Mental health services' continuity of care failure (13HDC00199, 24 April 2015)

District health board ~ Public hospital ~ Mental health ~ In-patient ~ Community health services ~ Suicide attempts ~ Right 4(5)

A man attempted suicide and, in doing so, sustained a head injury. The man was taken to a public hospital and admitted for observation. Following a 24-hour period of observation, the man was discharged. Due to staff and family concerns for his safety, the man was then assessed by a psychiatry registrar and a Crisis Assessment Treatment Team registered nurse. Following the assessment, the man was admitted to the psychiatric inpatient unit.

The following day, the man had his first meeting with the consultant psychiatrist at the inpatient unit at the hospital. The man, his family and the consultant psychiatrist agreed that the man's status be changed to "inpatient on leave", and the man went home with his family.

The man returned to the inpatient unit the following day for an appointment with the consultant psychiatrist, who was at that time concerned about ongoing symptoms of a head injury. The man underwent follow-up and was again admitted to hospital where he remained for two nights before being discharged. For the next week the man was an "inpatient on leave". The man had two appointments with the consultant psychiatrist and was contacted each day by the psychiatric inpatient unit's transition liaison service.

Later that week a member of the man's family contacted the inpatient unit as they were concerned for the man's safety. The next day the man had an appointment with a different consultant psychiatrist, who was on-call. At that appointment, the man denied suicidal intention. However, that evening, the man, while under the influence of alcohol and cannabis, again attempted suicide.

The man was then admitted to the inpatient unit and remained as an inpatient for a few days. Following discharge, a referral for community services through the Community Mental Health Team (CMHT) was sent, but was not received. Over a month later, the man's family raised concern with the consultant psychiatrist that they had not heard from CMHT. The consultant psychiatrist then raised concern with CMHT, who advised they did not have a referral form on file.

It was held that the consultant psychiatrist provided services of an appropriate standard to the man during his time as a patient of the psychiatric inpatient unit, and did not breach the Code.

It was also held that the district health board failed to ensure continuity of care for the man throughout his time at the hospital and as he transitioned from the inpatient unit to community services, breaching Right 4(5) of the Code.