Psychiatrist, Dr C

District Health Board

A Report by the

Mental Health Commissioner

(Case 14HDC01268)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A, aged 20 years, had no significant mental health history prior to these events in 2012.

2. On Day 1[1], Mr A, accompanied by his parents, presented to the Emergency Department (ED) at a public hospital (the hospital) complaining of testicular pain. Mr A was assessed in the ED. No source for the testicular pain was found, and the impression was "Anxiety and depressed mood — suicidal ideation." An acute mental health review was requested.

3. Mr A was then assessed in the ED by Community Psychiatric Nurses (CPNs) CPN E and CPN F, who carried out a formal risk assessment. CPN E identified Mr A's risk to himself as low–moderate and risk to others as low. CPN E documented her treatment plan as: "[U]rgent [assessment] by [Dr C] for possible ward admission."

4. Consultant psychiatrist Dr C then completed an assessment of Mr A. Following the completion of his assessment, Dr C's impression was of "Major Depression". His management plan was for Mr A to return home with his parents and to return for a further assessment the following morning.

5. The following morning Mr A, accompanied by his father, Mr B, attended a further assessment with Dr C. During the assessment Dr C had difficulty engaging with Mr A. At the completion of his assessment, Dr C concluded that Mr A was experiencing a major depressive disorder, with no imminent risk of self-harm.

6. Dr C made the decision to discharge Mr A with suggested follow-up with his GP for his testicular pain, and consideration for counselling in the community.

7. Mr A returned home with his father. Mr A's parents remained very concerned about Mr A. Mr A subsequently left the house and was later involved in an incident that resulted in injuries causing his death.

Findings

8. Dr C did not provide services to Mr A with reasonable care and skill, and, accordingly, breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to:

- ascertain and take into account Mr A's parents' opinions on risk and their views on the proposed management plan at the initial assessment;
- assess Mr A's level of risk adequately at the second assessment;
- admit Mr A, either voluntarily or compulsorily under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and, having decided not to

[1] Relevant dates are referred to as Day 1, Day 2.
[2] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

admit Mr A, failing to offer Mr A ongoing specialist follow-up, or to provide clear, specific guidelines to Mr A's GP; and

- provide sufficient information to Mr B about Mr A's condition, and not discussing the proposed management plan adequately or providing clear information about that management plan to Mr B.

9. Criticism is also made of Dr C's failure to document the formulation of his risk assessment adequately in the clinical notes.

10. The DHB is found not to have breached the Code.

Recommendations

11. It was recommended that Dr C undertake further training on communication with patients, that he undertake further professional development in relation to clinical assessment, and that he provide a letter of apology to Mr A's family for his breach of the Code.

12. In accordance with the recommendation of the provisional opinion, the DHB has agreed to undertake a review of all patients seen and discharged by mental health services during a one-month period, looking at short-term outcome, to assess whether risk assessments have been assigned appropriately.

Complaint and investigation

13. The Commissioner received a complaint from Mr and Mrs B about the services provided to their son, Mr A (dec), by Dr C. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Dr C in 2012.*
- *The appropriateness of the care provided to Mr A by the DHB in 2012.*

14. An investigation was commenced on 3 July 2015. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

15. The parties involved in the investigation were:

Mr B	Complainant/father
Mrs B	Complainant/mother
Dr C	Psychiatrist/provider
DHB	Provider

Also mentioned in this report:

Dr D	Psychologist

CPN F	Community Psychiatric Nurse
Dr G	Registrar
CPN H	Community Psychiatric Nurse
Dr I	Psychiatrist

16. Information was also obtained from CPN E, a community psychiatric nurse.

17. Independent expert advice was obtained from a consultant psychiatrist, Dr Brenda Brand (**Appendix A**).

Information gathered during investigation

Background

18. Prior to 2012, Mr A (aged 20 years at the time of these events) had no significant mental health history. He had had one possible depressive episode in 2011 and received counselling from psychologist Dr D.

19. In 2011, Dr D contacted the Mental Health Line for advice on how to manage Mr A. The Mental Health Line record of this telephone call notes that Dr D was advised that Mr A should be brought into the Emergency Department (ED) for assessment. On 30 November Dr D again contacted the Mental Health Line requesting further advice. The Mental Health Line record of this telephone call notes that Mr A had presented to the ED but left before the assessment was completed because he did not like some of the assessment questions. A request was then made for the Crisis Assessment & Treatment Team to contact Dr D. CPN E then contacted Dr D. A record from this telephone conversation, documented by CPN E, notes that Dr D was advised that Mr A needed to be assessed by his general practitioner (GP) and then referred to the community mental health team if appropriate. Dr D subsequently arranged for Mr A to see his GP for further assessment. There is no record that a referral was made. Mr A then had no further contact with mental health services until 2012.

Emergency Department assessment — Day 1

20. Mr A presented to the ED complaining of testicular pain, which had been present over the previous two days and had gradually increased. Mr A was accompanied by his parents, Mr and Mrs B.

21. At 4pm, Mr A was assessed in the ED by registrar Dr G. Dr G noted that Mr A "was not himself — family very concerned", that he was "low in mood, not wanting to be around other people, stayed in motel last night, not wanting family around". He reported suicidal thoughts and said that he had a plan in mind but was "not willing to reveal this".

22. Dr G also documented: "According to mother he [Mr A] has had periods like this previously 'melt downs' when he can't cope. Apparently [the] anniversary of death of [family member]." Mr A was noted to be "very very anxious looking, shaking,

looking at floor, avoiding eye contact, crouched over". He was noted to have good hygiene and was not smelling of alcohol.

23. Dr G found no source of the testicular pain, and her impression was: "Anxiety and depressed mood — suicidal ideation." Dr G requested an acute mental health review.

Mental health review

24. At 4.45pm, Mr A was seen in the ED by CPN E and CPN F. Mr A's parents were not present during this assessment.

25. CPN E documented that the ED staff had asked them to assess Mr A. The ED staff reported that Mr A had "high levels of anxiety, verbalisation of not wanting to be alive".

26. Mr A was noted to be living with his parents but not enjoying living there. He had not socialised for the last couple of months. He was unemployed and living off his savings. He was noted to have used cannabis in the past and occasionally to binge drink alcohol. He rated his mood as one to two out of 10, and appeared "low and flat in mood experiencing more bad days than good days recently". He had a loss of appetite, and poor sleep and concentration. He was noted to be hesitant in answering questions, answering with a nod or shake of the head. He was not willing to elaborate on his current thoughts, but CPN E documented that Mr A told them that the "CPNs were taking his energy from him". He reported hallucinations, which he would not elaborate on, but "appeared to be responding to unseen stimuli during [the assessment]". It was noted that he had limited insight, and: "Does not feel he requires hospital admission at present and is unable to verbalise how mental health services can assist."

27. CPNs E and F carried out a risk assessment. CPN E documented:

> "Denies current suicidal ideation. Reports experiencing intense suicidal ideation today. States he hasn't acted on them as he has no interest in hurting himself. Reports experiencing fleeting suicidal ideation for some time. Not able to expand on suicidal thoughts. States he is not enjoying life at present. Denies experiencing homicidal ideation."

28. At 5.10pm, CPN E completed a formal risk assessment and recorded that Mr A had current and historical suicidal ideations. Factors that could increase the risk were identified as: mental health symptoms; self neglect; environment; financial stress; employment problems; accommodation problems; and a tendency to hide the truth. CPN E also documented:

> "Low mood [with] depressive symptoms. Anxiety. Responding to unseen stimuli. Poor appetite. [Decreased] attention to self cares. Not happy [with] accommodation. Hesitant to discuss concerns. Reports mistrust of others."

29. CPN E identified Mr A's risk to himself as low–moderate, and his risk to others as low. CPN E documented her treatment plan as: "[U]rgent [assessment] by [Dr C] for

possible ward admission." CPN E then telephoned the mental health team (MHT) to hand over care.

30. CPN E stated to HDC:

> "Given the information obtained it was felt that due to his [Mr A's] denial of current suicidal intent and disclosure of 'no interest in harming himself' he was not at serious risk of harming or injuring himself or others at that immediate time. It was identified that there was the potential for risk to occur therefore the low and moderate risk tick boxes were marked. This assisted in informing the risk assessment plan recommendation of 'further assessment by a Psychiatrist' to formulate risk plan and review mental status."

31. Furthermore, CPN E stated:

> "In my professional opinion these assessments are subjective and dependent upon the information gathered at the time of the assessment. Risk can fluctuate and change over a brief period of time and the rating of risk was identified from the snapshot of information gained during the assessment of [Mr A] in ED."

32. CPN E contacted consultant psychiatrist Dr C to request an assessment of Mr A. Dr C said that currently he was with a patient and would attend as soon as he was available.

33. At 5.25pm, CPN H from the MHT attended the ED, and CPN E and F provided a verbal handover together with all the written documentation of the assessment.

Dr C

34. Dr C has full vocational registration as a psychiatrist.

Dr C's assessment — 6.30pm, Day 1

35. At 6.30pm, Dr C saw Mr A in the ED. Mr and Mrs B were both present. Dr C noted Mr A's history, in particular that there was evidence that he was not coping with life, but that Mr A did not consider he had any mental health issues. Dr C noted that there was some evidence of psychotic features, and that Mr A was reluctant to elaborate on his suicidal ruminations and associated hallucinations.

36. Dr C's impression was of "Major Depression".[3] In his contemporaneous records Dr C documented that the plan was for Mr A to go home with his parents that night, and to return at 9 o'clock the following morning for a further assessment. Dr C prescribed Mr A fluoxetine[4] 20mg and quetiapine[5] 25mg, and provided the crisis team contact details "in case matters deteriorate tonight". In response to the provisional opinion, Dr C told HDC that Mr A "gave little or no indication of being at risk. He simply wanted to go home and rest". Dr C stated that his understanding was that Mr A's illness was "driven by his […] study and stay in [another city] not having worked out the way he

[3] A mental disorder characterised by a pervasive and persistent low mood that is accompanied by low self-esteem and a loss of interest or pleasure in normally enjoyable activities.
[4] Fluoxetine (commonly known by its brand name, Prozac) is an antidepressant medication.
[5] Quetiapine prescribed at this low dose is used as an anxiolytic (anti-anxiety agent) and sedative.

wanted. He had come back home. It was clear that he and his parents were frustrated with this situation … At the same time, [Mr A] had also sought out help himself by accessing counselling in the community."

37. In respect of the discussions he had with Mr and Mrs B, Dr C stated to HDC:

> "[T]here was detailed discussion with the family as to why we would see [Mr A] the next day and why an admission may not have been the best outcome or choice."

38. In response to the provisional opinion, Dr C advised that he remembers involving Mr and Mrs B, and reiterated that he had a lengthy discussion with them. Dr C told HDC that he recalled that Mr and Mrs B seemed "initially surprised" that alternatives to admission were being discussed, which is why he took time to explain his intention of keeping Mr A engaged. Dr C further noted that there were "ample opportunities" for Mr and Mrs B to express any views that they could not cope with Mr A at home, but that "[n]o such views were expressed".

39. Dr C said that Mr A's father agreed to take Mr A home. However, there is no documentation of any other discussion or advice provided to Mr A or his parents.

40. Dr C told HDC that he considered that this management plan was reasonable, but acknowledged that his documentation does not "capture this information adequately".

41. Mr A's parents told HDC that Dr C did not explain his assessment to them or to Mr A. Both Mr and Mrs B recall that Mr A did not respond well to the way that Dr C spoke to him, describing Dr C's interaction with Mr A as confrontational. Mrs B said that Dr C wound up Mr A and that, at one stage, Mr A got up and left the room and, when Mr A was brought back by one of the nurses, Dr C gave Mr A some pills, told him to take them, and said that he could go home.

42. Mr B recalls Dr C saying to Mr A that he could go home if it was "ok" with his parents, but that Dr C never asked them directly. Mr B said that they felt that they had no choice but to take Mr A home, but they did not know how they would cope. Mr B said that they were never given any option or information other than being given the crisis team number to call if things deteriorated overnight.

43. Mrs B said that she was very surprised that Mr A was allowed to go home, as they understood from what the CPNs had told them that Mr A would be admitted that night, and that he needed help. Mrs B said that she recalls Dr C saying that he would not admit Mr A because he thought that it might make things worse, but he gave them no information about what was wrong or what they could do to help. She said that she cried throughout the appointment and was very distressed, and clearly not coping. She said that they were given no information about what was wrong with Mr A, and was not sure how they would cope with taking Mr A home, but felt that they had no choice.

44. In response to the provisional opinion, Mrs B stated:

> "I felt that [Mr A] and I were 'fobbed' off by [Dr C] and as far as he was concerned by prescribing pills and handing out leaflets for various organisations his job was done."

Further assessment by Dr C — Day 2

45. At 9am on Day 2, Dr C reviewed Mr A again as planned. Mr B was also present. In his documentation of this assessment, Dr C noted that over the previous six months Mr A had been experiencing symptoms of "hopelessness and helplessness, increasing frustrations and anger, introversion, social isolation, reduced food intake, change in dietary habits and reduced sleep".

46. Dr C noted that his assessment of Mr A was difficult because Mr A was "essentially coming from a position where he believed that his problems were within his control, that he did not require help from professionals and that he simply needed to get back to his previous way of life".

47. Dr C documented that Mr A reported ruminations about a number of issues including the "meaning of life", and that "[Mr A's] inability to find a reasonable answer to that ha[s] resulted in him being increasingly frustrated, preoccupied and ruminating around a whole range of situations to a point where he feels he is incapable of managing that safely". Dr C also noted that Mr A had had "brief thoughts of life not worth living". Dr C recorded that exploration around suicidal ideation, and its severity, were met with a "reasonable level of resistance in terms of his gentle evasiveness of answering that sufficiently".

48. Dr C documented that during the assessment he considered that Mr A was "still sufficiently unwell to meet the criteria for diagnosis of Major Depression even though one would want to wait with a period of time to establish the severity as being one severe enough to include psychotic features". Dr C documented that Mr A's "attitude towards life could be described as unorthodox" but that he was "unsure as to whether they could be described as specific psychotic features per se".

49. Under "mental state examination", Dr C documented that it was difficult to engage and build a rapport with Mr A. Dr C stated: "While generally responding to my questions asked, he showed a sense of ambivalence and difficulty in engagement and building rapport." Dr C stated that, as a consequence of the "shallow rapport", it was difficult to explore "specific contents of his thought processes but it was acknowledged that there ? were brief thoughts of 'life is not worth living' and associated feelings of suicidal ruminations". Dr C documented Mr A's mood as "depressed and angry".

50. In the "risk assessment" section, Dr C documented: "At this point in time there is some level of concern of suicidal ruminations and feelings of hopelessness but it does not appear to be significant enough to warrant immediate admission." In addition, he documented that if admission were to be considered, inpatient admission would be against Mr A's wishes and likely to lead to an escalation of behaviours, "which in turn would meet resistance and force to maintain a level of control and safety for everyone involved".

51. Dr C's Axis I[6] diagnosis was "Major depressive disorder — single episode, severe" with "Possible Schizoid personality" requiring further assessment. Dr C provided HDC with an outline of the conclusions he reached at the completion of his assessment of Mr A. Dr C stated:

> "A summary of the position we reached with [Mr A] on [Day 2] is that:
>
> — He was experiencing a major depressive disorder. However, he did not clearly present as being at imminent risk of self-harm.
>
> — I had a concern that [Mr A] would dis-engage with mental health and other support services, putting him at further risk. I therefore wanted to establish a therapeutic relationship and avoid an approach that would result in conflict.
>
> — While some risk of self-harm was acknowledged, in my clinical judgement the potential benefits of insisting on an inpatient admission (almost certainly requiring compulsion) were outweighed by the disadvantages of undermining [Mr A's] trust of engagement with mental health services."

52. Dr C commented to HDC that the evaluation of risk was difficult because of Mr A's evasiveness and lack of engagement. Dr C stated: "On reflection, it appears almost certain that [Mr A] was trying very hard to avoid a hospital admission and that his evasiveness was driven by the intent to avoid an admission if at all possible." Additionally, Dr C stated:

> "A decision to retain someone with severe mental illness under the follow-up of secondary mental health services is often taken on two counts. One would be the failed trial of primary care interventions or, alternatively, if the level of risk posed by the person was high or imminent. Given that in spite of establishing a diagnosis of Major Depression Disorder, we were not absolutely clear on the level of risk he posed; in hindsight closer follow up would have been useful."

53. Dr C stated that Mr A was "very guarded about his intent" and, as a result, "one could not with certainty establish admission to avoid risk of harm to self was the only or best option". Furthermore, Dr C stated: "[W]e were not in a position to establish with clarity a specific plan that [Mr A] had to take his life or imminence of risk … The severity was more in lines with passive thoughts of life not worth living and suicidal ruminations."

54. While Dr C acknowledged that a case could be made for Mr A meeting the criteria for compulsory admission under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act), he stated that "the assumption of higher levels of risk without knowledge of intensity, frequency, or imminence is speculative". Dr C stated:

[6] This is part of a diagnosis using the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. This is a multi axial diagnostic system covering mental illness, associated psychological states, physical health, social factors and a general assessment of functioning. An Axis I diagnosis refers broadly to the principal disorder requiring attention.

> "As the clinical notes reflect, hospitalisation was considered as a way to manage this uncertainty about [Mr A's] risk to self, but it became very clear that if we had gone ahead with an admission to the psychiatric ward, we would have faced significant resistance and worsening combative behaviour from [Mr A]. The use of the Mental Health Act and possibly even the use of the high needs unit or seclusion may have come into play. For someone who was deeply despondent and distressed, these measures would have been extremely traumatic and depressing. This, we thought, would have seriously affected the chances of establishing a productive therapeutic relationship with [Mr A] which in turn would have negatively affected his overall prognosis and probably increased his risk."

55. With regard to his decision-making about how best to manage Mr A, Dr C stated:

> "[T]he intent behind my decisions were driven by my desire to keep [Mr A] engaged in treatment rather than enforce treatment against his will. I believe irrespective of his consequent actions, the message from [Mr A] was clear, in that he would have resisted admission. I do not believe that this was driven out of lack of insight into his condition, but rather from fear of being in a mental health acute ward."

56. Dr C told HDC that at that time the inpatient acute admission option was not a suitable setting for all individuals owing to the "chaotic environment and mixture of patients. Some of them could be very disturbed and therefore intimidating to someone with a first onset depressive episode." Dr C said that he did not consider that the psychotic features Mr A was presenting with "directly worsened risk profile in this case, as there were no command hallucinations or persecutory delusions that contributed to a worsening risk profile". In addition, Dr C stated:

> "An admission is typically considered if the patient cannot be managed adequately in reference to safety. The second scenario where admission would be considered is if the patient or the family indicated difficulty supporting or managing him at home. The use of the Mental Health Act is considered if the alternative least restrictive options, including agreement from the patient, are not considered sufficient. In my recollection of the situation, particularly with the position that [Mr A] was inferring, it was my strong view that directing him to age appropriate services that would be less intimidating would have been a preferred option to forcing the MHA and admission against his wishes."

57. Dr C's plan was to continue on the fluoxetine and quetiapine and to increase the doses in three or four days' time if there was insufficient response.

58. In addition, Dr C suggested ongoing follow-up of Mr A's testicular pain with his GP, and consideration for counselling in the community. Dr C documented: "At this point in time I have suggested access to psychological support within the community as well as further follow up through the GP or primary Health Sector." In relation to this plan, Dr C stated: "Considering that this [was] the first formal access to psychological supports, a plan of accessing counselling either through [youth mental health services] or the [Primary Health Organisation] or alternatively other counselling in the community were suggested." Dr C documented that if there was further deterioration

or inability to manage Mr A in the community, referral back to Mental Health Services could be considered. Dr C documented:

> "At this point in time we do not foresee the need for immediate follow up or admission even though a decision of that was close to being made as a consequence of difficulty in engagement yesterday evening."

59. A copy of Dr C's assessment notes were sent to Mr A's GP. No other information was provided to Mr A's GP at that time.

60. Dr C told HDC that, on reflection, he accepts that "discussion with the GP or with [youth mental health services] would have been good". Dr C stated:

> "The focus and intent arrived at the end of the second assessment on [Day 2] was for a management plan to be put in place and passed on to primary care to implement in the first instance and get back to us if the clinical picture did not show signs of improvement."

61. Dr C acknowledged that the offer of short-term outpatient follow-up with the secondary mental health services should have been offered as an alternative to accessing services from youth mental health services. Dr C also accepted that he should have given Mr A's parents advice about what to do should Mr A fail to adopt any of these options. Dr C stated: "'What to do if [Mr A] failed to go to any of the services was a topic that should have been discussed with [Mr A] and his family." In addition, Dr C stated:

> "On reflection, I could have had a separate and independent meeting with the family on [Day 2] after the clinical evaluation of [Mr A] and sought their opinion on the proposed plan, their ability to supervise and monitor him, and why the relevance of admission as they saw it was important to them."

62. In response to the provisional opinion, Dr C accepted that he "should have negotiated a more comprehensive plan for Mr A's care in the community" but also noted that some alternative options were not available.

Mr B's account

63. Mr B told HDC that Dr C's communication approach with Mr A was confrontational. Mr B said that he felt that Dr C was becoming frustrated with Mr A during this appointment because Mr A would not respond to his questions. Mr B said that at one point he interrupted Dr C's questioning because he could see that Mr A was not responding well to the way he was being questioned. Mr B said that he spoke to his son and told him that Dr C was just trying to help him, and that he needed to respond to Dr C's questions if he wanted to be helped.

64. Mr B said that, at about that point, Dr C said that Mr A could go home, and gave them some pamphlets. Mr B said that Dr C never asked his opinion, and did not discuss his assessment findings with him or Mr A. Mr B said that when they left the assessment he had no idea what was wrong with Mr A, and remained very concerned about him,

but did not know what else to do. There is no record in the clinical notes about what information Dr C provided to Mr A and Mr B.

65. In response to this, Dr C stated:

> "I don't specifically recall [Mr B] raising concerns about the way I was speaking to [Mr A] and, from what he has written to HDC, I cannot be certain what it was about my demeanour and what I said to [Mr A] to upset [Mr A]. My assumption is that my efforts to try and engage [Mr A] in treatment without necessarily getting into an acrimonious first contact with mental health services may have been misinterpreted. Either way, I am sorry that I was unable to express my intentions clearly enough. Rather than being dismissive of the expressed concerns it was rather an attempt to engage with a young person who was not only struggling with the symptoms of depression, but was fearful of the involuntary treatment that his presentation may have entailed."

Subsequent events

66. Mr A returned home to his parents' house. Mr B told HDC that upon returning home he and his wife remained very concerned about Mr A and, while he and his wife were discussing what they should do, Mr A left the house.

67. Mr A was later involved in an incident that resulted in injuries causing his death. The Coroner considered that the evidence was not sufficient to establish that Mr A had attempted to take his own life. In conclusion, the Coroner stated: "[T]he verdict will be left open and the cause of death is as a result of the injuries received in the [incident]."

Further comment by Dr C

68. Dr C commented that in his view any discussion regarding the correctness of his risk assessments and the use of the Mental Health Act are dependent on the cause of Mr A's death. Dr C stated that given that there is uncertainty regarding how Mr A died (as discussed above, the Coroner was unable to conclude that the cause of death was suicide), "[a]ny reasoning based on an assumption of suicide is speculative".

69. Dr C advised that since this incident, when dealing with a patient in distress where the level of engagement is limited, he is now "particularly" aware of gathering information from other sources and obtaining independent opinion from family before deciding on a treatment plan. He advised that he is also more careful with his documentation.

Advice from Dr I

70. Dr C obtained an opinion from psychiatrist Dr I regarding the care Dr C provided (in response to the expert advice obtained by this Office from consultant psychiatrist Dr Brenda Brand). HDC then sought further advice from Dr Brand following receipt of this opinion.

71. In relation to the risk assessment on Day 1, Dr I commented that risk assessment "is generally acknowledged as never being able to achieve anything approaching high reliability and is only one part of the comprehensive mental health assessment of a

person". He commented that Mr A's degree of risk to himself was described as variable, and noted that there is no mention of factors that are protective or may decrease risk, which he considered are important in reaching a balanced risk assessment. However, Dr I considered that overall the risk assessments carried out on Day 1 were reasonable. Furthermore, Dr I considered that Dr C's tentative diagnosis of major depression appears reasonable, and his prescription of quetiapine and fluoxetine was appropriate. Dr I commented on the lack of evidence of discussion with Mr A's family, but noted that Dr C did provide the contact details of the crisis team.

72. In relation to Dr C's assessment and management of Mr A on Day 2, Dr I considered that Dr C's overall consideration of risk, as outlined in his clinical letter from that appointment, was "a thoughtful balancing of potential risk not only arising from [Mr A's] condition but from various alternative options with regard to treatment". Dr I commented that while in his opinion "a majority of peers would have considered there to be a somewhat greater risk than that recorded by [Dr C]", that would be considered a minor departure from the accepted standard of care.

73. Dr I commented that while he considered that Dr C's decision to prescribe fluoxetine and quetiapine was appropriate, he questioned the appropriateness of Dr C's advice to the GP that the dose could be increased in three or four days' time if there was no improvement. In relation to the plan for Mr A to access services in the community, Dr I commented: "It is easy to understand the reasoning that allowing [Mr A] to access non-specialist services might increase his acceptance of help and enable [Mr A's] engagement to a greater extent with therapeutic services." However, Dr I was critical of the lack of contingency plan should Mr A not engage with these services, commenting that arranging for follow-up with DHB community mental health services would have been a better option.

74. Dr I advised that Mr A's condition would have met the criteria for admission under the Mental Health Act, but, in Dr I's opinion, the fact that Dr C chose not to commence this is not outside the normal range of practice. Dr I commented, however, that opinions about this would likely be divided amongst his peers.

75. Dr I was critical of the lack of detail regarding the contingencies component of Dr C's management plan, such as there being no clarity about what signs of deterioration or failure to improve the GP should be looking out for, or any guidance on how frequently the GP should try to review Mr A.

Further comment from the DHB

76. The DHB advised that prior to these events it had no concerns about Dr C in relation to his clinical decision-making or communication with patients and their families.

Response to provisional opinion

Dr C

77. Dr C provided a response to the provisional opinion, which has been incorporated into this report as appropriate.

78. In relation to his communication with Mr A's parents on Day 1, Dr C submitted that it would not necessarily be a requirement to document the details of the discussion, stating that "there is a substantive difference between an expectation that clinical observations (such as temperature) will be recorded, and an expectation that a psychiatrist is to record every aspect of a complex mental health assessment conducted within a limited timeframe". Dr C stated: "For [Mr B] to say that he and his wife were not told what was wrong is, in my view, an indication of them feeling distressed and not remembering events clearly."

79. Dr C submitted that his evidence could not be discounted "out of hand", and that there was insufficient basis for the finding that he failed to involve Mr A's parents adequately in the decision-making.

80. Dr C further noted that it appeared that the nurses might have suggested that admission was a possible outcome, and this may have created an expectation in Mr and Mrs B's minds about what was an appropriate course of action. Dr C also suggested that Mr and Mrs B's recollections of the events should be treated with caution, particularly given that they were in an unfamiliar environment and were likely to have been stressed at the time, and due to the "likely conflation of their memories" with what later occurred.

81. With respect to his assessment of risk on Day 2, Dr C emphasised the highly subjective nature of risk assessments, and submitted that there is insufficient evidence to conclude that he failed to assess Mr A's level of risk adequately. Dr C submitted that Dr Brand's opinion that Mr A should have been managed more conservatively "is a valid alternative viewpoint, but it is not the same as having a rational basis for the opinion that [Dr C] failed to adequately assess risk". Dr C also noted that he had the advantage of conducting the interview and "was able to take into account a much richer and more complex array of information than could ever be reduced into a reporting letter".

82. Dr C submitted that his reporting letter as a whole was "competent and comprehensive", and that his assessment that Mr A was not at immediate risk of self-harm is "obvious from and inherent in his decision not to admit him".

83. In relation to his management plan, Dr C advised that he did not consider that Mr A needed to be admitted to be safe. Dr C submitted that the decision he made was well considered and based on all the information available to him at the time, and he considered that many clinicians would have an alterative view to Dr Brand.

84. In summary, Dr C told HDC: "It was [Mr A's] best interests that underpinned the decisions I made."

The DHB

85. The DHB advised that it did not wish to dispute any of the information gathered during the investigation, or the preliminary conclusions, proposed recommendations and follow-up actions in the provisional opinion, and accepts the provisional opinion and proposed recommendations and follow-up actions.

Mr and Mrs B

86. Mr and Mrs B's response to the "information gathered" section of the provisional decision has been incorporated into the report where appropriate. In addition, they stated:

> "[W]e hope that if mistakes have been made then the appropriate measures are taken to ensure that other families will not have to suffer in the same way."

Opinion: Introduction

87. The Coroner has found that Mr A died as a result of injuries following an incident.

88. My role is to assess the quality of care provided to Mr A, in light of the information that was known to his healthcare providers at the time that care was provided. Accordingly, my opinion should not be interpreted as having any implication as to the cause of Mr A's death.

89. As noted above, Dr C submitted a report from Dr I, who also analysed the care Dr C provided to Mr A. When forming my opinion, I considered both Dr I's report, and the response of my independent expert advisor, psychiatrist Dr Brenda Brand, to that report. I note that Dr Brand is an independent expert advisor, whereas Dr I's report was provided as part of Dr C's submission to HDC. I have taken both opinions into account, and my reliance on each reflects a number of factors, including the context of their provision to HDC.

Opinion: Dr C — Breach

Initial assessment — Day 1

90. Dr C first saw Mr A after he presented to the ED with his parents, complaining of testicular pain. Initially Mr A was assessed by ED registrar Dr G, who noted that Mr A was "very anxious looking, shaking, looking at floor, avoiding eye contact, crouched over, low in mood, not wanting to be around other people, stayed in motel last night, not wanting family around". Dr G's assessment was: "Anxiety and depressed mood — suicidal ideation." Dr G requested an acute mental health review.

91. Subsequently, Mr A was assessed by CPNs E and F, who carried out a full assessment and risk assessment of Mr A. CPN E documented: "[Mr A] [d]enies current suicidal ideation. Reports experiencing intense suicidal ideation today …" On completion of the assessment, CPN E identified Mr A's risk to himself at low–moderate, and his risk to others as low. CPN E requested "urgent [assessment] by Dr C for possible ward admission". CPN E provided a verbal and written handover to CPN H from the MHT. Dr C then attended to assess Mr A. He was provided handover from CPN H.

92. Dr C noted Mr A's history, in particular that there was evidence that Mr A was not coping with life, but Mr A himself did not consider that there were any mental health concerns. Dr C noted that there was some evidence of psychotic features, and that Mr A was reluctant to elaborate on suicidal ruminations and associated hallucinations. Dr C's impression was "Major Depression", but he did not document how he arrived at this diagnosis. His plan was to allow Mr A to go home with his parents, and to assess him again the following morning. Dr C prescribed Mr A fluoxetine 20mg and quetiapine 25mg and gave his parents the crisis team contact details "in case matters deteriorate tonight". There is no documentation of any further discussion with Mr A or his parents.

Adequacy of assessment

93. In relation to the adequacy of Dr C's assessment on Day 1, my expert advisor, psychiatrist Dr Brenda Brand, commented on the absence of a recorded formulation encompassing Dr C's views of Mr A's risk.

94. Dr Brand noted that "a brief impression" of major depression is documented at the end of Dr C's documented entry, but stated: "[I]t would be reasonable to expect that following an assessment, a psychiatrist would have an initial etiological and diagnostic formulation[7] that would encompass a view on the risks presented."

95. While Dr Brand considered that a definitive risk statement was not necessary, she advised that "a documented formulation [of the assessment] should still be attempted for the sake of clarity on the clinician's processing of the patient's presentation and the impression of weight of risk". Dr Brand advised that Dr C's failure to document a formulation of how he reached his risk assessment reflected a minor departure from accepted standards.

96. I accept Dr Brand's advice. Although I acknowledge that Dr C had the benefit of CPN E's and CPN F's risk assessment, which was already recorded in the clinical notes, and the risks appear to have been considered by Dr C, I am critical that he did not document his own formulation of risk adequately in the clinical notes.

Adequacy of management plan

97. Dr Brand advised that "overall" the decision not to admit Mr A at that time was reasonable in the circumstances, and that Dr C's prescription of fluoxetine and quetiapine was reasonable and in accordance with accepted practice. I accept that advice.

[7] Formulation refers to synthesis of data in order to provide a set of explanatory hypotheses for the cause of the patient's presentation. Etiological formulation refers to the possible causes of the disorder.

Communication

98. Dr Brand raised concerns about the level of Dr C's communication with Mr A's parents. Dr C stated that there was a detailed discussion with the family as to why he would see Mr A the next day and why an admission might not be the best choice, and that Mr B agreed to take Mr A home. Dr C reiterated this in response to the provisional opinion, and further suggested that Mr and Mrs B's recollections of the events should be treated with caution, given that they were in an unfamiliar environment, were likely to have been stressed at the time, and due to the "likely conflation of their memories" with what later occurred. However, Dr C also acknowledged that his documentation does not "capture this [discussion] adequately".

99. In contrast, both Mr and Mrs B said that Dr C never discussed his assessment findings with them or with Mr A, and did not ask their views about Mr A going home. Mr B recalls that Dr C told Mr A that he could go home if it was "ok" with his parents, but he never asked them directly. Mr B said that he felt that they were given no choice but to take Mr A home, and that they were not sure how they would be able to cope. Mrs B said that she cried throughout the assessment and was clearly not coping.

100. It is not disputed that Dr C did, to some extent, discuss his reasoning behind why he would not admit Mr A that evening. However, taking into consideration all the evidence available, including Dr C's account, and the accounts of both Mr and Mrs B, I am of the view that Dr C did not involve Mr and Mrs B adequately in his assessment of Mr A.

101. Dr Brand advised that, even taking into account Dr C's retrospective account regarding what was discussed, Dr C did not ascertain and take into account the family's opinions on risk, and their agreement with the proposed management plan.

102. While I note Dr C's submission that there was no requirement to document such a discussion, I acknowledge Dr Brand's view that "it would be widely clinically accepted that in the assessment of suicidal patients the views of family/carers [should] be sought and documented". Dr Brand advised that the failure to involve Mr A's family reflected a moderate departure from accepted standards.

103. I accept Dr Brand's advice. Mr A attended the assessment with his parents, and Dr C's plan was for him to return home with his parents. In the circumstances, my view is that there would have been value in involving them further in discussions about how best to manage their son by ascertaining their views or concerns regarding Mr A and his management.

Second Assessment — Day 2

Assessment

104. As planned, Dr C saw Mr A the following morning. Mr B was also present.

105. Dr C documented that during the previous six months Mr A had been experiencing symptoms of "hopelessness and helplessness, increasing frustrations and anger, introversion, social isolation, reduced food intake, change in dietary habits and reduced sleep".

106. Dr C noted that his assessment of Mr A was difficult as Mr A was "essentially coming from a position where he believed that his problems were within his control, that he did not require help from professionals and that he simply needed to get back to his previous way of life". Dr C noted that Mr A had experienced "brief thoughts of life not worth living", but exploration of suicidal ideation or its severity was difficult and met with a "reasonable level of resistance in terms of [Mr A's] evasiveness of answering that sufficiently". Dr C considered that Mr A met the criteria for major depression.

107. Dr Brand advised that, in her opinion, Dr C's assessment to that point was "thorough and appropriate". I accept that advice.

108. In relation to his risk assessment, Dr C recorded "some level of concern of suicidal ruminations and feelings of hopelessness but it does not appear to be significant enough to warrant immediate admission". Dr C stated: "While some risk of self-harm was acknowledged, in my clinical judgement the potential benefits of insisting on an inpatient admission (almost certainly requiring compulsion) were outweighed by the disadvantages of undermining [Mr A's] trust of engagement with mental health services." Furthermore, Dr C explained: "The intended purpose of trying to manage [Mr A] without an admission and in an environment considered age and need appropriate and for facilitating speed of psychological support, was specifically intended to build therapeutic alliance."

109. Dr Brand advised that Dr C did not fully explore the risk of not admitting Mr A. Dr Brand stated: "It is my opinion that [Mr A] presented a risk to himself, specifically compounded by his reluctance to engage and therefore highlighting a number of unknown factors that could further impact on the level of risk and eventual decision to manage this."

110. Dr Brand advised that "the level of risk identified by [Dr C] would be comparatively considered as higher [than Dr C identified] by most other clinicians upon review of [the] information". Dr Brand further advised that the lack of identification as to Mr A's level of risk reflected a moderate deviation from the standard of accepted care. I accept Dr Brand's advice. I acknowledge Dr C's point that he had the benefit of conducting the interview with Mr A in person. However, in my opinion, Dr C should have assessed Mr A's level of risk further, including fully exploring the risk of not admitting him. I also note that Dr I considered that Mr A's level of risk would be considered "somewhat greater" than that assigned by Dr C, but stated that he considered that this would be a minor departure from the accepted standard of care.

Management plan

111. Following his assessment, Dr C made the decision not to admit Mr A, and suggested that he access psychological support in the community, as well as further follow-up through his GP. Dr C told HDC that he did not consider that Mr A needed to be admitted to be safe. Other than sending a copy of his clinical notes to Mr A's GP, Dr C did not provide any specific guidelines or advice to Mr A's GP.

112. Dr Brand advised that, in her opinion, compulsory admission (under the Mental Health Act) would have been the preferred option after this assessment.

113. Dr C acknowledged that a case could be made for Mr A meeting the Mental Health Act criteria, but said that he did not consider this was appropriate in the circumstances. Dr C stated:

> "As the clinical notes reflect, hospitalisation was considered as a way to manage this uncertainty about [Mr A's] risk to self, but it became very clear that if we had gone ahead with an admission to the psychiatric ward, we would have faced significant resistance and worsening combative behaviour from [Mr A]. The use of the Mental Health Act and possibly even the use of the high needs unit or seclusion may have come into play. For someone who was deeply despondent and distressed, these measures would have been extremely traumatic and depressing. This, we thought, would have seriously affected the chances of establishing a productive therapeutic relationship with [Mr A] which in turn would have negatively affected his overall prognosis and probably increased his risk."

114. Furthermore, Dr C advised that at that time the inpatient admission option was not an appropriate environment for Mr A, and stated that some alternative options were not available.

115. Dr Brand advised that, taking into account Mr A's "lack of engagement, severity of symptoms, risk to self and identified impaired capacity to sufficiently care for himself", coupled with the fact that Mr A had not engaged with community supports previously, an inpatient admission would still have been the "preferred option" to manage Mr A at that time. Dr Brand also commented that there is nothing to indicate what Mr A's response to a suggestion of admission would have been. Dr Brand said that, during an initial crisis assessment, "the aim of initial intervention is safety containment, to allow a person to regain capacity and insight with treatment interventions". Dr Brand stated: "I am of the opinion that at this stage admission and therefore containment of risk would have been the most prudent decision." Dr Brand advised that admission would also have been an opportunity to assess Mr A's response to medications and to assess risk and psychotic symptoms, as well as to address the issue of carer burden.

116. Dr Brand advised that the risks of non-admission were "significant", and included the potential non-adherence to medication, non-attendance at follow-up arrangements in the community, risks of unrecognised psychosis, inability of Mr A's family to manage the situation, and the risk of suicide. In Dr Brand's opinion, on balance, these risks outweighed the potential risks of admission. Dr Brand considered that Dr C's decision not to admit Mr A represented a moderate departure from accepted standards, but noted that this issue "may divide opinion amongst peers".

117. In respect of the remainder of Dr C's management plan, Dr Brand was concerned that, having decided not to admit Mr A, Dr C failed to arrange ongoing specialist follow-up "with consistency in clinician access and secondary care psychological intervention". Dr Brand advised that the failure to offer Mr A follow-up in a secondary service represents a moderate departure from accepted standards. Dr Brand also advised that Dr C should have provided clearer and more specific guidelines to Mr A's GP, highlighting the possible presence of psychotic symptoms, suicide risk and risk level. Dr Brand considered that the failure to do so represented a minor departure from the

standard of care. I note that in response to the provisional opinion Dr C accepted that he "should have negotiated a more comprehensive plan for Mr A's care in the community".

118. Overall, I accept Dr Brand's advice. In my view, while I appreciate that Dr C wished to establish a productive therapeutic relationship with Mr A, I am critical that Dr C elected not to admit Mr A. Furthermore, although I acknowledge that some alternative options were not necessarily available, I am also critical that, having decided not to admit Mr A, Dr C failed to arrange ongoing specialist follow-up, and did not provide clear, specific guidelines to Mr A's GP.

119. In summary, it appears that Dr C's decision-making on Day 2 was heavily influenced by his belief that Mr A would resist admission. However, there is no evidence that admission and the significant risks of not admitting Mr A were explored fully. I note Dr Brand's view that "[i]t would appear … that the risk assessment is impacted on by obstacles in a potential management plan rather than the risk assessment informing the management plan".

Communication

120. Mr B told HDC that following this assessment Dr C told Mr A to take his medications and gave him some pamphlets, but did not discuss a diagnosis or a management plan with Mr A or himself. Mr B said that when they left the assessment he still did not know what was wrong with Mr A, and remained very concerned about him. There is no record in the clinical notes about what information Dr C provided to Mr A and Mr B. Dr C accepts that "'[w]hat to do if [Mr A] failed to go to any of the services' was a topic that should have been discussed with [Mr A] and his family". Dr C also stated: "On reflection, I could have had a separate meeting with the family on [Day 2] after the clinical evaluation of [Mr A] and sought their opinion on the proposed plan, their ability to supervise and or monitor him, and why the relevance of admission as they saw it was important to them."

121. Given that Mr A was being discharged into the care of his parents, it was important that at the time of the second assessment Mr B was provided with adequate information about Mr A's condition, and clear information regarding Dr C's proposed management plan for Mr A. I note Dr Brand's view that the absence of any evidence (of discussion) of the possible interventions with Mr A's family would be viewed as a moderate departure. I accept that advice. I am critical that Dr C did not provide sufficient information to Mr B about Mr A's condition, and did not discuss the proposed management plan adequately or provide clear information about that management plan to Mr B.

Manner

122. Mr and Mrs B told HDC that they found Dr C very confrontational, and said that Mr A did not respond well to him, describing how Mr A left the room during the initial assessment. Mr B also said that he had to intervene at one stage during the second assessment.

123. In response to this, Dr C stated that he was not sure exactly what Mr and Mrs B's concerns relate to. However, he said:

> "My assumption is that my efforts to try and engage [Mr A] in treatment without necessarily getting into an acrimonious first contact with mental health services may have been misinterpreted. Either way, I am sorry that I was unable to express my intentions clearly enough. Rather than being dismissive of the expressed concerns it was rather an attempt to engage with a young person who was not only struggling with the symptoms of depression, but was fearful of the involuntary treatment that his presentation may have entailed."

124. Given the differing accounts, I am unable to make a finding in relation to the manner in which Dr C communicated with Mr A. However, I suggest that Dr C reflect on the way he communicates with consumers and their families and the potential impact his manner may have on very vulnerable consumers.

Conclusion

125. I conclude that Dr C failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code by:

a) failing to ascertain adequately and take into account Mr A's parents' opinions on risk and their views on the proposed management plan at the initial assessment;

b) failing to assess Mr A's level of risk adequately at the second assessment;

c) failing to admit Mr A, either voluntarily or compulsorily under the Mental Health Act, and, having decided not to admit Mr A, failing to offer Mr A ongoing specialist follow-up, or to provide clear, specific guidelines to Mr A's GP; and

d) failing to provide sufficient information to Mr B about Mr A's condition, and not discussing the proposed management plan adequately or providing clear information about that management plan to Mr B.

126. I am also critical that Dr C did not document the formulation of his risk assessment adequately in the clinical notes.

Opinion: DHB — No breach

127. The DHB had a duty to Mr A to ensure that services were provided in a manner that complied with the Code. Furthermore, as an employing authority, consideration must be given as to whether the DHB is vicariously liable for Dr C's breaches of the Code.

128. As stated above, in my opinion Dr C's decision-making and assessment departed from accepted standards.

129. In my view, Dr C's failures in this case were individual clinical errors and cannot be attributed to the system within which he was working. The DHB did not have any previous concerns about Dr C, and was entitled to rely on Dr C, as a consultant psychiatrist, to provide an appropriate standard of care. While the DHB has a responsibility to have in place structures to ensure that all its patients are provided

with an appropriate standard of care, there is no evidence in this case that the systems at the DHB were such that Dr C was unable to perform his duties appropriately.

130. Accordingly, I find that the DHB did not breach the Code.

Recommendations

Dr C

131. I recommend that Dr C:

a) Provide a written apology to Mr A's family for his breaches of the Code. The apology should be sent to HDC within one month of the date of this report, for forwarding to Mr A's family.

b) Undertake further training on communication with patients. Dr C should provide evidence of his attendance/enrolment in an appropriate workshop/seminar within three months of the date of this report.

c) Undertake further professional development focused on clinical assessment, and in particular risk assessment and family engagement. Dr C should provide a report to this Office on what activities he has undertaken within three months of the date of this report.

DHB

132. In accordance with the recommendation of my provisional opinion, the DHB has agreed to undertake a review of all patients seen and discharged by mental health services during a one-month period, looking at short-term outcome, to assess whether risk assessments have been assigned appropriately.

Medical Council of New Zealand

133. Following notification of this complaint, the Medical Council of New Zealand decided that Dr C would be required to undergo a performance assessment. The Council advised that it would provide this Office with an update at the conclusion of the performance review.

Follow-up actions

134. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Psychiatrists, and they will be advised of Dr C's name.

135. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from psychiatrist Dr Brenda Brand:

"**1. Introduction**

1. I have been asked to provide further expert advice to the Health and Disability Commissioner on case number: C14HDC01268. (Original report 11 May 2015).

2. Following investigation further information had been received from [Dr C] and [the DHB]. A report had also been obtained from [Dr C's] own expert, [Dr I].

3. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

4. I do not have a personal or professional conflict of interest in this case.

5. I have not entered into any discussions about my advice with any party.

2. Instructions from the Commissioner

6. Request to review enclosed documentation and after review, amend or add to my original report and

7. in the event of a departure of accepted standards considered to include comment on:

   a) How significant the departure is considered to be; and

   b) How care provided would be viewed by peers.

3. Additional documents provided for this review

i) Copy of [Dr C's] letter dated 8 October 2015

ii) Copy of [Dr C's] letter [to CEO of DHB] dated 23 October 2014

iii) Copy of [Dr I's] advice report dated September 2015

iv) Copy of [the DHB] response dated 7 August 2015

v) Statement of [CPN E] dated 22 July 2015

vi) Copy of relevant policies and guidelines provided by [the DHB]

4. Background

8. I want to emphasize that my report to The Commissioner, dated 11 May 2015, was an opinion formed after reviewing all the documents made available to me at the time. This was an independent, unbiased opinion, with me holding no conflict of interest to any party involved. It was based on my own experience and practice gained from clinical work obtained through working in 3 separate

New Zealand DHBs and also clinical work in Queensland, Australia. I have often worked closely with first line clinicians and have been involved in many urgent crisis assessments. I am very aware of the real challenges faced by psychiatrists, including resource restraints, time restraints and the burden of making difficult decisions with at times limited and inaccurate information. I am therefore not without empathy for the clinicians involved in this case. The unexpected death of a patient and the subsequent assessment of events are extreme burdens that weigh heavy on every clinician in practice. I therefore take the expression of my opinion not lightly and I endeavour to be as fair and open minded as possible in my statements.

9. The reality is that I was asked to review a case where an adverse event had occurred and where I knew what the adverse outcome was. Despite this, I felt that I could provide an unbiased opinion, as my goal was not to comment on the immediate events surrounding the adverse outcome but to comment on the adequacy and appropriateness of the interventions proposed and carried out at the time of assessments. I have focused only on the instructions from the Commissioner and kept my comments to those questions posed to me.

10. Lastly I need to add that I do not believe that a risk assessment can be viewed as 'correct or incorrect' based on an outcome. A risk assessment is a process that is part of a general psychiatric assessment, meant to inform formulation and management of the presenting patient. My review focused on whether I was of the opinion that the process and eventual understanding and management of [Mr A's] difficulties were appropriate and of an adequate standard.

11. In my further review I have read all the additional documents provided to me and will comment on this as requested.

5. Findings:

1. The adequacy of the risk assessments carried out on [Day 1] Assessment by Initial Assessors: *ORIGINAL OPINION: The assessors utilized the structured tool mentioned as well as what would appear to be a well-structured interview. The main clinical and risk issues are identified appropriately. This method of combining a structured risk assessment tool augmented by clinical interview is supported by Ministry Of Health Guidelines. (2) The severity of symptoms, disability identified and the number of risk factors documented, contradict the conclusion of low/moderate risk to self as a higher risk to self would appear apparent from assessment. Despite this conclusion, the outcome at this stage reflect concern identified by the assessors 'for possible ward admission' and risk assessment by the initial assessors is viewed to be adequate and of an acceptable standard of care.*

12. REVIEWED OPINION: I accept that [CPN E] acknowledged in her statement to The Commissioner that the initial risk statement 'is a snapshot of assessment' at the time and included both risks to self and others and that on that specific time of assessment [Mr A] denied suicidal intent. Previously it is

mentioned in [CPN E's] report that [Mr A] had experienced 'intense suicidal ideation earlier that day'. [Dr I] points out in his report the contradictory statements about suicidal ideation as documented in the CPN's assessment documentation.

13. I continue to have concern about the conclusion of risk level, and although I agree that a risk assessment can be very subjective, the number of concerning objective data obtained during the interview remain in my view significant. I agree that a risk statement is part of a detailed assessment rather than an isolated statement and the purpose of carrying this out as an entity, separate and additional to the overall assessment, is to assist the clinician in recognizing the importance of risk in informing the formulation. Despite the conclusion (in my view judged not significant enough) of low–moderate risk, the action of the assessors was to refer [Mr A] for further assessment and management to the on call Psychiatrist. I am of the opinion that this was an appropriate course of action. I therefore continue to be of the opinion as stated in my initial report that the risk assessment and subsequent action by the initial assessors are adequate and meet an acceptable standard of care.

14. **Second Assessment by [Dr C]**: *ORIGINAL OPINION: It is my opinion that the lack of evidence regarding his family's view and involvement at this stage of assessment reflects a departure in acceptable standard of care. I believe this to be moderate. I am of the view that it would be widely clinically accepted that in the assessment of suicidal patients the views of family/carers be documented. (2) I also note the absence of a definitive risk statement in [Dr C's] notes. I am of the view that this reflects a moderate departure in the standard of care.*

15. REVIEWED OPINION: [Dr C] states in a letter to the Commissioner that: 'I can assure the Commissioner that there was detailed discussion with the family as to why we would see [Mr A] the next day and why an admission may not have been the best outcome'. [Dr C] further acknowledges that the hand written notes … 'do not capture this information adequately'. As reviewer of the process it is very difficult to comment on a process that has not been documented. [Dr C's] account of his discussions with the family (in retrospect), continues in my view to not include the family's opinions on risk, and their agreement with plans. It remains my opinion that the lack of evidence regarding [Mr A's] family's view and involvement at this stage of assessment reflects a departure in acceptable standard of care. I believe this to be moderate. I am of the view that it would be widely clinically accepted that in the assessment of suicidal patients the views of family/carers be sought and documented.

16. In regarding the risk assessment carried out by [Dr C] on [Day 1], my task is to give an opinion on 'an opinion' rather than an action. My opinion on this issue is made challenging as I have to solely rely on the clinician's documentation to provide me with insight into their thoughts at the time, and in absence of a definitive or indicative statement I have to infer this

information. I appreciate that [Dr C] did receive a handover from CPN H who received a handover from [CPN E] and colleague, as well as reviewed risk statements by the assessing CPNs. This process is partly confirmed by [CPN E's] statement and partly has to be inferred. I appreciate that [Dr C] wrote his entry (assessment), no doubt informed by above handovers, directly underneath that of the mental health nurse as pointed out by [Dr I]. The question then remains as to whether there was an absence of a risk statement or an absence of a documented risk statement.

17. [Dr I] states in his report that the 'assessment of risk is inherently provisional and dynamic and I would question if such a thing as a "definitive risk statement" could ever be made'. On reflection of this I am of the opinion that the question of adequacy of assessment does not relate to the presence or absence of a definitive risk statement. But I would propose that it would be reasonable to expect that following an assessment, a psychiatrist would have an initial etiological and diagnostic formulation that would encompass a view on the risks presented. From the records available to me, a brief impression is stated at the end of the assessment 'major depression'. No documentation to suggest a further formulatory statement. I accept that a risk assessment is part of an overall assessment and that other aspects of the assessment were documented. I have to therefore infer that a formulation was arrived at and then absence of such documented presents a minor departure from care at this stage of the management of [Mr A's] care. Most clinicians would view a specific risk statement as possibly duplication of previous mentioned statements, but would still view that a documented formulation should still be attempted for the sake of clarity on the clinician's processing of the patient's presentation and the impression of weight of risk.

2. The appropriateness of [Dr C's] management plan from [Day 1], including the prescription of Fluoxetine and Quetiapine;

18. *ORIGINAL OPINION*: *The lack of evidence of a discussion with [Mr A] and his family regarding a robust and collaborative safety plan suggests no intervention in alleviating [Mr A's] initial presenting risk and presentation concerns. Arrangements were made for a more extensive review, but I am of the opinion that the management plan on [Day 1] revealed a departure in the standard of care of moderate nature.*

19. *Regarding prescription of medications, the use of first line Fluoxetine (Selective Serotonin Reuptake Inhibitor) as mono therapy antidepressant is supported in the Practice Guidelines for Treating Depression by the Royal Australian and New Zealand College for Psychiatrists. (RANZCP)(4) As to whether this prescription should have been delayed until the next day after further assessment, I do not view it to have impacted on the standard of care. The purpose of Quetiapine use at this dose is not documented, but assumed to be of anxiolytic/sedative use. Use of Quetiapine for this purpose is in my experience a common off-label practice amongst peers and would not be viewed as a deviation in the standard of care.*

20. *Advice and guidelines suggest close follow[up] after prescription of antidepressants and specifically SSRIs.(2) [Dr C] arranged to review [Mr A] again the next day, and this intervention is seen as an appropriate and acceptable standard of care. The lack of documented discussion regarding side effects leaves uncertainty as to whether this was discussed with [Mr A] and his family. Given the arrangements to review [Mr A] and his family again the following day, it is not viewed as a deviation in standard of care at this stage. (2)*

21. REVIEW OPINION: Management plan: (excluding prescription of Fluoxetine and Quetiapine):

22. The issue of absence of documentation regarding family involvement in management plan again becomes an issue. [Dr C] informs the Commissioner retrospectively that '… detailed discussion with the family (was held) as to why we would see ([Mr A]) the next day and why an admission may not have been the outcome or choice.' Additionally it is documented that [Mr A's] father was 'agreeable to taking [Mr A] home and that crisis contact details were provided to [Mr A] and course of action in event of deterioration'. The letter of complaint received from the family documents concern about the perceived change in plans as stated by the initial assessors. This may reflect that the family was not without concern about the proposed plan on the night of [Day 1].

23. At this point, my opinion is that the absence of documentation at this time, regarding family involvement, has to be viewed as [Dr C's] lack of existing documentation of these discussions rather than a lack of actual involvement of the family and that I concede that extensive documentation of every interaction and discussion point is not realistic in practice. This issue aside and despite [Dr C's] retrospective statements about discussions, I am still struck by an overall sense of absence of family input in the documented process by [Dr C] on [Day 1]. I accept that previous input statements have been covered by the Emergency doctor and the CPN. I therefore am of the opinion that the issue at this stage is the lack of sufficient documentation to indicate family involvement. I believe this to be a minor departure in practice and that most clinicians would advise that documentation of family interaction to be necessary and best practice.

24. My opinion on the prescription of medication remains unchanged in that it is not a departure from accepted standard of care.

25. As to the overall management plan specifically not to admit [Mr A] at this point, on reflection it is reasonable that in the interest of therapeutic rapport, the patient's wishes and the supervision of family being provided, that reassessment was arranged for the following day. It is my opinion that this reflects an accepted standard of care.

3. The adequacy of the risk assessments carried out by [Dr C] on [Day 2];

26. *ORIGINAL OPINION: When conducting an assessment of suicide risk, the presence of a concomitant mental illness should be identified as this is associated with increased risk. (2) [Dr C] identified the presence of the symptoms of a Major Depressive Episode. [Mr A] endorsed criteria for this diagnosis in accordance with criteria specified in the Diagnostic and Statistical Manual of Mental Disorders. (DSM V)(3) Severity is specified by DSM V as 'the number of symptoms being substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupation functioning'.(3) [Mr A] fulfilled criteria for this specifier from documentation provided. [Mr A's] duration of symptoms and severity of symptoms suggest a higher level of risk than stated.*

27. *In this assessment process, despite significant attempts to engage [Mr A], therapeutic rapport was not able to be established. Ministry of Health guidelines recommend that, 'Establishing a therapeutic alliance is a key component to working with anyone who presents with suicidal ideation. This process facilitates their disclosure of information and may serve as a protective factor by encouraging a sense of hopefulness and connectedness.' (2) Clinicians are dependent on the information at hand and in this case the information gathered then impacted on informing the formulation of risk. [Dr C] formulated that the reason for [Mr A's] evasiveness was driven by a desire not to be hospitalized, and on reflection thought this to have been '... a conscious choice'. The possible impact of symptoms on [Mr A's] insight, judgment and capacity to make conscious choices are not addressed in the assessment, and not explored as potentially impacting on his ability to engage in a therapeutic alliance and to provide his clinician with information in formulating an accurate risk plan. This exploration could potentially have altered and elevated assessed level of risk.*

28. *Given the resultant lack of detail available regarding intent, planning, frequency and intensity of suicidal thoughts, in the assessment, it would suggest this to be sufficient enough to suggest an elevated risk. Additionally, the possibility, even if not clearly present, of psychotic features would raise risk to self further. (2)*

29. *I am of the opinion that a higher level of risk should have been identified than stated in the assessment process at this stage. The risk statement impacted on decisions to follow and I therefore believe this to be a departure in the standard of care of moderate nature.*

30. REVIEW OPINION: I acknowledge that the risk assessment process being cumulative but as I have stated previously, a risk assessment is part of each assessment resulting in a formulation and management plan. Therefore I do believe it reasonable to separate [the 2 assessments], given the potential for very different management plans.

31. [Dr C] details in his assessment letter that was copied to [Mr A's] GP, a thorough history and symptoms experienced by [Mr A]. The time line is identified as best as possible with the identification of changes in functional symptoms and a prodromal change in behavior. [Dr C] identified the difficulties in accessing the full extent of [Mr A's] suicidal thoughts. Further specifically hopelessness and helplessness are identified. On mental state identified that [Mr A] showed ambivalence in engagement, depressed mood and blunted affect. No overt psychotic symptoms were elicited. [Dr C] identified a MDE of severe nature. In my opinion the process to this point is thorough and appropriate. A severe illness is identified that by most opinions would be responsive to appropriate intervention.

32. [Dr C] mentions the potential risks of admission against [Mr A's] will. It would appear to me at this point that the risk assessment is impacted on by the obstacles in a potential management plan rather than the risk assessment informing the management plan. It is further my view that the risk of not admitting [Mr A] at this stage is not fully explored. I am also not clear on how [Mr A] would have responded if told that he required admission. It is my opinion that [Mr A] presented a risk to himself, specifically compounded by his reluctance to engage and therefore highlighting a number of unknown factors that could further impact on the level of risk and eventual decision to manage this.

33. [Dr I] comments on his belief of the inaccuracy of my statement 'that a higher risk should have been assigned' but acknowledges in the same paragraph that a 'somewhat greater risk' was present as identified by [Dr C]. Not only would this statement appear contradictory but becomes an exercise in semantics of the difference between 'high' and 'somewhat greater'. The essence in my opinion is that the level of risk identified by [Dr C] would be comparatively considered as higher by most other clinicians upon review of information. This error in judgment then impacted on the further management of [Mr A's] presentation. I believe the lack of identification of the level of risk at this point reflects a moderate deviation of standard of accepted care.

4. The appropriateness of [Dr C's] management plan from [Day 2], including whether [Mr A] should have been admitted;

34. *ORIGINAL OPINION: In my view the above factors contradict the benefits for non-admission and an admission should have been sought on [Day 2]. [Mr A] was unable to be engaged in a therapeutic process, he exhibited symptoms of a possible psychotic process, he had severe mood symptoms of significant duration possibly impacting on his capacity to make decisions about his health, his parents had significant concerns with no change in presenting situation and he met criteria for the MHA (Compulsory Assessment and Treatment) Act. Criteria for MHA identified in [Mr A] as abnormal mood, risk to self and diminished capacity to care for himself. I appreciate that clinicians face very difficult decisions daily and that retrospectively specific factors appear more important given the knowledge of outcome. I am of the opinion that if [Mr A] did not willingly consent to an admission, a compulsory*

admission under the Mental Health Act should have been pursued. I believe that [Dr C's] practice departed from the standard of accepted practice, and I am of the opinion that this is of moderate to severe in nature.

35. REVIEW OPINION: To some extent I accept that the opening statement in my original opinion on the matter of admission appeared on initial view as rigid without considering the complexities that [Dr C] faced on [Day 2]. I should have stated that I believed that in my opinion admission would have been the preferred option in management of [Mr A's] presentation.

36. There are clearly many more options available to any clinician after assessment, but every plan should be matched to the individual patient's needs. I viewed this option as a preference given my view on the balance of the factors mentioned, being lack of engagement, severity of symptoms, risk to self and identified impaired capacity to sufficiently care for himself. Additionally [Mr A] did not engage with previously attempted community supports. I am also unclear on what [Mr A's] response would have been to a suggestion of admission. It is alluded to. At times during crisis assessments the aim of initial intervention is safety containment, to allow a person to regain capacity and insight with treatment interventions. I am of the opinion that at this stage admission and therefore containment of risk would have been the most prudent decision. Additionally [Mr A's] response to medication, further assessment of risk and psychotic symptoms would have been able to be undertaken and the carer burden would have been addressed by an admission. The use of the MHA on initial assessment would in my mind have been met given the factors mentioned above. The risks of non-admission was significant in the potential for non-adherence to medication, non-attendance with follow up arrangements in the community, risks of ongoing unrecognized psychosis, inability of parents to manage the situation, and risk of suicide. I believe that on balance these factors outweighed the risks potentially encountered by admission. I continue to be of the opinion that this management approach to not admit [Mr A] was a moderate departure on the standard of care. I agree that this issue may divide opinion amongst peers.

37. Other lesser restrictive management strategies such as respite care and day hospital attendance (dependence on availability) are not documented as being explored. This could have relieved carer burden and provided some containment and level of supervision [and] a crisis case manager could have been assigned to assertively monitor [Mr A's] mental state, risk factors and medication adherence. It would also have provided an opportunity to reach more diagnostic clarity regarding psychotic symptoms that may have required more assertive treatment than Quetiapine 25mg daily. The lack of other assertive management strategies to manage risk reflects a moderate departure in the standard of accepted care.

38. The remainder of [Dr C's] management plan:

39. *ORIGINAL OPINION: I am of the opinion that [Dr C] could have provided clearer and more specific guidelines to the primary carer. Guidelines should*

have highlighted the possible presence of psychotic symptoms noted in the assessment, the need to enquire about this in follow up and the possible impact of this on risk. Additionally, no clear statement is made to the GP about [Mr A's] risk level at the time of discharge from Mental Health Services. Given the risk concerns raised, specific guidelines should have been provided about factors to consider when assessing risk and how often this is to be assessed. Given the lack of engagement and history of possible similar issues with his General practitioner, a direct liaison process could potentially have revealed more information to MHS in their proposed discharge plan and provided the GP with some guidelines. It is my opinion that this is a minor departure from an adequate standard of care expected. I am of the opinion that it would be met with minor disapproval from peers.

40. REVIEWED OPINION: No change to my original opinion.

41. *ORIGINAL OPINION: Given the identification of a Major depressive Disorder, severe in nature, with some lack of clarity about the possibility of psychosis and suicide risk, the issue of ongoing specialist care should have been more strongly considered and explored. Guidelines about management of primary care vs. secondary care for severe depression would vary in different centers and likely dependent on resources available. The decision of ongoing specialist care is a decision to be made on individual presentations but my impression is that given the complexity and risks identified, [Mr A] should have been offered ongoing specialist follow up, with consistency in clinician access and secondary care psychological intervention. In my view the plan not to offer [Mr A] follow up in a secondary service reflects a moderate departure in the standard of care.*

42. REVIEWED OPINION: No change to original opinion.

43. *ORIGINAL OPINION: This absence of evidence of the above interventions with [Mr A's] family reflects a departure on standard of care and is viewed as moderate in nature. It is my opinion that it would most likely be viewed with moderate disapproval from peers.*

44. REVIEWED OPINION: With all due respect to [Dr I's] comments regarding documentation, I am of the opinion that the lack of record keeping is not acceptable despite the reality of its existence. No change to original opinion.

45. This was a difficult report to compose, more so the second time. I have stated before that I have utmost empathy for the clinicians involved and the stress this must be causing. My task was to attempt as best as I could to comment on the issues of management involved in this tragic case without considering that outcome. It was a very difficult task. My condolences are with the family with their loss."