# Southland District Health Board

# Patients Aid Charitable Trust

## A Report by the

## Health and Disability Commissioner

## (Case 08HDC05072)

## Overview

Mr A, aged 37, had a long history of mental illness (schizoaffective disorder and mixed personality disorder). He was subject to an indefinite compulsory treatment order, but was granted conditional leave for treatment in the community. From November 2003, he lived in shared residential homes administered by Patients Aid Charitable Trust (PACT) until two years later, when he moved into his own flat in Invercargill. The goal was to trial independent living for three months with intensive support from PACT in preparation for Mr A's eventual return to where his parents lived.

During the period Mr A lived alone, Southland District Health Board (Southland DHB) funded PACT to visit him daily to assist with household chores. Mr A was also monitored regularly by a case manager from Southland DHB's community mental health team. The case manager was responsible for managing Mr A's clinical care along with other members of the Southland DHB mental health team. His parents visited him regularly.

During a morning visit, Mr A informed PACT support worker Mr F that he had the flu and refused to attend any outing. Mr F advised case manager Mr D of this, but Mr A received no other visits that day. When Mr A's parents visited the next day, they found him dead in his flat surrounded by vomit and urine. A post-mortem examination revealed that he died from an acute bacterial infection.

This report discusses the care Mr A received from Southland DHB's mental health team and PACT, the difficulties when two or more services are involved in co-ordinating a client's care, and the remedial measures taken to prevent a similar incident.

## Complaint and investigation

On 20 August 2007, the Health and Disability Commissioner (HDC) received a complaint from Mr A's parents about the services provided by PACT and Southland DHB. The following issues were investigated:[1]

- *The appropriateness of the services provided to Mr A by PACT over a period of nearly three months in 2006.*

[1] Following receipt of the complaint, HDC suspended any further action until the Coroner had completed his inquest. The inquest was held on 11–12 December 2007, and the Coroner issued his findings on 22 February 2008.



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- *The appropriateness of the services provided to Mr A by Southland District Health Board over a period of nearly three months in 2006.*

An investigation was commenced on 30 April 2008 and involved the following parties:

| | |
|---|---|
| Mr A (dec) | Consumer |
| Mr and Mrs B | Complainants/Consumer's parents |
| Southland DHB | Provider |
| Mr C | Southland DHB case manager |
| Ms I | Southland DHB case manager |
| Mr D | Southland DHB case manager |
| Patients Aid Charitable Trust (PACT) | Provider |
| Ms E | PACT community support worker |
| Mr F | PACT community support worker |
| Ms K | Community support worker |
| Ms L | Community support worker |
| Ms G[2] | PACT team leader |
| Ms H[3] | PACT Southland regional manager |
| Mr J | General Manager of Mental Health Services and Planning and Funding for Southland DHB |
| Ms N | PACT Chief Executive |
| Dr O | Psychiatrist |

## Information reviewed

Information from:
- Mr A's parents
- Southland DHB
- Mr C
- Mr D
- PACT
- Ms E
- Mr F
- Coroner
- ACC

Mr A's clinical records from:
- Southland DHB

[2] Ms G is no longer an employee of PACT.
[3] Ms H is no longer an employee of PACT.



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- PACT

Independent expert advice was provided by Tom Woods, a community mental health nurse, and is attached as **Appendix 1**.

## Information gathered during investigation

*Background*

Mr A was an invalid beneficiary and a longstanding patient of the Southland District Health Board's mental health service. At the time of his death, aged 37, he was subject to a Compulsory Treatment Order[4] for an indefinite period under the Mental Health (Compulsory Assessment and Treatment) Act 1992. He first came into contact with the mental health service at age 23 and was diagnosed with schizoaffective disorder and mixed personality disorder.

Mr A also had insulin dependent diabetes (type 1) which was first diagnosed when he was 16. He was followed up periodically by specialists including the diabetes nurse and physician at Southland Hospital, but otherwise managed his medication and blood sugar level monitoring independently.

In 2003, Mr A was admitted to Southland Hospital's mental health unit for treatment and care. Prior to the admission, Mr A's parents had attempted to care for him at home but the situation became untenable owing to his challenging behaviour and aggression towards his parents and other family members. Some of the aggression appeared to be alcohol and drug (cannabis) related. In August 2003, while an inpatient, Mr A attempted suicide, permanently impairing his mobility.

In November 2003, Mr A was discharged from the mental health unit and was referred to PACT. For the next two years, Mr A stayed in residential homes operated by PACT. However, he was disruptive and intimidating towards other patients, and sometimes damaged property. He also engaged in self-harming behaviours. It became increasingly difficult to manage Mr A in a shared residential facility, so he was moved to an independent living arrangement with intensive support from PACT.

[4] A Compulsory Treatment Order is a Court order requiring the patient to undergo treatment for his/her mental disorder. The Court can make either a community treatment order or an inpatient order.



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*PACT*

PACT is a non-governmental organisation that provides support services to mental health patients under a formal contract from various South Island district health boards. At the time of the events in question, PACT was the largest such provider in the Southland region.

Southland DHB has a base contract with PACT specifying the type and value of services it is to provide. The base contract is a high level agreement between both parties and no subordinate staff members below PACT's Chief Executive are authorised to enter into any variation of the contract. Similarly, Southland DHB case managers are not authorised to vary any of its terms. When services over and above the base contract are to be supplied for specific clients, additional funding called "Individual Package of Care funding" is agreed between PACT and Southland DHB, usually through an exchange of letters (as occurred in Mr A's case).

*PACT support workers*

The support services PACT provides to mental health patients are undertaken by its community support workers, many of whom hold a National Certificate in Mental Health Support Work.[5] The key tasks of a community support worker are:

- ensure that the goals recorded in the personal plan are attained by the client as part of his/her journey towards recovery
- monitor daily activities of living with the client
- monitor medication compliance and report non-compliance to the case manager
- identify areas of concern, and communicate them to the mental health services case manager and PACT team leader
- maintain relevant and current records of contact, support and observations within the PACT file.

The community support workers work in teams of four to five and report to the team leader, who in turn reports to the regional manager. At the time of the events in question, Ms G was the team leader, and Ms H was the regional manager.

*Meeting in late 2005*

An occupational therapy functional performance assessment of Mr A concluded that he was capable of performing basic domestic tasks such as personal hygiene and household cleaning. However, the occupational therapist recommended further assessment of Mr A's intellectual and occupational functioning before placing him in an independent living situation. It appears that the further assessment did not occur.

[5] The course focuses on mental health and supporting a client in relation to mental health issues but does not cover physical illnesses or symptom recognition and intervention. It also does not prepare the certificate holder to assess a client's physical health or fitness.



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A week later, a meeting was held to discuss Mr A's living arrangements. It was attended by Mr A, his parents, and representatives from PACT and Southland DHB mental health team.

Ms I, Southland DHB case manager, noted that since November 2003 PACT had attempted to support Mr A unsuccessfully in three or four residential homes. Mr A was told that he could not return to live with his parents although they were agreeable to periodic visits. Following discussion, a decision was made to move Mr A to his own flat in Invercargill and for PACT to assist him seven hours daily with household chores, subject to funding approval. The independent living arrangement, which was to be trialled for three months, was in part to prepare Mr A for his eventual return to the town where his parents lived.

*Request for extra funding*

The following month, Ms H wrote to Mr J (General Manager of Mental Health Services and Planning and Funding for Southland DHB), requesting an individual package of care for Mr A's transition to an independent living arrangement.[6] Ms H explained the difficulties maintaining Mr A in a group home situation and outlined PACT's plan of support:

> "… [T]o exit [Mr A] from [(the group home)] [this month]. The level of support required is assessed at 7 hours per day:
> 9am–11am (2hrs); 2pm–5pm (3hrs); 6.30pm–8.30pm (2hrs) for seven days a week, up to 3 months, with 2 weekly reviews and a decrease in hours, as indicated by [his] developing independence and ongoing risk reviews."

Ms H stated that PACT "[would] cover the hours between 6.30pm–8.30pm each evening per 7 days, with intensive staff support". She requested extra funding from Southland DHB to cover the remaining five hours per day for seven days per week, and stated that a case management plan would be put in place to "identify aims, interventions and goals to be achieved during the 3 months of this package". The care PACT was to provide was similar to level 3 supported accommodation (for residents with medium needs). However, a supports needs assessment was not conducted as Mr A had refused to participate in one.

A few days later, Mr J confirmed that Southland DHB had accepted PACT's request for additional funding, and stated that a review (aimed at increasing Mr A's independence and reducing his level of support) would take place after 12 weeks.[7] Mr J requested that PACT invoice Southland DHB monthly and provide "a short report each month updating progress and noting the resources utilised to provide the package of care support". Mr J envisaged returning to "support resources within currently funded levels" after the 12-week period.

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[6] The purpose of PACT's letter was to seek additional funding from Southland DHB as the care PACT would be providing Mr A was over and above its obligations under the base contract.

[7] The review did not take place as Mr A died earlier.



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Ms H did not respond to Mr J. In the course of arranging with Ms G (PACT's Southland team leader) the roster for visiting Mr A, it became apparent to Ms H that PACT's community support workers were able to accommodate visiting Mr A as part of their case load. In other words, Mr A's visits could be included as part of the base contract, and the additional funding from Southland DHB was not needed. However, Ms H did not advise Mr J of this, but assumed that he would be aware since PACT did not invoice Southland DHB for additional funding during the period it visited Mr A.

*Admission to Mental Health Unit: 6th –12th Month 1*

Mr A felt apprehensive living on his own and exhibited behavioural problems necessitating an admission to Southland Hospital's mental health unit from 6th to 12th Month 1. His apprehension was shared by his parents, who voiced their concerns to Ms I that Mr A would not be able to live independently, despite intensive support from PACT. However, throughout his time in hospital, there was no evidence of any mental disorders although Mr A reported feeling anxious about leaving the PACT shared home. During this admission, PACT staff assisted Mr A to find a suitable flat. After viewing several units, Mr A settled upon a flat in Invercargill.

In preparation for Mr A's discharge, a planning meeting was held on 12th Month 1 and attended by Mr A, representatives from Southland Hospital's mental health unit (including Mr C, the new case manager) and PACT. They discussed Mr A's new living arrangements, which would include assistance with daily living from PACT and regular follow-up with the case manager. This was documented in the discharge summary from Southland Hospital along with the various medications prescribed.[8] A follow-up appointment with the community psychiatrist was scheduled for 23rd Month 2.

On the day he was discharged, Mr A was seen by a Medical Officer in Psychiatry, who noted that there was "no evidence of psychosis and nil safety concerns", that Mr A was agreeable to the treatment plan, and that he would be seen by the community psychiatrist the following month.[9]

*Independent supported living*

On 13th Month 1, Mr A was discharged from Southland Hospital's mental health unit to his flat. The PACT support worker observed that he seemed "quite settled and happy".

Mr A lived on his own for 2½ months until his death. Throughout this time, he did not have a landline or a mobile phone as he was concerned that he could not afford one.

[8] Risperidone 2mg at night, citalopram 20mg in the morning, candesartan 8mg in the morning, risperidone (Risperdal Consta) depot injection fortnightly, Actrapid 12 units before breakfast, lunch, and dinner, and propranolol 20 units sc before bed.

[9] Consultant psychiatrist Dr O was Mr A's responsible clinician. Mr A was reviewed by Dr O in late 2005 and 23rd Month 2.



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Mr A's support plan (otherwise referred to as "personal plan") devised by PACT stated:

> "<u>9am–11am</u>
> [Mr A] up and showered, dressed, breakfast meds.
> Washing and support to keep house — cleaning chores etc.
>
> <u>1pm–3pm</u>
>
> Take [Mr A] to In-roads [Schizophrenia Fellowship], shopping etc.
>
> <u>4.30pm–6.30pm</u>
> Assist [Mr A] to prepare evening meal, check meds, bring in and fold washing. Intensive Community Support Team check in each evening around 8pm.
>
> Tuesdays [Mr A] is taken to supermarket.
>
> Thursday to collect medication, followed by a drive or visit to Day Centre. [Dr O] has prescribed walking 4x a week and this will be gently introduced into [Mr A's] routine."[10]

According to the original plan, Mr A should have received at least 219 visits.[11] In contrast, PACT records show that a total of 129 visits were documented by its support workers.[12] Between 13th and 31st Month 1, there were 40 documented visits (54 scheduled), while in Month 2, 44 visits were recorded (93 scheduled), and 45 in Month 3 (84 scheduled). Some days, Mr A did not receive the full number of visits, with only one or two visits documented. Often, the time and duration of each visit were not noted and, on the days they were, it appears that staff did not stay with Mr A for the entire period stated in the plan. The support workers documented their visits on separate sheets of paper, and the notes from the three shifts were not amalgamated (discussed below). The progress notes were kept in the filing cabinet at PACT's Southland office.[13]

The PACT support workers who assisted Mr A with his day-to-day cares were:

- Ms E, community support worker
- Mr F, community support worker
- Ms K, community support worker
- Ms L, community support worker.

[10] This differs from the plan Ms H outlined in her letter of 5th Month 1, which proposed a 3-hour visit in the afternoons from 2–5pm and also a 2-hour evening visit of 6.30pm–8.30pm.

[11] 57 visits in Month 1, 78 visits in Month 2 (excluding the 5 days Mr A was hospitalised) and 84 visits in Month 3.

[12] Refer to **Appendix 2** for a timeline of the visits Mr A received from PACT over this time.

[13] According to PACT, Southland DHB case managers were able to view the progress notes at any point. In contrast, Southland DHB case manager Mr D stated that the notes were "not open for the case managers to simply access" but were "reluctantly available on request". As a result of this case, Southland DHB mental health services team now has a Memorandum of Understanding with PACT that allows the mental health team to access PACT's personal plan.



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Ms E and Mr F tended to work day shifts while Ms K and Ms L usually worked in the evenings. Staff on evening shifts receive a handover from day staff.

Along with input from PACT support workers, Mr A was visited regularly by Southland DHB's Community Mental Health Team (CMHT) case manager.[14] There were five recorded visits in Month 1, 13 recorded visits in Month 2, and seven recorded visits in Month 3. Between 12th Month 1 and 11th Month 2, Mr C was Mr A's case manager, while from 12th Month 2 onwards his case was managed by Mr D.

*Care in Month 1*

On 14th Month 1, Mr C documented that Mr A appeared "settled and well from a mental state perspective". Mr C also recorded that "there were no problems at present". During the visit on the 15th, Mr A raised objections about his new living arrangements, and expressed his desire to return to the town where his parents lived. Mr C advised him to treat this period as a time to prove he was able to live independently, as he was not to depend on his parents when he returned eventually.

Following the visit, Mr C dropped into the PACT office and discussed the visit with Ms G and Ms E. Various strategies were discussed to manage Mr A, and Mr C documented that there were "no problems at present".

Between 16th and 17th Month 1, PACT support workers recorded observations about Mr A, including "very negative" and "not in a good space". On the morning of 18th Month 1, Ms E noted that Mr A was "very agitated saying that he had the wrong insulin", which he demanded Ms E to remedy "NOW". Despite assuring Mr A that he had the appropriate insulin, he was unsettled throughout the visit. Ms E left the flat as "things were escalating" and telephoned Ms G to discuss her concerns. She also recorded in the progress notes "don't feel safe by myself". That afternoon, Ms G accompanied Ms E on her visit, which was recorded as "[Mr A] very negative about everything in general. Nothing we could do to help him so we left."

During the morning visit on 21st Month 1, support worker Mr F found Mr A partially dressed in his nightshirt with faeces smeared on himself and on various spots around his flat. Mr A was unable to recall what had happened, and appeared mentally unwell. Shortly afterwards, Mr F telephoned Mr C to report the incident and request an assessment. He also informed Ms G.

That afternoon, Mr C saw PACT staff to ascertain further details about Mr A's state. Mr C learnt that Mr A had been "his usual self" except for 18th Month 1 when he aggressively told PACT staff to leave his flat, "which they duly did" for their personal safety. Mr C reminded PACT staff to ensure that "information of this nature" was

[14] The CMHT case manager is a health professional who provides direct clinical care to the client, and co-ordinates and implements the clinical care plan developed and supervised by a multidisciplinary team. Case manager visits are tailored according to the client's acuity and risk.



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relayed to him "in a timely manner so that [he] could have more involvement in managing the case with PACT" and could "gather vital information pursuant to continual monitoring of [Mr A's] emotion and cognitive state". Mr C documented in his notes the agreement that "PACT will provide [me] with more regular feedback of their visits to [Mr A] since they are the primary source of involvement in terms of daily contact with [Mr A]".

Following the discussion, Mr C visited Mr A, who was "in the state described by PACT". Mr C observed that Mr A seemed "somewhat 'lost' in affect" but was unsure if this was "a presentation [he] had voluntarily adopted for the occasion". Mr C documented that Mr A was "quite well known for 'sabotage' of therapeutic plans which he does not wish to work at", and ascertained that "there were no immediate or subtle risk issues at the time". In the absence of any clear deterioration in Mr A's mental state, Mr C concluded that he had "allow[ed] his behaviour to be modified by his negative thoughts". Mr C recorded that "the stresses [Mr A] is experiencing and subjecting himself may well precipitate a loss of control of mental state". He documented his plan to monitor Mr A carefully for "risk issues that may develop" and for any "deterioration in his mental state", and for increasing case manager visits over the public holiday period.

On the afternoon of 26th Month 1, Mr A informed PACT staff that he wanted to return to his parents. He expressed doubts about coping on his own, and stated that he "was not happy in his flat". Mr A also declined assistance with cooking dinner, and refused to go for a walk.

Two days later, Mr C visited Mr A together with PACT staff. Mr C recorded that "all appeared to be well and [Mr A] seemed to be managing with PACT support".

Mr C visited Mr A again the following day to administer his depot injection.[15] No mental health issues of concern were observed except for his "low mood", which Mr C noted was "more of a problem of habit".

On 29th and 30th Month 1, PACT staff documented that Mr A was "worried about his rent and food budget". He continued expressing doubts about managing on his own, and reiterated that he wanted to return to his parents' place. PACT's notes on 30th Month 1 stated that Mr A "doesn't know how to use stove & can't live in community". On the evening of 31st Month 1, PACT staff attempted to visit Mr A but there was "no response" when they called.

[15] A sustained-action drug formulation that allows slow release and gradual absorption over a prolonged period.



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*Care in Month 2*

There were 44 visits documented by PACT support workers. On the days when the duration of the visit was recorded, it ranged from 10 minutes to 1 hour 40 minutes. The time of day when the visits occurred was not recorded, and on 15 occasions, Mr A received only one visit for the day.

On 1st and 2nd Month 2, Mr A expressed anxieties to PACT staff about managing his budget and his medication. He also reiterated his wish to return to his parents.

The following day, Mr A's parents visited. When PACT staff called that afternoon, they observed Mr A packing his clothes from his bedroom and discarding unwanted clothing into rubbish bags. He reiterated that he wished to return "where his mother could look after him & there would be no problems with budgeting for food/rent". Although PACT staff attempted to make him a shopping list, Mr A refused their assistance.

On 4th Month 2, PACT staff visited Mr A twice and noted that he was "not happy" and continued packing more clothes into his bag. He reiterated that he was "not staying in the flat" and was uncommunicative towards PACT staff. Mr A remained uncommunicative during the two visits the next day, although he felt "less anxious" after Mr C administered his depot injection.

On 7th Month 2, Mr A's parents visited him again. That evening, PACT staff observed that Mr A appeared more settled. The next day, PACT staff recorded that Mr A was "OK, a bit negative".

From 12th Month 2 onwards, Mr D took over the management of Mr A (following a detailed handover from Mr C). During his first visit, Mr D noted that Mr A was "warm & welcoming" and reported "feeling much better than yesterday". The depot injection was administered without any objection. However, Mr A voiced his desire to return to his parents, and Mr D commented that this arrangement would not be feasible. He highlighted the possibility of Mr A moving into his own flat in the same town if he managed successfully on his own in Invercargill. Mr D also pointed out that there were "limited accommodation options available" should the independent living arrangements in Invercargill not succeed. That evening, PACT staff noted that Mr A "seemed fine", although he "never made eye contact" when spoken to.

On the following morning, Mr D telephoned Mr A's father about the change in case managers, and invited Mr and Mrs B to call if they had any concerns about their son. That evening, Mr A was observed to be "feeling low" and talked about returning to his parents. On the evening of 14th Month 2, PACT staff recorded that Mr A "didn't want to talk today, was down & started crying". He informed PACT staff that he "hadn't taken insulin all day" but "felt OK" without it. After settling Mr A into bed, the PACT support worker left. This was the only visit Mr A received that day, and the length of PACT's visit was not recorded. No concerns were noted during the evening visit on 15th Month 2 (the only visit Mr A received that day).



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On 16th Month 2, a meeting was held to assess Mr A's living arrangements, attended by Mr A, Mr C and Mr D from Southland DHB, and Mr F, Ms E and Ms G from PACT. Initially, Mr A expressed dissatisfaction with living on his own, but after positive feedback from the case managers and PACT, Mr A agreed to continue the existing arrangements and to report any concerns to PACT staff or the case managers. Mr A also agreed to attend Inroads (a support group for schizophrenia clients) two times a week. There was no mention in PACT's or Mr D's notes of this meeting regarding the frequency of PACT's visits.

No concerns were noted when Mr D visited Mr A on 17th Month 2. However, during Mr D's morning visit on 18th Month 2, Mr A vomited about five times. Mr D noted that Mr A's blood sugar level was 26mmol/L[16] and he had taken 37 units of insulin. Mr D made an appointment for Mr A to see his GP, and contacted Ms G. At 1.10pm, Mr D visited Mr A again. He reported a further incident of vomiting, and a blood sugar level of 25.6mmol/L. Mr D telephoned Mr F to ask that he accompany Mr A to his GP.

*First admission to hospital: 18th –19th Month 2*

That afternoon, Mr A was seen by a locum GP who queried a gastric ulcer and referred Mr A to Southland Hospital. The GP also documented "poorly controlled diabetes" in his referral. Mr D visited Mr A in hospital that evening and telephoned his parents to inform them of his admission. Mr A's father mentioned a previous hospitalisation some time ago, and commented that it occurred when his son "doesn't eat well".

Mr A was kept overnight for observation and stabilisation of his blood sugar levels and discharged from hospital the next day. In the discharge summary from Southland Hospital, the medical officer noted "a 3-week history of vomiting and epigastric pain with a random blood sugar level of 22.2[mmol/L]" and that Mr A had recently run out of his normal insulin and was using his old premix form.[17] The medical officer recorded that Mr A had experienced "dehydration secondary to DKA [diabetic ketoacidosis][18] in type 1 diabetic", and recommended monitoring his blood sugar levels closely, and giving him additional insulin if his blood sugar levels exceeded 15mmol/L. A referral was made to the diabetic nurse educator to assist Mr A to monitor his blood sugar levels.

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[16] The normal blood sugar levels range from 4 to 8mmol/L. A high blood sugar level reading of 26mmol/L indicates that the individual is not managing his diabetes well, including not taking his medication as prescribed.

[17] Although PACT's support plan included checking Mr A's medication during the evening visit, the progress notes recorded by PACT staff between 15 and 17 Month 2 make no mention of Mr A's diabetic medication.

[18] Diabetic ketoacidosis (DKA) is a life-threatening complication in patients with diabetes mellitus. Near complete deficiency of insulin and elevated levels of certain stress hormones increase the chance of a DKA episode. DKA is more common amongst type 1 diabetics and can occur in a patient who fails to take prescribed insulin or who falls sick.



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*20th –27th Month 2*

Mr D visited Mr A at midday on 20th Month 2. He reported a blood sugar reading of 9.5mmol/L and stated that he "felt much better than yesterday". He also mentioned that PACT had not visited him that day, and he had not been taken grocery shopping that week. Mr D followed up with Mr F, who agreed to assist Mr A. Mr D documented that there were "nil safety concerns at this time" and planned a further visit on 23rd Month 2. PACT's records show that Mr A received one visit on 20th Month 2 but it is unclear when it occurred.

Similarly, Mr A received one visit a day from PACT on 21st and 22nd Month 2. The PACT worker recorded (on 22nd Month 2) that Mr A was "apprehensive when he opened door".

On 23rd Month 2, Mr A was seen by his responsible clinician, psychiatrist Dr O. Mr D and Mr F also attended this appointment. Dr O reviewed the existing treatment plan, Mr A's mental state, medication, recent admission to hospital for diabetes control, and daily activities, and advised continuing his medications. Mr A was also advised to increase his exercise, and to attend Inroads and 494.[19] During this review, Mr A reported a blood sugar level of "less than 20mmol/L" and did not require any extra insulin at that point. He mentioned that his parents had visited the previous weekend. Dr O noted that Mr A's life had been "roughly stable, quiet, passive and isolated" but that his physical health had not been good.

On 25th Month 2, the diabetic nurse educator visited Mr A. He reported blood sugar readings of under 10mmol/L and said that there were no concerns at that point. Mr A was asked to contact the diabetic nurse educator if he had any concerns.

During the evening visit on 27th Month 2, PACT staff observed that Mr A had vomited and appeared "agitated". The PACT staff telephoned the community mental health team, who advised taking Mr A to the emergency department of Southland Hospital (ED).

*Second admission to hospital: 27th –31st Month 2*

Following initial assessment at ED, Mr A was admitted to the medical ward (on the night of 27th Month 2) for observation. However, the following day, Mr A left the medical ward and self-presented at the mental health unit complaining of auditory hallucinations and requesting an assessment. He was described as "obviously anxious & a little confused, frightened". A decision was made to keep him under observation in the medical ward to stabilise his blood sugar levels prior to a transfer to the mental health unit. Mr D was telephoned on the morning of 30th Month 2 and visited Mr A, who admitted "to both auditory and visual hallucinations". Mr D documented that although there was "evidence of psychotic symptomology, Mr A denied thoughts of harm to self or others and it appears that Mr A's mental state deterioration is

[19] Inroads is a drop-in centre for clients with schizophrenia run by supporting families. 494 is a day activity centre provided by the Southland DHB mental health service.



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secondary to his medical condition". Mr D accompanied medical staff on their ward review, where it was recorded that Mr A's "sodium levels were very low which could explain [his] mental state".

Mr D visited Mr A again on the morning of 31st Month 2. As his sodium levels had "improved considerably since admission", a decision was made to discharge him. Throughout this admission, Mr A's blood sugar levels were stable, and there was no change to his medication. He was transported home by Mr D, who also updated PACT and Mr A's parents about the second admission. Mr and Mrs B did not know about this admission until their son was discharged.[20]

*1st –27th Month 3*

In Month 3, PACT staff documented a total of 45 visits in the progress notes. Apart from 2nd and 7th Month 3, when three visits a day were recorded, Mr A received only one or two visits a day throughout the month. He was visited several times by Mr D.

During the visit on 1st Month 3, Mr D noted that Mr A's blood sugar levels were satisfactory (12mmol/L that morning and previous evening), and no concerns were recorded. Similarly, there were no concerns noted by PACT staff between 1st and 3rd Month 3. During the visit on 4th Month 3, PACT staff recorded "[Mr A] feeling unwell today. Was sick when I was there. Cooked him a meal which he said made him feel better." On 5th Month 3, Mr A reported "feeling a lot better". No visit was recorded on 6th Month 3. There were no concerns noted by PACT and Mr D between 7th and 9th Month 3.

On 10th Month 3, support worker Ms L recorded that Mr A had been "smoking a lot" and "hadn't been sleeping much". He informed her that "no one had been to drop his meds off to him" but said that he had "some to get through the weekend". It is unclear whether Mr A's concerns were relayed to his case manager.

On the afternoon of 11th Month 3, Ms L documented that Mr A was "worried about not having meds for [the morning of 13th Month 3]". Ms L left a telephone message for Mr D, which was retrieved by the mental health unit the next day. Mr D's colleague (another mental health nurse) documented "? [Mr A's] responsibility to collect [meds]".

During the morning visit on 12th Month 3, the PACT support worker documented that Mr A was "worr[i]ed about his health, stressing himself a bit". Apart from advising Mr A to eat properly, continue taking his medications and keep fit, there is no indication from the notes that the support worker contacted Mr D to discuss Mr A's

[20] In Mr A's mental health file, his parents are noted as the first contacts, whereas PACT is recorded as the first urgent contacts in Mr A's medical file. Yet prior to Mr D's telephone call, Mr and Mrs B were unaware about the second admission, and they subsequently expressed concern to Southland DHB that they had not been contacted earlier.



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concerns. On 13th Month 3, Ms E accompanied Mr A to collect his medications, and reported that he was more settled thereafter.

On the morning of 14th Month 3, Mr D spoke to Ms E, who said that she would accompany Mr A to his GP for follow-up blood tests, and to Schizophrenia Fellowship, when she visited that day. It appears that PACT did not attend that morning, and the first visit that day was from Mr A's parents at lunchtime. At 2.30pm, Mrs B informed Mr D that she and her husband had taken their son to the GP as Mr A had remarked that PACT were unaware of his follow-up blood tests. When Mr D clarified that Ms E was to accompany Mr A, Mrs B remarked that her son was "playing games with [them]". She also mentioned that his bathroom was "dirty" and that he appeared "to be vomiting lots".

An hour later, Mr D visited Mr A, who reported that he had vomited only once that day and thought it was phlegm. He denied experiencing any paranoia, self-harm or distressing auditory hallucinations. As he was unable to recall whether PACT staff were accompanying him for the follow-up blood tests, he asked his parents to do so when they visited. Sometime that afternoon, Ms E visited him and documented that he was "fine today" and that his "mum had taken him for his blood test". The time and duration of this visit was not noted.

Between 15th and 17th Month 3, PACT staff did not raise any concerns about Mr A. On 18th Month 2, the PACT support worker documented that "[Mr A] had been sick and had le[ft] a huge mess around the toilet, all over floor and wall". Mr A stated that he had been "sick last night but [was] much better today". On 19th Month 3, PACT staff observed that Mr A was "a bit weepy in the morning" and that "he was sick of his life". That afternoon, PACT staff observed that he "wasn't very responsive" and "didn't want tea". During Mr D's visit on 20th Month 3, Mr A denied any active psychotic symptoms, and reported that his blood sugar levels had been stable. He mentioned going cycling with Mr F, and commented that the experience was "alright". There were no thoughts of self-harm during this visit, and a further visit to administer his depot injection was planned for three days' time.

On 21st Month 3, PACT staff documented that Mr A was "negative today". On 23rd Month 3, Mr D administered Mr A's depot injection. Mr A commented that his power bill had not been paid. Mr D agreed to liaise with PACT staff on Mr A's behalf. Shortly afterwards, Mr D telephoned Ms G, who expressed concerns about the inconsistent information Mr A was providing to PACT staff. Mr D recorded that "as long as we all communicate with one another then we will be less likely to become fractured". That afternoon, Mr F took Mr A grocery shopping.

During the evening visit on 24th Month 3, PACT support worker Ms K recorded "[Mr A] very down this evening, crying and saying he doesn't know what to do". Ms K advised him not to "sit around by himself all day" and recommended writing "a list of things he enjoys doing". On the morning of 25th Month 3, Mr A was noted to be



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"grumpy". After visiting "for a while", the PACT support worker was told "to go, didn't want my visit anymore" and "don't come back this afternoon". In accordance with Mr A's wishes, no PACT staff visited him that afternoon and evening.

On the morning of 26th Month 3, Mr A informed Ms K that "he didn't want a visit and was going back to bed". When Ms K returned in the evening, Mr A reported feeling "sick" and was "not able to hold anything down". Ms K documented that Mr A "(was sick while I was there.) Later said he was feeling better." She prepared his dinner, sorted out his laundry, and observed that "his flat is still in a mess".

The only notes recorded by PACT on 27th Month 3 were from a morning visit between 10.30−10.55am when the support worker wrote "OK. Good interaction". That afternoon Mrs B telephoned Mr D as she and her husband intended to visit their son either on 28th Month 3 or the following day. Mr D advised Mrs B to liaise with Ms G regarding the timing to ensure that Mr A would be home.

*28th Month 3*

On the morning of 28th Month 3, Mr F visited Mr A. Mr F recorded in his statement to HDC:

> "On the [28th Month 3] I visited [Mr A] at 10.50 am. [He] answered the door. He didn't want to come out with me as he said he had the flu and was unwell. I asked if he needed groceries and if his blood sugars were ok. He said he was ok with both. I told him to jump into bed and to keep warm. He said that he would. I left.
>
> I rang [Mr D] at 10.52am and told him [Mr A] had the flu[21] and to visit him. I said that he would be able to figure out if [he] was manipulating/or putting it on … [Mr D] was non-committal if he was going to see him or not. [Mr D] seemed more concerned with [Mr A's] power account which I didn't know anything about. I told him he'd have to talk to [Ms E] about that as she was handling it. I thought at the time that it was odd as it was outside [Mr D's] role to be concerned about the power account.
>
> I returned to the office at 11.00am and informed my Team Leader, [Ms G], that [Mr A] had the flu and was unwell and that I had rung [Mr D]. At that time both [Ms G] and I believed [Mr D] would go and assess [Mr A], as he normally would."

Mr F also recorded in the progress notes, "Called on [Mr A]. Said he had the flu & felt ill. I told him to keep warm & to get into bed, which he did. I left & phoned [Mr D]." Mr F stated that during the telephone call, Mr D did not ask him to revisit Mr A on the afternoon of 28th Month 3. Mr F said that he would have obliged if he had been

[21] Mr F did not provide Mr D any other information about Mr A's condition or appearance, apart from telling him that Mr A had the flu.



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directed to do so. He said, "I believe on every occasion I responded appropriately, displaying duty of care."

Mr F's notes were written on a separate page following an entry from Ms G dated 28th Month 3 about Mr and Mrs B's proposed lunchtime visit the next day. During a subsequent internal investigation by PACT, it was found that Mr F's notes were not recorded on the day of his visit but subsequently.22 It is unclear exactly when Mr F wrote his notes for the 28th Month 3 visit.

Mr F was the last person to see Mr A alive as no one else visited that day. Knowing that Mr and Mrs B planned to visit the next day, Ms G did not instruct Ms E to visit Mr A that afternoon. (Ms E usually visited in the afternoon as part of her case load. That day, she also covered for Ms L (the PACT support worker on evening duty), who was ill. However, Ms L's duties that evening did not include visiting Mr A.)

PACT staff assumed that Mr D would visit Mr A sometime on 28th Month 3, and update them afterwards. However, as he explained in a subsequent statement, Mr D was unable to visit Mr A that day and planned to visit him two days later:

> "… I was unable to visit [Mr A] [that day] or the next because I had to attend a development day, but I was confident that PACT would visit [him] that afternoon and evening and the day and if they had any concerns, they would let me know, as this was the usual practice."[23]

*The following day*

On the following morning, Mr F did not visit Mr A as he had to attend a family funeral. Mr F recalls informing Ms G and arranging cover with another support worker, but he apparently forgot to tell the support worker to visit Mr A. PACT subsequently explained that its staff did not visit Mr A that morning "as it was known that his parents were to visit him around lunchtime".

At 11.45am, Mr and Mrs B arrived at their son's flat. Upon entering, they found him dead on the floor. There was dried vomit on his face and on the floor. Mr and Mrs B stated:

> "We arrived on [that day] about noon and firstly were shocked to find the back door of his flat slightly ajar, then even more disturbed to find [him] lying on

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[22] Mr F explained that he had just lost "a very dear [family member]" whom he viewed at lunchtime on [28th Month 3]. He was in "a distressed emotional state" thereafter and forgot to fill in his notes, and requested his colleague to visit Mr A the following day.

[23] The development day (staff training) ran for two days from 28th Month 3. Southland DHB's community mental health team has development days at regular intervals. Staff are available before the day commences formally at 10am and after it ends at 3.30pm. They also remain contactable by cell phone throughout the day.



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> the floor almost naked[24] with no apparent sign of life. We found the flat to be in a dreadful state with vomit and urine on the carpet. We were not sure at first if there had been an invasion[25] so we immediately rang 111. [He] was dead and had been so for a long period of time, perhaps over twenty four hours.
>
> … We as a family are particularly sad that [he] died alone in his flat without basic medical help and without any documented visits for at least 36 hours prior to our finding him [that day]."

*Post-mortem examination*
A post-mortem examination was conducted by a forensic pathologist who noted that there was no evidence of any opiate drug overdose and estimated Mr A's time of death as "evening [28th Month 3]". The cause of death was reported as:

> "Acute bacterial meningitis with Group B Streptococci. This has occurred in the context of insulin-dependent diabetes, which predisposes to this otherwise rare infection in adults, and has [resulted] in loss of control of his diabetes with the development of diabetic keto-acidosis. He could have died as a result of the diabetic keto-acidosis in its own right."

Mr A's death was reported to the Coroner.

*Sentinel event investigation by Southland DHB*
Southland DHB mental health services initiated a sentinel event investigation. The investigation team comprised a psychiatrist, psychiatric nurse, family advisor, psychologist, and diabetes nurse. Over the next year, information was sought from various parties, including Mr A's parents and staff from Southland DHB and PACT.

On 15 March 2007, Southland DHB issued its findings stating that Mr A's death "occurred in conjunction with a number of coinciding events — planned visits by his support worker did not occur as planned, [Mr A] had contracted bacterial meningitis which was an unexpected and rare e[vent] and there was a rapid deterioration in [Mr A's] physical health". The report also noted that "even if interventions had occurred, it is possible that there would still have been a fatal outcome".

The report contained several recommendations, the key one being to develop a Memorandum of Understanding between Southland DHB and PACT. The memorandum defines support worker and case manager roles and clarifies the processes underpinning the relationship and communication between PACT and Southland DHB. The memorandum was signed by both parties on 24 October 2007[26]

[24] Mr and Mrs B subsequently clarified that they did not find their son near naked, but his trousers were lowered.
[25] Mr and Mrs B subsequently clarified that it was the Police who thought that there had been an invasion.
[26] A copy of the Memorandum of Understanding between Southland DHB and PACT was provided to HDC by the DHB.



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and has been highlighted as a key document to all staff within the mental health service. Southland DHB commented that it has "strengthened the integration between the two providers with links and connections occurring at a number of levels from clinician to divisional manager level".[27]

Other recommendations implemented by Southland DHB include:

- individual packages of care and discharge (transfer of care) plans clearly defining responsibilities for all the services, and case manager and support worker roles
- ensuring that all mental health patients who receive individual packages of care from non-governmental organisation providers are enrolled in a general practice and have an identified GP
- ensuring that all patients of the mental health service who receive support within individual packages of care from non-governmental organisation providers have access to a landline or cell phone
- developing a system to ensure that the DHB's mental health provider arm services are informed when contracted services are not delivered according to the agreed plan.

In addition, Southland DHB has also initiated the following remedial measures:

- The mental health service has reviewed its existing model of care, and implemented an integrated model of care which requires the designated psychiatrist to maintain responsibility for the patient's care throughout community and inpatient contacts with the service.
- A "future directions mental health network" has been developed to improve the integration between the provider arm mental health services and the wider mental health sector. Key components include a regional mapping directory, a website, and linking and connecting providers, intersectoral groups, consumer groups and family groups.

*Internal investigation by PACT*

In March 2006, PACT initiated an internal investigation into the circumstances surrounding Mr A's death. As a result, several changes were made to its processes, including:

- requiring staff to keep contemporaneous notes, and to maintain one set of notes per client

[27] At the time of this report, the Memorandum of Understanding is undergoing a joint formal review by Southland DHB and PACT, and is expected to be completed during the second half of 2009.



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- requiring staff to document how they are meeting the contractual requirements for individual hours of support for each client, and to record contingency plans if this support is disrupted or altered

- monitoring community support workers' daily activities, and requiring community support workers to complete a weekly time sheet

- when a replacement community support worker is providing cover for a colleague, the replacement community support worker and team leader are to be made aware of the absentee's caseload.

As part of these changes, PACT has implemented various measures including:

- replacing handwritten notes with electronic records using Client Management System. This allows for integration and up-to-date client information to be shared among authorised staff who are required to enter client notes into CMS daily

- maintaining a daily diary (on CMS) of staff on annual leave, sick leave and training, along with a daily list of clients and the name of the staff member who is visiting that client

- introducing a recording system that details handover and any client-specific instructions

- providing regular supervision of support workers through fortnightly team meetings28 (as opposed to monthly in the past) and individual meetings between the support worker and service co-ordinator29 as and when required and on a formal basis each month

- auditing PACT residential homes (in the Southland region) in February, August and November 2008. This has resulted in improvements in record-keeping and client files

- reviewing its policies and procedures to ensure that they are in line with national Health and Disability Service standards.

[28] Minutes of these meetings are recorded.
[29] The service co-ordinator position was established following an extensive re-structuring of PACT Southland community support service, and replaces the team leader position.



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*Variation in visits*

According to Southland DHB, throughout the period PACT visited Mr A, neither the DHB's community mental health team nor its planning and funding section was aware that there had been any variation to the agreement. This came to light only when Mr A's parents provided Mr J with copies of PACT's correspondence (dated August 2006) detailing its visits.[30] PACT did not provide this information to Southland DHB directly.

PACT disputes this, stating that there had been discussion between the Community Mental Health case managers and PACT staff, about the need to reduce the hours of support for Mr A because he felt his privacy and space were being compromised by the number of people visiting.

Southland DHB explained that, as the level of support PACT proposed was agreed during a multidisciplinary meeting in November 2005, and formed part of the client's care plan, it cannot be altered without the multidisciplinary team's authorisation. The DHB stated that the case manager must be informed of any significant changes in order to seek approval from the clinical service team (comprising the client's family and the community mental health team). Because extra funding was authorised for Mr A, any variation to the contract required the approval of the planning and funding manager and the support needs assessment team. The DHB also stated that PACT's community support workers and their team leader are not authorised to change a client's support care levels without consulting the case manager.

In its original application for funding, PACT had stated that Mr A's support "would be reduced according to [his] changing needs and increasing independence". Ms G explained:

> "The support we provided to [Mr A] was flexible as some days he requested less than on others.
>
> …
>
> It is important to respect the level of support a person requires and be prepared to be flexible in the delivery of support."

In contrast, in Mr J's letter of 9th Month 1 to Ms H, he stated that a review would take place after 12 weeks, aimed at increasing Mr A's independence and reducing his level of support.

During the investigation, PACT informed HDC that, in retrospect, the arrangements for Mr A were "unrealistic" as PACT "does not usually commit to specific hours in

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[30] Refer to **Appendix 2** for a timeline of the visits PACT support staff made to Mr A's flat between 15th Month 1 and 28th Month 3.



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cases of individual support package, because the level of support and allocated hours had to be in accordance with [Mr A's] wishes as per the main contract".

There is also disagreement between PACT and Southland DHB about whether the reduced visits were appropriately highlighted to Southland DHB.

Ms G stated:

> "I met, on a daily basis, with the PACT support workers, to discuss the support plan and any concerns raised by either [Mr A] or the staff. We discussed on a number of occasions that [Mr A] was getting very [resistant] about the number of staff visiting him and I, in my role as Team Leader, determined that we would reduce the visits in response to this. The concern about too many staff visiting with [Mr A] and the decision to reduce the number of visits was discussed with the Case Managers. I personally discussed it with [Mr D] several times over the [weeks before Mr A's death], especially later, by telephone and in person. He and [Mr C] were often in my office and we had lots of discussions about [Mr A]."

Ms G, when interviewed by HDC, said that she "absolutely understood that PACT had an obligation to provide three daily visits, initially, but this was simply not possible".

In contrast, both Mr C and Mr D do not recall being part of any formal or informal discussions about the reduction of visits by PACT support workers. In any event, they had no authority to negotiate or vary the number of visits conducted since such matters were outside the case manager's role.

PACT disputes that Mr C and Mr D had no influence over the number of visits made to Mr A. PACT pointed out that the case managers were conversant with his situation and should have been aware of the agreement PACT had with Southland DHB, in particular, that the amount of support provided to Mr A would vary according to his needs.

*Reporting obligations to funder*

In situations where services are outsourced, Southland DHB requires its contractors to report quarterly on its activities. More frequent reporting is required for package of care funding as outlined in the letter of agreement from Southland DHB.

During the period PACT visited Mr A, no written reports were received by Southland DHB. This was not noticed at the time.



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*ACC*
On 21 August 2006, Mr A's parents' claim to ACC was declined as it did not meet the criteria for treatment injury. In arriving at its decision, ACC obtained external advice from an independent psychiatrist, Dr Bruce Spittle, who concluded:

> "… [Mr A] died from natural causes from bacterial meningitis developing as a complication of his long standing diabetes mellitus and … his death was not the result of his 'not being provided with the special funded care [Mr A] was entitled to' with his diagnoses of schizophrenia and diabetes."

*Coroner's inquest*
On 11–12 December 2007, the Coroner held an inquest into Mr A's death. In his findings of 22 February 2008, the Coroner stated that Mr A's death was "due to acute bacterial meningitis with group B streptococci occurring in the context of insulin-dependent diabetes resulting in loss of control of diabetes with development of diabetic keto-acidosis".

The Coroner noted that although Mr F had some knowledge of diabetes, he "could not reasonably have been expected to know what appeared to be 'the flu' might lead [Mr A] to lose control of his diabetes. Nor could he reasonably be expected to recognise the squinting as a possible sign of meningitis." The Coroner found that Mr F followed proper and accepted procedure by reporting to Mr D and Ms G on the morning of 28th Month 3.

The Coroner concluded that Mr D was unaware of PACT's reduced visits and that Mr J, the general manager of Southland DHB mental health service, was also not aware of the number and duration of visits provided to Mr A by PACT. The Coroner noted the remedial measures implemented by Southland DHB and PACT, but made an additional recommendation that the DHB consider compiling a template for PACT with information about symptoms that might indicate that a mental health patient has a type of physical illness.

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## Responses to provisional opinion

*Mr A's parents*
Mr and Mrs B stated:

> "We should never have found [Mr A] that day; if they had been doing what we believed they were it would not have happened. We trusted them and they not only failed [him], but they also let us down. …
>
> They say that time heals, maybe it does, but the circumstances surrounding his death will always be with us. … There has to be accountability as it should



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> never have happened. We owe it to [Mr A] and to ourselves. That way we can perhaps have some form of closure knowing that we have never given up."

*PACT*

PACT Chief Executive Ms N responded that PACT agrees that higher level communication did not occur, but that it is not immediately apparent how that would have assisted, given that PACT and Southland DHB staff involved in the day-to-day care of Mr A had reasonably frequent liaison and a reasonable degree of communication. She commented that the issue is whether Mr A was being appropriately monitored and looked after. Ms N stated, "This is not a situation where management intervention has been shown to have been likely to have had any material effect over and above the effect of the regular communication and liaison taking place between those dealing with [Mr A] on a day to day basis." She noted that Mr D was aware of Mr A's physical health on 18th Month 2 and 14th Month 3. He was visiting Mr A at that time, and had day-to-day liaison with PACT staff. Since it was Mr D's duty to respond to health issues, and not PACT's, PACT should not be criticised.

Ms N expressed concern that the provisional finding is based on independent community mental health nurse Tom Woods' advice that when Mr F telephoned Mr D to report that Mr A had the flu, he provided only "minimal information and level of concern". She said that this finding is "completely at odds" with the conclusion that there was reasonably frequent liaison between Southland DHB case managers and the PACT team leader, and that Mr A's poor health continued, unchanged, over a prolonged period. It is also at odds with the fact that PACT staff had only ordinary medical knowledge, and were in no position to give anything more than minimal information based on their untrained observations.

Ms N stated that she had "real concern that this finding has been influenced by the field of experience and expertise of your chosen expert advisor without a balancing view being put forward by any independent expert on disability service provision". She noted that Mr F informed Mr D that Mr A was feeling unwell and thought he had the flu "even before he drove away from the property". Ms N noted that Mr D, a registered nurse, was aware of the health risks associated with the condition of diabetes and is therefore the service provider who should have taken responsibility and acted on Mr F's information.

Ms N submitted that Mr F did not have any more information to give. She noted that the pathologist, giving evidence at the Coroner's Court, acknowledged that the symptoms that were the cause of Mr A's death would not have been recognisable to a person without medical training, and even then quite specific medical training would have been required. Ms N stated, "We urge you to rely on the findings of the Coroner on properly tested evidence rather than the opinion of Mr Woods."



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Ms N concluded:

> "PACT operates in a difficult field, and within that field provides services which are confined and discreet. It is not an organisation which supplements, or is a substitute for, medical care. … PACT is the day by day provider of human needs, which include such things as providing company, taking patients shopping, ensuring cleanliness, and ensuring that meals are being prepared and eaten and medications taken (although this is only able to be by checking medical supplies and asking the person, not by observation of symptoms). We accept that reporting of the person's condition to health care providers falls within this, but this cannot occur every time a patient is unwell if that is the norm for the patient.
>
> …
>
> PACT does not claim to have been without fault in its provision of support services to [Mr A], and will certainly tender to his parents an apology at the conclusion of your investigation. …"

*Southland District Health Board*
The Southland DHB Deputy Chief Executive acknowledged that continuous improvement of systems is an ongoing priority and has implemented a number of changes since these events.

She noted the comment made by Mr Woods that physical health care for mental health services users is often "haphazard" and often "inadequate", and that his comments appear to be attributed to Southland DHB mental health services. She noted that Mr Wood was expressing an opinion "generally about mental health services nationally", and that it is "fundamentally unfair to seek to hold SDHB to a standard" when the HDC expert "expresses significant doubt about its national acceptance".

The Chief Executive stated:

> "SDHB mental health service has continued upon a path of continuous quality improvement over the last two and half years. … SDHB undertook a sentinel event investigation which made a number of recommendations for improvement. These recommendations have all been implemented. …
>
> SDHB mental health services and PACT implemented the memorandum of understanding between the two providers. A joint formal review of this document is currently in progress. This document has strengthened integration between the two providers with links and connections occurring at a number of levels from clinician to divisional manager level.
>
> SDHB mental health services has also undertaken a review of its model of care and has successfully implemented an integrated model of care which requires



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the designated psychiatrist maintain responsibility for patients' care throughout the community and inpatient contacts with the service.

The SDHB has led and supported the development of the future directions mental health network which has enabled and driven improved integration between the provider arm mental health service and the wider mental health sector. Key components of this have been the development of a regional mapping directory, a website and linking and connecting of providers, intersectoral groups, consumer groups and family groups."

## Opinion: Breach — PACT

*Introduction*

Mr A had been a longstanding patient at Southland DHB's mental health service and was subject to a compulsory treatment order. A joint decision was made between Southland DHB, PACT, Mr A and his family to try him in an independent living situation (for 12 weeks) with close daily support from PACT, and regular visits from Southland DHB's case managers. According to the support plan, PACT support workers were to visit Mr A seven hours a day, and assist him with day-to-day tasks such as preparing meals, grocery shopping, cleaning, and checking his medication. Although their duties did not include conducting any assessments of his physical or mental health, PACT support workers were to report any concerns they observed about Mr A's health to Southland DHB's case managers. Of all parties who interacted with Mr A, PACT support workers had the closest involvement and were effectively "the eyes and ears" of the mental health service in checking how he was managing in the community.

In response to my provisional opinion, PACT submitted that referring to the support workers as the "eyes and ears" of the mental health service is overstating the position. The support workers are disability service providers; they are not health providers and have no training in health care. The PACT community mental health support workers have the National Certificate in Mental Health (Support) Work from Southern Institute of Technology, but they have no knowledge of health matters beyond those of any untrained member of society. The very most that they were able to do was to report observed symptoms or statements made by Mr A.

While I acknowledge that PACT's duties did not include conducting any assessments of Mr A's physical or mental health, PACT was responsible on a day-to-day basis for checking how Mr A was managing in the community. This included an obligation to report to Southland DHB case managers any concerns about his health and well-being that would be obvious to a support worker visiting him regularly. This duty was not



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discharged satisfactorily, as discussed below. This, coupled with deficiencies in PACT's systems and processes, impacted on the services Mr A received.

*Management of visits and co-ordination of care*

The key issue appears to have been a lack of clarity about the level of support PACT was providing to Mr A.

According to the plan initially agreed between PACT and Southland DHB, Mr A should have received three visits a day over a 12-week period. This should have amounted to at least 219 visits, but in actual fact he received only about half this number. It appears that most visits were brief (only for a few minutes) and did not total the seven hours daily that was planned. From the outset, PACT staff recognised that seven hours of face-to-face interaction daily was "unrealistic in practice". They believed that they could vary the arrangements, and did so when Mr A told PACT staff not to.

My expert community mental health nurse, Tom Woods, shared PACT's view that the original plan was "unsustainable" as it essentially involved spending "large amounts of time with [Mr A] in an unstructured way", which was "guaranteed to become intrusive for the client". This was indeed what happened. My expert noted that PACT "responded appropriately [by] reducing their visits".

PACT maintains that its staff, who met frequently with CMHT staff (Mr D and his predecessor Mr C), made them aware that three visits totalling seven hours of support per day were not occurring. The basis for this assumption is that PACT was not invoicing Southland DHB, so the DHB should have been aware that the visits were not occurring as planned. For PACT to assume that Southland DHB knew about the reduced visits because of the lack of invoices was risky. There is no evidence that Mr A's responsible clinician, or the Southland DHB managers who had signed off on the contract were aware that the visits had been reduced.

I am satisfied that Southland DHB's case managers were unaware that PACT had made a decision to reduce the number of visits to Mr A. While I note my expert's comment that, in his view, the case managers would have been aware that three visits totalling seven hours per day were not occurring, I am not convinced that they were aware of the significant reduction in the visits PACT was making to Mr A. There is no evidence that the issue of the frequency of PACT's visits to Mr A was discussed at any of the multidisciplinary meetings, and there is also no record of any such discussions in PACT's records or in the case manager's notes (which are very detailed). This is consistent with the Coroner's findings that Mr D did not know that three visits per day totalling seven hours were not being provided, and that it was unlikely Mr C agreed to a reduction in visits. I consider that PACT failed to communicate adequately with Southland DHB about their visits to Mr A, and this was one of the factors that contributed to the substandard care that Mr A received.



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Over time, Mr A became increasingly withdrawn and resistant to PACT's visits. I share Mr Woods' view that "greater attention should have been given to [Mr A's] increasing reluctance to engage with the support provided" and to his physical health. It appears that PACT staff did not routinely pass on their observations about Mr A's health to the case manager (who was responsible for ensuring that Mr A accessed appropriate primary and secondary health care when necessary). For example, during several visits in Month 3,[31] PACT staff noted that Mr A felt unwell, and was moody and worried about his health, but there is no indication that such observations were relayed to Southland DHB's case manager. The lack of information from PACT to the case managers meant that there were missed opportunities to respond promptly to his health problems. I do not accept PACT's submission that because Southland DHB's case manager liaised closely with PACT, it follows that PACT support workers also communicated adequately with the case manager.

In response to my provisional opinion, PACT challenged the suitability of my expert (a community mental health nurse) to comment on the appropriateness of the conduct of PACT staff. I acknowledge that he is not a peer of PACT support workers. However, the focus of my investigation is the organisational duties of PACT and Southland DHB to a mental health consumer living in the community, and my expert's advice on the adequacy of PACT's systems and processes is helpful on these issues. Mr Woods is clearly familiar with the nature of community support for mental health consumers, and I do not see the need for specialist advice to make general observations about the reasonable expectations of such an organisation.

The bottom line is that the PACT support workers had a duty of care to help Mr A adjust to independent living and, in a general way, to check that he was managing his health, eating properly and taking his medication. One of the key tasks of a support worker, as described by PACT, is to monitor medication compliance and report non-compliance to the case manager. Furthermore, PACT had agreed to a support plan that included PACT staff checking Mr A's medication.[32] If PACT staff had done so, it would have been obvious (even to a support worker who was not a health professional) that Mr A was becoming unwell and not taking his medications as prescribed. If PACT staff had communicated information about Mr A's health earlier, his case managers could have taken steps to manage this — including reviewing the viability of his placement.

In my opinion PACT did not manage Mr A's visits appropriately or communicate adequately with the DHB.

[31] For example, on the morning of 19th Mr A was observed to be "a bit weepy", he was unresponsive, and refused his dinner that afternoon; he was described as "negative" on 21st; was "very down" on the evening of 24th; and reported feeling "sick" and refused a visit on 26th.
[32] The plan recorded that the 4.30pm–6.30pm visit was to include "check[ing] meds", and that on Thursdays Mr A was to be taken to collect his medication.



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*Care on last two days*
At the heart of this case are the visits Mr A should have received on the last day he was seen alive, and the following day. I have concerns about PACT's management of these visits.

At 10.50am on the morning of 28th Month 3, support worker Mr F visited Mr A, who declined an outing as he had the flu. It appears that this visit was very brief. Mr F advised Mr A to rest in bed, and contacted Mr D (at 10.52am). Mr F also informed his team leader. These were appropriate communications by Mr F.

The Coroner noted that although Mr F had some knowledge of diabetes, he "could not reasonably have been expected to know what appeared to be 'the flu' might lead [Mr A] to lose control of his diabetes. Nor could he reasonably be expected to recognise the squinting as a possible sign of meningitis." I agree with the Coroner's comments. In my view, Mr F followed accepted PACT procedure by reporting to Mr D and Ms G.

However, this did not absolve PACT from its obligation to visit Mr A that afternoon/evening, and to provide practical assistance to ensure his well-being. Mr D had not provided any specific assurance to Mr F that he would visit; the question who would visit that day was not resolved.

The situation was exacerbated by PACT team leader Ms G's decision to instruct the support worker (Ms E) not to visit that afternoon and evening because Mr A had the flu; PACT staff absences during the evening shift and the following morning; and Mr D's absence to attend a two-day training course from 28th Month 3.

I share the Coroner's view that the directive not to visit Mr A was "strange" since "a fragile person with minimal ability to live alone is likely to require more rather than less support when he is ill". His views are supported by my expert, who commented "common sense would hold that if Mr A was feeling unwell, he might require some extra assistance to ensure he had adequate food and fluid available to him, that he was able to rest comfortably, and that he had the means to contact people if needed".

In my view, PACT did not manage the visits appropriately, and failed to discharge its obligations to provide support to Mr A.

*Documentation*
Over the period PACT visited, there were daily entries in Mr A's progress notes and the level of observation recorded was acceptable. Staff essentially recorded "plain observations" of ongoing events and Mr A's general level of health. Mr Woods advised that "the content provided was sufficient for a non-clinical support work team".

However, he identified several deficiencies in PACT's system of documentation, including "a lack of synthesis and planning" of Mr A's care, and noted that the progress notes were not physically available to all staff at times. At the time of the



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events, the progress notes were not amalgamated and different teams recorded their notes in separate files. Consequently, daytime staff were not always aware of what the evening staff had recorded, and there appears not to have been a consistent practice of reading the previous day's notes during handovers by PACT staff.

I also note that there was no mention in the PACT staff notes about the decision to reduce the visiting hours or to hand over care to the community mental health team. In addition, my expert noted "some inconsistencies in the record around the time of [Mr A's] death". Specifically, Mr F did not keep contemporaneous notes of his visit on 28th Month 3, and the notes he subsequently recorded made no mention of PACT's response to Mr A's complaint about having the flu. This entry was directly below an entry by Ms G (about Mr and Mrs B's proposed visit at lunchtime the next day). Mr Woods noted that both entries were on a separate page and do not appear "contiguous with previous entries" (dated between 10th and 27th Month 3).

It is important to keep contemporaneous records as subsequent recollection may cast doubt on the accuracy of the information recorded. Following these events, PACT now requires its staff to keep contemporaneous notes.

In my view, PACT's system of documentation did not encourage co-operation and communication between providers to ensure continuity of services. PACT has accepted that its record-keeping was inadequate.

*Conclusion*
Overall, I conclude that PACT did not fulfil its responsibilities and provide appropriate support to Mr A. I appreciate that PACT support workers are not medically trained, and were respecting Mr A's wishes in reducing the number of visits he received. However, by not communicating adequately with DHB staff, not managing Mr A's reduction in visits appropriately, and failing to have an adequate record-keeping system, PACT failed to provide services to Mr A with reasonable care and did not co-operate with other providers to ensure a quality service. Therefore, PACT breached Rights 4(1)[33] and 4(5)[34] of the Code of Health and Disability Services Consumers' Rights (the Code).

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## Opinion: Breach — Southland District Health Board

*Assessment and management of care*

[33] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[34] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."



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Many aspects of Southland DHB's psychiatric monitoring, assessment and management of Mr A appear to have been reasonable. A day before he was discharged to independent living, he was seen by a Medical Officer in Psychiatry and received regular visits from his case managers (Mr C and Mr D) over the ensuing 2½ months. There were 25 recorded visits in total. In addition to monitoring Mr A's health needs (eg, administering depot injections, checking that the appropriate medication was supplied and that Mr A attended medical appointments), the case managers also updated his parents regularly and liaised closely with PACT about his progress.

Although Mr A initially settled into his flat, subsequent events from the middle of Month 2 cast doubt on the appropriateness of the placement. Between 18th–19th and 28th–31st Month 2, Mr A was admitted to hospital with diabetes-related complications. Over Month 3, there were several entries by PACT staff stating that Mr A was moody and withdrawn, and felt unwell. My expert commented that at this point, Mr A's physical and mental health "required active support for the placement to succeed".

All patients subject to an inpatient order (as Mr A was) must have an assigned responsible clinician who is in charge of his or her treatment and determines the terms and conditions of any leave of absence from hospital.[35] There were two joint reviews or planning meetings between Mr A, Southland DHB community mental health team and PACT on 16th and 23rd Month 2. Mr A's responsible clinician, Dr O, attended the meeting on 23rd Month 2, and reviewed his current plan. A further review was planned for three months' time.

My expert highlighted several areas where the co-ordination of Mr A's care could have been better. He commented that "ideally, a community occupational therapy assessment would have been offered to assess Mr A's ability to plan and shop for the preparation of meals". Although the occupational therapist recommended further assessment in late 2005, it appears that no further assessment was undertaken. Following Mr A's first discharge from hospital on 19th Month 2, he was referred to a diabetic nurse educator for assistance with monitoring his medication and blood sugar levels. However, Mr Woods considered it "unfortunate" that the home visit from the diabetic nurse educator was not co-ordinated so that both the community mental health team and PACT staff were present. This was a missed opportunity to discuss the difficulties Mr A had in managing his own care, and to identify practical measures that could have been taken.

In response to the provisional opinion, Southland DHB acknowledged that the communication between Mr D, the diabetic educator, and Mr A's GP could have been improved. All of these parties had copies of the discharge letters from the medical ward and the mental health inpatient unit. Although Mr A's GP was the main provider of his physical health in the community, Mr D had a responsibility to ensure that Mr A accessed the appropriate primary and secondary health care when indicated.

[35] The Mental Health (Compulsory Assessment and Treatment) Act 1992, sections 2, 7 and 31(2).



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I share my expert's concern that "[Mr A's] case highlights a lack of integration between physical and mental health services, and between primary and secondary care". Although the community mental health team made efforts to ensure that Mr A had access to primary health care by arranging financial assistance via WINZ and communicating with the GP liaison officer, there was little direct communication between the secondary mental health services and primary care. For example, there is no indication of any discussion between the community mental health team and Mr A's GP about his hospital admissions in Month 2. The decline in Mr A's physical health and the relevance of this appears to have been missed by both the community mental health team and the inpatient mental health team. Mr Woods commented that this "is not an uncommon situation" when communication between health sectors is "poor".

Southland DHB submitted that this is a problem around the country, and queried whether the lack of communication between the secondary mental health services and primary care was therefore a departure from accepted standards. As Commissioner, it is my role to determine the reasonable standard of care and coordination that a consumer is entitled to receive. In my view, there were gaps in Southland DHB's management of Mr A's care, and the DHB did not appropriately co-operate with other providers to ensure quality and continuity of services to Mr A.

*Communication*

In managing a complex placement, good communication between all parties is vital. The communication from Southland DHB's case managers was generally very good — they kept in close contact with PACT, and frequently dropped in to PACT's office to discuss Mr A's management. The case managers also communicated regularly with Mr A's parents, mainly over the phone. Efforts were made to contact Mr A's parents soon after his two admissions to hospital.

However, my expert noted "a lack of higher-level service co-ordination and review between Southland DHB and PACT regarding the intensive support Mr A was receiving". Following the exchange of letters regarding additional funding for Mr A, there was no other communication between Mr J and Ms H in the ensuing weeks.

Given the resources involved in Mr A's placement (along with the additional cost Southland DHB would have incurred had PACT invoiced it), it was in the DHB's interests to monitor and assess the viability of this placement. It would also have been good mental health practice to do so. Although a formal review between Southland DHB and PACT was planned at the three-month mark, interim formal reviews would have provided earlier opportunities to discuss whether the placement was still appropriate. Between 23rd Month 2 and the end of Month 3, no multidisciplinary meetings took place to review Mr A's placement.

*Monitoring of service provider's compliance with agreement*



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Despite the agreement that PACT visit Mr A three times per day, Southland DHB's community mental health team was not expected to monitor PACT's compliance with the contract. This is not unusual since there is a "fair degree of independence" when mental health clinicians work in parallel relationships with community social work services. The community mental health team would only be expected to intervene when there are specific concerns about a patient's mental health or safety.

As discussed above, I am satisfied that Southland DHB's case managers were unaware that the visits were not occurring as planned. My expert commented that even if they were, it would have been appropriate to give some leeway to the community social work team on a day-to-day basis and to intervene only if Mr A's health or safety was at risk.

It is certainly unfortunate that Southland DHB's planning and funding section was unaware of the lack of reports from PACT during the period when it visited Mr A. Indeed, it was only when the DHB investigated the events surrounding Mr A's death that this omission came to light. This does not reflect well on a DHB tasked with the responsibility of allocating resources and funding services.

*Decision to defer visit on 28th Month 3*

Shortly after his visit, PACT support worker Mr F telephoned Mr D (at 10.52am) to report that Mr A had the flu. Mr D was not provided with any other details about Mr A's condition or appearance. In light of the information relayed, it was understandable that Mr D deferred assessing Mr A for two days while he (Mr D) attended a work training course. It was also reasonable for Mr D to expect PACT to continue visiting and supporting Mr A in the interim, since Mr D and Southland DHB were unaware of PACT's reduced visits.

*Conclusion*

I share my expert's view that the shortcomings in Southland DHB's care and communication with PACT constituted a moderate departure from the appropriate standard. In these circumstances, Southland DHB breached Rights 4(1) and 4(5) of the Code.

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## Actions taken

Since these events, Southland DHB has initiated a sentinel event investigation and implemented various recommendations. It has also devised a template for PACT with information about symptoms that might indicate a physical illness, as recommended by the Coroner. In addition, the Southland DHB's mental health service has reviewed its model of care, and implemented an integrated model of care that requires the designated psychiatrist to maintain responsibility for the patient's care throughout community and inpatient contacts with the mental health service.

PACT has also initiated its own investigation into the circumstances surrounding Mr A's death, and comprehensive changes have been made to improve its services.

Both Southland DHB and PACT have jointly developed a Memorandum of Understanding to clarify the processes underpinning the working relationship and communication between Southland DHB and PACT. A joint formal review is in progress and is scheduled for completion during the second half of 2009.

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## Recommendations

I recommend that PACT:

- apologise to Mr and Mrs B for its breaches of the Code. The apology is to be forwarded to HDC by **21 August 2009** for sending to Mr and Mrs B

- update HDC on the improvements made to client files following the audits in February, August and November 2008, by **21 August 2009**.

I recommend that Southland District Health Board:

- apologise to Mr and Mrs B for its breaches of the Code. The apology is to be forwarded to HDC by **21 August 2009** for sending to Mr and Mrs B

- update HDC on the review of the Memorandum of Understanding with PACT, by **30 November 2009**.

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## Follow-up actions



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- A copy of this report will be sent to the Coroner, ACC, and the Director of Mental Health at the Ministry of Health.

- A copy of this report with details identifying the parties removed (except the expert who advised on this case, Southland Hospital, Southland District Health Board and PACT) will be sent to the Mental Health Commission, the Mental Health Foundation of New Zealand, and the Schizophrenia Fellowship New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.



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## Appendix 1

## Independent advice to Commissioner — Community mental health nurse Tom Woods

*Initial advice*

**Preamble**

I have been asked to provide an opinion to the Commissioner on case number 08/05072 as to whether Southland District Health Board (SDHB) and Patients' Aid Charitable Trust (PACT) provided an appropriate standard of care to [Mr A].

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

**Qualifications, Training and Experience**

I am a Registered General and Obstetric Nurse (Auckland Hospital 1985) and Registered Comprehensive Nurse via Psychiatric Nursing (Nelson Marlborough Institute of Technology 1987) with a Post Graduate Diploma in Health Sciences (University of Auckland 2004) and a Master of Nursing (University of Auckland 2008). I have previously worked in general, psychopaedic and psychiatric inpatient settings. Since 1992 I have worked in the area of community mental health as a case manager and in crisis intervention roles, with a more recent emphasis on primary care liaison. As Nurse Specialist for St Lukes Community Mental Health Centre (Auckland District Health Board) my role includes working with a clinical caseload, liaison with community providers, supervision, service development and clinical input into policy and quality initiatives. Over the last twelve years I have worked with a number of Community Support Work services in caring for service users. I am a member of Te Ao Maramatanga, the New Zealand College of Mental Health Nurses.

[At this point, Mr Woods sets out a précis of the case which has been omitted for brevity.]

**Supporting Information**

- Complaint from [Mr and Mrs B], marked "A" (pages 1–7)
- Investigation letters to SDHB and PACT, marked "B" (pages 8–13)
- Response from SDHB, marked "C" (pages 14–307)
- Response from PACT, marked "D" (pages 308–529)
- Interviews with SDHB staff, marked "E" (pages 530–545)
- Interviews with PACT staff, marked "F" (pages 546–549)
- Coroner's findings marked "G" (pages 550–567).



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## Advice

### 1. Were the services provided to [Mr A] appropriate?

The services provided were appropriate, allowing for the variance in the frequency of visits by the PACT team. For a person living independently, one or two visits per day by a community support worker (CSW) continuously over a period of several months would be seen as more than sufficient to monitor and assist a client in their recovery.

The level of care originally agreed to was highly intensive, and unrealistic in hindsight, given [Mr A's] uncooperative demeanour and his particular physical and mental health issues.

### 2. What standards apply and were those standards complied with?

Health and Disability Sector Standards

The National Mental Health Sector Standards

Service Specification for 'Adult Community Residential Services: Service Type Description For Other Residential Support'

Nursing Council of New Zealand Competencies for Registered Nurses (2007)

Te Ao Maramatanga Standards of Practice for Mental Health Nursing in New Zealand (2004)

Generally the care given did comply with the standards required of health professionals and the provider services.

Under the Service Specification for 'Adult Community Residential Services: Service Type Description for Community Residential Support' [Mr A] had previously been assessed as requiring Level IV Community Residential Care. This had been the case for most of the time he spent under PACT care. Level IV care offers '24-hour intensive support provided by a mix of clinical (professionally qualified) and non-clinical staff…to meet individual needs' (p 275a).

SDHB understood that a Package of Care was being offered, to substitute for Level IV care. This kind of arrangement falls outside of the Service Specification for 'Adult Community Residential Services' and is intended to provide a high degree of coordinated care for those living independently who might otherwise be in Level III or IV care.

The documentation provided indicates there was confusion over the level of care that was subsequently offered. PACT indicated they believed the care that was actually being delivered could be funded under the 'main contract' for residential support (pp 308–309). If so then the hours originally agreed to (six or more hours per day) were in



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excess of those typically provided e.g. one to three hours per week under the main contract.

**3. In your view, was it appropriate for [Mr A] to be placed in supported living?**

[Mr A's] care presented specific difficulties to the services involved. He was found to be unsuited to living in group home situations, and his most recent admission to the inpatient unit had lasted nearly a year. Such long admissions often indicate problems or barriers have arisen in the discharge process. His wish upon discharge was to return to his parents' home town (where community psychiatric support is limited) in order to be close to family. Previous behaviour had indicated that he was unable to live safely with them, and therefore he required a period of support in which to learn to live more independently. PACT and SDHB had little choice but to attempt to maximise [Mr A's] independence and recovery, while living in Invercargill where appropriate services could be provided.

[Mr A] was moved to independent supported living not because his level of independence had increased, but because others found his behaviour intimidating (p 322). In hindsight it could be seen as unwise to attempt to provide such high levels of one-to-one contact with [Mr A], who was known to exhibit antisocial behaviours. The plan intended seemed rudimentary, consisting of basic domestic support. It was not clear what would be attempted or achieved via the five to seven hours of daily personal interaction (p 390).

Some factors favoured this option; his mental state had been relatively stable, he was no longer using drugs or alcohol and he was agreeing to take medication prescribed. In both group homes and during hospital admission it had been observed that he was able to monitor his blood sugar levels and maintain his own insulin therapy under supervision. [Mr A] was seen to have made real progress over the previous three years, as noted by [Mr F] in his statement (p 461). However given [Mr A's] personality issues and physical health problems the placement was probably overly ambitious. It required an unprecedented level of input and coordination between a number of health services.

An Occupational Therapy (OT) Functional Performance Assessment carried out in November 2005 concluded that while he was capable of performing basic domestic tasks (e.g. of personal hygiene and household cleaning) those requiring higher functional ability (budgeting, grocery shopping and meal planning) had not been assessed as [Mr A] was unwilling cooperate (p 76). The OT writing the report suggested that further assessment was required if he were to be placed in an independent living situation (the proposed intention at the time), of both [Mr A's] intellectual and occupational functioning.

The report made no mention of his diabetic condition or his ability to manage it. [Mr A] had lived with the condition since his teens and had at times reassured caregivers that he could adequately self-manage his diabetes. However in recent years he had



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lived in situations where 24-hour staffing had been on hand to monitor blood sugar levels and insulin therapy. While it was observed that he could take his own blood sugar readings and self-administer correct doses of insulin, it was not known whether he could manage these cares independently. Self-management of diabetes also requires an ability to plan a household budget, shop appropriately and prepare meals.

**Advice in relation to SDHB**

**1. Did [Mr A] receive appropriate clinical assessment and management, including whether he was adequately monitored?**

The psychiatric monitoring, assessment and management of [Mr A] appears to have been adequate. He was seen by [a Medical Officer in Psychiatry] on the day of discharge ([12th Month 1]). After the subsequent physical health admission that occurred in [Month 2], [Mr A] kept a booked appointment with [Dr O], a community psychiatrist. I find no clinical notes from this appointment but [Mr D's] note of [23rd Month 2] refers to these being written (p 110). [The Medical Officer] saw him again at the time of his second medical admission. Psychiatric opinion held that [Mr A's] mental state was essentially stable, though it had been adversely affected probably as a result of the low sodium levels precipitating that admission.

[Mr A] also received medical attention for his physical health needs after discharge from the psychiatric unit. [A locum GP] saw him and initiated the first medical admission, when diagnosed with diabetic keto-acidosis (DKA). There was a home visit by the diabetic nurse educator two days prior to the second medical admission, which occurred this time via the Emergency Department of the local hospital. He did miss an outpatient appointment with the fracture clinic at that time. One week after discharge from the medical ward he visited his GP with a PACT worker ([7th Month 3]) which appears to be the last time he was seen medically.

Some concern was raised at the time by [Mr D] and subsequently by [the family] that [Mr A] could not afford to attend the GP as often as he needed. [Mr D] communicated with GP liaison staff, and funding options were investigated and confirmed, using a disability allowance to be paid by Work and Income New Zealand (WINZ).

The nursing notes of the Community Mental Health Team (CMHT) indicate that [Mr A's] case managers during that time (of which there were three [over the two and a half months]) made regular visits and assessed his physical and mental health status appropriately. His ability and willingness to monitor his own blood sugars and administer insulin was specifically reported on.

Most of the CMHT input at this time involved checking that [Mr A] attended appointments, had blood tests done, that medication was supplied, that his disability allowance was in order, and that the power account was paid. In his visits with [Mr A], [Mr D] repeatedly noted that he seemed mentally well and had no complaints.



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Despite this attention, [Mr A] had two medical admissions during the twelve weeks he spent in independent living. The discharge summary from the first admission (p 425) attributes [Mr A's] condition to a three week history of vomiting and epigastric pain from late [Month 1] through to mid [Month 2]. [Mr A] was discharged after his second medical admission on the last day of [Month 2] and by mid [Month 3] CMHT notes ([14th Month 3]) show that family were concerned that he was vomiting yet again. The entry (p 114) mentions [Mrs B's] concern that "he seems to be vomiting lots" and that the bathroom was dirty. Because of this concern [Mr D] visited [Mr A], who reassured him he was sick only once, saying "it was flem" (sic). Given the information available this was appropriate response and follow-up.

The coroner's report shows [Mr A] was found to have died of complications due to acute bacterial meningitis and DKA. The bacterial infection and subsequent meningitis could not have been foreseen, being a relatively rare condition that develops quickly. It is easily misdiagnosed as something less harmful such as influenza, as the public has been informed in recent education campaigns. But as the Coroner states the level of monitoring and assessment around the immediate time of death, or lack of it, was inevitably linked to the adverse outcome.

Given the minimal information and level of concern relayed to [Mr D] by [Mr F] on [28th [Month 3] it seems unsurprising that [Mr D] felt he could wait 48 hours before assessing [Mr A] again. It appears he expected PACT to continue to visit and support him, and seek medical attention from a GP if needed.

**2. Did [Mr A] receive appropriate multidisciplinary care and review?**

In light of the two general hospital admissions, the lack of coordinated concern and awareness for [Mr A's] physical and mental health during [Month 3] reflects poorly on the decision taken to place [Mr A] in independent living. This was an instance where both physical and mental health required active support for the placement to succeed.

There was insufficient communication with the GP, and with the diabetic nurse educator. There were no joint reviews or planning involving PACT and CMHT staff during these 12 weeks, despite the reasonably frequent liaison between SDHB case managers and the PACT team leader. I saw no clear indication that a consultant psychiatrist was actively engaged in the ongoing review of this complex placement. Though [Mr A's] psychiatric condition was stable, he was a client on an indefinite order under the Mental Health Act.



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**3. Did SDHB appropriately communicate with PACT about [Mr A]?**

From the notes made by both SDHB and PACT staff it appears that staff did communicate to a reasonable degree with PACT on a day to day basis. However there was a lack of higher-level service coordination and review between SDHB and PACT regarding the intensive support [Mr A] was receiving. If this had occurred it would have provided an opportunity to address issues regarding his reluctance to allow more frequent visits, his vulnerable health status and therefore the questionable success of the placement.

**4. Were [Mr A's] family adequately involved with his care?**

[Mr A's] parents were living in [another town], and the notes show there was adequate communication with them by phone. [Mr D's] notes show evidence of calls with both [Mr and Mrs B] in regard to their son's physical health, on [18th Month 2] and [14th Month 3] respectively.

**5. Were SDHB's policies and procedures appropriate?**

They were appropriate to the generally accepted standards of community mental heath care and to the follow-up of a service user in independent living, with intensive support from a CSW team.

**6. Did SDHB adequately document [Mr A's] care?**

Though I was unable to find the assessment made by [Dr O] (community psychiatrist) after the appointment on [23rd Month 2], [Mr D's] note on that day indicates it was written ("see his notes next page", p 110). Other than this the record contains an adequate level of observation, assessment and planning.

**7. Did SDHB adequately monitor PACT's compliance with the agreement to provide three daily visits to [Mr A]?**

Though at odds in some regards, the service coordination correspondence between SDHB and PACT service managers indicates that a review of the arrangements would occur at the three month mark. A review of [Mr A's] arrangement was in fact due. Presumably, the issue of the hours of care provided would have been a topic of this review.

Though PACT was effectively contracted to SDHB in offering services to [Mr A], the CMHT staff themselves were not expected to monitor the services provided in terms of compliance. Mental health clinicians often work with CSW services in 'parallel' relationships, and with a fair degree of independence. I am of the opinion that CMHT staff would have been aware that three visits totalling seven hours per day were not occurring, but that this was accepted in deference to the CSW's methods i.e. working



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with clients in accordance with their wishes as much as possible. CMHT notes give no indication that staff felt PACT input was insufficient or inadequate.

If [Mr A] was giving PACT staff the impression that he found the frequency of visits intrusive, they would be required to take his views into account. CMHT staff would give the CSW team some leeway in making the decision to reduce hours, on a day to day basis, as tolerated by [Mr A]. Only if this appeared to be adversely impacting on his mental health or safety would they be expected to intervene.

**8. What else, if anything, should SDHB have done in the circumstances?**

Ideally a community Occupational Therapy (OT) assessment in the home would have been offered to assess [Mr A's] ability to plan and shop for the preparation of meals. While this was recommended by the inpatient OT in [late] 2005, it is not clear if this kind of assessment was available in the community.

It is unfortunate that the home visit from the diabetic nurse educator was not coordinated in such a way that both CMHT and PACT staff were present. This may have helped bring to light the difficulties [Mr A] apparently had in self-managing care.

[Mr A's] case highlights a lack of integration between physical and mental health services, and between primary and secondary care. Though CMHT staff did make efforts to ensure that he had access to primary health care by arranging financial assistance via WINZ and communicating with the GP liaison, there is little if any evidence that direct communication occurred between secondary mental health services and primary care. [The GP] is mentioned in relation to the ordering of blood tests, but no discussion appears to have taken place between the CMHT and the GP in regard to the two physical health admissions. The relevance of [Mr A's] physical health issues in attempts to support him in independent living seem to have been missed, by both of the mental health-oriented services involved in his care. This is not an uncommon situation, and communication between health sectors is often poor. It is one example of the kinds of situations that have Ministry of Health statistics showing life expectancy for long-term mental health service users as significantly less than that of the general population.

**9. Please provide any further recommendations for improvement.**

It has been my experience that when those managing service coordination have some direct involvement with the CSW staff, clinical staff and the client themselves, ongoing adjustment occurs as care proceeds. It is unclear to me from the notes provided what communication occurred between the SDHB service coordinator who arranged the PACT contract, and the SDHB staff involved in [Mr A's] care, or between the service coordinator and PACT's managerial staff, or their caregivers.



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Reasonably frequent contact between those overseeing such intensive resource allocation and those providing the care would have been more useful than monthly written reports as originally envisaged. Due to the misunderstandings around the service coordination arrangements, it appears these reports were not provided by PACT, hence care continued for nearly three months without review.

**Advice in relation to PACT**

**1. Did PACT appropriately manage [Mr A's] apparent resistance/ reluctance to visits?**

From the outset of the placement, it seems that those involved were aware that providing seven hours of face to face interaction daily was unrealistic in practice. The PACT notes indicate that visits were increasingly focussed on and in response to the domestic necessities of shopping, cooking, cleaning, and the need for transport to appointments. [Mr A] and PACT staff did not always appear to have a particularly easy rapport, this being most notable with some of the female staff. Attempts to get him more socially involved were largely unsuccessful.

Maintaining rapport with service users is fundamental to community mental health care. Most community work takes place in clients' homes and health professionals are effectively 'guests' in this environment. The client's wishes are of particular concern to CSWs who are required to work alongside service users, assisting to effect independence and recovery. [Mr A] specifically told PACT staff not to visit on a number of occasions, as noted in PACT records.

Though it would have been unreasonable to insist on the level of visits as originally agreed to, greater attention should have been given to [Mr A's] increasing reluctance to engage with the support provided. The combination of increasing reluctance to engage with staff and the two admissions he required to general health services should have alerted them to the fact that the placement was in jeopardy.

[Mr A] was on a compulsory and indefinite order under the Mental Health Act.

Though PACT may have been less concerned with his apparent lack of alliance than the CMHT staff (responsible for administering the Act) both teams should have shown more concern that his physical health appeared fragile. But there was no overt discussion noted about the changing situation, and no process of ongoing review where such issues might have been addressed.

It seems from PACT managers' correspondence that the care delivered was not necessarily seen as falling under the requirements and funding for a 'Package of Care'. No formal plan had been drawn up (p 552). PACT staff appeared to believe they had some flexibility in deciding day to day what level of contact was required. SDHB was never invoiced for the seven hours originally agreed to, and these were never in fact provided.



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## 2. Did PACT communicate appropriately with SDHB about [Mr A]?

Both sets of notes show there was ongoing liaison between the teams. However on a number of occasions PACT staff did not seem to understand the relevance of the observations they made. [Mr A] returned home from his second admission on [31st Month 2] but as early as [4th Month 3] a PACT entry shows that he was unwell again and that he was observed to have been sick (p 392). Though the worker took care to see he had fresh drinking water and advised him to 'take small sips when drinking' there is no indication that this concern was reported any further. Certainly, in a number of similar entries following, the possibility of alerting the CMHT is not mentioned.

Further observations (pp 393–397) regarding [Mr A's] poor physical health and low mood, none of which appear to have been relayed to the CMHT include:

[12th Month 3] "[Mr A] worried about his health, stressing himself a bit."

[18th Month 3] "[Mr A] had been sick and had leave (sic) a huge mess around the toilet, all over the floor and wall … [Mr A] said he was sick last night but much better today."

[19th Month 3] [Mr A] "weepy in the morning" and "sick of his life", he "wasn't very responsive in the afternoon. Didn't want tea, said he would cook baked beans later."

[21st Month 3] "[Mr A] negative today."

[24th Month 3] "[Mr A] very down this evening, crying and saying he doesn't know what to do." Advised not to "sit around by himself all day."

[25th Month 3] "[Mr A] grumpy today. Visited for awhile and he told me to go didn't want my visit anymore and don't come back."

[26th Month 3] "AM> Woke [Mr A] up this morning he didn't want a visit and was going back to bed. PM> Called back this evening. [Mr A] is sick. He says he is not able to hold anything down (was sick while I was the[re]). Later said … he was feeling better. Put tea on for him and sorted out his washing."

Going through the nine CMHT notes made by [Mr D] during this period there is no indication that PACT were concerned about either [Mr A's] mental or physical health, sufficient enough to bring it to [Mr D's] attention. PACT notes refer on at least eight occasions to vomiting, feeling unwell or seeming low in mood during these two weeks. Yet these observations failed to elicit the appropriate level of response. [Mr A] may have downplayed his sickness, but PACT staff appeared to lack sufficient training to be aware of the health implications, and report these symptoms to the clinical team.



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In a number of these entries, while acknowledging his physical illness and low mood, staff showed their primary concern was to help clean up and 'cheer up' [Mr A], and that once this was done their responsibility for his care appeared to end.

The intensive team and the regular 'day time' CSWs did not work from the same set of notes and it may be that these observations were minimised during the conversations that took place between team members (p 532) or were missed due to the lack of shared documentation.

There was some concern voiced by [Ms G] on the [23rd Month 3] (p 160) that [Mr A] was telling "one thing to one and something different to someone else". [Mr D's] liaison with PACT was mainly via [Ms G] the team leader, though she did not appear to have much direct contact with [Mr A]. [Mr D] and [Ms G] agreed that good communication was key, ensuring "we will be less likely to become fractured". It is possible that there was an intention on [Mr A's] part to allay concerns about his health as such concern might adversely affect his chances of moving back to [his parents' home town].

**3. Please comment on whether PACT provided adequate care to [Mr A] on [28 Month 3].**

As the Coroner's findings observe, "A fragile person with minimal ability to live alone is likely to require more rather than less support when he is ill" (p 565). It is difficult to see how PACT could be satisfied with the level of support provided to [Mr A] over the 24 hour period from the morning of [28th Month 3].

Upon finding him unwell on Tuesday morning, [Mr F] appropriately made contact with [Mr D] to let the CMHT staff know. [Mr F] states this was in the expectation that nursing staff would visit and assess [Mr A's] health. Although a reasonable expectation, it did not prevent or absolve PACT from the requirement to visit as well, as they had been doing up until that time, to provide the practical assistance that ensured [Mr A's] ongoing wellbeing.

The notes indicate no specific assurance was given to [Mr F] regarding a CMHT visit, and PACT's own investigation state that "the Case Manager did not confirm whether or not he would visit" (p 523). The letter from [Ms H] to [Mr J] (p 178) actually states that [Mr F] "left a message" for [Mr D] stating [Mr A] was unwell, though this is in conflict with [Mr F's] own statement (p 537). The issue of who would or would not visit cannot be said to have been sufficiently negotiated or resolved.

… Unfortunately, the effect of [Mr F's] action at this time was exacerbated by (a) the decision made by [Ms G] not to visit [Mr A] that evening, (b) PACT staff absences during the following two shifts, and (c) [Mr D's] required attendance at training the following day.



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## 4. Did PACT appropriately document [Mr A's] care?

As the Coroner observed, there was a problem with documentation as different teams within the PACT service recorded information in separate files. The daytime staff was not always aware of what the evening staff had recorded in their notes. It does not appear there was a consistent practice of reading the previous day's notes in the handovers done at PACT.

Generally the level of observation recorded in the notes was of a standard to be expected of a CSW service i.e. they were the day to day observations of [Mr A's] domestic activity, his needs, goals and psychological wellbeing. Some attention was given to recording his level of compliance with diabetic self-cares, and his medication regime. Essentially it was plain observation, intended to describe ongoing events and [Mr A's] general level of health.

The team failed to ascribe any particular relevance to observations that [Mr A] was physically unwell (vomiting), and that his mood was consistently low during the last two weeks of his life. Though these factors were well enough noted concern was not relayed to the clinical team. [Mr D's] notes indicate it was family, and his own observations that led to the knowledge that [Mr A] had been unwell. If PACT had liaised appropriately regarding [Mr A's] condition during these two weeks, it would have had some influence on the direction and level of care provided.

According to the 'PACT Group report on the investigation into the circumstances surrounding the death of [Mr A]' the note made by [Mr F] for the visit of [28th Month 3] was not written on the day of the actual visit (p 522). The two notes made for that date appear on a separate page, and from their appearance in the copies provided to me, they do not seem contiguous with previous entries (pp 39–398). The same report states that notes were not always consulted in handovers, so even if they had been available on [28th Month 3] the outcome may well have been the same. [Mr F's] notes give no indication of how PACT might respond to [Mr A's] apparent bout of flu'. There is no mention in the notes immediately around that time that any decision had been taken to reduce the hours of visiting, or to hand care over to the CMHT.

## 5. What else, if anything, should PACT have done in the circumstances?

Common sense would hold that if [Mr A] was feeling unwell he might require some extra assistance to ensure he had adequate food and fluid available to him, that he was able to rest comfortably, and that he had the means to contact people if needed.

It is concerning that [Mr A] did not have a telephone in the flat. [Ms H's] letter to [Mr J] states that there were "many discussions" about this with [Mr A] but that the issue had not been resolved (p 179). How was [Mr A] expected to raise the alarm if he was incapacitated? Notes indicate he was not inclined to use a pre-paid phone that was offered. Why was a landline, subsidised by WINZ disability allowance, not … made



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available? PACT should have continued providing their contact and support, as [Mr A's] changing needs could only be monitored by visits to the home.

Liaison with the CMHT regarding the outcome of their expected visit could have been expected, and with it discussion about whether GP input was required. [Mr A's] health status was changing, and with that the responsibilities of the two services involved would change also.

**Please provide any further recommendations for improvement.**

In a number of the statements made by staff, there were instances where individuals felt their concerns about the management of [Mr A] were being ignored, either by CMHT or senior PACT staff. In cases where the safety of service users (or staff) are an issue, or when there are disagreements about management, health workers should be able to discuss solutions with a senior colleague, in the context of supervision.

I was unable to confirm if any of the CSW staff had regular supervision about the care they were providing. Clinical supervision is a requirement for registered health professionals, and given the complex nature of the cases the PACT intensive team deal with, supervision would offer an added level of safety in practice.

*Additional advice*
Mr Woods subsequently clarified his advice as follows:

In relation to Southland DHB
Regarding my criticism of the care given … the question of whether care departed from accepted standards, and to what degree raises the issue of what exactly are the acceptable standards? My observation of standards of physical health care for mental health service users generally is that they are haphazard and often inadequate. This stems from a lack of communication and integration between sectors, a point I make in the report … in regard to [Mr A's] case, but this could equally be observed in any number of instances nationally.

This opinion comes from ten years of working as a liaison nurse between community mental health and primary care services, and is confirmed by research I have done within the ADHB CMHS. A lack of recognised standards of care and liaison between primary and secondary services (one predominantly physically oriented, the other psychiatric) has contributed to disproportionate morbidity and mortality statistics for mental health service users, who die of physical health conditions in higher numbers and at a younger age than the general population. Alex Handiside's 2004 report for the Mental Health Commission 'Our Physical Health…Who Cares?' gave a succinct overview. Lack of sufficient communication between services is the norm, especially where services differ in their aims e.g. between the CSW service and the DHB ('practical' vs. 'clinical' support) or the DHB and the GP ('psychiatric' vs. 'medical' care).



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What I would emphasise on re-reading is that though [Mr A] was on an indefinite order under the Mental Health Act, from the information I was given I formed no impression of there being a Responsible Clinician i.e. a psychiatrist overseeing care of [Mr A], a 'difficult' client in a novel and complex placement.[36] [Mr A] was seen by at least two psychiatrists during this time but the record showed no sense of medical guidance or direction. I think it shows in the lack of service co-ordination and planning that occurred, and in the general lack of awareness regarding physical aspects of [Mr A's] care, and how this impacted on his physical *and* mental wellbeing.

With 'acceptable standards' generally so poor, the circumstances described in this case could be seen as only a moderate departure from typical practice.

<u>In relation to PACT</u>
Did PACT appropriately manage [Mr A's] apparent resistance to visits? Again the question hinges on what was a reasonable expectation. The original plan for three visits per day was unrealistic. [Mr A] was assessed as needing 24-hour care (level 4) that could not be provided as he intimidated other residents. In the absence of appropriate rehabilitation facilities (another feature of mental health services nationally) a plan was devised to spend large amounts of time with him in an unstructured way, guaranteed to become intrusive for the client and therefore prove unsustainable. PACT therefore responded appropriately in reducing their visits. However they did not pro-actively follow this up with SDHB; they could have requested a meeting to review the situation. If they had, the issue of his ongoing physical ill-health may have come to the attention of the DHB.

Did PACT communicate appropriately with SDHB about [Mr A]? Briefly, no. Numerous times PACT notes indicated problems with his physical and mental health that were not reflected in SDHB notes. I list instances of PACT's reporting on health issues on page nine. The Coroner was of the opinion that there was an insufficient level of general health knowledge amongst the team; though they noted the problems [Mr A] was having they did not recognise their significance, or report it to the clinical team.

Regarding the appropriateness of documentation, my notes … indicate there was a significant departure from an acceptable standard. There were clear deficiencies in the location, storage and access to the notes, which were not physically available to all staff at times. Though I believe the content provided was sufficient for a non-clinical support work team, there was a lack of synthesis and planning observed within the notes. There were also some inconsistencies in the record around the time of [Mr A's] death that are of concern.

[36] *Commissioner's note*: Mr A did have a responsible clinician, psychiatrist Dr O.



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Summary

I have tried to answer your questions fairly, forming an opinion from information received and having no direct knowledge of the events or those involved. ‘Reasonable’ standards of practice are subjective and ‘levels of departure’ from these even less clear, and are not discrete. It was an unexpected acute physical illness that caused the death of [Mr A], something ‘off the radar’ for both of the services providing care. As often happens a constellation of events conspired, with the most obvious, and serious departure from acceptable standards … occurring at the time when PACT first became aware of his ’flu-like symptoms, and failed to support or monitor [Mr A] through this.



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# Appendix 2

## Timeline of visits by PACT

time line of visits

- request for package of care to General Manager, Planning and Funding Mental Health Services S.D.H.B.

- letter accepting the application of funding for "Support Package of Care".

| Date | Number of visits | Time spent |
|---|---|---|
| | Discharge from Inpatient Unit to flat – 3 visits documented | Time not notified |
| | 1 visit documented | Time not notified |
| | 3 visits documented | 1 x 25 minutes noted, 1 x 20minutes noted, 1 time not noted |
| | 3 visits documented | 1 x 1hr.30 minutes noted, 1 x 2 hour noted, 1 no time noted |
| | 2 visits documented | Time not noted |
| | 2 visits documented | 1 x 1hr.30minutes noted & 1 x 15 minutes noted |
| | 2 visits documented. Parents visit noted | 1 x 45 minutes & 1 x 2hrs noted. |
| | 3 visits documented | 1 x 1 hr. 2 time not noted |
| | 3 visits documented. Review with Case Manager & 3 PACT Staff. | No time noted. |
| | 3 visits documented | 1 x 40 minutes noted, 2 no time noted |
| | 2 visits documented | 1 x 1.10 minutes noted, 1 no time noted |
| | 2 visits documented | 1 x 30 minutes noted, 1time not noted |
| | 2 visits documented. Parents visit noted | No time noted. |
| | 2 visits documented | No time noted |
| | 2 visits documented | No time noted |
| | 1 visit documented | No time noted |
| | 1 visit documented | No time noted |
| | 1 visit documented | No time noted |
| | 2 visits documented | No time noted |
| | 2 visits documented | No time noted |
| | 3 visits documented. Mangers visit noted. | No time noted. |
| | 1 visit documented. Parents visit noted. Manager's visit noted. | No time noted |
| | 2 visits documented | 1 x 20 minutes noted, 1 no time |



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| | | |
|---|---|---|
| | | noted |
| | 2 visits documented | 1 x 40 minutes noted, 1 no time noted |
| | 2 visits documented | No time noted |
| | 1 visit documented. Parents visit noted. Manager & CSW visit noted | No time noted |
| | 1 visit documented | No time noted |
| | 1 visit documented | 10 minute visit noted |
| | 1 visit documented | 30 minute visit noted |
| | 1 visit documented | 10 minute visit noted |
| | 2 visits documented | No time noted |
| | 2 visits documented | No time noted |
| | 1 visit documented | No time noted |
| | 1 visit documented | No time noted |
| | 1 visit documented. To PACT Office to meet with Case Manager/SW's to review Recovery Plan. | 1hr .40 minutes visit noted |
| | 1 visit documented | 30 minute visit noted |
| | Admitted to hospital following G.P. visit | 2 hour visit noted |
| | Discharged from hospital met with Case Manager at flat. | 10 minute visit noted, 1 no time noted |
| | 1 visit documented | No time noted |
| | 1 visit documented | No time noted |
| | 1 visit documented. Parents visit noted | No time noted |
| | 1 visit documented. Taken to G.P. | 1 hour |
| | 2 visits documented | 1 x 15 minutes noted |
| | 2 visits documented | 1 x 10 minutes noted |
| | 1 visit – but for bike ride. 2 visits documented | 1 x 1 hour 5 minutes noted. |
| | 2 visits documented, admitted to hospital overnight | No time noted |
| | In hospital – 1 visit | |
| | In hospital – 1 visit | |
| | In hospital – 2 visits | |
| | Discharge from hospital. 2 visits | 1 hour |
| | 2 visits documented | 1 x 30 minutes noted |
| | 3 visits documented | 1 x 30 minutes. 1 time not noted, 1 no response (8.30pm). |
| | 2 visits documented | No time noted |
| | 1 visit documented | No time noted |



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| | | |
|---|---|---|
| | 1 visit documented | No time noted |
| | No visit documented | |
| | 3 visits documented | 1 x 30 minutes noted, 2 time not noted |
| | 2 visits documented | 1 x 30 minutes noted, 1 time not noted |
| | 1 visit documented | No time noted |
| | 2 visits documented | 1 x 1hr noted, 1 no time noted |
| | 2 visits documented | No time noted |
| | 2 visits documented | No time noted |
| | 2 visits documented | No time noted |
| | 1 visit documented<br>Mother's visit noted | No time noted |
| | 1 visit documented | No time noted |
| | 2 visits documented. Out for bike ride. | 1 x 1 hr .20 minutes, 1 time not noted |
| | 2 visits documented | 1 x 10 minutes noted, 1 time not noted |
| | 2 visits documented | No time noted |
| | 2 visits documented | No time noted |
| | 1 visit documented | 1 x 10 minutes noted |
| | 2 visits documented | 1 x 5 minutes noted, 1 time not noted |
| | 1 visit documented | 1 x 2 hrs.30 minutes noted |
| | 2 visits documented. Taken for blood test. | 1 x 1 hr & 45 minutes noted, 1 time not noted |
| | 1 visit documented | No time noted |
| | 1 visit documented | No time noted |
| | 2 visits documented | No time noted |
| | 1 visit documented | 1 x 5 minutes noted |
| | 1 visit documented | No time noted |



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