Psychiatrist, Dr B

Te Whatu Ora|Health New Zealand
Te Pae Hauora o Ruahine o Tararua MidCentral
(formerly MidCentral District Health Board)

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC01201)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the mental health care provided to a man by a consultant psychiatrist and Te Whatu Ora|Health New Zealand: Te Pae Hauora o Ruahine o Tararua MidCentral (formerly MidCentral District Health Board (MCDHB)). The report also discusses the care the man received leading up to this admission.

2. This case highlights the importance of following the legal process designed to protect vulnerable mental health patients and of effective mental health care within the community, including the effective coordination of care.

3. In 2017, an administrative error on the part of MCDHB resulted in a missed appointment for the man. The error was repeated when a letter outlining the man's treatment plan was sent to his former GP instead of his current GP. This resulted in a lack of support for the man and his family, and to confusion and frustration, particularly concerning conflicting direction over the man's medication.

4. In 2018, the man presented to the emergency department at the public hospital seeking assistance and treatment for his mental health condition. The man was assessed by the psychiatrist. The proposed management plan was for the man to be admitted to the High Needs Unit (HNU), and to be detained as an inpatient to undergo a further five-day period of assessment and treatment.

5. However, a lack of communication and inadequate handover between staff, and no doctor-to-doctor handover between the psychiatrist and HNU staff, resulted in the man being placed in seclusion. This was not compliant with the process required under the Mental Health Act.

Findings

6. The Deputy Commissioner found that MCDHB breached Right 4(5) of the Code for the administrative errors in 2017, the lack of adequate communication between staff, inadequate handovers of care between staff, and a lack of clarity amongst staff about their roles and responsibilities.

7. The Deputy Commissioner also found MCDHB in breach of Right 4(2) of the Code, as the use of seclusion did not meet the legal requirements under the Mental Health Act.

8. The Deputy Commissioner found that the psychiatrist breached Right 4(1) of the Code as the psychiatrist did not provide an adequate handover of care, and the process followed failed to meet the legal requirements under the Mental Health Act.

Recommendations

9. The Deputy Commissioner recommended that MCDHB provide a written apology to the man and his family, and provide HDC with an update on the implementation of its "client check-in form" for patients to confirm their correct contact details and details of their current GP.

The Deputy Commissioner also recommended that MCDHB provide HDC with the results of audits of compliance with its policies on admission to acute mental health services and on internal referral and transfer, and use this report for further training of the staff involved in the man's care.

10. The Deputy Commissioner recommended that the psychiatrist provide a written apology to the man and his family. The Deputy Commissioner also recommended that the psychiatrist undertake a refresher course on the Mental Health Act process, and that the Medical Council of New Zealand consider whether a review of the psychiatrist's competence is warranted.

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the mental health care provided to her husband, Mr A, by Dr B and Te Whatu Ora|Health New Zealand Te Pae Hauora o Ruahine o Tararua MidCentral (formerly MidCentral District Health Board (MCDHB)).[1]

12. The following issues were identified for investigation:

- *Whether MidCentral District Health Board provided Mr A with an appropriate standard of care from September 2017 to May 2018 (inclusive).*
- *Whether Dr B provided Mr A with an appropriate standard of care from September 2017 to May 2018 (inclusive).*

13. This report is the opinion of Deputy Commissioner Deborah James, and is made in accordance with the power delegated to her by the Commissioner.

14. The parties directly involved in the investigation were:

Mr A	Consumer
Mrs A	Complainant
Dr B	Provider/psychiatrist
MidCentral District Health Board	Provider

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to MCDHB now refer to Te Whatu Ora|Health New Zealand Te Pae Hauora o Ruahine o Tararua MidCentral.

15. The following people are also referred to in the report:

Clinical Nurse Specialist (CNS) C	Provider/clinical nurse specialist
Registered Nurse (RN) D	Provider/registered nurse

16. Independent advice was obtained from a consultant psychiatrist, Dr Alma Rae (Appendix A), and a mental health nurse, RN Anne Brebner (Appendix B).

How matter arose

Introduction

17. On 30 April 2018, Mr A presented to the Emergency Department (ED) at MCDHB seeking assistance and treatment for his mental health condition. Mr A was admitted to hospital and placed in seclusion. However, Mr A's seclusion was not compliant with the process required under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act).

18. This report discusses the care Mr A received from MCDHB and consultant psychiatrist Dr B. It also discusses the care Mr A received leading up to this admission.

19. In August 2018, MCDHB's Mental Health and Addiction Services (MHAS) undertook a review of the events. A copy of the Serious Incident Review Report (MCDHB's Report) was provided to this Office. Given its detailed review of the events, extracts from MCDHB's Report have been cited to outline the background and a summary of the care provided to Mr A.[2]

20. MCDHB's Report described Mr A's patient psychiatric history as follows:

> "[Mr A was] a [man in his thirties], married with … children … He had his first involvement with mental health services … due to depression, anxiety and suicidality … [H]e was again referred to the MCDHB mental health service in 2002 with low mood and thoughts of ending his life. He came under the care of [the] Community Mental Health Team, during which his mood improved and he was discharged a year later.
>
> Since that time he has managed through the help of his wife, who is very supportive, and his general practice team. He has also maintained full time employment, currently as … His medication has included [paroxetine[3]] and [clonazepam[4]] for anxiety. [Mr A] had problems accessing the mental health service due to a … referral being sent to a residential address the family had not lived at for 16 years. The resulting confusion and

[2] Some of the factual information contained in MCDHB's Report is disputed by Mr A and, as it is not material to my opinion, it has been removed.
[3] Paroxetine is used to treat depression, panic attacks, obsessive-compulsive disorder, anxiety disorders, and post-traumatic stress disorder.
[4] Clonazepam is used to prevent and treat panic disorder and anxiety.

frustration on the [family's] part, particularly concerning conflicting direction over his medication, resulting in him stopping his medication …"

Summary of care

21. MCDHB's Report contained the following summary of the care provided to Mr A prior to his presentation to ED as well as on the day of the seclusion incident:

"**1. Prior to presentation to ED**

In October of 2017 [Mr A] went to see his GP as he felt his medication wasn't working any more. He was eventually referred to specialist services and was seen by a Registrar who developed a plan.

After not hearing from the service his wife rang to find out that his psychiatrist had disagreed with the plan which indicated that [Mr A] increase his paroxetine dose.

They made another appointment where they were advised the plan was to switch to Venlafaxine[5] and that a script would be faxed to a local pharmacy … By this stage [Mr A] reports he lost faith in the mental health service, had no medication left and therefore stopped taking any [of] his medication at that time. Over the next months [Mr A] deteriorated in terms of his mood, anger and intention to self-harm.

The day before [Mr A's] presentation to ED on 30th April 2018 he had been telling his wife of his struggle to find the energy not to kill himself and in the morning of this episode he had been very upset and tearful while organising the children for school … [H]e asked his wife to call community mental health. She called the 0800 (Mental Health) line and was told to go to ED and that they would let them know in advance of his arrival.

'For me, this was a combination of a whole series of events. It went back to nothing happening in October. Long series of things not happening as they should. I had given up on the service, coming was last resort after cold-turkeying it. It was disappointing it hadn't been actioned back then and got to this point.' [Mr A]"

"**2. The Initial Assessment**

[Mr A] presented to ED accompanied by his wife on the 30 April 2018 at 9.50am. No one appeared to know about them when they arrived as they had been advised on the phone. [Mr A] was triaged by the ED nurse and asked to wait in the waiting area as he would be seen by the Mental Health Consult Liaison Service (CNS[6]) when she had finished with another service user. The wait was two hours during which he got very anxious and agitated.

[5] Venlafaxine is used to treat major depressive disorder, generalised anxiety disorder, panic disorder, and social phobia.
[6] Clinical nurse specialist.

[Mr A] was then seen in ED by [CNS C] but due to an inability to find a suitable interview space in ED they walked to the Community Mental Health Rooms in [a building] a short distance away. Having commenced the interview [CNS C] involved the Acute Care Team (ACT) doctor [Dr B] who agreed to see him at 1pm. There are conflicting opinions regarding the extent of the assessment undertaken, however, as a result of this assessment [Mr A] and his wife were informed that he was at such risk of suicide that he would be admitted to [the HNU]. [CNS C] phoned the ward to inform them of a possible admission that day.

> 'I felt like the assessment didn't happen. It was "I read your notes". And that's fine. For me it would have been much more of a conversation. I can understand there would be times where you need to step in and pull people but I felt like I had come pretty desperately for help. If we had sat down and had conversations about best course of action and "what do you think?" and bit of [to] and fro, much gentler.' [Mr A]
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> 'There was a definite sense of no one listening to what we had to say. And people making a whole lot of assumptions without verifying anything. And the fact they kept coming in and out of the room, quite unusual.' [Mr A's wife]"

"**3. [Building] Foyer events and transfer to [the HNU]**

At about 13.10pm, while in the interview room and in response to the news that [Mr A] was to go to [the HNU], he stated that he wanted to go home. While the paperwork was being completed to place him under the Mental Health Act, a requirement for admission to the High Needs Unit (HNU), he attempted to leave the building. Because of the assessed risk his movement toward the door was intercepted by [two of the ACT clinicians] (on being prompted by [Dr B]) who eventually had to use personal restraint to prevent him from leaving (an action covered by the Crimes Act, Section 41).

> '… came back for assessment. Was not assessment. Just telling me I need to be here and they have authority or permission to do any treatments they deem necessary.' [Mr A]

… At 13.30pm, following a discussion with [Dr B] and another ACT RN, the ACT Clinical Coordinator [RN D] phoned the ward to inform them that they would be transferring [Mr A] to [the HNU] immediately. No medical hand over was given. The ACT clinicians appeared at the door of the interview room to inform [Mr A] that they were there to take him to [the HNU]. [Mr A] was then transported to [the HNU] by car accompanied by two ACT RNs and two security guards. [CNS C] stayed with his wife [in the interview room]."

"**4. [HNU] Admission and Seclusion Event**

On arrival through the emergency entrance at 2.15pm … the ACT Clinical Coordinator [RN D] indicated to the [HNU] Coordinator that [Mr A] needed to go straight into

Seclusion indicating that he was already under the Mental Health Act. This was not in fact correct and no formal handover occurred at this time.

The [HNU] staff expressed concern about the absence of a formal hand over process and the decision to move straight to seclusion, but accepted that the ACT staff [were] more aware of [Mr A's] risk profile than they and that [Mr A] was under [the] mental health act though this was not evidenced by documentation as is normal.

[Mr A] was then escorted directly from the interview room to his allocated seclusion room. [Mr A's clothes were changed] into a stitch gown with a female member of staff holding up a sheet in an attempt to protect his privacy while male staff stood by. The staff [then] left the room and the door was locked at 2.20pm.

> 'Quick transition from interview room. Got out of car with security and nurses and escorted into … room in [HNU]. Felt anxious. Didn't understand why I was going through this process. Even in Comm MH there wasn't really a conversation — was just "read your file, you are sick, need to be committed".' [Mr A]"

"**5. The Mental Health Act Process**

One of the ACT RNs who had helped escort MS and who was a Duly Authorised Officer (DAO) was asked by the ACT Clinical Coordinator to act as DAO to oversee the Mental Health Act process which was still incomplete (though [Mr A] was already in seclusion). Shortly after this at 2.20pm [Dr B] arrived with the intention of completing the Mental Health Act papers that had been interrupted by [Mr A's] departure [from] the ward. At [Dr B's] request the staff had opened his room door [and Dr B] delivered the papers. At 3pm [Dr B] then left the ward …

At about 2.30pm [CNS C] arrived at the ward accompanied by [Mr A's] wife. [CNS C] spoke to the afternoon [HNU] staff to give them a handover on [Mr A]. Seclusion was terminated that evening at 21.30pm. [Mr A's] wife was not given any access to her husband or asked any questions around his wellbeing by ward staff."

22. Mr A stated that he was released from seclusion the following morning, on 1 May 2018, and not at 9.30pm on the evening of 30 April 2018. He told HDC that he was held in the seclusion room for 19 hours, from 2.15pm on 30 April 2018 until approximately 9.30am on 1 May 2018. He said that this was "an extremely traumatic" experience for him.

Summary of key issues

23. MCDHB's Report identified a number of key issues in the care provided to Mr A, as summarised below.

24. The Report found that Mr A's care was characterised by inadequate assessment, hasty decision-making, and significant deviation from accepted organisational and legal processes, designed to ensure safe care. The Report noted that the events contributed to psychological trauma for Mr A and his wife, and to a breach of Mr A's rights as a service user.

Communication with Mr A and his whānau

25. MCDHB's Report stated that the initial assessment of Mr A by CNS C and Dr B was "questionable", and that the communication with Mr A and his wife was conducted in a manner that did not take into account their perspectives adequately.

26. The Report suggested that if the decisions around Mr A's treatment plan had been made in partnership with Mr A and his wife, Mr A's anger, his attempt to leave, and Mrs A's distress, may have been prevented.

27. Mr A's wife said that there was little regard for Mr A's family, as she was asked to remain in the building, rather than accompany Mr A to the ward.

28. Mrs A told HDC that she advised CNS C that she did not think Mr A's admission was necessary, and that the family would be able to provide supported care. Mrs A said that she felt disregarded as Mr A's support person, and that "events proceeded at pace".

29. Dr B stated that the rationale for the proposed intervention was discussed with Mr A and his wife and their input on the proposed management plan was sought. Dr B believed that the communications with Mr A and his wife were respectful and encouraged open communication. Dr B told HDC that Mr A had left the building early on in the assessment, and that subsequently the assessment was continued when he returned to the interview room.

30. Dr B said that the requisite time was taken to interview Mr A, which included "introductions, taking a full history with mental state examination and risk assessment, talking to [Mr and Mrs A], and explaining the Mental Health Act process". Dr B said that "listening with empathy does not however mean that clinical staff have to agree with [Mr and Mrs A] when there were serious safety concerns".

Coordination of care

Communication

31. MCDHB's Report stated that there was a lack of communication between individual staff members, and a lack of communication between the ACT and the HNU team.

32. The Report noted that CNS C, as the primary assessor, was in the best position to continue the ongoing communication about Mr A's assessment and presentation, but she did not accompany him on his transfer to the HNU. The Report stated that CNS C's decision not to accompany Mr A to the HNU led to communications becoming "disjointed" with RN D, the ACT coordinator who transferred Mr A to the ward.

33. RN D acted on brief instructions from the psychiatrist, Dr B, which resulted in him providing a limited handover to HNU staff. MCDHB's Report stated that a formal handover should have occurred to ensure that RN D had a more complete knowledge of Mr A. RN D acted on the limited information he had, and his misunderstanding that it was Dr B's instructions to place Mr A in seclusion.

34. RN D agreed that it was not "the perfect process" and that he may have misunderstood Dr B's instructions about seclusion.

35. Dr B believes that the discussions with RN D were robust and sufficiently comprehensive as to constitute a formal handover. Dr B disputed that the information provided to RN D was limited and that he had insufficient knowledge about Mr A's condition or treatment plan.

36. Dr B stated that it was open to RN D to seek further information, and that he did not do so.

37. In addition, MCDHB's Report noted that no handover from the community doctor to the inpatient doctor occurred prior to the ward admission. The Report stated that this contributed to HNU staff's lack of preparedness for the admission, and lack of knowledge of Mr A's presentation.

38. MCDHB's Report also noted that the ACT team over-rode the authority of the ward staff, including bypassing standard handover procedure and placing Mr A in seclusion. The Report stated that normally this would be initiated by inpatient staff, and required Mr A to be under the Mental Health Act, which he was not at that stage.

39. MCDHB accepted that there was poor communication within the ACT and limited assessment information available to make sound clinical decisions.

Roles and responsibilities

40. MCDHB's Report stated that there was a lack of clarity as to who was leading Mr A's care as he transitioned from the ACT to the HNU, and at no point were the roles and responsibilities established, especially regarding the role of lead clinician. The Report noted that CNS C should have led the team responsible for transporting Mr A to the HNU, and that her failure to do so contributed to the role confusion and the later poor decision-making.

41. MCDHB's Report stated that RN D's decisions, in the absence of CNS C's more comprehensive knowledge and understanding of Mr A's mental state, resulted in Mr A being placed in seclusion. The Report considered that if CNS C had remained as the primary lead, the transfer and the more comprehensive assessment would have enabled a better understanding of Mr A's presentation, and could have avoided the confusion that led to the decision to seclude.

42. CNS C told HDC that when the time came for Mr A to be transferred to the acute inpatient ward, two clinicians and two security guards came to the door. She said that she realised that they would not all fit in the car, and so she agreed "to stay and support [Mrs A] as she was very distressed". CNS C said that one of the clinicians, a DAO, did not advise her that she needed to accompany them.

43. CNS C stated: "[I]n these situations, we have always been taught that the DAO coordinates and takes the lead. At this point, I was not a [DAO]."

44. MCDHB's Report stated that the evidence suggested that HNU staff did question the appropriateness of seclusion among themselves, but not to the point of challenging the authority of RN D in this regard. The Report said that this suggested a lack of clarity in the transition of care process.

Handover

45. MCDHB's Report stated that if protocol had been followed, CNS C should have led the care process and the transition of care to the HNU. RN D, who provided the handover to the HNU team, had a limited knowledge of Mr A, and continued to act on his misunderstanding of Dr B's instructions to seclude Mr A.

46. MCDHB's Report also stated that there was no doctor-to-doctor handover between the ACT and the HNU.

47. MCDHB said that at least a verbal handover by Dr B to the ward consultant would have been expected. In contrast, Dr B disagreed and told HDC:

> "[T]here would be a DAO co-ordinating the whole process and our process would involve booking the bed first by handing over to the ward — it is standard procedure at the service."

48. Dr B recalled that the inpatient consultant was not available when the ward was called to book the bed, so the admission was either accepted by the junior doctor (registrar) or the ward manager/nurse in charge. Dr B said that the ward would always be called if the senior medical officer (SMO) was not contactable, and a message would be left if there was no answer. Dr B said that given the inability to reach the ward SMO on the afternoon of 30 April 2018, handover was completed on the phone, with the next person of seniority on the ward.

Adherence to Mental Health Act process

49. MCDHB's Report stated that the Mental Health Act procedure was not followed correctly, and Mr A's seclusion was without a legal mandate. The Report noted that the Mental Health Act documentation was not completed until after Mr A had been placed in seclusion.

50. MCDHB's Report stated that had the expected admission procedure been followed, Mr A would have been in the interview room of the HNU until such time as the Mental Health Act documentation and the transition of care to the HNU team had been completed. The Report stated that there was an opportunity at the ward to take a "pause" in proceedings, but this did not happen, resulting in Mr A being detained in seclusion illegally.

51. MCDHB's Report also stated that a further breach of the Mental Health Act occurred, as CNS C completed the documentation under section 8B[7] on the direction of Dr B, who also

[7] Section 8B of the Mental Health Act applies when a mental health practitioner is asked by an applicant to issue a certificate to accompany the application form, or a mental health practitioner is the applicant and wishes to issue a certificate to accompany his or her application form.

completed the documentation under sections 10[8] and 11.[9] The Report stated that Dr B was not independent regarding sections 10 and 11 of the Mental Health Act. This means that a different doctor should have completed the documentation under sections 10 and 11 of the Mental Health Act.

52. MCDHB acknowledged that the use of seclusion appears to have been illegal.

53. Dr B told HDC that "the DAO was fully involved" in the Mental Health Act process. Dr B accepted that the process undertaken did not meet the legal requirements.

Further information

The family

54. Referring to the events that occurred in October 2017, prior to Mr A's admission, Mr A's wife stated that the failure in the process led to Mr A being completely unsupported for a period of approximately six months, after he had been assessed in October 2017 as being at risk of self-harm. She also stated that Mr A's questioning and assessment was inadequate, and the treatment he received was inappropriate.

MCDHB

55. MCDHB's Report noted that even before Mr A presented to the ED, there was a history of poor follow-up and communication, leading Mr A to "fall between the gaps".

56. MCDHB's Report concluded that the overall picture was one of significant systems and professional practice failings. The Report stated:

> "[F]ragmented assessment, confusion with roles definition and poor communication led to a domino effect whereby the staff involved effectively lost control of the situation involving an extremely vulnerable service user and his wife. To compound this, the legal process designed to protect [Mr A] in these situations, was mismanaged to the extent that he was secluded illegally. Most of all, this incident is characterised by a lack of compassion and respect for the rights of [Mr A] and his family with whom [staff] are obligated to work in partnership."

57. MCDHB asked HDC to convey their heartfelt apologies to the family for the distress that this incident and the enquiries have had on them. MCDHB acknowledged that "things went wrong" during the referral process in 2017, and that the care Mr A received was not satisfactory, and that it did not meet his family's or MCDHB's expectations.

[8] Section 10 of the Mental Health Act provides that after completing the assessment examination, the mental health practitioner must record his or her findings in a certificate of preliminary assessment.

[9] Section 11 of the Mental Health Act provides that if the mental health practitioner records a finding under section 10(1)(b)(ii) (being that there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment), the mental health practitioner must require the patient to undergo further assessment and treatment throughout the first period. The mental health practitioner must give the patient written notice of this requirement.

58. MCDHB made an offer of psychological support to Mr A and his family to acknowledge the distress caused by the events.

Dr B

59. Dr B told HDC that the actions taken throughout were in good faith. Dr B said that Mr A's presentation to the ED on 30 April 2018 with severe symptoms of acute mental distress and marked suicidal thinking required clinical intervention and for Mr A's safety to be a priority.

CNS C

60. CNS C told HDC that at the time of Mr A's assessment on 30 April 2018, she had been in her role as clinical nurse specialist consult liaison in the ED only for "a very short time". She said that Mr A's admission was her first under the Mental Health Act, and she agreed that she was not aware of the related procedures at that time.

Responses to provisional opinion

61. Mr and Mrs A were given an opportunity to respond to the "How matter arose" section of the provisional opinion. Mr A's comments have been incorporated into this opinion where relevant.

62. Mrs A told HDC:

> "The failure to follow up [seven] months earlier, for a [person] who they knew was actively suicidal and severely depressed is also completely unacceptable, this occurred after the two visits to the [MCDHB] community mental health team in October 2017. This lack of care caused [Mr A] to disconnect from all health services, and his depressive illness over the next [seven] months had a significant negative impact on his family and his work. With appropriate follow up in October this whole incident may never have happened."

63. Mr A told HDC that a key reason for the complaint to HDC was because he and his wife, and "a number of staff on [the HNU] at the time" felt that seclusion was "completely unnecessary" and that it had occurred "because of inappropriate and unprofessional actions and decisions made by the staff involved in the process". Mr A stated:

> "[MCDHB's Report] makes the admission into seclusion sound like an administration error, whereas [my wife and I feel] it was malpractice both by the psychiatrist and the nurses on duty — who failed to provide appropriate care, and who instead caused significant harm and trauma."

64. Mr A disagreed that he attempted to leave "in response to the news" that he had to go to the HNU, as stated in MCDHB's Report. He told HDC that while he was in the interview room, Dr B re-entered the room "with notes and without preamable asked [him] about [a traumatic childhood event]. Mr A said that Dr B's questioning led him to ask Dr B about the content of the clinical notes, as Dr B's question was not based on accurate information and "immediately caused concern about the veracity of other content". He said that this caused

him considerable distress "on top of his already considerable anxiety". He stated that it was the "feeling of complete lack of emotional safety" that caused him to ask to go home.

65. Mr A told HDC that both he and Mrs A felt that "the inappropriate questioning by [Dr B], combined with that morning's process in [ED] and the approach of [RN D] led to an escalation of events that could have been prevented".

66. Dr B was given an opportunity to respond to the relevant sections of the provisional opinion. Dr B's comments have been incorporated into this opinion where appropriate.

67. Dr B told HDC that the issue of previous assault was raised by Mr A. Dr B stated: "I would never have addressed such a delicate matter in the way [Mrs A] described."

68. Dr B said that with the benefit of hindsight, there were Mental Health Act process issues associated with the care provided to Mr A on 30 April 2018. Dr B acknowledged the importance of getting admissions under the Mental Health Act right. Dr B noted Dr Rae's comments that very few people are permitted to detain others in New Zealand, and that the right of mental health professionals to do so must be taken seriously and used with great care.

69. MCDHB was given an opportunity to respond to the provisional opinion. MCDHB accepted the provisional findings.

70. CNS C was given an opportunity to respond to the provisional opinion. CNS C's comments have been incorporated into this opinion where appropriate.

71. CNS C apologised for the undue distress that her actions caused Mr A and his wife. CNS C told HDC that she is now aware of all the necessary procedures, and ensures "that client and whānau welfare is always at the [centre] of her care".

Opinion: Te Whatu Ora|Health New Zealand Te Pae Hauora o Ruahine o Tararua MidCentral (formerly MCDHB) — breach

Introduction

72. First, I would like to acknowledge the distress that these events have caused Mr A and his family.

73. This case highlights the importance of effective mental health care within the community. Due to a number of administrative errors that occurred in 2017, prior to Mr A's admission, he did not receive the mental health care and treatment he required.

74. This case also illustrates poor coordination of care, and inadequate transfer of information between teams within MCDHB, and between individual staff members. Effective

coordination of care is vital in the mental health setting, where a vulnerable consumer with complex mental health needs is receiving care from different teams and transitioning between them. There were deficiencies in the overall level of coordination between the ACT and HNU team, and between individual staff members.

75. Further, the legal process designed to protect patients in these situations was not followed, which resulted in Mr A being secluded illegally.

76. MCDHB had overall responsibility for the services provided to Mr A when he presented to the ED for mental health care and treatment. A series of errors and failings on the part of multiple staff members led to the poor care provided to Mr A. While individual staff members hold some degree of responsibility for their failings (which is discussed further below), I consider that MCDHB bore overall responsibility at a service level for the deficiencies set out below.

77. As noted above, I have at times referred to MCDHB's Report for a description of the factual events that occurred. However, for the avoidance of doubt, while the findings of MCDHB's Report are important and have been taken into account, I have relied on my own assessment of those facts, and have considered the advice from my independent advisors, Dr Alma Rae and RN Brebner, in reaching the conclusions in this report.

Coordination of care

Care provided in 2017

78. Due to an administrative error on the part of MCDHB and its database not having been updated, Mr A did not receive the appointment letter dated 29 September 2017 sent by the community health service. This resulted in a missed appointment.

79. The administrative error was repeated when the letter dated 6 November 2017 outlining Mr A's treatment plan was sent to his former GP, instead of his current GP.

80. These administrative errors had a negative impact on Mr A's mental health. First, it resulted in delayed treatment. Then, it resulted in Mr A receiving no anti-depressive treatment for approximately seven months (from the beginning of October 2017 to the end of April 2018), causing his mental health condition to deteriorate.

81. In my view, these administrative errors meant that there were multiple missed opportunities for Mr A to receive timely and appropriate treatment. Mr A is a vulnerable consumer with a long history of mental health issues, and it was critical to ensure that he was provided with the care and treatment he needed.

Care provided on 30 April 2018

Communication and handover

82. In assessing whether there was adequate co-ordination of Mr A's care between staff, I have relied on the independent clinical advice provided by Dr Rae.

83. Dr Rae advised that there seems to have been no communication from Dr B to the HNU consultant. Dr Rae stated that although there can be circumstances in which it is not possible to speak to the receiving consultant immediately and the need for admission is urgent, these are unusual, and in this case there is no evidence that the HNU consultant was not available. Dr Rae considered that the failure to communicate with the receiving consultant fell "well short of accepted practice", and represents a moderate departure from accepted practice.

84. Dr Rae also advised that the handover between the ACT and HNU staff was "chaotically inappropriate".

85. I accept Dr Rae's advice. In my view, a series of events demonstrated a lack of communication and inadequate handover between staff.

86. There was no doctor-to-doctor handover between Dr B and HNU staff. This lack of communication and inadequate handover contributed to HNU staff having a lack of information about Mr A's presentation.

87. RN Brebner also advised that there was no evidence of a formal handover between ACT staff and HNU staff.

88. As commented on in MCDHB's Report, CNS C's failure to accompany Mr A to the ward resulted in communications between staff becoming "disjointed". This led to a communication breakdown between Dr B and RN D. Dr B provided RN D with only limited information about Mr A's assessment, which caused RN D to misinterpret Dr B's plan and the use of seclusion.

Roles and responsibilities

89. The purpose of MCDHB's policy that was in place at the time of the events[10] was to describe the pathway for access to the HNU, and to give clarity on the roles and responsibilities of staff. A number of staff members failed to follow the correct procedure, which in my view resulted in a lack of clarity amongst staff about their roles and responsibilities.

90. CNS C failed to follow the correct procedure, as she did not escort Mr A to the ward. MCDHB's procedure in place at the time of events[11] clearly provided that the assessing clinician should escort the service user to the inpatient facility, and remain with the service user until the handover has been completed in full. As both the senior nurse and the initial assessor, CNS C was in the best position to lead Mr A's care during the transfer to the ward, and she should have led the team responsible for transporting him to the ward.

91. In my view, the failure by CNS C to follow the correct procedure contributed to the role confusion amongst staff, and the later poor decision-making.

[10] Policy on Acute Inpatient Mental Health High Needs Unit — policy document number MDHB-4922.
[11] Procedure on Admission to Mental Health Services Acute Inpatient Unit (the HNU) — procedure document number MDHB-1513.

92. As commented on by Dr Rae, the DAO should also have insisted on the correct procedure being followed, but failed to do so.

93. Further, it is the role and clinical responsibility of HNU staff to decide on the need for seclusion, not the ACT staff. While HNU staff expressed their concerns about the absence of a formal handover process and questioned the appropriateness of seclusion, they did not challenge the authority of the ACT coordinator in this regard, or take sufficient action for the process to be stopped. This further demonstrates a lack of clarity amongst staff about their roles and responsibilities, for which I hold Te Whatu Ora|Health New Zealand Te Pae Hauora o Ruahine o Tararua MidCentral responsible.

Conclusion

94. Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code) provides that every consumer has the right to co-operation among providers to ensure quality and continuity of services. As discussed above, I consider that MCDHB breached Right 4(5) of the Code for the following reasons:

- There were serious administrative errors in 2017, resulting in Mr A not receiving his appointment letter from the community health service, and resulting in his treatment plan being sent to his former GP, instead of his current GP;

In 2018, when Mr A presented to the emergency department at the public hospital:

- There was a lack of adequate communication between staff;
- There were inadequate handovers of care between staff; and
- There was a lack of clarity amongst staff about their roles and responsibilities.

Compliance with legal standards in Mental Health Act

95. Dr Rae advised that both limbs of the Mental Health Act, as required for a compulsory admission, had been met, and that the clinical rationale for Mr A to be detained under section 11 of the Mental Health Act was reasonable.

96. RN Brebner advised that the use of the Mental Health Act and the use of seclusion was appropriate in this case, as staff had concerns for Mr A's safety. She commented that clinicians can and should take all steps necessary to ensure the safety of the "proposed patient", and that the Mental Health Act was the correct mechanism in this case.

97. While I accept the advice that the clinical rationale for Mr A to be transferred to the ward was reasonable, I do not accept that the correct legal process was followed. RN Brebner's advice appears to be focused around the clinical decision-making, but I consider that it does not reflect the legal requirements accurately.

98. The documentation under sections 10 and 11 of the Mental Health Act was not completed prior to Mr A being placed in seclusion. Mr A was placed in seclusion at 2.20pm, but the documentation under sections 10 and 11 was not completed until 3.00pm.

99. MCDHB's Report noted that in accordance with the admission procedure, Mr A should have remained in the interview room in the HNU until such time as the Mental Health Act documentation had been completed, and the transition of care had been handed over to the HNU team.

100. Mr A's detention was illegal, as he was placed in seclusion prior to the required documentation under the Mental Health Act being completed.

101. Section 71 of the Mental Health Act allows for the use of seclusion of a "patient". A "patient" is defined in the Mental Health Act as a person who is required to undergo assessment under sections 11 or 13 of the Mental Health Act, a person who is subject to a compulsory treatment order made under Part 2 of the Mental Health Act, or a person who is a "special patient" (as defined in the Mental Health Act).

102. Under the Mental Health Act, a person becomes a "proposed patient" when an application is made under section 8A, and stops being a "proposed patient" when a mental health practitioner records a finding under section 10(1)(b)(i), in which case the person does not become a "patient", or under section 10(1)(b)(ii), in which case the person becomes a "patient".

103. At the time of his seclusion at 2.20pm on 30 April 2018, Mr A was not a "patient" as defined in the Mental Health Act. At that time, he was only a "proposed patient", as the documentation under section 10(1)(b)(ii) had yet to be completed. Mr A became a "patient" under the Mental Health Act only at 3.00pm, when the documentation under section 10 had been completed. The use of seclusion therefore did not meet the legal requirements under the Mental Health Act.

104. MCDHB accepted that Mr A's seclusion was illegal.

105. Accordingly, I find that MCHDB breached Right 4(2) of the Code by failing to provide Mr A with services that complied with legal standards.

Conclusion

106. As discussed above, I consider that MCDHB breached Right 4(2) of the Code as the use of seclusion did not meet the legal requirements under the Mental Health Act.

Opinion: Dr B — breach

107. Mr A was assessed by Dr B following his presentation to the ED on 30 April 2018. Dr B's proposed management plan was for Mr A to be admitted to the HNU, and to be detained as an inpatient to undergo a further five-day period of assessment and treatment. In assessing whether the care provided to Mr A by Dr B was reasonable, I considered the independent advice from a consultant psychiatrist, Dr Alma Rae.

108. Dr Rae advised that Dr B's assessment report, for the purpose of completing sections 10 and 11 of the Mental Health Act, indicates that all of the relevant information was gathered and recorded. Dr Rae also advised that Dr B's management plan was comprehensive and sensible.

109. Dr Rae advised that both limbs of the Mental Health Act, as required for a compulsory admission, had been met, and that Dr B's rationale for Mr A to be detained under section 11 of the Mental Health Act, and to be admitted to the ward, was reasonable. At the time of the assessment, Mr A had a clear history of major depression and post-traumatic stress disorder (PTSD), with severe symptoms and marked suicidal thinking. In addition, Mr A had attempted to leave the hospital, which demonstrated that a voluntary admission would have been unsafe.

110. I accept that Dr B's proposed management plan for Mr A to be transferred to the HNU was appropriate. However, there were deficiencies in Dr B's handover and following of the appropriate process under the Mental Health Act, as outlined below.

Care and skill — breach

Handover to HNU consultant prior to Mr A's seclusion

111. Dr Rae advised that there seems to have been no communication from Dr B to the HNU consultant. MCDHB's Report also noted that no "doctor-to-doctor" handover occurred between Dr B and an HNU consultant prior to Mr A's admission to the ward.

112. MCDHB's policy on the acute inpatient mental health high needs unit[12] in effect at the time of events provided:

> "All HNU admissions require a handover to the nurse in charge of the shift … prior to admission so that risks can be assessed. There must also be a medical handover between Consultants. This MUST occur prior to admission."

113. Dr Rae advised that Dr B did not follow the procedure for admitting patients to the ward. Dr Rae considers that this represents a moderate departure from accepted practice.

114. I accept Dr Rae's advice. MCDHB's procedure at the time of events clearly provided that a medical handover between consultants was to occur prior to a patient being admitted to the inpatient ward. Dr B failed to follow this procedure, as Dr B did not provide a formal handover to an HNU consultant prior to Mr A being admitted to the ward.

115. I reject Dr B's submission that the standard procedure was for a DAO to co-ordinate "the whole process", which included a handover to the ward. This is not in accordance with MCDHB's policy in place at the time of events.

[12] Policy document number MDHB-4922.

116. MCDHB also agreed with Dr Rae's advice, and said that it would have expected there to have been at least a verbal handover from Dr B to the ward consultant.

Adherence to Mental Health Act process

117. Dr B did not complete the documentation under sections 10 and 11 of the Mental Health Act prior to Mr A being placed in seclusion. Mr A was placed in seclusion at 2.20pm, but the documentation under sections 10 and 11 was not completed until 3.00pm.

118. Dr Rae advised that Mr A's detention was illegal, as the requirements under the Mental Health Act had not been met.

119. Dr Rae also advised that as Dr B was involved in the documentation under section 8B of the Mental Health Act, and had instructed CNS C to complete this, Dr B was not independent, and should not have completed the assessments under both sections 10 and 11 of the Mental Health Act.

120. Dr Rae concluded that the entire Mental Health Act process was "nowhere near expected standards or accepted practice and represents a very serious departure therefrom".

121. I accept Dr Rae's advice, and agree that Dr B failed to follow the process under the Mental Health Act.

122. Dr B was not independent, and therefore should not have completed the assessments under both sections 10 and 11 of the Mental Health Act.

123. Dr B and MCDHB also agreed that the process followed by Dr B failed to meet the legal requirements.

Conclusion

124. To conclude, I find Dr B in breach of Right 4(1) of the Code, as Dr B failed to provide services with reasonable care and skill because Dr B did not provide an adequate handover of care, or follow the legal requirements under the Mental Health Act.

Assessment — adverse comment

125. Mr A and Dr B had different recollections of events around Dr B's assessment.

126. Mr A stated that his recollection of events is that "there wasn't really a conversation — [it] was just 'read your file, you are sick, need to be committed'." In relation to the assessment, he also stated: "[It was] just telling me I need to be here and they have authority or permission to do any treatments they deem necessary."

127. Mr A told HDC that Dr B's "inappropriate questioning" about a traumatic childhood event caused him considerable distress and that "the feeling of complete lack of emotional safety" was what had led to him wanting to go home and not be admitted.

128. Dr B denied having addressed the issue of a prior traumatic event in the way that Mr A described. Dr B's recollection of events is that the rationale for the proposed intervention

was discussed with Mr A and his wife, and that their input on the proposed management plan was sought.

129. Dr B also denied that the assessment of Mr A was brief, and stated that it was inconceivable and erroneous to suggest that it took only 10 minutes. Dr B told HDC that the requisite time was taken to interview Mr A, which included "introductions, taking a full history with mental state examination and risk assessment, talking to [Mr and Mrs A], and explaining the Mental Health Act process".

130. Dr Rae advised that although Dr B's decision for Mr A to be transferred to the ward was appropriate, if Dr B's assessment took ten minutes, it would be "unusually brief", which would indicate that Dr B had made the decision in a hasty manner, and without taking the time to explain matters to Mr A and his wife adequately and develop a therapeutic alliance.

131. MCDHB's procedure in place at the time of events[13] provided that when an admission is deemed appropriate, the admitting psychiatrist should discuss the rationale for the proposed interventions with the consumer and their family (where appropriate). Dr Rae advised:

> "[I]t is certainly accepted practice to get alongside patients and their families as much as possible and unless there was a very good reason why this did not happen, then the assessment process fell short."

132. Dr Rae concluded that overall, the assessment process followed by Dr B lacked the appropriate communications with Mr A and his family.

133. I acknowledge Dr Rae's advice. However, due to contradictory evidence, I am unable to determine whether Dr B's assessment was brief, or involved Mr and Mrs A adequately, and whether the manner in which Dr B questioned Mr A about the prior traumatic event was appropriate. However, I acknowledge that this experience was deeply distressing for both Mr A and his wife, and that Dr B's questioning was a factor in the breakdown in the relationship. It is clear that Mr A and his wife did not feel they had satisfactory input into the assessment or were listened to.

134. Mr A had the right to an environment that enabled him and Dr B to communicate openly, honestly, and effectively. The importance of good communication with patients during the assessment process, and taking a consumer-centred approach by involving the patient and their family in the treatment plan, where possible, cannot be overstated.

Handover and communication with clinical coordinator — adverse comment

135. On 30 April 2018, after Mr A was restrained and prevented from leaving the hospital, Dr B had a brief discussion with the clinical coordinator, RN D, but no formal handover occurred. RN D stated that Dr B advised him "what had happened and what was to happen", and that

[13] Procedure on Admission to Mental Health Services Acute Inpatient Unit (the HNU) — procedure document number MDHB-1513.

Mr A needed to go to the HNU under the Mental Health Act. RN D stated that based on his discussion with Dr B, it was his understanding that Dr B had directed that Mr A be secluded.

136. Dr B submitted that the direction that Mr A be secluded was never given, and that there was no mention or documentation requesting seclusion.

137. Dr B submitted that RN D was given adequate information, and it was open to RN D to seek further information. I am unable to determine exactly what information Dr B conveyed to RN D, and consequently cannot find any breach of the Code in this regard. However, it is clear that a miscommunication eventuated and RN D had insufficient knowledge about Mr A's condition, or the treatment plan. This was a factor in the resulting misunderstanding about Mr A's care, and led to Mr A being detained in seclusion. While I acknowledge that RN D could have sought more information, in my view, ultimate responsibility rested with Dr B as the consultant psychiatrist to ensure that the clinical coordinator had all the information he required.

Opinion: CNS C — adverse comment

138. RN Brebner advised that there is no evidence of a handover between the ACT staff and the HNU.

139. I agree that no formal handover occurred, and consider that CNS C, as the assessing clinician, did not follow the correct procedure when care of Mr A was handed over to the HNU.

140. MCDHB's procedure in place at the time of events clearly provided that the assessing clinician should escort the consumer to the inpatient facility, and remain with the consumer until the handover has been completed in full.

141. MCDHB's Report also noted that CNS C should have led the team responsible for transporting Mr A to the HNU, and that her failure to do so contributed to the role confusion and the later poor decision-making that led to Mr A's seclusion.

142. As commented on by RN Brebner, communication of patient information between clinicians is a fundamental component of health care, and mental health acute care settings are dynamic environments and rely on timely and accurate information to plan care and manage risk.

143. I am concerned that CNS C did not follow the correct procedure, and have made a recommendation for her to review and familiarise herself with Te Whatu Ora|Health New Zealand Te Pae Hauora o Ruahine o Tararua MidCentral's current policies and procedures relating to the Mental Health Act process.

Changes made since events

144. The reviewers in MCDHB's Report made a number of recommendations for changes as a result of the events. Full details are set out in the extract of the Report included as Appendix C.

145. MCDHB provided HDC with evidence that all of the recommendations set out in the Report are in the process of being implemented. MCDHB also said that it put in place important improvements in its processes to ensure that an incident of this nature does not occur again in the future.

146. MCDHB told HDC that over the last few years, the inpatient team has seen substantial changes in its practice, which have resulted in a significant reduction in the use of restrictive practices, including seclusion. MCDHB said that it is committed to seeing an overall reduction in the use of the Mental Health Act.

147. MCDHB also told HDC that it has been implementing a "client check-in form" where, upon attending appointments, patients will be asked to confirm their correct contact details, and details of their current GP.

Recommendations

148. Taking into account the changes implemented by MCDHB since the events, I recommend that MCDHB:

a) Provide a written apology to Mr A and his family for the failings 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 A and his family.

b) Provide HDC with an update on the implementation of the "client check-in form" for patients to confirm their correct contact details, and details of their current GP. The update is to be provided to HDC within three months of the date of this report.

c) Consider how the client check-in form can be applied retrospectively to ensure that there will be visibility over patients who may be lost to follow-up, or non-responsive to referrals prior to the implementation of its client check-in form. Te Whatu Ora|Health New Zealand should report back to HDC on its consideration of this issue within three months of the date of this report.

d) Provide HDC with the results of the audit of compliance with procedure document MDHB-1513 (Procedure on Admission to Mental Health Services Acute Inpatient Unit (the HNU), as set out in recommendation 1 of MCDHB's Report, within three months of the date of this report.

e) Provide HDC with the results of the audit of compliance with procedure document MDHB-725 (Procedure on Adult Mental Health and Addiction Services — Internal Referral Transfer Form), as set out in recommendation 2 of MCDHB's Report, within three months of the date of this report.

f) Use this report as a basis for training and reflection for all ACT and HNU staff who were involved in Mr A's care. Evidence of the training is to be provided to HDC within three months of the date of this report.

149. I recommend that Dr B:

a) Provide a written apology to Mr A and his family for the failings 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 A and his family.

b) Undertake a refresher course on the Mental Health Act process. Evidence of this is to be provided to HDC within three months of the date of this report.

c) Consider reviewing the manner of communication with patients during any assessment process, to ensure that Dr B is taking a consumer-centred approach by involving the patient and their family in a treatment plan, where possible.

150. In addition, I recommend that the Medical Council of New Zealand consider whether a review of Dr B's competence is warranted.

151. I recommend that CNS C review and familiarise herself with Te Whatu Ora|Health New Zealand's current policies and procedures relating to the Mental Health Act process. Evidence of this is to be provided to HDC within three months of the date of this report.

Follow-up actions

152. A copy of this report with details identifying the parties removed, except MidCentral District Health Board/Te Whatu Ora|Health New Zealand Te Pae Hauora o Ruahine o Tararua MidCentral, and the advisors on the case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

153. A copy of this report with details identifying the parties removed, except MidCentral District Health Board, Te Whatu Ora|Health New Zealand Te Pae Hauora o Ruahine o Tararua MidCentral, and the advisors on this case, will be sent to the Director of Mental Health and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from a psychiatrist, Dr Alma Rae:

"Thank you for referring this case for an expert opinion.

My qualifications for commenting on it are a 30 year career in general adult psychiatry, much of it in the community, including work in various emergency mental health teams. I also have a Masters in Bioethics and Health Law. Please see attached CV for further details.

In preparing this report I have received and read:

- Letter of Complaint
- MidCentral DHB's response
- Clinical records from MidCentral DHB
- Copies of relevant policies

I have been asked to comment on:

1. The initial assessment by the ACT doctor upon [Mr A's] arrival to the hospital;
2. The appropriateness of the use of restraint when [Mr A] attempted to leave the [building];
3. The appropriateness of the handover between the ACT and HNU;
4. The appropriateness of the use of seclusion and adequacy of the Mental Health Act process;
5. Any other matters I consider amount to a departure from accepted standards of care.

For each question, my advice is requested on:

a. The standard of care/accepted practice;
b. If there has been a departure from the standard of care/accepted practice, how significant is that departure;
c. How my peers would view this case;
d. Any recommendations I may have for improvement so as to prevent a similar occurrence.

1. The initial assessment by the ACT doctor upon [Mr A's] arrival to the hospital.

The only documentation of this appears to be the Clinical Report written by [Dr B] when [Dr B] examined [Mr A] for the purpose of completing sections 10 and 11 of the Mental Health Act (MHA). However, the report, in legible longhand, indicates that a comprehensive and apposite range of information was gathered and recorded.

[Dr B] notes previous history and diagnosis as well as more recent history including the stopping of his medication. A functional enquiry is recorded, and a mental status examination, brief but vivid. The details of his suicidal thoughts were not described but this may well have been because he was too withdrawn or ashamed to say exactly what they were. Nevertheless, the important fact of his access to … was elicited, along with his insistence that he did not feel able to keep himself safe, which in my view completed the rationale for [Dr B] going on to detain [Mr A] under s11 of the MHA. At the time of assessment [Mr A] had a clear history of major depression and PTSD with severe current symptoms and marked suicidal thinking. In addition, he attempted to leave, demonstrating that a voluntary admission would be unsafe. He thus met both limbs of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA) as required for a compulsory admission.

It followed that an admission to the High Needs Unit (HNU) was required because it is the only locked ward.

[Dr B's] management plan as recorded in [the] Clinical Report is sensible and comprehensive. I particularly note that no mention is made of seclusion or of stitch gear. Judging by the rest of [Dr B's] report, I would expect to find that written there, if seclusion and stitch gear were what [Dr B] intended. Therefore, it seems possible that [Dr B] did not intend these things, but of course I cannot be certain.

According to the times given in the Serious Incident Review Report (SIRR), [Dr B's] interview with [Mr A] lasted 10 minutes before [Dr B] took the decision to admit him formally. This is unusually brief for such a major intervention to be decided upon. Certainly, all the information in [Dr B's] clinical report could not have been gathered by [Dr B] in this short period of time, although having said that it is common for the examining doctor to read the notes of other staff, and to use that information. Equally, while avoiding repetition of every question previously asked, it is important to obtain first-hand information about the most salient details. [Mr and Mrs A] were clearly taken aback by the brevity of their encounter with [Dr B] [p6 of the SIRR]. It seems that no empathic rapport or therapeutic alliance was established between [Dr B] and [Mr and Mrs A], which is an important failure in such a context, given how anxious and ill-at-ease they must both have been feeling. Establishing a therapeutic alliance cannot be done in ten minutes, but it is important, especially when formal admission is being contemplated.

In short, in my opinion, [Dr B] made the right decision, but … made it in too hasty a way, that is to say, [Dr B] did not exhibit the empathy or take the time necessary to establish a degree of comfort for the very distressed [Mr and Mrs A]. If [Dr B] had, the subsequent events may not have happened as they did, because at root the whole episode was the result of things being done in a rush, and without getting the couple on board with the plan. Reading between the lines, it seems that [Dr B] may have been in something of a panic.

No doubt [Dr B] has been asked for [an] account of things, which you will have received. It would not surprise me to learn that [Dr B] had several urgent concurrent calls on [Dr B's] time and judged that [there was] the information necessary to make a sound clinical decision. If that was indeed the case, [Dr B's] initial assessment (see next para) did meet the accepted standard, the accepted standard being the gathering of all pertinent information and the making of a clinical decision that kept the patient safe while having an eye to the least restrictive care. In this case, a locked ward (but not seclusion) was necessary to keep [Mr A], who was clearly in a very distressed state of mind, safe. I doubt that any of my peers would be critical of this in particular. On the other hand, if there were no other pressing calls on [Dr B's] time, then I would regard [Dr B's] assessment as a moderate departure from accepted standards; it is certainly accepted practice to get alongside patients and their families as much as possible and unless there was a very good reason why this did not happen, then the assessment process fell short.

I want to make a distinction here between the s10 clinical assessment and Clinical Report, commented on in the previous paragraph, and the overall process followed by [Dr B], which was disorganised, lacked appropriate communications, and failed to meet the legal requirements. It also failed to meet [Mr and Mrs A's] need for calm explanation and empathy. Therefore I consider that overall, [Dr B's] assessment represents a serious departure from expected standards; if it had been legal I would have rated it as a moderate departure. I would expect my peers to agree with this view, although if [Dr B] were snowed under at the time then the gentler among them might regard it as mild.

As to the venue for the s10 assessment, there is nothing illegal in completing this part of the overall process in a secure place, if risk indicates that this would be sensible. [Dr B] did not specify actual seclusion in written notes; that decision appears to have been made by others. However, in the latter case [Dr B] might have queried the use of seclusion; I assume that is where {Dr B] saw [Mr A] for the s10 examination.

I warmly recommend that [Dr B] receive regular supervision around these aspects of … practice, including [Dr B's] own feelings and emotional reactions at stressful times.

2. The appropriateness of the use of restraint when [Mr A] attempted to leave the [building].

This was appropriate. [Mr A] was suicidal and unable to contain his distress and impulsivity. Restraint under these conditions is permitted by s41 of the Crimes Act 1961: 'Everyone is justified in using such force as may be reasonably necessary in order to prevent the commission of suicide'. Not to do so in these circumstances would have amounted to callous negligence. However, as noted in the Serious Incident Review Report, had [Mr and Mrs A] been appropriately handled by staff he may not have attempted to leave.

3. The appropriateness of the handover between the ACT and HNU.

This was chaotically inappropriate. Indeed, calling the relevant events 'handover' is flattering. No doubt others have been asked to comment on nursing aspects of this and so I will comment only on the (lack of) medical handover.

From the medical point of view, there seems to have been no communication from [Dr B] to the [HNU] Consultant. This is not accepted practice and represents a moderate departure therefrom. There can be circumstances in which it is not immediately possible to speak to the receiving Consultant, and the need for admission is urgent, but these are unusual and there is no evidence that in this case the [HNU] Consultant was not available. My peers would also regard failure to speak to the receiving consultant as falling well short of accepted practice.

My recommendation regarding this would be re-training/refreshing staff on precisely how this transfer should have been managed. The SIRR includes a description of the expected process that is clear but was not followed. The policy for admission of clients into HNU (MDHB-4922 p13) is clear, reasonable and detailed and should have been followed.

[Dr B] should be included in training in this policy.

4. The appropriateness of the use of seclusion and adequacy of the Mental Health Act process.

The use of seclusion does not appear to have been clinically appropriate in this case. Neither was it legal (see below).

- Seclusion should be used very sparingly and only for patients whose behaviour endangers themselves or others <u>at the time of seclusion</u> and cannot be managed in any other way. There is no evidence that [Mr A] met these criteria. Instead he should have been seated in the interview room with staff calming, encouraging and explaining things to him. His wife could perhaps also have been present if the couple wished.
- Until ss8(a) and (b) and s9 were completed, which did not occur in the … building before [Mr A] was taken to the HNU, [Mr A] was not 'under the MHA' and so secluding him was not, in my opinion, legal. Also, it was entirely wrong for [Dr B] to be involved in both the s8 and s10 assessments, and also to instruct someone to complete the s8(b) after embarking on the s10 process. It is mandatory that the documents be completed in the order in which the MHA requires.

Therefore, his detention was illegal and would have been even if he were not in seclusion but simply in the HNU, which is locked.

I was initially concerned that the 8(b) may have been completed by an unauthorised person but am reassured that such was not the case. Correspondence received from the Operations Executive, Mental Health and Addiction Service indicates that the nurse

concerned was a 'very senior and competent registered nurse working in Mental Health' and would thus meet the requirement stated in s8B(6)(c).

Once [Mr A] had been presented with the s9, then it would have been legal and appropriate for [Mr A] to be escorted to the HNU as there is nothing in s9 that specifies locked or unlocked premises for the preliminary examination (s10). However, even if the s9 was given to him in the building, it would not have been legally valid as there was no 8(b). Also, it is not clear to me from available information when and where the s9 was given to [Mr A].

[Dr B] was responsible for the adequate conduct of this part of the process and failed. The DAO should also have insisted on the proper process being followed.

The entire MHA process was nowhere near expected standards or accepted practice and represents a very serious departure therefrom. I have no doubt at all that my colleagues would agree.

(My analysis of the MHA process has been slightly difficult as it is not clear exactly where and when some of the documents were completed. It is not usual practice anywhere as far as I know, but it could be useful to write the time as well as the date on MHA papers.)

My recommendation would be retraining [Dr B] and other relevant staff in the correct way to make use of the MHA, and the importance of getting it right. Very few people are permitted to detain others in this country and the right of mental health professionals to do so must be taken seriously and used with great care.

5. I have no other comments to make.

Dr Alma Rae MBChB FRANZCP MBHL
Consultant Psychiatrist
16 November 2020"

Appendix B: Independent clinical advice to Commissioner

The following advice was received from mental health nurse RN Anne Brebner:

"24th May 2020

I have been asked to consider if the care provided to [Mr A] by MidCentral DHB was reasonable in the circumstances and why.

The HDC have asked that this opinion focus on:

1. The appropriateness of the use of restraint when [Mr A] attempted to leave the [building].
2. The appropriateness of the handover between the Acute Care Team and High Needs Unit.
3. The appropriateness of the use of seclusion and the adequacy of the Mental Health (Assessment and Treatment) Act 1992 (MHA) process.
4. Any other matters deemed to be a departure from accepted standards of care.

For each of these questions the advice will include

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
c. How would this be viewed by my peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

1. The appropriateness of the use of restraint when [Mr A] attempted to leave the [building].

Background: Personal restraint: Personal restraint is defined by NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards as: 'Where a service provider uses their own body to intentionally limit the movement of a consumer. For example, where a consumer is held by a service provider.' (Standards New Zealand, 2008b.) Legislation that permits the use of restraint in Aotearoa New Zealand is the Mental Health (Assessment and Treatment) Act 1992 (MHA), specifically Section 122b (which permits the 'use of force' where necessary in an emergency). In addition, if the MHA is not already activated, a Registered Nurse may initiate S111 2(b) MHA to detain a person and take them to a place of further assessment by a medical practitioner to examine and detain the patient (Ministry of Health, 2012b).

Aotearoa New Zealand has a national programme of de-escalation and aggression management training called Safe Practice, Effective Communication (SPEC) (Te Pou o Te Whakaaro Nui, 2017) that teaches a programme of de-escalation, engagement and use of safe personal restraint 'holds' if necessary. The personal restraint holds that are taught as part of this programme, have a range of 'holds' that increase in containment

depending on the response required. As described in the documentation it appears that the restraint holds as described in the DHB 'response' dated 13th September 2019, appear to be consistent with the lesser containment holds taught in SPEC.

The appropriateness of the use of restraint: The use of 'personal restraint' at this time to redirect an individual to a safer environment would be considered usual practice and this would occur when there were safety concerns for that individual. This can occur when a Registered Nurse applies S111 MHA as described above, and which did occur in the instance that is described.

In summary: It is my expert opinion that the kind of restraint and the rationale for the use of the restraint are both consistent with common practice and in this event was used appropriately. The correct use of S111 Mental Health Act allowed for this to occur and moreover was appropriate, therefore I believe there is no departure from expected and common practice. My peers would concur.

However, there are a number of other factors worth considering:

- There was considerable time that elapsed from the time of initiating assessment to the time of admission. It appears, from the documentation available to me, that [Mr A] had been waiting for an outcome since 8.30am in the morning. The admission and subsequent 'restraint' event occurred in the early afternoon. This is a gentleman who was seeking help, not actively avoiding it (at the point of assessment in Emergency Department), with this in mind there are likely to be practice and hospitality issues that may have improved engagement and expedited the process that may have mitigated an event such as this.
- [Mr A] was 'seeking' help, and this in and of itself could have been better leveraged and there may have been a possibility that a more restrictive approach was not needed.
- Progressing an admission is a process that is frequently fraught with fear and anxiety. Heightened emotions would be expected during an admission process, in common language — we can expect the closer the time to actual admission the more likely there is for emotions to escalate. It would not be surprising that [Mr A] began to feel increasingly upset at the transfer to [the HNU] and his behaviour reflected those emotions. Could the mental health team consider if there are alternate, less stressful ways to proceed to an admission to reduce the level of anxiety that a service would experience in a situation like this? Would Peer workers make a difference in a situation like this? Use of sensory modulation to manage escalating emotions?

2. The appropriateness of the handover between the Acute Care Team and High Needs Unit.

Background: Communication of patient information between clinicians is a fundamental component of health care, and mental health acute care settings are

dynamic environments and rely on timely and accurate information to plan care and manage risk (Waters, Sands, Keppich-Arnold, & Henderson, 2015).

I am unable to locate a document that outlines the handover from Acute Care Team to High Needs Unit. There are multiple documents that are titled 'Internal Referral Notification Form' and 'Initial Assessment Mental Health and Addiction Service'. I can locate the Mental Health Act papers and can see from these documents that initial contact from [Mr A's] wife to the 'After Hours Mental Health Service' was at 8.08am on the 30/4/18. However, I cannot apart from the response letter from Mid Central DHB, find a reference to the Handover (verbal or written).

Given the above I cannot make a determination on the appropriateness of the handover between the Acute Care Team and High Needs Unit.

3. The appropriateness of the use of seclusion and the adequacy of the Mental Health (Assessment and Treatment) Act 1992 (MHA) process.

Background: Seclusion is defined as 'where a consumer is placed alone in a room or area, for any time, and for any duration from which they cannot freely exit' (Ministry of Health, 2010, p. 1). The legislation that allows seclusion to occur is The Mental Health (Assessment and Treatment) Act 1992 (Ministry of Health, 2012b) specifically Section 71. 'Seclusion should be an uncommon event and should only be used when there is an imminent risk of danger to the individual or others and no other safe and effective alternative is possible' (Ministry of Health, 2017, p. 45). With these definitions in mind, clinicians who instigate seclusion should only do so once other options have been explored and or deemed not appropriate for the situation.

The use of seclusion: After reading through the available documentation, it appears the decision to utilise seclusion was made as the staff were very concerned with escalating behaviours that, in their opinion, appeared dangerous. This would be considered an appropriate use of seclusion. However, contemporary practice is to try to avoid seclusion where possible, and I cannot find written evidence that once [Mr A] entered the High Dependency Area, where the seclusion rooms are, that he continued to present with disturbed behaviour warranting the use of seclusion. The description that [Mr A] complied with the request to change clothes would indicate a level of compliance, and it is uncertain from the clinical documentation whether locking the seclusion room door was warranted, or whether close observation within a contained environment would have had the same effect. These observations offered with the proviso that documentation cannot replicate the dynamic ever-changing acute environment and other factors that the staff were needing to consider at the time.

It would be my expert opinion from the clinical documentation that the use of seclusion was appropriate for the time frame of this event (i.e. 2018). Since this time there has been a lot of quality initiatives to support reducing restraint and seclusion and it is worth noting that recent national work that is a collaboration between the Health Quality and Safety Commission and Te Pou o Te Whakaaro Nui is focussing on reducing and

ultimately eliminating seclusion (Ministry of Health, 2017, p. 45). My peers and colleagues would concur with me.

The use of the Mental Health (Assessment and Treatment) Act 1992: The mental health act is one entry point to services for people experiencing a mental illness which causes or may cause serious harm to themselves or others. There are clear definitions for being able to enact this legislation and it would appear that this was used appropriately on this occasion. It is not uncommon for an individual to initially seek treatment voluntarily and then change their mind once admission is recommended. When this occurs (the individual no longer wants to seek voluntary treatment yet they present with serious risks to themselves or others) the clinicians can and should take all steps necessary to ensure the safety of the 'proposed patient' and the use of the Mental Health Act is the correct mechanism.

It is my expert opinion that the use of the Mental Health Act was used appropriately on this occasion as the staff documented the concerns, they had for the safety of [Mr A] should he leave the [building]. I believe my peers and colleagues would concur with this.

4. Any other matters deemed to be a departure from accepted standards of care.

My final comment is in regard to the frequency of the observations taken while [Mr A] was in seclusion. They are recorded as taken every 10 minutes, which although is not a departure from the stated Ministerial guidelines, the guidelines do suggest that 'Observation shall be continuous or as frequent as possible. The longest interval between recorded observations shall be 10 minutes. (The interval should vary within the 10-minute interval, without being longer than 10 minutes.)' (Ministry of Health, 2010, p. 2). My comment is that, where possible, services should use continuous observations while a person is in seclusion, as the practice of seclusion is most restrictive practice that can occur in an acute mental health unit. When the seclusion event occurs soon after an admission, there are variables that clinical staff are often not aware of, and these may emerge during those first few hours of admission and therefore extra vigilance and safety for all is paramount. Many acute mental health services are moving to providing continuous observations when a person is placed into seclusion. On this matter my peers and colleagues would concur.

References:

Ministry of Health. (2010). *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Wellington: Ministry of Health.

Ministry of Health. (2012b). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992* (s ed.). Wellington: Ministry of Health.

Ministry of Health. (2017). *Office of the Director of Mental Health and Addiction Services Annual Report 2017*. Wellington: Ministry of Health Retrieved from https://www.health.govt.nz/publication/office-director-mental-health-and-addiction-services-annual-report-2017

NZS 8134.2:2008 Health and Disability Services (restraint minimisation and safe practice) standards (2008b.).

Te Pou o Te Whakaaro Nui. (2017). Safe Practice, Effective Communication launch. In Te Pou o te Whakaaro Nui (Ed.).

Waters, A., Sands, N., Keppich-Arnold, S., & Henderson, K. (2015). Handover of patient information from the crisis assessment and treatment team to the inpatient psychiatric unit. *International Journal of Mental Health Nursing, 24*(3), 193."

Appendix C: Extract from MCDHB's Report

Appendix 1: Action Plan							
Title		Specialist Review — Service user locked in seclusion room without being placed under Mental Health Act					
Serious Incident Date:		**30 April 2018**					
Riskman Incident Number:		**#**					
Rec No.	**MHA Service**	**Recommendation**	**Actions to achieve recommendation**	**Implementation Lead**	**Implementation by when**	**Evidence of Completion**	**Monitoring & evaluation arrangements**
1	**ACT & the HNU**	**Lack of communication between teams/Lack of clarity of staff roles & responsibilities.** The service is to ensure compliance with MDHB-1513, and that mental health assessments (mental health examination, risk assessment and management) are completed to NZ Nursing Council Standards.	Clinical Managers to arrange education sessions for staff regarding MDHB-1513. Flow chart to be displayed in office areas of both teams. All staff to attend refresher courses on Mental Status examination and clinical risk formulation. To consider this to be completed on an annual basis.	Nurse Director & Clinical Managers (W21 & ACT) Clinical Managers (W21 & ACT)	February 2019 February 2019	List of all staff that have attended the education session. Flow chart displayed in staff areas List of all staff that have attended the refresher training. To be part of annual performance appraisals	Nurse Director — audit MHAS SAERG Nurse Director — audit MHAS SAERG

	ACT & the HNU	**Recommendation 2 — Inadequacy of handover process** The service is to develop and implement clear guidelines for the transfer of care from the community to the inpatient unit, with clear supporting documentation and identified roles and responsibilities.	Clinical Managers to arrange education sessions for staff regarding MDHB-725. This to be audited on a regular basis	Nurse Director & Clinical Managers (W21 & ACT)	February 2019	List of all staff attending education session 3/6 monthly audit that MDHB-725 is being utilised	Nurse Director — audit MHAS SAERG Nurse Director audit MHAS SAERG
	ACT & the HNU	**Recommendation 3 — Mismanagement of MHA** The service is to develop and implement an update on the use of the Mental Health Act for ACT and the HNU clinicians.	Clinical Managers to ensure staff have completed the Ko Awatea online Mental Health Act training and the Seclusion reduction training Review of DAO knowledge of the Mental Health Act	Clinical Executive, Nurse Director & Clinical Managers (W21 & ACT)	February 2019	List of all staff that have completed the identified training	Clinical Managers Nurse Clinical Executive MHAS SAERG

			including embargo on nurses doing 8b until national guidelines established Audit of Situations where service users have come under the Mental Health Act on admission to assess the scope of practices where service users may be detained illegally				
	ACT & the HNU	**Recommendation 4 — Lack of respect, dignity and privacy** ACT and the HNU undertake specific communication education training centred on MidCentral DHB's vision, values, and desired behaviours, which is also specific to Mental Health and includes a focus on Health and Disability Services Standards consumer rights.	Training to be provided to ACT and W21 staff	Nurse Director — Education	April 2019	List of all staff that have completed the identified training	Clinical Managers Nurse Director Clinical MHAS SAERG

		This should be through ACT staff undertaking training in up to date approaches to de-escalation as included in the new national Safe Practice					