHB identified … (a Social Worker from Te Korowai Hau Ora Maori Health Unit) and … (a Cultural advisor for Te Korowai Hau Ora) as the supervisors for [Social Worker A]. The period of this supervision was not specified and there is no information as to the form or proposed content.

[Social Worker A] did not show evidence of taking responsibility in actively pursuing educational qualifications appropriate to his social work role within the mental health unit or the field of mental health or dual diagnosis. [Social Worker A] has worked for the Southland District Health Board for two years. He stated to the Panel that he is not "psychiatric trained" and relies on his colleagues for this input. He referred to having done some learning relating to the mental health field, but could not specify what this learning was. [Social Worker A] showed no evidence of seeing this gap in knowledge as something that should cause some concern. [Social Worker A] did not show any insight into his knowledge deficit as being of any importance in his work in this field.

C5 (b): Aotearoa New Zealand Association of Social Workers Standards of Practice

[Social Worker A] advised the Coroner in his brief of evidence that he was a member of the Aotearoa New Zealand Association of Social Workers (ANZASW).

The ANZASW Standards of Practice require a social worker to establish an appropriate and purposeful working relationship with clients. The contacts that [Social Worker A] had with Mr Burton appear to have largely been very informal. [Social Worker A] was not able to explain fully the purpose of his interventions with Mr Burton, apart from establishing a trusting relationship with him. He talked of avoiding interactions that Mr Burton might perceive as intimidating. He describes his interventions as largely "task orientated" and through discussion with the Panel it appears that much of his role was that of an observer rather than active seeker of new information and internal phenomena.

The social worker is expected to implement goal oriented interventions in accordance with the ANZASW Standards of Practice and Code of Ethics. There is limited evidence to suggest that [Social Worker A's] interventions with Mr Burton were "goal directed" apart from the occasion when they went looking for a suitable flat and the car maintenance group with a specific task at hand.

The ANZASW Standards of Practice require that the social worker has knowledge about social work methods, social policy and social services.

There appear to have been mixed expectations regarding the role of [Social Worker A] during the period of leave. [Social Worker A] himself was very clear in his discussion with the Panel that he relied upon close contact with nursing staff in making assessments of mental state, risks and signs of relapse. He did not see himself as able to have a role in monitoring Mr Burton's mental state in that week of leave.

[The Team Leader] however had that expectation, noting in her statement to the Commissioner that her expectation of [Social Worker A] was "to monitor medication compliance, living environment, general well being, social functioning, alcohol/drug issues and report back any change in his mental state".

Mr Burton's primary nurse at the time of leave noted in the file that [Social Worker A] was to follow-up each day. The purpose is not clear from the record. [Staff Nurse A] told the Panel that [Social Worker A] was not assessing mental state "but he was visiting him …" and that he documented his observations.

It might therefore not be surprising if [Social Worker A] was unsure of his role in the face of these differing expectations, especially with his lack of mental health experience.

But even with the experience he did have, [Social Worker A] failed to see that structured intervention within an office setting (rather than casual exchanges in less 'formal' settings) need not be an abuse of power within the consumer/social worker relationship. [Social Worker A] appears to have limited understanding of the issues around confidentiality and privacy and the opportunities for creating a safe environment for a consumer by organising an effective setting in which to engage with Mr Burton. [Social Worker A] failed to see the possibility of utilising the office environment while acknowledging the power differential between worker and consumer, limiting authority and empowering Mr Burton to participate in discussion regarding issues, decision-making and future goals.

Standard 6 of the ANZASW standards of practice set out that the social worker should only work where systems of accountability are in place in respect of his agency, clients and the social work profession. This standard notes that the social worker works within agency policy and procedures. Specific policies are referred to later in this section of the report, with evidence that [Social Worker A] has failed to reach the standards as described.

The social worker is accountable for his/her practice through supervision or some other oversight. As noted above, in discussion of his supervisory relationship [Social Worker A] talked of his understanding of supervision, which led the Panel to consider whether he was familiar with the supervision policy for ANZASW or the clinical supervision policy for Southland DHB.

As also noted already, the evidence about whether there was actually any individual supervision in place at the time of Mr Burton's care is unclear.

ANZASW Standard 8 requires that the social worker acts to ensure the client's access to resources and opportunities.

With reference to this standard, [Social Worker A] has shown attempts to put Mr Burton in touch with resources and opportunities, such as the programme run at [Dee] Street. [Social Worker A] failed however to identify the factors impeding access to resources or other therapeutic interventions. He did not recognise for example that Mr Burton might be handicapped by negative symptoms of a psychotic illness, rather than simply "choosing" not to get out of bed, or that continuing to decline contact with his family in the forum of a family meeting might be related to persisting symptoms of psychosis, rather than simply feeling rejected.

[Social Worker A] failed to identify the gaps in Mr Burton's care in the flatting situation where he had no supports for the entire weekend period and only contact from [Social Worker A] himself during the week. He documented some of his observations, but did not disseminate the information about client needs in order that they would be addressed. In this way he failed to use the ward processes, such as the weekly review, to advocate effectively for Mr Burton's needs to be addressed. Although he did apparently discuss

some concerns with [the MOSS], there was no involvement of this other weekly forum with the potential contribution from other disciplines that might have added to the range of options available to Mr Burton.

[Social Worker A] did not demonstrate knowledge and understanding of the roles and contributions of others in addressing Mr Burton's needs or other agency resources and services that are available to meet a client's needs.

C5 (c): Organisational policies and procedures

The Southern Health Mental Health Unit procedure "Clinical Risk Assessment and Management" (11 December 2000) is silent as to whether assessment of risk is a responsibility of staff of disciplines other than medicine (psychiatry) and nursing. [Social Worker A] certainly did not see himself as having any role in assessment or formulation of risk. [Social Worker A] saw the role of assessment of risk as a nursing role "on the unit". He appeared to have very limited knowledge regarding risk assessment or management. [Social Worker A] did not indicate that he has had any formal training with regards to risk assessment.

The Ministry of Health Guidelines for Clinical Risk Assessment and Management (MoH 1998) suggest that risk assessment is an integral part of *every* clinical observation or assessment. It would not therefore be unreasonable to expect all clinical staff to have an understanding of principles of risk assessment, and to have some ability to assess and manage clinical risk. [Social Worker A] failed to ensure that he pursued or gained the knowledge required to perform these core mental health workforce tasks, although if there is little organisational expectation that social workers would be involved in such assessment, that is perhaps understandable.

The Southern Health Mental Health Unit "Family and Carer Participation" procedure (September 2000) notes that family and carers are involved in discharge planning and that a family meeting format is utilised to develop a treatment plan in partnership with the patient, family and carer. [Social Worker A] stated to the Panel that for him as a social worker, "a family is everything, it's the be all and end all. It's the most important context that anyone could possibly be in." In his interactions with Mr Burton, [Social Worker A] referred to having an awareness of the problems that Mr Burton had had with his family. It is not evident that he actively tried to engage the family in Mr Burton's care or to pursue the possibility of a family meeting or family input into Mr Burton's discharge plan, although there are indications that he hoped over time that there would be an increase in contact between Mr Burton and his parents.

During the week of leave, [Social Worker A] had telephone contact with Mr Trevor Burton, but did not inform him of how the trial leave was progressing or raise any concerns pertaining to Mr Burton's drinking.

The Southern Health Mental Health Unit procedure entitled "Consumer Record and documentation" (dated 25 November 99) notes that clinical activities are to be documented to assist in the coordinated delivery of care. Any treatment or intervention is to be documented in the clinical notes.

[Social Worker A] did not achieve these documentation standards. [Social Worker A] indicated that he does not necessarily record casual interactions. However, because much

of his interaction with Mr Burton was informal or casual, there was a need to have these informal discussions documented which would have in turn added to the comprehensive picture of Mr Burton during his admission in the unit.

What documentation was completed however, though unstructured, appears to reflect observations that could have been made use of by medical and nursing staff in preparing a care plan and discharge plan.

During his discussion with the Panel [Social Worker A] commented with reference to Mr Burton "obviously he was so unwell so I only got small windows of insight like a couple of times I got to see some really exciting things". This does not appear to have been documented in the clinical notes in such a way as to portray this as a concern.

The Southern Health Mental Health Unit Discharge Policy (January 2000) aims to achieve continuity and coordination of care and treatment. [Social Worker A] was at the meeting with [the MOSS] and [Enrolled Nurse B] on the 14th March where the decision was made for Mr Burton to seek a suitable flat for discharge. According to [Social Worker A], he could not specify on what basis this decision regarding a flat was made, although he recalls thinking it was a good idea. [Social Worker A] did not contact [the Mental Health Needs Assessor] to consult with her regarding the needs assessment.

The consideration of a flat as a suitable accommodation option without assessing Mr Burton's support needs, appears contrary to the discharge policy. It was not developed collaboratively with one of the key other professionals involved in care. The discharge plan is required to contain a needs assessment. The social worker would be expected to ensure that the assessment necessary for placement recommendation had been completed.

There was no crisis plan as part of the discharge plan. It would have been prudent, and sound professional practice, for [Social Worker A] as the designated team member to follow-up Mr Burton during the week trial leave, to insist that these were completed and familiar to him. [Social Worker A] made observations regarding Mr Burton's use of alcohol and disturbed sleep patterns and documented these observations. Apparently due to lack of mental health knowledge and combined with his lack of insight about his own experience of being unemployed and in a new flatting situation, he failed to see this as increased risk for Mr Burton. He did not raise it specifically at the discharge meeting or seek advice or support from the community mental health team nursing staff.

On the 30th March, according to [Social Worker A] he had no prior knowledge that [the Community Mental Health Nurse] was going to attend the meeting. This would indicate that [Social Worker A] was not familiar with the discharge policy for the Southland Mental Health unit.

***C5 (d): Adequacy of performance of* [Social Worker A]**

It appears that [Social Worker A] was not actually given much clarity regarding the purpose of his involvement in the week of trial leave. By his account he did inform [the MOSS] of the significant use of alcohol noted within the first few days of leave, as would have been appropriate. In the absence of further instruction in regard to his role, he does then appear to have had at least some discussion with Mr Burton regarding the alcohol use.

[Social Worker A] appears to have recognised at least some of the limitations of his training and the constraints this placed upon the scope of his role, at least as far as assessment of mental state is concerned. This does not seem to have extended however to an appreciation that his own life experiences and values may not be a sound base upon which to build an understanding of someone with a reality that was possibly distorted by positive and negative symptoms of a psychotic illness. Whether or not he had experience in mental health work however, it was a failure in preparation for [Social Worker A] not to have read old notes in regard Mr Burton.

The reality however appears to be that [Social Worker A] was set up to carry out a task for which he was poorly equipped, with respect to skills and experience in mental health work. He was not given any clear indication that Mr Burton was someone about whom there needed to be any concern, and even his report on alcohol use did not elicit any change in approach to Mr Burton's management. This might have contributed to his apparent decision not to report the episode of suspicion that Mr Burton had used marijuana while on leave, but that in turn led to an opportunity being missed for reconsideration of the plan.

Such limited experience in the mental health sector adds emphasis to the importance of a sound supervisory relationship. The Panel is unclear what weight to put on [Social Worker A's] comments regarding presence of a supervisory relationship at the time of his involvement with Mr Burton. The Panel is clear however that his views of the possible content of a supervisory relationship, and the potential benefit of discussion of specific cases, would not reflect commonly held views of the purpose and reasonable content of supervision.

[Social Worker A] was unable to be clear to the Panel what further training he had had in aspects of mental health assessment and care although noted that one of the advantages that he offered was of having a different perspective. It does appear however that neither he nor his senior staff had attended to the question of how his skills could be developed, given his limited experience in mental health care while still allowing the perspective he offered, on the basis of other experiences, to be maintained.

C6 [Enrolled Nurse A]

[Enrolled Nurse A] … has worked in ward 12 since 1976, although took some time off work in 1984 to 1985 to have children. [Enrolled Nurse A] appears from the notes to have had a reasonably high level of contact with Mr Burton while in the ward during his most recent admission. She also had involvement in his care in Mr Burton's earlier admission to hospital in 2000. In the admission in February 2001, [Enrolled Nurse A] was the nurse who joined [the MOSS] in the admission interview.

A number of documents set standards against which [Enrolled Nurse A's] performance can be judged.

C6 (a): Southern Health: Director of Nursing and Midwifery policy: The Scope of Practice of Enrolled Nurses (1 October 1999)

This document sets out a number of aspects of practice that are in accord with legislative requirements and national guidelines for the scope of practice of enrolled nurses.[67]

This document notes that an enrolled nurse provides nursing care to someone whose needs are relatively predictable and for which the nursing skills and judgements to meet these needs are uncomplicated. As Mr Burton was a new admission and had not yet been assessed, it is difficult to know how he might have been seen as meeting this criterion of suitability for an enrolled nurse to be involved in his care.

This document adds however that in situations involving more complex skills and nursing judgements, the enrolled nurse may assist the registered nurse under his/her direct guidance and supervision. Direct supervision means allocated to a specific registered nurse and working closely with that nurse.

There is no evidence that such a working relationship existed at that stage of Mr Burton's care. There is no evidence that a registered nurse delegated responsibilities to [Enrolled Nurse A], under supervision or otherwise.

[Enrolled Nurse A] developed the initial care plan for Mr Burton. Neither she nor anyone else subsequently reviewed and updated that document.

[Enrolled Nurse A] discussed her role in assessment of risk. She noted that the doctor does the risk assessment and that nurses do not actually do it. A nurse would countersign simply to indicate that he/she was there. [Enrolled Nurse A] did sign an annotation in the risk alert section of the documentation on the day of admission. [Enrolled Nurse A] saw the role of the nurse as just to sit in on an assessment with little contribution unless she actually knows the patient and the doctor does not. She commented that nurses have not been taught how to do risk assessment. In her view, risk assessment was about risk on the ward.

Apparently as a consequence of this view, [Enrolled Nurse A] was not therefore concerned following receipt of the letter from Mr Trevor Burton, that a review of risk was not done,

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[67] Nurses Act 1977

- Section 57(1) The requirement for nurses to be only appointed to carry out duties within their particular 'class' of the Act.
- Section 53 A The requirement for enrolled nurses to work under direction and supervision of a registered nurse or medical practitioner.

Nursing Council of New Zealand Code of Conduct for Nurses and Midwives

Principle One
The nurse complies with legislated requirements
1.3 practises within the area appropriate for the part(s) of the register or roll of the nurses in which her/his name is entered

Principle Two
The nurse acts ethically and maintains standards of practice.
1.6 demonstrates expected competencies in the practice area in which currently engaged
1.7 upholds established standards of professional nursing practice
2.9 accurately maintains required records related to nursing practice

Nursing Council of New Zealand document on Direction and Supervision (see Attachment 3)

as Mr Burton was in a mostly locked environment. She noted "… a lot of our risk thoughts are within the ward not if they leave …". She suggests that that view may have changed since that time however.

With regard to other aspects of assessment, quite reasonably, [Enrolled Nurse A] told the Panel that nurses are doing assessments all the time, "… eye to eye, what you are observing". She appeared to suggest however that only untoward things would be documented but reflected that in hindsight not enough had been documented in the past and that now much more was recorded. She did not see it as solely a primary or associate nurse responsibility to undertake assessments of mental state in their interactions with people.

Over the course of Mr Burton's care in the ward, [Enrolled Nurse A] had a substantial degree of involvement with his care, with evidence in the file of her being attached to him (at least as shown by her documenting in the file) on approximately 20 days of the approximately 6 weeks he was an inpatient. [Enrolled Nurse A] forwarded a referral to the Queenstown Community Mental Health Team and sent a needs assessment referral.

Her evidence suggests that she did appear to establish a relationship with Mr Burton of sufficient degree that she was able to identify systems of persisting psychosis. Documentation is not detailed but identifies some key elements of behaviour and thought content, especially with regard to persisting persecutory ideas. There appear to have been attempts to actively solicit access to thought content, rather than simply observing whether such phenomena were presented spontaneously by Mr Burton.

C 6 (b): Southland DHB Position Description for Enrolled Nurses

The position description does not clearly indicate the Enrolled Nurse's responsibility to work under the supervision and direction of a Registered Nurse or doctor. This failure means that the limits of enrolled nurse practice determined by the Nurses Act are not clearly set out in the internal organisational description of this nursing role.

The position description, amongst other things, requires the enrolled nurse to "ensure consistency and quality of nursing care, maintain professional skills and maintain good communication and interpersonal relationships within the Southland DHB". There is evidence that [Enrolled Nurse A] fulfilled these requirements in relation to Mr Burton within the limits of her training and qualification.

***C6 (c): Adequacy of performance of* [Enrolled Nurse A]**

[Enrolled Nurse A] is an experienced nurse who provided sound care within her level of training and qualification. She formed a good rapport with Mr Burton, assessed his mental state on most shifts and reported this reasonably clearly, although briefly, in the notes. She ensured that the process of care was followed through to the degree that she was instructed by the team or saw necessary from her own experience.

It seems likely that [Enrolled Nurse A] took the role of primary nurse (in everything but name) and co-ordinated his care with little direction from a registered nurse. This is a breach of the Nurse Act, Nurses Code of Conduct and Southland DHB's own policy. Although she is clear that there would have been someone nominated at all times as primary nurse, she appeared by default to take overall responsibility for Mr Burton's care. The evidence that [Enrolled Nurse A] was taking the primary (lead) role includes that she:

- admitted him
- wrote the care plan
- cared for him on every shift she was available except two.
- took a large role in coordination of his care.

The fact that [Enrolled Nurse A] worked outside her scope of practice was her responsibility, but others colluded to make this happen. The registered nurses allowed her to complete the initial assessment and care plan without supervision and did not adapt either of these documents. This meant that there was no formal 'direction' of Mr Burton's nursing care.

There are aspects of Mr Burton's care that are less than satisfactory in terms of involvement of the family, comprehensive planning, needs assessment, discharge planning and coordination with community services. Although [Enrolled Nurse A] appears to have been responsible for the coordination of his care, it is unreasonable to hold her accountable for these deficiencies since she is limited by her training and qualification.

C7 [Staff Nurse A]

[Staff Nurse A] is a registered comprehensive nurse. She is employed as a staff nurse on the adult inpatient mental health unit at Southern Hospital, Ward 12. In her evidence to the Coroner [Staff Nurse A] stated that she was Mr Burton's Primary Nurse from 14 February 2001. However, in her interview with the Panel [Staff Nurse A] stated that she was Mr Burton's Primary Nurse only for the last 2 weeks of Mr Burton's admission. There is a great deal of uncertainty around the role of Mr Burton's primary nurse and this is examined in more detail elsewhere in this report. This section comments specifically upon [Staff Nurse A] in relation to that role.

C7 (a): Primary nursing role

Functions of a Primary Nurse are important so the Panel gave some considerable attention to this area of responsibility.

[The Acting Team Leader] of the Mental Health Inpatient Unit told the Panel that the role of the primary nurse is to check and coordinate care of a patient.

[Staff Nurse A] agreed that the role of the primary nurse is to coordinate care amongst the service, to liaise and to work in partnership with other nurses in the best interests of the patient.

The role of the Primary Nurse is not spelled out clearly in any single one of the documents supplied to the Panel. Reference is made to key responsibilities in various policy and procedure documents however.

The Southland Mental Health Unit Discharge Policy (dated 18 January 2000) notes that all patients will be assessed prior to discharge by their consultant psychiatrist in conjunction with the key worker, primary nurse and other team members involved with the patient. Specific responsibilities are identified for the primary nurse, including (amongst other things):

- Involvement of the service to be responsible for the care of the patient after discharge.
- Consultation with relevant parties in regard to needs of the patient after discharge.

- Referral to applicable professional support services.
- Development and documentation of a crisis plan (in partnership with the patient and others).
- Signing, with the patient, the discharge plan.

The Southland District Health Board, Mental Health Unit procedure document titled 'Entry' (dated 14 November 2000) notes that the primary nurse is responsible for facilitating referral to the Community Mental Health Team requesting a key worker to be allocated or informing the key worker when their client is admitted.

Another document, the Southland District Health Board procedure titled 'Quality Care and Treatment' (dated 1 August 1999) notes that primary nurses liaise with appropriate persons to ensure minimal impact of admission upon the consumer and their family.

Using these documents as a guide, and the Team Leader's outline of the role, consideration can be given to whether [Staff Nurse A's] actions and statements are compatible with the role of primary nurse.

In the Coroner's Court, [Staff Nurse A] on several occasions noted that she "was not in the role of making sure people do their job in another area" (with reference to whether the community key-worker followed up Mr Burton in the week of leave) and "I don't think it's my role to monitor that" (with reference to risk assessment forms being completed).

Somewhat at conflict with this comment however is a further remark made by [Staff Nurse A] at the inquest, in which she said (in response to a question about her writing the discharge plan and whether it was checked by anyone) "I'm sure that if anyone had concerns with the document they would let me know". In response to a question as to whether [Staff Nurse A] followed up with the community team to check they were doing what she thought they were doing (that is, to assess Mr Burton's mental state while on leave) she commented "That would be the role of the community … team".

These comments relate to matters that occurred within a time period in which [Staff Nurse A] identified herself as primary nurse.

There is, as noted already, some confusion over the period for which [Staff Nurse A] was identified as Primary Nurse. Several elements however point to a period in which it seems clear that she was definitely identified as Primary Nurse. Her own statement to the Panel puts her in this role from 2 weeks prior to Mr Burton's discharge. It seems likely however that this refers to 2 weeks prior to Mr Burton having a week of leave, and so places that responsibility as dating 3 weeks prior to discharge. This fits with other statements that [Staff Nurse A] identified herself as primary nurse from just before [Enrolled Nurse A] taking leave, which commenced on 5 March and ended with her return to work on 13 March.

Within that time period a number of elements of a primary nurse role in relation to discharge clearly apply.

[Staff Nurse A] did initiate completion of a discharge plan document for Mr Burton. Timing of this is unclear, but it appears that this occurred prior to the commencement of the period of trial leave on March 22. There is reference in the document to an interview

for a job ("Has interview for job on 23/3/01") that suggests the plan was commenced prior to the period of leave.

Commencing the documentation of the discharge plan is congruent with [Staff Nurse A] having the role of primary nurse.

Other Primary Nurse responsibilities noted above in relation to discharge are less clearly completed.

This leaves the Panel concerned that either [Staff Nurse A] was not Primary Nurse (and therefore misrepresented this to the Panel) or was in that role but failed substantially in the conduct of the associated tasks.

"*Involvement of the service to be responsible for the care of the patient after discharge*"

In the view of the Panel, this responsibility of a Primary Nurse could reasonably be expected to cover periods of leave as well as the period after discharge. It seems likely, even if this responsibility does not extend to a period of leave, that [Staff Nurse A] actually regarded the period of leave as inevitably leading to discharge from the ward. She identified herself as having been Mr Burton's primary nurse for the period of 2 weeks prior to discharge (but which was probably 2 weeks prior to his leave and 3 weeks prior to discharge) and initiated completion of the discharge plan before the period of leave. Even if we accept that starting such a document is reasonable well in advance of discharge, rather than documenting in it an event that will occur prior to discharge (such as the job interview) it would be more useful to identify the outcome of that event. This seems to suggest that it was expected that going on leave was simply a precursor to an inevitable discharge, no matter how successful the leave period might be.

[Staff Nurse A] was clear at the Coroner's inquest that the primary nurse or associate nurse would not leave the ward to monitor the mental state of a person on leave. Her response to the question "would you ask the patient to come to you for review whilst on leave?" was vague, replying "Yes they do". There is no evidence that [Staff Nurse A] made a clear plan for Mr Burton to return for review of his mental state in the period of leave.

[Staff Nurse A] was clear at the inquest, in her statement and in discussion with the Panel that she left a telephone message for [the Community Mental Health Nurse], who was to be community key-worker, that Mr Burton had gone on leave. Evidence as to what [Staff Nurse A] expected [the Community Mental Health Nurse] to do however was less clear.

In her statement [Staff Nurse A] comments that inpatient nurses were not responsible for monitoring Mr Burton's mental state while he was on leave (there had been no arrangement for him to return for such review during leave) and that nurses were being made aware of his ongoing progress by [Social Worker A]. [Staff Nurse A] notes that she understood the responsibility for assessing Mr Burton's mental state was that of [the Community Mental Health Nurse]. There is no evidence however that such request had specifically been made.

As noted elsewhere [the Community Mental Health Nurse] (and other members of the community team) did not expect routinely to be involved in a monitoring role during a period of leave. No specific request was made for that for Mr Burton. [Staff Nurse A] had made no firm arrangement for such action, simply leaving a message that Mr Burton was

on leave, despite knowing (as she told the Panel) that Mr Burton's mental state was something that needed to be followed up on leave. [Staff Nurse A] knew that [Social Worker A] was not able to perform such assessment of mental state, but did not fulfil the primary nurse responsibility of involving adequately the service to be responsible for Mr Burton after discharge.

There was no attempt made to follow-up the telephone message left for [the Community Mental Health Nurse] to ensure follow-up was implemented. [Staff Nurse A] notes that [the Community Mental Health Nurse] had been into the unit previously (in fact this is noted in her evidence at the inquest to have been several weeks before) and was aware of Mr Burton's situation. She noted too the opportunity for community teams to attend the weekly reviews, but added that whether they chose to do so or not was up to them. Such failure to ensure that the community team actually knew what recent concerns had been identified (such as persisting persecutory ideas within a day or two of leave commencing), even if there was a clear plan for the community key-worker to follow-up, appears incompatible with a reasonable standard of practice that would ensure coordination and continuity of care. In identifying the possibility for the community worker to attend, [Staff Nurse A] overlooks her own responsibility in that regard in ensuring that that would occur.

"*Consultation with relevant parties in regard to needs of the patient after discharge*"

As noted above, [Staff Nurse A] did not discuss clearly with the community team any plan for their involvement in the period of leave. [Staff Nurse A] was not involved at the discharge meeting on 30 March.

[Staff Nurse A] told the inquest that it was never expected of [Social Worker A] that he would have a role in assessing Mr Burton's mental state on leave, but did not consult with any other person to arrange such assessment. [Staff Nurse A] had no further part in arrangements for Mr Burton following his discharge from hospital.

"*Referral to applicable professional support service*"

This has been discussed above. It is evident that [Staff Nurse A] did make a referral to the Invercargill Community Mental Health Team (dated 15 February). This apparently, by her evidence to the Panel, was before she became primary nurse even though such referral would ordinarily be a primary nurse responsibility. [Staff Nurse A] also left the telephone message with [the Community Mental Health Nurse] advising that Mr Burton had gone on leave. There was no follow-up action to determine that follow-up was taking place.

It is accepted and understood that [Staff Nurse A] was not able to follow-up Mr Burton while he was on leave. She seems clear that some arrangement for follow-up was necessary. At the inquest [Staff Nurse A] stated that even though she now knows that [the Community Mental Health Nurse] was not involved, she knew that [Social Worker A] would be visiting. [Staff Nurse A] was clear to the Panel however that [Social Worker A] was not there to oversee mental state.

"*Development and documentation of a crisis plan*"

There is no evidence that this responsibility of the primary nurse was completed. Signs of becoming unwell are identified, but no actions in relation to these signs are identified.

Other elements of the discharge plan to be completed by the primary nurse (as outlined in the discharge policy) such as identification of needs assessor, name and address of main support person, and signature of patient and nurse, are incomplete.

Somewhat conflicting accounts are given by [Staff Nurse A] in regard to another aspect of the role of the primary nurse. The discharge policy states that the mental state of all patients will be assessed prior to discharge by various people including the primary nurse.

In her statement [Staff Nurse A] notes that on 21 March she was aware of signs of irritability and paranoia evident the day before. She notes she was careful to look for further signs of this. Her entry in the file on that day is scanty noting the only significant features being "mood bright", "conversation appropriate" and "settled a.m." Significant positive or negative findings, such as concerns regarding Mr Burton's mother and whether these were present or not (or even whether Mr Burton would discuss them) are not noted.

[Staff Nurse A] assessed Mr Burton "briefly and informally" on 27 March. At this time she was on night duty and met Mr Burton in a car park when he arrived to meet with [Social Worker A]. There is no documentation of that assessment. There is no documentation of any concern of [Staff Nurse A] in relation to the amount of alcohol consumed in that week of leave.

[Staff Nurse A] notes her practice is to document any issues she has concerns about. She would also raise concerns at the weekly management meeting.

[Staff Nurse A] in her statement noted that she assessed Mr Burton's level of risk every time she cared for him, identifying a number of appropriate factors that she included in her consideration. At the inquest however she disagreed with a suggestion that she appeared to be undertaking risk assessment from time to time.

"*Requirements to consult with others*"

[Staff Nurse A] advised the Panel that as Primary Nurse she was responsible for the documentation of the discharge plan, in conjunction with [Enrolled Nurse A] in her role as associate nurse. [Staff Nurse A] was on night shift from 24 March so had little opportunity to discuss plans with [Enrolled Nurse A]. She documented elements of the plan on the basis of clinical notes available to her, identifying in particular those of a meeting of March 1st. She notes that she gauged some idea of the outcomes of the meeting.

The Panel have difficulty agreeing that a discharge plan could be based upon notes of that meeting of March 1st, even if taken in combination with the notes of [the MOSS] of 28 February to March 1st, in considering options available.

[The MOSS] noted on 28 February "Discussion about discharge. [Mr Burton] keen to return to Queenstown. Told father not happy with this idea. Suggest look at In'gill (sic) possibilities for accommodation and occupation and leave thought about Q'town (sic) until down track". On 1 March another note reflects [the MOSS's] views that Odyssey House might be a suitable arrangement. The meeting that day involving [Mr Trevor Burton] reflects discussion of Odyssey House, and "[Mr Burton] agreeing to same".

Documentation of this discussion for Mr Burton to go to Odyssey House would appear to be the outcome of this meeting upon which [Staff Nurse A] states she based the subsequent

discharge plan document – but which notes that Mr Burton would go to Invercargill. She did not consult with anyone else.

In response to questions about who she consulted, [Staff Nurse A] cited her discussion with Mr Burton's father on the day he went on leave. "We discussed about what would happen if things didn't go well during the leave period. We also discussed what would happen following his leave, whether it would be successful, whether he would be discharged or not …" It appeared to the Panel that this did not constitute a consultation for the purpose of discharge planning and that no other community staff or family members were approached for their contribution.

***C7 (b): Adequacy of performance of* [Staff Nurse A]**

Objective assessment of [Staff Nurse A] is assisted by reference to a number of documents that outline standards for practice by mental health nurses in this country. Deficits are noted in a number of areas. The documents and relevant standards in which deficits are noted are:

Nursing Council of New Zealand Code of Conduct for Nurses and Midwives
(Specifically, Principle Two)

"The nurse acts ethically and maintains standards of practice."

- *Criteria 2.4 demonstrates expected competencies in the practice area in which currently engaged*

[Staff Nurse A] did not demonstrate the competencies expected of a registered mental health nurse in the acute setting. She did not undertake comprehensive nursing assessment and planning or update the existing plans for Mr Burton. Neither did she complete mental health assessments on shifts in which she cared for him. She did not co-ordinate Mr Burton's care to ensure that all aspects were addressed and failed to complete an adequate discharge plan.

- *Criteria 2.5 upholds established standards of professional nursing practice*

See comments on the Australian and New Zealand College of Mental Health Nurses Standards for Practice for Mental Health Nursing in New Zealand

- *Criteria 2.9 accurately maintains required records related to nursing practic*e

The daily notes written by [Staff Nurse A] were on the whole inadequate to provide informed decision-making by the clinical team. This either indicates that she was not undertaking sufficient assessment or she was relying on verbal communication.

Australian and New Zealand College of Mental Health Nurses Standards for Practice for Mental Health Nursing in New Zealand.

These standards are expected of a registered psychiatric or comprehensive nurse who has been working in the mental health context for a period of the equivalent of two years full-time practice.

(see Attachment 4 for more detail on the relevant Standards that have been identified as not having been met in this instance)

Standard II: The Mental Health Nurse establishes partnerships as the basis for a therapeutic relationship with consumers.

There is little evidence that [Staff Nurse A] established working partnership with either Mr Burton or his family in the planning and evaluation of his care. She also demonstrates a lack of willingness to reflect on her own practice or accept responsibility for her own judgements and actions, both of which are requirements of this Standard. For example, in her responses at the inquest and with the Panel she took no responsibility for her part in the communication breakdown between the inpatient unit and the Community Team over what was expected during Mr Burton's trial leave.

Standard III: The Mental Health Nurse provides nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan.

There is little evidence that [Staff Nurse A] facilitated a process of assessment and care planning for Mr Burton. She did not update his care plan when she took on the role of primary nurse. She did little to co-ordinate the team or involve Mr Burton's family or other interested parties in the planning, implementation and evaluation of his care.

Standard VI: The Mental Health Nurse is a health professional who demonstrates the qualities of identity, independence, authority and partnership.

[Staff Nurse A] did not demonstrate an understanding of professional accountability in her dealings with the Panel and at the inquest. The Panel has difficulty placing much credibility on some of [Staff Nurse A's] statements. There are inconsistencies that to the Panel seem to reflect an attempt to look good, rather than admission of deficiencies, oversights or errors on her or her team's part.

For example, [Staff Nurse A] was asked if she knew whether [Enrolled Nurse A] had updated the care plan. She stated "I know that she did update it. I think there are some copies in the notes of an updated care plan". In fact, there was no updated care plan and [Enrolled Nurse A] had admitted that no one had updated it. [Staff Nurse A] herself admitted that she did not update it when she took over as primary nurse. Had she actually been functioning as primary nurse at that time then review of the care plan contents would have been reasonable practice, and would have revealed that it had not been updated.

[Staff Nurse A] told the Panel that she had been concerned that she hadn't heard any feedback from [the Community Mental Health Nurse] during Mr Burton's trial leave. She was asked why she had not made a note of these concerns. She stated "Well the difficulty in that point was that I was on night shift and [Enrolled Nurse A] was on holiday". She then rescinded her earlier comment and said that she didn't know that [the Community Mental Health Nurse] had not visited during the trial leave until after [Mr Burton] was discharged.

In fact there was no overlap of the period of [Staff Nurse A's] night duty and [Enrolled Nurse A's] holiday. The roster shows [Enrolled Nurse A] on leave for the period 5 March to 9 March, returning to afternoon duty on 13 March. [Staff Nurse A's] night duty commenced no earlier than 24 March.

Nurses Act 1977, and "Direction and Supervision" (Nursing Council of New Zealand)

Section 53A of the Nurses Act sets out the requirement for enrolled nurses to work under direction and supervision of a registered nurse or medical practitioner.

The Direction and Supervision document provides clarification of the meaning of supervision and direction as stated in the Nurses Act. (see Attachment 3)

[Staff Nurse A] was the primary nurse for Mr Burton for at least 2-3 weeks of his inpatient stay. Despite this, most of the coordination of his care was left with [Enrolled Nurse A], … It seems that [Enrolled Nurse A] was expected to complete the discharge plan, assess the outcome of the trial leave and with [the MOSS] and the social worker, make the plans of his community follow-up. There is no evidence of supervision for [Enrolled Nurse A] in this process. It would seem reasonable to expect a registered nurse in the primary nurse role to provide direction and supervision for an enrolled nurse who was carrying through care of this complexity.

Nursing Council Competencies for Registered Comprehensive Nurses

There are a number of Mental Health Nursing competencies that [Staff Nurse A] did not demonstrate in her care for Mr Burton. These include:

Professional Judgement

- Identifies situations in a mental health setting requiring a nursing response
- Assesses situations in a mental health setting in a manner that reflects an understanding of safety issues and patient/consumer needs
- Identifies the mental health care needs of the patient/consumer in partnership with the patient/consumer, their family and whanau.

[Staff Nurse A] lacked professional judgement when she failed to provide adequate assessment of Mr Burton's fitness for trial leave and his needs on discharge. She did not assess the situation, ie. trial leave for safety of the client or others and she did not ensure that a 'nursing response' was available in that week to closely monitor his mental state and safety.

Management of Nursing Care

"… manages nursing care in a manner that is responsive to the client's needs, and which is supported by nursing knowledge"

- Carries out mental health assessment status as part of a broader nursing assessment
- Uses a nursing framework to assess, plan and implement mental health nursing care with patients, their family and whanau
- Evaluates the effectiveness of mental health nursing care in partnership with patients/consumers, their families and whanau.

[Staff Nurse A] demonstrated little comprehensive assessment and planning of care for Mr Burton. On the shifts in which she was caring for him there is little documented evidence of mental health assessment and in the period when she was responsible as his primary nurse, there is no evidence of care planning with or without his family.

Management of the Environment

"… promotes an environment which maximises client safety, independence, quality of life and health"

- Understands the principles of community mental health
- Identifies potential risk factors within the mental health setting and community environments.

[Staff Nurse A] did not appear to understand the risks of a community environment for Mr Burton despite the availability of comprehensive notes from his previous community team in Queenstown. She took a laissez-faire approach to his care, leaving assessment and decision making to the social worker and enrolled nurse, both of whom were unqualified for implementing complex mental health care.

By neglecting to complete an adequate discharge plan and not consulting with the family and other health professionals, [Staff Nurse A] showed a lack of understanding of community mental health.

Interprofessional Health Care

"… promotes a nursing perspective within the interprofessional activities of the health team"

- Advocates for the patient/consumer, their family and whanau within the health care team
- Provides input from nursing assessments to participate in the decision-making processes of the mental health team
- Promotes the delivery of integrated and co-ordinated mental health care.

[Staff Nurse A] provided little nursing assessment from which the team could make decisions. The lack of comprehensive nursing assessment, eg. mental state, family and social issues, drug and alcohol use undermined the ability of the team to make effective and safe decisions on Mr Burton's discharge.

Southland DHB Staff Nurse Position Description

The Primary Objective is to provide holistic, culturally safe nursing care in line with Southland District Health Board's clinical care objectives, standards, philosophy and priorities.

The first Area of Responsibility is "to ensure consistency and quality of nursing care" which includes 'demonstrating and utilising knowledge and providing the following concepts in nursing practice':

- Individualised patient care
- Effective nursing documentation, inclusive of discharge planning
- Current nursing theory and practice.

The second Area is "to maintain good communication and interpersonal relationships within the SDHB"

- Liaise between nursing, medical and other health professionals for the ultimate care of the patient
- Act in a professional manner in relationships with all staff.

Ensure consistency and quality of nursing care

[Staff Nurse A] failed to provide consistency and quality of nursing care. This failure covered the period when she said that she was Mr Burton's primary nurse as well as in the longer period when she was likely to have been his primary nurse.

[Staff Nurse A] spent very little time with Mr Burton. The records suggest that she only allocated herself to his care on 4 morning or afternoon shifts. [Staff Nurse A] did not update Mr Burton's nursing care plan, even in the period when she confirmed she was actually primary nurse, and in her own words her coordination of his care entailed waiting for other staff to tell her if there were problems. She told the Panel "Well I guess if they had difficulties they would come to me, if they needed some direction then I'd be there giving them some direction really".

[Staff Nurse A] did not assess or document Mr Burton's mental state on a daily basis. For example, on the fifth day of the admission, [Staff Nurse A] noted that Mr Burton did "not appear preoccupied". On the sixth day the extent of her documentation on mental state included "mood appeared bright – nil preoccupied behaviour observed". When the Panel asked about whether she actually checked with Mr Burton about the content of his thoughts, she said "When I've written 'mental state settled, not appearing preoccupied' I think if there was anything untoward then I would have documented it".

[Staff Nurse A] neglected to ensure that the period of trial leave was properly monitored. She passed over [Mr Burton's] care without ensuring that the community nurse had received the message and understood the requirements.

[Staff Nurse A] appears to have written the discharge plan with no consultation of the relevant parties. As noted elsewhere, it is not clear when the documentation of the plan was commenced. [Staff Nurse A] told the Panel that a difficulty for her in writing the plan was that she was on night shift. If in fact the documentation was commenced prior to the job interview on 23 March, as that entry on the plan suggests, [Staff Nurse A] was not on night duty. If it was written when she was on night duty (which commenced after 23 March) the outcome of the interview would have been available. There is little evidence of [Staff Nurse A] following up to ensure that her role as primary nurse had been properly discharged by ensuring documentation was completed adequately by other staff.

Maintain good communication and interpersonal relationships

[Staff Nurse A] neglected to ensure that the period of trial leave was properly monitored. She passed over [Mr Burton's] care without ensuring that the community nurse had received the message and understood the requirements.

C8 [Clinical Director]

[The Clinical Director] is a psychiatrist with an additional qualification in Child and Adolescent psychiatry, and is the Clinical Director of the Mental Health Service. He was not directly involved in the care of Mr Burton, but attended the weekly review meetings from time to time. [The MOSS] regarded [the Clinical Director] as his supervisor.

C8 (a): Position description

The position description for the Clinical Director sets out the primary objectives of this position. Of particular significance in relation to the provision of care to Mr Burton are the objectives:

- To ensure the effective provision of clinical services
- To ensure training and development of medical staff as appropriate.

[The Clinical Director], when asked about these aspects of his position description, was unfamiliar with the document. Whether or not familiar with the document outlining his responsibilities, it would not be unusual for the Clinical Director of a service to attend to these aspects of service delivery. A key function of the most senior clinician in a service engaged in the process of improving systems is to review and critically appraise serious incidents.

The Panel was told that [the Clinical Director] did apparently conduct a review of aspects of the care of Mr Burton. There was however no documentation of this review and key findings or outcomes were not available to the Panel. [The Legal/Risk Advisor] to the DHB provided this information, that a review had been undertaken, to the Panel. [The Clinical Director] however could not recall having done this review. The Panel was surprised and concerned about this and wondered whether there were other examples of failure to critically reflect on practice, or to develop systems to address matters identified as requiring attention or even simply to minimise risk of problems arising.

Failure to provide clear direction or guidelines in regard to supervision of Medical Officers of Special Scale – and of [the MOSS] in particular – appears to be an example of this. There was no systematic review of the performance of [the MOSS]. There was no clear directive that senior medical staff should attend the weekly review meetings, which appear to be the sole occasion for medical staff to review the practice of colleagues, and to offer support and guidance. Such direction would have been appropriate from [the Clinical Director].

[The Clinical Director] commented to the Panel that he felt to review the practice of [the MOSS] would be "ungentlemanly". Not only was this a clear oversight of an element of [the Clinical Director's] job description but it is also a remarkable statement from the clinical head of a service in which it would be expected that review of its human resource would be standard practice.

[The Clinical Director], in response to a question from Dr Hobbs [Expert Advisor to the Coroner] at the inquest, told the Coroner that he did not feel that [the MOSS] was employed in a role that was appropriate for his level of training and qualification. [The Clinical Director] told the Panel however, in response to a direct question whether [the MOSS] could in effect be seen as a psychiatrist, that he could. Later he told the Panel, referring to [the MOSS], that "a qualified and reasonable physician would bring things to somebody else if they felt they weren't managing".

However [the Clinical Director] saw [the MOSS] though, it is clear that there was no effective monitoring of his practice.

It is unclear if [the Clinical Director] did not see himself as having a role in monitoring clinical standards of medical staff, who actually might do that. [The Clinical Director] was

clear at one point in his discussion with the Panel that that would not ordinarily be a role of the Team Leader. He wondered whether it was in anyone's consciousness to do so. Later however he said that if there was "a trend or general sloppiness or negligence that somebody, the team leader or quality control process and in the ideal world the clinical director" would address the problem.

In fact, with regard to [the MOSS's] standards of documentation, no one appears to have addressed it. There was a general trend of poor performance in that respect. [The Team Leader] by her own account was aware through discussion with a nurse that [the MOSS] had not documented a lot in the file, and says that that was discussed with him. There is vagueness though about who might have done so. [The Team Leader] noted that if it had been an ongoing and continuous problem with a number of patients then it would have been flagged with [the Clinical Director] to discuss with [the MOSS]. The Panel does not know whether this applied to other patients, but it is certainly evident that there were ongoing inadequacies in [the MOSS's] file entries for Mr Burton. [The Team Leader] said that if there were a concern she was aware of, she would "at times" raise it with [the Clinical Director]. She then told the Panel that files would be flagged to her if there were concerns, but that this had not occurred with Mr Burton's file.

[The Clinical Director] told the Panel that the issue with regard to responsibilities of the community team in following up inpatients during periods of leave remained contentious in December 2001.

This was apparently so despite a recent decision that the community team would or could be involved if specifically requested to be so. This decision had not been announced to the various relevant staff however, and it was evident to the Panel that staff had some strong feelings of confusion and uncertain expectations about the matter.

In response to specific questions about this, [the Clinical Director] replied that a clear directive had not been issued as staff had been through a difficult time. It seemed to the Panel however that offering a clear view and being explicit regarding these responsibilities would not just have been helpful to the staff who were unhappy with the prevailing uncertainty, but may also importantly have reduced an area of clinical risk by ensuring that there was clarity of responsibility for review of patients on trial leave.

Another important area of clinical practice is the application of the Mental Health Act.

[The Clinical Director] told the Panel that he felt that [the MOSS] was more liberal than [the Clinical Director] was himself in relation to use of the Mental Health Act. Although [the Clinical Director] commented that he had only just formulated this view, it was presumably based upon experience over time, experience that to date had not been followed up with any discussion with [the MOSS] regarding his practice in this area.

The Panel recognises that some of these specific failures to provide leadership are much more recent than the period of care of Mr Burton, and thus fall outside the period of particular interest. The underlying matter of responsibility for direction and for clinical system improvement was however one that was relevant to the period of interest.

[The Clinical Director] discussed aspects of the structure of the weekly review meetings. He noted that presentations were largely made by nursing staff, but now the expectation is that junior medical staff present the information. [The Clinical Director] noted that he

"hoped" that this made a difference to the information presented – but that he didn't know whether that was so.

This was an area of concern with regard Mr Burton's care. The documentation of the weekly reviews does not suggest that information of significance was discussed. There appears not to have been attention to persisting psychotic symptoms, to untoward incidents that occurred during his inpatient care, or to a range of other possible interventions, such as supported accommodation, drug and alcohol treatment, completion of needs assessment, or use of the Mental Health Act.

Discussion of these matters may have been determined by the quality of information presented. Attention to ensuring that quality of information presented has improved seems therefore to be highly relevant. The Panel was concerned that [the Clinical Director] did not know whether this was so.

Another matter of potential quality improvement relating to the weekly reviews was documentation of the outcomes of the discussion. In Mr Burton's case the documentation of the weekly reviews was scanty. The format for documenting these discussions and the outcomes has been revised since Mr Burton's care. [The Clinical Director] was unable to comment whether the revised format had made a difference. He told the Panel that he had not checked this himself.

[The Clinical Director], in his discussion with the Panel, seemed to have some views with regard to the demands upon the service that were at variance with perceptions of other staff. [The MOSS] for example felt that the large number of people with comorbid mental illness and substance abuse disorders was a recent phenomenon. [The Clinical Director] commented though that this was of some duration, certainly not a new problem.

[The Clinical Director's] views of the training priorities did not match well with those of the Patient Services Manager's training priorities, as discussed earlier in this report.

[The Clinical Director] came to the role of Clinical Director from a position as psychiatrist in the service. There was no reduction in his direct clinical responsibility when the Clinical Directorship was assumed. The General Manager of Hospital Services, [the General Manager] advised the Panel that some additional resource was made available in the form of an office and some administrative support. The General Manager accepted though that the role of Clinical Director was stretched in the context of a shortage of psychiatrists.

The Clinical Director reporting relationships are not detailed in the Position Description. The Panel was offered information in regard to lines of reporting that suggests the purposes of the reporting relationships and the associated accountabilities are not clear.

In a covering letter (12 October 2001) accompanying a number of documents provided to the office of the Health and Disability Commissioner, [the Legal/Risk Advisor] advises that the Patient Services Manager has accountability for the management and delivery of the service. [The Clinical Director's] direct report is noted to be the General Manager of Hospital Services.

[The General Manager] indicated that the Patient Services Manager had overall responsibility for the Mental Health Service. This also seems to be supported by the position description for the Patient Services Manager. Although not explicit in regard to

overall responsibility for the Mental Health Service, there is a direct reporting relationship to the Chief Executive Officer, rather than to the Clinical Director of Mental Health. There is no reference in the Patient Service Manager position description to the nature of the relationship with the Clinical Director of Mental Health, although there is brief reference to functional relationship with Clinical Directors (amongst others).

The Clinical Director Position Description offers no clarity in regard reporting relationships, except in relation to provision of an annual report on training and development of medical staff to the appropriate Medical Advisor.

It was not clear to which of the Medical Advisors this reporting relationship might be. The Medical Advisors were described by [the General Manager] as "3 Wise Men" who meet regularly with the CEO. All issues from a clinical governance perspective are brought up at that meeting.

The Clinical Directors from across the organisation meet monthly with the General Manager, where clinical concerns may be brought forward for discussion. [The General Manager] talked of this as a reporting relationship, through this forum.

[The Clinical Director] told the Panel that he would not use the 3 Wise Men as a source of wisdom. He noted that usually the things he was stuck with are either around resource, or "Mental Health Act type things", and that he would turn to the Ministry of Health. That would indeed be a useful point of advice in regard Mental Health Act matters. However, where resources are concerned, it would seem appropriate for there to have been strong representation within the organisation for redistribution of resource, or for alternative uses for resource dedicated to another purpose to be approved.

For example, the Panel was told of an opportunity to appoint a Forensic Psychiatrist, but that only a part-time position was funded and the potential candidate wanted a full-time post. Similarly, there has been a vacant part-time occupational therapy post in the ward.

Discussion internally, including gaining the support of the Medical Advisors, might have assisted the arguments being presented by the Patient Services Manager with regard to use of available resources.

[The Clinical Director] stated to the Panel that he fitted in the responsibilities of Directorship in addition to his direct clinical activities as he could within the long hours that he worked.

[The General Manager] indicated to the Panel that he recognised the difficulty encountered by Clinical Directors in meeting demands of clinical duties as well as that of their Directorship roles. He accepted that practical reality of clinical demands often meant that these demands needed to take priority over Directorship roles. Such priority is not stated in an explicit manner to Directors but appears to be understood and accepted. [The General Manager] understood too that there was a significant shortage of psychiatrists.

It is possible therefore that some of the responsibilities of Clinical Director could not be carried out by [the Clinical Director] because of clinical demands. In the view of the Panel however that does not explain some notable omissions or other elements of his conduct.

Language, for example, is not usually subject to time constraints. There are many examples of language used by [the Clinical Director] in his interaction with the Panel that suggest he is not familiar with or accepting of the concepts of destigmatisation and recovery oriented services.

Another matter that might not be expected to be constrained by time is that of knowledge of core elements of one's role. Time to carry out the functions may be constrained, but [the Clinical Director] appeared to have little realisation that he might even need to find the time to carry out performance reviews, for example.

[The Clinical Director] might be expected to be very familiar with training priorities if he is required because of clinical demands to put an emphasis on hands-on clinical service delivery, yet the difference in his views of training priorities were at such variance with those of [the Patient Services Manager] that it appeared these had not been discussed between them.

[The Clinical Director] seemed unfamiliar with the concept of recovery with respect to mental health problems. The recovery-based approach has been a prominent element of the orientation of the Mental Health Commission over the last few years and has been adopted in the service delivery frameworks and contracting arrangements. Familiarity with that approach should not be a matter of having time dedicated to a leadership role, as this direction has been evident for at least several years.

The term is not simply limited to drug and alcohol services or to presence of features that suggest an inpatient might return home. Rather the recovery orientation emphasises the particular strengths and goals of each individual, which can be built upon and into an approach to treatment, without necessarily implying that the disease process will go away.

Lack of awareness of a recovery approach puts the [Southland] District Health Board Mental Health Service at risk of being out of step with this lead taken by the Mental Health Commission. It is not an issue of time being required to change orientation, but is a matter of maintaining contact with the wider mental health service context.

[The Clinical Director] did not claim that time constraints were the reason for his failure to give explicit direction to the service in regard the matter of clinical cover for patients on leave. His responses to questions about whether he had been explicit to the Invercargill team were somewhat indirect.

Q: Why is it contentious who follows up during a period of leave?
A: It's contentious because … (notes some of the background history). It has never really been clarified for them …
Q: Do you have a clear view … now?
A: I'm clear with the Invercargill team now, yes.
Q: But it is still contentious …?
A: Yes.
Q: You haven't made your clear view evident to those teams?
A: My clear view being evident will not necessarily make it less contentious …
Q: Would it make it happen?
A: Yes.
Q: Have you made your clear view known to the teams?
A: Not as clearly as I need or intend to.
Q: Why is that?

A: Two reasons. One, we're exceedingly busy and two, we've been up to our neck in being investigated … and there is limited point in doing much until we get through all of this."

C8 (b): Adequacy of performance of **[the Clinical Director]**

[The Clinical Director] clearly has considerable demands upon his time. This must be taken into account in evaluating his overall performance. [The Clinical Director] has responsibilities as a clinician within the service, as well as Clinical Director. The Panel has not attempted to focus on his clinical psychiatric responsibilities as [the Clinical Director] was not directly involved in the clinical care of Mr Burton, except through participation in the ward weekly clinical review meetings.

From documentation of the proceedings and outcomes of that forum, no indication is available that [the Clinical Director] made a particular contribution to Mr Burton's care. Records of attendance suggest however that [the Clinical Director] did not attend weekly clinical review meetings often, being present for two of five reviews during the period of Mr Burton's care. [The Clinical Director's] attendance as psychiatrist and Clinical Director could potentially have set a precedent and model of practice for other senior medical staff however, demonstrating the importance of that forum, and absences may also have had a role in setting the tone of the service.

The Panel has focussed on matters that should not be constrained by availability of time, to evaluate performance in the role of Clinical Director.

Language used by [the Clinical Director] is commented upon elsewhere, but in brief suggests a paternalistic style that is not congruent with current emphases on destigmatisation and recovery.

A clear deficit is evident in the fact of [the Clinical Director] not having any knowledge of his position description. Even without that knowledge though, standard elements of performance of a clinical leader of a service, of responsibilities for monitoring and reviewing standards of practice, were not considered by [the Clinical Director]. This does not appear to have been a matter of whether time was available to conduct these functions. [The Clinical Director] seemed simply not to realise the importance of even attempting to find the time to do so, or to develop systems for other people to do so on his behalf. ("I didn't see it as something you should be doing.")

[The Clinical Director] seems to have failed to identify the skills and experience necessary for effective function of staff in the service. We would expect [the Clinical Director]… to be closely involved with establishing roles and responsibilities for medical staff. The evidence appears to be that he regarded [the MOSS] as a psychiatrist, despite absence of a specialist qualification and despite [the MOSS's] limited formal training in psychiatry. This failing to differentiate between classes of experience of doctors, and thereby determining their scope of unsupervised practice, is sometimes seen amongst non-medical staff, but is an important failing of [the Clinical Director].

The Panel recognises that service needs are such that non-specialist medical staff must be engaged. Safe practice however suggests that they must be supervised in some manner, and this is now a requirement of registration set out by the Medical Council of New Zealand.

[The MOSS] obtained general registration in 1993. Being on the general register and employed as a MOSS in psychiatry, he was required to work under general oversight of a vocationally registered psychiatrist. General oversight does not have the same rigour as supervision, as defined by the Medical Council, but the guidance notes in relation to General Oversight ("*General oversight – Guidance for doctors receiving and providing general oversight*"; *Medical Council of New Zealand, 2000*) reflect that sometimes supervision might be necessary. Given the importance of work in an acute psychiatric unit, the Panel is of the view that the more rigorous requirements of supervision as set out by the Council would be appropriate for [the MOSS]. It is evident however that even the more general requirements of oversight were not met. [The Clinical Director] appears to have been the doctor recognised as having the role of overseer. Even if not responsible for provision of the oversight, as Clinical Director he should have ensured that someone was identified, and that the requirements were being met.

[The Clinical Director] might be less involved in appointment processes of other staff groups, in part because of constraints of time, but also because there are other professional leaders or advisors who would be expected to take a role. He may not therefore know that staff have been appointed without the skills and experience necessary for adequate conduct of their responsibilities. Regular attendance at the weekly ward forum where there is an opportunity to review interventions by the range of staff involved in care would however provide an opportunity to give some direction, and to identify areas for development of practice by these staff. There is no evidence that [the Clinical Director's] view of the training priorities for the service was informed by attendance at these reviews. His placement of risk training on this list was because of repeated investigations, rather than observations of practice. He did not place training in assessment or care planning, or on methods of coordinating care or developing comprehensive treatment plans, on this list of training priorities.

[The Clinical Director] has a clear and appropriate view in regard to some important aspects of practice. For example, with respect to risk assessment, he advised that risk assessment is part of every assessment, rather than as something special and distinct. There appears to be a problem though with how that message is conveyed. [The Clinical Director] said that the message "is spread by those of us who believe that". He said, "The style of practice tends for better or worse to be taken from those of us who are perceived as the more senior clinically".

That seems inadequate. There is no evidence that this method of conveying this message made any difference to the care of Mr Burton. There are many staff who hold a view that risk assessment is something special and that conduct of it is limited to only some staff, and there appears to have been no systematic effort to address that commonly held misunderstanding. The training that has been offered seems inadequate.

The Panel accepts that modelling desired behaviour can be a useful method of changing standards of practice, but there may be other methods required as well.

[The Clinical Director's] lack of follow up of decisions (e.g. to assess whether quality of presentation at weekly review had changed, or to review impact of change in weekly review documentation) may have been due to constraints of time. There is no evidence however that he had identified this as being required and that he had sought assistance from others to review the implementation and impact of these changes. This style, of

insufficient follow through of decisions to ensure that the desired outcome is achieved, is evident elsewhere in the service.

C9 [Alcohol and Drug Services Counsellor]

[The Alcohol and Drug Services Counsellor] is a member of the staff of Rhanna Clinic, the drug and alcohol service.

Mr Burton was referred to Rhanna Clinic in early March 2001, by [Enrolled Nurse B]. The date is not clear in the notes available to the Panel. The referral appears to be dated 2 March (although the date is unclear on the copy of the referral note) and there is an entry in the file that day made by the writer of the referral, which refers to [the MOSS's] preference for a mental health rehabilitation unit with drug and alcohol input.

C9 (a): Position description

[The Alcohol and Drug Services Counsellor's] position description include the following elements:

- Demonstrated ability in developing and implementing new programmes/practices as dictated by service requirements.
- Carry out treatment interventions with Rhanna Clinic clients, being aware of family/whanau supports
- Work autonomously with referred consumers utilising other team members' expertise and support where appropriate.
- Work in accordance with the harm reduction model, providing individual Treatment Plans.

Clinical competence

The referral form notes a response date of 8 March. The nursing file note of that day reflects that "[Mr Burton] is feeling he has a drug and alcohol problem – a referral to Rhanna Clinic would be beneficial". It goes on to note an appointment on Monday, with the service being noted as Rhanna Clinic, then deleted and replaced with the "MHU". The note continues that Mr Burton was not happy to attend Rhanna Clinic but was happy for [the Alcohol and Drug Services Counsellor] to attend the ward.

A fairly comprehensive assessment is recorded by [the Alcohol and Drug Services Counsellor], utilising the format of the Mental Health Services Initial Assessment document. [The Alcohol and Drug Services Counsellor] did not however involve Mr Burton's family at all in this assessment. He did not seek advice from them or consult with them with regard to the impact of Mr Burton's substance abuse.

The assessment document is dated 12 March, 2001. This document was accompanied by a number of instruments intended to assist with rating the severity of any drug and alcohol abuse.

The rating information available on the completed instruments themselves suggests the following:

- AUDIT questionnaire – score 19 (a total score of over 10 indicates a severe problem)
- SADD questionnaire – score 9 – low dependence (1-9 low dependence, 10-19 medium dependence)

- Readiness to change questionnaire – rating suggests little thought of changing drinking
- CAGE questionnaire – response suggests some degree of dependence.

The information obtained by [the Alcohol and Drug Services Counsellor] notes a history of arrests not documented elsewhere in this period of contact with Mental Health Services. It notes also Mr Burton's clear intention to "just play the game".

No overall conclusions were documented following this assessment. [The Alcohol and Drug Services Counsellor] told the Panel that it was his practice to tell Mr Burton what the findings were of his assessment, and that he would pass his documentation to the ward staff to integrate into the ward file.

[The Alcohol and Drug Services Counsellor] noted that he would not normally summarise his overall assessment of the interview and rating scales, and implied that it was not standard practice to do so. It should be noted though that the rating scales carry the clear caution that they are not to be administered without appropriate training (and presumably therefore some degree of expert knowledge is required in their interpretation).

He added that Rhanna Clinic staff "don't give diagnosis" and that even though asked to do so "we are not actually paid to give diagnosis".

This is surprising. It seems to the Panel that one purpose of a specialised assessment is to provide a more expert perspective than available from a general clinician and this assessment should be followed with some conclusion in regard to the findings. It does not seem sufficient to complete a variety of ratings without further assisting by commenting what the ratings mean.

In the view of the Panel, this was a substantial failure. It appears that [the Alcohol and Drug Services Counsellor] does not appreciate the significance of the place of a specialist service in the spectrum of care.

He noted to the Panel that the assessment documentation he used (and that is understood to be the standard assessment format for the service as part of the wider mental health service) needs to be adjusted to the particular needs of the service. He pointed out the brief reference to drugs and alcohol history in the standard documentation, noting "I should have just filled that out and walked away".

Such action would have been completely inappropriate of a service requested to undertake a specialised intervention. To his credit [the Alcohol and Drug Services Counsellor] did not just complete that section of the document, and took a much more complete history than documented elsewhere.

In discussion with the Panel, [the Alcohol and Drug Services Counsellor] noted that his impression of Mr Burton was of a "normal young man". He said, in relation to the quantity of alcohol used by Mr Burton, "It all depends how much he had on the day … It all depends again you know where he's at, who he was with, what he's actually doing because for a lot of young teenagers that live in Invercargill that would be just a standard night out".

These comments appear to fail to recognise that the quantity of alcohol consumed was substantial, and that it appeared to be occurring in short periods of time, and alone, rather

than in a social context. These comments overlook that Mr Burton had the additional problem of a mental illness, and that there was evidence that use of alcohol contributed to an increase in risk of aggressive actions. Normalisation of alcohol use in this way was not appropriate, in the view of the Panel. It is of concern that [the Alcohol and Drug Services Counsellor] in his position within a specialist drug and alcohol unit, relies on the validity of the use of substances by 'average teenagers in his local area' as a comparison for Mr Burton's use of substances, rather than what constitutes excessive intake.

[The Alcohol and Drug Services Counsellor], when specifically asked by the Panel whether he felt Mr Burton had a problem with alcohol, agreed that he abused it but was not dependant upon it.

In fact there do appear to be suggestions that Mr Burton did have some degree of dependency. This however is perhaps less important than the way in which his alcohol use was viewed overall.

Lack of dependence does not mean there is no problem with alcohol. The documented use of alcohol by Mr Burton was substantial, but seems to have been minimised by the service. It is not accepted by the Panel that consumption of the magnitude recorded is, as noted by [the MOSS] on Mr Burton's return from leave, "a bit".

It is not clear what information was provided to the staff in the ward following [the Alcohol and Drug Services Counsellor's] assessment. [The Alcohol and Drug Services Counsellor] said that "usually" he would find out who was working at the time and let them know "the position". He added "I would usually write to them I suppose, I just didn't that day".

The lack of reference in the nursing entries to the assessment and its findings suggests that the information obtained in the assessment was either not discussed with the staff at any length, and that options for addressing the issues were not discussed with staff, or perhaps that the recipient did not perceive the information as significant. [The Alcohol and Drug Services Counsellor's] assessment documentation was filed in the notes. There is no evidence to suggest that this information was accessed at all as part of the treatment or discharge planning process. The notes do not reveal any discussion of the assessment on or around that date of the assessment by [the Alcohol and Drug Services Counsellor]. The record of the next weekly review meeting following the drug and alcohol assessment makes no reference to that assessment.

It can be seen that at least with regard to Mr Burton, there was limited opportunity for [the Alcohol and Drug Services Counsellor] to carry out a treatment intervention. Mr Burton was resistant to the concept of alcohol or other drug use being a problem. There is little evidence to suggest that advice was given to nursing staff or other members of the clinical team as to how to continue to attempt to engage with Mr Burton in efforts to increase his motivation to change this aspect of his behaviour. There is no evidence of [the Alcohol and Drug Services Counsellor] working toward a harm reduction approach, or encouraging other staff to do so. There is little evidence of use of expertise by other clinical staff, especially in the domain of risk assessment. The entry in the file made by [the Alcohol and Drug Services Counsellor] notes simply "M H U hopefully to do one". This does not reflect much communication with staff of Ward 12, and whether there was discussion about the state of understanding of risk by that part of the service.

Professional development

The clinical competencies required for this position do not indicate knowledge of mental illness or dual diagnosis as a requirement. Given that this service is located within the mental health services and that there is no other specialist dual diagnosis service, this appears to reflect a gap in the range of skills that ought to be represented in the service.

In a component of the position description that refers to personal and professional development there is reference to "actively pursue educational opportunities appropriate to the alcohol and drug services as approved by the unit manager". According to the interview with [the Alcohol and Drug Services Counsellor], he actively sought to attend training on dual diagnosis, but this was refused on the grounds that the Rhanna Clinic team had knowledge and expertise in the alcohol and drug field. The Patient Services Manager did not acknowledge the specialist knowledge required when working with consumers with both a mental illness and a substance abuse problem.

C9 (b): Adequacy of performance of **[the Alcohol and Drug Services Counsellor]**

[The Alcohol and Drug Services Counsellor] responded promptly to the referral from ward 12 and appears to have engaged with Mr Burton in a manner that allowed identification of aspects of the history not documented elsewhere in the record. There was no information gathered from other sources however. [The Alcohol and Drug Services Counsellor] demonstrated respect for Mr Burton's wishes regarding his lack of motivation to address his substance abuse problem, but he had little appreciation for the need for ongoing active intervention by way of counselling or group involvement, in order to motivate Mr Burton along the 'continuum of change' towards contemplation of addressing the abuse problem. It is of concern that [the Alcohol and Drug Services Counsellor] did not have any comprehensive understanding of [Mr Burton's] psychiatric disorder. Nor did he seem to have an understanding of this comorbid substance abuse potentially impacting on Mr Burton's mental state in an adverse fashion.

The impression is that Mr Burton did not receive services of an appropriate standard in respect of substance abuse due to the lack of knowledge and skill on the part of [the Alcohol and Drug Services Counsellor], but in the view of the Panel he should not be held responsible for this. [The Alcohol and Drug Services Counsellor's] limited understanding of psychiatric problems has impacted on the standard of appropriate care. [The Alcohol and Drug Services Counsellor] has attended some training to develop his skills in the area of mental health and has shown interest in gaining knowledge regarding 'dual diagnosis'. He was however asked to perform in an area for which he was ill equipped with the specialist skills required. None-the-less, documentation of a conclusion and recommendation in the clinical notes would have highlighted the result of his own specialist assessment and may have promoted these being brought into discussion at the team meetings when discussion of treatment and intervention plans was occurring.

D: MEETING WITH MARK BURTON

The aim of this meeting was largely to discuss with Mr Burton his recollection of his treatment at Ward 12. The meeting was arranged through the psychiatrist currently responsible for his care, after a preliminary discussion with that psychiatrist to outline the intention of the meeting and to determine whether Mr Burton was fit for such purpose. This psychiatrist determined that Mr Burton was agreeable to the meeting and the meeting was arranged for 8 March 2002.

Two members of the Panel met with Mr Burton at Wakari Hospital. A further explanation of the purpose of the discussion was provided, and Mr Burton confirmed his willingness to participate.

Many of the details of the admission are now not clear to Mr Burton and he frequently responded to questions with indications that he could not recall the events about which we were asking. There were however several matters about which he seemed quite clear.

Overall he had no particularly positive or adverse comment about his care. He could not recall whether the more recent admission was substantially different to his previous experience at ward 12. With regard the staff he said “there were some good ones, and some wankers”. He could not recall any in particular from either category, nor could he recall that any of the staff spent more time with him or seemed to have a particular role in his treatment. Of all the staff apart from [the MOSS], the activities coordinator seemed to be most clearly remembered, and in a positive manner.

His recollection was that the ward was locked most of the time he was there, although he could not recall any particular restrictions on his movements. He felt he could come and go much as he wished, although agreed that often there would be someone else, a staff member, present. He described a number of outings from the ward, some with the activities coordinator, but others simply with a staff member who might go out for a drive with Mr Burton and perhaps also with another client.

Mr Burton recalls having little contact with [the MOSS], and that that did take place was mostly in settings around the public areas of the ward, although he recalls one or two discussions in quieter more private areas. He is clear that [the MOSS] was not agreeable to him returning to Queenstown, and that the arrangement to go flatting in Invercargill was because of that.

Mr Burton does remember some discussion with [the MOSS] about the content of his thoughts, initiated by direct questions from [the MOSS]. His words to describe [the MOSS’s] reaction to his account of his thoughts about his family were that “he blew it off”. Further discussion of this indicated that Mr Burton meant that his ideas were not pursued further.

Mr Burton could not recall use of prn (as required) medication, or why he had requested it. He could not recall whether anyone was especially interested in whether he was having problems with the medication with which he was treated.

Mr Burton does not recall alcohol or drug use being a subject of much discussion, although agrees that [the MOSS] raised it with him.

The placement of objects on the door of his bedroom was something that Mr Burton appeared to remember clearly. He is confident that the reason for this, to monitor whether someone was entering his room at night to interfere with him (as he thought was happening), was not sought by the ward staff.

Another matter about which Mr Burton seemed clear was that there was no discussion with him about whether his family would be involved in a meeting to discuss his treatment and to assist in making plans, or of encouraging him to agree to a meeting with his family.

He was also clear that he had no real idea of what he would do following discharge to the flat. He says he was not aware of any plans for ongoing involvement with outpatient or community-based services and seemed unaware that [the MOSS] intended to follow him up as an outpatient.

It is clearly difficult to know what weight to put on Mr Burton's comments. As noted, in general Mr Burton was handicapped by the passage of time. Some elements of his contact with the service did appear much more vivid to him than many others, and were expressed with a degree of forcefulness that was suggestive of clear recall.

Elements of his account confirmed some evidence provided by other interviewees. Mr Burton confirmed for example that despite the lack of evidence in the clinical file, [the MOSS] did on at least one or two occasions sit down with him in a quiet space and attempt to ascertain thought content. There are several possible reasons for Mr Burton's enduring impression that [the MOSS] "blew off" the description of his thoughts, but what seems clear is that Mr Burton was not left with any enduring understanding of how [the MOSS] thought of or explained these phenomena.

<u>E: THE NATIONAL MENTAL HEALTH STANDARDS</u> (Ministry of Health, 1997)

These standards were released by the Minister of Health in June 1997. They were expected to apply to all mental health service providers by 2000, with a view to improvement in quality and [consistency] of care across mental health services nationally. A set of standards was developed encompassing a variety of components of quality mental health services. The standards are summarised in Attachment 5 of this report.

Although the entire set of standards are applicable to the Southern Health Mental Health Service, certain of them are clearly directly applicable to the care provided to Mr Burton during the period of interest. When the care is measured against these standards a number of deficiencies are evident.

Standard 5: Rights

The criteria of this standard do not in themselves refer to an individual's right to effective treatment, but refer to other regulations, statutes and professional standards that protect and respect the rights of people with mental illness. Reference is made to the Code of Health and Disability Consumers' Rights.

People with a mental illness do have a right to treatment, which must be balanced against their right to refuse treatment and to determine for themselves what course of treatment they will follow.

The ability of the individual to make an informed judgement must be taken into account in reaching a decision regarding the most appropriate course of action. An informed judgement may be compromised by illness.

In the care of Mr Burton, there is evidence that staff went to some length to attempt to engage with Mr Burton, although no one thinks that that was especially successful. There was however a reluctance to insist upon certain interventions in case engagement was compromised by that insistence. It appears this may have resulted in attempts to assess thought content that were less assertive than they should have been, and less confrontational (e.g. as to whether he had actually been smoking marijuana while on leave) than may have been helpful. Evidence suggests that when the clinical team was clear with him, Mr Burton complied (e.g. by staying in Invercargill rather than returning to Queenstown).

Mr Burton had the right to services of an appropriate standard, in accord with the Code of Health and Disability Consumers' Rights. In the view of the Panel, the services provided fell short of appropriate standards.

The Code of Health and Disability Consumers' Rights also provides that consumers have the right to be treated with respect, and have the right to dignity. The Panel noted many examples of language that appear paternalistic and stigmatising.

Standard 7: Consumer record and documentation

This aspect of practice of [the MOSS] has been discussed earlier in the report. Documentation by other staff however also fails to meet the criteria of comprehensiveness established by this standard. The term "settled" to describe Mr Burton's mental state appears frequently through the clinical record. It is relatively meaningless however. It conveys a sense that there were no behavioural problems observed, but gives no idea as to whether clinical phenomena such as delusions, hallucinations, or even negative symptoms of schizophrenia (such as anergia, amotivation, withdrawal) or of mood disorder were evident, or sought after and unable to be assessed. These details are the essential criteria against which clinical progress can be measured in much the same way as cardiac rhythm and features of the pulse are critical components of monitoring of cardiac status (rather than simply noting heart beat present). In general the documentation of symptoms is so inadequate that an observer uninvolved in care would not be able to determine accurately whether Mr Burton is really ill in any way, or what progress he has made.

The use of the term "settled" was discussed by the Panel with [the Team Leader]. She acknowledged, in response to a question to this effect, that sometimes she wondered if the term might just indicate that someone had not actually spent any time with the person and that it was simply easier to write "settled". She said that she would be concerned if she saw that term every day. If concerned, she would take someone aside and talk with them about it.

In fact the term is used very frequently in the notes. It appears some 13 times in the first 7 days of the admission, apparently being used in a variety of ways. One entry on 17

February notes "settled duty" yet describes Mr Burton as having thoughts of his mother and brother trying to twist his mind. The same day he is later described as settled, yet the note reflects also that he was given prn medication for paranoid thoughts. Other entries in which he is described as settled indicate no symptoms of illness. A week later the term "settled" appears in the context of a note which describes Mr Burton needing encouragement to be out of bed by 1030 hrs. On another occasion (March 4) the term "settled" is used to describe a duty period in which there was also described an episode of verbal conflict with another patient.

[The Clinical Director] agreed too that the term had passed its "use by" date, and commented that language used in handing over information would be as loose as it was allowed to be. He commented that such terms as "settled" might well be used in the weekly reviews or in other settings in which staff conveyed information from one to another. If such terms that appear to be used by a variety of people to describe different sets of phenomena are the main way in which information is passed from one staff member to another, there can be little confidence that there is a shared understanding of precisely how an individual is actually presenting at any point in time, or over time.

There is little to suggest that action had been taken by senior staff to change this practice and to encourage rigour in the description of phenomena.

Southland DHB has a variety of standardised documents available that appear to represent reasonable approaches to developing a structured and consistent clinical record for all clients. It can certainly be useful for staff to know that information will be available in a particular place in a file, and structured documents reduce the risk that information will be buried in the body of a file and overlooked. The Panel notes however that many of these documents were not completed adequately for Mr Burton. It appears that the assessment document was not available at the weekend. The Rhanna Clinic staff member completed the same type of assessment pack as would have been expected of [the MOSS], and it is not clear whether further assessments require new documents to be completed or can be added to existing documents, to build a cumulative record on the document over time.

Comment has been made elsewhere in this report about deficiencies of care planning, another criterion of this standard.

Standard 10: Family and carer participation

It is evident that Mr Burton had a family who were interested in being involved in his assessment, care and review of progress. Prior to the admission in February 2001, the Queenstown Community Mental Health Team had had a reasonably high level of contact with the Burton family. Mr Trevor Burton had written to the Patient Services Manager concerned about level of service provision, and there was documented evidence in the community file of their own initiatives in respect of aspects of Mark Burton's behaviour. Trevor Burton took the trouble, shortly after his son's admission, to outline in some detail the family concerns regarding Mark's illness and their perceptions of what was in his best interests. The family had engaged with Schizophrenia Fellowship (SF) New Zealand.

There is however little evidence that the inpatient team responded positively to this clear evidence of a family who were interested in the welfare of Mr Burton. The family was provided with insufficient information for them to participate meaningfully in decisions about plans. Although Mr Trevor Burton was involved in a discussion identified by some

staff as part of a discharge planning process, the option discussed at that point was of a residential rehabilitation facility. Mr Trevor Burton rang back on 9 March to check progress with that plan and was told to call back the following week when needs assessment information would be available. Within a few days and without further discussion with the family, plans were being developed for Mr Burton to go flatting in Invercargill.

Speculation existed about the family's views of Mark Burton, and his view of them. [Social Worker A] was of the view that Mr Burton felt rejected by his family, without evidence of this. Because Mr Burton did not wish to involve his family, a strong weight was given to that preference, even though there was likely to be a foundation of that view that rested upon psychosis. There is no evidence of active and ongoing attempts to change that stance, no matter what its origin, even in the face of such a clear wish of the family to be involved.

It might be argued that involvement of family in Mr Burton's care was not appropriate at a time that he was acutely ill, with marked persecutory ideas about his family. In such circumstances, the extent of involvement might be limited to meeting with the family without the client of concern present, to provide an opportunity for discussion of family concerns and to outline the likely course of treatment and proposed plans.

There is little evidence that efforts were made to encourage such contact or that systematic attention was given to ensuring appropriate involvement of the family in the treatment process.

[The MOSS], despite being in contact with Mr Trevor Burton from time to time, had no idea whether the family was even invited to attend the discharge meeting. He simply said that he hoped they were.

[The MOSS] told the Panel that if he were to do things differently than had been so with the care of Mr Burton, he would have worked harder to involve the family. He appears to have recognised their interest and concern, but noted that they gave the impression that they did not want to be involved in Mr Burton's care any more.

There is no clear evidence of a basis for this view. Mr Trevor Burton wrote outlining clear concerns to be taken into account, and in that letter identifies matters to be taken into account should his son return to the family home. He said clearly that in his view, that home is the best place for his son to get security and some sort of supervision, and that he was welcome back at home. He offered his availability for contact at any time. He made contact himself with the ward on several occasions, and travelled to Invercargill to be involved in meetings.

There is no evidence of work by [the MOSS], or by any of the clinical team, to involve the family. [The MOSS] noted to the Panel that he thought the priority "was for [Mr Burton] to have a meeting with his Mum so that I could make an assessment of where the problems were". Although this aim falls short of fully involving family members as part of a therapeutic process, at least such an assessment might be a beginning. There is though no evidence of efforts to do this. The only person who appears to have gone to some effort to involve the family was [the Mental Health Needs Assessor], in the process of attempting to complete the needs assessment.

Standard 12: Leadership and management

A number of criteria in relation to workforce development are outlined within this standard. In examining the care of Mr Burton it is evident that workforce development is an area of some importance, with respect to both numbers and skills of staff.

Psychiatrist workforce has been identified as needing an increase in numbers yet little clear strategy is evident to address the deficit.

Occupational therapy presence within the inpatient setting has also been discussed. There is evidence as well that staff appointed to positions in which a knowledge of mental health problems in general and psychiatric illness in particular is a highly relevant part of the set of prerequisites for safe conduct of the role do not actually have this background. This is especially evident with respect to [Social Worker A] – social worker Ward 12 and [the Alcohol and Drug Services Counsellor] – counsellor Rhanna Clinic.

It might be argued that Rhanna Clinic staff predominantly have a role in providing for people whose problems are solely those of substance abuse, but if that is so then there is a large gap in service availability for people with comorbid problems of substance abuse and mental illness. Training has been provided for mental health staff to assist them with addressing substance abuse disorders as part of their standard practice, and is thus highly appropriate. It appears however that the requirements of Rhanna Clinic staff, to assist them with an understanding of the particular aspects of mental illness relevant to substance abuse, have not yet been systematically addressed in an attempt to bridge at least some of the gap in service availability.

The Panel received conflicting comments about core aspects of practice such as risk assessment. Some staff were clear that this was not part of their role, apparently because they were not part of the core inpatient team ([the Mental Health Needs Assessor, the Alcohol and Drug Services Counsellor]). Many of the inpatient team did not understand their part in the process either. [Social Worker A] left that to other staff. Nurses left risk assessment to the doctors. Nurses said they did not have training in risk assessment, yet the Director of Nursing and Midwifery said they did. This clearly is an area of practice that needs much more clarity of expectations and standards within the organisation, as well as considerable development of skill.

Supervision of all staff is another criterion of this standard. There is evidence that supervision was not in place for some staff with key roles in Mr Burton's care. [Social Worker A] appears to have had a regular supervision relationship only subsequent to care of Mr Burton. Although [the MOSS] appeared at least to understand [the Clinical Director] to be the person to whom he would refer for supervision there was no access of that potential resource. [The Clinical Director] did not utilise the resource available to him, in the form of the "3 wise men". The Panel understands that subsequently firm arrangements have been made for all of these staff to be involved in supervision.

Comment is made in the section of this report that focuses on nursing, with regard to nursing leadership.

Failures of other staff to provide leadership have been discussed also in sections relating to specific staff with leadership responsibilities.

Standard 15: Consumer assessment

Southern Health has policy and procedure documents that generally are in accord with the criteria established by this standard. In practice however, the standard was not achieved for Mr Burton. In particular there was little input from the variety of staff available to contribute to the assessment process.

[The MOSS] undertook a limited assessment of the history and presenting problems. Some key historical information was not obtained or incorporated into the assessment (e.g. – past history of contact with police, risk assessment available from community team). The nursing contribution to the initial assessment was limited and subsequent assessment by other staff specifically sought to assist with treatment planning were incomplete and overlooked in determining treatment options.

A thorough assessment of substance abuse was carried out. Curiously this did not result in any definitive statement from the assessor in regard to the outcome but it is not clear that this information in any way altered the approach to care – or even was identified as having been concluded. As noted earlier in relation to [the MOSS], information obtained in that assessment was not noted until after Mr Burton's discharge.

Another assessment that was commenced, in the form of the needs assessment that would form part of the basis of a service coordination role, was not completed. The failure of completion of this assessment was not evidently followed up in any way, and thus a further opportunity for another perspective to be applied to the treatment planning was not utilised appropriately.

Some information was available from Mr Burton's family. At least some of this was taken into account in developing an initial approach to treatment, and in determining matters such as whether Mr Burton would return to Queenstown. Trevor Burton's letter of 11 February is however very clear in identifying some of the requirements for satisfactory care for his son. He noted "[Mr Burton] needs security and some sort of supervision … He would need constant monitoring by a mental health worker as to his medication and his involvement with drugs/alcohol. He would also need assistance to finance a life in the community".

These matters are not extraordinary and sit within domains of need that are common to most people, yet there is little evidence of a systematic attempt to identify these or to address them in a comprehensive manner. There was little exchange of information in an ongoing manner however that enabled the family to contribute to discussion on progress, or of concerns regarding events in the course of care, that may have contributed to the review of the plans that were being made.

As noted, a structured needs assessment process did commence. It appears however that there was a limited view by the clinical team of the purpose of such assessment, it being perceived, at least by [the MOSS], to be limited to a gatekeeping role for access to PACT housing.

Standard 16: Quality care and treatment

In the view of the Panel, criterion 16.1 ("Treatment and support provided by the mental health service meets accepted professional and culturally safe practice, for consumers and

their families") of this standard was not achieved. More specific comment is made earlier in this report in relation to the various standards of professional practice of specific staff.

There was little breadth to the treatment plan. Attention was paid to pharmacological intervention (although as noted earlier there was insufficient consideration of further intervention in that domain) and to some aspects of social support (housing, attendance at a social/support programme and reference was made to a job interview) but a fundamental matter, such as whether it was actually still reasonable to be planning discharge in the context of such substantial substance abuse, likely persisting psychotic symptoms, and limited engagement, was not explicitly addressed with the range of people who could contribute to such discussion (including the Clinical Director/supervisor, and community mental health team who actually did have questions about Mr Burton's ability to cope on his own).

It does appear that at times there is thought given to how the availability of the recreation coordinator can assist with achieving some specific goals for individual clients. It appears that activities are not only seen as an end in themselves, but that they may achieve other outcomes. There is evidence for example that sometimes a referral will be made with the goal of improving social function, or motivation, with recreation being the vehicle to achieve those ends. With regard to Mr Burton, there is no specification of the intended outcome of his being involved with the recreation coordinator so it is not clear, despite him having quite a lot of contact with her and being involved in a number of activities, how this fitted in to his treatment plan.

Criterion 16.4 of this standard makes reference to the recovery process. The concept of recovery seemed unfamiliar to [the Clinical Director]. He said that he did not know why people use the term. The notion of applicability of the concept of recovery beyond drugs and alcohol seemed unfamiliar to him, and he wondered if it meant what would be seen as an indication that someone was fit to go home.

A great deal of weight was given to Mr Burton's own preferences, which is entirely in accord with criterion 16.8 of this standard. It is the view of the Panel however that this was not necessarily in his best interests and that more consideration ought to have been given to a more assertive approach determined by the service itself, or in conjunction with his family.

Some of the criteria of this standard set expectations in regard to the variety of resources available to contribute to assessment and treatment. One such resource would be the presence of occupational therapy within the inpatient unit.

There was no such presence during the course of Mr Burton's contact with the ward in 2001. The part-time role (0.2 FTE) had not been filled since that OT took maternity leave. Such absence meant that aspects of assessment (such as assessment of function, or utilising activity based interventions to facilitate access to thought content and perceptions) did not occur.

One of the arguments however was that it was difficult to fill such a part-time position. There is however considerable under-spend of the mental health budget, but allocation of the additional resource already available and potentially able to be utilised for such purpose had not taken place.

Standard 17: Community support options

This standard contains a number of criteria with regard to a range of community options that maximise choice, safety and quality of life for the consumer.

Generally these options presuppose an adequate assessment of needs, and comprehensive plans designed to address these needs across a range of domains. Such assessment and planning was not completed for Mr Burton.

Mr Burton could not recall any clear plans for after his discharge. The last nursing entry in the file reflects that at a further meeting planned for after discharge, an exercise programme and future employment were to be discussed. How he would spend his time appears not to have been clear at the point of discharge. Support that would be available to him was also not determined, other than the social worker maintaining contact for a further week and a visit from the community mental health team key-worker after 3 days.

Standard 18: Discharge planning

This has been discussed elsewhere in this report. It has been noted that the discharge plan itself was scanty.

A particular failure is evident with regard to criterion 18.5 however. This criterion requires that the service ensures that consumers referred to other service providers have established contact and that the arrangements made for followup are satisfactory to the consumer, their family and other service providers prior to the consumer exiting the service. This is an important factor relating to Mr Burton because an opportunity to review the decision to discharge was missed.

Elsewhere in this report the absence (at the discharge meeting) of the community team member who was to become the key worker has been noted. This staff member had had brief contact with Mr Burton earlier in the course of his inpatient stay and had some awareness of the plans to discharge. She and her community colleague had reservations about the proposal that Mr Burton be discharged to a flat on his own. This may have been discussed further had she been present at the meeting following Mr Burton's week of trial leave.

Certainly there was limited discussion with Mr Burton's family with regard to the discharge plans. There was no discussion with them about the alcohol use that was noted during that week of leave. Mr Trevor Burton was clear to the Panel that had he known of that, plans for his son continuing in the flat on his own would not have been supported.

F: GUIDELINES FOR CLINICAL RISK ASSESSMENT AND MANAGEMENT IN MENTAL HEALTH SERVICES (Ministry of Health in partnership with the Health Funding Authority, 1998)

In the foreword to this document, the Director of Mental Health noted that clinical practice always carries some risk, and that it is vital that clinicians working in mental health services are well informed and appropriately informed in the assessment and management of the range of risks with which they are presented. The guidelines note that it is the

responsibility of every mental health service to ensure appropriate strategies, protocols, teaching programmes and audit tools are developed and used. The document takes a broad approach to risk but notes that the most important way to minimise risk is good clinical management.

Such good clinical management is underpinned by comprehensive assessment, including assessment of risk. Risk assessment is noted not to be a 'one-off' event, but part of every clinical observation or assessment, in an ongoing manner.

There is little evidence of this ongoing assessment of risk in the records of the contact of Mr Burton with Southern District Health Board in the time period of interest.

As noted in the earlier parts of this report, risk assessment was largely viewed by nurses as being a medical responsibility. [The MOSS], who accepted a particular responsibility for risk assessment, did not document a risk assessment on admission nor during the course of the admission, intending to do so at discharge. Important historical information available in old notes (and a completed recent risk assessment in those notes) was not used to add to the detail known at admission, to formalise and document an overall view of risk. Ongoing assessment of risk would have included incorporating the incidents that occurred during the inpatient stay into the overall assessment of risk.

The Southern Health policy on risk assessment is reasonably compatible with the Ministry Guidelines, but practical operation of the policy is clearly not consistent with either document.

[The Clinical Director] commented to the Panel that there has developed a great deal of attention to risk assessment, as an entity in itself rather than as part of an ongoing interactive process involving the patient. In this way his views are in accord with the Ministry guidelines. Unfortunately his view has not been conveyed clearly to other staff to a sufficient degree to influence behaviour in this important element of clinical practice.

The guidelines are clear that it is not possible to identify and eliminate risk entirely, and that even in the best of circumstances adverse events will still occur from time to time. Good clinical risk management aims to minimise the likelihood of adverse events and is based upon a good formulation of risk. This formulation should include background features, current context and the risk factors themselves, along with comment about likely risk events and their circumstances.

A great deal of emphasis was placed upon Mr Burton not being a risk while in the inpatient unit, and thus a more comprehensive attention to risk in other contexts was missing. But even despite statements to this effect in regard to the context, there is no evidence that adverse events that took place within that context (e.g. seeking and abusing alcohol, threatening behaviour, and continued persecutory ideation and what appears to have been self-protective precautions) were taken into account in stimulating a revision of the minimal documentation of risk.

When Mr Burton is considered in relation to each of the factors to be considered in assessing risk (as set out in the guidelines) – and then in relation to addressing these in a comprehensive manner, a number of deficiencies become evident in those aspects particularly relevant to him.

Behavioural, affective, cognitive and perceptual elements

It is evident that Mr Burton had features of disturbance in at least some of these domains. It is probably reasonable to anticipate that these were related to underlying psychotic experiences, although there is no documented evidence that these connections were systematically explored by the inpatient team during this period.

Adequate treatment of the psychosis might be expected to ameliorate some, and possibly all, of the risk associated with those symptoms. Mr Burton was indeed noted to improve in some respects, although what appear to have been persisting psychotic symptoms in the very short period prior to discharge were not explored and no change was made in drug treatment to try to address these features.

Substance abuse

This was recognised as a problem, but no firm action was taken to minimise the risk that was amply evident from his acute use of alcohol (e.g. incident of threatening behaviour while an inpatient). Although his ability to freely access alcohol while still an inpatient was limited following use on the ward, no action was taken in response to clear evidence of use while on leave. No more coercive approach was taken despite clear failure by this time of attempts to work in a cooperative and mutually agreed manner.

Absence of support

Mr Burton was established in a flat in a city in which he had little personal support, had few financial resources and where he had not engaged with the professional supports that were available to him in an ongoing manner.

Attitude

Mr Burton had made it clear that he would only "play the game" for as long as he was in hospital, with respect to alcohol use. He had not allowed staff to access the content of his thoughts and had not engaged in a truly cooperative way with planning of his ongoing treatment.

There is no clear information available to the Panel that even if Mr Burton had had a comprehensive assessment of risk completed that the clear conclusion would have been that he might seriously harm someone in the near future.

Information available from the recent history would point to a need for caution however. There is insufficient documentation of the content of his thought to be sure of the impact that Mr Burton's psychotic symptoms would have, although some elements do point to concerns that he may harbour delusions regarding his family. Incomplete treatment of the psychosis would contribute to a risk that he might act in response to these delusions, and there is evidence that he had made aggressive approaches to his mother in the past, precipitating this recent admission, that appeared related to psychotic phenomena.

Aspects of his past behaviour point also to concern that risks of aggressive actions increase in certain circumstances. Alcohol use was associated with aggression on at least one occasion during the course of this admission. There were clear indications of ongoing substantial use of alcohol.

The guidelines note that to minimise risk it is important to ensure that there are effective monitoring systems that can detect early signs of relapse and ensure ready access to services that will deal with these promptly. There is no evidence of a documented systematic attempt to identify early indicators of relapse for Mr Burton. One feature, however, sleep disturbance, is on the discharge document that appears to have been started to be recorded prior to his week of trial leave. It was subsequently noted during that week that his sleep had been poor.

Neither this, nor his significant use of alcohol, resulted in the trial of absence from the ward being terminated. The most favourable explanation of a possible cause was placed upon the poor sleep, rather than there being a high index of therapeutic suspicion. This is congruent with the under-assertive way in which many other elements of his presentation had been managed (the tape on the door handle, preferring to engage in 'casual' assessments of mental state, complying with his preferences about contact with family), thus reducing opportunities for minimising risk through more assertive intervention.

Overall it is evident that the practice of Southern Health did not meet the standard set out by the Ministry guidelines. The Team Leader … is of the opinion that the nurses were responding to observable changes in the degree of immediate risk. She said they are "looking at risk as part of the mental status. Like they are looking at risk to others, to themselves within the unit environment", but felt were not likely to formally assess risk, commenting "… but I think formulation is where they would have difficulty".

There were many statements made by nursing staff that they had not had training in risk assessment. This is somewhat at odds with the statement of the Director of Nursing and Midwifery, …, who noted that clinical risk management is covered as part of orientation training for nursing staff when they enter the mental health service. [The Director of Nursing and Midwifery] also identified 4 training sessions available to all mental health staff, related to risk in the six months prior to the period of Mr Burton's care in ward 12 in 2001. It was apparent to the Panel that the inpatient nurses had had limited access to this training. [Staff Nurse A] stated "I'd be surprised if there was anyone involved that went from the ward". The Panel was also told that this training was merely an "introduction to forms", not a training in risk assessment.

Another form of risk identified by the Ministry guidelines is that of risk posed to the consumer by systems and treatment itself – including those of institutionalisation and stigma. The Panel noted evidence, in the form of language used by key staff in positions of influence, that Mr Burton was at risk himself of stigmatisation by the service. This is outlined in more detail elsewhere in this report.

G: INCIDENT REPORTING

In 1992 The Ministry of Health published a document entitled "Measures to Improve the Quality of Incident Reporting in Mental Health Services". This document noted the potential for systematic reporting of adverse incidents to be used as a tool for risk-management and for quality improvement. Strategies for improving the quality of incident reporting in mental health services were proposed. A set of steps were outlined, commencing with an event that is physically or psychologically harmful to a patient or other person.

The philosophy of this Ministry document has been incorporated into the current 2-page Southland District Health Board policy titled "Incident/Complaint Reporting and Management" dated 7 November 2001. This apparently supplements a 10-page procedure document with the same name dated 27 October 2001 (specific to the Mental Health Service), which in turn appears to be an updated version of the documents current at the time of Mr Burton's contact with ward 12 (Southern Health Mental Health Services Policy: "Incident Reporting and Management" 20 July 2000, and Southern Health Mental Health Services procedure: "Incident Reporting and Management" (5 September 2000). These documents from 2000 note that all incidents occurring within the Mental Health Services of Southern Health are included in the scope of the policy.

Having identified that all incidents are within the scope of the policy, the document then outlines a process for Incident Investigation. Criteria in this section are more limited than in the initial scope of policy statement and involve an element of harm or potential harm, as well as damage to property, accidents and equipment failure.

This difference clearly left the potential for some sub-threshold incidents to occur without investigation in accord with the procedure. The more recent version of the document appears however to have closed this gap.

Given however that the July and September 2000 documents were current at the time of Mr Burton's care it is possible to review how practice occurred in relation to the standards that existed at the time, as set out in these policy and procedure documents.

The procedure document identifies that the Team Leader is responsible for prompt investigation of all incidents in his/her area of responsibility. This assumes that such incidents are drawn to the Team Leader's attention.

[The] Director of Nursing and Midwifery, in her statement prepared for the Coroner, noted that incident reporting has long been an established requirement of all staff by the Board. Nursing staff are encouraged to report all incidents and are introduced to the process in their orientation training.

The procedure document identifies the threshold for incidents to be investigated, as noted above. During the period of Mr Burton's inpatient care several incident forms were completed. Copies of these were made available to the Panel. Of the five forms made available, two related to Mr Burton being charged with the death of his mother. One form identifies an incident in which Mr Burton was absent from the ward and bought and consumed a quantity of alcohol (#29933, 28 February). Another identifies "equipment used for drugs" being found in his room (#29965, 18 March). Other incidents of misuse of alcohol were not documented in incident forms, although appear evident from entries in the clinical file. One of these incidents was associated with Mr Burton becoming aggressive in manner, hitting a wall and threatening to hit a security man (24 February).

Another occasion of aggressiveness on 1 March was not documented on an incident form. On that day the clinical record notes that Mr Burton hit another patient. On another occasion the clinical record reflects an episode of verbal conflict with another patient (4 March). This file entry adds a further comment about what appears to be persisting persecutory ideas. No incident form was completed.

An incident form was completed (#29959) following another episode of aggressiveness on 12 March. The clinical record that day reflects that Mr Burton hit another patient in the eye.

It is evident therefore that on at least two occasions, and possibly one other, the threshold of "actual or potential harm to patients, employees …" or "compromise to safety of patients …" was achieved without an incident report form being completed.

Is there evidence of actions being taken in response to the incidents that were identified and documented on the standard form? The incident form in relation to the episode of absence from ward and use of alcohol simply reflects "Procedure followed. Patient voluntary".

This incident occurred on a Wednesday afternoon nursing duty. The nursing note in the file simply records the event. The following day a nursing file entry reflects [the MOSS's] decision that Mr Burton could have leave only when escorted by staff. There was no review of the risk alert sheet.

The incident form from 12 March notes [the Team Leader's] comment "incident was followed up with staff".

The incident form of Sunday, 18 March identifies the finding of equipment used for drugs, being "a pin roach holder, end of pipe with resin". Apart from the brief reference to this in the nursing notes, there appears to be no other entry in relation to that event or to any actions taken. The comment on the incident form simply notes "Procedure followed. Discussed with patient". That note by [the Team Leader] does not indicate who discussed this with Mr Burton, nor does the clinical file reflect such a conversation.

The incident of Saturday, 24 February that is documented only in the clinical notes, in which Mr Burton hit a wall and threatened a security man after drinking, does not appear to have any follow-up evident in the body of the notes, or in the risk alert form. The same applies to the incident of 1 March when he hit another patient. In fact there is no record of that being followed up directly with Mr Burton at all, as the account of the incident apparently was reported by another patient.

There is no evidence that any of these incidents, singly or collectively, were discussed at the weekly review meetings. "Routine obs" is the consistent entry in the "safety/risk management" section of the weekly review summary, except for the first weekly review of 14 February where there is no entry at all.

It is evident therefore that the standard set by the Southern Health procedure document is not achieved with respect to documentation of incidents. There is little evidence that these incidents were investigated to any degree. There is little evidence that these incidents, other than one which resulted in a restriction of leave instituted a few days later, had any impact upon approach to treatment.

There is a section on the standard incident document that requires the person in charge of the area at the time of the incident to make a comment. The policy and procedure documents in force at the time of Mr Burton's care do not clearly indicate the purpose of this section. It is not clear for example whether the intention is for the person in charge to

confirm the event, to attempt to analyse the causes, or to identify actions taken in response to the incident or to address the cause. This has not been revised in the updated documents.

At the time of Mr Burton's care the policy/procedure documents did not require a copy of an incident form to be filed in the clinical record. The revised procedure document notes that one copy of the form is filed in the clinical record, when appropriate.

This may be helpful, as it is perhaps possible that the incidents for which incident forms were completed for Mr Burton were not identified to members of the clinical team beyond the staff who were immediately involved in the event. The Panel was repeatedly told that the staff are good communicators, suggesting that there is less reliance upon the clinical record within the unit for transfer of information. Other matters identified in this report however suggest that this perception of good communication is flawed, and thus it seems quite possible that non-completion of incident forms meant that at least some members of the wider clinical team did not know of these events.

Even those incidents however that were documented in the clinical notes, rather than on a form held separately, did not result in changes in approach to treatment.

As noted earlier, incident reports are intended to serve as a part of an ongoing process of quality improvement. A culture of critical reflection, using incidents as an opportunity to consider factors that might contribute to occurrence of an event (even if not solely responsible, or even if the event itself was not suggestive of system failure) and to identify and institute prompt changes, is an important part of a continuous quality improvement programme. For serious incidents, the need to rigorously review the events and its circumstances is an important responsibility of managers and clinicians and is identified as one of the 10 steps for quality improvement in the Ministry guideline on improvement of quality of incident reporting. The uncertainty therefore by the Patient Services Manager and the Legal/Risk Advisor as to whether an internal incident review actually took place following the death of Paddy Burton, and if it did the lack of recall of it and absence of documentation, suggests a clear failure to meet this standard and to take the responsibility seriously.

H: RECOVERY ORIENTATION

The Blueprint for Mental Health Services in New Zealand (Mental Health Commission, 1998) sets out a number of principles that were intended to guide the direction of Mental Health Services in this country. The Government has committed to full implementation of the Blueprint – a clear signal that the mental health workforce must adopt this orientation and must be educated and competent in the recovery approach.

The principle of "recovery" is relatively unremarkable. The Blueprint defines recovery as the ability to live well in the presence or absence of one's mental illness. In November 2000 the Mental Health Commission released a document "Realising Recovery through the Education of Mental Health Workers". Ten major recovery competencies are outlined. The document notes that a competent mental health worker:

1. Understands recovery principles and experiences in the Aotearoa/New Zealand and international contexts.
2. Recognises and supports the personal resources/illness of people with mental illness.

3. Understands and accommodates the diverse views on mental illness, treatments, services and recovery.
4. Has the self awareness and skills to communicate respectfully and develop good relationships with service users.
5. Understands and actively protects service users rights.
6. Understands discrimination and social exclusion, its impact on service users and how to reduce it.
7. Acknowledges the different cultures of Aotearoa/New Zealand and knows how to provide a service in partnership with them.
8. Has comprehensive knowledge of community services and resources and actively supports service users to use them.
9. Has knowledge of the service user movement and is able to support their participation in services.
10. Has knowledge of family/whanau perspectives and is able to support their participation in services.

As noted earlier in this report, [the Clinical Director] appeared to have little idea of the concept of recovery. The concept of this orientation applying to people with problems other than substance abuse did not appear familiar to him. This is of concern for the Clinical Director of the service. The incumbent of this position potentially has a significant impact upon the orientation of the rest of the service.

There are many examples of language used by the Clinical Director in describing Mr Burton that are inconsistent with the recovery competencies. Similar elements of stereotyping were noted in language of some other staff.

In the view of the Panel language used by [the Clinical Director], such as "… this boy was a danger …", "… this boy as predicted …", "the schizophrenic boys of that age …", "a lot of our young schizophrenics seem to do", "he is a young schizophrenic with alcohol on top …",[68] "[Mr Burton] is a young schizophrenic who …" is not compatible with an understanding of the impact of paternalistic attitudes or low expectations. This paternalism seemed to extend to matters beyond Mr Burton himself, with [the Clinical Director] commenting to an important piece of correspondence as "this famous letter".

[The Team Leader] echoes some of these types of language, as noted already. Another nurse, in discussion with the Panel, noted "He was a 20 year old boy. He liked to drink and drug". [Enrolled Nurse B]

Another important recovery competency of particular relevance to Mr Burton is that of understanding the impact of mental illness on family relationships. There appear to have been assumptions that there were problems between Mr Burton and his parents. There is little to suggest however that such problems were more than those often seen in parents who are understandably concerned about their child's illness, and who are eager to do their best to assist with treatment. A prominent component of that illness, in the form of delusions, apparently resulted in Mr Burton developing ideas about his parents which led him to want to limit contact with them. Effective treatment of his illness may have been sufficient to solve these difficulties.

[68] Southland DHB in its response to my provisional opinion noted that it considered it unfair to use an example "he is a schizophrenic with alcohol on top" as Southland DHB considered that the phrase was taken out of context and, in fact, the Clinical Director was expressing that Mr Burton is more than his mental illness and was objecting to stigmatisation.

There were however examples of other staff who did appear to embrace aspects of the recovery philosophy. [The MOSS] for example put a great deal of emphasis on the right of Mr Burton to determine for himself what course of action would be followed. [Social Worker A], and others apparently attempted in their conversations with Mr Burton to discourage him from the use of alcohol and drugs. There was some attempt to identify early warning signs (at least as identified on the discharge document, although it is not clear to what degree these were discussed with him).

[Social Worker A] clearly identified aspects of his own life that were apparently similar to aspects of Mr Burton's life. Unfortunately it appears that the risks associated with such an approach, especially for someone lacking substantial experience in mental health care, were not managed adequately through provision of a close and effective supervisory relationship.

I: NURSING CARE

Nursing leadership and nursing development

The evidence available to the Panel suggests that there is a lack of understanding within the management of Southland DHB about the nature and professional needs of mental health nursing. There also seems to have been a neglect of the professional and educational needs of these nurses, as evidenced by a number of factors.

There is no mental health professional nursing leadership position.

The Director of Nursing is not qualified in the specialty, and the Patient Services Manager had no real understanding of whether this person had a mental health background or experience in a mental health setting. This would be of less concern if there was a professional leader (nursing) position for Mental Health, but there is not. The management of Southland DHB is relying on the Director of Nursing for advice on mental health nursing.

Until only two months before the visit of the Panel there were no professional support positions for Mental Health Services despite [the Director of Nursing and Midwifery's] evidence to the Coroner that "Practice Development Nurses" are employed "across most practice settings".

The Director of Nursing and Midwifery in her statement prepared for the Coroner noted that the DHB supported the development of Clinical Career Pathways, a programme designed to assist nurses with obtaining more advanced competency and skills. This Career Pathway has not been applied to Mental Health. There was no evidence of any work being done to adapt it to the mental health nursing specialty, though the Team Leader was positive that it was "in the pipe line" and was "in the early development phase".

Although Southland DHB is supporting nurses to make use of the CTA funded post-graduate programmes, there seem to be few other educational opportunities for the mental health nurses. In-service education courses are particularly underdeveloped and those that are available are difficult to access for the inpatient staff. There is however some indication that the employment of Practice Development Nurses is changing this.

The evidence presented to the Panel suggests that there is a need for the organisation to identify the learning needs of the mental health nursing workforce and to target training directly at clinical practice issues. For example, much was heard of whether nurses were trained in and could participate in and contribute actively to risk assessment, or assessments more generally.

More positively, Mental Health Services have established clinical supervision opportunities for most nurses and the Practice Development Nursing positions were established recently.

Primary nursing

As noted in other sections of this report, the Panel was concerned about the efficacy of the primary nursing system in the care of Mr Burton. The question of who was the primary nurse has been dealt with elsewhere. The Team Leader and other staff maintained that primary nursing was not working well because of the demands of shift work and the high proportion of relatively inexperienced registered nurses. These are issues that are experienced by many acute inpatient units in New Zealand and it is important that they are addressed if care is to be consistent and of high quality.

The Ward 12 nursing team have decided to move to a Team Nursing approach because of these difficulties. There has also been a change in the conduct of the weekly review meetings in that the junior medical staff now present the patient's progress, rather than nurses.

The Panel has some concerns about both of these decisions.

Team Nursing may assist with the supervision of junior staff, but it does not guarantee consistency of care or clear lines of responsibility. It is important that the model of care allows for a "named nurse" who the client and family can identify, a nurse who is able to coordinate care and have input into the multi-disciplinary decisions on the care plan. Shift work does pose difficulties and the ward may need to explore ways to allow some of the more experienced nurses to work Monday to Friday shifts so that they can coordinate care.

It is apparent to the Panel that some important nursing assessments of Mr Burton's mental state and behaviour were not taken into account at the weekly reviews.

Since nurses are the staff who are having the most contact with the patient on a day to day basis, it is important that the nursing input into review of care is as direct and active as possible. It is commendable that the ward management is attempting to improve the quality of information and process at the reviews. [The Team Leader] commented that "we still haven't got it right – they (the meetings) are developing … they're getting better" and that the "doctors are presenting their patients now but it's important that we get that nursing input across too". This could be done by demanding a higher standard of presentation from the nurses and providing training and coaching to attain this. This would provide a more comprehensive view of patient progress than relying on junior medical staff who have less contact with the patient and have usually had little experience in psychiatry.

The primary nurse role implemented, and identity of Mr Burton's primary nurse

At the time of Mr Burton's inpatient care Ward 12 was using a primary nursing system. A primary and associate nurse were allocated for each patient and recorded on the white

board in the office. It appears that the only other place where this was recorded was on the discharge plan and sometimes on the admission documentation. As noted elsewhere, the "Entry" Procedure sets out that the primary nurse is allocated within 24 hours of admission, the nurse is responsible for the patient's care and will be identified from the earliest point, preferably prior to admission.

Responsibilities of primary nurse confirmed by the Team Leader … included facilitating referral to the community mental health team, requesting [the] key worker to be allocated, or informing the key worker that their client had been admitted.

Responsibilities of the associate nurse were to assist the primary nurse, and to carry through things that the primary nurse isn't able to do, and to enable some consistency of care.

[The Team Leader] told the Panel that an enrolled nurse would always be an associate nurse.

Since this role was potentially so important to the coordination of [Mr Burton's] care, the Panel endeavoured to ascertain who was his primary and associate nurse. All those interviewed agreed that [Enrolled Nurse A] was his associate nurse, but there was a great deal of confusion and loss of memory about who was the primary nurse. Members of the Panel were left wondering why there was so much difficulty over this when memories of other aspects of Mr Burton's care were much clearer.

The Panel was told by various staff that [Staff Nurse A] or [Staff Nurse B] may have been Mr Burton's primary nurse; or perhaps one started and the other took over; or alternatively no-one was allocated for a period of time and [Staff Nurse A] took the role in the last few weeks. It seems likely that one of the registered nurses had their name on the white board as the primary nurse, though this cannot be verified. On the evidence available however, in the form of documented activities that are consistent with the role of the primary nurse, it seems that [Enrolled Nurse A] took most of the responsibility of a primary nurse throughout the admission, although she may have been identified as associate nurse on the office whiteboard. [Staff Nurse A] was the primary nurse for some or all of the time.

There appear to be several possibilities as to why staff were not clear who was responsible for the primary nurse role:

1. They cannot remember because [Enrolled Nurse A] was acting as a primary nurse in all but name and therefore it is difficult to remember who was the named registered nurse, and they do not want to admit that she was working outside her scope.
2. They do not want to admit that the responsible Registered Nurse did not carry out the duties expected of a primary nurse.
3. The system of allocation is so poor that there is little impact of identification as primary nurse on work practices.

Examination of what took place may help with identification of who actually functioned in the capacity of primary nurse, assuming that Mr Burton's primary nurse would have cared for him on most shifts worked. Such a pattern is understood to be the standard arrangement although may vary if there is another patient who needed their attention more, in which case the associate nurse would take over.

[Staff Nurse A] cared for Mr Burton on only 5 shifts (except for night shift). There were, in fact 17 shifts in which she could have cared for him but didn't. (For 8 of these [Enrolled Nurse A] was allocated to his care.)

[Staff Nurse B] cared for Mr Burton on 9 shifts (except for nights). Although these were not many shifts, [Staff Nurse B] was allocated to his care every time she was available except for two. On these two, [Enrolled Nurse A] was caring for him.

[Enrolled Nurse A] cared for Mr Burton on 17 shifts plus involvement in his care on 2 other shifts during his last week in the ward. She cared for him every time she was on duty except for two shifts.

In her evidence to the inquest [Staff Nurse A] notes she was primary nurse from 14 February but that she "did not care for [Mr Burton] on every shift that I worked because I was allocated to other patients that were more unwell than [Mr Burton]. She went on to say, "I remained his primary nurse however and this meant I still oversaw his care and that whoever was allocated to care for him would come to me if they needed to".

During the inquest, in response to questions from [the Expert Advisor to the Coroner] on this issue [Staff Nurse A] said she would not be allocated to work with [Mr Burton] on a shift "if the associate nurse was allocated".

It seems to the Panel that it would be very odd for a primary nurse to only care for their patient when the associate is not available. The Panel is of the view that usual practice would be for [the] primary nurse to be usually involved and an associate nurse only when the primary is not available. That would also accord with [the Team Leader's] comment about the role of an associate nurse.

When interviewed by the Panel [Staff Nurse A] changed her statement about the time she was primary nurse. She said "I need to make it clear at this point that I was the primary nurse but only for the last two weeks of [Mr Burton's] admission. [Mr Burton] didn't have a primary nurse prior to that time". "[Mr Burton] had an associate nurse but wasn't assigned a primary nurse …".

Later in the interview [Staff Nurse A] was less clear about when she took responsibility as primary nurse for Mr Burton ("There isn't a specific date where I picked him up"). She referred to [Enrolled Nurse A] going on holiday and [Staff Nurse B] who "had a lot of involvement with [Mr Burton], she was going on study leave and another week's holiday" and noted "no-one had allocated themselves as [Mr Burton's] primary nurse. There seemed to be a void there and [Enrolled Nurse A] and I discussed that I would pick him up in the last few weeks".

In response to direct questions from the Panel, [Staff Nurse A] claimed that Mr Burton did not officially have a primary nurse and that although it wasn't usual practice for an enrolled nurse to take this role, [Enrolled Nurse A] was doing it in all but name. This seems to be supported by the manner in which [Staff Nurse A] speaks about her care for Mr Burton. Even where it is documented that [Staff Nurse A] had direct responsibility for Mr Burton she distanced herself from any meaningful involvement or responsibility. At one point [Staff Nurse A] noted "I had my own set of patients which I looked after".

When the Panel met with [Enrolled Nurse A] she noted she was sure there was a primary nurse but could not remember who it was until [Staff Nurse A] picked up that role towards the end of the inpatient stay. [Enrolled Nurse A] said that she doesn't remember being concerned at the time because there would have been someone allocated. ("As I say I can't remember who – there was obviously someone else because – associate nurses aren't on the board on their own.") Again later in the interview [Enrolled Nurse A] was adamant that there would have been a named primary nurse. "It's up on the whiteboard (in the office). It's pretty obvious. It's on the whiteboard."

[Enrolled Nurse A] agrees she wrote the initial care plan and that the primary nurse is responsible for updating it. This was not done however. She also says that [Staff Nurse B's] role was "just a staff nurse, she was going to pick [Mr Burton] up but then decided not to because she was going on holiday".

[Staff Nurse B] is somewhat unclear in response to the Panel's question as to whether she was Mr Burton's primary nurse. She stated that she "was going to allocate myself as his primary nurse ..." but because of study leave and annual leave decided it was best not to "stay as primary nurse". "I didn't think it was appropriate to stay as a primary nurse." She then said, "I'm not sure who took over … I think I looked after him for a couple of days and then I went on a period of leave so I'm not sure who took over".

Her language implies that she was in fact allocated as Mr Burton's primary nurse for a period of time. The question the Panel was left with is when [Staff Nurse A] took over.

The matter of when [Staff Nurse A] picked up responsibility for Mr Burton's care came up again in her interview with the Panel. [Staff Nurse A] stated that she only picked Mr Burton up when [Enrolled Nurse A] went on leave. This seems to confirm that [Enrolled Nurse A] was in effect acting as the primary nurse. [Enrolled Nurse A] was on leave from March 4th to March 12th, returning on March 13th.

There are evident then some possible dates when [Staff Nurse A] may have started caring for Mr Burton as his primary nurse. These are February 14th, when [Staff Nurse B] was on study leave, and/or March 4th, when [Enrolled Nurse A] went on annual leave.

[Staff Nurse A] did appear to have taken on some of the primary nursing responsibilities from the 14th February. For example she wrote in the notes on the 14th that she would "talk to […] tomorrow re an exercise programme. Have yet to discuss this with [Mr Burton]" and on the 15th she made the referral to Invercargill CMHT.

The Team Leader […] cannot remember who was the primary nurse. She said, "I believe that for the first two or three days that [Staff Nurse B] became the primary nurse, then [Staff Nurse B] went on study leave and annual leave and I can't think who was in the middle then, but we had some changes of staff around that time and then [Staff Nurse A] picked [Mr Burton] up in the last two to three weeks, I think".

[The Team Leader] wrote in her statement to the Health and Disability Commissioner that she discussed [Mr Trevor Burton's] letter with [Mr Burton's] allocated nurse on the 13th February and with [Staff Nurse A] and [the MOSS] the next day. Although [the Team Leader] could remember that discussion specifically, she could not remember referring the matter to Mr Burton's primary nurse.

On the weight of the evidence, it would seem that [Staff Nurse B] might have been the allocated primary nurse from Mr Burton's admission on the 10th until the 11th or 13th February. It seems likely that [Staff Nurse A] allocated herself (or was allocated) as the primary nurse after this. It seems likely that the reason that everyone is vague about the dates is because the inpatient team did not take the responsibilities of the role seriously and were happy to leave the coordination of care to an enrolled nurse, [Enrolled Nurse A].

An alternative explanation is that contrary to policy, there was no primary registered nurse allocated, and that coordination of care was left to [Enrolled Nurse A].

A further alternative explanation, that the role was taken by another member of staff who left during the period of care, seems unlikely as there is no evidence of another staff member undertaking significant responsibilities of primary nurse during that period, or who was involved in care on a regular basis.

Nursing process

Australian and New Zealand College of Mental Health Nurses Standards for Practice for Mental Health Nursing in New Zealand

<u>Standard III</u> *The Mental Health Nurse provides nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan.*

There is evidence that suggests that the Ward 12 nurses are frequently passive participants in the processes of patient assessment and care delivery and when nursing activity occurs, there are variations in the quality of recording and practice.

For example, there is little evidence of independent nursing assessment. The Panel was told that nurses would often simply sit in on interviews with doctors or other staff and would not actively solicit information. [Enrolled Nurse B] for example described her role in the Needs Assessment interview as "being there". There seemed to be little appreciation of an active role with the consumer needs as central. Several nurses expressed a belief that risk assessment is the doctor's responsibility and not their own. [The Team Leader] said that for someone being admitted and assessed and who is quite disturbed, then the assessment tends to be directed by the doctor.

Care planning was restricted to a computerised format that had been developed for the whole hospital and was not useful for care planning in the mental health setting. The care plan for Mr Burton was never completed by his primary nurse and was not updated by anyone.

Although some nurses were clearly assessing Mr Burton's mental status on each shift, others were relying solely on observation of "anything out of the ordinary".

The nurses' documentation was variable in quality. Some documented well, describing mental status, behaviours of concern and changes to plans. Others made little if any reference to mental state, commenting only upon events observed. The word "settled" was used on a number of occasions to describe Mr Burton's demeanour on a shift without any elaboration of what this might mean in terms of mental status or general well being.

Clinical decision-making by the multi-disciplinary team was limited because nursing observations and assessments were not incorporated in the regular patient reviews. The

Panel heard frequently of the good communication within the team, but there are clear examples of information being overlooked because information was not passed on (for instance, verbal handover to the nurses by the Rhanna Clinic counsellor). There seemed to be a heavy reliance on this "good communication" within the team rather than good documentation. Communication of decisions following the weekly reviews failed too, for example leaving [the Mental Health Needs Assessor] unaware that plans were being made for Mr Burton to go flatting even though the needs assessment had not been completed. This was not documented in the weekly reviews until after a flat was found.

Enrolled nurses scope of practice

It is important to discuss the scope of practice of enrolled nurses, given the contribution made by such staff to the care of Mr Burton.

Three documents are relevant to this consideration. These are the Nurses Act (1977), a statement from the Nursing Council in relation to Direction and Supervision, and the Southland DHB policy on scope of practice of enrolled nurses.

Nurses Act 1977

- Section 57(1) The requirement for nurses to be only appointed to carry out duties within their particular 'class' of the Act.
- Section 53A The requirement for enrolled nurses to work under direction and supervision of a registered nurse or medical practitioner.

Direction and Supervision (Nursing Council of New Zealand)

This document provides clarification of the meaning of supervision and direction as stated in the Nurses Act. (See Attachment 3.) Amongst other things it requires enrolled nurses to only care for patients/clients with "stable and predictable health outcomes".

The Scope of Practice of Enrolled Nurse Southland DHB policy

This document refers to these requirements of the Nurses Act, and provides guidance in relation to the role of the enrolled nurse alongside other members of the nursing profession.

In relation to the nursing process, the document states the "Enrolled Nurse has a major contributory role in the assessment, planning, implementation and evaluation of care".

Later the document suggests a less central role in the process, noting "The initial assessment must be carried out in conjunction with the registered Nurse. Ongoing assessment is the joint responsibility of the Registered Nurse and Enrolled Nurse".

Further again the document continues, "The Registered Nurse may not delegate the planning, implementation and evaluation of care to the Enrolled Nurse".

It appears then that it would not be envisaged that an enrolled nurse would take a central coordination role nor would a primary (registered) nurse be able to delegate this responsibility to an enrolled nurse.

The SDHB Policy on enrolled nurses' scope of practice is unhelpful, particularly for work in an acute psychiatric setting. It is questionable, for example, whether any patients within

an acute inpatient psychiatric unit have “stable and predictable needs”. Although there was some distinction between acute and sub-acute patients in Ward 12, it is not at all clear that those who were classified as ‘sub-acute’, including Mr Burton for some of his admission, would fall into the above categories of need.

Some comments to the Panel by both the registered and enrolled nurses indicate that there may be a lack of understanding about the limitations of the role. Some of the enrolled nurses were very experienced and this may have contributed to the other staff placing too much reliance on them. [Enrolled Nurse B] assured the Panel in relation to her presentation of patients at the review meetings, “I’m quite vocal about my patients and if I’ve got a concern then I make it very loud and clear … I might just be an enrolled nurse but I have had a bit of experience – 30 years – …”. [Staff Nurse A] “left some of the (discharge plan) documentation for [Enrolled Nurse A] to complete. She had more involvement than I had”.

[Staff Nurse A], by her own admission, did not coordinate or direct [Enrolled Nurse A’s] care of Mr Burton. She instead expected [Enrolled Nurse A] to approach her if there were any problems. She told the Panel “Well I guess if they had difficulties they would come to me, if they needed some direction then I’d be there giving them some direction really”.

Some of the responsibility for this lack of direction lies with the Team Leader. [The Team Leader] must have been aware that [Enrolled Nurse A] was taking primary responsibility for planning, implementing and coordinating Mr Burton’s care. [The Team Leader] was responsible for the overall management of a ward in which the nurses self-rostered and self-allocated as primary and associate nurses. This system required close monitoring to ensure that client care was adequately covered.

It was [the Team Leader’s] responsibility to ensure that nurses worked within their legal scope of practice. It seems that the ward culture was such that the nurses were comfortable with an enrolled nurse taking the responsibility for a client’s care as long as there was a named primary nurse. Such ‘naming’ did not appear to carry more weight than a label on the whiteboard in the office.

J: CONCLUSIONS

General remarks

A number of principles regarding Total Quality Management in a health service environment are set out in a 1992 paper prepared by Mary Bonner, John Coughlan and Ron Parker, then of the Canterbury Area Health Board (“*Introducing Total Quality Management in an Area Health Board*”). This paper was subsequently published by the Ministry of Health in “A Resource Manual – Quality Assurance in Mental Health Services” (October 1996).

Although this paper is now 10 years old, many elements of the framework apply as much now as they did then. It is possible to examine how Southland DHB, at least as reflected in its systems of delivery of care to Mr Mark Burton, measures against this framework for quality.

In the view of Bonner et al, good quality care is about optimal outcomes, minimal risks to patients, clients and staff, consumer satisfaction and the efficient use of resources. Total Quality Management seeks continuous improvement, involving everyone with an emphasis on quality in all processes. The role of management is to provide leadership, communicate a clear vision, and provide the support and education to create the required cultural change within the organisation. Teams should be empowered to continuously improve the process and build quality into the system.

The National Mental Health Standards (Ministry of Health, 1997) aim, amongst other things, to promote continuous quality improvement and to ensure that services offer the highest level of care to those who use these services. They thus provide some useful direction for clinical and operational leaders within an organisation.

Southland District Health Board has available a wide variety of policy and procedure documents applicable to its Mental Health Service. These establish a reasonably sound base for operation of many of the important functions of a mental health service and set standards that in general are congruent with those of the National Mental Health Standards, Ministry of Health guidelines, and standards of professional practice. It is evident that good work has gone into developing these documents, and there is evidence that they are reviewed regularly and that such reviews take account of changes in practice standards and recommendations from incident reviews.

The Panel has found however that there are substantial gaps in implementation of many policies, with notable examples including some that are critical to effective operation and good outcomes of systems for assessment and treatment planning, and some that are more relevant to processes of quality improvement.

In particular, the most important deficits are found in implementation of policies in regard to clinical assessment and treatment planning, risk assessment, discharge planning, and documentation. There are deficits in operation of policies for consumer and carer participation in services, and in relation to incident reporting and review. As outlined in the sections of this report addressing specific elements of the National Mental Health Standards, there are a number where the necessary standard is not achieved.

Effective operation of a service is facilitated by clear lines of accountability and clear reporting relationships between parts of the system that enable necessary changes to be authorised and implemented. The Panel found that the partnership between the Clinical Director and the Patient Services Manager is not sufficiently close for each to be aware of the other's view of training priorities for the service, and an especially critical gap was evident in relation to the outcome of any internal review of the care provided to Mr Burton. The Clinical Director reported that he does not find a specified reporting relationship to the organisation's medical advisors to be useful, and he largely does not use it.

Other useful reporting and supervisory relationships were not in place for key staff involved in the care of Mr Burton. This is most notable with respect to [Social Worker A and the MOSS].

The failure by the organisation to ensure proper supervision and oversight is especially important for these two staff. [The MOSS] does not have specialist qualification in psychiatry, but was in effect seen as a psychiatrist. [Social Worker A] had limited experience in mental health services, yet was given tasks requiring skill in assessment.

Examples of staff with limited skills operating without sufficient oversight of their practice, or out of context of the clinical team, or outside of their scope of practice, are also found ([the Mental Health Needs Assessor, the Alcohol and Drug Services Counsellor, Enrolled Nurse A]).

Bonner et al note that the role of management is to provide clear leadership. The Panel found a number of examples of a lack of critical analysis in the style of leadership, and sees evidence that this pervades many aspects of function of the service. These examples included apparent acceptance by [the current] General Manager that standards of practice were satisfactory, without evidence of clear systems for review of performance for medical staff. At the levels of Patient Services Manager, Clinical Directors and Team Leader there was insufficient analysis of the skills required to conduct a role safely, resulting in appointments of staff without appropriate skills, or being asked to carry out tasks for which they were not prepared. There was a lack of analysis of incidents. Problems in performance (e.g. scanty documentation, use of short-cut descriptions such as "settled") were not apparently addressed systematically. There was insufficient consideration of causes for aspects of Mr Burton's behaviour. Even when some staff paid attention to things that caused them concern, more experienced staff appeared to pay insufficient attention to possible causes and implications.[69]

Leadership was not evident in oversight of systems of allocation of nurses to patients. There was no consistent follow through of plans and there appeared to be no systems to ensure that actions planned were commenced or completed, and with what outcome.

Overall, there appears to be no rigour to the application of systems for investigation, assessment, reporting and monitoring through many aspects of the mental health service.

This is a specialist service, where standards of care should be high and where there should be rigorous attention to detail. There should be a high index of suspicion with respect to matters that may indicate signs of mental illness, with considerable focus applied to processes of assessment and investigation, with assertive follow through to completion of any plans. Treatment processes must be similarly of a high standard. Systems for operation of the organisation should support the provision of this expert service. In the view of the Panel, the findings outlined in this report suggest that the service provided to Mr Burton fell well short of the standard expected of specialist services. Southland District Health Board failed to maintain systems to ensure the provision of a specialist service.

Gaps do exist in the range of services that should be available to meet the needs of people such as Mr Burton. Presence of supported accommodation that is tolerant of some use of drugs or alcohol (along the lines of a harm reduction model of working with clients with a dual diagnosis) may have created another option for his care. Although the evidence

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[69] […], for example noted that there appeared to be a change in Mr Burton's behaviour, with lability becoming evident. She wondered if it may be due to alcohol use and was concerned to document it. There appears to have been no follow up by other staff of this event.

[The Mental Health Needs Assessor] noticed a change in Mr Burton when interviewing him as she explored some matters in relation to his family. She was concerned enough to discuss it with the nurse present at the time, but the nurse made no record of this.

[Social Worker A] in conducting the drug and alcohol assessment obtained information not gathered by any member of the inpatient team. Although he documented this, the team overlooked it.

[…], a new graduate nurse, was particularly concerned to pass on to staff that Mr Burton had contacted his father and was expressing paranoid ideas. She felt that the concerns in the letter had to be taken seriously.

available to the Panel suggests that a PACT home may have been suitable for his residential care needs, without referral to that facility and without therefore giving the chance of assessment, Mr Burton was denied an opportunity to access that service.

Specific services for people with comorbid substance abuse and mental illness may also have been helpful, but, as for access to PACT housing, the appropriate referral route was initiated without follow through to ensure that exhaustive exploration of these possibilities was completed.

Mr Burton clearly had little if any motivation to change his pattern of substance use. He may not therefore have engaged with services had they been available. From what evidence is available however, there was insufficient exploration of the possible options with regard to facilities and programmes as well as with respect to using more assertive or restrictive approaches to care (such as not continuing with discharge plans, or more active consideration of use of the Mental Health Act).

These service gaps, along with that that might be filled by an inpatient rehabilitation service, should not exist and are the responsibility now of the District Health Board to address, but in themselves these gaps do not explain the deficiencies in the care that was actually provided within the range of facilities and services available at the time.

Conclusions specifically in relation to the terms of reference

Contact and coordination with Mr Burton's family

There is some evidence that staff found Mr and Mrs Trevor and Paddy Burton difficult to reach by telephone at times. Trevor and Paddy Burton did however make contact with the ward on a number of occasions and there were several meetings and telephone conversations, particularly with Trevor Burton, in which plans were discussed by the clinical team and in which Mr Burton had opportunity to discuss his concerns and views regarding plans for his son.

It seems clear however that not all the information that should have been available to Trevor Burton was made available to assist him in reaching a view regarding the plan for his son to go flatting. It seems clear that no information was provided with regard to Mr Burton's drinking while on leave. Trevor Burton is also clear that there was no information provided to him about incidents that occurred in the ward, such as the episode of vomiting after alcohol use, or the persisting psychotic symptoms. Had that been known, and had he had a chance to participate in review of the plan to discharge following the week of leave, Mr Trevor Burton "would like to think" he and his wife would have urged reconsideration of the discharge plan. That would certainly be consistent with the content of his letter of 11 February.

There was no opportunity for that participation in the discharge meeting as no-one invited that.

It appears therefore that although there was some involvement of the family in discussing aspects of the treatment plan, there was insufficient transfer of information for Mr Burton's parents to be fully informed about progress and to judge for themselves whether plans were appropriate. In short, contact and coordination was not adequate.

Discharge planning, including formulation, implementation and review of discharge plans

A number of discussions and meetings referred to in the file were understood by various staff as being related to discharge planning. There is reference in a number of parts of this report to deficiencies in this process.

If the standard set in standard 18 of the national Mental Health Standards is regarded as that against which performance is to be measured, performance was not adequate.

Similarly, the requirements of the Ministry of Health guidelines for discharge planning were not achieved.

Appropriateness of Mr Burton's discharge

Some matters relevant to this issue have been outlined in the section above. There are however further aspects of the treatment process that point to whether discharge is appropriate. Consideration of whether goals of admission were achieved helps with this question.

As stated by [the MOSS] to the Panel, the priorities to address in the treatment of Mr Burton were his drug and alcohol use first, and helping him come to terms with his illness, second.

There is no evidence of effective intervention in either of these domains. The assessment by the drug and alcohol counsellor was not apparently even read by [the MOSS]. There was no systematic involvement of that counsellor in developing treatment plans, or in checking options for residential treatment. Substantial use of alcohol in the week of leave did not result in any change of plan to discharge.

[The MOSS] had difficulty engaging with Mr Burton. It is possible that this therefore limited his ability to engage Mr Burton in discussion about the significance of his symptoms and about his illness. There is certainly little to suggest that there was much progress with helping Mr Burton come to terms with his illness.

If therefore a measure of appropriateness of discharge is positive progress toward achieving goals of admission, discharge was not appropriate.

The Panel has assumed too that there was a further goal, to treat symptoms of psychosis. Although not well documented, there appear to have been attempts to access thought content to determine the presence of symptoms of psychosis.

[The MOSS] told the Panel that Mr Burton was fairly guarded and his delusions were fairly evident on the ward, "so clearly the illness was very much present". Within two days of commencing trial leave the nursing notes indicate persisting delusional thoughts, although there is then no further evidence of exploration of these prior to the point of discharge. If resolution of psychosis was thought to be a measure of appropriateness of discharge then again discharge does not appear to have been appropriate.

Further markers of appropriateness of discharge are the presence of arrangements for shelter, for financial support, and for involvement in meaningful activity. Mr Burton did have a flat, but as the needs assessment had not been completed the support he required in order to maintain himself successfully was unknown. The community mental health worker

who would become responsible for his community follow-up had some reservation about his ability to manage in a flat on his own, but as she was not involved in the planning process had little opportunity to express those concerns.

Finally, consideration must be given to whether there has been adequate involvement of other relevant services. As noted, the community staff member to be involved in follow-up was not involved in the final discharge planning meeting, and had had little involvement in developing any plans.

By any of these standards therefore, discharge was not appropriate.

Coordination with the community mental health teams

The Queenstown Community Mental Health Team had had considerable contact with Mr Burton and with his family, and therefore had a great deal of information that would have been relevant to his ongoing care within Ward 12, and subsequently in Invercargill. A risk assessment was completed by the Queenstown staff following the events at the time of Mr Burton's admission and was forwarded to Ward 12. Mr Burton's associate key-worker from Queenstown thought it was a good idea for Mr Burton to remain in Invercargill, although did not know of that plan until she visited him in the ward. There is no evidence of involvement of the Queenstown team in developing treatment plans.

This associate key-worker identified that sometimes a new key-worker would make contact in order to gain information about interventions and approaches that had been helpful in the past, or this might be initiated by the former key-worker. There appears not to have been sufficient involvement of the staff formerly involved however for them to know that initiating contact was necessary in respect of Mr Burton. There was limited opportunity therefore for the view, based upon the substantial experience of the Queenstown team, that follow up should be by someone well-grounded clinically as well as a social worker, to be conveyed to the team responsible for arranging ongoing care.

A referral was made to the Invercargill community mental health team early in Mr Burton's admission to Ward 12. The person expecting to be his new key-worker did not anticipate seeing him until late in February as she did not think he was going anywhere in the near future. When she saw Mr Burton on 27 February, he was not clear that he was remaining in Invercargill. This key-worker designate, [the Community Mental Health Nurse], had a brief discussion with someone from the ward. Aside from her own reading of notes there was no other particular way she was kept informed of progress of Mr Burton's care. In her view, it was her responsibility to find out what was happening. She was not clear however until the point of Mr Burton going on leave that he was going to end up on her caseload. This was, she said, because nobody had come back to her.

[The Community Mental Health Nurse] recalls a conversation in the corridor in which she expressed her reservations to the inpatient Team Leader that Mr Burton may not be well enough for discharge. She felt that with substance abuse and mental illness there was a high chance of quick deterioration in health. It is not clear that this conversation affected plans in any way, although she acknowledges that she did not know Mr Burton well enough to know if the concerns were specific to him or whether they were more related to her general experience of that situation of comorbidity.

[The Community Mental Health Nurse] was invited to a meeting to take place on 1 March. This meeting was called a discharge meeting. She was unable to attend due to other appointments. In her view, this was not a discharge meeting. In her view, a discharge meeting was usually held on the day of discharge, although her preference was for it to be a week or so prior to that in order to be able to plan for care.

[The Community Mental Health Nurse] learned of the trial leave by finding a message left for her by [Staff Nurse A]. The message was found on a scrappy piece of paper on her desk. Mr Burton was already on leave. No arrangement had been made for the community team to be involved during the week of leave. During the course of that week of leave, [the Community Mental Health Nurse] discussed her concern that Mr Burton was not ready for discharge with a colleague and with the inpatient Team Leader, and intended discussing this further in a discharge planning meeting. She did not think the leave was going well, from her reading of the notes during that period, and believed that there was to be a meeting that week in which discharge would be discussed. In her view, she did not think Mr Burton would be discharged, as the leave had not gone well.

As it happened, Mr Burton arrived early for the meeting. [The Community Mental Health Nurse] was in the building, but no one contacted her to request she attend at the earlier time. She was advised of the outcome of the meeting by way of a note that informed her that the meeting had happened, and that a further meeting was planned for the following week.

There was thus little direct contact between [the Community Mental Health Nurse] and the members of the clinical team directly involved in the care of Mr Burton. There was little opportunity for [the Community Mental Health Nurse] to express her concerns within the established systems for coordination, as these systems did not operate in the usual manner on this occasion. There was therefore little coordination with this community team.

Conclusions in relation to performance of Southland District Health Board and individual health care providers

A number of problems are evident when the overall performance of the District Health Board is considered. Some of these have been covered in the introductory general remarks to this section of this report.

Overall there is an impression of staff having roles beyond the skills they bring to those positions, without sufficient oversight and support, and sometimes without meeting the qualification requirements of their position descriptions. This is evident at a number of levels.

There is no nursing leadership position for mental health. Although the Director of Nursing and Midwifery has experience as a manager in a mental health service, she is not qualified as a mental health nurse. Senior managers appeared to rely on her however for the responsibility for nursing standards within the mental health service. Until recently there were no other staff positions specifically focussed to address skill development and practice standards for mental health nurses.

The MOSS was in effect practising as a psychiatrist, without adequate supervision.

The social worker had little experience or professional development in psychiatry or mental health work, yet was solely involved in monitoring someone who remained ill in a very unsupervised environment in a flat on his own.

An enrolled nurse functioned beyond her scope of practice.

There appeared to be little appreciation of the importance of having time to carry out functions effectively. There is a chronic shortage of psychiatrists, without clear strategies in place to resolve that problem. The Clinical Director is stretched in his ability to perform the tasks of that Directorship in addition to his direct clinical responsibilities. The Inpatient Team Leader was appointed to a role too big to fit into the time in which she was employed.

There appear to be inadequate monitoring and control mechanisms to ensure that staff practise safely, that incident and risk management strategies are in place, and that policies and procedures are followed.

The Panel has concerns that adequate standards of practice were not achieved by a number of staff. For those staff who were notified they were under investigation, comments are outlined specifically in relation to each of them in the relevant sections of the body of this report.

For some, the concerns reflect the staff being expected to carry out tasks for which they were ill prepared through insufficient training and experience. This applies to [the Mental Health Needs Assessor, the MOSS, Social Worker A, and the Alcohol and Drug Services Counsellor].

Some staff appeared to carry out responsibilities for which they had some relevant training and experience, but where they operated outside what would usually be regarded as reasonable scope of practice. This applies to [the MOSS and Enrolled Nurse A].

For all of the staff notified, aspects of performance even within the realm of intervention for which they should have sufficient experience and training was inadequate. The most serious deficits though, and those that seem unrelated to constraints such as availability of time, were in respect of [the MOSS, the Patient Services Manager, Staff Nurse A, Social Worker A and the Clinical Director].

In respect of [the Team Leader], the Panel notes inadequacies in her performance which may reflect deficiencies in leadership and skill, but notes that there may be constraints associated with her part-time role.

K: RECOMMENDATIONS

Terms of Reference for this inquiry do not specifically ask the Panel to make recommendations with respect to any findings. It appears however, given the range of matters identified, that there may be some point in noting some actions that may be helpful in addressing concerns. The Panel appreciates however that it is the role of the Health and Disability Commissioner to make final conclusions and to determine the appropriate course of action.

The following section of this report suggests some actions with respect to each of the staff notified that they were under investigation, then comments on possible actions in regard other aspects of service provision.

[Mental Health Needs Assessor]

Southland DHB to conduct a review of the position description for the Needs Assessor and Service Coordinator role, with a particular focus on the skills and qualifications required for this role.

Southland DHB to review the qualifications, skills and experience of [the Mental Health Needs Assessor] (and other Service Coordinators and Needs Assessors) in light of the revised position description, with a focus on training needs and development of a professional development plan.

Southland DHB to establish standards for timeliness and completion of assessment and service coordination processes.

Supervision to be arranged by Southland DHB with particular attention to:
- Timeliness and completion of assessment and service coordination processes
- Attention to full gathering of information, including old records
- Professional development
- Adequate communication with clinical staff.

Southland DHB to audit:
- Integration of Needs Assessment and Service Coordination files
- Processes of communication and coordination between Needs Assessment and Service Coordination service, and clinical team

to ensure that deficits identified in this inquiry are addressed.

[Medical Officer Special Scale]

Health and Disability Commissioner to confirm with Medical Council that a Competence Review has been commenced (the Panel understands that [the MOSS] may have initiated this process himself).

Southland DHB to ensure supervision and audit of [the MOSS's] practice with particular attention to standards of practice and training needs in relation to:
- Comprehensive assessment and treatment planning, implementation and review
- Assertiveness of follow through of plans
- Documentation
- Comprehensive assessment of risk and development of risk management plans
- Family and carer participation
- Comorbid substance abuse and mental illness.

Southland DHB to establish clear criteria for clinical case supervision.

[Patient Services Manager]

Southland DHB to develop clear performance criteria for [the Patient Services Manager's] practice and for the service with respect to:

- Implementation of standards, policies and procedures
- Development of culture of critical appraisal and reflection
- Development of workforce, with attention to numbers and skills of staff, to ensure comprehensive high quality clinical service can be delivered
- Closure of gaps in service provision
- Follow through of incidents
- Development of partnership model of leadership, with Clinical Director.

Southland DHB to ensure adequate arrangements for supervision and for audit of practice, with particular attention to standards of practice and training needs in relation to:
- Recovery competencies
- Capacity to critically appraise and monitor systems of care, and to develop practice improvement strategies
- National Mental Health Standards.

[Team Leader]

Southland DHB to ensure review of the range of responsibilities of the Inpatient Team Leader position, and the size of the job, with reference to needs for clear clinical leadership and for monitoring and developing nursing standards of practice.

Southland DHB, following completion of this review and any adjustment to size and scope of [the Team Leader's] responsibilities, to develop performance criteria and implement performance monitoring systems.

Southland DHB to ensure adequate arrangements for supervision and for audit of practice, with particular attention to standards of practice and training needs in relation to:
- Recovery competencies
- Organisational policies
- Capacity to critically appraise and monitor systems of care, and to develop practice improvement strategies
- National Mental Health Standards.

Southland DHB to develop clear performance criteria for [the Team Leader's] practice with respect to:
- Implementation of standards, policies and procedures.

[Social Worker A]

Southland DHB to ensure arrangements are made for assessment of [Social Worker A's] competence in accord with the requirements for full membership of the Aotearoa New Zealand Association of Social Workers.

Southland DHB to ensure supervision and audit of practice, with particular attention to standards of practice and training needs in relation to:
- Assessment and treatment of mental disorders
- Documentation
- Assessment of risk and development of risk management plans, in accord with role of social worker
- Family and carer participation

- Comorbid substance abuse and mental illness.

Southland DHB to review the position description for the inpatient service social worker (Ward 12), with a particular focus on the skills and qualifications required for this role.

Southland DHB to specify in the form of a written agreement arrangements for professional supervision for [Social Worker A].

Southland DHB to ensure that in light of **all the above** a professional development plan is developed and implemented for [Social Worker A] with clear time frame for review of progress.

Southland DHB to ensure that clear criteria and processes for clinical case supervision are established and implemented.

[Enrolled Nurse A]

Southland DHB to ensure sufficient supervision and staffing support to ensure the practice of enrolled nurses remains within enrolled nursing scope of practice.

[Staff Nurse A]

Southland DHB to review competence of [Staff Nurse A] against the standards of the Australian and New Zealand College of Mental Health Nurses and Nursing Council Code of Conduct.

Southland DHB to ensure supervision and audit of practice with particular attention to standards of practice and training needs in relation to:

- Comprehensive assessment and care planning
- Comprehensive assessment of risk and development of risk management plans
- Coordination of care
- Family and carer participation
- Recovery competencies
- Capacity to critically appraise and reflect upon own practice.

Southland DHB to ensure that in light of **all the above** a professional development plan is developed and implemented for [Staff Nurse A].

[Clinical Director]

Health and Disability Commissioner to refer [the Clinical Director] to Medical Council for Competence Review.

Southland DHB to carry out a review of the range of responsibilities of this position and the size of the job, with reference to needs for clear clinical leadership and for monitoring and developing standards of practice.

Southland DHB to ensure adequate arrangements for supervision and for audit of practice, with particular attention to standards of practice and training needs in relation to:

- Recovery competencies

- Capacity to critically appraise and monitor systems of care, and to develop practice improvement strategies
- National Mental Health Standards.

Southland DHB to develop clear performance criteria for [the Clinical Director's] practice and for the service with respect to:
- Implementation of standards, policies and procedures
- Development of culture of critical appraisal and reflection
- Development of workforce, with attention to numbers and skills of staff, to ensure comprehensive high quality clinical service can be delivered
- Closure of gaps in service provision
- Follow through of incidents
- Development of partnership model of leadership, with Patient Services Manager.

[Alcohol and Drug Services Counsellor]

Southland DHB to conduct a review of the position description for the role of the Drug and Alcohol counsellor, with a particular focus on the skills and qualifications required for this role.

Southland DHB to ensure supervision for [the Alcohol and Drug Services Counsellor] with particular attention to:
- Professional development, to assist with familiarisation of aspects of disorders of mental health
- Formulation of expert opinion and provision of advice to clinical staff of mental health service
- Adequate communication with clinical staff
- Assessment and management of risk
- Processes of communication and coordination between Drug and Alcohol service, and clinical team.

Other actions

Southland DHB to:

- Develop internal audit and monitoring processes to audit compliance with policies and procedure documents, with most immediate attention to consumer assessment, consumer record and documentation, incident reporting, risk assessment and management, quality care and treatment, discharge, supervision, and family and carer participation.

- Review policy and procedure implementation mechanisms to ensure adequate attention to these documents in orientation of new staff.

- Assess training needs across the service in relation to Recovery Competencies, comorbid mental illness and substance abuse, family and carer participation, comprehensive assessment and treatment planning, risk assessment and management, and the National Mental Health Standards.

- Develop culture of critical appraisal and reflection by all inpatient (Ward 12) staff and by senior medical staff. Initial priorities should be to review impact of changes in inpatient team weekly review processes (attendance and active participation of all senior medical staff, presentation of cases, documentation of outcomes, communication of decisions) to ensure desired effects of system changes are achieved.

- Review, confirm and demonstrate its commitment to development of nursing standards.

- Identify specific areas of skill for acute inpatient nurses (e.g. nursing and risk assessment, presentation skills and goal-directed therapeutic engagement), and develop, implement and monitor performance measures/indicators for mental health nursing standards of practice.

- Ensure development of a mental health nursing structure across the DHB to provide professional support for nurses, formal links with education providers, the setting of standards and a process for provision of advice to management on mental health nursing issues.

- Ensure development of a comprehensive nursing clinical career pathway.

- Explore and implement a model of nursing that allows for a "named nurse", co-ordination by experienced, skilled nurses and proficient nursing input into multi-disciplinary review.

- Mental health services undertake a training needs analysis of skills for nurses based on their active contribution to patient outcomes, as above.

- Review the employment of enrolled nurses in the acute psychiatric setting, including consideration of whether there is a place for enrolled nurses, and if so, ensure implementation and audit of policy with regard to scope of practice.

- Develop urgent strategies for increased input of senior medical staff to service, including clear action plan for recruitment, increased use of teleconferencing, relationships with other centres.

- Develop clear criteria for supervision content of MOSS staff, including as a minimum attention to new cases, cases of concern, use of Mental Health Act.

- Ensure clear criteria and process for review of performance of medical staff, including use of external reviewers, and for attention to performance problems.

- Ensure the weekly ward review becomes a priority for senior medical staff attendance. In circumstances of limited psychiatrist presence within the service, develop teleconferencing links with other centres to ensure psychiatrist participation.

- Review position descriptions and person specifications to ensure skills and experience identified for roles are clearly identified. Review of developmental needs of current staff to address skill gaps, where review shows skills required are not already present.

- Develop procedures to ensure effective involvement of services such as Needs Assessment and Service Coordination, and drug and alcohol services, into the routine

activities of the inpatient team to ensure effective integration of those specialist assessments and processes into care planning and implementation.

- Develop systems to improve processes of communication and coordination between Drug and Alcohol service, and clinical team.

- Ensure adequate attention to substance abuse within mental health services, through development of skills of mental health staff, development of skills of drug and alcohol service staff, development of appropriate documentation for use by specialist services, and approaches to intervention that are not reliant upon readiness of the consumer to cease substance misuse.

In conjunction with the South Island Regional Mental Health Network, Southland DHB to:

- Review contracts for provision of and access arrangements to:
  - Dual Diagnosis (Mental Illness and Substance Abuse Disorders) services
  - Inpatient rehabilitation services
  - Supported accommodation which tolerates substance abuse and which works with consumers to address substance abuse problems.

In conjunction with the South Island Regional Mental Health Network and Ministry of Health, Southland DHB to:

- Review whether with limited senior medical staff, services can be safely continued in Southland, and what core service provision is necessary and can be safely maintained within the District.

Attachment 1

Focus of investigation

Matters relating to the quality of care provided to Mr Mark Burton from 10 February 2001 until 30 March 2001 by Southland District Health Board's inpatient mental health services were to be investigated.

In particular the following matters were to be investigated to determine whether any acts or omissions by Southland District Health Board, or any individual health care providers employed by Southland District Health Board, have breached Mr Burton's rights under the Code of Health and Disability Consumers' Rights:

- contact and coordination with Mr Burton's family
- discharge planning, including formulation, implementation and review of discharge plans
- appropriateness of Mr Burton's discharge
- co-ordination with the community mental health teams.

Attachment 2

Interviews

Interviews during the 3-day period December 8, 9 and 10, 2001

Southland District Health Board staff

[...]	New-graduate registered nurse, ward 12
[Mental Health Needs Assessor]	Needs Assessor, Southland Hospital
[Enrolled Nurse B]	Casual enrolled nurse, Ward 12
[...]	Registered comprehensive nurse, Ward 12
[...]	Registered comprehensive nurse, Ward 12
[MOSS]	Medical Officer of Special Scale, Ward 12 and Community Mental Health Service (Invercargill)
[Community Mental Health Nurse]	Community Mental Health Nurse (Invercargill)
[Patient Services Manager]	Patient Services Manager, Mental Health Service
[...]	Occupational Therapist, Community Mental Health Team (Invercargill)
[Social Worker B]	Social Worker, Community Mental Health Team (Queenstown)
[Social Worker A]	Social Worker, Ward 12
[Enrolled Nurse A]	Enrolled nurse, Ward 12
[Staff Nurse A]	Registered comprehensive nurse, Ward 12
[Clinical Director]	Psychiatrist and Clinical Director, Mental Health Service
[General Manager]	General Manager, Southland District Health Board provider arm
[...]	Recreation coordinator, Ward 12
[Staff Nurse B]	Registered comprehensive nurse, Ward 12
[Alcohol and Drug Services Counsellor]	Alcohol and Drug Services Counsellor/case worker

Also interviewed during the course of these 3 days were:

Trevor Burton	[Mr Burton's] father
[...]	Field Worker, Schizophrenia Fellowship, Central Otago

Other interviews

[…]	(Paddy Burton's sister) – in Auckland
Mark Burton	– in Dunedin
[…]	(Director of Nursing and Midwifery, Southland DHB) – telephone discussion

Attachment 3

Direction and Supervision, Nursing Council of New Zealand

This document provides clarification of the meaning of supervision and direction as stated in the Nurses Act.

- "The Nurses Act (1977) defines and distinguishes between registered nurses/midwives and enrolled nurses". It requires that a licensed hospital must only appoint nurses who are under the specific class of the Act, eg. registered or enrolled nurses, to carry out the duties of a nurse within that class (p1).
- "Accordingly, the differences in 'duties' must be clarified in accordance with the preparation for the particular 'class' of registered nurse, or midwife, or enrolled nurse and the requirement that 'no person shall be appointed … to carry out the duties of …' unless the person appointed is registered or enrolled as the case may be" (p2).
- While the application may vary in different settings, direction and supervision refer to the active process of directing, guiding, monitoring and influencing the outcome of an individual's performance of an activity related to assigned aspects of nursing practice or a delegated activity …
- The paper distinguishes between "direct supervision", when the nurse or midwife is actually present and "indirect supervision" when the nurse or midwife must be available for "reasonable access". "This includes ensuring that the enrolled nurse knows when, and where to obtain assistance or further direction from the registered nurse or midwife" (p2).
- "Enrolled nurses practice nursing … to implement nursing care for people who have relatively stable and predictable health outcomes …"
- "Registered nurses and midwives must, therefore exercise professional judgement regarding the degree of direction and supervision in the delegation of responsibilities to enrolled nurses. … The extent of the direct and indirect supervision depends on the complexity of nursing skills and judgement involved" (p3).
- "Enrolled nurses … must be aware of the limitations of their role and be willing to accept the direction and supervision … While remaining accountable for their own actions and limitations" (p3, 4).
- In the context of Section 53A of the Act the registered nurse and the registered midwife have accountability for the direction and supervision provided. This includes that the enrolled nurse … is not placed in a position of being accountable for clients/patients … whose nursing care requires knowledge and skill outside the parameters of their preparation" (p4).
- The responsibility for direction and supervision lies with the registered nurse. "Direction and supervision from the registered nurse … is about appropriate activities or aspects of care in relation to the stable and predictable needs of the assigned patient/client … and the education and skill of the enrolled nurse …" (p4). "The registered nurse … retains responsibility for direction and supervision" (p5).
- In accepting assigned nursing care, the enrolled nurse … has a responsibility to ensure that she/he … is able to name the registered nurse … who is providing the direction and supervision with regard to every patient … to whom she/he has been assigned or for whom aspects of care has been assigned" (p4, 5).

Attachment 4

Australian and New Zealand College of Mental Health Nurses Standards for Practice for Mental Health Nursing in New Zealand

These standards are expected of a registered psychiatric or comprehensive nurse who has been working in the mental health context for a period of the equivalent of two years full-time practice.

Standard II The Mental Health Nurse establishes partnerships as the basis for a therapeutic relationship with consumers.

Skills
The Mental Health Nurse is able to:
I. Relate effectively to others
II. Establish and maintain nursing partnerships
III. Plan, establish, maintain and evaluate therapeutic relationships with consumer, family or whanau and other
IV. Reflect on own practice to analyse strengths and weaknesses
VI. Justify and accept responsibility for own judgements and actions.

Performance Criteria
The standard has been met when:
The consumer, family and/or whanau expresses satisfaction with the process and outcome of the nurse/consumer partnership and the therapeutic relationship.

Standard III The Mental Health Nurse provides nursing care that reflects contemporary nursing practice and is consistent with the therapeutic plan.

The Mental Health Nurse is able to:
IV Facilitate the process of comprehensive nursing assessment
V. Assess the contextual factors which are impacting on the consumer and the therapeutic relationship
VI. Identify and interpret recurrent patterns of behaviour
VII. Collaborate with consumer, family or whanau, and other colleagues to develop a nursing plan of care
VIII. Document assessment outcomes, nursing management plan, strategies for care and outcomes
IX. Communicate nursing plan for care to consumer and other members of the therapeutic team
X. Implement nursing care in a systematic, co-ordinated, caring and consistent manner
XI. Initiate steps to address deficiencies/limitations in the nursing and therapeutic plans
XII. Evaluate and document the effectiveness of planned interventions in consultation with the multidisciplinary team
XIII. Review nursing interventions and outcomes and revise when appropriate.

Performance criteria
A. The consumer and their family or whanau confirm that they have been fully involved in all aspects of care

B. The Mental Health Nurse is able to interpret and justify the nursing plan and therapeutic relationship to contemporary Mental Health Nursing and current approaches to mental health care
C. The nursing management plan accurately reflects the outcomes of nursing assessment, collaboration with the consumer, family or whanau and consultation with other members of the mental health team.

Standard VI The Mental Health Nurse is a health professional who demonstrates the qualities of identity, independence, authority and partnership.
Skills
I Demonstrate the characteristics of professional practice in the context of Mental Health Nursing practice.
II. Describe the nature of professional accountability to self, profession, peers, individual consumers and community.

Performance Criteria
A. Feedback from the consumer, family or whanau, peers and employer indicate the nurse is demonstrating an acceptable quality of professional practice.
B. There is evidence that the Mental Health Nurse is actively involved in the profession, accepts collective responsibility for nurturing and promoting safe practice, and for resolving instances of unsafe practice.
C. There is evidence that the Mental Health Nurse is practising in accordance with the standards for Mental Health Nursing.

Attitudes
I. Accepts accountability for own practice

Attachment 5

The National Mental Health Standards. Ministry of Health, 1997

Standard 1: **Tangata Whenua.** The mental health service will provide appropriate services to meet the needs of all whanau, hapu, and iwi.

Standard 2: **Pacific People.** The mental health service delivers and facilitates appropriate services to meet the needs of Pacific people affected by mental illness, their families, carers and others as nominated by the consumer.

Standard 3: **Cultural Awareness.** The mental health service delivers treatment and support which is appropriate and sensitive to the cultural, spiritual, physical, environmental and social values of the consumer and the consumer's family and community.

Standard 4: **Children and Young People.** The mental health service delivers assessment, treatment and support to children, young people and their families, who are affected by mental illness or mental health problems. The mental health service also delivers consultation liaison services to other professionals involved with children and young people with mental health problems.

Standard 5: **Rights.** The rights of people affected by mental illness and mental health problems are respected, acknowledged and upheld by mental health services.

Standard 6: **Safety.** The activities and environment of the mental health service are safe for consumers, their families, carers, staff and the community.

Standard 7: **Consumer Record and Documentation.** Clinical activities are documented to assist in the coordination delivery of care.

Standard 8: **Privacy and Confidentiality.** The mental health service ensures the privacy and confidentiality of consumers and their families.

Standard 9: **Consumer Participation.** Consumers are involved in the planning, implementation and evaluation of the mental health service.

Standard 10: **Family and Carer Participation.** Families and carers are involved in the planning, implementation and evaluation of the mental health service.

Standard 11: **Prevention and Early Intervention.** The mental health service works with groups in the community in prevention, early detection and early intervention.

Standard 12: **Leadership and Management.** The mental health service is led and managed effectively and efficiently to facilitate the delivery of coordinated service.

Standard 13: **Access.** The mental health service is accessible to the community.

Standard 14: **Entry.** The process of entry to the mental health service facilitates timely and ongoing assessment for consumers.

Standard 15: Consumer Assessment. Consumer care, treatment and support is based on a comprehensive assessment which is completed by a health team with appropriate knowledge and skills.

Standard 16: Quality Care and Treatment. Consumers and their families are able to access a range of high quality mental health care, treatment and support options.

Standard 17: Community Support Options. The mental health service provides access to a range of community support options which maximise choice, safety and quality of life for the consumer.

Standard 18: Discharge Planning. Consumers are assisted to plan for their exit from the mental health service to ensure that ongoing follow-up is available if required.

Standard 19: Follow-up and Re-entry. The mental health service assists consumers to exit the service and ensures re-entry is facilitated and occurs according to consumer needs.

Standard 20: Promoting Mental Health and Community Acceptance. The mental health service promotes mental health and community acceptance of people affected by mental illness and mental health problems.

APPENDIX II

Recommendations from Dr Taumoepeau's Clinical Audit of the care of Mark Burton

RECOMMENDATIONS

1. **Assessments**
   Each patient must have a full mental status examination recorded at admission and, at a minimum, a full review of that mental status examination close to the time of discharge. This is primarily the responsibility of the medical staff. The alcohol and drug history taken by the medical staff in the mental health services should be detailed, regardless of whether or not the patient will subsequently be referred to the drug and alcohol services.

2. **Treatment plans**
   The medical staff, after assessment, must outline at least the basic treatment plan and ensure which individuals will carry out that plan.

3. **Completion of documentation**
   On the whole, the documentation available to clinicians is good and assists clinicians in ensuring that they have addressed key issues. This documentation must be completed on admission and discharge and at other key times, eg if there is a marked change in the patient's situation or referral to a different part of the service. If key parts of the documentation had been completed it may have ensured a better understanding of the patient's mental status and provided better focus for the treatment, eg the assessment of risk form and the discharge plan form.

4. **Review procedures**
   The inpatient weekly review form is unsatisfactory and does not really assist staff to look at treatment goals and tasks to be undertaken. The "review report" form is better and could be adapted for both inpatient and outpatient use. It should include such issues as "barriers to discharge" and tasks to be undertaken, by whom and in what time frame, rather than "recommendations". This form could be usefully colour coded, but not in a dark colour as this impedes easy photocopying. If the patient is being reviewed as an inpatient on a weekly basis the form should be sent as a matter of course to the patient's community team. Several services around the country have developed such forms and may be useful as resources when Southland District Health Board is reviewing their forms.

5. **Communication**
   While it is the responsibility of medical staff to ensure they adequately read the notes when they review a patient, there should be a system whereby staff (who would be mainly nursing staff) can highlight patients of concern who need review by the medical staff. This could be done by using a highlighter in the notes, using stickers in the margin of the notes or having a doctor's book where staff can indicate that a patient needs to be seen urgently or outline any specific concerns. A system should be in place to ensure regular checking of the book.

6. **Incident reporting system**
   The incident reports should be filed in the clinical notes in chronological order alongside the day to day progress notes. Staff should be clear about the threshold for filling in an incident report and there should be a list available to staff as to which incidents require a report to be written. A note of the incidents should be included in the weekly review. The incident forms in the patient's file could also be colour coded so that one can easily recognise the frequency of such incidents.

7. **Supervision**
   Medical officers (MOSS) employed by the mental health services need to have formal, regular supervision by a consultant psychiatrist. The terms of reference of supervision should be recorded and should include frequency, length of supervision sessions and content. The content should include a requirement for the medical officer to present all new patients to the psychiatrist and to follow up on recommendations made by the psychiatrist. In other words, the medical officer should be treated as a registrar in terms of supervision and accountability.

8. **Training**
   Training should be provided in certain key areas, eg risk assessment, mental status examination, or any other areas that are identified as in need.

   Competencies should be identified if these are not already in place for all disciplines, eg mental status examination, alcohol and drug assessment, early warning signs, psychopharmacology etc.

   Resources should be identified and in particular the various guidelines that have been produced by the Ministry of Health, eg in *Clinical Risk Assessment, Management of Suicidality, Use of Seclusion* etc.

   Regular training sessions for the multidisciplinary team should be put in place and register kept of people's attendance. All multidisciplinary team members should be encouraged to present at those sessions.

   Medical staff should be required to attend peer review and/or clinical review educational sessions, as well as attending relevant conferences. Any medical staff who attend conferences should be required to give a talk to their colleagues or to the wider team on return from the conference.

   Medical staff should be requested to identify areas of expertise they would like to explore or achieve and to develop an educational plan to meet those needs.

   A wide range of educational tools should be explored, eg journals, videos, proceedings of meetings, access to library, internet, video links with other training programmes, eg in Dunedin or Christchurch.

9. **Service provision**
   Careful consideration should be given to increasing the availability of psychiatrist input to smaller towns, eg Queenstown. While face to face interviews are invaluable and recommended particularly for the first interview of a new patient, regular video conferencing should be implemented. This could be used for both staff support and education, as well as actual interviewing of patients. Protocols could be developed,

particularly in the area of explanation to, and reassurance of, patients. A regular psychiatrist should be employed to undertake this service and should be the same person that could also visit for the purpose of face to face interviewing. There should be considerable savings in time and costs using this method, with the ability to review a larger number of patients more frequently and allow more urgent consultations.

Consideration should also be given to developing a training scheme for general practitioners (GPs) in smaller towns. GPs interested in psychiatry should be identified and the possibility of a training scheme explored. This could include formal education packages, joint clinics with visiting psychiatrist and the possibility of obtaining a diploma or certificate. The College of General Practitioners Rural Practice Division, the Department of Psychological Medicine at Otago University and the Canterbury Rural Psychiatry Service could all be consulted to further this area.

10. **Rehabilitation services**
I would recommend that negotiations are pursued regarding access of patients to inpatient intensive rehabilitation services. Such services exist on a regional basis in other parts of New Zealand, eg Wellington which services the lower North Island. It would appear important that there is equity of access throughout the country for patients with severe ongoing illnesses, particularly young people and particularly those who may demonstrate dual diagnosis with drug abuse. This would be a matter which will, of course, have to be negotiated with the Ministry of Health.

Along a similar vein, consideration should be given to at least a small number of supported accommodation places in smaller towns such as Queenstown. It is extremely difficult to manage patients with serious ongoing illness when the only facilities available are either their family or independent flatting. As an equity issue, it does seem unfair that in order to access any kind of supported accommodation a patient may have to move to another town. While this is understandable if the patient lives in a very small settlement, it would seem appropriate, however, that towns of such a size as Queenstown should be able to provide some degree of supported accommodation. Again, this is a matter which will need to be negotiated with the Ministry of Health regarding their contracts with accommodation providers.

APPENDIX III

Coroner's recommendations from the inquest into the death of Patricia Anne Burton

RECOMMENDATIONS

With regard to inpatient management it is recommended that the following be implemented:

1. Training be provided in risk assessment to ensure that all staff who may be involved in the formalities of admission or discharge are training in risk assessment to the effect that they would be able to make an informed and considered assessment. That all other clinical staff are trained so as to have an understanding of "best practice" risk assessment principles. Risk assessment refresher courses be scheduled for all clinical staff other than qualified psychiatrists, on a regular basis, say every three years. Participation in the training programme should be a condition of employment. (I am advised that procedures similar to this have already been implemented at Invercargill. The recommendation remains, as it may be applicable beyond Southland.)

2. An auditing system be implemented that ensures that the documentation for each patient is properly completed and maintained.

3. The accuracy of the risk assessment of every patient be verified by a qualified psychiatrist.

4. In the case of any patient having an increased risk (2 or above on the scale used at Kew Hospital) the appropriateness of risk management and the effectiveness of treatment be reviewed at release and discharge by a qualified psychiatrist.

5. Medical Officers Special Scale (MOSSs) be required to conform to the same requirements as to supervision and accountability, as registrars. (It may well be that in future, by taking into account experience or formal training, some form of accreditation may be appropriate to enable individual MOSSs to take personal responsibility in some of those areas. Such accreditation would need to be standardised and recognised on a national basis.)