General Practitioner, Dr D

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC02266)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his late brother, Mr A, by general practitioner (GP) Dr D, Health New Zealand|Te Whatu Ora (Health NZ), an ENT surgeon, and an anaesthetist. Issues related to the care provided by the ENT surgeon and anaesthetist have been addressed during the assessment process. The following issue was identified for investigation:

   - *Whether Dr D provided Mr A with an appropriate standard of care during Month3 to Month23 (inclusive).*

2. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

3. The parties directly involved in the investigation were:

Mr B	Complainant/brother
Mr C	Complainant/father
Dr D	Provider (GP)

4. Further information was received from:

Medical centre	GP practice
Health NZ	Provider
Private hospital	
Help line	
Private ENT surgeon	
Anaesthetist	
Psychologist	

5. In-house clinical advice was obtained from GP Dr David Maplesden (Appendix A).

Information gathered during investigation

Background

6. Mr A was a young man who had struggled with episodes of anxiety and depression at times throughout his life. He sought help for his symptoms, including difficulty sleeping, from his GP, Dr D, whom he had known for several years and with whom he had had a trusting therapeutic relationship.

7. Mr A's brother, Mr B, told HDC that Mr A's mental health deteriorated over a period of 12–18 months, culminating in a rapid deterioration in the two weeks prior to his tragic death.

8. This report assesses the care provided to Mr A in the 18-month period leading up to his passing, including the prescribing of zopiclone[1] to assist him with sleep. It is important to note that the post-mortem toxicology results indicated that all medications, including zopiclone, were measured at levels consistent with normal therapeutic use. Whilst this report discusses the prescribing of zopiclone in the context of the care provided to Mr A in the months prior to his passing, there is no indication that zopiclone is directly implicated in his death.

9. On 25 Month1, Dr D saw Mr A for issues related to old injuries. Dr D told HDC that he had known Mr A since 2003, and Mr A had begun to see him again after returning to New Zealand from one of many trips overseas. Dr D said that he referred Mr A to an otolaryngologist,[2] for difficulty breathing through the left nostril due to an old injury.

10. There is no record of a discussion regarding difficulty sleeping, but 20 tablets of zopiclone 7.5mg (0.5–1 tablet to be taken as needed at night) was prescribed. This is the usual dose recommended for an adult. Dr D informed HDC that Mr A 'had a history of difficulty with sleeping which was partially related to his chronic nasal obstruction'.

First presentations with low mood

11. Mr A consulted Dr D on 9 Month3 with issues of low mood, erratic sleep, and relationship issues. Dr D told HDC that previously Mr A had had counselling for low mood while he was overseas, and in the past he had used an antidepressant medication, citalopram, which was an older version of escitalopram.[3] At this appointment, Dr D prescribed Mr A a three-month supply of escitalopram and a further 20 tablets of zopiclone. No safety-netting information was provided, and no plan to follow up or review Mr A was documented.

12. Mr A saw Dr D again on 24 Month5. Mr A's clinical record noted that he had plans to travel and stated: 'mood improved ++'.

13. On 1 Month9, Mr A saw Dr D for colorectal symptoms. Dr D told HDC that Mr A had stopped taking escitalopram after two weeks because he did not like the depersonalising effect it had on him, and that anxiety and sleep remained an issue. Dr D prescribed Mr A a one-month supply of mirtazapine,[4] a new medication, which Dr D intended to review in a month's time. However, there is no record that a review occurred.

14. On 13 Month11 Mr A requested an additional prescription for zopiclone, stating that he had lost the previous script while moving house and was not sleeping well.

15. On 22 Month12 the usual prescription of zopiclone was sent through to Mr A's local pharmacy.

[1] A hypnotic medication used for the treatment of insomnia.
[2] Ear, nose, and throat surgeon.
[3] Antidepressant medication.
[4] Medication used to treat moderate to severe depression.

16. Contemporaneous clinical records show that during this period, zopiclone continued to be prescribed as a regular medication. The dose remained at 7.5mg, 0.5–1 tablet as needed at night.

Deterioration in mood and counselling sessions — Months 14–16

17. Dr D explained that when he saw Mr A on 5 Month14, he was well, aside from difficulty with sleep. Mr A had had recent surgery on his nose and was planning to travel overseas. He asked for a prescription for zopiclone sufficient to cover his trip overseas. At this time, his zopiclone prescription was increased to double the previous dose by doubling the number of tablets (7.5mg, 1–2 tablets as needed at night — 40 tablets). Dr D told HDC that the reason for this change was to ensure that Mr A would have enough medication to cover his travel period. Zopiclone is a medication that is restricted to monthly prescribing. To enable patients to access medication for longer than one month without needing another prescription, it is common practice to prescribe an increase in dose, allowing for additional tablets to be dispensed.

18. Dr D saw Mr A again on 21 Month15, by which time New Zealand was in lockdown due to COVID-19. Dr D documented that Mr A's planned travel was unable to go ahead and he was feeling frustrated, and Dr D arranged to see him for a counselling session, which occurred on 4 Month16.

19. The clinical record shows that Mr A's regular prescription of zopiclone was not reduced following the cancellation of his travel plans. It remained at 7.5mg, 1–2 tablets as needed at night — 40 tablets. Dr D told HDC that Mr A was experiencing multiple physical problems, and that in this context, insomnia was an increasing problem, causing Mr A to take zopiclone more regularly, which '[he]expect[s] justified the increased quantity'.

20. Dr D told HDC that at the counselling session on 4 Month16, Mr A reported being frustrated with the cancellation of his travel plans and having relationship issues. His mood had deteriorated to the point where he was feeling trapped and hopeless, and he had thoughts of suicide. His PHQ9[5] score was 23 (severe). This is supported by clinical notes taken at the time, which confirm the PHQ9 score and state that Mr A had low mood, black feelings, and hopelessness, with suicidal ideation.

21. Dr D diagnosed Mr A with depression and scheduled a further counselling session. Dr D prescribed another antidepressant medication, sertraline[6] 50mg to be taken at night.

22. Dr D reviewed Mr A three days later, on 7 Month16. It was documented that Mr A reported sleeping better and was feeling a little better, although he had decided not to take the sertraline as he wanted to manage without medication. His PHQ9 score had reduced to 18 (moderately severe). Dr D demonstrated mindfulness techniques and discussed further reading on self-help through depression. Dr D told HDC that Mr A did not consent to family involvement.

[5] Patient Health Questionnaire 9. A tool used to screen for the presence and severity of depression and to monitor response to treatment. A score between 20 and 27 is rated as severe.
[6] Medication used to treat depression and other conditions.

23. At a further counselling session with Dr D on 14 Month16, Mr A admitted struggling with low mood in the morning and having occasional thoughts of suicide. The lockdown restrictions meant that he had been unable to go to the gym and was keen to return. He was taking zopiclone at night for sleep issues but no other medication for mental health concerns.

24. Also on this day, Dr D referred Mr A to external counselling services.

Incident on 4 Month17 and first contact with mental health services

25. On 4 Month17 Mr A harmed himself. He self-rescued by contacting a friend, who took him to the Emergency Department at the public hospital.

26. The clinical notes record that Mr A denied intending to harm himself. He did acknowledge his struggles with low mood and was seen by Liaison Psychiatry prior to being discharged home. Mr A appeared more forthcoming with the Liaison Psychiatry Nurse Specialist. The record states:

> 'Reviewed prior to discharge, [Mr A] is ambivalent re the intent of [self harm] last night, did not believe it would be fatal, however does experience frequent suicidal ideation. Currently has regular contact with trusted GP who has organised psychology referral, encouraged to action this. Given resource information to utilise & emergency contact numbers for MHS [Mental Health Services]. We will send letter to GP.'

27. The clinical summary sent to Dr D on 4 Month17 informed him that full notes on the Liaison Psychiatry contact were available on an online portal 'via mental health'. A follow-up letter, which also contained the detailed summary that was on the online portal, was sent to Dr D on 8 Month18. An apology for the delay is included in the letter, which indicates that a comprehensive discussion took place.

28. The detailed summary outlined that at his presentation to the ED, Mr A admitted feeling low and having passive thoughts of suicide prior to harming himself, but he did not think that the method of self harm would kill him. Mr A told the Liaison Psychiatry nurse that he was ambivalent about the fact that he had survived.

29. The summary also stated that Mr A discussed several factors that were affecting his mental health with the nurse specialist from the Liaison Psychiatry service. These factors had resulted in strong feelings of worthlessness and emptiness for several years, and had caused anxiety and panic episodes, and regular and increasing suicidal ideation (with no intent or plan). His anxiety symptoms were chronic and distressing, and he worried a lot at night.

30. It is recorded that Mr A informed Liaison Psychiatry that he had never engaged with psychological input previously, but he had an appointment to start the first of four funded sessions that had been arranged by his GP. The benefits of psychological input were discussed with him, and he was given information and encouraged to attend the sessions. The summary stated that Mr A did not meet the criteria for Community Mental Health specialist input.

Arrangements for counselling and further appointments with Dr D

31. Dr D told HDC that on 8 Month17 he received correspondence that Mr A had not engaged with the Psychology Counselling Service to which he had referred Mr A (see paragraph 24). Mr A had reportedly not responded to attempts to contact him via phone, and therefore the referral was declined due to 'patient not contactable'.

32. As noted, Dr D was made aware of the self harm incident via a letter dated 4 Month17. On 22 Month17 Dr D provided Mr A with another prescription of zopiclone, without seeing Mr A in person. The dose remained at 7.5mg, 1–2 tablets at night (40 tablets), which had been unchanged since Mr A's admission to the Emergency Department on 3 Month17. At this point, Dr D had not seen Mr A face to face since 14 Month16.

33. Mr A's next appointment with Dr D was on 16 Month18, for chronic nasal congestion and insomnia. Mr A was prescribed a further 40 tablets of zopiclone (enough for a further few weeks). There is no record of Dr D having considered transitioning to weekly dispensing at this stage, nor of considering other strategies to manage any risk. Dr D informed HDC that at that time, Mr A had not replied to calls from the psychology service, and he was re-referred.

34. In his response to HDC, Dr D said that he did not assess Mr A's use of zopiclone to treat insomnia as a risk factor in and of itself and said that Mr A saw the ability to access zopiclone, at the dose prescribed, as protective. Dr D stated:

> '[O]ver the years we discussed many other options for treatment. [Mr A] was keen on finding natural solutions but ultimately, [Mr A] found that zopiclone was the most effective tool to at least give him some sleep. Mr A found it difficult to shut down when he went to bed at night. Zopiclone provided him a means for some relief from his anxious and ruminating thoughts. I considered it important and productive for his mental health that [Mr A] be assisted to get some sleep through the relevant period.'

35. The clinical record shows that on 21 Month19, Mr A requested buspirone[7]and further zopiclone. Dr D was on leave, and therefore Mr A's request was reviewed by another GP at the medical centre, who declined a prescription of buspirone as there was no record of it having been prescribed previously. The GP prescribed a limited number of zopiclone tablets (10 tablets) and recorded that this needed a face-to-face review. It was documented that Mr A was telephoned and advised that he needed to make an appointment to see Dr D for those matters.

36. Dr D told HDC that the last time he saw Mr A in person was on 27 Month21. Dr D said that Mr A's mood had improved but was still low. He recalled that Mr A told him that he did not want to involve his family in his problems. Dr D said that counselling and mindfulness were discussed, and 24 tablets of zopiclone were prescribed. The clinical record supports Dr D's comments. A PHQ9 score of 14 is recorded, which falls at the high end of the moderate range.

[7] Medication used for the treatment of anxiety disorders.

37. On 5 Month22 Mr A attended the first of four funded external cognitive behavioural therapy (CBT) sessions. These sessions were with a psychologist.

38. A further prescription for zopiclone (24 tablets) was provided by Dr D on 10 Month22.

Deterioration in wellbeing

39. At the second CBT session with the psychologist, which occurred on 12 Month22, it was documented that Mr A's mood had deteriorated significantly due to a recent event. The record states that Mr A had suicidal ideation with high intent but no plan. The psychologist documented that he attempted to establish a safety plan, but Mr A was not able to guarantee safety. This prompted the psychologist to email the public mental health crisis team. Health NZ mental health services assessed Mr A on 13 Month22. He was prescribed sertraline, lorazepam,[8] and zopiclone 3.75–7.5mg. Mr A was put on weekly dispensing and asked to return any excess medication prescribed previously. A follow-up plan was arranged, and Mr A continued to have regular contact and review over the next few weeks.

40. On the evening of 2 Month23 Mr A contacted a help line that told HDC that it received a call from Mr A's number, but he did not leave his name, and he disconnected before a full assessment of risk could be done. The staff member attempted to call back but there was no answer. Sadly, Mr A was found deceased the following morning. The autopsy found that the direct cause of Mr A's death was not related to his medications, which were all reported to be below or consistent with normal use.

Relevant standards

Medical Council — Good prescribing practice

41. The Medical Council of New Zealand (MCNZ) produced a statement on good prescribing practice, which was updated in Month14. I have referred to the MCNZ statement that was available to Dr D at the time of the events, dated November 2016, although the information below is consistent in both versions.

42. The initial paragraph states:

> 'Good prescribing practice requires that a doctor's customary prescribing conforms within reason to patterns established by the doctor's peers in a similar practice. Inappropriate prescribing (which may include indiscriminate, excessive or reckless prescribing) is unacceptable, both clinically and ethically.'

43. Zopiclone is a medication that has the potential for addiction. The relevant section on prescribing medication with a risk of addiction or misuse states that doctors should keep in mind the possible consequences to patients, which include overdose, development of a

[8] Medication used to treat moderate to severe anxiety and insomnia associated with anxiety.

drug habit, and patient safety. A list of warning signs includes, 'nominates the medicines they are seeking' and 'obtains medicines from multiple prescribers'.

44. The section on shared care between clinicians states:

> '[T]he doctor with the responsibility for continuing management of the patient has a duty to keep him or herself informed about the medicines that are prescribed and the monitoring required for patients on that medicine to ensure safe and effective use.'
>
> 'If you are the doctor signing and issuing the prescription you bear responsibility for that treatment; it is therefore important that, as the prescriber, you understand the patient's condition as well as the treatment prescribed and can monitor any adverse effects of the medicine should they occur.'
>
> 'In most circumstances there should be timely and full information flow between all doctors responsible for the care of the patient and other relevant health practitioners about the indications and need for particular therapies.'

45. The section on prescribing for patients abroad or travelling abroad states:

> 'For patients travelling overseas and returning to New Zealand within the timescale of a normal prescription (usually 1 and no more than 3 months …), medication should be prescribed in sufficient quantity to cover the period overseas provided that it is clinically appropriate. It may be useful for the prescribing doctor to provide a supporting letter that lists the names of all medicines prescribed to the patient and the total amount of medicines prescribed for the period of travel.'
>
> 'For longer trips away (over 3 months), the patient should be advised to register with a local doctor in the destination country for continuing medication.'

Medsafe data sheet and prescriber update for zopiclone

46. Medsafe issued a prescriber update entitled 'Zopiclone — Indicated for short-term use only'. The key messages in the update were that zopiclone should be used at the lowest effective dose for a short period, no longer than four weeks. The safety and effectiveness of prescribing zopiclone for longer periods had not been established, and there were risks associated with long-term use, including tolerance and dependence.

47. The update recommended that zopiclone used to manage insomnia should be used in conjunction with non-pharmacological approaches such as managing expectations, improving sleep hygiene, lifestyle factors, and addressing underlying health conditions.

48. The Medsafe data sheet that was available at the time zopiclone was prescribed to Mr A reiterates the message that zopiclone should be prescribed for short-term use.[9]

[9] On 2 May 2023 the prescription was revised to specify a period of 7–14 days.

49. At the time of the events, the data sheet contained the following information on the recommended dose for an adult: '7.5mg by oral administration shortly before retiring. This dose should not be exceeded.'

50. The Medsafe data sheet stated that epidemiological studies had identified an association with zopiclone use and psychological adverse events such as depression and suicide, although it had not been established that zopiclone caused an increase in psychiatric conditions. The data sheet included specific information on prescribing zopiclone to patients who had been diagnosed with depression. It stated:

> 'As with other hypnotics, zopiclone does not constitute a treatment of depression and may even mask its symptoms. Caution should be exercised if zopiclone is prescribed to depressed patients, including those with latent depression, particularly when suicidal tendencies may be present and protective measures may be required.'

51. I note that after the events, on 1 July 2023 zopiclone was reclassified[10] and added to the controlled drug schedule, making it subject to the prescribing and dispensing requirements specified in the Misuse of Drugs Act 1975 and the Misuse of Drugs regulations 1977.

Responses to provisional report

52. Mr C was provided with a copy of the 'facts gathered' section of my provisional opinion and given the opportunity to comment. Mr C expressed his hope that this Office take regard to what he described as the failure of Dr D to provide greater safeguards as a result of a subjective belief that he knew Mr A well.

53. Dr D was provided with a copy of my provisional opinion and given the opportunity to comment. Dr D advised HDC that he accepted my opinion and recommendations and had no further comments.

Opinion: Dr D — breach

Introduction

54. It is evident from the information gathered during this investigation that Mr A had struggled with anxiety and depression for a long time and was dealing with multiple stressors in his life that were affecting his mental health. In addition, activities that he enjoyed and used to improve his mood were restricted because of the COVID-19 pandemic. My deepest sympathies are extended to the family, who are dealing with the loss of a beloved son and brother.

[10] Medsafe — Upcoming reclassification of fentanyl, tramadol, zopiclone and zolpidem. 19 June 2023 https://www.nzoa.org.nz/sites/default/files/Upcoming%20reclassification%20of%20fentanyl%2C%20tramadol%2C%20zopiclone%20and%20zolpidem%20(19%20June%202023).pdf Accessed 1 February 2024.

55. I acknowledge the support provided by Dr D in the form of counselling sessions and discussion on self-help and mindfulness. It is clear from the documents provided to HDC that Mr A had a good therapeutic relationship with Dr D and was comfortable to discuss his distress and seek support.

Review of new medication

56. A three-month supply of escitalopram was prescribed by Dr D on 9 Month3. This was a new medication, although Dr D informed HDC that Mr A had used an older form of escitalopram previously.

57. Dr Maplesden is mildly to moderately critical of this consultation and considers that it was not documented adequately, particularly the assessment of self-harm risk and follow-up arrangements. Dr Maplesden stated:

> 'I believe prescribing of a three-month supply of escitalopram (which I have assumed did not have any dispensing restriction) without any scheduled follow-up (or documented attempts at follow-up) or documented risk assessment was inconsistent with accepted practice (per cited HealthPathways guidance). I acknowledge this was a recurrence of depressive symptoms rather than a new diagnosis, and I assume [Mr A] had responded positively to escitalopram in the past without adverse effects. Nevertheless, I believe [Dr D's] management of [Mr A] on this occasion, with respect to prescribing and follow-up, would be met with mild to moderate disapproval by my peers.'

58. I accept Dr Maplesden's advice and am critical of the lack of follow-up to assess Mr A's response to newly prescribed medication.

59. I am also cognisant of a similar occurrence when Dr D prescribed mitrazopine on 24 Month5, intending to review after one month. The review appears not to have occurred, although on this occasion only one month's supply of medication was prescribed. I remind Dr D of the importance of appropriate documentation and review of new medications, and I recommend that Dr D review the HealthPathways guidance cited in Dr Maplesden's report.

Prescribing of zopiclone — breach

60. In his complaint, Mr B raised concerns about the regular prescriptions that Mr A was receiving from his GP. Mr B told HDC that he believed Mr A had substance dependency issues and, despite documented substance abuse behaviour, Mr A was in possession of a large quantity of prescription medication, including regularly prescribed 'benzodiazepines[11]'. I am concerned about the prescribing of zopiclone, and in making my decision I have relied on standards and information available at the time, along with the clinical advice provided by Dr Maplesden.

[11] Benzodiazepines are medications that slow down activity in the brain and nervous system. They can be misused or abused, and their use can lead to dependence, even when taken at the recommended dosage. New Zealand dispensing data shows that diazepam and lorazepam are the most dispensed benzodiazepines.

61. For clarity, zopiclone is a hypnotic medication used to treat insomnia. There is no record of Dr D having prescribed Mr A benzodiazepines. Mr A was prescribed a benzodiazepine (lorazepam) by mental health services in Months 22–23.

Over prescribing

62. Mr A was prescribed zopiclone on 25 Month1 on his first visit following his return from overseas. This initial prescription dose was consistent with recommended practice and in line with the data sheet provided by Medsafe (see paragraph 49). Dr D continued to prescribe zopiclone regularly at the same dose up until 5 Month14. Although prescribing zopiclone for longer than a period of four weeks is not in line with recommended practice, or consistent with the statement released by Medsafe on 7 June of 2019 titled 'Zopiclone — Indicated for short-term use only' (see paragraph 46), I accept Dr Maplesden's advice that, at the time, recommended practice and common practice differed regarding the prescribing of hypnotics, and Dr D's prescribing at this point was in line with common practice. I also accept Dr Maplesden's analysis of the prescribing pattern, and opinion, that there was no reason to suspect zopiclone abuse up to this point.

63. Following an appointment on 5 Month14, Mr A was prescribed zopiclone at double the recommended dose — a total of 40 7.5mg tablets (1–2 tablets to be taken as needed at night). Dr D told HDC that the rationale for prescribing this dose was that Mr A had requested sufficient supply of medication for a planned trip overseas.

64. The MCNZ good prescribing practice standards outline the process to be followed when prescribing for overseas travel. The standards do not state that it is appropriate to increase the dose to cover travel time. However, Dr Maplesden advised that increasing the daily dose of medication is a method commonly used by doctors to increase the number of tablets a consumer can have dispensed, as a pharmacist cannot dispense more zopiclone tablets than is required to fill a one-month prescription. Initially, Mr A's dose was increased in line with this practice, and I am not critical of this.

65. However, due to the COVID-19 pandemic, Mr A's trip was cancelled, but the daily dose of zopiclone he had been prescribed remained the same higher dose from 5 Month14 until his death on 2 Month23.

66. Dr D told HDC that Mr A had increased his use of zopiclone during a period when he was dealing with multiple physical issues. Dr D said that he did not assess Mr A's use of zopiclone to treat insomnia as a risk factor in and of itself. He told HDC that he believed that Mr A was taking zopiclone as directed, and he had no concerns regarding a pattern of abuse.

67. Dr Maplesden acknowledged that there is a tension between addressing the distress Mr A's insomnia was causing him and the risk of him stockpiling zopiclone. However, Dr Maplesden's view is that by 16 Month18, Mr A's apparent increasing use of zopiclone indicated use in excess of the daily dose recommended by MedSafe. By 16 Month18 weekly dispensing should have been considered, or alternatively a robust assessment of current patient safety documented.

68. I agree with this advice. I note that the over-prescribing of zopiclone was common but not necessarily good practice. I also accept that initially the high dose of zopiclone was prescribed for convenience to cover a period of travel, and that Mr A had a therapeutic relationship with Dr D. However, I am critical that Dr D continued to over-prescribe zopiclone to Mr A for long periods, sometimes without face-to-face review. Mr A's diagnosis of depression increased the risk profile, and as stated in the MedSafe datasheet, should have prompted additional caution. Further, as noted by Dr Maplesden, by 16 Month18 the pattern of zopiclone use indicated that the daily recommended dose was being exceeded. I also note that at this time, Mr A was not engaging with the mental health services to which he had been referred. Lastly, I note that a month after this consultation, in Month19, another GP at the medical centre did take action to limit the supply of zopiclone in that he prescribed only 10 tablets and documented the need for a face-to-face review. I also note that it was not until the urgent care mental health service became involved, on 13 Month22, that weekly dispensing was implemented. Considering all the above, in my view, by 16 Month18 it was inappropriate for Dr D to be continuing to prescribe zopiclone at this level with no actions (such as considering weekly dispensing) taken to address Mr A's risks.

Action taken following self-harm of 4 Month17

69. Dr Maplesden was critical of the care provided by Dr D on 22 Month17 following Mr A's admission to the Emergency Department. Dr Maplesden noted that on 4 Month17 Dr D received a clinical summary informing him of the self-harm event, and on 8 Month17 he received a notification from Primary Mental Healthcare informing him that the referral he had sent though had been rejected because Mr A could not be contacted. Dr D went on to prescribe Mr A further zopiclone on 22 Month17 without a face-to-face review.

70. Dr Maplesden found a mild to moderate departure from the accepted standard of care. It is his view that, under the circumstances, it was unwise for Dr D to prescribe further zopiclone (40 tablets) to Mr A on 22 Month17 without prior contact (ideally face to face) to establish his current mood and safety. Dr Maplesden is also somewhat surprised that there was no documented attempt by practice staff (at Dr D's request) to ascertain Mr A's wellbeing and need for re-referral when the rejected psychology referral was received.

71. I accept Dr Maplesden's advice and am critical that Dr D did not establish contact with Mr A to assess his mood and safety before continuing to prescribe zopiclone on 22 Month17, considering evidence that Mr A was not engaging with other health services, and the information available to Dr D regarding Mr A's mental state after he harmed himself (see paragraphs 26–30).

Conclusion

72. In my view, the failure to manage the risk of stockpiling medication while prescribing double the recommended dose of zopiclone to a patient with diagnosed depression, and the failure to take immediate action to limit the supply of zopiclone or document a robust risk assessment following a self-harm event compromised patient safety. I consider that Dr D failed to provide services to Mr A in a manner that minimised potential harm, and

therefore I find that Dr D breached Right 4(4)[12] of the Code of Health and Disability Services Consumers' Rights.

Recommendations

73. I acknowledge the communication from Dr D in response to reviewing Dr Maplesden's advice. Dr D stated that he reviewed the bpac[nz] article cited in Dr Maplesden's report and found it informative. I also acknowledge Dr D's reflection and agreement that he should have prescribed a one-month trial of escitalopram.

74. I recommend that Dr D:

a) Provide a formal written apology to Mr A's family for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr C.

b) Review the region's HealthPathways guidance on 'Depression in Adults and Older Persons' and provide HDC with a written reflection on the learning gained, within six weeks of the date of this report.

c) Audit the last 20 patients for whom he has prescribed zopiclone, to determine the degree of compliance with the recommendations included in the Medsafe data sheet for zopiclone. A summary of the audit findings with any corrective actions is to be provided to HDC within one month of the date of this report.

Follow-up actions

75. A copy of this report with details identifying the parties removed, except the clinical advisor on this case, will be sent to the Medical Council of New Zealand. It will be advised of Dr D's name.

76. A copy of this report with details identifying the parties removed, except the clinical advisor on this case, will be sent to Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[12] Right to services of an appropriate standard: (4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

Appendix A: In-house clinical advice to Commissioner

The following advice was obtained from Dr David Maplesden on 30 August 2021, and an addendum was included on 9 January 2024. Dr Maplesden is a registered GP who has been a practising GP since 1986. He has provided clinical advice to this Office since January 2009.

'1. My name is Dr David Maplesden. I am a graduate of Auckland University Medical School and I am a practising general practitioner. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr B] about the care provided to his late brother, [Mr A], by [Dr D] of the medical centre. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from [Mr B]
- Response from [Dr D]
- GP notes [medical centre]
- Clinical notes [private hospital]
- Clinical notes [public hospital]
- Coronial post-mortem result

3. [Mr A] sadly passed away on 2 [Month23] [in his twenties]. Coronial post-mortem established cause of death to be …. Toxicology results did not show presence of any drug levels beyond that expected by normal therapeutic use. [Mr B] raises concerns at the prescribing of zopiclone and benzodiazepines to his brother in the 18 months leading up to his suicide, including the comment that his brother suffered from a benzodiazepine dependence. I have been asked to review the following issues:

- *Whether the care provided by [Dr D] at each appointment was adequate/ appropriate.*
- *Whether the management of his prescriptions and repeat prescription requests was adequate/appropriate, in particular following his [self-harm] in [Month17].*
- *Comment on [Mr B's] (complainant) concern that [Mr A] had developed a benzodiazepine dependence.*
- *Any other issues that you consider amount to a departure from accepted practice.*

4. [Dr D] notes in his response: *I had known [Mr A] since he was 13 years old. I have counselled him many times over these years. He was at his happiest when travelling overseas. He had a history of anxiety and depression but never found antidepressants to be of any help. He had long standing sleep issues which were exacerbated by his chronic nasal obstruction. Zopiclone appeared to be the only effective solution for his sleep. He had had repeated counselling, have explored mindfulness and read widely on*

self-help for his depression. I did not prescribe benzodiazepines at all. I discussed the prescribing risks of zopiclone with [Mr A] but could find no other immediate solution. [Mr A's] actions in the end were a complete surprise to me. My subsequent comments are made with the knowledge that [Dr D] had a longstanding therapeutic relationship with [Mr A] which [Mr A] reported to other providers as being a good relationship. I believe in this context, it was reasonable for [Dr D] to rely on his familiarity with [Mr A's] historical presentations as well as the current presentations to ascertain the likely degree of psychological distress and risk [Mr A] was presenting, and how much trust he could place in [Mr A's] responsibility to self-manage his medications. The impression from this type of assessment is sometimes at odds with "objective" tools such as the PHQ9 questionnaire. Furthermore, there are many subtle observations involved in a face-to-face consultation that may not be evident from the clinical notes but which may influence management decisions. I refer to the [local] Region HealthPathways section "Depression in Adults and Older Persons" as a representation of recommended best practice guidance in the clinical scenario described by this case. Below is a summary of relevant consultations and other clinical interactions between [Dr D] and [Mr A] from [Month1] to [Month23]. Prescriptions for zopiclone for the same period are summarised in Appendix 1. There is no record of [Dr D] prescribing [Mr A] benzodiazepines over this period although lorazepam was prescribed by DHB mental health services in [Month22] and [Month23].

5. [Medical centre] 25 [Month1] — issues of chronic nasal congestion and right thumb pain following [old injuries] discussed and referrals subsequently made to [orthopedic surgeon] (metalware removed R thumb 22 [Month10]) and [an ENT surgeon]. Notes also refer to difficulties with a sensitive issue while overseas. There is no specific documentation of disordered sleep. Small supply of zopiclone provided (20 tabs, ½ to 1 nocte).

Comment: Several unrelated issues were addressed apparently including longstanding insomnia. Best practice would be to document all new issues raised. I note [Mr A] later requested a prescription for zolpidem (a hypnotic similar to zopiclone but not available in New Zealand) suggesting he may have received similar treatment for insomnia when overseas in the past. A small supply of zopiclone was prescribed on this occasion which is consistent with recommended practice[1]. The cited Medsafe reference includes: *Zopiclone is indicated for short-term treatment of insomnia. Treatment with zopiclone should not exceed 4 weeks* which reiterates previous prescribing instructions. However, there is a gap between recommended best practice and common practice in regard to prescribing of hypnotics. A 2021 BPAC article[2] (update of a 2015 review) noted: *Zopiclone is the most widely dispensed funded hypnotic medicine in New Zealand. The number of people dispensed zopiclone in the 12 months from [Month9] to [Month20], was greater than the total number of people*

[1] Medsafe. Zopiclone — Indicated for short-term use only Prescriber Update 40(2): 32, Month5. https://www.medsafe.govt.nz/profs/PUArticles/June2019/Zopiclone-Indicated-for-short-term-use-only.htm Accessed 30 August 2021

[2] https://bpac.org.nz/2021/benzo-zopiclone.aspx Accessed 30 August 2021

dispensed any benzodiazepine … Many patients are being prescribed large quantities of zopiclone: one-fifth of people dispensed zopiclone received 180 or more tablets in the 12 months from [Month9] to [Month20]. [Mr A] was in this category. While I make further comments regarding zopiclone prescribing subsequently, my general comment is that although [Dr D's] prescribing of zopiclone for [Mr A] departed from best practice, it was not necessarily a departure from common practice. [Mr A's] overall use of zopiclone over the period examined was the equivalent of about 0.7 of a 7.5mg tablet each night on average. He did not show any prescription request or use pattern to suggest zopiclone abuse, but if he suffered symptoms such as rebound insomnia when he stopped taking the drug, he may have become dependent on it. However, I am unable to confirm this.

6. [Medical centre] 9 [Month3] — notes include: *low moods, no issues at work, wary in relationships, sleep erratic, has had counseling in the past, has been on SSRI in past.* Prescription provided for zopiclone x 20 and escitalopram 10mg x 90. There is no record of follow-up plan or safety netting provided. [Dr D] notes in his response that [Mr A] had used escitalopram in the past, and had received counselling overseas for low mood.

Comment: While I regard [Dr D's] longstanding relationship with [Mr A] and familiarity with his history as mitigating factors, I believe this consultation is inadequately documented particularly with regard to assessment of self-harm risk and follow-up arrangements. I believe prescribing of a three-month supply of escitalopram (which I have assumed did not have any dispensing restriction) without any scheduled follow-up (or documented attempts at follow-up) or documented risk assessment was inconsistent with accepted practice (per cited HealthPathways guidance). I acknowledge this was a recurrence of depressive symptoms rather than a new diagnosis, and I assume [Mr A] had responded positively to escitalopram in the past without adverse effects. Nevertheless, I believe [Dr D's] management of [Mr A] on this occasion, with respect to prescribing and follow-up, would be met with mild to moderate disapproval by my peers. If the recurrence of symptoms had occurred within a short time period following cessation of an effective therapeutic course of escitalopram, I would be somewhat less critical.

7. [Medical centre] 24 [Month5] — notes include: *travelling [overseas], mood improved ++*. Blood pressure checked and cryotherapy to cheek lesion. Zopiclone x 20 tabs prescribed.

Comment: [Mr A's] zopiclone use was modest (not daily). Management was reasonable.

8. [Medical centre] 1 [Month9] — presentation with colorectal symptoms (investigated with blood tests and fecal calprotectin). Noted intolerance of escitalopram (tiredness). Prescribed mirtazapine 20mg x 30 tabs and zopiclone x 20. No follow-up documented. Blood tests normal but calprotectin elevated and referral made for gastroenterology review. Ongoing gastroenterology review following

colonoscopy. Colonoscopy and biopsies 10 [Month9] normal and MRI enterography normal 21 [Month12].

Comment: There were two major issues addressed: rectal bleeding which was investigated and managed appropriately. Ongoing depressive symptoms with sleep disturbance evidently a prominent feature (although this was not well documented). [Mr A] had stopped escitalopram because of tiredness. Given the prominence of sleep disturbance symptom, it was reasonable to trial mirtazepine and to provide a one month supply. Zopiclone prescribing remained modest (20 tabs per prescription with prescribing records not suggestive of excessive (beyond prescribed dose) or escalating use. However, best practice in this regard is acknowledged as discussed previously. It is also best practice to document follow-up arrangements, particularly in regard to monitoring of response to mirtazepine.

9. [Medical centre] 4 [Month11] — URTI symptoms addressed (thumb surgery imminent). Zopiclone x20 tabs prescribed. On 28 [Month12] the prescribing instructions and dispensed amount of zopiclone was changed to zopiclone 1–2 nocte x 40 tabs (portal repeat prescription request). It is not evident from the clinical notes why these changes were made (prescriber recorded as [locum]). I am mildly to moderately critical at the increase in dose and prescribed quantity without any accompanying note to explain the rationale for the increase.

Addendum 9 January 2024. Prescriber [initials] was [a locum GP]. [The locum] has provided Testsafe records and an audit of the prescription he provided to [Mr A] on 28 [Month12] and I can confirm the prescription was for [Mr A's] "usual" dose of ½–1 7.5mg zopiclone nocte x 20 tabs. This prescription was dispensed to [Mr A] on 29 [Month12]. The increase in zopiclone dose and dispensed amount was made by [Dr D] on 5 [Month14] as [Mr A] was to be overseas for a period (see below). I therefore withdraw any adverse comment in relation to the prescription provided on 28 [Month12]. However, it is of some concern that the clinical record on that date was altered and became inaccurate, possibly due to some software malfunction. I recommend [Dr D] investigate this situation with the software provider.

10. [Medical centre] 5 [Month14] — URTI symptoms prior to planned travel overseas. [Mr A] was recovering from recent septoplasty (26 [Month13] — [ENT surgeon]). No reference to psychological symptoms. Zopiclone x 40 tabs prescribed. [Dr D] states this was sufficient to cover the anticipated period of overseas travel. A repeat prescription for zopiclone was provided on 21 [Month15] (travel was abandoned because of Covid restrictions) and review arranged within the next fortnight.

11. [Medical centre] 4 [Month16] — notes include: *QoL score: 2, Assessment: PHQ9 23. What matters: black feelings Goal: to feel better; Safety: reaching out for help; Practice Notes: low mood feelings of hopelessness, suicidal ideation.* Diagnosis of depression recorded and prescription provided for Sertraline 50mg x 30 tabs. Blood tests ordered (unremarkable results). No follow-up or safety netting advice recorded but review took place three days later 7 Month16 with notes: *feels a little better,*

sleeping better, decided not to take sertraline. QoL score: 5; Assessment: PHQ9 18; What matters: Managing thoughts; Goal: Tools to manage thoughts; Safety: reaching out for help; Practice Notes: feeling a little better, shown mindfulness technique, discussed further reading, did not start sertraline — would like to manage without medication. Further review undertaken on 14 [Month16] with notes: *QoL score: 4, Assessment: PHQ9 (not recorded); What matters: struggling with low mood in the morning; Goal: managing mood; Safety: reaching out for help; Practice Notes: still morning low mood, occ suicidal ideation, looking forward to getting back to gym, little work at present, reading self-help books.*

Comment: [Dr D] has elaborated in his response that he saw [Mr A] on 4 [Month16] and undertook counselling. Further counselling was undertaken on 7 [Month16] and improvement in PHQ 9 noted (score of 23 consistent with severe depression, 18 with moderate depression). A referral was made for community psychologist input following the third counselling session. The combined approach of counselling and antidepressant is consistent with accepted practice per cited HealthPathways guidance. It appears [Mr A] was enrolled for PHO funding of GP led counselling on 4 [Month16] and this required completion of a progress template at each review which then wrote back into the GP notes. This has given some structure to the consultations but as discussed in section 4, is unlikely to represent the complexity of the consultations. I believe management over this period was reasonable although more detailed documentation of the safety assessment and follow-up plan might have been desirable.

12. [Public hospital] ED: discharge summary filed at [the medical centre] 4 [Month17] referring to [Mr A's] attendance on 3 [Month17]. Summary includes: *Presents after taking 10 Zopiclone. Has a small amount of alcohol. Wanted to sleep so took tablets. However has also had low mood for some time (worsening). Has previously been on medications for depression but has been off them for 12 months. Feels worse on medications. Mental health is managed by GP. Also has a psychologist …* Examination was unremarkable and [Mr A] was referred for Liaison Psychiatry input prior to discharge. Psychiatry summary (as part of the ED discharge summary) records that full notes are available through the [online portal] and: *Reviewed prior to discharge. [Mr A] is ambivalent re the intent of [self-harm] last night, did not believe it would be fatal, however does experience frequent suicidal ideation. Currently has regular contact with trusted GP who has organised psychology referral, encouraged to action this. Given resource information to utilise & emergency contact numbers for MHS. We will send letter to GP.*

13. [Medical centre]: 8 [Month17] — note filed from Primary Mental Healthcare rejecting previous referral as [Mr A] was not contactable. Request for zopiclone received on 21 [Month17] and prescription provided on 22 [Month17] for zopiclone x 40 tabs (no consultation). [Mr A] seen by [Dr D] on 16 [Month18]. Notes are: *insomnia, has taken some CBD oil which helped, chronic nasal congestion.* No assessment of current mood documented. Prescription provided for zopiclone x 40 tabs and CBD oil.

Comment: Taking into account the reports received on 4 and 8 [Month17] and [Dr D's] contact with [Mr A] during the previous month, I am somewhat surprised there was no documented attempt by practice staff (at [Dr D's] request) to contact [Mr A] when the rejected psychology referral was received in order to ascertain his wellbeing and need for re-referral. I believe, under the circumstances, it was unwise for [Dr D] to prescribe further zopiclone (40 tabs) to [Mr A] on 22 [Month17] without prior contact (face to face ideally) to establish his current mood and safety given the preceding events. I believe [Dr D's] actions on this occasion would be met with mild to moderate disapproval by my peers. However, I note there was an assessment and re-referral for psychology input on 16 [Month18]. A further prescription for 40 zopiclone tabs was provided on this occasion suggesting [Mr A] was using in excess of a 7.5mg tab each night. [Dr D] notes in his response: *I did not assess [Mr A's] use of zopiclone to treat insomnia as a risk factor in and of itself. Indeed, [Mr A] saw the ability to access 1–2 zopiclone … to assist with sleep as protective. I also noted that the psychiatric liaison had not recommended stopping the prescribing of zopiclone and had also noted that [Mr A] did not meet the criteria for Community Mental health specialist input.* I acknowledge the tension between addressing the distress [Mr A's] insomnia was causing him and the risk of him stockpiling zopiclone …. While weekly dispensing does not completely remove the risk of stockpiling, I believe this strategy required consideration under the circumstances (apparent increasing use of zopiclone (transient in hindsight), recent [self-harm]) or at least a robust (and documented) assessment of current patient safety if this strategy was not to be considered. I am mildly critical of the standard of clinical documentation for the consultation of 16 [Month18], and I believe a significant number of my peers would have considered restricted (weekly) dispensing of zopiclone if the drug was to be continued.

14. 8 [Month18] [DHB] Liaison Psychiatry full report received in relation to ED attendance on 3 [Month17]. [Mr A's] past psychiatric history and current issues described in some detail. Relevant extracts include:

- *endorses anxiety as his main issue of long duration and in varying degrees since age 22 with accompanying negative self cognitions and feelings of worthlessness, nil psychotic sx, …*
- *He has suffered with strong feelings of worthlessness and emptiness for several years. He experiences panic episodes and passive SI (with no intent or plan) regularly — says this has been increasing over the past year … Nil suicide attempts in past. Nil deliberate self harm behaviours …*
- *He has trialled 2x SSRI's via GP. Says he has not been taking the prescribed Sertraline (prescribed after he rang his GP several weeks ago and was very tearful on the phone — spoke to GP for a while) as he does not like the "numb" feeling he gets from antidepressant medication … Good relationship with GP …*
- *Nil sx of overt depression although he has had sleep problems for many years — worries a lot at night. Using Zopiclone for sleep via GP. His sx of anxiety appear to be chronic and distressing for him. He describes distorted negative self cognitions which occur daily. As noted above he states he has passive thoughts of suicide but has never acted on these until his seemingly ambivalent [self-harm] last night.*

- *Discussion/education around benefits of psychological input. Validation given around his insight into psychological issues he would like to address. [Mr A] given literature around anxiety/online CBT information and [DHB] mental health crisis number. Also given information on low cost therapy options in [area] … [Mr A] feels future focused and is looking forward to engaging in psychology sessions organised via GP (he understands that this is a beginning in terms of psychological input and he will need to look into longer term low cost options for therapy after this). He does not meet criteria for CMHC input. He feels safe for d/c.*

15. [Medical centre]: 21 [Month19] — practice nurse notes include: *Request via CM for repeat medication and also referral to [psychologist]. Rx to fax as below. Has seen [Dr D] in last 6/12. Requesting buspirone & zopiclone Deferred to [locum GP] to complete request or if needs a review or virtual consult.* Provider [locum] provided a prescription for a small supply of zopiclone (x10 tabs) but declined to provide buspirone with supporting documentation: *request for: 1. buspirone — no record of prior Rx, declined; 2. zopiclone — ... subsequent Rx 16/7/20. This needs a face to face review; 3. referral letter to [psychologist] — best written by his usual GP who returns from leave next business day Plan: Rx zopiclone 10 tabs, to make appt with [Dr D] for the other issues*.

Comment: I believe [the locum] provider[s] actions were consistent with accepted practice. It would certainly have been inappropriate to prescribe a new psychoactive drug (buspirone) without patient review and I note [the locum] appropriately considered [Mr A's] recent self-harm attempt in the decision to prescribe only a small amount of the requested zopiclone and to advise face-to-face review before any further prescribing.

16. [Medical centre] 27 [Month21]. Notes include: *mood down, [family member with health issues]. QoL score: 6; Assessment: PHQ9 14; What matters: managing mood; Goal: managing mood; Safety: reaching out for help; Practice Notes: fluctuating mood, insomnia, … discussed mindfulness* Zopiclone x 24 tabs prescribed. Referral made again to Primary Mental Healthcare for community psychologist input and acceptance letter received 5 [Month22] ([psychologist]) noting first appointment scheduled that day. [Mr A] not seen subsequently at [the medical centre] but a further prescription was provided as per Appendix 1.

Comment: Management and documentation was reasonable taking into account use of the template previously referred to and concurrent referral for psychologist input. It appears [Mr A] had had a period of mood stability and improved sleep in the preceding two months with no request for medication over that time, and there was no further request received to reactivate the psychology referral. I note [Dr D] did not see [Mr A] again, but a further prescription for zopiclone x 24 tabs was requested by [Mr A] (and supplied by [Dr D]) on 10 [Month22]. This was two weeks following the previous prescription which indicated frequency of use similar to that of [Months 18–19], and [Mr A] was receiving psychologist input over this period. The prescription was

requested and provided prior to receipt of [Mr A's] reported contact with the DHB Urgent Response Team (see below).

17. Report received from [the psychologist] on 5 [Month22] giving basic background information on [Mr A's] mental health issues. Further report dated 13 Month22 includes: *[Mr A] presented with sig. low mood after breaking up with his gfriend the previous day. He reported sig. suicidal ideation, with moderate–high intent (6–9/10), with no plan. [Mr A] very socially isolated, and not willing to make contact with anyone. Reluctant to discuss current distress and SI with parents given [ill health of family member]. Attempts to establish safety plan, although [Mr A] unable to guarantee safety. [Mr A] open to writer ringing the crisis team to inform them of his risk.* Crisis team was contacted.

18. 13 Month22 — detailed report (4 pages) received from DHB Mental Health Services (Urgent Response team) signed by [psychiatrist]. Relevant extracts include:

- *[Mr A] reported longstanding depression and anxiety which has become progressively worse over the last year and acute deterioration with suicidal ideation in the last two days following relationship break up.* Past history of recurrent concussions also noted.
- *He described his mood as "low". Rated it as 2/10 today, over the last 1/12 it has ranged from 1–4/10 … Sleep — sleeps ok with Zopiclone — from 10pm to 5am but then lies in bed for a few hours ruminating (negative self-cognitions), mind "doesn't shut down".*
- *Current risk — describes having intermittent suicidal ideation for several years but last night it was "very extreme ... wanted to die". No specific plans or researching means but started to think about what he would put in a goodbye letter, made "key notes". Today SI has lessened a bit, feels numb to the world and has on going passive ideation.*
- *Has been prescribed SSRI's in the past, escitalopram and citalopram Stopped Escitalopram after a couple of weeks as felt constantly drowsy. Wanted to "beat my depression naturally". Was prescribed sertraline in [Month15] this year, but never took it.*
- *Risk Statement: Longstanding suicidal ideation, increased in intensity in the last two days with no clear plan or intention to act on them. Feels some hope for the future and willing to engage and start medication.*
- *Immediate Plan:*
  - *Script with sertraline 25 mg mane for one week, and then increase to 50 mg mane + PRN for two weeks 0.5–1 mg lorazepam up to twice a day and zopiclone 3.75 to 7.5.* [no reference to quantities dispensed]
  - *Weekly dispensing. Will return excess of previous medications.*
  - *Follow up by PAC team to monitor risks, mood and medication, with potential med review in 2–3 weeks. Would appreciate a text prior PC to avoid anxiety.*
  - *Aware of 0800 and to call if required.*
  - *GP to please refer to concussion clinic for assessment of previous head injuries.*

19. 19 [Month22] — *progress report received from [the psychologist] including: [Mr A's] mood improved over the last week. Has been assessed by [DHB] crisis team following writer's referral after the last session; [Mr A] has been prescribed medication. [Mr A] has not experienced SI since last week, nil intent/plan. Discussed [Mr A's] relationship and how he will proceed with it. Consider mindfulness.*

20. 26 [Month22] — discharge summary received from [the private hospital] and operation note from [the ENT surgeon] with reference to [Mr A's] surgery (bilateral turbinoplasty on 26 Month22). Note of discharge medications (including Sevredol, paracetamol, tramadol and Celebrex) although quantities prescribed not specified (on review of hospital records, 10x10mg Sevredol, 10x 50mg tramadol, 40 x 500mg paracetamol, 5 x 20mg Celebrex).

21. 2 [Month23] — report received from [Mental health Services]. Report includes:

- *[Mr A] reports that his mood is still low but he now longer has "mood crashes" when he feels filled with despair. This is a significant improvement for him. Anxiety has improved but still significant issue, requires lorazepam to go to work. Denies SI* [suicidal intent] *for past 3/52. No thoughts of DSH* [deliberate self-harm].
- *Plan*
  - *Continue sertraline for 1/52, if side effects don't improve consider alternative medication*
  - *Script for zopiclone and lorazepam 1/52 with 1x repeat*
  - *PAC phone contact Friday to assess mood, mental state and side effect situation*
  - *… to investigate depression/anxiety support groups*
  - *Follow up with writer in 1/52*

21. Final comment: [Dr D] did not prescribe benzodiazepines for [Mr A] but did prescribe zopiclone for a prolonged period which is inconsistent with best practice but not a departure from common practice. There were some aspects of the zopiclone prescribing, particularly following [Mr A's] [self-harm] in [Month18], of which I have been critical and I recommend [Dr D] review the cited 2021 BPAC article on zopiclone prescribing. I believe the documentation surrounding the assessment of [Mr A's] depressive symptoms might have been improved on occasions, particularly as regards safety assessment and follow-up plans, although this may have been constrained by the PHO template required. I recommend [Dr D] review the cited HealthPathways guidance with respect to recommended follow-up of patients with symptoms suggestive of moderate or severe depression.'

Appendix 1: Summary of psychoactive medication prescribing (PR = patient prescription request via patient portal)

Date	**Rx**	**Comment**
25 [Month1]	Zopiclone x 20	Consultation — zopiclone Rx ½ to 1 nocte PRN

9 [Month3]	Zopiclone x 20 Escitalopram 10mg x90	Consultation — trial of antidepressant
22 [Month4]	Zopiclone x 20	PR zolpidem: *Require my usual prescription of zolpidem*
25 [Month5]	Zopiclone x 20	Consultation
1 [Month9]	Zopiclone x 20 Mirtazepine 30mg x30	Consultation — did not tolerate escitalopram. Change to mirtazepine trial
4 [Month11]	(Zopiclone x 20)	Consultation — script lost (see below)
13 [Month11]	Zopiclone x 20	PR zopiclone: *I unfortunately cannot find my previous script after moving house and am not sleeping well. Hoping I can have a new script*
22 [Month12]	Zopiclone x 20	PR zopiclone: *Usual prescription*
28 [Month12]		PR zopiclone: *Please send my prescription to above fax number — the last one wasn't received as I think it was their old number.*
28 [Month12]	**Zopiclone x 20**	**See s9 — Notes suggest Rx directions changed to zopiclone 1–2 nocte and dispensed amount increased to 40 but Testsafe data and notes audit indicate the prescription details altered on 5 [Month14] to match the prescription made by [Dr D] on that date (see below). This may be result of a software error.**
5 [Month14]	Zopiclone x 40	Consultation prior to overseas trip
20 [Month15]	Zopiclone x 40	PR zopiclone: *Running low on Zopiclone after bad sleep*
4 [Month16]	Sertraline 50mg x30	Consultation — trial of new antidepressant (never started sertraline)
14 [Month16]	Zopiclone x 40	Consultation with ongoing depressive symptoms
21 [Month17]	Zopiclone x 40	PR zopiclone: No comment. First request following ED assessment after [self-harm].

16 [Month18]	Zopiclone x 40	Consultation
20 [Month19]		PR busiprone, zopiclone: *Can you also please send my referral to [psychologist] they are waiting for it. Thanks*
21 [Month19]	Zopiclone x 10	Request reviewed by [locum]. Recent [self-harm] attempt noted and request for buspirone declined, reduce number of zopiclone provided, to see usual GP for psych referral.
27 [Month21]	Zopiclone x 24	Consultation. Psychology referral made
10 [Month22]	Zopiclone x 24	PR zopiclone: *Hi [Dr D] — Realised I only got 1/4 of my usual zopiclone amount last time I saw you. I'm not sleeping well last few weeks and hoping to get a new prescription to keep me going for a while.*
2 [Month23]	No prescription provided	PR zopiclone: *Running low on my usual prescription.* Provider comment ([initials]): *needs appt see discharge letter 2 [Month23]*