Consultant Psychiatrist, Dr C

Hutt Valley District Health Board

A Report by the

Health and Disability Commissioner

(Case 13HDC00199)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Relevant facts

1. On 17 Month1[1] 2012, Mr B attempted suicide. Mr B was found by emergency services and taken to a public hospital (the Hospital). As a result of a head injury he sustained, Mr B was admitted to the General Surgical Unit (the Unit) for observation. Following a 24-hour period of observation, Mr B was discharged from the Unit. Due to staff and family concerns for his safety, Mr B was then assessed by psychiatry registrar Dr D, and a Crisis Assessment Treatment Team (CATT) registered nurse. At 11pm on 18 Month1, Mr B was admitted to the Psychiatry Inpatient Unit at the Hospital (the Inpatient Unit), under Section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

2. On 19 Month1, Mr B had his first meeting with consultant psychiatrist Dr C at the Inpatient Unit. Dr C, Mr B and Mr B's family agreed that Mr B's status be changed to "inpatient on leave", and Mr B went home with his parents.

3. Mr B returned to the Inpatient Unit the following day, 20 Month1, for an appointment with Dr C. During that appointment, Dr C became concerned that Mr B had ongoing symptoms of a head injury. Mr B then underwent a computed tomography (CT) scan[2] and was again admitted to the General Surgical Unit at the Hospital, where he remained for two nights before being discharged and given the status "inpatient on leave" from the Inpatient Unit.

4. During the week of 22 Month1 to 27 Month1, Mr B's status continued as "inpatient on leave". Mr B had two appointments with Dr C and was contacted each day by the Inpatient Unit's transition liaison service.

5. On 28 Month1, Mr B's mother contacted the Inpatient Unit as she was concerned for Mr B's safety. An appointment was arranged with the on-duty consultant psychiatrist, Dr E, for the following morning. At that appointment, Mr B denied suicidal intention. However, during the evening of 29 Month1, while under the influence of alcohol and cannabis, Mr B again attempted suicide.

6. Following the second suicide attempt, Mr B was again admitted to the Inpatient Unit and remained as an inpatient until 2 Month2, when he was discharged with the support of his parents. A referral for community services through the Community Mental Health Team (CMHT) was sent, but this was not received by the team.

7. On 9 Month3, Mr B's mother contacted Dr C by email, informing him that they had received no follow-up from the Inpatient Unit since Mr B's discharge. Dr C raised concern with the management of CMHT, who initiated contact with the family and arranged further support for Mr B.

[1] Relevant dates are referred to as Month1-Month4 to protect privacy.
[2] An imaging method that uses X-rays to create pictures of cross-sections of the body.

Findings

8. Dr C provided services of an appropriate standard to Mr B during his time as a patient of the Inpatient Unit, and did not breach the Code of Health and Disability Services Consumers' Rights (the Code).

9. Hutt Valley DHB failed to ensure continuity of care for Mr B throughout his time at the Hospital and as he transitioned from the Inpatient Unit to community services. Hutt Valley DHB breached Right 4(5) of the Code.[3]

Complaint and investigation

10. The Commissioner received a complaint from Mrs A about the standard of care provided to her son, Mr B,[4] by Hutt Valley District Health Board and Dr C. The following issues were identified for investigation:

- *Whether Hutt Valley District Health Board provided Mr B with an appropriate standard of care between Month1 and Month4 2012.*
- *Whether Dr C provided Mr B with an appropriate standard of care between Month1 and Month4 2012.*

11. The parties directly involved in the investigation were:

Mrs A	Complainant, consumer's mother
Mr B	Consumer
Dr C	Consultant psychiatrist
Hutt Valley District Health Board	Provider

Also mentioned in this report:

Dr D	Psychiatry registrar
Dr E	Consultant psychiatrist
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
CPN I	Community psychiatric nurse

12. Independent expert psychiatric advice was obtained from Associate Professor Wayne Miles (**Appendix A**).

[3] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."
[4] Mr B supports the complaint.

Information gathered during investigation

Background

13. In 2012, Mr B was in his early twenties. Mr B had previously been diagnosed with Tourette's syndrome,[5] Asperger's syndrome,[6] obsessive-compulsive disorder,[7] depression, and other associated disorders. Mr B was prescribed fluoxetine[8] and zopiclone.[9]

Initial suicide attempt

14. At approximately 9.50am on 17 Month1, in the context of relationship difficulties, Mr B attempted suicide at his home. Before attempting suicide, Mr B sent a text message to his mother, Mrs A, indicating his intention to commit suicide.

15. Upon receiving the text message, Mrs A immediately contacted emergency services, who arrived at Mr B's address at around 10am (both the police and ambulance staff attended). Upon arrival, Mr B was found unconscious. Mr B sustained a laceration to the back of his head. Mr B was checked by the ambulance officers and taken by ambulance to the Emergency Department (ED) at the Hospital.

ED admission and overnight observation

16. Mr B arrived at the ED at approximately 10.40am. He was conscious when he arrived at the hospital, with neck pain. The ambulance notes record that he had no neurological deficits.

17. Following an assessment, Mr B underwent a computerised tomography scan[10] (CT scan) of his head. The results revealed a contrecoup cerebral contusion,[11] and Mr B was admitted to the General Surgical Unit for overnight neurological observation.

18. On 18 Month1, at approximately 7.30pm, Mr B was discharged from the General Surgical Unit. Surgical Unit staff and Mr B's family were concerned for his safety, as he had expressed an intention to leave the hospital and commit suicide successfully ("do it properly"). At this time, Mr B's family and staff in the General Surgical Unit expressed concerns for his safety, and an assessment from the Psychiatry Inpatient Unit was requested. Mr B was assessed by a psychiatry registrar, Dr D, in the

[5] A neuropsychiatric disorder with onset in childhood, characterised by multiple physical (motor) tics (sudden, repetitive, non-rhythmic movements) and at least one vocal (phonic) tic.
[6] An autism spectrum disorder (ASD) that is characterised by significant difficulties in social interaction and nonverbal communication, alongside restricted and repetitive patterns of behaviour and interests.
[7] A disorder where the person experiences ongoing intrusive thoughts and fears, which cause anxiety and obsessions.
[8] Also known by the trade name Prozac, and used to treat major depressive disorder, obsessive-compulsive disorder and panic disorder, among others.
[9] For insomnia.
[10] An imaging method that uses X-rays to create pictures of cross-sections of the body.
[11] A bruise to the brain on the opposite side of the site where the trauma occurred.

presence of a Crisis Assessment Treatment Team (CATT)[12] registered nurse (RN). Dr D formed the view that it was difficult to assess Mr B's mental state. Dr D told HDC that "due to lack of clarity, the concerns of his family and his serious suicide attempt […] the day before, [Mr B] was escorted to the psychiatric ward".

19. Mr B was admitted to the Inpatient Unit under Section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.[13] Dr D discussed her assessment with the consultant psychiatrist on call, who also reviewed Mr B. The consultant psychiatrist recorded in the clinical notes that Mr B was "currently not fully, i.e. sufficiently, capable to fully take care of himself", and that his "capacity to stay safe [was] significantly reduced currently".

Inpatient Unit admission/initial assessment by Dr C

20. At around 2.30pm on 19 Month1, Mr B was reviewed by consultant psychiatrist Dr C, who was assigned to oversee Mr B's care. Mrs A and Mr B's brother were present during the assessment, and Mr B's father was involved in the discussion by telephone.

21. Dr C told HDC that he "formulated the impression that [Mr B's] presentation had taken place in the context of an Acute Adjustment Reaction with an associated impulsive suicide attempt".

22. Dr C stated:

> "Based on this initial assessment, mental state examination and [Mr B's] stated lack of suicidal ideation and intent, and review of the medical admission notes and discussion at MDT [Multi-disciplinary Team], I formulated the opinion that it would be safe to allow [Mr B] home supervised by his parents."

23. Dr C told HDC that Mr B identified protective factors[14] and, according to Dr C, "the presence of protective factors [were noted] in making my decision to allow [Mr B] to leave".

24. Dr C also stated:

> "At this assessment I made the family aware of how to contact me if they had any concerns, and offered my DHB email address, as well as confirming that the family had the contact number of the Ward, transition liaison service and CATT. I invited the family to contact me if they had any concerns and encouraged them to use my email contact as well rather than taking the risk of missing a telephone call."

[12] The CATT team at Hutt Valley DHB deals with mental health emergencies in both secondary and community settings.
[13] Section 11 allows for five days' compulsory assessment and treatment following a preliminary assessment where, in a medical practitioner's opinion, there are reasonable grounds for believing that the person is mentally disordered, and it is desirable that he or she undergo further assessment or treatment.
[14] A combination of individual, relational, community and societal factors that decrease the risk of suicide.

Inpatient Unit leave

25. After the appointment, Mr B was put on leave from the Inpatient Unit, and he went to stay with his parents, with a plan to return to the Inpatient Unit the following day for a further appointment with Dr C.

26. The Inpatient Unit has a transition liaison service (TLS), which is a part of its inpatient service and supports patients on leave. TLS is available seven days a week until 4pm each day. Outside of these hours, according to the DHB's model of care, the crisis team (CATT) manages any acute concerns.

27. The family was unaware that the Inpatient Unit normally provided a care plan for patients before they went on leave. As such Mr B left before the Inpatient Unit staff were able to develop a care plan with the family. According to the clinical notes, between 4pm and 10pm that evening, a Registered Mental Health Nurse (RMN) rang Mr B's family and discussed the care plan, in particular what to do if Mr B's mental state deteriorated.

28. At 8.40am the following day (20 Month1), Mrs A emailed Dr C. Having reiterated her concern for her son, she stated:

> "[T]hank you for your kindness and support yesterday. What you said resonated with [Mr B] and we were able to remind him that he was not the first person in this position and that you believed he would get through it."

Second assessment by Dr C/General Surgical Ward readmission

29. At 1pm on 20 Month1, Mr B attended his second appointment with Dr C at the Inpatient Unit (with Mrs A also in attendance). Dr C recorded in the medical notes that Mr B's mental state was "settled, less distressed, not suicidal".

30. During the appointment, Mr B complained of increased headache, photophobia,[15] nausea, and one episode of vomiting. Dr C advised HDC that, in light of Mr B's presentation, he was "concerned [the symptoms] could be suggestive of an extension of his head injury". Dr C therefore contacted the Neurosurgical Unit at another hospital, and Mr B underwent a second CT scan that afternoon. Medical notes record that the CT scan revealed a small frontal haemorrhage, which was resolving. Mr B attended the Hospital ED and was admitted to the General Surgical Unit at 10.55pm.

31. In terms of Mr B's psychiatric care following that admission, Dr C advised HDC:

> "I liaised with my on-call consultant psychiatric colleague and the duty psychiatry registrar to make them aware of [Mr B's] admission to the General Surgical Ward for observation under the care of the general surgeons, and also made specific mention of my concern of the likely risk of agitation arising out of the head injury."

[15] An experience of discomfort or pain to the eyes due to light exposure.

32. Mr B stayed two nights on the General Surgical Unit. The clinical notes record that Mr B suffered headaches and pain behind the eyes but was otherwise well. An afternoon nursing note on 21 Month1 states that Mr B expressed "nil suicidal ideation".

33. On 22 Month1 at 10.20am, Mr B was reviewed by the on-call psychiatry registrar in the presence of his parents. Mr B was then discharged from the General Surgical Unit. The clinical notes from that assessment record that Mr B "denied any thoughts of wanting to harm self/others". It was also recorded that Mrs A was happy to take Mr B home, and that a leave care plan was put in place. The medical notes also state: "Mum very complimentary of [Dr C's] care [and] her experience [with] Mental Health." An appointment with Dr C at the Inpatient Unit was arranged for the following day. Subsequently, Mr B was discharged from the General Surgical Unit and given the status "inpatient on leave" from the Inpatient Unit.

Inpatient Unit leave

Third assessment by Dr C

34. On 23 Month1, Mr B returned to the Inpatient Unit to attend his third consultation with Dr C (along with both of his parents).

35. Dr C recorded in the clinical notes that Mr B was experiencing "reoccurring intrusive images of his girlfriend", which Mr B found "anxiety provoking". Dr C outlined that these symptoms would need to be monitored and, if they did not decrease in intensity, then consideration would be given to referring Mr B to a psychologist who specialises in eye movement desensitization and reprocessing (EMDR).[16] Dr C told HDC that Mr B was experiencing "underlying anxiety, no suicidal intent and an improving mood profile leading to the impression that he was not suicidal, and that the crisis appeared to be resolving". The clinical notes record that Mr B was to continue on leave from the Inpatient Unit at his parents' house until his next appointment with Dr C, scheduled for 27 Month1. There is no record of Mr B's family's input into the assessment or whether they raised any concerns during the assessment.

Follow-up by Dr C

36. On 24 Month1, at the request of Mr B's family, Dr C contacted a colleague in the private sector who had expertise in EMDR. That morning, Dr C called Mr B and provided him with the contact details of that provider.

TLS

37. Each day between 23 Month1 and 25 Month1, TLS contacted Mr B by telephone to check in and assess Mr B's mental state. In addition, on 25 Month1 at 10.45am, Mr B was assessed at his home by TLS staff. In the course of the assessment, it was recorded that Mr B "denie[d] suicidal intent, plan to harm himself or others". It was also noted that Mr B was still experiencing headaches and blurred vision.

[16] A psychotherapy technique that involves recalling a distressing image while receiving one of several types of sensory input, including side-to-side eye movements. The technique aims to alleviate the intensity of a memory and give patients coping mechanisms while dealing with the distressing image.

Further neurological investigation

38. At 4.20pm on 25 Month1, Mr B was reviewed by a house surgeon for his ongoing headaches and blurred vision. He was referred for an appointment at the Hospital the following day.

39. At 1.30pm on 26 Month1, Mr B was reviewed by a neurologist. The neurologist was concerned about a possible cerebrospinal fluid (CSF)[17] leak and referred Mr B to an Ear, Nose and Throat specialist. A subsequent examination showed an intact ear drum and no evidence of a CSF leak.

Emails to Dr C/fourth assessment by Dr C

40. During the evening of 26 Month1, Dr C received three emails from Mrs A, as Mrs A was concerned about Mr B's worsening mental condition. Mr B had left his parents' house and returned to his home. The last email, sent at 8.58pm, reads:

> "The situation has escalated this evening — things have really deteriorated and [Mr B] really needs help. [Mr B's father] has just driven across to [Mr B's home] because it sounds like a battleground and we are very worried. Please find someone for [Mr B] to talk to tomorrow."

41. Dr C advised HDC that he received the above email in the evening, but did not reply as he had an appointment scheduled with Mr B at 11.30am the next day.

42. At 11.30am on 27 Month1, Mr B returned to the Inpatient Unit to attend his fourth consultation with Dr C. Mrs A was also present at this appointment. At this appointment, Dr C recorded in his clinical notes that Mr B presented as "a little irritable", and that Mr B was continuing to experience traumatic images that were "intrusive and distressing". Dr C prescribed a low dose of lorazepam[18] to assist with Mr B's anxiety. Dr C recorded in the clinical notes that Mr B had had "problems with antipsychotic medication in the past", and that the addictive risk of the drugs was discussed. No comment is made in the clinical notes regarding whether Mr B had any suicidal ideation. Furthermore, no comment is made in the clinical notes as to whether Mr B's family raised any concerns. Dr C advised HDC that the outcome of the fourth consultation was as follows:

> "… [Mr B] was advised to contact the private psychologist whose details I had telephoned through to him earlier in the week, that he would be going home with transition liaison team support over the weekend and he would be reviewed by my psychiatry registrar as I would be away [on 30 Month1]."

Family concerns

43. Mrs A advised HDC:

> "When he [Mr B] was again released [23 Month1] (with a revisited leave plan), his behaviour had changed and as his parents, we were seriously concerned for his

[17] Clear colourless bodily fluid found in the brain and spine.
[18] A benzodiazepine drug, often used to treat anxiety disorders.

> safety. We communicated this to [Dr C] ([Mr B's] consultant psychiatrist), verbally at hospital appointments (25 and 27 Month1) and through email (three emails 26 Month1) both communication channels [Dr C] had advised us to use in order to contact him."

TLS/CATT

44. In the morning on 28 Month1, TLS contacted Mr B by telephone. TLS's notes from that discussion record that Mr B's mood was "alright" and that he was "keeping himself busy". Mr B denied any suicidal intention. A home visit was arranged for between 4.30 and 5pm that afternoon.

45. Later in the day, the clinical notes record: "[P]hone call to [Mr B] — unable to H/V [home visit] today happy to see me or [another staff member in TLS] tomorrow."

46. At approximately 5pm, the clinical notes record that Mrs A contacted TLS and spoke with a registered nurse, RN F, who reported: "[Mr B] has become increasingly angry over the day. [Mrs A] says [Mr B's father] feels he can't leave [Mr B] as concerned he may hurt himself or someone else."

47. RN F then telephoned Mr B's house and spoke to Mr B. The clinical notes record that Mr B reported as "fine and didn't want to hurt himself or anyone else". RN F also talked to Mr B's father and former girlfriend, who were both at the house. The clinical notes record that RN F advised:

> "… [Mr B's father's] presence appears to be aggravating the situation and since [Mr B's former girlfriend] is reporting that she feels safe and is happy to keep an eye on [Mr B] it may be better for [Mr B's father] to leave."

48. RN F also recorded in the clinical notes that the CATT team was contacted by telephone and advised of the situation, including Mr B's history, recent head injury, and doctor's reviews. The clinical notes record: "CATT will decide on further action, but will inform the Inpatient Unit." A meeting with consultant psychiatrist, Dr E, was set up for Mr B the following morning.

49. At 6.10pm, RN G of CATT contacted Mr B by telephone and recorded that Mr B was "now quite calm". Mr B was "able to assure he is not a risk to [his former girlfriend] or himself. Declined offer of returning to the Inpatient Unit for the night believing this to be more detrimental than helpful". RN G advised Mr B that he would need to contact his father to confirm that he supported Mr B staying home. RN G then contacted Mrs A to obtain Mr B's father's number. Mrs A confirmed that she supported Mr B remaining at home if his former girlfriend was safe. Mr B's father also supported his son staying at home. In addition, RN G received a text from Mr B's former girlfriend outlining that she also supported Mr B staying at home.

50. At 9.45pm, RN G telephoned Mr B's former girlfriend, who reported that things had settled down, and that Mr B had taken his evening medication and was preparing for bed.

Assessment at the Inpatient Unit

51. During the morning of 29 Month1, Mr B returned to the Inpatient Unit and attended an appointment with consultant psychiatrist Dr E (along with Mrs A and Mr B's former girlfriend). The clinical notes from that appointment record that Mr B denied any suicidal thoughts, and that he had an appointment the following day with a private psychologist, which "he [was] looking forward to". No further actions or outcomes of the meeting were documented in the clinical notes.

52. During the appointment, a disagreement between Mr B and Mrs A arose, as to whether Mr B should be given additional medication. Mrs A wanted Mr B to be prescribed additional medication to control his anxiety, and Mr B refused. Dr E recorded in the clinical notes that Mr B was "found to be argumentative. Otherwise there is no abnormal behaviour noted. He denies any further suicidal thoughts."

53. Mrs A advised:

> "I accompanied [Mr B] to this appointment and believe I made it very clear to the on-duty psychiatrist … that both [Mr B's] father and I were extremely concerned about [Mr B's] changed behaviour. I again asked for support in managing [Mr B], especially for the afternoons when his behaviour seriously deteriorated. None was forthcoming …"

Second suicide attempt

54. At approximately 7pm on 29 Month1, in the context of continued relationship difficulties, alcohol and cannabis use, Mr B again attempted suicide at his home. Mr B's former girlfriend called emergency services. At around 7.20pm, two ambulance paramedics arrived and found Mr B conscious on the floor of the garage. At first Mr B cooperated, but after a few moments he became aggressive and physically assaulted the two paramedics. The police were called and arrived at the scene. The police subdued Mr B and transferred him to the ED at the Hospital.

ED/the Inpatient Unit admission

55. At approximately 8.10pm on 29 Month1, Mr B was admitted to the ED and remained there until he became sober. At around 12am on 30 Month1, Mr B was readmitted to the Inpatient Unit.

56. Upon readmission to the Inpatient Unit, Mr B was reviewed by Dr D, who diagnosed Mr B with "adjustment disorder with depressed mood, secondary [to] break-up of relationship". The possible neurological injury from Mr B's first suicide attempt was also noted by Dr D. Mr B's night dose of lorazepam was withheld because of his alcohol intake, although he was given his other medication. Mr B agreed to remain at the Inpatient Unit.

57. In the late afternoon on 30 Month1, Mr B met with a psychiatry registrar. At that time, the clinical notes record: "[Mr B's] mood [is] depressed, tearful, denies ongoing suicidality, acknowledging need to abstain from alcohol." The clinical notes record that the plan was to "continue Rx [medication] as charted" and "further review".

58. Mr B's clinical notes record that, between 30 Month1 and 2 Month2, Mr B's mood was variable — at times pleasant, and at other times anxious. On several occasions the notes record concerns about Mr B's risk to himself. There is mention in the hospital clinical notes that Mr B did not like being in the Inpatient Unit.

59. Mr B continued to visit a private psychologist during his the Inpatient Unit admission.

60. On 1 Month2, the clinical notes state:

> "T/C [telephone call] from mother, she would like to speak with doctor and talk about plan, explained that as they only met with ψ [psychiatry] reg [registrar] yesterday they may have to now wait to meet again."

Referral

61. On 1 Month2, while Mr B was still at the Inpatient Unit, [an RN] completed a "Mental Health and Addiction Services — Referral" form for Community Mental Health Team (CMHT) services. The form noted the following safety issues: "[S]uicide risk = serious, moderate risk of aggression if provoked, relationship instability — serious." the Inpatient Unit has a record that the form was sent, but it was never received by CMHT. Dr C stated:

> "Hutt Valley DHB has supporting administrative processes that ensure the transfer of clinical notes between the inpatient and community teams. This is not an activity that I as a clinician would be involved in."

Fifth assessment by Dr C/ Inpatient Unit leave

62. On 2 Month2, Mr B was again assessed by Dr C. Mr B's parents attended the meeting. Prior to this consultation, Dr C said that he had reviewed Mr B's medical notes after his readmission to the Inpatient Unit, and had been at a multidisciplinary meeting that morning, where Mr B's situation had been discussed.

63. Dr C's clinical notes from the above consultation record that he discussed with Mr B the events leading up to the second suicide attempt. Dr C noted that Mr B had "increasing anger, use of alcohol and associated increased impulsivity secondary to intoxication". The notes record that Mr B "did not want to die" and showed remorse for his actions. Dr C undertook a mental state assessment and concluded that Mr B presented with "euthymic mood, absent suicidal intention, and he had improving insight".

64. It was agreed that Mr B would go on leave for the night with his parents, and return the following day for another appointment with Dr C. In addition to a leave partnership plan being put in place, Dr C recalls discussing "an outline of the intended follow-up post-discharge through CMHT".

65. Also on 2 Month2, a "Mental Health Risk Assessment Report" was completed for Mr B by RN H. The report stated: "[F]or last three days his [Mr B's] mental state is improving, taking medication and food+fluid intake is very good, no suicide thoughts or plan. [Dr C] has given permission for overnight leave with Father and Mother."

The report outlines risk indicators as follows: "suicide, nil", "disinhibiting factors, RISK: not applicable, nil", "behavioural issues, RISK: non applicable, nil" and "Other Contributing Factors, RISK: relationship instability, LOW".

66. In regard to the report, HVDHB advised:

> "In regards to [RN H's] risk assessment and management plan we accept … that contributing factors were not included. The service is currently reviewing our risk assessment management plans and how they can be incorporated into the holistic view of patient management. This will include a template redesign."

Sixth assessment by Dr C/discharge

67. At 11am on 3 Month2, Mr B returned to the Inpatient Unit with his mother to attend his sixth and final consultation with Dr C. Dr C's clinical notes from that consultation record that Mr B showed "no acute signs and no evidence of suicidal thinking". It was noted that this appointment was for a review before discharge.

68. During the appointment, Dr C outlined the community services that would be provided to the family following Mr B's discharge, to assist with Mr B's further treatment. Mrs A told HDC that Dr C stated that the following services would be offered through Hutt Valley DHB:

> "1. CMHT [Community Mental Health Team] (dependent upon his [Mr B's] GP [general practitioner])
> 2. Post-vention team[19] (no time given)
> 3. Community psychiatrist (greater or less than 4 weeks following discharge)
> 4. Community nurse (to phone in week post-discharge)."

69. Mr B was then discharged from the Inpatient Unit. A DHB "Discharge & Coding Summary" form was completed by Dr D on 21 Month2, on behalf of Dr C. The form records: "[C]ontinue seeing psychologist in private", and "[R]egular follow-up with CMHT."

Delay in CMHT follow-up

70. On 9 Month3 (five weeks after Mr B's discharge from the Inpatient Unit), Mrs A emailed Dr C and advised that Mr B had not been followed up by CMHT. On 10 Month3, Dr C responded to that email as follows:

> "I am concerned about this, and will ask our senior community team manager to look into this and get back to you as soon as possible.
>
> In the meantime, please get in touch with me if you have any concerns about [Mr B]."

[19] A regional team that follows up with patients (and their families) following a suicide attempt.

71. Dr C then contacted the CMHT, who advised him that they did not have a referral form on file regarding Mr B. Dr C told HDC:

> "I had previously made myself available for contact by email for both [Mr B] and his mother — [Mrs A] was able to contact me directly about the issue of CMHT follow-up. It is concerning to hear that the follow up arrangements in the community after discharge had not been actioned. As soon as this was brought to my attention by [Mr B's] mother, I escalated this issue to management to ensure that there was prompt action to rectify the situation."

72. On 11 Month3, a member of the CMHT called Mr B. Hutt Valley DHB advised HDC that, during that telephone phone call, "[Mr B] reported that he was doing ok, had seen his GP the previous day, and was happy with an appointment with [CMHT] [next week]."

73. Overall, Mrs A provided HDC with the following comment regarding the delay in the CMHT follow-up:

> "Following his discharge from [the Inpatient Unit], [Mr B] was not contacted by anyone in [Hutt Valley DHB's] community teams. [The Hutt Valley DHB Operations Manager] tells me DHB practices have changed. I would like to be sure this is the case as I would not want another suicide survivor or their family to endure what we have been through."

CMHT follow-up

74. On 19 Month3, a community psychiatric nurse (CPN), CPN I, a member of CMHT, met with Mr B and completed an "Initial Assessment — New Referral" form. The form noted that Mr B was regularly seeing a private psychologist, and that, "based on observation and self-reporting he is no longer in [the] same place he was, and has learned skills and strategies for coping". In addition, the form records Mr B's concern about lack of follow-up, stating: "[Mr B] told me his concern is for others in the system not him, others do not have access to [a] private psychologist as he does."

75. On 21 Month3, CPN I telephoned Mrs A and apologised for the lack of follow-up of Mr B. In addition, CPN I offered options around further support of Mr B. The notes from that conversation record that Mrs A would "decide what actions she takes after".

76. On 26 Month3, CPN I called a private psychologist regarding Mr B. It was recorded in CPN I's clinical notes that the psychologist would continue to work with Mr B, that Mr B was functioning well, and that the psychologist undertook "regular safety checks" with Mr B to ensure he was ok.

Discharge from CMHT

77. On 9 Month4, a "Mental Health Discharge Tasks Checklist" was completed for Mr B by a doctor. The form outlined the reason for discharge as that Mr B "did not attend" CMHT. A clinical note by the doctor on that day records: "[Mr B] and family do not wish further public health input." No other discharge summaries or forms were completed, although a referral to Mr B's GP was completed.

Additional information

Clinical notes

78. HVDHB provided HDC with both electronic and handwritten notes from Mr B's time at the Inpatient Unit. HVDHB advised HDC:

> "The mental health service and the medical services each maintain a paper and electronic record. In the mental health and addiction services, our electronic records include comprehensive assessments, risk assessment plans, clinic letters, clinic notes in the community, Mental Health Act paperwork and discharge summaries."

Dr C's response

79. Dr C told HDC:

> "Hutt Valley DHB has a policy which determines the community based follow-up for patients that are discharged from the Inpatient Unit. I was part of the team that helped to improve the system of psychiatric follow-up for patients that had been discharged from the inpatient services."

HVDHB response

80. Hutt Valley DHB stated that it is confident Mr B received the appropriate care during his admission in the General Surgical Ward and the Inpatient Unit. The DHB expressed concern over the lack of follow-up after Mr B's discharge from the Inpatient Unit. The DHB stated:

> "[Mr B's] case has been discussed within the Mental Health Service, but has not been formally reviewed or investigated by the DHB as we believe we provided [Mr B] with an appropriate level of care during his admission to the Inpatient Unit, and in the community.
>
> There was, however, a delay in the follow-up care which was inadequate. We apologised to [Mr B] and [Mrs A] at the time, and we have reviewed and modified the referral process to minimise the risk of reoccurrence.
>
> We also acknowledge that [Mrs A] and her husband did not feel heard, and that communication with [Mr B's] family could have been better.
>
> …
>
> Overall, in many respects the DHB and its staff provided high quality care to [Mr B]. However, some aspects fell below our own expectations. Where that is the case we have apologised, and have made or are in the process of making adjustments to improve our systems."

Relevant policies at Hutt Valley DHB

81. At the time of the events in question, Hutt Valley DHB had the "Post Acute Care Policy" (the policy) in place. The policy was designed to ensure that two CMHT clinicians followed up with patients discharged from the Inpatient Unit for a minimum of 28 days in the community. The policy recognised that consumers required an intensive period of monitoring and follow-up post discharge.

82. The policy stated that referrals "should be completed within 24 hours of the consumer's admission to mental health inpatient services as part of embedded admission processes". Additionally:

> "Once referral for 28-day follow-up is allocated the [CMHT] clinicians will attend inpatient MDT [multidisciplinary team meetings] and/or discharge planning meetings with regard to the consumer. In their absence, the appropriate Team Leader or a nominated locum may attend. It is expected that through these clinical processes, time-frames and frequency of follow-up contacts will be clarified on a case-by-case basis."

83. Finally, "[N]otification on the day of formal exit from inpatient services will occur in the first instance via email …" The policy then goes on to expand on the nature of the 28-day follow-up and the assessment at the end of the 28 days to determine whether more services are needed.

Hutt Valley DHB changes

84. Hutt Valley DHB told HDC that it has modified procedures to ensure that referrals are received:

> "We have reviewed and modified the procedure to minimise the risk of delays in contacting patients following discharge from the Inpatient Unit. Any person admitted to the Inpatient Unit is transferred to the community team within 48 hours of admission via our electronic system."

85. Hutt Valley DHB also said that it has made the following changes to the Inpatient Unit:

> "The Mental Health Service is introducing a family meeting model into the Inpatient Unit, and the family advisor is working with staff to ensure delivery of the model and utilisation of the template tools in order to accurately capture and report on family input into family meetings or assessments."

Response to provisional opinion

Dr C

86. In response to my provisional opinion, Dr C provided the following comment:

> "In a busy inpatient environment I accept that notes can always be more detailed, but that said, where appropriate, family concerns have been recorded elsewhere in the clinical record by members of the multi-disciplinary team…, as well as the email correspondence which in my view are part of the clinical record."

87. Dr C also advised:

> "The recording of conclusions about the head injury [were] carried out by multiple medical entries in the notes, and given the MDT [multidisciplinary team] nature of working in an acute inpatient environment this cannot solely be the responsibility of a single medical practitioner".

Hutt Valley DHB

88. In regards to Mr B's time as an inpatient at Hutt Valley DHB, the DHB provided the following comment to my provisional opinion:

> "We accept that a decision to assess [Mr B] following his admission to the General Surgical Unit could have been made earlier. However, once the decision that a review was necessary was made, we did take steps to ensure that a review was carried out as promptly as possible. I believe that a review by the on-call team after hours was preferable to waiting until the next regular working day."

89. In addition, Hutt Valley DHB provided the following comment on Mr B's transition to community services:

> "We accept that the DHB's continuity of care whilst [Mr B] transitioned from the Inpatient Unit to the community services was suboptimal and that there were some deficiencies in documentation."

Opinion: No breach - Dr C

90. Dr C was assigned to oversee Mr B's care while he was a patient at the Inpatient Unit between 18 Month1 and 2 Month2. I agree with my expert advisor, psychiatrist Professor Wayne Miles, that concerns about Mr B's care are better addressed by considering wider DHB system issues.

91. Overall Professor Miles advised me that "from [Dr C's] response, what he claims to have heard, acknowledged and responded to would be adequate". I agree with Professor Miles and consider that overall Dr C responded appropriately to the family and provided appropriate care to Mr B. I do not find that Dr C breached the Code.

Opinion: Breach - Hutt Valley District Health Board

System fragmentation

Initial assessment by mental health services

92. Mr B was brought to ED at the Hospital during the morning of 17 Month1. He was then admitted to the General Surgical Unit for observation. At approximately 7.30pm on 18 Month1, Mr B was discharged from the General Surgical Unit. At this time, concern was raised about his safety, and he was reviewed by the Inpatient Unit psychiatry registrar and a CATT nurse. At 11pm that same day, Mr B was transferred to the Inpatient Unit.

93. By the time Mr B was assessed by members of the mental health team at the Hospital, he had been in the hospital for over 30 hours. The decision to assess and transfer him

was made late in the evening by the on-call team. This assessment happened only after surgical unit staff and Mr B's family expressed concerns for him.

94. Professor Miles noted that there were a large number of clinicians and clinical teams involved in Mr B's assessment and care. Furthermore, Professor Miles was concerned that Mr B's evaluation was conducted by the on-call team rather than being conducted during normal working hours, resulting in a risk of fragmentation of care. He considered that the decision to assess Mr B should have been made earlier, following his admission to the General Surgical Unit but before his discharge. I agree with Professor Miles and consider that it was inappropriate for the on-call team to assess Mr B so late on 18 Month1. Mr B was admitted to hospital following a suicide attempt. The Inpatient Unit should have been notified that Mr B was in the General Surgical Unit, and he should have been assessed earlier.

Documentation

95. While Mr B was a patient at the Hospital, both electronic and handwritten records were used. It does not appear that there was one repository of clinical information on Mr B. Furthermore, at times it appeared that clinical notes were filled in inappropriately. One example of this is the "Mental Health Risk Assessment Report" completed for Mr B on 2 Month2, where the risk indicators identified do not align with risks identified in other clinical records. At other times there are omissions in the notes, such as conversations had and decisions made during multidisciplinary patient review meetings.

96. In his advice, Professor Miles highlighted the importance of the thoroughness of clinical notes to allow other clinicians to fully understand risk and care plans when subsequently treating the patient. Omissions or errors in clinical notes create a significant risk of key information not being transmitted.

97. In situations such as this, with multiple staff involved in care, it is critical that appropriate information is recorded in clinical notes, and that clinical records are thorough and complete. As this Office has stated on multiple occasions, the importance of adequate documentation cannot be overstated.

Referral to community services

98. Hutt Valley DHB's process for referrals in Month2 is outlined in its "Post Acute Care Policy" (the policy). The policy sets out processes to ensure that the transition between acute inpatient services and community services is seamless, and that high-risk patients are cared for appropriately following their discharge. The policy outlines multiple handover processes between inpatient acute mental health clinicians and the community services team.

99. The policy states that referral to the community services team should be completed within 24 hours of the consumer's admission to mental health inpatient services as part of embedded (electronic) admission processes. Once that has occurred, CMHT clinicians (or CMHT team leaders) are to attend inpatient multidisciplinary team meetings and/or discharge meetings to ascertain a patient's community follow-up requirements.

100. On the day of discharge, the Inpatient Unit is to send an email to CMHT to activate the 28 days of community follow-up where both a nurse and a psychiatrist work with the patient in the community.

101. In Mr B's case, there were a number of instances where the policy was not followed. First, referral from acute inpatient services to CMHT within 24 hours of Mr B's admission did not occur. Instead, Mr B's referral for community services happened just before he was discharged (and, while this was sent from the Inpatient Unit, it was not received by CMHT). Secondly, the required interaction between the acute inpatient team and the community service team clinicians before Mr B was discharged did not occur. Finally, no email was sent to the community services team alerting them that Mr B had been discharged.

102. In addition, I consider that it would have been appropriate for clinical staff at Hutt Valley DHB to inform Mr B and his family who they should contact had they not heard from CMHT within a set period of time. This would have enabled Mr B to be a partner in his own care, and provided him and his family with an opportunity to alert Hutt Valley DHB to the breakdown of its systems.

103. I am guided by Professor Miles, who has advised me that "this failure to arrange community follow up of a patient who has twice tried to [commit suicide] must be seen in the severe range". I agree with Dr Miles, and consider that Hutt Valley DHB's failure to ensure Mr B was appropriately referred to community services was a serious departure from accepted standards of care.

Summary

104. Providing seamless care requires effective communication between providers and services. While Mr B was a patient at Hutt Valley DHB, his care was managed by a number of providers, services and units. Between Mr B's hospital admission on 18 Month1 and his discharge from community care on 9 Month4, there were a number of documentation and system failures, most notably the missed referral to community services. For not ensuring continuity of care for Mr B, I consider that Hutt Valley DHB breached Right 4(5) of the Code.

Recommendations

105. I recommend that Hutt Valley DHB:

a) Provide a written apology to Mr B for its breach of the Code. That apology should be sent to HDC, for forwarding to Mr B, within **three weeks** of the date of the final report.

b) Provide evidence that Hutt Valley DHB now has processes in place to alert the Inpatient Unit when patients with a high risk of self-harm are admitted to other clinical units, within **three months** of the date of the final report.

c) Provide evidence that Inpatient Unit team reviews are annotated in patient files, within **three months** of the date of the final report.

d) Provide evidence that consideration has been given to having one repository of clinical notes so that all patient notes (electronic and handwritten) are in one location for each the Inpatient Unit patient, within **three months** of the date of the final report.

e) Provide evidence of its electronic referral process from the Inpatient Unit to the community services team, and audit the effectiveness of the process, within **three months** of the date of the final report.

f) Provide evidence of steps it has taken to ensure that relevant staff at the Inpatient Unit and in the mental health community services team are aware of the Post Acute Care Policy, and that the policy is being followed. Evidence is to be provided within **three months** of the date of the final report.

g) Arrange for clinical staff in the Crisis Assessment Treatment Team, the Inpatient Unit, and the Community Mental Health Team to undergo training on the importance of, and expectations for, clear, full and accurate clinical documentation, and report back to HDC within **three months** of the date of the final report.

h) Provide evidence that the family meeting model has been introduced at the Inpatient Unit, and that this model is being followed, within **three weeks** of the date of the final report.

i) Provide evidence that it has shared this report, for educational purposes, with clinical staff of the Inpatient Unit, the Crisis Assessment Treatment Team, and the mental health community services team, within **three months** of the date of the final report.

Follow-up actions

106.
- A copy of this report with details identifying the parties removed, except Hutt Valley DHB and the expert who advised on this case, will be sent to the Royal Australian and New Zealand College of Psychiatrists.

- A copy of this report with details identifying the parties removed, except Hutt Valley DHB and the expert who advised on this case, will be sent to the Medical Council of New Zealand, who will be advised of Dr C's name.

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

Appendix A — Independent expert advice from Associate Professor Wayne Miles

The following expert advice was obtained from an expert psychiatrist, Associate Professor Wayne Miles, on 18 June 2013, with additions on 25 September 2013 (those additions are in italics):

"This response is based on the material forwarded by the Office of the Commissioner including the written complaints of [Mrs A], the response from [Dr C], the response from Hutt Valley DHB and the clinical notes for [Mr B] for the period in question.

In my review of the material provided there are a number of emergent issues that I believe could warrant further investigation.

1. **The large number of clinicians and clinical teams involved in this man's assessment and care over what was quite a brief period of time**.
   It appears that he was seen by at least 10 doctors from house officer to registrar to consultant (that is limiting to mental health contacts).
   Nursing and allied health contacts were with at least 18 different staff.
   At one point of care there seems to have been in-patient, transition team and CATT concurrently.

   This multiplicity of staff many of whom have only one or two contacts will contribute to lack of clarity of the assessment and also to a large risk of plans not being made or implemented.

   Though his contacts are sporadic during the episode it seems that [Dr C] had more contact than any other doctor (and perhaps even any other staff member) so it is not surprising that he is the target of the family concern.

   The [DHB] response confirms the large number of doctors involved.
   Other responses explain this on the complexity of acute care.
   I remain concerned that these multiple agents will always increase risk of loss of plan or information at hand over. The DHB seems to minimise this risk. I would prefer to see active plans to minimise the number of hand-overs made.
   [Dr C] mentions regular team reviews in the inpatient setting; it would be desirable for these to be annotated in the patient's file so others who have to make decisions out of hours are aware of such discussion.

2. **Why are so many decisions taken by 'out of hours' teams when it seems he was around during standard working hours?**
   One such example is the first admission to [the Inpatient Unit]; as I read it he came to the ED 17 [Month1], was seen for urgent assessment then observed in the General Surgery Observation for 24 hours. The evaluation was however left until the evening of 18 [Month1] so had to be conducted by the on-call team. My impression is that a number of other assessments and decisions

might have been made in normal working hours rather than leaving to out of hours services.

I am not persuaded by the arguments offered that such was always needed. The first obvious case is his first contact with the mental health services post [suicide] attempt. From my review he was in the hospital for a day and a half before such contact was initiated. He could easily have been seen by the mental health team during ordinary hours but it was left to an on-call registrar. There are other examples less overt. (It is important that I make it clear that I am not in this case saying that the decision of that on call registrar was faulty. It is rather that such out of hours work carries with it increased risk of fragmentation and will make it more difficult to also spend time with family/whanau.)

3. **Documentary confusion**
   Dates of and on the 'Discharge and Coding Summary' sheets are inconsistent in dates which I assume is because they have been printed off and the electronic version prints as date of printing. Setting that aside though some of the admission discharge dates are not consistent with other written notes. One such summary is attributed to [a practitioner in the Inpatient Unit] but has no relevant content.

   That attributed to [RN H] (setting aside dates) is worrying re the 'Risk indicators'. There are form questions which one assumes is designed to assist clinicians. These have been completed as: Suicide level 'nil'; Poor judgement 'low'; and Disinhibiting factors 'nil'. All evidence in the notes would not support any of these conclusions.

   Labels as to responsible clinician do not as far as I can see align regularly with who is actually in charge.

   Much of the notes I was given are hand written, leading me to assume that the DHB relies mostly on written notes for communication. It is not clear if teams have their own notes or there is a single record shared by all. Again it is not clear if these notes are always available including out of standard hours. Such note availability would be crucial in a system with so many care handovers as was seen in this man's episode of care.

   Nothing I have read would force me to change my views. I note occasional reference to 'the electronic record'. I am unclear if there is indeed such material for [Mr B] and if so did the material I received have printed versions of that. It may be that the reference to such records is something new of coming.

4. **An apparent lack of consideration of the impact of the head trauma on his behaviour.**
   While there is repeated comment about the head trauma and he had CT Scans confirming that there is a bewildering absence of any assessment of or

comment about the possible impact of that head injury on his judgement, anger control and the like.

I accept [Dr C's] expanded explanation and can see that it may have been more in his and maybe his team's mind than was apparent in the notes. I accept that he can see that more careful statement of that would have been helpful for continuity of care by multiple teams.

5. **No mention of possible disinhibition risk of benzodiazepines post head injury**.
   The risk of dependence on these is repeatedly mentioned but there appears to have been no consideration that these could contribute to disinhibition in a man who has had a recent brain trauma.

   I am persuaded by [Dr C] that this is probably not a relevant contributor here.

6. **Possible linking of 'impulsivity' and 'aware of consequences of behaviour' with low suicide risk.**
   There is a thread running through the notes that suggest that the seriousness of especially the first [suicide] attempt was down-played. On 18 [Month1] it was reported as '[a serious suicide attempt]' (in the certification for compulsory treatment). As time passes words such as impulsive slip in and though I cannot be sure I wonder if the likelihood of a repeated attempt was minimised because it was 'impulsive'. The description of being 'aware of the consequences of behaviour' might also detract from the severity of the suicide threat. It is not uncommon in Mental Health for this distinction to be drawn when the problem is seen as 'behavioural' and related to personality issues.

   [Dr C's] comments are reassuring. In the end it is quite difficult to detect underlying constructs and cultures that affect decisions made for care and indeed determination of risks.

7. **Lack of consideration of Asperger's syndrome**
   While there is brief reference in notes there is nowhere an appraisal of that disorder's relationship to either the response to the change/loss of partner, the unpredictability of acting out type behaviour or the propensity to misinterpret social cues.

   Again [Dr C's] additional comments are reassuring. He indeed makes observations about the behaviours and social abilities of [Mr B] that I would have thought deserved consideration. I agree with him that more comment in the notes would have been helpful for those providing ongoing care.

Turning to the specific complaints against [Dr C].

1. **Failure to respond to the family's expressions of concern**.
   From [Dr C's] response what he claims to have heard, acknowledged and responded to would be adequate.

The written notes do not substantiate all those claims; it could be that there are significant contacts that are minimally reported.

There are occasions where one or both parents are recorded as being present at an assessment but there are no records of their statements, opinions or understanding (notably 23 [Month1], 27 [Month1]).

There is evidence in the notes that the family expressed concerns on a number of occasions to a number of people. It is also evident that people making a subsequent assessment of risk and care need were not direct recipients of those concerns. The points made in 1, 2 and 3 above create a significant risk that key information is not transmitted; they would also make it very likely that a family member would have the view that the messages they had given were being ignored.

The notes of 28 [Month1] and 29 [Month1] highlight that potential where one service says it cannot home visit, a second records a very serious set of circumstances then yet another party goes to assess the problem.

I believe that this complaint may well represent a significant deficiency in care provided. I think that is a matter that is more the responsibility of the DHB as a whole rather than one specific doctor. I wonder if the doctor is targeted because the parents believe he should have had the capacity to know more and respond better, while the system was not set up for him to be able to do that.

This failure would be in the moderate to severe range.

The additional information
a) Strengthens my view that the complaint directed to [Dr C] might more properly be addressed by the DHB system as a whole.

- *[The DHB response] explains the roles and time responsibilities for the TL team and the CATT team but I do not think that helps explain deficiency, if anything it highlights the possibility. I note that the TL team was in touch, but purely by phone, and further that it seems to pass on possible concerns for the CATT to follow up 'as they see fit'. I would have thought that a client and family would like to think that support from a TL team would be an extension of the ward and the primary care plans would be dictated by the ward team who we would expect to know the patient and the patient's risk best.*
- *A note written on 1 [Month2] says 'T/C from mother. She would like to speak with doctor and talk about plan, explained that as they only met with ψ reg yesterday they may have to now wait to meet again'. It would not be hard for a family member to take this as saying staff and especially doctors do not want to talk with families. I would hope this is not reflective of a general DHB culture.*
- *Further perusal of notes strengthens the previous observation of minimal statement re what family thought.*

b) Increases the amount of 'meta-communication' with the family especially from [Dr C]. I support wholeheartedly his insight regarding the problem that the use of emails to the patient and family can cause (and may well have in this case). I think that there needs to be work done to allow the use of email as a regular communication device in health (bringing it in line with most other day to day communication) but also allows the capture of that communication in clinical notes so it informs others.

I have not changed my view that the prime responsibility here lies within the DHB's system and procedures (may be even culture) and is not one to be directed solely to [Dr C]. I see this at least a moderate level of failure.

2. [Redacted as outside jurisdiction — related to a matter better addressed by the Office of the Privacy Commissioner.]

3. [Dr C's] failure to pass on clinical notes.
Though there is not evidence in written form in the notes there are statements that suggest community follow up would happen. The failure for this to be delivered must lie fully with the DHB; it should not rest with any single doctor. The DHB's response suggests they accept such responsibility.

This failure to arrange community follow up of a patient who has twice tried to [commit suicide] must be seen in the severe range.

All that has been produced serves only to confirm my view that this was a serious failure on behalf of the DHB (again I do not think that [Dr C] can be held personally responsible. The notes have a well written referral summary which claims to have been faxed. I note the DHB continues to apologise for this failure. The discussion of and provision of the '28 Day Follow Up' procedure is not reassuring however. The issue here is that a man who must have been seen by the service as a high risk client (two [suicide attempts] in two weeks, and period of enforced in-patient care because of risk) was allowed to fall through the cracks. […] There should always be a careful agreed management plan that is acted upon by the community team and a method by which there is detection of those not seen.

Assoc Prof S W Miles MDChB, Dip Psychiat, RANZCP
18.06.2013

Inconsistencies in the new evidence

1. When [Mr B] presented to hospital

[DHB] letter	*10.42 am*
[DHB] letter attachment	*10.45 pm*
Ambulance	*10.37 (am assumed as use 24 hr clock I think)*
EW	*1040 am*

I think that the time was in morning; this is of relevance to time that elapses before he is seen by mental health and the on-call registrar involvement.

2. [Dr C's] presence
In the end his own summary clarifies it for me and does show that he was not always in service to provide clinical lead.

3. [Dr E's] involvement
There is a 'Clinic letter' written 16 August 2013 by [Dr E] to [a practitioner in the Inpatient Unit]. It refers to an assessment of 27 [Month1] while in the notes it is 29 [Month1]. I assume that he is referring to the 29th urgent assessment.

These inconsistencies do not substantially influence my opinions.

Assoc Prof S W Miles

26.09.2013"