Psychiatrist, Dr C

Psychiatrist, Dr D

Canterbury District Health Board

A Report by the

Health and Disability Commissioner

(Case 07HDC16607)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mr A, aged 36, was found unconscious in his room while an inpatient in the secure unit at Hillmorton Hospital, run by Canterbury District Health Board (CDHB). He died shortly after, despite attempts by staff to resuscitate him.

Mr A had been involved with mental health services since 1990. Throughout this time, there was considerable uncertainty about Mr A's diagnosis. Initially, Mr A was diagnosed with schizotypical personality disorder after a number of brief contacts with the Psychiatric Emergency Service. However, following an inpatient stay in July 1990 he was diagnosed with factitious disorder[1] with underlying histrionic and narcissistic personality traits.

Mr A was seen intermittently by the community team at CDHB South Sector Adult Community Psychiatric Service (South Sector) over the next 10 years. He also had a number of acute admissions. Throughout this time, Mr A was treated for schizoaffective disorder, and was prescribed a combination of mood stabilising and antipsychotic medications with which he was largely compliant, although a diagnosis of factitious disorder also continued to be considered.

In October 2002, Mr A was discharged from CDHB mental health services. At this time, it was considered that Mr A's diagnosis was "likely a factitious disorder". The clinical records document that Mr A remained stable and was compliant with his medication regime. In contrast, his father, Mr B, advised that Mr A had begun to significantly deteriorate around this time.

Over the next year, Mr A presented acutely to mental health services on a number of occasions. Friends and family also contacted CDHB mental health services expressing concerns for his safety, as well as their own. However, all requests for assistance were declined on the basis that Mr A could be managed in the community by his general practitioner (GP), even when his GP made a referral for review.

In August/September 2003, following further deterioration, Mr A was assessed and admitted to an inpatient unit. At the time of his discharge in October 2003, his diagnosis had been changed to bipolar affective disorder. Following discharge Mr A continued to be followed up by South Sector. On 29 October he was reviewed by Dr D, who diagnosed "underlying personality disorder" with a mixture of psychotic and factitious presentation.

On 4 January 2004, Mr A was admitted to the inpatient unit at Hillmorton Hospital. At this time, he was assessed as being acutely psychotic, with a low risk of suicide and

[1] Factitious disorder is a relatively rare and complex mental health disorder in which the patient acts as if they have a physical or mental illness when in fact they are deliberately producing the symptoms.

medium risk of violence/aggression. This relapse into psychosis was thought to be due to non-compliance with his medication. Initially, Mr A was admitted into the open ward and restarted on his medications. He was later transferred to the secure unit because of increased aggression and agitation towards staff. Shortly after his transfer Mr A was found unconscious in his room, and died soon after, despite attempts by staff to resuscitate him.

This report examines the appropriateness of the care that Mr A received from two psychiatrists, Dr C and Dr D, and the Canterbury District Health Board over the last three years of his life.

Police investigation

The Police immediately became involved following Mr A's death, and an investigation was commenced. A lengthy criminal investigation followed, taking three and a half years. The delays (which occurred notwithstanding several requests by HDC to expedite the process)[2] have significantly frustrated the normal accountability processes for the health professionals and organisations involved in this case. The comments I made in another case involving a manslaughter investigation (which led to the unsuccessful prosecution of a midwife) are pertinent: [3]

> "There is a place for the criminal law in the clinical setting where a health practitioner kills a patient by reckless acts or omissions. But in cases of unexpected patient death, even where gross negligence may be proved, a manslaughter prosecution is likely to do more harm than good. It delays and frustrates the regular mechanisms for health practitioner accountability. Most importantly, no health practitioner is likely to share their mistakes in a peer review setting if Police search and seizure is a possibility. The real causes of patient deaths will remain hidden, and the potential to learn from mistakes will be lost."

In this case, at the conclusion of their investigation in July 2007, having obtained expert advice from psychiatrist Dr Allen Fraser,[4] the Police decided not to press charges. They concluded that while there were failures of mental health services, "they

[2] See **Appendix A** for the timeline of the complaint and Police involvement in this case.

[3] Refer http://www.hdc.org.nz/files/hdc/opinions/04hdc05503midwives-www.pdf, 28 November 2006.

[4] The key findings of Dr Fraser's report are summarised in **Appendix C**.

Names have been removed (except Hillmorton Hospital/Canterbury DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

did not reach the high level required for any charges of a criminal nature against anyone involved in [Mr A's] care and or treatment over this period".[5]

HDC investigation

In February 2004 HDC received a complaint about the care provided to Mr A. A decision about what action to take was postponed, pending the outcome of the protracted Police investigation.

On 26 September 2007 HDC commenced an investigation into the standard of care Mr A received between January 2001 and his death in January 2004.

The following issues were investigated:

The appropriateness of the care provided to Mr A by Dr C in July 2001.

The appropriateness of the care provided to Mr A by Dr D between January 2001 and his death in 2004.

The appropriateness of the care provided to Mr A by Canterbury District Health Board between March 2003 and his death, including the adequacy of the information provided to Mr A and his family.

The parties directly involved in the investigation were:

Mr A	Consumer
Mr B	Complainant/parent
Dr C	Provider/psychiatrist
Dr D	Provider/psychiatrist
Canterbury District Health Board	Provider

Other parties:

Dr E	Psychiatrist

Independent expert advice was obtained from psychiatrist Dr Murray Patton (see **Appendix B**).

[5] The Police considered charges pursuant to sections 145, 151, 156, 157 and 160(2)(b) of the Crimes Act 1961, and section 114 of the Mental Health (Compulsory Assessment and Treatment) Act 1992, but concluded that there was insufficient evidence to lay such charges.

Chronology of care, 2001–04

The following is a summary of the care provided to Mr A between January 2001 and January 2004. Appendix B (Dr Murray Patton's expert advice report) contains a more detailed account of the care provided to Mr A.

2001
Dr C was Mr A's primary psychiatrist from 1995 to 2001. He had been involved in his care since September 1992, treating him primarily for schizoaffective disorder with features of factitious disorder. Dr C was a full-time consultant psychiatrist at Canterbury District Health Board in the South Sector Adult Community Psychiatric Service.

In January 2001, Mr A's care was transferred from Dr C to Dr D. Dr D was a full-time permanent employee with CDHB between January 2001 and January 2004, working three and a half days with the South Sector and one and a half with another service. In accordance with the New Zealand Medical Council vocational training programme, Dr D worked in a collegial relationship with Dr C from September 2001 until February 2002 when he gained full vocational registration.

Dr D remained Mr A's primary psychiatrist until 4 October 2002 when Mr A was discharged from mental health services. Dr D was not directly involved in Mr A's care again until following his admission in September 2003.

Dr D first saw Mr A on 14 May 2001. Following his assessment, Dr D diagnosed Mr A with schizophrenia, noting that he remained symptomatic and was non-compliant with his current medication regime.[6] Dr D decided to follow up Mr A every three months and have a South Sector case manager follow up with his medications and general well-being in the interim. In his report following this assessment, Dr D noted that Dr C was of the impression that Mr A suffered from bipolar disorder.

On 12 July, in Dr D's absence, Dr C saw Mr A in relation to a request from his GP for a psychiatric opinion needed to obtain a class 2 heavy traffic licence. Dr C was familiar with Mr A's history and provided a report for his GP.

Following review of the clinical records and a discussion with Mr A, Dr C noted that he had been experiencing intermittent psychotic symptoms, but was reported to be functioning well in a work situation. At the time, Mr A was working full time for a furniture removal company. Dr C did not consider that there was any psychiatric contraindication to Mr A holding a class 2 heavy traffic licence.

[6] At this time, Mr A was on a combination of mood-stabilising and antipsychotic medications. The doses of these medications were at a range consistent with maintenance treatment of ongoing psychotic illness.

In carrying out his review of Mr A's clinical records, Dr C added a handwritten amendment to Dr D's earlier report. Dr C documented:

> "12/7/01 I have just read this report. There seems to have been a misunderstanding. I do not believe [Mr A] had Bipolar Disorder or any other Axis I psychiatric disorder. I am of the firm belief that [he] has a factitious presentation."

Further, in a letter dated 13 July 2001 to Mr A's GP, Dr C stated: "[I]t has long been my personal opinion that the nature of [Mr A's] supposed psychiatric illness is in fact factitious, although this view has not generally been the one taken by mental health services."

Dr C made no other reference to factitious disorder in the clinical records.

Mr A was next seen by Dr D on 9 August 2001. He had not been seen by his South Sector case manager since May. Dr D noted Dr C's opinion that Mr A's presentation was factitious, but documented that he did not plan to change his treatment. On 29 November, following Mr A's failure to attend an appointment, Dr D made the following entry into Mr A's clinical records: "though officially diagnosed as Schizophrenia, we are treating [Mr A] as for factitious disorder". The plan was for Mr A to continue to receive medication and follow-up from the South Sector psychiatric registrar.

2002

Throughout 2002, Mr A remained on the same medication regime. It appears that he was generally compliant with his medications. While appointments continued to be offered by South Sector, he failed to attend many of his appointments. There was no clear plan about how to respond to his non-attendances. Dr D stated:

> "[Mr A] had a known history of distant and intermittent engagement with the mental health service. For a number of years prior to my psychiatric oversight he had refused to engage with a case-manager and would remain hostile and confrontative with them so as to protect his privacy. He had remained a voluntary customer of our Service. While his adherence to medications and his disclosed history could not always be relied upon, he had been known to function satisfactorily."

On 24 September, Dr D reviewed Mr A for the purposes of renewing his Class 2 heavy traffic licence. In a letter to the Land Transport Safety Authority, Dr D documented that Mr A was displaying no overt psychiatric symptoms of any concern.

On 1 October, Mr A was discharged from the South Sector to the care of his GP. In a discharge letter to the GP, Dr D noted that for the last year Mr A had been well in the community and adherent to his medications. He advised that he could not identify any

"mood, neurovegetative or psychotic symptomatology" and commented that, although there was a past diagnosis of schizoaffective disorder, it is "our impression that it is most likely a factitious presentation". Dr D added that Mr A remained vulnerable to the re-emergence of pseudo-psychotic symptoms when under stress and "would benefit from an early intervention or contact with the Psychiatric Service should that occur". He recommended maintaining his current antipsychotic and mood-stabilising medications.

2003
Following his discharge, Mr A did not have any contact with mental health services until 12 March when his GP referred him to South Sector. In the referral, his GP advised that Mr A had ceased taking his medications and had developed seizures. His GP queried schizoaffective disorder and requested review.

South Sector declined the referral because Mr A did not meet the threshold for acceptance for assessment, due to the fact he had stopped taking his medications and had only recently been discharged from the service. Dr D subsequently discussed the referral with Mr A's GP, ascertained that the GP was comfortable managing Mr A at that time, and offered advice on management including a recommendation that the GP recommence Mr A on his medication regime.

Over the next few months, Mr A presented to the Psychiatric Emergency Service (PES) on a number of occasions. On 15 April he was assessed by PES after being taken there by Police. A diagnosis of factitious disorder was recorded and no follow-up was arranged. On 20 April PES assessed Mr A after his family raised concerns. The next day, he was admitted voluntarily into an acute inpatient mental health unit (the acute unit) at Hillmorton Hospital for assessment. Following review by the clinical team he was noted to have stopped his medications. On 22 April Mr A was reviewed by a psychiatrist (who noted no overt signs of any major psychiatric disorder) and given leave with an arrangement for review in a few days' time. The documentation shows that he returned in the interim, but was later discharged when he left the ward and did not return for the arranged review appointment. The diagnosis on the discharge record states factitious disorder. There is no mention of medications or follow-up (other than GP). After re-presenting at the acute unit on 25 April, Mr A was advised to attend the ED or PES if he wanted to be seen. An assessment by a PES psychiatrist on 28 April noted unusual behaviour but concluded that Mr A was experiencing an emotional/psychological disturbance and medication should be continued.

Mr A presented to PES on a regular basis. Numerous contacts with PES by his family and friend are also documented. However, on each occasion, Mr A was referred back to his GP as he was not considered to reach the threshold for acceptance into the mental health service. Around this time, factitious disorder became more prominent as

Mr A's recorded diagnosis and as explanation for his abnormal behaviour. The following contacts were made with CDHB mental health services:

- On 21 May PES was called by Mr A's neighbour, and then ambulance staff, who were concerned about his behaviour. PES's response was that Mr A was "not primarily a psy [sic] problem" and the Police should deal with any concerns. The Police subsequently contacted PES, and received the same response.

- Later on 21 May, Mr A presented at ED expressing concerns that he might hurt someone. An initial assessment was completed by a psychiatry registrar, who subsequently discussed the assessment with a PES psychiatrist. After discussion with the PES psychiatrist, Mr A was discharged. Following this, a PES psychiatrist wrote to South Sector advising of Mr A's recent contact. A handwritten note to Dr D dated 23 May requested he contact the PES psychiatrist to discuss this referral. Dr D documented this conversation (in an email to South Sector's clinical coordinator), noting that they agreed Mr A's presentation was factitious and that he should be managed in primary care with crisis management through PES. PES subsequently withdrew the referral and discharged Mr A back to his GP.

- On 17 June, Mr A presented at PES. The note states that Mr A was mildly pressured in his speech and that there was "no safety concerns expressed".

- On 27 June, Mr A presented at ED. ED staff asked PES to review Mr A, but he declined to be assessed by PES and left the hospital.

- On 2 July, Mr A was referred to PES by the CDHB head injury clinic, but this referral was refused as PES was "unable to offer any help".

- On 15 July, PES was contacted by a GP advising that Mr A was presenting as psychotic. After discussion with a PES worker, it was agreed that the GP would ascertain if Mr A was suicidal or violent. Mr A later presented at ED complaining of back pain and was noted to be psychotic. After a discussion with PES during which Mr A's "situation" was discussed, it was agreed that "PES not to be involved".

- On 19 July, following several phone calls from his family, PES visited Mr A. PES's record of the assessment noted that his home was in a squalid condition and he gave convoluted answers to questions, but concluded that he probably had a factitious disorder. A need for discussion regarding follow-up was noted in the record, but there is no indication that this occurred.

- On 23 July, Mr A presented at PES. Following an assessment Mr A was noted not to be psychotic or have any thought disorder. The summary states that this was

"[n]ot a psychiatric emergency". It also makes reference to Mr A being well known to the mental health service, with a diagnosis of factitious disorder.

- In July and August further calls of concern (from Police, a friend, and a psychiatrist in another city [City 2]) were noted in Mr A's file. After a number of calls on 23 August, PES visited Mr A's home but he was absent. Later in the day PES again attempted to visit Mr A at his home, but he refused them entry. Mr A's sister reported that he had attempted to strangle her the night before, and she was very concerned about his mental health. PES's plan was to follow up the next day. On 24 August, his sister reported to PES that he had threatened harm to his ex-partner. On 25 August, PES advised Mr A's sister that the only option available was for her to complete an application to put Mr A under compulsory care.

- On 26 August, Mr A presented at PES. Assessment by the PES staff identified that Mr A was irritable and agitated, with mildly pressured speech. Persecutory and disjointed thoughts were also noted. Mr A declined an urgent appointment with the consultant psychiatrist and left (the recorded plan was to "await contact"). However, he was later persuaded to attend an appointment the following day and was seen by psychiatrist Dr E.

  Dr E documented that he had contacted Mr A's father and a friend to get information from them about Mr A's behaviour. He noted the longstanding conflict over Mr A's diagnosis "between genuine psychosis and a factitious disorder" and concluded that further assessment was necessary, together with the involvement of Mr A's family and friends. He documented:

  > "Given the concerns of his friends [and] family, I suspect it will be necessary to do a further inpatient evaluation to clarify the diagnosis and regardless of diagnosis I think he needs psychiatric supervision at present."

- A home visit was organised to review Mr A's living conditions. However, on 29 August before that assessment took place, Mr A travelled to City 2 and assaulted his father. Mr A was taken by Police, assessed, and then sent back to Christchurch.

- On 1 September, Mr A was admitted to the acute inpatient unit.[7] During this admission, he was recorded to have a diagnosis of bipolar affective disorder (current episode manic with psychotic symptoms). His antipsychotic medication was changed from risperidone to olanzapine.[8] There were discussions between the inpatient team and South Sector staff about Mr A's diagnosis (on 3 and 24 September).

[7] This admission was initially voluntary, but Mr A was committed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 after he deteriorated later that day.

[8] Risperidone and olanzapine are both antipsychotic medications.

- On 15 October, Mr A was discharged to the South Sector team, with a diagnosis of bipolar affective disorder.

- On 29 October, Dr D reviewed Mr A. Following this assessment, Dr D's general impression was that Mr A had "underlying personality disorder (narcissistic, antisocial) and at times of stress can present with extreme instability, decompensation, with a mixture of affective, psychotic and factitious presentation". Dr D planned to continue him on a slightly reduced dose of olanzapine in light of some reported side effects on the current dose, with further review in four weeks.

- On 24 December, Mr A attended a follow-up appointment with a South Sector mental health nurse who noted that Mr A had not been taking his medication as it had been making him too tired. A plan was made to continue Mr A on his medication regime and a follow-up appointment was made for 8 January.

2004

In January, Mr A presented to ED in acute distress. He complained of physical pain, poor motivation and low energy. Mr A was initially thought to be having a relapse of bipolar affective disorder with psychotic features, and an admission to the acute inpatient mental health unit was subsequently arranged.

Upon admission, a risk assessment noted Mr A's risk of suicide was "Low". On 4 January, it is recorded that Mr A had experienced thoughts of suicide, but they were noted to have subsided.

Two days later, a psychiatrist assessed Mr A and concluded that he had bipolar affective disorder and was currently psychotic.

The following day, a further assessment was carried out in which Mr A was described as "extremely labile, agitated and paranoid with delusions of persecution involving staff". He was noted to be having some suicidal thoughts, but no plan to commit suicide. A risk assessment determined that Mr A was a high risk of violence to others and describes the risk of suicide as "medium".

Admission to Intensive Care Secure Unit

Shortly afterwards, Mr A was assessed as being psychotic with manic features, with the risk of violence as high. Accordingly, he was transferred to the intensive care area, because of concerns about the safety of others. The intensive care secure unit (the secure unit) is a locked unit with 1:2 (staff to patient) nursing ratio and 15-minute nursing observations. However, because Mr A was not considered to be of significant risk of self-harm, no specific restrictions or increased level of observation (ie, a special nurse in constant attendance) were implemented.

On arrival at the secure unit, Mr A's care was formally handed over to staff. Throughout the day Mr A was noted to be agitated. At 4pm he was given lorazepam because of agitation. At this time he was noted to be socialising with other patients in the courtyard. A registered nurse who was working as the shift coordinator, advised that the information staff were given about Mr A was that he had been transferred from the acute unit because he was a high assault risk to others and was agitated; they "were not advised that Mr A was at risk to himself in any way". Mr A was therefore on routine 15-minute observations.

Death
At approximately 4pm, the staff nurse caring for Mr A went for a walk with another patient. The care of Mr A was handed over to another staff nurse, but he was not checked again until approximately 4.45pm, when he was found unconscious. Resuscitation was commenced immediately, and was initially successful in re-establishing circulation. However, Mr A vomited and breathing could not be re-established using the emergency resuscitation equipment.

Ambulance staff arrived a short time later. They intubated Mr A and continued resuscitation, without success.

Comment from family
Mr A's family believe that Dr C's actions in July 2001 had a significant impact on the care Mr A subsequently received. They consider that factitious disorder was the incorrect diagnosis. They believe that Dr C and Dr D colluded to prevent Mr A from accessing mental health services. Furthermore, the family believe that earlier intervention by mental health services may have prevented Mr A's 2004 acute admission and subsequent death.

Comment from Dr C
Dr C advised that throughout his supervision of Mr A's case he "attempted to minimise the potential for his care to become fragmented and inconsistent. [He] encouraged the staff to provide consistent treatment appropriate to the diagnosis of Schizoaffective Disorder, whilst trying not [to] overreact to the dramatic elements to his presentations."

In relation to his report to Mr A's GP in 2001, Dr C explained that this was a specialist report for the purposes of assessing Mr A's fitness to hold a heavy traffic licence. In providing the report he was required to justify his opinion that Mr A was fit to hold a licence.

Mr A informed him that he had fabricated the symptoms. Dr C explained that it would have been professionally irresponsible for him to disregard Mr A's account. Furthermore, Mr A's reported level of symptomatology described three months earlier to Dr D would have been incompatible with performing at work to the level the employer described. Dr C advised that "stating my opinion that the supposed

psychiatric illness was factitious was a means of supporting Mr A's explanation rather than dismissing it as evidence that he was denying a state of illness that would have indicated he was unfit for such a licence".

In relation to why he annotated Dr D's report when he saw Mr A in 2001, Dr C explained: "I felt it ascribed to me a position of certainty with regard to the diagnosis of Bipolar Disorder that I did not, in fact, hold."

Comment from Dr D

Dr D explained that throughout the period when he treated Mr A, his diagnosis remained as schizoaffective disorder. Dr D stated that while there was some debate over Mr A's diagnosis, he was treated for a psychiatric illness. Mr A also believed he had a psychotic illness. Dr D stated:

> "It is important to note that despite the diagnostic controversy, [Mr A's] medication and treatment had remained consistent throughout my oversight period as appropriate for a schizoaffective condition (i.e. an anti-psychotic medication and a mood stabiliser), and throughout [Dr C's] oversight as well. Given the complexity of his presentation, I have always kept an open mind to any atypical presentation.
>
> … Given that this was his well-entrenched view, which most likely supported some deeper psychological needs, we had supported his understanding. Our education had always centred around medication adherence, symptoms recognition and early intervention."

Dr D explained that his decision to discharge Mr A in 2002 was the end result of a very gradual process of almost two years of discharge planning. Mr A had been requiring only a low level of input from mental health services for a number of years. When Mr A was discharged he was considered stable, but it was made clear to him that he could be referred back at any time for further assessment and treatment.

Dr D advised that, following his discharge, he had no further contact with Mr A until October 2003, apart from an incidental encounter when he presented to South Sector in March 2003. At that time, Dr D had no concerns regarding his mental state. Accordingly, Mr A was advised to return to his GP. Dr D felt it important to communicate with Mr A's GP. He recommended that the GP resume Mr A on his normal treatment regime "although we were uncertain if his presentation might have been factitious".

Dr D emphasised that Mr A's atypical features did not have a detrimental effect on his care. He stated:

> "An understanding of a Factitious Disorder often draws the clinicians involved to be extra careful and empathetic towards [Mr A's] unconscious psychological

needs that might manifest as psychiatric symptoms; rather than stigmatising him or punishing him for presenting that way."

In relation to the information he provided Mr A about his illness, Dr D advised that the South Sector team had ongoing discussions about his treatment and management. Further, Dr D explained that "being aware of [Mr A's] psychological needs, defences and vulnerabilities to rejection and stigmatisation, our team had been careful about the way we discussed interactions and framed along the stress-vulnerability model, and modelled through consistency of input, empathy and practical support".

In relation to information provided to the family, Dr D explained that it had always been Mr A's wishes not to involve his family. Dr D stated that "[Mr A] had been adamant against any disclosure to his family" and had reported that his father had sexually abused him previously and that he was angry with one of his sisters. Mr B (Mr A's father) was aware of the allegations of sexual abuse, and commented that his son would make these types of allegations when he became unwell.

Dr D explained that Mr A's refusal to involve his family "restricted severely any information we could pass to them and our involving [Mr A's] family in his treatment".

Comment from CDHB
CDHB advised that discharging Mr A in October 2002 was a "considered decision" reached by the clinical team in consultation with Mr A. It was decided that any ongoing issues could be managed by his GP. PES then became the point of contact if either Mr A or his GP considered further assistance was required.

CDHB advised that Mr A was declined an assessment appointment in 2003 because "he did not meet the threshold set out in the acceptance criteria".

A sentinel event review carried out following Mr A's death revealed some concerns. In particular, no formal handover was carried out when Mr A's staff nurse became involved with another patient and unable to perform the routine 15-minute patient check, and the emergency trolley in the secure unit where Mr A died had not been appropriately checked prior to this event, and a number of pieces of equipment were either absent or not functioning correctly. In addition, staff had not been adequately trained in emergency response.

CDHB advised that extensive work has been undertaken to implement each of the review recommendations. They included reviewing the policy for nursing observations in the acute inpatient unit, and reviewing the emergency trolleys to ensure they all met the requirements. Significant training and education has been implemented in emergency medical response, and ensuring that all staff receive orientation to the emergency trolley.

Responses to provisional opinion

Dr C

Dr C advised that, in treating Mr A, "the reality was that there was diagnostic uncertainty". In his view, not documenting that diagnostic uncertainty would not have been reasonable. Dr C stated that "uncertainty should not paralyse a competent clinician". Furthermore, "inappropriate treatment can occur when clinicians operate on an assumption of diagnostic certainty, when no such certainty is clinically justified".

Dr D

Dr D's lawyer responded on behalf on Dr D. The lawyer submitted that Dr D was not solely responsible for Mr A's diagnosis of factitious disorder, rather the diagnosis resulted from a multidisciplinary team decision that had been in place for many years prior to Dr D's involvement. He stated:

> "… [Dr D] was but one member of a multi-disciplinary team where the decision making was by consensus rather than by any one individual member of that team, i.e. it is a multi-disciplinary team which makes a multi-disciplinary decision."

Furthermore, the lawyer submitted that the diagnosis of factitious disorder did not result in Mr A being refused services. Dr D and his team treated Mr A for schizoaffective disorder, while also taking into account his atypical presentations.

The lawyer stated that "[b]ecause factitious disorder is relatively rare, clinicians are generally very careful to diagnose it unless [the] patient's presentation is obviously atypical". The lawyer commented that Dr C had a long history with Mr A and would have had enough clinical experience to enable him to reach a firm conclusion about Mr A's diagnosis. While Mr A had remained relatively stable throughout Dr D's involvement with him, Dr D could not disregard this history. Notwithstanding this, "[Dr D] has always reserved an open mind to such a diagnosis, even though he continued the management as of schizoaffective disorder. In addition, the complexity of a potential factitious presentation required more careful support and engagement with the patient." Accordingly, Dr D's diagnosis was that Mr A had an "underlying personality disorder, with a mixture of psychotic and factitious presentation". The

lawyer submitted: "It would have been professionally irresponsible for [Dr D] to simply take one view over the other, as [Mr A's] presentation over the years was clearly difficult to reconcile."

CDHB
CDHB accepts that it failed to co-ordinate the services involved in Mr A's care in 2003. It also accepts that it did not ensure that staff adequately considered involving Mr A's family in his care. It has taken steps to address these issues, including implementing each of the recommendations from the sentinel event review and ensuring that there is now greater staff awareness of the importance of involving family in care.

In relation to Dr D's involvement in Mr A's care, CDHB explained that the multidisciplinary team plays an important role in mental health services and that the care provided to Mr A should be considered in this context, rather than singling out any one provider. Furthermore, CDHB highlighted the fact that the diagnosis of factitious disorder had been made by a number of health professionals over nearly 15 years.

In relation to Mr A's final admission, in particular his transfer to the secure unit, CDHB explained that Mr A was transferred because of an increased risk of violence. Given his past history of violence, CDHB considered that it was reasonable that the clinical focus was on managing this risk. Mr A did not have a history of self-harm. While his risk of self-harm was increased from low to medium as a result of a statement he made about wanting to kill himself if transferred to the secure unit, this comment was not supported by a change in behaviour indicating increased suicidal ideation.

CDHB explained that a medium risk of suicide is not unusual for patients on the secure unit. Around 80% of patients would have a medium risk of suicide and most of these patients would be on 15-minute observations. While CDHB acknowledged that Mr A's risk of self-harm was not clearly communicated to staff on the secure unit, it does not consider that this would have changed the way Mr A was managed, or his level of observation. The next level of observation (one-on-one specialling) would not have been feasible or appropriate.

Discussion

Diagnosis
Mr A was first seen by mental health services in 1990. Due to his atypical presentation, there was a view that he might be misrepresenting some of his symptoms, and the diagnosis of factitious disorder was therefore considered.

Following further contacts with mental health services, diagnoses of schzophrenia and schizoaffective disorders were also considered and he was treated accordingly. The treatment appears to have been effective in stabilising his symptoms, but aspects of Mr A's presentation remained atypical. As a result, no definitive diagnosis was made, and references to factitious disorder occurred in the context of diagnostic uncertainty.

Dr C advised that throughout his involvement with Mr A there were many symptoms strongly suggestive of factitious disorder, and considered this to be a component of his illness. However, when he reviewed Mr A in 2001, Dr C moved more strongly towards the view that Mr A had factitious disorder.

When Dr D took over Mr A's care in 2001, he noted the longstanding controversy over the diagnosis, but continued to provide treatment appropriate for schizoaffective disorder. However, Dr D was clearly of the view that factitious disorder was an important feature of Mr A's presentation. He stated:

> "Given the complexity of [Mr A's] presentation, I have always kept an open mind to any atypical presentation."

Psychiatrist Dr Allen Fraser, in his expert advice to the Police, considered that, given the unconventional nature of Mr A's illness (particularly his apparent rapid resolution of illness without medication), "it was not unreasonable to have an open mind about whether or not he had a psychotic illness". However, as also noted by my expert advisor, Dr Murray Patton, factitious disorder started to feature more prominently as a diagnosis during Mr A's repeated presentations to PES in 2003. As a result, inconsistencies in Mr A's presentation became readily attributed to factitious disorder and care planning became unclear and inconsistent. Dr Patton stated:

> "It appears … that generally these atypical elements, rather than being seen as or carefully explored as possible unusual presentations of a chronic illness and that were perhaps influenced by aspects of [Mr A's] character, came to be seen as indicative of Factitious Disorder."

Due to the complexity of factitious disorder, it is a notoriously difficult diagnosis to confirm, and there is no one recognised treatment. For this reason, treatment should be a carefully planned, collaborative approach. As noted by Dr Patton:

> "These are complex presentations, difficult to manage even within specialist mental health services and requiring a high level of communication and coordination between specialist services and primary care and emergency departments — and perhaps even other agencies."

Ongoing treatment 2001–2002

Throughout 2001 and 2002 Mr A had only a few contacts with mental health services. While attempts were made to maintain regular contact with Mr A throughout this

time, the clinical records document a number of missed appointments and note that he only made contact when his medications had run out. However, medications continued to be prescribed regularly and appropriately for schizoaffective disorder.

Dr D acknowledged that there was significant diagnostic controversy surrounding Mr A's presentation, as discussed above. However, despite this, he stated: "[Mr A's] medication and treatment had remained consistent throughout my oversight period as appropriate for a schizo-affective condition (i.e. An anti-psychotic medication and a mood stabilizer) …"

Dr Fraser, in his independent expert advice to the Police, stated that "there is little doubt that the diagnosis of factitious disorder had considerable influence on the way in which Mr A was assessed by staff, particularly in the community teams". Nonetheless, he considered that "[Mr A's] management through this period of time was appropriate, in that medication was continued, he was seen whenever he had acute concerns, and he was allowed to establish a degree of independence for himself."

Similarly, Dr Patton advised that the care during this time was appropriate. He stated:

> "In general, while perhaps lacking in assertiveness with regard [to] strategies to assist adherence to medication and to engage in follow up, care through 2001 and 2002 was otherwise of a satisfactory standard. There is evidence of some careful review by [Dr D] and [Dr C], both of whom appear to have tried to make sense of the sometimes apparently contradictory and atypical elements of [Mr A's] presentation."

2002 discharge

In October 2002, Mr A was discharged from mental health services. Dr D explained that the decision to discharge Mr A was made based on the low level of input Mr A had required over the previous years and was the "end result of a very gradual process of almost two years of discharge planning and [Mr A] was consulted and intimately involved with the discharge process".

Dr Patton agreed that Dr D's decision to discharge Mr A in 2002 was generally appropriate. He stated that "[i]t would not be unreasonable for someone with a fairly stable presentation, even of a psychotic illness, to be discharged to a General Practitioner". He also considered that the indication of the ongoing availability of the service for advice and consultation was appropriate.

However, Dr Patton commented that due to the complexity of Mr A's presentation, it was important to ensure a "carefully planned and coordinated agreed plan developed and implemented jointly between primary care and mental health services (and often other services, including emergency departments, ambulance and police services)".

Dr Fraser also considered that, although the decision to discharge Mr A was appropriate, in light of the complexity of his presentation careful planning with the full involvement of Mr A and the GP was required. Dr Fraser advised that Mr A's discharge was abrupt and lacking clear communication with the GP.

Deterioration in 2003

Following his discharge in 2002, Mr A initially remained stable. However, during 2003 his mental health deteriorated. In March 2003, there is evidence of re-emergence of his symptoms and a referral was sent to the South Sector by Mr A's GP stating "? Schizoaffective disorder" and requesting review. This was declined on the basis that he had discontinued his medications and had only recently been discharged from the service. His GP was recommended to recommence his medications and advised that his presentation was most likely factitious. In April, Mr A had two crisis contacts which resulted in a brief admission to the inpatient unit. However, when he left the ward and failed to attend an appointment he was discharged with the diagnosis of factitious disorder. Mr A was not recommenced on his normal medication regime. Dr Fraser advised:

> "In light of the relatively sudden recurrence of contacts and loss of function, restarting the same medication would have been an appropriate intervention."

Dr Patton considered that Mr A's behaviour was readily attributed to factitious disorder with little exploration of possible psychiatric deterioration.

Throughout the next few months, numerous telephone contacts from Mr A's family and friends were received by PES. Crisis contacts, and contacts by the Police and ambulance service, are documented. A further call of concern from the GP was received in July. Despite the clear concern about Mr A's condition, there was no direct response by PES. Dr Patton stated:

> "This [lack of response by PES] seems to have been inadequate in the face of the clear concern about [Mr A's] behaviour and potential risks he was presenting, even for someone not known to the service, but also incongruent with the plan already identified in respect to his presentations, that PES would provide crisis assistance."

In Dr Fraser's opinion, factitious disorder had a "considerable influence" on the way Mr A was assessed by staff. Dr Fraser stated:

> "… I believe that staff failed to appropriately evaluate the clinical presentation in the light of information available (or potentially available) in the notes of past admissions. In consequence the changes in level of functioning, the altered mood state, the presence of psychotic symptoms, and the resurfacing of potential and actual violence, were not regarded as evidence for the relapse of a major psychotic illness."

Similarly, Dr Patton stated:

> "It seems very clear that by this time the diagnosis of Factitious Disorder was strongly influential in the response being provided and that odd behaviour was to be dealt with by other agencies, despite the plan to provide crisis assistance. This response was not appropriate in these circumstances."

Dr Patton commented that around 2003 the approach in mental health services was to discharge anyone who was not thought to have an ongoing major mental illness. As a result, "people with disturbances of personality and behaviour, despite the clear difficulties in responding to their presentations in a coherent manner in any social service system, tended to by rebuffed when referred". However, Dr Patton stated:

> "[I]t would have been appropriate, at the very least, to have convened a case conference involving the various agencies involved in intermittent contact with [Mr A], to develop a coordinated approach to his increasing presentations."

Mr A continued to deteriorate throughout 2003 and was eventually assessed on 27 August 2003, by Dr E. Subsequent to this assessment Mr A was admitted as an inpatient in the acute mental health unit. This admission resulted in a revision of his diagnosis to bipolar disorder. Mr A was discharged with follow-up care arranged with South Sector. He remained "fairly stabilised" in the community until the end of the year. However, on 24 December, he reported that he had not been taking his medications because they were making him feel very tired.

Dr Fraser considered that when Mr A reported non-adherence to his medications, "appropriate intervention would have been to follow him more closely, and again to consider a change of antipsychotic to that he had previously tolerated".

In contrast, Dr Patton considered that the care during this period was appropriate. Although Dr D did continue to attribute some aspects of Mr A's presentation as factitious in nature, the care he actually provided was reasonable for someone with a psychotic illness. Dr Patton also considered that when Mr A reported side effects on his current medication regime, Dr D appropriately reduced his prescribed dose and planned to carry out a further review in another four weeks.

Communication with family

Mr A regularly expressed reluctance for his family, in particular his father, to be involved in his care. Mr A's father, Mr B, advised that when Mr A was delusional and unwell he would make statements about his family. Although they were normally very close, when Mr A became unwell he would stop communicating with them.

The CDHB policy on 'Family, Whanau and Carer Involvement in Mental Health Services' affirms a consumer's right to refuse contact with his or her family, but requires staff to "give consideration to the part that illness may play in their attitude to

family, whanau or carers when the consumer is refusing involvement of or contact with their family". In Dr Patton's opinion, this policy was not adhered to. He stated:

> "There is no evidence that [Mr A's] concerns regarding past abuse within the family, which could at least in part have contributed to some reluctance to involve them fully in discussion, was fully considered by the clinical teams. … Even in the absence of willingness of [Mr A] to allow such contact, the standard set by the DHB's own policy, that staff will actively encourage consumer to involve such key people, does not — by the evidence available in the records I have seen — seem to have been achieved."

2004 admission

By early January 2004, there was evidence of deterioration in Mr A's condition, and he was admitted to the acute inpatient unit. Dr Patton considered that this was "reasonable intervention" given the circumstances.

During this admission, Mr A's initial risk assessment was considered to be low. Mr A continued to be monitored over the next few days. An increasing risk of self-harm was noted, together with an increased risk of violent aggression. Accordingly, Mr A was transferred into the higher security area.

Dr Patton advised that, in his view, this increased concern about self-harm was not clearly understood or communicated to staff in the secure unit. Dr Patton noted that the understanding of staff in the secure unit was that Mr A was on routine 15-minute observations, was at high risk of assault to others, and was agitated. Staff were not told that he was at risk of harming himself. Dr Patton also considers that it was inappropriate that reassessment was not carried out upon his transfer. Dr Patton stated:

> "I am concerned however that this important information about changed rating was not known to nursing staff immediately responsible for care. This appears to represent a failure of communication of important information."

Despite being on 15-minute checks, Mr A was left unattended for between 15 to 35 minutes. After being left unattended, Mr A was found unconscious in his room, and died soon after. I note Dr Fraser's comments:

> "[Mr A's] transfer to the intensive care part of the secure unit was a recognition of the need for extra nursing observations. Later that same day he was [left] unobserved. This suggests a failure of systems for monitoring new admissions to intensive care."

Commissioner's Opinion

Dr C — No breach

Dr C had a longstanding clinical relationship with Mr A, having been involved in his care from 1992. Throughout his involvement in Mr A's care, Dr C held significant doubts about the precise diagnosis. In July 2001, Dr C was asked by Mr A's GP to provide a specialist opinion in relation to Mr A's fitness to hold a heavy duty traffic licence. Dr C did not consider that there was any psychiatric contraindication to Mr A holding a heavy traffic licence, and reported to his GP accordingly. Dr C also documented in the clinical records his "firm belief" that Mr A had a factitious disorder and that he did not have a psychiatric illness. In his report to the GP, Dr C noted that "this view has not generally been the one taken by mental health services".

Dr C now justifies his statement of his "firm belief" by noting "the reality … that there was diagnostic uncertainty", which "should not paralyse a competent clinician". In my view, it was unusual for Dr C to document his opinion in this way. I find it curious that a psychiatrist who is no longer treating a patient would seek to highlight "diagnostic uncertainty" by documenting in the clinical records a firm view that the diagnosis is "x" not "y". While experienced clinicians are always free to document their professional opinion, this seems an odd way to "set the record straight".

Nonetheless, by 2001 the establishment of a coherent treatment plan for Mr A was the responsibility of the treating psychiatrist, Dr D. The subsequent shortcomings in Mr A's care (discussed below) were not primarily the result of Dr C's note, and there is no evidence of collusion between Dr C and Dr D.

Overall, Dr C's assessment of Mr A in July 2001 was appropriate. I conclude that Dr C did not breach the Code of Health and Disability Services Consumers' Rights (the Code).

Dr D — No breach

2001–2002
Dr D first became involved in Mr A's care as his primary psychiatrist in January 2001. At this time he undertook a careful examination and concluded that Mr A had schizoaffective disorder. While this remained the "official" diagnosis, following Dr C's review in July, it became clear that Dr D regarded factitious disorder as a prominent feature of Mr A's presentation. As noted by Dr Patton, follow-up became less proactive during 2001 and 2002. However, the care continued to be generally appropriate for someone with a psychotic illness.

2002 discharge
In discharging Mr A in October 2002, Dr D made it clear to Mr A's GP that they were treating him for factitious disorder and that psychotic symptoms could re-emerge when under stress. There is evidence of communication with the GP in relation to the availability of the service for consultation and advice in the recurrence of symptoms.

I accept that the decision to discharge Mr A at this time was appropriate based on his having been stable over the previous years. Although the complexity of Mr A's presentation and diagnosis were not well captured by the discharge or treatment plans, at the time of his discharge there was no indication that there would be any significant problems.

2003
Following Mr A's discharge, Dr D was not involved as Mr A's primary psychiatrist again until he saw him in October 2003 after his care was transferred to South Sector following an inpatient admission. While Dr D was involved in discussions with other services during this time (Mr A's GP in April and a PES consultant psychiatrist in May), he did not have any further formal involvement in Mr A's care until 2003.

Prior to Mr A's transfer to the South Sector team Dr D was involved in the discharge planning meeting. Mr A was then seen regularly by the South Sector team until early January 2004 when he was admitted to the inpatient unit. In relation to his management of Mr A, Dr D stated:

> "The outpatient team took [Mr A's] management seriously after discharge and with full knowledge of the difficulties that had occurred in the past. At no time was his presentation disregarded."

Dr D considered that Mr A remained "fairly stabilised" during his period of involvement. Dr D responded to Mr A's complaint of excessive sedation on his current medication regime by reducing the dose and planning further review in four weeks.

I note Dr Fraser's reservations in relation to the influence the diagnosis of factitious disorder had on the level of follow-up provided during this time. Dr Fraser stated:

> "[Mr A's] care during this period of outpatient follow-up was below acceptable standards for a patient subject to compulsory status as a result of violence occurring while psychotic, and who was openly non adherent with antipsychotic medication."

Dr Fraser advised that, in light of Mr A's previously good response to risperidone, Dr D should have considered changing Mr A's medication regime at this time.

In contrast, I note Dr Patton's view that Dr D's contacts and treatment during that time was a reasonable response in the circumstances.

Conclusion
Following Dr C's involvement in 2001, Dr D's view clearly changed to favour the diagnosis of factitious disorder, although the "official" diagnosis remained schizoaffective disorder. Clearly, Mr A was a difficult patient to diagnose and treat. It is apparent that there were many inconsistencies in his presentation and, in light of this, as noted by Dr Fraser, it was "not unreasonable to keep an open mind about whether or not he had a psychotic illness".

I accept that at the time of Mr A's discharge in 2002 he had been fairly stable for some time and there was no indication that there would be any problems with his discharge. Furthermore, Dr D made it clear that the community team was available should it be required. While I consider that it would have been wise for the South Sector team to have taken further steps to ensure the complexity of Mr A's presentation was fully understood by staff involved in his ongoing care, I do not believe that Dr D can be held responsible for the subsequent decisions not to readmit Mr A to the service in 2003.

Similarly, I accept that Dr D provided adequate follow-up to Mr A following his discharge to South Sector in 2003. I note the differences in professional opinion of Dr Fraser and Dr Patton, particularly in relation to the management of Mr A's medication. However, the regular contacts by the South Sector team during this time indicate that the team was alert to Mr A's risk of deterioration. When he reported some side effects from his medications, Dr D made a minor change and continued to monitor him. This was in line with the care plan developed at the time of Mr A's discharge. It would not have been appropriate to discontinue the medication after he had recently been established on it following a long inpatient stay.

Overall, while I have concerns about the communication and decision-making in Mr A's management (discussed further below), I conclude that Dr D did not breach the Code.

Canterbury DHB — Breach

2003
CDHB did not provide Mr A with services of an appropriate standard in 2003. Despite repeated calls for assistance and review, no response by PES was forthcoming. Instead, any unusual behaviour seems to have been attributed to factitious disorder, rather than to the psychotic aspects of Mr A's illness. It was not until his review in August/September 2003 that Mr A was accepted back into mental health services.

Whatever the correct diagnosis, there was a lack of clear care planning about how to manage Mr A.

I acknowledge that, at the time, it was a common approach in mental health services for patients who did not have a psychotic illness to be discharged and managed by primary care services. However, given the lack of diagnostic clarity, staff involved in Mr A's care (including staff from PES, Ambulance and the Emergency Department) should have developed a coordinated care plan, particularly when repeated calls of concern were received at the beginning of 2003.

Ideally, such a plan should already have been in place. The level of concern in relation to Mr A should have prompted the clinicians involved to formulate a cohesive approach to care. As noted by Dr Patton:

> "Even if it was correct that the correct diagnosis was of Factitious Disorder, it would have been sensible for that diagnosis clearly to have been identified as the 'official' diagnosis and for there to be a clearly documented plan for how to manage that condition, including how to respond to missed appointments and what part medication might play."

CDHB had a responsibility to identify and respond to the trend in Mr A's condition. In light of the frequent crisis contacts, the "management plan" of ongoing care being primarily through his GP should have been reviewed. The failure to do so appears to have occurred because no one person within the DHB was responsible for recognising the significance of the multiple contacts and assessments, and generating a single, multidisciplinary comprehensive care plan. There is no indication that Mr A's GP, as the clinician responsible for management of his day-to-day care, was kept informed of his repeated presentations to ED and PES.

Overall, I do not consider that CDHB responded adequately to the repeated contacts for assistance. In failing to record a clear care plan, an uncoordinated and unassertive approach to care resulted. This contributed to delay in treating Mr A's deterioration. I agree with Dr Patton that the reluctance of the mental health services to respond to requests for assistance was "clearly insufficient". Accordingly, I conclude that CDHB breached Right 4(5) of the Code by failing to co-ordinate the services involved in Mr A's care in 2003.

Family involvement

Mr A had made it clear that he did not want his family involved in his care. I acknowledge the importance of maintaining patient privacy. However, as outlined in the CDHB policy, due consideration should be given to the part the illness may play in the attitude of the consumer when refusing family involvement.

It is well acknowledged that good working relationships between mental health staff and families/whānau usually help the recovery of people with mental illness.[9] The *National Mental Health Sector Standard* (NZS 8143:2001) emphasises this involvement of family in providing quality treatment and support services, particularly when being discharged from the service (see standard 16). Section 7A of the Mental Health (Compulsory Assessment and Treatment) Act 1992 requires a medical practitioner or responsible clinician to consult with family/whānau during the compulsory assessment and treatment process, unless it is not in the best interests of the patient or proposed patient or it is not reasonably practicable.

There would certainly have been value in involving the family at the time of Mr A's discharge in October 2002. Subsequent to his discharge, family and friends contacted mental health services on a number of occasions expressing concern for Mr A's well-being. Yet there is no evidence, other than a few documented discussions with Mr A's sister, that involvement of his family and friends was ever thoroughly explored. As noted by Dr Patton:

> "Even in the absence of willingness of [Mr A] to allow such contact, the standard set by the DHB's own policy, that staff will actively encourage the consumer to involve such key people, does not — by the evidence available in the records I have seen — seem to have been achieved."

Policies and procedures are only useful when staff are appropriately trained in their implementation and steps have been taken to ensure their competence in relation to their documented responsibilities. Staff should have explored involving the family, particularly in relation to the provision of ongoing support and crisis management in 2003. The failure of CDHB staff to do so suggests that the DHB's policy was not well known to staff. By failing to ensure that staff adequately considered involving Mr A's family in his care, CDHB did not comply with relevant standards and breached Right 4(2) of the Code.

I acknowledge CDHB's advice that steps have been taken to address these concerns. CDHB advises that there is now greater staff awareness of the importance of involving family/whānau in care.

2004

CDHB clearly failed to provide care to an appropriate standard during Mr A's 2004 admission. Although Mr A was appropriately transferred to a higher security unit when the level of risk to others was assessed as high, there was a failure to adequately communicate the increased risk of self-harm. I accept that the majority of patients on the high security unit have a medium risk of self-harm. That is no excuse for not

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

maintaining the 15-minute check. The fact remains that the routine 15- minute observations were not followed and, during an unobserved interval of 15 to 35 minutes, Mr A was found unconscious in his room, and died soon after.

The lack of recognition of Mr A's risk was compounded by his primary nurse providing an informal handover to another staff nurse while she attended another patient. CDHB did not have appropriately functioning resuscitation equipment to hand or staff adequately trained in emergency response, when Mr A was found unconscious.

This was a tragic sequence of events. My primary concern is the failure of staff to adequately communicate the increased risk of self-harm at the time of Mr A's transfer to the high security unit. I agree with Dr Fraser that the fact Mr A was left unobserved suggests "a failure of systems for monitoring new admissions to intensive care". Overall, I conclude that CDHB breached Right 4(5) of the Code.

Improvements in CDHB mental health services

CDHB advised that extensive work has been undertaken to implement each of the recommendations from the sentinel event review, including ensuring formal handover of patients in the acute inpatient unit when a staff nurse is called away and unable to carry out his or her routine checks. It has also undertaken significant training and education for staff in emergency medical response.

CDHB advised that the Specialist Mental Health Service has developed a comprehensive sentinel event review process which includes the monitoring of any recommendation made during an event review.

CDHB has also taken steps to ensure greater staff awareness of the importance of involving family/whānau in care.

Follow-up actions

- A copy of this report will be sent to the Coroner, the Police Commissioner, and the Medical Council of New Zealand.

- A copy of this report, with details identifying the parties removed, except the names of advisors Dr Patton and Dr Fraser, CDHB and Hillmorton Hospital, will be sent to the Director of Mental Health, the Mental Health Commission, the

Privacy Commissioner, the Royal Australian and New Zealand College of Psychiatrists, the New Zealand College of Mental Health Nurses, and Schizophrenia Fellowship New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Hillmorton Hospital/Canterbury DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A — Timeline of complaint and Police involvement

January 2004	Mr B complains to Coroner
February 2004	Mr B complains to HDC
Jan–March 2004	Mr B complains to Police/Police commence investigation.
March 2004	Coroner advises Inquest deferred until completion of Police investigation.
April 2004	CDHB external inquiry deferred until completion of Police investigation.
May 2004	HDC defers decision on action to take on complaint until completion of Police investigation.
February 2006	HDC writes to Police asking for update and timeframe for completion of investigation.
February 2006	CDHB gives Police names of potential expert advisors.
February 2006	Police advise CDHB that they have concluded initial investigation and are looking for suitable expert to review case. No timeframe given for completion of investigation.
March 2006	Police advise HDC that they are having difficulty finding a suitable expert who is available and willing to be involved. No timeframe given for completion of investigation.
April 2006	Police request advice from HDC re, suitable psychiatric expert. HDC provides contact details for College of Psychiatrists.
June 2006	Police briefing two psychiatrists in Auckland with a view to instructing one of them to give advice.
June 2006	HDC meets with Police Deputy Commissioner to discuss the issue of manslaughter charges against health professionals, and specifically, the Police investigation into this case.
September 2006	Police send file to psychiatrist Dr Allen Fraser, for expert advice.
September 2006	HDC receives request from Advocacy Services, on behalf of Mr A's family, that this matter be progressed.

Sept–Dec 2006	Ongoing discussions between HDC and Police regarding progress investigation and access to Dr Fraser's advice.
January 2007	HDC write to Police expressing concern about the length of Police investigation and asking for advice on whether the Police will be laying criminal charges.
March–April 2007	Ongoing discussions between HDC and Police regarding progress of investigation.
April 2007	HDC write to Police expressing ongoing concern about the length of Police investigation and asking for advice on timeframes for the Police decision.
July 2007	Copy of final Police report received by HDC.

Names have been removed (except Hillmorton Hospital/Canterbury DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B — Advice to HDC from psychiatrist Dr Murray Patton

Thank you for your letter of 30 January 2008. You have sought advice about whether [Dr C], [Dr D] and Canterbury District Health Board provided an appropriate standard of care to [Mr A] between 2001 and 2004.

I am a vocationally registered psychiatrist. I obtained Fellowship of the Royal Australian and New Zealand College of Psychiatrists in 1989. I have subsequently held clinical roles in general adult psychiatry in community and inpatient acute settings and have held senior clinical administrative roles in mental health services in Auckland (Clinical Director roles in Auckland and South Auckland services), Tasmania (Statewide Director) and most recently in Wellington (Clinical Director). I have assisted investigations undertaken by District Inspectors in relation to their powers under the Mental Health (Compulsory Assessment and Treatment) Act and have provided advice to the Health and Disability Commissioner on a number of previous occasions.

I am not aware of any personal or professional conflict in this matter.

To assist me in reaching a view on these matters you have provided me with a variety of documents. This material was presented in three bundles which consist of pages numbered consecutively from 00001 to 00824. The content of these bundles is set out as an appendix to this report.

This material is clearly substantial in quantity. It is not clear to me unfortunately how the original clinical material was structured and there appear to be some elements that are either missing from the copies of the clinical records, or perhaps no record was made. Some elements appear several times, presumably indicating that the original material has been copied and transferred to other separate files, then amalgamated in to this bundle copied to me. It may also be however that due to the lack of a clear structure to the substantial volume of these records that I have not identified a relevant record. I shall try to make clear in my following comments where I feel I may be missing relevant information and in my conclusions I shall outline any subsequent limitations in my opinion.

Summary of care provided to [Mr A] between 2001 and 2004.

2001
The clinical files show that over the months prior to 2001 [Mr A] had been attending outpatient appointments with [a] Medical Officer. The notes of those contacts are brief but suggest no particular concerns reported by [Mr A] who appears to have been prescribed risperidone in a dose of 3mg at night.

In January 2001 [the Medical Officer] noted that he would be leaving the service and that [Dr D], psychiatrist, would be taking over [Mr A's] care.

In February a note is recorded by a senior nurse in which concern is expressed that [Mr A] had reported that for the last 2 weeks he had not taken his risperidone. He described increasing irritability, decreased concentration and general lethargy. The nurse planned to discuss this with [Dr D] the following day and suggested [Mr A] restart risperidone.

I can not locate any record of any further discussion as planned.

The next file note available to me is a typed progress note authored by [Dr D] and dated 16 May 2001. It simply contains a heading "INTERIM SUMMARY 14 MAY 2001" and the text "Please see Free text format for details of this report".

This text appears to refer to a document dated 18 May 2001 written by [Dr D]. This three and a half page report summarises [Mr A's] history, identifies a past diagnosis of schizophrenia/schizoaffective disorder and notes that [Mr A] had missed several appointments since last seen on 13 February.

A mental state examination is described and the report concludes with an assessment summary, noting a diagnosis of schizophrenia. A plan outlines [Dr D's] intention to continue to follow up [Mr A], rather than transferring care to a newly arriving Medical Officer, because of some complexities in his presentation.

This report refers to some comments made by [Dr C] who is reported to have said that [Mr A] would likely remain detached from the service and might "act up" when unwell to get support. [Dr C] is also reported to comment that he felt the diagnosis was of bipolar disorder.

[Dr D] planned for [Mr A] to continue with treatment with risperidone and with sodium valproate although noted some concern regarding adherence to this medication regimen. [Dr D] planned to see [Mr A] in 3 months.

The next file entry records a visit made to [Mr A] at home following several attempts to telephone him. The nurse notes that he appeared grandiose but makes no other reference to mental state. The record notes [Mr A's] request for a change of case manager. A plan to discuss with the team is noted. I can find no record of that discussion or its outcome.

The next file entry appears to be on 10 July and notes briefly a call from a doctor wanting information on [Mr A] in respect of him wanting to sit a heavy duty driver's license.

A progress note dated 2 days later authored by [Dr C] records what appears to have been a file review by [Dr C], in the absence of [Dr D], in response to [Mr A's] seeking a psychiatric opinion to state that he was fit to hold a Heavy Traffic License.

[Dr C] notes the phenomena reported by [Dr D] in May and records his own view that the nature of [Mr A's] supposed psychiatric illness is in fact factitious. [Dr C] observes however that this view has not generally been the one taken by mental health services.

[Dr C] telephoned [Mr A] and discussed the request for a report for this license and an outcome was jointly agreed. [Dr C] appears to have accepted that [Mr A] did intermittently experience psychotic symptoms although his function remained intact in the work situation.

In August [Dr D] reviewed [Mr A] and notes that there had been no contact with case managers since May. I can find no file entry to confirm actions taken between May and August, although [Dr D's] note of 9 August alludes to [Mr A] avoiding staff. It is not clear what actions were taken in response to this avoidance behaviour. No psychotic symptoms were elicited at this appointment although [Mr A] described feeling that medication helped him maintain his well being.

[Dr D] records that he noted [Dr C's] report of July and that he planned to continue the current medication treatment approach with further review in 3 months.

A copy of a prescription written by [Dr D] dated 9 August 2001 for a 3-month supply of sodium valproate and risperidone is in the material copied to me. There is also a copy of an earlier prescription written by [Dr D] for a 3-month supply of the same medication, dated 5 July 2001.

[Mr A] was seen by a psychiatry registrar in September. It is not clear what prompted this appointment. It appears that the outcome was that the prior treatment approach was to be continued and the registrar planned to discuss follow-up with [Dr D]. I can not find a record of that planned discussion or its outcome. Records of the results of laboratory tests apparently arranged at this appointment appear to have been initialled by [Dr D].

On 8 November a record is made of a call from [Mr A's] employer who described some concerns about [Mr A]. The registrar who had seen him in September was advised of the call. A nurse followed this up the following day apparently because [Mr A] had made no contact with the service, as he had been expected to do so. [Mr A] had instead attended a General Practitioner. He had reported that he had not been taking sodium valproate and risperidone because he was not psychotic. The GP prescribed zopiclone, a sleeping tablet.

There appears to have been a further appointment on 19 November. This assessment is summarized in a letter from the registrar to a GP on 4 December and reports what appears to be an association between resolution of some unusual experiences and the resumption of medication. The plan simply identifies continuation of medication.

On 29 November a progress note made by [Dr D] records that [Mr A] had not attended an appointment 3 days previously. This record does not appear to reflect a further direct assessment but to summarize [Dr D's] formulation of recent events and to provide some outline to guide future management. [Dr D] notes that although the official diagnosis is of schizophrenia, the treatment approach was based upon a diagnosis of factitious disorder. The plan was for the registrar to continue to review [Mr A] and then for a further registrar to continue care, presumably following the rotational changeover of registrars.

There is no explanation of why [Dr D's] intention noted in May, to continue his own direct involvement because of complexities in [Mr A's] presentation, had changed.

In December 2001 the registrar notes a telephone contact with [Mr A]. This registrar notes that a further doctor, presumably the new registrar in the rotating attachment, would continue follow up.

2002
The new registrar entered a record in January 2002 identifying that [Mr A] had missed an appointment and that he had a tendency to non-attend unless he needed WINZ forms completed. He planned to send an appointment for February.

The next two progress notes by this registrar record non-attendance at appointments in February and again in March. The February note records that medication would run out at about that time. A new appointment was to be posted. In March, non-attendance resulted in a plan to discuss with the team.

A copy of a prescription written by this registrar and dated 3 April records a further 3-month supply of risperidone and sodium valproate. I can not find a corresponding clinical record.

Although I can not find a corresponding clinical file entry, the bundle of documents contains a copy of a Special Authority application for use of olanzapine, dated 12 June, stamped as completed by [Dr C]. This application appears to be a further application for approval of use of this medication, for which an authority number had already been provided but which expired in February 2002. There is a corresponding response letter of approval of this application dated 13 June.

Special Authority applications require the applicant to be satisfied that the patient meets the clinical criteria for use of this Medication. In June 2002, this required the patient to have a diagnosis of schizophrenia or related psychoses.

It is unclear where this application fits in the context of [Mr A's] contact with services at that time and with [Dr D's] later record of current medication in September 2002, which does not include olanzapine.

The bundle of documents also contains a copy of a prescription dated 25 June 2002 written by a further doctor. I can not find a corresponding clinical record. This prescription is for sodium valproate and risperidone and does not include olanzapine for which further approval had been granted by this time.

The material available to me includes copy of a letter dated 20 September to [Mr A] identifying an appointment on 4 October with a named person. The role or designation of this person is not identified and the letter (as copied in the material available to me) is not signed and the role of the writer is not identified.

A progress note dated 1 October 2002 records "Current medications 24 September 2002" and identifies sodium valproate and risperidone. There is also a letter from [Dr D] on the file, to the Land Transport Safety Authority, dated 25 September. This letter records an appointment the day before, noting no overt psychiatric symptoms of any concern. It notes that [Mr A] is on two psychotropic medications and that he was in remission of psychiatric symptoms.

By way of letter dated 1 October however [Mr A] was discharged from the South Adult Community Psychiatric Service, to the care of his GP. This letter to [Mr A] suggests that if he does not have a GP, he was recommended to get one.

It is unclear how this letter of discharge reconciles with the letter of 20 September offering an appointment on 4 October.

A Discharge/transfer summary completed by [Dr D] and dated 11 October 2002 identifies neither diagnosis nor follow-up arrangement but does make reference to another document in the form of a letter to GP.

[Dr D] wrote on that date to "The General Practitioner" at [a] Medical Centre. This is headed "Psychiatrist Review 24 September 2002". [Dr D] notes that there had been a period of a year in which [Mr A] had maintained well in the community. He notes that [Mr A] had been adherent to medications in the form of sodium valproate and risperidone (2 mg). The letter adds that [Mr A] had found valproate helpful in stabilising his mood.

[Dr D] notes that he could not identify any mood, neurovegetative or psychotic symptomatology. A mental state examination is recorded.

[Dr D] identifies that although there was a past diagnosis of schizoaffective disorder, "our impression" is that it is most likely a Factitious Disorder. He adds that [Mr A] held to the idea that he had a major psychiatric disorder and that [Dr D] saw little reason to confront that belief. [Dr D] further adds that [Mr A] remained vulnerable to the re-emergence of pseudo-psychotic symptoms when under stress and would benefit from an early intervention or contact with the Psychiatric Service should that occur.

Maintenance of the current medication was recommended and thanks for taking over management are noted.

2003
A referral was sent from a GP to the South Adult Community Psychiatric Service in March 2003. This referral identifies a diagnosis of "? Schizoaffective disorder" requesting review. The referral identifies [Mr A] had stopped sodium valproate and developed seizures noting that fits had been observed and that Neurology review had also been sought and was awaited.

The record contains a letter to the same GP, dated 20 March from the South Adult Community Psychiatric Service. This letter appears incomplete simply thanking the GP for a referral then adding an invitation to contact the service if the GP wishes to discuss the decision further. No decision is recorded however.

This letter has some handwritten comments added apparently indicating telephone contact with the GP. A note dated 24 March indicates that a discussion took place with this GP who had only seen [Mr A] once. [Mr A] had stopped sodium valproate himself and developed "??fits". The note adds "is this part of his factitious d/o". Advice was apparently given to the GP on background and continuation of "psy. meds even though his presentation is likely factitious". The note concludes that an appointment would not be given at this stage and that the GP is "ok" with that.

Further copies of this referral of 12 March and the incomplete letter of 13 March in response are also on the records copied to me. Each has various handwritten comments added but how these relate to each other is not fully clear.

A letter was sent to a GP in April 2003 recording that her referral in March had not been accepted. The letter notes that [Dr D] had discussed the referral with the GP and had offered advice on management.

A handwritten note which is undated but which appears to relate to events at around this time notes that [Mr A] had taken away a form to put in a formal complaint. It notes "Referral 13/3 sent by GP" then adds "[Mr A] was his usual unpleasant, very demanding, accusing, complaining self". Various demands are listed and the note identifies that he was intimidating. The interaction appears to have been concluded by the writer, who is not identified, advising of the availability of Psychiatric Emergency Service (PES) or his GP.

On 15 April 2003 [Mr A] was assessed by PES. A "First notice of Assessment" dated 15 April identifies a provisional diagnosis of Factitious Disorder. Initial management is identified as "see GP". A letter authored by a house-officer to a GP dated 21 April summarizes the contact. In the introductory paragraph the letter notes that a final diagnosis of factitious disorder has been reached by the Psychiatric Services. The

handwritten record of the assessment notes however that he had previously been felt to have "schizophrenia/BPAD".

[Mr A] had been brought by the Police for assessment following reports of odd behaviour. [Mr A] himself said that he was there because he wanted a sleeping pill. Functional enquiry revealed little of note although is limited in its scope, as documented. There is no reference to exploration of the behaviours that led to Police involvement. A diagnosis of Factitious Disorder was recorded. No follow-up was arranged and he was advised to continue his current medication of risperidone and sodium valproate. It was noted that he had an appointment to see his GP on 16 April.

The clinical record contains a stamp identifying this presentation was "Presented at Rounds" on 16 April.

Further contact took place on 20 April. A call was received (it appears by the PES) from [Mr A's stepmother], concerned about [Mr A's] behaviour. A call was made by PES to [Mr A] then to his sister. It was arranged that a DAO would attend to assess [Mr A]. Record of that assessment identifies some features that would be consistent with symptoms of mental illness but these are not explored in detail. The assessment appears to have been ended by [Mr A] asking PES to leave. Further discussion took place with his sister and further odd behaviour is outlined.

The record is a little unclear with respect to the plan following this assessment. It appears there was some concern about risk but it appears that an arrangement was made for medical review on 22 April, although with contact with PES or the Police in the interim if the situation deteriorated.

A First Notice of Assessment dated 20 April records provisional diagnosis as BPAD1 (bipolar affective disorder, type 1) and identifies further follow-up by mobile visit by PES. A similar notice was completed on 21 April, this time identifying provisional diagnosis of "?mood disorder ?factitious disorder" and that [Mr A] was admitted to Hillmorton Hospital.

The next few pages in the records available to me following this entry of 20 April are not dated but appear to reflect contact on 21 April. [Mr A] apparently phoned PES seeking help, wanting admission. It appears he brought himself to PES for assessment. Some exploration of concerns and a functional enquiry is documented along with a mental state examination. The impression of "?depressed/mood disorder" is noted along with previous diagnosis of Factitious Disorder. Review by the on-call psychiatry registrar was arranged.

The notes of the registrar also record diagnosis of "?Factitious dx ?schizoaffective ?BPAD" .

The record continues outlining a reasonable overview of history although with limited exploration with [Mr A] of the more peculiar aspects of the recent presentation. A decision was made that he would be admitted voluntarily to hospital.

On 21 April [Mr A] was admitted to the acute adult inpatient mental health service.

The document outlining the management of nursing issues for the first 24 to 48 hours of admission identifies some suspiciousness and odd behaviour and notes reference to talking of suicide in the past few days. There is no further reference to exploration of these previous thoughts of suicide although the D-shift nursing entry of 21 April records that he "denies suicidal ideation".

Notes of the review by the consultant on 22 April are recorded by the house-officer and document no assessment of mental state at that time. No conclusions are documented. The discharge letter to a GP prepared by this house-officer notes that on assessment by the consultant on the day after admission unusual ideas were identified but that it was concluded that there were no overt signs of any major psychiatric illness.

This letter identifies that [Mr A's] sister had noted a deterioration in his function over the period from Christmas 2002 with more marked disturbance of behaviour over the preceding 2 weeks but draws no conclusions about the origin of this behaviour.

On 22 April [Mr A] was allowed leave to return later in the week for review. He later left the ward, returning after only a few hours and requesting to remain on the ward overnight. The next day he left the ward without informing staff. A telephone call to his sister that day revealed her concern that he was not safe to be left alone at home noting that in the past he had lit the stove and then fallen asleep almost burning the house down.

He did not return at the agreed appointment time and was discharged after 2 unsuccessful attempts to contact him at home. No follow-up arrangements were made other than "General Practitioner".

The typed discharge summary to the GP (dated 6 May) confirms the follow-up arrangements being with the GP. Factitious Disorder is reported as the diagnosis.

A copy of a discharge diagnosis summary sheet printed on 22 May in relation to this admission from 21 April to 24 April 2003 records a discharge diagnosis of Factitious Disorder and Dependent Disorder.

Later on the evening of 24 April [Mr A] arrived at what appears to be the same ward, [the acute unit]. He was told by a nurse that he could not be re-admitted and that he would need to go to E.D. or to PES. The record of this interaction makes no reference to discussion with on-call medical staff. Some 7 hours later however, at 0645, the on-

call registrar rang the ward seeking information about [Mr A] who had presented at E.D.

Notes made by this registrar are dated at 0100 on 25 April 2003. These notes reflect that [Mr A] was recently rediagnosed as having factitious disorder and that he attended appointments when disability allowance was due. An earlier diagnosis of schizophrenia/schizoaffective disorder is also noted. A fairly comprehensive assessment is recorded. The registrar noted persecutory ideas, the history of changes in mental health in recent weeks and some odd behaviour during the interview and concluded that he (or she) concurred with the diagnosis of Factitious Disorder. A discussion took place with the on-call consultant psychiatrist and an arrangement was made for review "Monday".

[Mr A] was seen on 28 April by a PES psychiatrist. Unusual behaviour (dry retching and lying on the floor) is described along with odd ideas although there is no conclusion about the nature of these. The record notes "He alternates between vague pseudo psychological language and vague answers, and quite specific focused and sharp comments when wanting to make his needs clear". Despite these observations, the two-word description of mental state examination is "coherent, articulate".

A discussion took place with the inpatient psychiatrist who had recently been involved in care and also with [Mr A] with a friend.

This psychiatrist concludes that [Mr A] had an "emotional/personality disturbance NOS triggered by GF leaving him". The final plan was to continue sodium valproate and to increase risperidone to 2 mg.

The next line of the plan is illegible but includes reference to "3/7" and might indicate an intention for review in 3 days. A record does appear on 1 May with the entry "DNA" and an illegible signature which may be consistent with a plan for such further review. No further action is identified following that subsequent non-attendance. A letter dated 6 May however, to [Mr A], identifies his recent non-attendance and offers to arrange another appointment should he wish to make one.

On 21 May there is record of a call made to PES by a neighbour, concerned about [Mr A] who was visiting her and voicing unusual ideas. PES suggested to the neighbour that she spend minimal time with him. [Ambulance staff] then rang PES to state that he wanted to sexually abuse. PES told the ambulance service that [Mr A] "was not primarily a psy [sic] problem and that the police were to deal with this as they would for anyone". The Police then rang to indicate that they would be bringing him in anyway, and the PES response was to indicate that they were not to be involved. The record continues, in response to an indication that [Mr A] wanted to be taken to hospital, "He is not to be taken where [sic] and is not to be taken there".

What appears to be the next file entry is dated 21/5/3. This records [Mr A] presenting at EOA with the police after he phoned them reporting he was at imminent risk of perpetrating a crime. I am unclear what EOA means, but within the record of the assessment reference is made to this assessment taking place at the Emergency Department. A functional enquiry is documented with responses by [Mr A] indicating some features of mood disturbance. Mental state examination is reasonably comprehensive although makes reference to there being "no complaints of sensory disturbances". It is not clear whether this reflects this aspect having been explored in detail with negative responses, or simply that [Mr A] did not spontaneously describe such phenomena.

The RN doing this assessment makes no conclusions but planned for medical review to take place at PES.

A file entry also dated 21 May reports an assessment by a psychiatry registrar. This record notes probable deterioration for the last 5 months and identifies several stresses. Some history is outlined. No mental state examination is clearly recorded although there is reference to "not responding to internal stimuli" and to some of the content of [Mr A's] thoughts. The registrar concludes [Mr A] had a Factitious Disorder but also questions the possibility of an emerging depression. He discussed the assessment with a PES psychiatrist and "not for admission" was agreed. It appears the plan was for the case manager to follow up later in the week.

It is not clear to me however that [Mr A] had a case manager at this time.

A stamped entry dated 22 May 2003 records "Presented at Rounds", without record of any discussion.

In May 2003 a PES psychiatrist wrote to the South Adult Community Psychiatric Service apparently seeking an assessment for [Mr A]. This letter notes that early in his history [Mr A] was thought to have had a possible psychotic disorder but that current diagnosis appears to be Factitious Disorder.

The letter notes that since discharge in April he has twice presented to PES in a dramatic fashion. The writer states that he appears to have Factitious Disorder and an underlying personality disorder.

A handwritten note to [Dr D] dated 23 May asks that he contact the PES psychiatrist to discuss the referral noting that a referral earlier in the year had been declined but also noting a subsequent admission.

[Dr D] apparently spoke to the referring psychiatrist and by email advised the outcome to the South Adult Community Psychiatric Service clinical coordinator. This email notes that [Mr A] had claimed to have seizures following cessation of sodium valproate, that he had attended South Sector in a dramatic presentation referring to

complaining and demanding appointments, and notes that "we" have spoken to the GPs on 2 occasions regarding presentation and management directions.

This email adds that the PES psychiatrist agrees with [Mr A's] factitious presentation and that longer term management should largely be in primary care with crisis management through PES.

A copy of a Referral Screening Document identifying a referral in May 2003 is available in the material provided to me. Although not completely self-evident from this document, it appears to reflect that a referral to the South Adult Community Psychiatric Service was being withdrawn and that PES was to discharge [Mr A] back to the GP.

In May there is also a progress note entered by a PES senior nurse, reflecting that [Mr A] had been seen that day. It appears that an arrangement was made for him to be reviewed by the psychiatrist 6 days later but he did not attend. A discussion took place with [Dr D] and it is noted that the South Sector Base had decided "not to pick him up", so [Mr A] was to be discharged back to his GP.

On 10 June a letter was written to [Mr A's] GP identifying [Mr A] had been assessed on 25 April and that last contact had occurred on 23 May. The GP was identified as responsible for immediate follow up.

I have not clearly identified other contact with the GP with respect to this assessment or ongoing arrangement.

No diagnosis is recorded, but bizarre behaviour is identified as the problem, along with ideas of wanting to harm others. No recommendations regarding management are recorded. No conclusion regarding the nature of the bizarre behaviour is recorded.

The GP was offered contact with PES if further information was required. Medication was identified, along with the date of a prescription, but there is no indication of the duration of the supply. There is no discussion of the indications for the medication prescribed, an antipsychotic, nor what should be considered when the medication was reviewed.

Further contact took place with PES on 17 June when [Mr A] presented himself there, mildly pressured in his speech. The note reports little other information but adds "no safety concerns expressed", although it is not clear how this was explored. This file entry is stamped "Presented at Rounds" on 18 June, but there is no record of that discussion.

Another file entry on 27 June 2003 identifies that [Mr A] was seen at the Emergency Department where ED staff asked for PES assessment. [Mr A] declined to be seen by

PES and left the hospital. A stamped entry "Presented at Rounds" is dated 30 June, with no further detail.

A record dated 2 July 2003 identifies a contact apparently by phone from the Head Injury Clinic where [Mr A] appears to have been voicing "S.I." (which may refer to suicidal ideation) and "inappropriate ideation". A reasonably comprehensive assessment is then recorded, although the author of the record is not clearly identified. The record identifies, amongst other things, ideas of past abuse; persecutory thoughts; ideas of causing harm to other people; reduced appetite; weight loss; lowered energy; depressed mood and hopelessness/helplessness; and reduced motivation and enjoyment. This record notes that he had been prescribed "Aropax" 2 months previously although does not record by whom or for what reason. Sodium valproate is noted to have been discontinued several weeks before.

Mental state examination records tearfulness at times, disordered speech and a preoccupation with past and possible current abuse. No conclusion is recorded and a plan simply identifies to be seen by another doctor. The record of this further assessment appears to follow, starting with the entry "ψ RV". This record identifies similarities of the current presentation to past presentations, including thoughts of harm unless someone helps him. The assessor commented that despite the bizarre content of thoughts, [Mr A] appeared in touch with reality and not psychotic. PES is noted to be unable to offer any help. The impression recorded was of a factitious disorder, and "PD NOS" (presumably Personality Disorder, not otherwise specified). Risk was assessed as being low and chronic in nature.

An entry on 8 July records "Presented at Rounds", although there is no record of the content the discussion.

On 15 July a file entry refers to a call from a GP who had not met [Mr A] before. The GP felt he was psychotic. The PES worker simply read to the GP a letter of 22 May and it appears to have been agreed that the GP would ascertain if [Mr A] was suicidal or had thoughts of violence.

Later that day [Mr A] attended the emergency department with a complaint of back pain and is reported as having been presenting as psychotic. The record notes "situation with [Mr A] explained + PES not to be involved".

On 19 July following several phone calls from family members who believed he was psychotic, PES recorded a visit to [Mr A]. There is a record of exploration of some psychotic symptoms, although there is no reference to exploration of the ideas of abuse that were prominent when he had been seen in early July. There is no reference to whether there was any exploration of whether he was taking medication.

His home was noted to be in squalid condition. There is reference to him giving long convoluted answers to questions, but nonetheless he is described as having no evidence of psychosis or thought disorder.

The assessment concludes that [Mr A] probably had a factitious disorder. His sister was contacted and advised of the outcome. She appears to have identified that he had not been taking his medication, with noticeable consequences, and that she believed he was unwell.

This file entry concludes with the comment that there needs to be a discussion at rounds, with a view to determining whether he should be under a service "for follow-up/stability as has happened in past".

A stamped note "Presented at Rounds" immediately follows this file entry dated 21 July, but there is no record of the discussion.

The following entry on the reverse of this page has the date incompletely copied. It records a phone call from the community constable, advising of concerns from a local minister who noted concerns about [Mr A] getting in to disputes with people. The constable was advised of recent contact and diagnoses and the note concludes "Nil safety issues", despite the information about disputes.

On 23 July [Mr A] self presented to PES. Persecutory ideas are noted along with an account of recent behaviour. A mental status examination records "∅ psychotic" and "∅ thought disorder", but does not discuss the significance of the odd ideas described nor of the long-winded account of problems also identified. The summary includes reference to [Mr A] being well-known to the mental health service with a diagnosis of factitious disorder.

The plan was "1. no PES f/up 2. PES prn".

On 24 July a stamp "Presented at Rounds" was entered in the file, again with no other record of the discussion.

Further calls of concern about [Mr A] are noted on 7 August (from the psychiatrist in [City 2] who had previously been involved in treatment) and on 21 August (from Police, concerned [Mr A] was hanging around children's playgrounds). Neither call appears to have resulted in action by PES.

A further record in August reflects a call from a friend (date incompletely copied in my record) concerned that [Mr A] was starving himself, and comments that he had never been seen like this before. The record identifies him as being inappropriate in conversation with increasing paranoia. The caller was advised [Mr A] needed to be seen by his GP, or if he did not have one to engage with a practice close to his address.

On 23 August several calls of concern regarding [Mr A] are documented. These resulted in an attempt to visit [Mr A], but he was not at home. The house was found to be dilapidated with glass smashed. Subsequently [Mr A's] sister reported that [Mr A] had attempted to strangle her the previous evening. She was refusing to involve the police as she was sure this was due to mental illness. A further visit was arranged but [Mr A] refused entry to PES. PES attempted to make further contact with his sister without success and the plan was made to try again the following day, with advice about commencing compulsory assessment under the Mental Health Act.

On 24 August a phone call was received from [Mr A's] sister, advising he had visited his ex-partner and threatened harm. The file note of this call does not reveal what action was taken by PES.

On 25 August a call was made to [Mr A's] sister apparently to "inform of outcome", although the note is unclear as to the outcome of what. It appears that the PES staff member discussed that [Mr A's] sister should complete an application for compulsory assessment, but she was unwilling to do so as she was at work and could not do so after work because of child care commitments. She restated her reluctance to involve police.

The PES staff member repeated that the only option available to PES was for the sister to complete the Mental Health Act application as she was the only person who had seen him in the necessary time period.

On 26 August contact was made with a friend of [Mr A] and it appears some negotiation took place regarding her assisting [Mr A] attend an appointment with a PES psychiatrist. This assessment had been arranged in response to the various calls received outlining concern regarding [Mr A].

The appointment was set up for 27 August.

On 26 August [Mr A] arrived at PES to collect a copy of his file, reportedly requested two weeks previously. The appointment later that day with the PES psychiatrist was discussed but [Mr A] said he had other plans. This record identifies that [Mr A] was irritable and agitated, with mildly pressured speech and was difficult to interrupt. Persecutory themes to thoughts were noted along with rambling and disjointed thoughts. He is noted to have denied being suicidal or a threat to others, although it is not clear from this record whether recent concerns regarding his behaviour were discussed. He was offered a further appointment with the psychiatrist the following day. This record ends with the plan "await contact".

[Mr A] arrived the following day, although late, for the appointment with the psychiatrist. The psychiatrist appears to have spoken with [Mr A's] father and a friend and received information from them of their concerns, especially in relation to what appeared to be deterioration in [Mr A's] behaviour and in his care of himself. The

record of the assessment identifies features consistent with a disturbed mental state, noting "obvious diagnostic conflict…between a genuine psychosis and a factitious disorder." "The strong family history and the deterioration in functioning level tend to support a major mental illness, though his presentation certainly has inconsistencies". The psychiatrist concluded that inpatient evaluation was likely to be necessary and that concerns regarding [Mr A's] wellbeing justified involvement with family and friends against his wishes.

The plan was for a visit to check his living conditions.

A visit did not occur the following day due to pressure of work. A file note on 29 August (Friday) recording this difficulty identifies "discussed in rounds today" and a plan to try again on Monday 1 September.

On 29 August the PES psychiatrist records a conversation with [Mr A's] [sister]. She also described deterioration since [Mr A] ceased medication and since a relationship breakup early in the year. She described a recent event in which [Mr A] had tried to strangle her. That day a call was also received from [Mr A's stepmother], identifying that [Mr A] had attacked his father. Notes were faxed to Mental Health Services in [City 2] and [Mr A] was later understood to be in Police custody in [City 2]. The PES psychiatrist identifies that he spoke with the police apparently advising that he thought [Mr A] ought to be admitted.

On 31 August a conversation with [Mr A's sister] is recorded. She was enquiring if there was any further contact with her brother. She described that he had come to police attention after he had left a bus whilst in transit from [City 2].

Subsequent entries in the file record communication with [City 2] services to ascertain what had taken place there.

Records in the file include a copy of the assessment on 29 August completed by someone whose signature is illegible and whose role is not clear, although it appears to be a psychiatry registrar in [City 2]. Some background history is briefly outlined. There is no record of exploration of subjective experiences or of a functional enquiry. This record notes [Mr A] to be angry and hostile and a brief account of [Mr A's] thoughts that his sister had stolen his belongings, resulting in him grabbing her around the neck. This assessment record notes the records from Christchurch suggest a recent diagnosis of Factitious Disorder. The writer concluded there was no need for psychiatric follow up in [City 2].

On 1 September multiple phone calls are documented recording efforts to try to locate [Mr A].

That day a reasonably full assessment is recorded by a registrar. The signature is illegible. The records identify that PES managed to locate [Mr A] who had agreed to

attend for review and admission. The diagnosis is recorded as "?psychotic disorder" and the plan was to admit [Mr A] voluntarily to [the acute unit].

The summary of this admission which lasted from I September to 15 October sets out a range of odd ideas and disturbances of behaviours during the course of the admission. Treatment with sodium valproate and olanzapine was in place at the time of discharge and the discharge diagnosis is recorded as Bipolar Affective Disorder current episode manic with psychotic symptoms. Follow-up was to be with a named case-manager and [Mr A] remained subject to the Mental Health Act.

The detailed records of this admission include a management plan template that appears to have been periodically updated and which reflects changes in treatment and in observation levels along with prompts with respect to investigations all of which appear congruent with the more detailed notes in the progress reports.

A very detailed treatment plan is also available, dated 18 September. A range of issues/problems is identified with clear steps in respect of each domain. A further recording chart identifies patient centred goals and corresponding planned interventions along with a section for evaluation of each. Yet another document identifies observation and leave instructions.

The admission records reflect a meeting on 3 September with the South Sector team. Records of this meeting made by the Trainee Intern identify discussion that [Mr A] had previously taken a long time to discharge from the outpatient service; that there were risks of violence; that he had been stable on medication previously, and that "officially" he had schizoaffective disorder. Other diagnostic possibilities appear also to have been discussed. Benefit of medication "even if factitious" is noted.

On September 3rd [Mr A] absented himself from the ward. There was concern about the perceived risk of violence to his father with whom ward staff made contact to inform of [Mr A's] absence from hospital.

[Mr B] is reported to have described his son's fluctuating mental state and the similarity in his presentation to that of his mother who had a diagnosis of schizophrenia.

Following [Mr A's] return to hospital, there was a period of very disturbed behaviour which resulted in a period of seclusion. Because of this extending to more than 24 hours a second psychiatric opinion was sought with this opinion being recorded is the notes on 5 September. This psychiatrist concluded "We need to dispense with the factitious disorder label." On reviewing the records including reasons for seclusion this psychiatrist identified a persistent pattern of what appeared to be delusions and marked thought disorder and records an opinion that [Mr A] has schizophrenia. This psychiatrist could not find a good history of mood symptoms. Seclusion was confirmed as having been an appropriate intervention.

Over the following days persisting disordered thoughts are noted. Intermittent references in nursing notes reflect some grandiosity and some expressions of anger. On 10 September a record made by the Trainee Intern identifies that [Mr A] "remains elevated". In general nursing notes identify aspects of behaviour and mental state that appear relevant to tracking progress. A very thorough typed nursing entry appears on 8 September.

Liaison with a prior treating psychiatrist in [City 2] is recorded along with further contact with [Mr A's] father.

By mid September marked behavioural disturbance had diminished but there were still episodes of irritability with evidence of persisting delusions. Further records on 17 September and 18 September are identified as being written by the Trainee Intern. The latter of these records note [Mr A] as stating "you are making me so depressed I may kill myself". The writer took this as an attempt for him to get his own way and concluded the suicide risk was low.

A Mental Health Act review is recorded in the progress notes as having taken place on 22 September. There is no entry in the progress notes detailing this assessment. A brief record made by the registrar appears the following day.

On 24 September a discussion between the South Sector Base and the inpatient team is recorded. This record reports "Diagnosis discussed intensely i.e. Factitious vs Bipolar D". No conclusion regarding diagnosis is recorded.

On 26 September the psychiatrist who had provided the second opinion on seclusion on 5 September again makes a record in the file, although in what capacity at this time is not clearly identified. A later nursing entry on 30 September refers to "…until Dr [treating psychiatrist] returns…", so it seems possible [Mr A's] usual psychiatrist was on leave at this time. This entry identifies subjective and objective assessment including reference to key mental state features and concludes that [Mr A] remained elevated in mood with some thought disorder.

The registrar entered a brief note on 29 September identifying persisting irritability and many complaints by [Mr A]. The Trainee Intern saw [Mr A] on 30 September, apparently at the request of the registrar. This record identifies more details of [Mr A's] complaints about the service he was getting. He identified that he was considering [committing suicide].

That record concludes "no change to management/leave/meds at this time". There is no specific reference to level of observation in response to the possible risk of self-harm, nor that the Trainee Intern was to discuss this assessment with other more senior medical staff.

The Trainee Intern again entered a record on 1 October. This record reflects that another doctor had reviewed the leave status, although this other doctor made no entry in the record him/herself.

The registrar made a file entry on 3 October reflecting an assessment that day. Ongoing irritability and grandiosity is noted, although there was thought overall to have been progress since admission.

A file entry dated 7 October records an interview with the consultant, apparently recorded by the registrar. Only a cursory mental state examination is recorded — "settled during interview and began to discuss the way forward". No conclusions regarding mental state or diagnosis are recorded. At a South Sector Base meeting the following day, the Trainee Intern records diagnosis as "BPAD". Discharge planning was to commence. A further note (apparently also that day, although the page has photocopied poorly cutting off the day) entered by the registrar records some somatic complaints that are outlined briefly although no conclusion is drawn regarding their nature.

On 10 October a note was entered by the registrar simply identifying "N/S have no concerns at present — leave as per yellow … (illegible word)". It does not appear the registrar assessed [Mr A] directly. On 13 October there is a record reflecting assessment by the registrar. There is no reference to mental state examination other than "various complaints but generally more amenable".

On 15 October the registrar saw [Mr A] again, noting that he appeared euthymic and keen to be discharged. There is no further reference to mental state, or to exploration of symptoms. Follow-up was to be by the South Sector team, and this note concludes "Not wishing any contact with family".

Further file entries that day record that his father rang and was given information about the discharge, and that his sister was rung and a voicemail message left for her.

This record notes that as threats had been made to harm family, and his ex-fiancée (for whom a message was also left), these people all needed to know of the discharge.

There is no record of exploration with [Mr A] what status these thoughts had at this time. Subsequent to the reference by the Trainee Intern on 29 September about [Mr A] commenting about [committing suicide], there is only one further reference to suicidal ideation or other risk concerns, in a brief reference in a nursing note on 9 October — "θ suicidal, homicidal".

A record of review by the treating psychiatrist on 15 September is unsigned and makes no reference to an objective assessment of mental state. Plans for blood tests are noted but there is no conclusion regarding current state.

[Mr A] was seen by his case manager in late October 2003. The record of this appointment notes that there had been an issue with [Mr A] having been discharged from hospital without an approval number for olanzapine.

[Dr D] reviewed [Mr A] on 29 October. The report of this appointment is regarded in a typed assessment/ interim summary note of 10 November as well as in a letter to a GP, on that same date.

The interim summary records that [Mr A] had been admitted in May 2003. I can find no record of an admission in May and assume this reference is to the admission in April 2003.

Aside from this detail however, this summary provides a reasonably comprehensive overview of events for [Mr A]. [Dr D] notes that there is greater clarity about the diagnostic formulation, the general impression or agreement being that [Mr A] has "underlying personality disorder (narcissistic, antisocial) and that at times of stress can present with extreme instability, decompensation, with a mixture of effective [sic], psychotic and factitious presentation". This summary concludes with [Dr D] intending to continue to prescribe a slightly reduced dose of olanzapine and continuation of sodium valproate with further review in 4 weeks.

A progress note dated 24 December records that [Mr A] attended the base that day having forgotten the previous appointment. He spoke of some concerns and some possible solutions were discussed. There is not recorded any broad functional enquiry although a reasonable mental state examination is recorded. This record ends with a comment that an outpatient appointment is scheduled for 8 January.

2004

I can find no further record until [very early in 2004 when Mr A] presented himself to E.D. requesting respite. He complained of physical pain and on functional enquiry other symptoms suggestive of disordered mood were identified. The PES staff who initially saw him considered he had a probable relapse of bipolar affective disorder with psychotic features and arranged review by the psychiatry registrar with a view to arranging admission to hospital. The registrar agreed that he was relapsing and beginning to display psychosis.

The registrar notes "risks as documented by PES staff" but does not elaborate on this. The PES record had noted the following comments in a paragraph that commences "Risk assessment":

> *"States has thoughts of riding bike in front of car.*
>
> *Feels dead currently.*
>
> *Feels hopeless.*
>
> *Denies intent to harm others currently.*

Risk to self. Low → Moderate
Risk to others — currently low"

Admission was arranged.

A risk assessment (HCR 20) completed that day records a view that the "Final Risk Judgment" was Low.

Whilst in the ward the records of the next few shifts describe aspects of [Mr A's] behaviour but there is little reference to his mental state. One entry [the following day] notes that he had experienced thoughts of suicide but they were noted to have subsided.

[The next day] a file entry made by a house-officer following assessment by several staff, one of whom does not have their role identified other than by the title "Dr" (it may be this is the registrar) appears to record an impression that [Mr A] had bipolar affective disorder and was currently psychotic but then somewhat oddly notes that no mood component was established. There is no record of exploring mood in detail but there is reference to [Mr A] wanting to pass away and that thoughts may be sped up and that his affect was irritable and restricted. These elements would in fact be consistent with some element of disordered mood.

The next file entry records an assessment with several staff present again, with the consultant. This entry does not record objective assessment of mental state but concludes that there is evidence of psychosis with thought disorder. A further comment regarding the disturbance of mood in this current presentation compared with a prior event appears to have been incompletely copied in the record available to me, so how this compared is not clear.

File entries over the next few days make observations of his behaviour. There is no record of exploration of risk concerns. It appears a Trainee Intern saw [Mr A] [the following day] but that file entry is brief and does not include any reference to psychiatric symptoms or mental state. There appears to have been a discussion by the house-officer [the next day] with the community team but there is no record of direct review of [Mr A].

A nursing note that day also reflects an interaction between [Mr A] and a doctor with regard to behaviour and gait and a reassurance about possible TIA (transient ischaemic attack) but there is no corresponding entry made by the relevant doctor.

On 7 January however a further risk assessment document was completed by the house-officer. This records a final judgment of risk as "High". This document notes the presence of suicidal ideas but no plan and describes risk of suicide as "medium".

The nursing entries in the file on this day do not reflect whether this change in overall risk judgment resulted in any change in nursing care.

The record of the consultant review [the next day] appears to have been made by the Trainee Intern.

The record seems to reflect a difficult interaction. The record concludes with the conclusion that [Mr A] was psychotic with manic features and that the risk of violence was high. The record does not reflect any exploration of ideas of self-harm other than referring to a question asked by [Mr A] — "are you trying to make me kill myself?"

Transfer to [the secure unit], which I understand to be a more secure intensive care setting, was arranged. Later that evening [Mr A] was found [unconscious]. A nursing note made that evening after that event records that at an earlier point in the shift [Mr A] had angrily commented that he would kill himself once he got out of there. There is no elaboration of the context of that remark or what response had been made.

Opinion

Were the services provided to [Mr A] appropriate?

Overall the range of services available to [Mr A] appears to have generally been appropriate to his needs. That is, in the period of focus from 2001 to 2004 there were general community mental health services, psychiatric emergency services and acute adult inpatient services available to and accessed by [Mr A]. He was also in at least occasional contact with a General Practitioner.

Although in general the specific individual services and overall range appears in themselves to have been appropriate, the important element of this question is whether they were applied to his circumstances in a manner that was appropriate.

The answer to this is not simple and requires broad consideration of how they were applied to the disorder that [Mr A] was understood to have, and whether reasonable consideration was given to the nature of that disorder.

In the first part of the period on which I have been asked to focus, from 2001 to 2004, [Mr A] was engaged with a community mental health service and was receiving treatment with an antipsychotic medication, risperidone, and with a mood stabilizing agent, sodium valproate. The doses of these medications are within a range that is ordinarily reasonable for maintenance treatment of an ongoing psychotic illness. The working diagnosis at that time, as reflected in the summary prepared by [Dr D] in May 2001, was of schizophrenia or schizoaffective disorder. This medication in this dose would be appropriate for this disorder.

In February when it was noted that [Mr A] had not been adherent to the medication regimen and in the face of features consistent with emergence of some symptoms, a nurse advised him to restart treatment. This in some respects mirrored the approach taken in 2000, when some difficulties are also documented with re-emergence of symptoms following poor adherence to medication, and was also a very appropriate plan.

It is not clear however how this was then followed up. In the presence of a history of an apparently long-standing psychiatric illness and in the face of concerns regarding ongoing regular use of the medication (without which regular use, relapse of illness is highly likely), reasonably assertive action to monitor well-being and to encourage medication use would be appropriate. There is no clear evidence that this took place. Although it appears the plan had been to continue to review [Mr A], there is no record of whether increasingly assertive action was being taken to engage with [Mr A] in response to the several appointments he missed.

A reasonably comprehensive review was carried out by [Dr D] when he saw [Mr A] in May 2001. This was an appropriate action for a psychiatrist newly engaging with someone with a significant history. Noting some complexities in the presentation, [Dr D] also very appropriately decided to maintain involvement in care himself rather than transferring to a newly arriving doctor. [Dr D] also noted concerns regarding regular use of medication, although no clear plan to address that is identified. There then appears to have been difficulty maintaining contact with [Mr A], but there is no evidence in the files available to me of how that was managed.

Despite difficulty engaging in regular appointments, it appears that some effort was made to ensure that [Mr A] continued to receive treatment through this period. There appear to have been prescriptions written to ensure continued supply of medication, although it does appear that there may have been some overlapping of prescriptions and more medication prescribed than was required.

Despite [Dr D] planning in May to continue involvement in care himself, in September 2001 [Mr A] was seen by a registrar. [Dr D] then in November documented his interpretation of recent events, identifying some difference between the official diagnosis of schizophrenia and the disorder for which treatment was actually being based, being a factitious disorder. [Dr D] did not apparently feel the need to maintain his view of earlier in the year with regard to his own role in management, despite this apparent further complexity in the treatment approach.

Although registrars clearly must be involved in provision of care in services such as this, the lack of continuity of treatment is potentially a problem. As [Dr D] had earlier indicated, minimising changes in medical responsibility for care in more complex cases is one way of ensuring consistency of approach and in ensuring sufficient attention is paid to the possible nature of the more confusing aspects of the

presentation. In the absence of such continuity of medical carer, a clear summary and a well-detailed treatment plan to guide interventions becomes more important.

At this stage I do not think that such clarity was available to the incoming registrar. There does not appear to have been a clear summary of what the treatment approach should be for a Factitious Disorder. Medication was to continue, but how to respond should [Mr A] fail to attend was not clearly evident. There is some evidence that there were discussions planned as to how to respond to the missed appointments, but there is no record I can find of the outcome of those discussions. Nonetheless, further prescriptions for medication were written.

In mid 2002, a Special Authority application was completed, suggesting (in so far as the requirements for Special Authority require the applicant to be satisfied that the clinical indications are met) that [Mr A's] treatment was for schizophrenia or related psychosis. It is not clear how this aligns with the statement by [Dr D] in November 2001 that treatment was based upon a diagnosis of Factitious Disorder.

In my view, treatment that appears to have been based upon and was appropriate for a chronic psychiatric illness became somewhat confused and unassertive through the latter part of 2001 and in 2002. Although antipsychotic and mood stabilizing medication had apparently continued, the reason for this continuation seems to have become less clear and there appears to have been less assertive follow-up than was appropriate for a chronic mental illness where there was evidence of emergent symptoms when medication was taken inconsistently.

Even if it was correct that the diagnosis was of Factitious Disorder, it would have been sensible for that diagnosis clearly to have been identified as the "official" diagnosis and for there to be a clearly documented plan for how to manage that condition, including how to respond to missed appointments and what part medication might play.

There appears to have been further confusion of plans late in 2002. Around the end of September, within days of a letter offering a further appointment and before the date of that appointment, another letter was written discharging [Mr A] from the service. This seems to suggest some incomplete coordination of the discharge planning process.

By this time the predominant view of diagnosis, as recorded in [Dr D's] letter to the GP, is of Factitious Disorder. [Dr D] notes however that [Mr A] remained vulnerable to pseudopsychotic symptoms when under stress.

It appears to me that there was by this time insufficient attention to the possibility that apparent deterioration in well-being may have been associated with incomplete adherence to the prescribed medication regimen. In August 2001 [Mr A] reported that medication helped him feel well. Earlier in that year there was evidence of emerging

symptoms when not taking medication consistently. In November 2001 there again appears to have been an association noted between resolution of unusual experiences and resumption of medication. Whilst [Dr D's] hypothesis is plausible, it seems to me that a higher index of suspicion may usefully have been applied to the relationship between what seemed possibly to be emergent symptoms and the failure of consistent medication, especially in someone with a long history of what had previously been identified as a psychotic illness.

To reach a clear view regarding diagnosis in a situation where there are incongruous features, especially where the view that is being taken is not in accord with the previously held views and the previously apparently successful associated treatment (at least as measured by psychosocial and occupational stability, freedom from symptoms when taking medication, and a subjective improved well-being when taking medication), careful discussion with colleagues and careful consideration of corroborative history from key informants such as family and friends would generally be required.

To this stage of treatment in the period from 2001, I can not see clear evidence of such careful process of consultation.

If however the diagnostic formulation reached by [Dr D] is accepted, the associated recommendation regarding early contact with the psychiatric service was appropriate.

It appears however that there was subsequently inadequate attention to this aspect of [Dr D's] view, with responses to concerns increasingly being based upon the apparent belief that if the main problem was of a Factitious Disorder, there was little the psychiatric services could or should do.

Two crisis contacts in April document little exploration of behaviour of concern or of psychiatric phenomenology. There appears to have been a ready attribution of the problems to being related to Factitious Disorder and insufficient attention to the possibility that there may be emergent features of the previously diagnosed psychotic illness.

Factitious Disorders can in fact be complex problems for mental health services to manage. They can certainly be difficult to manage within primary care settings. A carefully planned and coordinated agreed plan developed and implemented jointly between primary care and mental health services (and often other services, including emergency departments, ambulance and police services) is usually required. Such an approach becomes more important as multiple contacts take place and where many agencies are involved. There was by this time increasing evidence (in the form of multiple contacts with mental health services; expressions of concern about very odd behaviour; some evidence of concerns about risk; contacts with other services) that such an approach might be required, but there is no evidence of developing such an approach and the problems were again referred back to primary care.

[Dr D's] view that primary care services would be largely responsible for ongoing care, and that crisis management would be provided through PES, appears to have been confirmed in May 2003, in communication with a PES psychiatrist, even though the problems with which [Mr A] was presenting resulted in a brief inpatient stay in April.

There is however further evidence in May of what appears to have been an inadequately responsive service to calls from other emergency services. Neither the ambulance service nor Police were able to elicit offers of assistance from PES. This seems to have been inadequate in the face of the clear concern about [Mr A's] behaviour and potential risks he was presenting, even for someone not known to the service, but also incongruent with the plan already identified in respect of his presentations, that PES would provide crisis assistance. It seems very clear that by this time the diagnosis of Factitious Disorder was strongly influential in the response being provided and that odd behaviour was to be dealt with by other agencies, despite the plan to provide crisis assistance. This response was not appropriate in these circumstances.

A further example of poor response to assist other services is found in July when [Mr A] was referred by the Head Injury Clinic. Although assessed on this occasion, the threshold of concern that he may have been experiencing a relapse of a psychotic illness appears to have been very high and the conclusion drawn (that he was not psychotic) does not seem fully congruent with the documented assessment (of bizarre thought content). The problems were attributed to Factitious Disorder, without sufficient consideration of possible other explanations. As a result, PES felt unable to offer further help.

Despite another call of concern in July, from a GP who felt [Mr A] was psychotic, there was no direct involvement of PES except to read out a letter. The GP was left to manage this presentation without the direct involvement of PES. Not only does this seem a very inadequate response to what ought to be an important referral prompt (possible psychosis), this response too was incongruent with the earlier plan to provide crisis response to support primary care.

A similar failure to respond, this time to another part of the same DHB, occurred later that day when ED sought assistance.

A few days later an assessment was arranged following calls from family, but the assessment seems to have been limited in its scope. There is no record of discussion of how his home came to be in such a poor condition and again the conclusions of the assessment are not fully congruent with the details of the examination that are recorded. Again there seems to have been insufficient attention to other possible causes of the findings and a ready attribution to Factitious Disorder.

Although after this assessment there appears to have been some thought, very appropriately, that there should be discussion about re-engaging in a treatment service, there is no clear evidence that this resulted in any change. Four days later calls of concern in which some potential risks were identified again resulted in a decision that PES would not follow up, except if needed.

This pattern of inadequate response continued through August, again despite some indications of potential risk. Only toward the end of that month were more active efforts to review [Mr A] and to respond to possible risky behaviour evident.

Appropriately, [Mr A] was eventually admitted to hospital.

Overall this period of community care through 2002 and 2003 until admission in September appears to have been insufficiently assertive and there appears to have been an insufficient index of concern about the features presented by [Mr A]. There was insufficient concern about and response to the increasing requests from other agencies for assistance, with little evidence of reflection about what this may mean both with respect to the causes of these presentations and how ongoing management might be modified.

There seems to have been insufficient support to primary care to manage what was clearly a complex set of problems.

The 6 week admission from September 2003 resulted in a revision of the diagnosis. Appropriately, one psychiatrist felt that the diagnosis of Factitious Disorder should be dispensed with. Also very appropriately, the service was concerned about risks [Mr A] presented to his father and potentially to other people, and notified them at points when such indication was clearly indicated. There appears to have been reasonable consideration to a range of matters relevant to [Mr A's] ongoing welfare and to his longer term treatment. Consideration was given to his level of observation and to his freedom to move about the ward and beyond.

Some attention was given to presence of ideas of harm although these are not described in detail in the records.

The admission lasted some 6 to 7 weeks. This is possibly a little longer than the usual length of stay in an acute adult inpatient service and probably is reflective of the slow response to treatment shown by [Mr A]. It seems substantial progress with resolution of symptoms occurred only in the last week or two of this admission. There was reasonable persistence with the approach to treatment.

It is evident that there was some opportunity for additional opinions to be provided with regard to diagnosis and treatment, one such occasion being early in the admission when seclusion was prolonged. In this circumstance, that was a very good thing to do and is commendable.

Another opportunity appears to have arisen late in September in the absence, perhaps on leave, of the usual treating psychiatrist.

It may be that this possible absence on leave explains what does appear to have been some inadequacy in the level of psychiatrist review of [Mr A]. There appears to have been less direct involvement of the treating psychiatrist in ongoing assessment of [Mr A] than I would have expected for someone who had posed diagnostic challenges and who was a little slow to respond to treatment. Many of the file entries reflecting assessment by medical staff are made by the Trainee Intern or House Officer, with only some of these indicating the presence of more senior medical staff. What may be important factors in the presentation — such as [Mr A] reporting to the Trainee Intern that he was considering committing suicide, and on another occasion that he was being made to feel so depressed that he might kill himself, appear not to have been discussed with other medical staff — or if they were, there is no record of this. The consultant review on 7 October, recorded by the registrar, reflects only a cursory mental state examination.

There is no subsequent detailed examination of mental state recorded between that date and the discharge a week later.

It is not uncommon in inpatient services for assessments to be recorded by more junior members of the medical staff team. Usually these would record the roles of other staff present in the assessment. It is possible that there is more detail discussed than is documented in these situations, but where this information is important in providing a clear opinion regarding diagnosis, progress and ongoing treatment, some care should be taken with ensuring a comprehensive record of the discussion and the consultant opinion. It is sometimes helpful for file entries made by junior staff to be countersigned by the most senior medical staff member present, or added to as necessary by that person, as endorsement of the content of the record and its relationship to the assessment.

Follow up after this admission was to have been with the South Sector community mental health team. That was an appropriate plan. [Mr A] appears to have been seen by his case manager and by [Dr D] within 2 weeks of discharge. Contact within that period is consistent with reasonable standard of practice. A reasonably comprehensive overview of [Mr A] is recorded in the summary of that review. This report identifies the mixture of features with which [Mr A] presents with the formulation reflecting a reasonable attempt to reconcile the somewhat confusing elements of his presentation. It is not clear whether the view of the psychiatrist who provided a second opinion in hospital, that the diagnosis of Factitious Disorder should be dispensed with, was known to [Dr D] who continued to attribute some aspects of the presentation to being of that nature. The treatment that was planned to continue however was reasonable for a psychotic illness with an element of mood disturbance, and the minor change that

was recommended at that appointment was appropriate in view of some reported adverse effects of the treatment.

It appears that a month went by without further contact, [Mr A] having forgotten at least one appointment. Once he was seen the further plans for further review were reasonable in the absence of any clear evidence of deterioration. By early January 2004 however there was evidence of relapse and admission was arranged and was a reasonable intervention at that time.

In the course of this final admission, there is evidence of assessment of risk. Consideration of this is evident in the PES note of [the day of his admission], although there is no detail of the ideas of harm that are recorded having been explored in much detail. It is not fully clear on what basis the view of a low to moderate risk of harm to self was based, but there is evidence of some consideration being put in to this rating.

The presence of ideas of suicide was explored again [the following day] in the nursing records and again in review [the next day] when seen by some of the medical staff. Further review that day, with the consultant present, makes no reference however to risk formulation.

On [the following two days] the clinical notes record no discussion of ideas of self harm.

[The next day], in the context of review by the consultant, [Mr A] appeared very unwell and asked the psychiatrist "are you trying to make me kill myself?". There is no record of further exploration of this, nor does the plan reflect how this statement was to be regarded. I note that in his report to the Coroner, the treating psychiatrist identifies that although [Mr A] did talk of suicide, this was in the context of wishing to die in an accident if his chronic back pain was to continue indefinitely.

Reasonably, in view of the degree of disturbance with which [Mr A] appears to have been presenting at this time, an arrangement was made for him to be transferred to what I understand to be a more intensive nursing setting.

Overall however, at least for the staff involved in the assessment in [the acute unit], there was an increase in concern of staff about the possibility of self-harm, leading to an adjustment of the rating of this risk, to moderate. It appears, as evident from the treating psychiatrist's comments in his report to the Coroner rather than from the clinical records themselves, that there was consideration given to the balance of risk. There was good reason to believe that [Mr A] may pose a risk to staff, having previously assaulted several staff, and there was therefore a reasonable attempt to balance the possible benefit of increased nursing scrutiny (and thus possibly managing the moderate risk of harm to himself) against the potential adverse effect of this (in the form of potentially increasing the already high risk of harm to staff).

This increase in concern about self harm was not clearly understood by nursing staff in [the secure unit]. It is not clear from the clinical record what information was conveyed regarding this question he had put to the psychiatrist about harm to himself. A statement to the Police made by the coordinator of the afternoon shift of [the day Mr A died] notes however that the afternoon staff were told [Mr A] was on routine (15 minute) observations, was a high risk of assault to others and that he was agitated. The afternoon staff was not advised that he was at risk to himself.

Two other nurses present at that handover told the police in their statements that they did not recall being advised that [Mr A] was a risk to himself. Risk of assault to others was however identified. One of these nurses did note during the shift that [Mr A] made a comment about committing suicide when he got out of [the secure unit] and notes that such statements are common in that setting, apparently attributing this to the prevalence of people with personality disorders.

These statements appear to reflect inadequate transmission of the heightened concern regarding risk of self-harm. There was therefore a lost opportunity to consider further comments made by [Mr A] about self-harm in the context of this increased concern regarding risk, potentially therefore missing the prompt to further review the level of observation.

It may be that even with the information about the revised rating of an increased risk of self harm, the level of observation may have remained the same as there was still concern regarding more prominent features of [Mr A's] behaviour.

I am concerned however that this important information about the changed rating was not known to nursing staff immediately responsible for care. This appears to represent a failure of communication of important information.

[Mr A] was being treated with sodium valproate, olanzapine and lorazepam during this last admission. These were appropriate to his condition at the time. The medication was revised on [the day he died] following assessment, with an appropriate plan for incremental adjustment in the antipsychotic medication over several days. Lorazepam was used, apparently appropriately, in an effort to assist with the level of agitation shown by [Mr A].

Overall, especially in the period of treatment in the community in 2001 and 2002, the service was less assertive and less responsive than it could have been given the range of services apparently available. The focus, once Factitious Disorder became the prominent understanding of the presentation, seemed to be to minimise the role of the mental health service and to place responsibility upon primary care and other agencies to manage presenting problems.

This is probably consistent with the approach taken in many mental health services, although this does not mean this is acceptable practice.

Generally speaking, public sector mental health services are expected to provide services for the three percent of the population with serious and enduring mental illness. Services are measured against access targets, being expected to see a percentage of the population of the districts they serve. This access target is broadly based upon this three percent figure, although with some negotiation of the target to fit characteristics of each DHB and their population.

Although there is scope within service specifications and service contracts for people with other complex problems to be assessed and treated by mental health services, there has been some tendency for the absence of a psychotic illness or serious disorder of mood to be regarded as not meeting criteria for entry to service. The focus in general community mental health services has been to try to discharge people who are not thought to have an ongoing major mental illness, by which is more commonly meant schizophrenia or other psychotic illnesses and major mood disorders. People with disturbances of personality and behaviour, despite the clear difficulties in responding to their presentations in a coherent manner in any social service system, tended to be rebuffed when referred. Considerable work has sometimes been necessary to ensure sufficient rigour of approach to their assessment and to the consideration of other aetiological factors, and to ensure these are not compromised by the presence of these other diagnoses. For [Mr A], it seems that being understood to have a Factitious Disorder and/or other Personality Disorder, resulted in him being seen as unable to access services for people with serious mental illness.

[Dr D], in his letter of 30 October to the Deputy Commissioner, identifies that around the time of his involvement in [Mr A's] care there was a shift in the organisational philosophy regarding long-term patients who had been stably managed. He notes that the level of involvement required from the service had been low for a number of years. Discharge, planned in a manner actively involving [Mr A], was therefore thought to be appropriate.

This appears to have been reasonable at this time in 2002, given the apparent level of support required by [Mr A] and his reasonable psychosocial function. However, once [Mr A] began presenting with more frequent crisis contacts, the arrangement for ongoing care primarily through the GP should have been reviewed, especially as the possible diagnosis of Factitious Disorder become more prominent.

These are complex presentations, difficult to manage even within specialist mental health services and requiring a high level of communication and coordination between specialist services and primary care and emergency departments — and perhaps even other agencies. To expect this complexity to be managed within primary care alone is often unreasonable and unrealistic.

However, even though this reluctance to respond may have been common with other mental health services at this time and perhaps to some degree even now, the particular reluctance of PES and the South Sector team to respond to multiple requests

for assistance through 2003 does seem especially striking and clearly insufficient. It would have been appropriate, at the very least, to have convened a case conference involving the various agencies involved in intermittent contact with [Mr A], to develop a coordinated approach to his increasing presentations.

There is some evidence that once [Mr A] was admitted to hospital there was joint review of his presentation and of plans for ongoing care.

In the final admission to hospital in January 2004, reasonable consideration was given to the pharmacologic treatment. There was consideration of concerns regarding risk, but there seems to have been incomplete transmission of the increased concern to the staff in [the secure unit] at the time of his transfer.

What standards apply?

There are a number of standards that are relevant to the care provided to [Mr A]. These include the specific guidelines and policies of Canterbury District Health Board itself as well as the standards more generally applicable to other mental health services, as well as more generally to health and disability services as a whole. These include National Mental Health Service Standards, various Ministry of Health guidelines, the Mental Health (Compulsory Assessment and Treatment) Act and the Health Information Privacy Code of Practice.

I shall identify these more specifically in the next section of this report.

Were the standards complied with?

Family involvement

A policy titled "Family, Whanau and Carer Involvement in Mental Health Services" sets out provisions with the stated purpose of ensuring that family, whanau and significant others are consulted and involved in the planning, provision and evaluation of mental health services, as well as to meet the requirements of current legislation.

This policy specifically refers to and is broadly encompassing of standards established by the Mental Health (Compulsory Assessment and Treatment) Act; the Health Information Privacy Code, the Code of Health and Disability Services Consumers' Rights, and the National Mental Health Sector Standard. Additionally other relevant guidelines such as the Guidance Notes for involving families, developed by the Royal Australian and New Zealand College of Psychiatrists, are also identified as reference documentation.

As the DHB's own policy is compatible with and encompasses these other standards and guidelines, I shall focus just on the DHB policy in this section of the report except where there appears to be some variation from these other documents.

The orientation of the DHB policy is weighted toward the appropriate provision of information to a family, or other carers, rather than also on the value of information from such people in contributing to an understanding of a complex presentation. This appears to be the one area where there is perhaps some difference in the weighting given to this aspect of practice, the policy under-emphasising the added benefit of such contribution from families.

The policy contains provisions for managing circumstances in which a consumer is reluctant to allow family involvement in care. These provisions seem appropriate. There is evidence that [Mr A] was reluctant to have at least some members of his family involved in discussion about his care and treatment. The policy suggests that staff must give consideration to the part that illness may play in the attitude of the consumer when refusing involvement of family in care.

I do not feel that this standard was achieved, at least with respect to family. There is no evidence that [Mr A's] concerns regarding past abuse within the family, which could at least in part have contributed to some reluctance to involve them fully in discussion, was fully considered by the clinical teams. There is no evidence that in the contact that did take place this important concern, which seemed to contribute to some elements of the risk that [Mr A] presented and a full understanding of which may have helped diagnostically and from a developmental perspective, was explored with the members of the family who were in contact with the clinical team. There is no evidence that efforts were made in the period from 2001 to 2004 to systematically explore with family aspects of [Mr A's] development and history that may have helped understand his complex presentation. Even in the absence of willingness of [Mr A] to allow such contact, the standard set by the DHB's own policy, that staff will actively encourage the consumer to involve such key people, does not — by the evidence available in the records I have seen — seem to have been achieved.

There is some evidence of involving friends with documented reports of concerns of friends about [Mr A's] presentation and changes in his state over time. These contacts largely appear to have been in the form of receiving expressions of concern. There is less evidence of the service inviting these friends, who seemed more acceptable to [Mr A] with regard to contact with the service, to participate in planning of ongoing support and responses to crises.

Family did make contact, but were otherwise not actively engaged in discussion by the service, except at times when there was some perceived risk of harm. That contact in these circumstances of concern did seem to be appropriate and in accord with the policy.

Risk assessment and management

The policy documents supplied within the bundle of documents include a Canterbury DHB Mental Health Service Clinical Risk Assessment and Management Policy, dated

as issued in June 2001. A review date of June 2002 is identified on this document although I have not been supplied with any revised document current at the time of [Mr A's] death in 2004.

This policy specifically refers to and is broadly encompassing of standards established by the Mental Health (Compulsory Assessment and Treatment) Act; Ministry of Health Guidelines for Reducing Violence in Mental Health Services; Ministry of Health Guidelines on the Management of Suicidal Patients; Guidelines for Clinical Risk Assessment and Management within Mental Health Services; and the Health Information Privacy Code.

As above, the DHB's own policy is compatible with and encompasses these other standards and guidelines.

There is some evidence of formal assessment of risk, at least in the periods when [Mr A] was admitted to hospital. In addition, consideration of what restrictions should be placed upon [Mr A] while an inpatient, with particular reference to leave and levels of observation, is evident within the records and reflects some consideration in an ongoing manner of the risks associated with his presentation.

Additionally, within the ongoing progress notes there is reference both within the community and inpatient services to intermittent consideration of ideas of harm by [Mr A] to himself and to other people. As I have noted however in the summary of events in the course of care, at times this attention to these ideas appears somewhat cursory, at least as evident in the documentation, with little elaboration of the details of exploration of ideas.

In addition to ideas of actual physical harm to himself or to others through intentional acts by [Mr A], there is some reference to other risks such as financial hardship and neglect of or damage to his physical surroundings. There appears to be little ongoing attention to management of these aspects of his needs however, nor is there clear evidence of consideration of what was contributing to these aspects of his presentation.

This policy refers to the requirement that risk summaries "will be documented in the clinical progress notes/appropriate forms". This appears to suggest that either option is suitable, although may also indicate that documentation in the progress notes and template form is required. Assuming the former however, there appears to be reasonable adherence to this standard with respect to the ongoing identification of issues of risk, and to brief documentation of this. I have commented elsewhere however on the issues of the care provided and the implications of that with regard to overall management of risk.

Of some concern is the comment made by the nurse of the afternoon shift of [the day Mr A died], in her statement to police. The observation, in respect of comments by

patients about intentions of committing suicide, that "such comments are common in the secure unit, which has a large number of anti-social/personality disorder patients", seems to imply — in the context in which this remark is recorded — that no response is required to such commonplace remarks. Apparently the remark by [Mr A] did not result in any change in behaviour of the nursing staff. It is not clear whether this observation represents a view that because such remarks are made by people with personality disorders, they need not be taken seriously. This would be highly inappropriate, given the significant association between self-harm and personality disorder, where careful consideration must be given to threats of self-harm and the responses to such threats carefully planned.

Levels of Observation

Canterbury DHB Mental Health Services procedure "Levels of Observation and Specialling" identifies the clinical indications for increasing and/or decreasing the level of observation and clarifies the processes of authorisation of this, with the aim of ensuring the safe clinical management of a patient.

I note that in the statement of the coordinator of the afternoon shift of 8 January, this nurse states that admission risk of suicide would normally be carried out without input from nursing staff. This nurse refers several times to the assessment of risk taking place at admission. There seems to be little recognition of the need for risk to be reviewed at critical times during the course of care, such as when transfer to a different level of care occurs. This nurse later states that "nursing staff did not consider there was any need to increase … level of observation from routine … as there had been no request from a doctor to do that and that simply transferring … his level of observation was increased to the routine 15 minute observations from a lesser observation time on [the acute unit]". This statement that implies responsibility for changes in level of observation rests with medical staff is not congruent with the DHB's own procedure and policy statements on this matter.

Communication and coordination of care

Standards of good practice in respect of these aspects of care are not well defined. In general however it would be expected that there is some form of communication with the General Practitioner that assists the GP in understanding the diagnostic formulation and the treatment plan. There is evidence of some communication of this nature with the GP.

[Dr C], in his letter of 9 November 2007 to the Deputy Commissioner, identifies that Factitious Disorder is a notoriously difficult diagnosis to confirm. That is certainly correct. It requires careful consideration of the presentation, often requiring corroboration from a variety of other sources of information. It is also a disorder that requires careful planning and coordination of treatment across the range of services with which a person may have contact so that each may be clear about their part in responding to the various ways in which the patient may present to them.

I do not think there is good evidence of this careful communication and coordination with regard to [Mr A].

The records in some places identify that further discussion was planned, for example in February 2001 when a nurse was concerned about adherence to medication and re-emergence of symptoms, but there is no record of the further discussion. It may be that this did not occur, or is documented elsewhere. A similar gap is evident in respect of [Mr A] requesting a change of case manager in 2001. Yet another element appears to be missing, when in February 2002 following missed appointments, the registrar planned to discuss this with the team. There is no clear record of that discussion.

Of more concern is the apparent failure of communication in [Mr A's] final admission, when information about the increased concern of self-harm was not conveyed to or understood by the afternoon staff.

Were [Dr C's] actions especially with respect to amending the record and writing to the GP appropriate?

[Dr C] in his letter of 9 November 2007 to the Deputy Health and Disability Commissioner has provided justification for this letter. It seems clear that [Dr C] was acting in [Dr D's] absence and was attempting to provide a service for [Mr A] with regard to his seeking a Heavy Traffic Licence. Given that [Dr C] had had substantial contact with [Mr A] in the past and that he was apparently standing in for [Dr D] in that psychiatrist's absence, it was reasonable for him to respond to this request.

[Dr C] in his file entry did note his view of the diagnosis, but did add that that had not been the view generally taken by the mental health services. His file note outlines the justification for his view and sets out the unusual circumstances facing him in confirming that view at that time.

[Dr C's] actions as outlined in his letter to the Deputy Commissioner appear reasonable. There is evidence of longstanding contact between [Mr A] and mental health services, including [Dr C], with aspects to his presentation that did not readily fit clear diagnostic profiles. [Dr C] was in a position to reach a view about diagnosis and so it was reasonable for him to identify his own conclusions regarding that.

Appropriateness of [Dr D's] care in discharge in 2002.

[Dr D], in his letter of 30 October 2007 to the Deputy Commissioner identifies that care was given to the discharge planning process. He reports that there was communication verbally and in writing with the GP. There is some evidence of this in the records.

It would not be unreasonable for someone with a fairly stable presentation, even of a psychotic illness, to be discharged to a General Practitioner. This would generally

require communication with the GP about the ongoing treatment and how it should be reviewed, possibly with an indication of what features might be evidence of emergence of deterioration, the circumstances in which that might occur and what to do should that happen. Although not all these details are evident in the communication from [Dr D], there is evidence of some aspects and is probably reasonable given the indication of ongoing availability of the service for advice and further consultation if required.

Appropriateness of care in 2003 including whether the diagnosis of factitious disorder had any negative impact.

[Dr D], in his letter of 30 October 2007 to the Deputy Commissioner, comments that the diagnosis of schizoaffective disorder was never changed to that of Factitious Disorder.

I am not sure that that statement is supported by the evidence available to me.

In his progress note of late October 2001 [Dr D] did state that the official diagnosis was schizoaffective disorder. Late in 2002 however in his letter to a GP summarising his assessment of 24 September, [Dr D] notes the impression is that [Mr A] most likely had Factitious Disorder. In March 2003 advice was given to the GP that [Mr A's] presentation was most likely factitious. On 15 April 2003 a provisional diagnosis of Factitious Disorder was identified in a First Notice of Assessment. A letter written by a house-officer to a GP on 21 April 2003 notes that a final diagnosis of Factitious Disorder had been reached by the Psychiatric Services. This diagnosis also appears in the summary of the admission from 21 April to 14 April 2003. This summary signed by a House-Surgeon and Consultant identifies a diagnosis of Factitious Disorder and Dependant Personality. In May 2003 the PES psychiatrist in a referral to South Sector team noted that current diagnosis appears to be Factitious Disorder. In an email message in May, [Dr D] noted that the PES psychiatrist agreed with the factitious presentation.

There is evidence that this diagnosis had an impact upon treatment. In the progress note of late October 2001 in which [Dr D] stated that the official diagnosis was schizoaffective disorder, he also stated that treatment was being based upon a diagnosis of Factitious Disorder.

It does appear that the diagnosis of Factitious Disorder had an impact following that time, as the level of assertiveness following missed appointments and the rigour shown in ensuring adherence to medication was not consistent with a diagnosis of a chronic mental illness that had been shown to have relapses following cessation of medication. An effect of this diagnosis was certainly evident by 2003. There was question about the nature of some seizures in March 2003, with some reference to these possibly being related to Factitious Disorder. There is no evidence that there was follow-up of the outcome of the referral to the Neurology Service, nor of

consideration that the seizures may have been related to recent cessation of sodium valproate.

There were several efforts to refer [Mr A] back to the South Sector community team that were declined, apparently on the basis of [Mr A] not having a major mental illness. There were several occasions of only a very limited response from the PES. On at least one occasion this was explicitly identified as being because he was understood to have a Factitious Disorder.

In May PES told ambulance services that [Mr A] "was not primarily a psy [sic] problem", and told the Police they would not be involved with [Mr A].

I have already commented above in more detail on the adequacy of the care through 2003. It does seem that this pattern of limited responsiveness was based upon the view that [Mr A] had a Factitious Disorder.

Whilst treatment with an antipsychotic agent and with a mood stabilizer did apparently continue at least through a large part of this period, the pattern of responsiveness of services particularly in 2003 seems to have been based upon the view that [Mr A] had a Factitious Disorder.

Communication with the family

There is little evidence in the period through 2001 to September 2003 of communication that would have facilitated an understanding of the longer-term presentation of [Mr A]. I understand however that [Mr A] was unwilling for family to be involved in his care and there is some evidence of reluctance for them to be contacted. This limited the opportunity for collection of information that may have helped with the diagnostic formulation.

Some contact did take place prior to and during the admission in September 2003. There was some exploration at that time of prior features of [Mr A's] presentation, which may have contributed to the revision of diagnosis at that time.

I have commented already on other aspects of communication with the family.

Was care in the admission in 2004 appropriate?

I have commented on this question elsewhere in this report. I note that the Serious Event Review Report identifies some difficulties were experienced during the attempt to resuscitate [Mr A], due to problems with equipment. I have little detail of this and can not comment on this aspect of care other than to note the review findings and what seems to be appropriate recommendations regarding this aspect of care.

Summary

[Mr A] appears to have been someone who presented some diagnostic challenges. In such circumstances, ongoing attention needs to be paid to the range of possible causes of the features being presented, and foreclosing on conclusions where apparently confusing and perhaps contradictory elements is hazardous. It is helpful for all elements of the history and examination to be carefully and objectively considered.

Overall, there are in my view deficiencies evident in the care provided to [Mr A]. Each of these would in my view be regarded with differing degrees of disapproval by peers.

In my view, there are examples of a number of different staff making conclusions that did not fully reconcile with the observations they recorded. The critical analysis necessary in a specialist service faced with a diagnostic difficulty and with some complexities in management is not uniformly evident. This may however be reflective of the range of experience available within the service and as a result may be viewed by peers with mild disapproval. It is nonetheless an important matter to consider in improving quality of specialist services.

In general, while perhaps lacking in assertiveness with regard to strategies to assist adherence to medication and to engage in follow-up, care through 2001 and 2002 was otherwise of a satisfactory standard. There is evidence of some careful review by [Dr D] and [Dr C], both of whom appear to have tried to make sense of the sometimes apparently contradictory and atypical elements of [Mr A's] presentation.

It appears however that gradually these atypical elements, rather than being seen as or carefully explored as possible unusual presentations of a chronic illness and that were perhaps influenced by aspects of [Mr A's] character, came to be seen as indicative of Factitious Disorder. There was no clear statement available to the range of staff with whom [Mr A] came in to contact as to how these phenomena might be explored or understood, and what started as a reasonable plan — for discharge with GP care but with psychiatric review when crises arose — appears to have become understood as the psychiatric service having little to offer in the presence of a Factitious Disorder.

Good practice, in the face of multiple presentations to different agencies, would have been to convene discussions of various agencies to develop a coordinated plan of care

that could be widely available to guide service response. Failure to develop such plan would in my view be regarded by peers with moderate disapproval, although this would have been more pronounced had this pattern continued and had [Mr A] not been admitted in September 2003.

Finally, in [Mr A's] admission in 2004, there is evidence of some failure of communication of the higher level of concern of self harm. Whilst this did not clearly result in failure to change the level of observation and perhaps therefore have limited [Mr A's] opportunity to harm himself, because of the other factors that were weighed up in reaching decisions about nursing care at that time, this was an important piece of information that should have been known by staff involved in ongoing care. Inadequate communication or understanding of such information would in my view be regarded by peers with severe disapproval.

Appendix C — Advice to Police from psychiatrist Dr Allen Fraser

[Comment on care in 2001/2002]

For almost five years, [Mr A] had remained not only out of hospital, he also had very few crisis contacts with mental health services. Indeed, there were two years (2000, and November 2001 to October 2002) when he saw no one and was (as far as can be seen) adherent with medication. Given the small amount of staff input over this time, medication seems most likely to explain his remaining well, especially as he did make contact a number of times when he had missed some or all of his medication only to restart it after identifying signs of early relapse.

[Dr D's] discharge letter is unfortunate in this context in that it gives a strong message that the medication was unnecessary, and he stated definitively that the opinion of the services was that his presentation was factitious.

Despite this view apparently being held by staff in the services, [Mr A's] management through this period of time was appropriate, in that medication was continued, he was seen whenever he had acute concerns, and he was allowed to establish a degree of independence for himself. It would have been ideal for him to have been seen by a doctor rather more often than once a year, given the medications he was being prescribed. If the view of the service was that he would be more likely to get that in primary care, discharge to a GP was appropriate.

[Comment on care in 2003]

The quality of assessments in April 2003 (both before and during the admission) appears to have been quite competent; there was an adequate amount of information gathered and during the admission staff spoke with his sister and the information she gave is included in the notes. However, the conclusions reached and the absence of treatment was below acceptable standards, in my opinion.

Only following the first admission (which had lasted just five days) had there previously been a diagnosis, after an admission, of Factitious Disorder. (After the third admission no discharge diagnosis was recorded.) After all the other admissions, a diagnosis of either schizoaffective disorder or schizophrenia was made. I would have expected this information to have been available, and to have been considered during the formulation process.

Furthermore, the prolonged period of wellness, with few crisis contacts, since his last discharge was while he was apparently mostly adherent with sodium valproate and risperidone. Again, this information does not appear to have formed any part of the process of understanding his presentation in April 2003.

Regardless of the diagnosis, this information strongly suggested that maintaining [Mr A] on moderate doses of sodium valproate and risperidone long term was associated with wellness, functioning in the community, and absence of contacts with services. In the light of the relatively sudden recurrence of contacts and loss of function, restarting the same medication would have been an appropriate intervention.

[Mr A's] care in the community after his precipitate discharge in April 2003 was inadequate. Some of the assessments conducted were of high standard. However, I believe that staff failed to appropriately evaluate the clinical presentation in the light of information available (or potentially available) in the notes of past admissions. In consequence the changes in level of functioning, the altered mood state, the presence of psychotic symptoms, and the resurfacing of potential and actual violence, were not regarded as evidence for the relapse of a major psychotic illness.

Beginning with [Dr E's] assessment on 27 August 2003, there was a significant change in the evaluation of [Mr A's] presentations, and during this admission he was appropriately diagnosed and treated. My only question would be as to why he was not put back onto the risperidone which had been the drug he took along with valproate for so long with such good response. The use of olanzapine initially (possibly more sedative and calming than risperidone) was not inappropriate.

However, as his relapse was associated with non adherence with the medication rather than loss of efficacy, return to what had been both effective and acceptable to the patient would have been more appropriate.

[Comment on care following Mr A's discharge in October 2003]

[Mr A's] community care again leaves some cause for concern. I have suggested that the olanzapine should have been changed to risperidone before discharge. That became more indicated when he complained of excessive sedation. It became imperative when he reported that he had stopped taking the medication, and there were some indicators of early instability recorded.

It was then totally unacceptable (with [Mr A] being subject at the time to a compulsory community treatment order) that no action was apparently taken when he missed appointments with [Dr D] and [a psychiatric nurse]. The next opportunity to prevent relapse was again not taken, when he was clearly agitated and voicing paranoid ideas, yet was sent away with an appointment for two weeks later and an arrangement to be made for olanazapine to be prescribed at a lower dose.

His care during this period of outpatient follow-up was below acceptable standards for a patient subject to compulsory status as a result of violence occurring while psychotic, and who was openly non adherent with antipsychotic medication.

I consider that there was also insufficient recognition of the importance, and severity, of his depressive symptomatology at the time of admission. As indicated above, the notes record significant depression (treated with antidepressants) during admission 2 after the manic episode had resolved, causing admission 5, and after admission 6. He complained of depression after admission 7 also, but did not receive an antidepressant that time.

Although he may have appeared to be becoming more manic during this admission, a central feature of the affect in Bipolar Disorder is its instability during mood episodes. Nevertheless, intervention was appropriate. He was transferred to ICU for closer observation. In the sort of state he was in that day, antidepressants would not have been indicated, nor likely to have made any difference.

I do have some concern about medication, however, in that he received seven doses of lorazepam during this admission (three on the last day), and just five evening doses of 5 mg olanzapine. Even when the decision was made to transfer him to intensive care, and indeed increase his antipsychotic, no additional sedation with an antipsychotic was offered during the day.

View on whether the diagnosis of factitious disorder would have, or did have, an effect on [Mr A's] care and treatment.

There is little doubt that the diagnosis of factitious disorder had considerable influence on the way in which [Mr A] was assessed by staff, particularly in the community teams.

The initial questioning of this as a possible diagnosis is easy to dismiss in retrospect. At the time, and with apparent rapid resolution of illness without medication, it was not unreasonable to have an open mind about whether or not he had a psychotic illness. There were some indicators of why he might have produced factitious symptoms.

The fact that he was treated for his first psychotic illness in [City 2] rather than Christchurch (and as a private outpatient), meant that at the time of his next presentation the staff probably had no knowledge of between his discharge with a diagnosis of factious disorder and a presentation where he left "when challenged".

However, the admission which followed that presentation by just less than two months was notable for the careful evaluation by [City 2 psychiatrist], the sending of information to Christchurch from [a private psychiatrist], a psychological assessment suggesting a manic psychotic disorder, a good clinical response to standard antimanic treatment, a post manic depressive swing, and a final diagnosis of schizoaffective disorder.

I would also like to comment further on the psychologist's evaluation. He performed an MMPI (Minnesota Multiphasic Personality Inventory). This is a well established test, which despite some criticisms does have a very important aspect. This is that the test very accurately detects when a patient is faking, good or bad. The psychologist stated that the test was valid meaning that there was no evidence of fabrication of symptoms. This was reported on 30 January 1992.

Nevertheless, from later in that year there are repeated examples of staff interpreting his presentation as being factitious. These appear to have occurred primarily when he was seen in a community setting.

On 10 September 1992 [Dr C] wrote that he had been "*duped*" by "*manufactured*" symptoms. During his third admission in March 1993, staff made no diagnosis and did record the past diagnosis of factitious disorder. Nevertheless in both these situations, [Mr A] was offered appropriate medication.

The admission of March 1993 is notable for not entering a definitive diagnostic statement. Both schizoaffective disorder and factitious disorder were mentioned as past diagnoses. Treatment was as if for schizophrenia, suggesting that care and treatment was not influenced unduly by the past diagnosis of factitious disorder.

On 20 November 1993, [a Nurse] recorded that she did not explore his symptoms, which were psychotic in nature, because of "*suspicion of Factitious Disorder*." Not only did he not receive intervention at this point, six days later he assaulted a preacher, was arrested and spent time in the forensic inpatient unit. I consider this indicates that on this occasion the diagnosis of factitious disorder adversely influenced clinical care and treatment.

In July 1995 [Dr C] again raised the issue of Factitious Disorder at a time of increased symptoms and contact. Nevertheless, he recorded that the presumptive diagnosis was schizophrenia and offered medication, which was declined. On this occasion, the diagnosis of Factitious Disorder appears to have not been the factor interfering with treatment and possibly leading to admission three weeks later; rather it was [Mr A's] refusal to accept medication.

[Dr C] was the central clinician in [Mr A's] outpatient care through the last few months of 1995 and early in 1996. Despite continuing to raise the issue of Factitious Disorder as the diagnosis, the medication provided to [Mr A] was appropriate to his presentations being a result of a psychotic disorder. When [Dr C] and [a Nurse] visited him at his home on 05 December 1996, there is nothing in the notes to suggest that the decision to take no action was the result of anything other than that his clinical presentation was better than it had been a few days previously, and therefore they concluded that admission was unnecessary.

The admission which then occurred in January 1997 apparently resulted in a decision to offer a mood stabiliser (sodium valproate). The evidence for that was that [Dr C] recorded that he was given that information the day after discharge, by the patient in a clearly difficult interview. Perhaps because [Dr C] clearly believed that the real diagnosis was Factitious Disorder, he instead appears to have acceded to [Mr A's] requests for symptom relief with particular medications.

This approach does appear to have been relatively successful in helping [Mr A] to continue with an antipsychotic drug (pimozide) throughout most of 1997. In December 1997, [Dr C] again recorded his belief that a significant aspect of [Mr A's] presentation was "staged for effect".

Although he did continue the antipsychotic at a reasonable dose, I have concerns that the subsequent follow up to ensure treatment adherence and prevent deterioration, was not more assertive is possible that a belief that the diagnosis was Factitious Disorder had a negative influence on care and treatment, delaying effective treatment with a possibly avoidable admission following.

The admission which did occur in January and February of 1998, was the first time since 1992 that [Mr A] received a definitive diagnosis and management for schizoaffective disorder. In that sense, and because the next four to five years were a stable time for [Mr A], the admission was actually beneficial.

Through the remainder of 1998, 1999, 2000 and the first six months of 2001, the diagnosis of schizoaffective disorder appears to have been accepted by staff, and his care was provided within the framework of that diagnosis. In July 2001, [Dr C] again saw [Mr A] (in [Dr D's] absence). This was for an assessment in support of an application for a driving licence, not because of any instability of illness.

[Dr C] wrote a correction on a summary written in May 2001 by [Dr D], in which [Dr D] had asserted that [Dr C] had believed [Mr A] to have Bipolar Disorder. [Dr C], correctly, noted that he believed the diagnosis to be Factitious Disorder.

He also sent a letter to [Mr A's] GP in which he stated that he had long been of the opinion that the diagnosis was Factitious Disorder, even though that was not the generally held view. It is unclear to me why [Dr C], who was not at that time involved in [Mr A's] care, felt it necessary to make this statement, which effectively challenged a diagnosis that over the preceding three years had informed treatment which appeared to be effectively preventing both crisis calls and admissions.

The diagnosis of Factitious Disorder subsequently appears to have gained increasing prominence in decision making. Thus, in apparent justification for not assertively following up non attendance at an outpatient appointment shortly after a (reported by [Mr A]) brief relapse off medication, [Dr D] wrote that he was being treated "*as for factitious disorder*".

Despite that, [Mr A] was provided with regular prescriptions by mental health services, even though he kept no appointments from November 2001 until September 2002. It would seem that he was functioning well. In September or October 2002 a decision was made to discharge him to the care of his GP, and given that in his letter of discharge [Dr D] referred to the probability that [Mr A] had a "*factitious presentation*", this diagnosis appears to have been an important aspect of the decision making.

I think that a very good case could he made for expecting that [Mr A] could receive good care for a schizoaffective disorder from a GP, especially when he had been mostly stable for more than four years. However, [Dr D's] letter made the transfer less likely to be successfully managed by his mention of factitious.

I also have concerns about the abruptness of the transfer and that there was not any encouragement to the GP to refer back if there was non adherence with treatment and/or appointments (only for recurrence of symptoms). If these aspects of the transfer were on the basis the diagnosis, I believe that this was a further instance where the diagnosis had a distinctly negative outcome on the quality of care he received.

When [Mr A] presented again in crisis in early 2003, the diagnosis of Factitious Disorder appears to have been extremely influential in the assessments and interventions (or lack of interventions), until Dr E's assessment in August 2003. Clear records were made on a number of occasions of psychotic symptoms, which were (it would seem) repeatedly discounted as real symptoms on the basis of the diagnosis of Factitious Disorder.

This delayed unnecessarily the reinstitution of medication (sodium valproate and risperidone) which had been associated with almost five years of not needing either admission or crisis intervention. In my view, therefore, the diagnosis had a powerful adverse effect on [Mr A's] care and treatment over the first eight months of 2003.

The influence of the diagnosis unfortunately appears to have continued during his outpatient care after the admission in September 2003. Although [Dr D's] letter of 10 November 2003 (relating to his assessment of [Mr A] on 29 October 2003) notes that he was *"in a rather bad state"* when admitted, it calls into question the diagnosis made in the discharge summary; Bipolar Disorder, Manic Episode with Psychosis. Instead, [Dr D] emphasised the presence of personality disorder and asserted that he was *"suffering as a result of the long term association with the Mental Health Service"*.

This belief may have resulted in the apparent lack of action when [Mr A] told them of his non adherence with medication, and then failed to keep two appointments. If so, then once again the diagnosis of Factitious Disorder was adversely affecting the standard of care he received.

View on the standard of care and treatment [Mr A] received.

I have commented on this in a number of places in this report so far. It would probably aid in clarity if I make further and more specific comments here.

The standard of care and treatment provided to [Mr A] during his second admission, from October 1991 to February 1992, was (in my view) excellent. The assessments undertaken included psychiatric and psychological. The notes indicate that the [inpatient psychiatrist most involved] was aware of [Mr A's] "difficult" presentation, and the questions which had previously been raised about personality issues. His letter of 11 December 1991 is a sound formulation of the history and findings. Furthermore, an earnest effort was made to provide rehabilitation, after the passage of the acute phase of his illness.

Although subsequent care occurred in the apparent context of a rejection of [the psychiatrist's] diagnosis, it would seem that the medication prescribed was a not unreasonable approach to have taken. There is, however, no indication of any attempt to provide [Mr A] with either the psychoeducation warranted by a diagnosis of Schizoaffective Disorder, or the psychotherapy/counselling justified by a diagnosis of Factitious Disorder. I acknowledge that he may well have declined such treatments.

The quality of the assessments and interventions he received, or (more accurately) did not receive, in the latter half of 1993 was inadequate. Despite indications in the notes that staff were observing psychotic phenomena, assessment was coloured by, and treatment approach driven by, the belief that he had a Factitious Disorder. It was fortunate that his assault on a preacher in Cathedral Square was relatively minor.

The assessment and treatment he received during the period he was under the care of the forensic psychiatry service was sound. From the clinical records, I would have expected that rather more weight would have been given to the affective component in his illness (particularly in the light of the diagnosis and management in late 1991), rather than diagnosing and treating for schizophrenia. Nevertheless, it is likely that the reason he seemed to remain well for the rest of 1994 and well into 1995 was the presence of consistent doses of medication through the use of a long acting injection of an antipsychotic.

In June and July 1995 his developing acute relapse was not fully appreciated; however, medication was offered and was declined. On the basis that a discharge diagnosis of schizophrenia was made following the brief admission from 30 July 1995, and the evidence that he did not present acutely while on haloperidol decanoate injections, prescribing the same oral medication which he had only a month previously declined to take, appears a risky approach.

However, he does appear to have managed to remain relatively well and out of hospital for about 18 months. Throughout this time, [Dr C] was most often the

psychiatrist involved, and he generally prescribed antipsychotics. Additionally, he did occasionally prescribe antidepressants. Although he remained convinced of the incorrectness of a diagnosis of either schizophrenia or an affective disorder, he treated [Mr A] pharmacologically as for a schizoaffective disorder in a conventional manner.

[Mr A] presented again for admission in January 1997. It would appear both from the discharge diagnosis and the comment by [Dr C] the day after discharge about sodium valproate having been recommended, that a review of past information had been undertaken in addition to the clinical assessment and treatment of current presentation.

If that were so, then I would have expected good practice to have included the prescription of a mood stabiliser while he was still an inpatient. No real change of approach was made during this admission. [Dr C's] note indicates that there had been no discussion with him as the subsequent clinician responsible for [Mr A's] care. He had only the patient's statement, and a claimed reason for valproate being recommended was to treat his anxiety, which was the patient's main concern. This was a poor quality transfer of care from one part of the service to another.

Over the next year he continued to be regarded as having a Factitious Disorder by the treating community psychiatrist (? and team), and be treated with antipsychotics as for a diagnosis of schizophrenia. Eventually, as in previous years, he became fully non adherent and was readmitted in January 1998.

This admission was notable for the making of a definitive diagnosis of Schizoaffective Disorder, and consequent prescription of sodium valproate (a mood stabiliser) along with an antipsychotic (risperidone). The next period of time was the most stable period for him. He was prescribed these medications on a consistent and persistent basis for the next almost five years. Although [Dr C] has indicated that prescriptions were not being picked up, the duration of medication supply and the frequency of prescriptions was consistent with more or less adherence.

During this time he had (from what I could gather) only one episode of instability which was associated with having stopped his medication, restarting spontaneously when he realised what was happening. There is additionally the information included by [Dr D] in his letter in early 2001 which suggests somewhat low level chronic ongoing psychotic symptoms. Nevertheless, he was able to manage without acute presentations to services for assistance or admission.

[Mr A] was not particularly co-operative with staff, and frequently appears to have made it very clear what he would and would not accept in the way of treatment. His not keeping appointments over a protracted period is consistent with that. This is likely to explain the purely pharmacological approach to his care.

I have previously made comment on the discharge from secondary care to primary care in September 2002. A well planned and gradual transition may have increased the

possibility of success. The apparently abrupt transfer was associated with a statement in the discharge letter that he was being treated for a Factitious Disorder. This would give a clear indication to any doctor taking over his care that [Mr A] did not really need the medication he was being prescribed.

The standard care provided in this process was below the standard I would have expected. The fact that [Dr D] wrote to a practice rather than to a specific clinician, strongly suggests that there had been at most limited liaison with the doctor to whom [Mr A] was being referred.

This was a man who had a twelve year history of receiving treatment from the services, and during those years he had had eight admissions, and many emergency contacts. He had twice been admitted after assaulting someone, and one of those times resulted in a forensic admission. Although he had been relatively loosely engaged with mental health services over the preceding year, there were indicators of medication adherence, something which had previously been a major issue.

Transfer of such a patient required careful planning and full involvement of patient and receiving doctor. Not only was that apparently minimal, the referral letter served to confuse giving an "official" diagnosis and what they were treating him for. (In fact, the treatment using an antipsychotic and a mood stabiliser was appropriate for the official rather than the putative diagnosis.) If it is accepted that it was necessary to convey this information, the complexity was such that a meeting and careful discussion was essential.

I consider that this diagnostic uncertainty indicates a major system failure. The diagnosis of Schizoaffective Disorder arose from repeated inpatient assessments, and could also be seen as being supported by his acute and longer term response to appropriate medication. The diagnosis of Factitious Disorder, in contrast, appears to have little to support it, led to no appropriate treatment (psychotherapy rather than medication), and to have been related as much to the difficult relationship [Mr A] had with outpatient services and doctors.

With there being such diametrically opposed views of diagnosis (and in consequence, management) a properly functioning system would have ensured that there was appropriate discussion between the disagreeing clinicians, and a single message being given to the GP. It is unclear if the system had provision for such an approach to have occurred.

When [Mr A] presented again in early 2003, with psychotic symptoms following cessation of medication, the quality of the care and treatment provided was below acceptable standards. The assessments appear to have been thorough (on the basis of the information recorded), and it is the quality of the formulation and then management decisions which I regard as substandard. Although I recognise that his

manner in dealing with staff was never easy, and that variability in symptoms was often observed, the lesson of the previous five years was ignored.

The absence of care over the period from discharge in April 2003 and [Dr E's] assessment in August 2003 was below an acceptable standard of practice. On at least one occasion, evidence of serious psychosis was completely ignored in favour of the diagnosis of factitious disorder. Repeated phone calls seeking assistance appear to have resulted in almost all requests being declined.

When he was admitted in September 2003, he was appropriately diagnosed and treatment was acceptable in the cross section. However, I could find no stated reason for not returning to the combination which he had found so helpful for five years, valproate and risperidone. There may have been a justification for such a change; not recording that justification is substandard practice. Changing for no clinically valid reason, is also substandard.

When the olanzapine was associated with significant unwanted effects, he should have been changed to risperidone at that point in his outpatient follow-up. When he reported non adherence on the basis of these side effects appropriate intervention would have been to follow him more closely, and again to consider a change of antipsychotic to that he had previously tolerated.

I believe that this was an unacceptably low standard of care almost certainly arising from the conception of his problems as not being able to be treated with medication despite the past evidence to the contrary.

During his last admission, care and treatment was relatively unremarkable. My comments about the use of olanzapine rather than risperidone apply again, perhaps even more so, given that he had been so unhappy with the effects of olanzapine that he had stopped it.

His potential for dangerousness to others was clearly seen as of more concern than was dangerousness to himself. It is easy in retrospect to identify the frequency with which severe manic psychosis was followed relatively shortly afterwards by a depressive state. The depressive state was never straightforward; his symptoms were ambiguous and his presentation more uncooperative and querulous than simply unhappy.

His transfer to the intensive care part of the secure unit was a recognition of the need for extra nursing observations. Later that same day he was [left] unobserved. This suggests a failure of systems for monitoring new admissions to intensive care.

View on the issue of equipment on the resuscitation trolley.

This was clearly identified by the inquiry as a problem and has been dealt with, I believe. I would doubt that equipment failure had any significant effect on the outcome in this case. It is inappropriate for me to comment further on this at this time well after the fact.

Suicide is a tragic outcome of mental illness, and can occur in even the best circumstances. Psychiatrists, and other workers in mental health services, may be unable to prevent death by suicide despite the highest quality of care being provided.

A second important point is the importance of the functionality of the system. Good people in a dysfunctional system achieve less than they might, and a good system will assist and develop the individuals working in it. The almost complete disjunction between inpatient staff and community based staff, and the (apparent) under utilisation of past records allowed the development of an inpatient view of [Mr A's] diagnosis and a community view which were starkly different.

In conclusion, I wish to raise a caveat. An analysis such as that I have undertaken is inevitably retrospective. As such it suffers from the twin faults of knowledge of the outcome, and the propensity to explain that outcome on the basis of particular aspects of the case. All life, and in particular the realities of the care of the patients, is by contrast lived without knowledge of the outcome.

Melvyn Bragg wrote that

> *Hindsight is the bane of history. It is corrupting and distorting and pays no respect to the way life is really lived — forwards, generally blindly, full of accidents, fortunes and misfortunes, patternless and often adrift.*

The challenge which comes from providing care to a person with a mental illness is to try one's best to avoid the accidents and misfortunes, and attempt to impose a pattern onto the care and therefore the person's life. For much of the time [Mr A] was under care, there was a pattern to that care. In retrospect the change of pattern, and then the absence of any discernible pattern for a period of about nine months, appears significant. That it resulted in a particular outcome cannot be presumed.