Serenity Trust Home

Social Worker, Ms B

Registered Nurse, Ms D

Hawke's Bay District Health Board

A Report by the

Deputy Health and Disability Commissioner

(Case 05HDC05329)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer (deceased)
Mrs C	Complainant/Consumer's mother
Hawke's Bay District Health Board	Provider
CAHMS	Child & Adolescent Mental Health Service/ Provider
Serenity Trust Home	Provider
DHB 2	Another District Health Board
CAMHS 2	Child & Adolescent Mental Health Service associated with DHB2
Ms B	Provider/Social Worker
Ms D	Provider/Registered Nurse
Ms E	Manager/Serenity Trust Home
Dr F	Acting Clinical Director and Consultant Psychiatrist
Dr G	Clinical Psychologist
Ms H	Liaison Worker
Mr I	Clinical Leader
Dr J	Psychiatrist
Ms K	Psychotherapist/Serenity Trust Home
Ms L	CAMHS Kaimanāki and Key Worker
Ms M	CAMHS Key Worker
Dr N	General Practitioner
Mr O	Clinical Leader, CATT

Complaint

On 14 April, the Commissioner received a complaint from Mrs C about the services provided by Hawke's Bay District Health Board Mental Health Services and Serenity Trust Home, to her daughter, Ms A, the previous year.

An investigation into Hawke's Bay District Health Board (HBDHB) and Serenity Trust Home (STH) was commenced on 9 August and, on 29 November, the investigation was extended to include social worker Ms B and registered nurse Ms D. The following issues were investigated:

Hawke's Bay District Health Board

- *The appropriateness of the care Hawke's Bay District Health Board provided to Ms A.*

Names have been removed (except Hawke's Bay DHB and Serenity Trust Home) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

Serenity Trust Home
- *The appropriateness of the care Serenity Trust Home provided to Ms A.*

Ms B
- *The appropriateness of the care social worker Ms B provided to Ms A.*

Ms D
- *The appropriateness of the care registered nurse Ms D provided to Ms A.*

This investigation has taken over 18 months due to the complexities in investigating the relationship between the providers and the need to extend the investigation to include the standard of care provided by two individual providers. There were further unavoidable delays in obtaining expert advice.

I issued my first provisional opinion in December 2006. As a result of the responses I received from various providers I decided to issue a second provisional opinion on 30 March 2007.

Information reviewed

Information received from:

- Hawke's Bay District Health Board, including the sentinel event report
- Ms E
- Ms B
- Ms D
- Mr I

Also reviewed were:

- The report to the Coroner prepared by Dr F, Acting Clinical Director and Consultant Psychiatrist, Mental Health and Addiction Service, Hawke's Bay District Health Board;
- Ms A's medical records and documentation from Serenity Trust Home, Child & Adolescent Mental Health Services, (CAMHS 2) and Child & Adolescent Mental Health Services, Hawke's Bay District Health Board (CAMHS Hawke's Bay);
- Responses to my first opinion from the following providers:
    - Ms D

- The HBDHB
- Ms L — CAMHS Kaimanāki and Key Worker
- Mr I
- Ms B
- Ms E for Serenity Trust Home

- Responses to my second provisional opinion received from:
  - Ms D
  - The HBDHB
  - Ms E for Serenity Trust Home
  - Mrs C

Independent expert advice was obtained from psychiatric nurse Ms Christine Lyall and social worker Mr Reg Orovwuje.

Information gathered during investigation

Background
Ms A was aged 17 years when she ended her life at Serenity Trust Home (STH) in the early hours.

On 14 April 2005, the Commissioner received a complaint from Ms A's mother, Mrs C, about the services provided by HBDHB Mental Health Services and STH, to her daughter. Mrs C wrote that her daughter had been diagnosed with borderline personality disorder and suicidal ideation, culminating in periods of self-harm. She had previously tried to commit suicide. The week she died her mother had telephoned her every day because she was concerned about her daughter's "state of unwellness". Mrs C stated:

> "I cannot understand why, when the reports from the staff of Serenity House and CATT [Crisis Assessment Treatment Team] indicated the urgency of the situation that more was not done by management of the [Mental Health Inpatient Unit (MHIP)] to take action and to provide a placement for her in the unit. I believe the excuse that [Ms A] was not an adult and therefore not prioritised in respect to her needs is not good enough and the case needs more in-depth follow up."

Mrs C provided a report dated 18 February 2005 prepared at the request of Coroner, by Dr F, Acting Clinical Director and Consultant Psychiatrist at HBDHB. The report included comments on the difficulties in the diagnosis and treatment of people with borderline personality disorder (BPD) and the action taken by HBDHB as a result of

its Sentinel Event Review of the circumstances surrounding Ms A's death. Excerpts of this report are attached as **Appendix I.**

The Coroner has adjourned his inquiry into Ms A's death pending the outcome of the Commissioner's investigation.

Ms A's history
Ms A had been under the care of the CAMHS 2 for some time. She had been diagnosed with borderline personality disorder as well as depression, panic attacks, post-traumatic stress disorder, disassociative disorder, hyperventilation, multiple losses, and multiple stressors with family and rape.

Mrs C said that Ms A had been ill for about 18 months. She was close to her mother and her brother. When she was well she was loving but quite the opposite when unwell. She could go from a state of wellness to being very unwell in a matter of minutes.

Application to Serenity Trust Home and risk assessment plan
Dr G, clinical psychologist at CAMHS 2, applied for Ms A to be accepted at Serenity Trust Home (STH) for therapy. STH is a residential therapeutic facility for women with borderline personality disorders and other mental illnesses. It is a regional service with five beds and takes referrals from six DHBs. It is funded by the Ministry of Health through HBDHB. A full description of the services offered by STH is attached as **Appendix II**. Dr G enclosed a report from a psychiatric registrar (for a consultant psychiatrist); a risk management plan; and a special appeal to accept Ms A, because she was under 20 years old.

Dr G's risk assessment sent to STH was extensive and listed the following risks: accidental risk from self harming, use of cannabis, impulsive suicide attempts from intense distress, and intention to commit suicide because she is depressed and despairing of ever becoming well. His assessment also included an action plan, describing Ms A's behaviour at times of acute stress, and what she would do to avert self-harm and/or suicide. He included instructions on what should be done for elective admissions and acute emergency episodes. Ms A had "warning signs" that she and carers were aware of. When she exhibited these signs they needed to be appropriately managed and contained.

Dr G said the early warning signs were: withdrawing, becoming physically agitated and restless, covering her head, feeling angry, confused or disorientated, mind racing and losing concentration. Late warning signs were: feeling stressed out, distressing body symptoms, experiencing "the enemy" (nightmares), feeling persecuted by people or objects, failing to make eye contact, and feeling unpleasantly hot, dizzy and short of breath.

Dr G included a plan to manage her behaviour and ensure her safety when her distress escalated to crisis proportions. However, there was no direct communication or referral of care from the DHB 2 to the HBDHB as would usually be expected.

Mrs C, Ms A's mother, described how Ms A self-harmed because she felt the "enemy" within her and needed to cut the "enemy" out. She explained that it was necessary to intervene when Ms A started to withdraw in order to help her, otherwise she would self-harm. Mrs C had previously visited STH with Dr G and Ms A to see if it was a suitable placement for Ms A. Mrs C said that her daughter wanted to get better and went to STH with that intention.

Mrs C said there were times when Ms A did not want her to be involved, and she respected her daughter's need for privacy.

Transfer to Serenity Trust Home

Soon afterwards, Ms A was accepted at STH, and the manager, Ms E, faxed the referral to NASC (Needs Assessment Service Coordinator). As NASC deals with adult mental heath services only, she also copied the referral to CAMHS Hawke's Bay for key worker allocation. STH usually only accepted residents aged over 20 years although Ms E informed me that their contract with HBDHB allowed for some flexibility regarding the age of clients. She also stated that this was the first time since she had become manager of STH that STH had accepted a client in the CAMHS age range.

Ms B, a CAMHS Hawke's Bay social worker, triaged the referral from Ms E and was informed that STH was requesting key worker support within CAMHS Hawke's Bay. Ms B was advised that Ms A was not currently suicidal or a danger to herself. Ms A's referral was processed by CAMHS Hawke's Bay clinical leader, Mr I.

A few days later, Dr G, with a psychiatric nurse from CAMHS 2 and Ms A's boyfriend, took Ms A to STH. Ms H was appointed her liaison worker at STH. Ms A seemed to settle in well. She was reported to be sleeping for long periods, eating well, gradually getting to know staff, and participating in household tasks such as helping to prepare meals with other residents. STH notes indicate that Ms A responded well to psychotherapy, and was excited when she completed her two-week orientation.

Originally another CAMHS key worker, Ms M, was assigned to Ms A with Ms B as co-worker support. However, due to Ms M's case load, eight days after Ms A's arrival, Mr I appointed Ms B as the CAMHS key worker.

CAMHS Hawke's Bay assessment

The following day, Ms B telephoned Ms H at STH to arrange a meeting. Ms B said that she wished to clarify her role and responsibility as a key worker in relation to residents in STH because she understood that STH would be providing "full treatment

including their own therapists, day programme and 24 hour a day support for residents". She spoke to Ms L (CAMHS key worker and Kaimanāki) who agreed to accompany her to STH on this first visit.

A week or so later, Ms B and Ms L visited Ms A at STH to determine with Ms A and STH what Ms B's role would be, as CAMHS had not worked with STH previously. Ms B said she was unclear about her role in Ms A's care because of this and because therapy was provided by STH's psychotherapist. She stated:

> "We [she and liaison worker Ms H] agreed that [Ms A's] current risk management plan [prepared by Dr G] would remain in place until Serenity staff further assessed [Ms A] through the course of her treatment. Any change to the risk management plan I believe would have needed to involve all staff at Serenity Home who had/would be working with [Ms A]; of particular importance would have been her therapist's input who was not present at the time of our initial interview. I was informed by [Ms H] that Serenity Home had regular monthly review meetings to discuss residents' progress. I expected these meetings would have seemed an appropriate place for both Serenity and CAMHS to discuss and develop plans with all parties input. [Ms H] informed me that Serenity had yet to arrange a meeting in relation to [Ms A]. It was not clear that Serenity wanted our input at those meetings, rather it was my suggestion that we attend. [Ms H] agreed that she would telephone me with the [date and time of the next meeting] but I did not hear from her subsequently about any future meetings.
>
> It was clearly established and assessed on […] that there were no current risks to Ms A."

Ms B also stated that she was well aware of the role and responsibilities of a key worker and that she knew that a new risk assessment was an important component of this role. However, STH and Ms A did not want her involved. She explained the importance of the risk assessment to Ms A and Ms H. Ms B said that she attempted to engage with Ms A and she completed an initial assessment. Ms B recognised that this was not a full assessment and therefore offered twice to meet with them again. She states:

> "All my questioning regarding risks was met with answers that [Ms A] was fine, was settling in well and doing very well … I recognised the need for an opportunity to engage with [Ms A] and undertake a full assessment. However they [Ms A and STH] were very clear that they did not want to engage in an indepth discussion then nor later, declining my offers to meet with them again for this purpose. And, [Ms H] was very clear to myself and [Ms L] that she, [Ms H], was going to key work [Ms A] and that my role was limited to arranging a psychiatric review."

Ms B states that she could not undertake a full assessment without the cooperation and consent of Ms A, which was not forthcoming. Ms B stated that she spoke with Ms A on her own only very briefly, as Ms H from STH was present during most of the meeting and answered many of the questions Ms B tried to put to Ms A.

Ms L, who also attended the meeting, confirmed that Ms B explained her role as a CAMHS key worker and her expectation and desire to undertake an assessment of Ms A. However, it was made "very clear" that they were "not needed or wanted" and that all STH wanted was a psychiatric appointment when required.

Ms B's notes confirm that it was agreed that "[Ms H] to key-work & [Ms A] to contact writer should she need to. Non-urgent medical review to be arranged." Ms B has confirmed that it was STH who specified that the review was non-urgent as Ms A had settled in well over the previous two weeks, and that STH had made it clear that they would contact her if needed.

Following this initial meeting Ms B discussed with her colleague, Ms L, her concerns about her role and Ms A. On several occasions Ms B also discussed with Mr I her concerns about her role.

Mr I states:

> "We discussed her concerns that STH and [Ms A] did not want her to be involved in any clinical or therapeutic way nor in any care coordination role apart from securing a CAMS psychiatrist appointment for [Ms A].
>
> [Ms B] told me that both [Ms A] and STH informed her they did not want her to be involved and declined her request to make another appointment to see [Ms A] again. [Ms B] was concerned because she could not do a proper assessment in these circumstances. [Ms B] said to me it did not make sense for her to stay involved when there was no role for her. Both of us recognised and acknowledged that it was not appropriate for a key worker to be allocated just to access a psychiatrist. We also recognised that [Ms B] could not be involved without the consent of the client, and STH and [Ms A] had made it clear to [Ms B] that they did not want her to be involved in [Ms A's] care and they had refused her request for a further meeting with her. I told [Ms B] that a meeting was being arranged with STH and that I would clarify the situation with them concerning their needs and how these could be met by CAMHS. [Ms B] meanwhile was going to contact the mental health team [at DHB 2] for further information on [Ms A] as there hadn't been any formal hand-over or contact between [Ms A's] CAMHS psychiatrist and HBDHB psychiatrist."

Under normal circumstances, the key worker's role includes taking responsibility for monitoring risk. (A copy of the job description for key workers at the HBDHB is

attached as **Appendix III**.) However, Ms B felt that she could not do this if she did not have regular contact with or input into Ms A's care and treatment, and it appeared her only role was to arrange a non-urgent appointment with the psychiatrist. She and Mr I agreed that she was to call Dr G to get a better sense of Ms A's needs and clarify the role of CAMHS Hawke's Bay in her care. Ms B left several messages for Dr G, but he did not return her calls.

Eight days later, Ms B spoke to Dr J, CAMHS Hawke's Bay psychiatrist, about an appointment for Ms A. Dr J works part-time at CAMHS and, as the appointment was for a non-urgent review, Ms B did not think the delay in contacting Dr J was unreasonable. He told Ms B that he was uncertain about the arrangement between CAMHS Hawke's Bay and STH too, but would talk with Mr I and Ms A's psychiatrist before making an appointment to see her.

Six days later, Ms B finally contacted Dr G, who advised her that he would leave Ms A's file "open" and continue to liaise directly with STH.

Telephone call
A week later, Ms H recorded:

> "Spoke with [Ms B] about the Olanzapine [antipsychotic medication] reduction for Ms A. She said that [Dr G] has said a reduction is not necessary at this stage so a psychiatrist appointment will be needed in a few months."

Ms B denies that she spoke to Ms H that day. She said:

> "I did not record any such conversation in the health record which I did at all other times in this case; I would not give advice regarding changing medication because it is not my role nor expertise; I do not believe STH could be considering a reduction in medication at this time when they state [Ms A] was deteriorating […] … I would never have stated a psychiatrist appointment "will be needed in a few months" at a time when, I was actively trying to secure [Ms A] an appointment with [Dr J]."

I note that Ms H's notes of this conversation are not recorded as part of Ms A's daily notes and are on a separate sheet of paper, with two other notes apparently recorded on different days. On balance I am not satisfied that these notes are contemporaneous or accurate and I accept Ms B's statement that she did not have a discussion with Ms H.

Two days later, Ms B spoke with Dr J again (as still no appointment had been made), informing him about her consultation with Dr G. Dr J said that he would speak to Ms A's previous psychiatrist and Mr I about clarifying HBDHB's and STH's roles and

how the services would work together, by establishing a policy or memorandum of understanding. No appointment for a psychiatric review was made.

Self-harm — first incident
The records show that about a month after her arrival at STH, Ms A admitted to smoking marijuana, as a result of which she was placed on one month's probation. She initially seemed to respond well, and followed STH's rules. However, STH notes indicate that about ten days later Ms A began isolating herself from others at STH, spending more and more time in her room and not taking opportunities to interact with staff or other residents. These incidents were not reported to Ms B or anyone else at CAMHS. Ms A's mother stated that these were clear signs that Ms A's mental health was seriously deteriorating.

A week later, the sleepover staff received a phone call from Ms A's mother asking them to check Ms A's whereabouts. Mrs C stated that as she knew her daughter well, she knew from her conversation with Ms A that evening that she was not well and that was why she rang. The sleepover staff found Ms A in the garage, where she had attempted to commit suicide. Ms E was called to assess Ms A and spent over an hour with her until she went to sleep. It appears that Ms A was becoming very anxious about her relationships with her mother and boyfriend. Ms E said that usually family were involved with treatment programmes but at this stage Ms A did not want her mother involved. Ms A was placed on "Staff Alert", which meant that staff had to check her whereabouts every 10 minutes.

Discussions between Ms B and Ms H
The following day, Ms H telephoned Ms B to inform her about Ms A's attempted suicide, and request a psychiatric review. Ms H recorded in Ms A's notes:

> "[Date] 9.20am. [Ms A] has gone for a walk this morning. I phoned [Ms B] who was going to organise a meeting with the psychiatrist. Subsequent phone call revealed that the psychiatrist will not/cannot see [Ms A] and is unwilling to review her meds at this time. [Ms B] made no offer to come and see [Ms A]. I will take her to the doctors at 12am to check her physically after the suicide attempt and to get prescription for PRN [medication]."

Later in the day Ms H also appears to have recorded on another sheet of paper (the same sheet as the record of the alleged [previous] telephone call):

> "Called [Ms B] to tell her about the incident last night and she did not seem interested. I asked for an appointment to review her [Ms A's] meds and prescribe PRN but she could not give one.
>
> I took [Ms A] to [Dr N] (GP) who prescribed Lorazepam as a PRN up to three times a day.

> [Ms A] says her meds are not working. I will ring [Dr G] today to ascertain his idea on things."

Ms B's records state that she received a telephone call from Ms H at STH at 8.30am. Ms H informed Ms B of Ms A's attempted suicide and said that there had not been any events or triggers prior to this and that she believed Ms A's actions were triggered by some event on a television programme. Ms B recorded that Ms H had told her that Ms A was "settling well" and that there was no conflict with her mother or boyfriend. Ms B asked whether Ms A had been seen by a doctor since her attempted suicide, and recommended that she be assessed by her general practitioner as soon as possible. Ms B's notes state that at the time Ms H felt able to monitor Ms A, and Ms H did not feel that Ms A was at immediate risk of a repeat attempt as she was "remorseful about her attempt". The notes record that Ms H requested "a psychiatric review for meds". Ms B was not informed by STH of the earlier incidents or any other indications that Ms A's mental health was deteriorating.

Ms B also denies that she spoke to Ms H twice that day. She states:

> "I remember that day as I was extremely busy. After receving [Ms H's] call at 0830 I immediately phoned and spoke to [Dr J] and then spoke personally to [Mr I] … [Mr I] was in a MDT [multi-disciplinary team] meeting and I had to interrupt the meeting to speak with him then. Having done these things I had to leave CAMHS to attend to my other clients and I did not speak to [Ms H] again. I never stated to [Ms H] that a psychiatrist will not or cannot see [Ms A], nor did I say to her that a psychiatrist is unwilling to review her medication at that time. I am also very upset that [Ms H] had recorded I did not seem interested. This is certainly not what I recall. I was very concerned and I told [Ms H] this and that I would speak with [Dr J] and [Mr I] immediately ..."

Having reviewed the notes kept by both STH and Ms B, I consider it more likely than not that Ms H spoke to Ms B only once that day. Ms B's notes are in a consistent format and are chronological. The reference to the second phone call in STH's notes and comments that the psychiatrist will not/cannot see Ms A and is unwilling to review her meds at this time is not consistent with the action taken by Ms B and recorded in her notes. Ms B's records show that following Ms H's phone call, Ms B immediately telephoned Dr J and informed him of Ms A's attempted suicide and that STH had requested a psychiatrist's review. Dr J said he would be working at CAMHS the following day and that he would meet with Ms B then to arrange an appointment. Ms B then met with Mr I to tell him about the attempted suicide and reiterated how uncomfortable she felt in her role, having no clinical input but having to relay such news. She said that Mr I agreed that it was inappropriate for her to be involved and to just make an appointment with the psychiatrist. He said that he had arranged to meet

with Ms E that day to clarify roles and how STH and CAMHS Hawke's Bay could work together because of the concerns raised by Ms B and Dr J.

As suggested by Ms B, Ms H took Ms A to Dr N, who increased the lorazepam from half to one tablet a day, to assist her during panic attacks and when she felt overwhelmed. Ms H asked the staff to check Ms A regularly. Ms A had an unsettled night and the sleepover staff slept in the lounge with her.

Closure of CAMHS file
On the afternoon of that day a meeting was held between STH and the HBDHB to discuss their working relationship.

Mr I describes the two-hour meeting that afternoon as "positive and collaborative" with two staff from the HBDHB adult community mental health services, a member of HBDHB's NASC and three STH staff attending. He states that Ms A's case was discussed carefully, but he was not informed about Ms A's earlier cannabis consumption or that Ms A was anxious about her relationships with her mother and her boyfriend. Ms E made it very clear that STH and Ms A did not want any therapeutic or care coordination role from the CAMHS key worker, and that they only wanted to access a CAMHS psychiatrist and CATT when needed. He and Ms E agreed that STH staff would contact him directly should they require a psychiatric review but STH did not request an appointment during the meeting. Mr I recorded what was agreed at the meeting with STH as:

> "Agreement that the involvement of key workers in the service was unnecessary if the service users are primarily receiving treatment at Serenity House. As such, a situation would for key workers enhance risk.
>
> Agreement that if Serenity Home required psychiatric services, they would access the clinical leader, who would set up an appointment with the psychiatrist.
>
> Agreement that if anyone entering or exiting Serenity Home from outside the DHB area, then Serenity would inform the clinical leaders of the relevant DHB services."

At 3pm the same day, Ms B received a telephone call from Mr I, asking her to close the CAMHS Hawke's Bay file.

Ms E from STH confirmed that a meeting of the clinical leaders took place and that Mr I questioned STH's need for the involvement of the CAMHS Hawke's Bay key worker with their clients. However, she disagrees with Mr I's description of this meeting. Ms E asserts that she "conceded to the wishes" of the HBDHB representatives and that non-governmental organisations are used to "being told what to do" by DHBs. She states that she said that she mentioned that therapeutic intervention was not required

but that care coordination was. In her view CAMHS was in chaos at the time. Ms E states that Mr I thought that STH believed it needed a CAMHS key worker to gain access to CATT (Crisis Assessment Treatment Team) after hours, but that was not the case. Ms E states that the meeting decided to trial not having a key worker. She did not understand that this meant closing the CAMHS file. Ms E said that STH could contact the Mental Health Inpatient Unit (MHIPU) staff directly but in the past when they had done so they were usually told the unit contained a number of really violent patients and was not a suitable placement for STH clients. Furthermore, if a client refused admission, STH had to have the client committed under the Mental Health (Compulsory Assessment and Treatment) Act. Ms E said that STH received excellent support from their GPs, who have a lot of knowledge about the treatment of borderline personality disorder.

Ms B said that she was frustrated with the length of time it took to clarify the role of CAMHS Hawke's Bay and her role as a key worker, and to secure a psychiatric appointment. Rather than wait, Ms B telephoned Dr J because she believed that the delay in offering Ms A a psychiatric appointment was inappropriate. It is not clear what happened to the meeting Ms B had organised with Dr J for the next day to arrange an urgent psychiatric appointment for Ms A. It appears to have been superseded by the new agreement to make psychiatric appointments through Mr I.

Self-harm — second incident

In the days following Ms A's suicide attempt, she was noted to be agitated and that "some concern exists due to the unpredictability of her attempt ie no warning signs and unable to talk to staff about her feelings of wanting to die".[1] Two days later Ms H telephoned Dr N who increased Ms A's lorazepam to four a day if necessary. Ms H reported that this "is only a short term measure to get over her high anxiety surrounding her suicide attempt".[2] Also recorded is an appointment to see Dr N after a week at 1.40pm and "she is on the waiting list at CAMHS for a psychiatrist appointment".

Ms H has recorded (again on the separate sheet of paper):

> "[Date] phoned CAMHS to asked [Mr I] to book [Ms A] in for a psychiatrist appointment. She is on the waiting list."

Mr I has stated that he received a call that day requesting an appointment for Ms A with a CAMHS psychiatrist and that he made an appointment for her in nearly three weeks' time as STH had not requested or given any indication that the appointment was urgent. He disagrees with Ms H's statement that she was on "the waiting list".

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[1] Serenity Trust House, Daily report book.
[2] Serenity Trust House, Daily report book.

At about 9pm that day, Ms A cut her wrist with a pair of scissors following a telephone conversation with her boyfriend. Ms E attended and described the cut as "superficial". The sleepover staff slept in the lounge with Ms A during the night, as they had been doing for four days. Ms A remained on "Staff Alert". CAMHS were not informed of this incident.

The next morning Ms E discussed Ms A's deterioration with STH staff and it was decided that Ms A needed a psychiatric risk assessment and a request for admission to IPCU (Intensive Psychiatric Care Unit). Ms E recorded "must be admitted!" in her notes, and states that she stressed to staff that she needed inpatient care for 24–48 hours, as they could not guarantee her safety. No written record of this is available.

At 11.40am the following day, STH psychotherapist Ms K contacted CATT seeking a risk assessment. When the call was first received by CATT they were not aware of the decision made by STH and CAMHS not to use a CAMHS key worker and queried why the request had come directly to them. The CATT worker told STH that she needed to speak to her team leader as per HBDHB policy regarding the role of key workers in this situation. The HBDHB policy at the time was that the key worker was responsible for acute assessments during the normal working week. CATT had not been informed about the agreement reached earlier in the week by STH and Mr I regarding access to their services. This was resolved by a brief telephone call between Mr I and the CATT clinical leader.

In the meantime, Ms H called Dr G and had a lengthy conversation with him and another psychiatrist about Ms A's medication. Dr G was able to provide more clinical information, and suggested other medication if lorazepam was ineffective. He asked if he could come to see Ms A.

CATT assessment[3]

That day, registered nurse Ms D was on duty for CATT on the afternoon/evening shift. At about 2.50pm, the clinical leader, Mr O, told her about STH's referral. Mr O said that Ms A was "not open" to CAMHS Hawke's Bay and there was no clinical file.

HBDHB advised that whether one or two staff attend an assessment is a matter of personal and clinical judgement. In this case, Ms A was in a residential care facility and STH staff would be present during the consultation. It considered that it was appropriate for Ms D to be the only one to respond to STH's call-out.

[3] HBDHB Mental Health & Addiction Service *Crisis Assessment & Treatment* policy outlines the roles and responsibilities for CATT staff. CATT is predominately an out-of-hours case support team which offers crisis support to NGOs during the acute phase of a resident's illness. The originating team (STH) maintains overall client management and any alteration in care plans should be clearly agreed upon with STH.

At 6pm, Ms D went to STH to assess Ms A. Two staff from STH were present during the assessment — Ms K (Ms A's psychotherapist) and Ms P (STH sleepover staff). The only information available to Ms D was provided by Ms K. In Ms D's opinion the referral was "semi-urgent" because the self-harming incident had occurred almost 24 hours previously, and Ms A had confirmed that it was not suicidal (rather that she "wanted to feel pain"), and was not an "immediate crisis response". Furthermore, Ms A's impulsive self-harm was "chronic", and neither Ms A nor STH staff could identify psychosis, thought disorder, substance abuse, delusions, or "high risk" indicators at the time.

Ms A told Ms D that she could act impulsively but had no current active plans or intent to do so. Ms A wanted to remain at STH. The plan was that Ms A would remain at STH with one-on-one support and maintain her medication regime, and that Ms D would fax notes to CAMHS and seeking an urgent follow-up and psychiatric review. Ms A was noted as a client of concern for the weekend. STH staff were to contact CATT if risk indicators increased further or they were unable to contain Ms A.

Ms D said that STH staff agreed with the plan. She said that she offered formal admission if needed. The plan was in accordance with the risk management plan from CAMHS 2. Ms D was informed by STH staff that the plan had been discussed between CAMHS Hawke's Bay and CAMHS 2 in conjunction with STH and it had been agreed that that plan would continue to be relevant. Admitting Ms A did not appear appropriate based on Ms D's assessment, current practice at HBDHB and Ms A's current management plan. Ms D concluded that Ms A's thoughts were not of impulsive self-harm but of a chronic nature, in the context of a history of intermittent deliberate self-harm. To admit Ms A, particularly as she wanted to stay at STH, would mean invoking the Mental Health (Compulsory Assessment and Treatment) Act. Ms D did not consider this appropriate and STH staff agreed.

Ms E disputes the suggestion that staff at STH agreed with Ms D that Ms A's referral was "semi-urgent" and states that her clinical team had assessed Ms A as being acutely (not chronically) suicidal. She suggests that rather than agree with Ms D's assessment they respected her "expert" opinion. She states that her clear and precise instruction to Ms K, to relay to CATT, was that Ms A must be admitted, and that this was ignored or dismissed by Ms D. Ms E suggests that Ms D did not perform her role competently owing to the stress she was experiencing from the busy day. Ms D rejects this assertion and stated that the nature of CATT work is that they consistently have "busy days". Ms E has also stated that Ms D did not have a relationship with Ms A, unlike staff at STH, so knew nothing about her history or pervasive thoughts of dying, and that Ms D should not have taken Ms A's wishes into account. She said:

> "I find it unprofessional and dangerous, that [Ms D's] decision to "take [Ms A's] wishes into account" and stay at STH while [Ms A] was in apparent crisis, was not

> challenged. [Ms A] was clearly unable to make such a decision and [Ms D] should have had the knowledge and skills to ascertain the situation."

Ms E is also critical that Ms D made the decision on her own and did not consult with the first or second medical officer from CATT.

Although STH staff state that they did not agree with the plan, the contemporaneous notes recorded by staff do not indicate any disagreement. The notes state:

> "CATT team arrived at 1830 hours. Met with [Ms A], and [Ms K] and this staff, discussed ways of keeping safe with support from myself and o/c and [Ms K] if necessary. Still quite flat and sad after meeting but asked this staff if she ring her mum as she needed to clear some stuff with her as she had guilt feeling after speaking to her mum on previous night. After phoning her mum [Ms A] was much brighter and had lost that sad flat look she previously had. The staff very pleased and relieved with her change of mood. [Ms A] also expressed desire for ACC counselling …"

However, in the early hours of the following morning Ms A wrote farewell notes and ended her life.

Serenity Trust Home — CATT interface
Ms E, Manager of Serenity House, advised:

> "Serenity Trust Home has always had a battle with the CATT from day one, to admit clients in crisis. I believe this is a result of the client group. Often these women are viewed as 'difficult, drama queens, take up too much time and have out of control behaviour'. I know the unit is reluctant to admit women with Borderline Personality Disorder for the time they can consume staff. Our understanding of what action to take when the MHIPU [Mental Health Intensive Psychiatric Unit] was full was to contain the client at Serenity. This decision was made by the sole member of the CATT. This decision was not AGREED to by the staff at Serenity, but we are dealing with an entity that is not in the habit of making collaborative decisions. The decision to admit to the unit lies solely with the CATT. The onus of consulting with the first, second on-call and the clinical director, lies with the CATT member who is carrying out the assessment of the client in crisis. CATT policy and protocol was not adhered to in this instance and as stated in the email mentioned, 'As you know practice is not always kept consistent with policy and your feedback re incidents which seem outside of what is described would be helpful', is cause for much concern. What use are policies and procedures if they are not adhered to.
>
> A flowchart is enclosed which I developed soon after [Ms A's] death. I have offered a number of times, to educate the staff at the unit on the issues and

> concerns regarding BPD [borderline personality disorder] and their behaviours but to no avail. This flowchart does not mean the unit will necessarily respond to our requests. The staff at Serenity work with the most complex and highly suicidal group in the mental health system and we realise that the decision to suicide is imminent with particular clients, every day. We cannot prevent this from happening, but instead carry that risk and develop our policies, procedures and plans incorporating every aspect, humanly possible, around prevention. At the end of the day it's about choice and someone will, unfortunately, succeed in taking their life.
>
> …
>
> [Ms A] referred to Serenity because she could see no other way of escaping the traumatic past and family relationships/dynamics she was exposed to. Suicide was constantly in her thoughts and […] predominately the method of choice. Serenity does not provide lock up facilities but we provide 24 hour support and a staff member available to be contacted for support at night. We usually endeavour to inform the family/whanau of what Serenity's protocols and expectations regarding self-harm and suicide are, so then they have an understanding of what to expect. Unfortunately because [Ms A] did not wish her family involved in her journey here and what she was hoping to accomplish, we did not have the opportunity to inform [Mrs C] about the service, motivation and commitment required of the clients' self responsibility regarding self-harm and suicidal ideation and the long, tenuous road to recovery from trauma. The death of [Ms A] has a profound affect on all the staff and clients at Serenity, but we are passionate and committed to continue to provide a much needed service for this unrecognised client group."

Mr I said that CAMHS worked in the community with high-risk adolescent patients. The service was faced with crises on a daily basis, which always took priority over patients in STH. He said that he dreaded the situation when an adolescent required inpatient management after midday just before the weekend because there were often no inpatient beds available. In the case of [Ms A] he knew that she would have care within a service that had expertise with BPD and it was likely she would be safe. He thought the only reason STH believed it needed a key worker from CAMHS Hawke's Bay was to gain access to out-of-hours services and access to the CAMHS psychiatrist. That was not the case, as STH could notify CATT directly.

Hawke's Bay DHB investigation

Following Ms A's death, HBDHB conducted a Sentinel Event Review. The Review identified several instances of sub-optimal care and made a number of recommended changes to practice. The report is included as **Appendix IV**.

New STH policy for CATT assessments
Ms E provided the STH flowchart for CATT Assessment and Unit Admission (crisis assessment and admission) that STH and CATT now use. In all cases where STH seek CATT assessment with a view to inpatient admission, two members of CATT must assess the resident either personally or in discussion with doctor/s on duty. The decision taken must be agreed to by CATT and STH staff. If not in agreement, STH staff will consult with the duty manager of IPU, or the clinical director or Manager of STH.

Ms E reported that the relationship between CAMHS and STH has been more collegial since these events. STH staff are recognised as having expertise in caring for women with BPD and are the providers of primary services. However, CAMHS accept that sometimes residents with acute deterioration in mental health need admission for short periods of time.

Independent advice to Commissioner

I have received expert independent advice from Ms Christine Lyall, who is a registered nurse with mental health nursing defined as her scope of practice, and Mr Reg Orovwuje, a consultant social worker. This advice is attached to this opinion as **Appendices V and VI**. In summary, both Ms Lyall and Mr Orovwuje are critical of the HBDHB for failing to have established protocols and policies regarding their relationship with STH, and for the delay in arranging a psychiatric assessment of Ms A. Ms Lyall is also critical of Ms D's failure to admit Ms A to the IPCU (Intensive Psychiatric Care Unit) and for not discussing her assessment and plan with the CATT staff or on-call medical staff.

Mr Orovwuje is critical of Ms B's failure to undertake the necessary risk management assessments of Ms A or to perform a mental state examination. He criticises her for interpreting her key worker role too narrowly. He notes that when dealing with clients with complex needs, the care coordination role of the key worker is as important as therapeutic aspects, and that the absence of therapeutic input does not nullify the importance of the key worker's primary task of ensuring that a client's care needs are maximised using available resources.

Since receiving these reports I have been provided with new and significant information that was not available at the time the reports were commissioned. Therefore, while my advisor's reports are of some assistance, the new information provided to me following my first provisional opinion means that they are of limited relevance and must be read in that light.

I have also received expert advice from Mr Andrew Malone, who was engaged by the HBDHB to review Ms B's social work practice and Mr Orovwuje's report. This is attached to this opinion as **Appendix VII.**

Responses to second provisional opinion

Serenity Trust House
Ms E expressed her dissatisfaction at my second opinion, describing it as damning and inaccurate.

She does not agree with the comments made in my second provisional opinion that STH staff had lost sight of their professional duties. She states that STH staff pride themselves on providing an empowering and client-focused service, and that this is evident with the achievement of Accreditation and Certification (twice), which verifies that STH achieves above and beyond the necessary standards for adequate care.

She rejects my opinion that STH did not encourage or facilitate CAMHS involvement in Ms A's care. She expressed the view that Ms B should have performed her role as a CAMHS worker even if she felt unwelcome or uncomfortable at STH. Ms E stated:

> "Surely [Ms B's] role required her to perform her duties competently even if she perceived she was "unwelcome"? Since when has feelings of being "uncomfortable" and "unwelcome" prevented anyone from performing their role with confidence and professionalism?"

Ms E also asserted that "STH has always encouraged key worker involvement, but even to this day have been met with opposition and reluctance from the HBDHB". She stated the HBDHB community mental health team has recently made a decision not to allocate STH clients key workers, and that STH had no say in this matter.

Ms E informed me that STH had a formal Memorandum of Understanding with HBDHB Healthcare Services Mental Health and that this included CAMHS. HBDHB acknowledge that there was an MOU drafted at about the time these events occurred.

Ms E also states that she did inform CAMHS of critical incidents such as Ms A's attempted suicide. However, in her view, the second incident was "self harm" and not a critical incident, and therefore the staff at STH were more than capable of monitoring this. She acknowledges that the CATT assessment was requested in light of this self-harm and deteriorating mental state, but unfortunately STH was made to wait before an assessment was made.

Ms E expressed concern that this report will not help improve relations between STH and the HBDHB and may drive an "even bigger wedge" between them. She also commented that:

> "... a service may have 'flawless' systems operating and still tragedy will occur. It is not the systemic failings or policies or procedures that contribute to suicide, it is quite often just what the person desires. Why is it not enough for the Health and Disability Commissioner to respond to the complaint, regarding [Ms A's] suicide, that 'all care' was adequate from all service providers and at the end of the day this was [Ms A's] choice to die? [Dr G's] comments, in various reports, were that [Ms A] was going to succeed in her death. I and the rest of the staff at STH know and believe we did all that was humanly possible for [Ms A] and we can all go to sleep at the end of the day comfortable with that knowledge."

Ms D
Ms D disagrees with Ms E's comments that CATT is an "entity that is not in the habit of making collaborative decisions". She reiterates her view that the decision made with respect to Ms A's care was entirely collaborative and there was no dissent from STH staff.

Ms D also notes with disappointment that STH failed to provide her with clinical information and suggestions made regarding medication that had been obtained from Dr G by STH staff earlier on the day that she assessed Ms A.

HBDHB
The HBDHB is satisfied with the opinion and acknowledges that there were systemic failings and that this was a case where there was a lack of clear system and well-functioning inter-service relationships. It accepts the recommendations made in my second provisional opinion and is very willing to work with STH to build a positive relationship.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

…

(5) Every consumer has the right to cooperation among providers to ensure quality and continuity of services.

Clause 3
(1) A provider is not in breach of the Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with duties, in this Code.

Overview

The care Ms A received prior to her tragic death was riddled with systemic failings. The professionals involved in her care appear to have lost sight of their professional duties as they struggled to work out "policies", "guidelines" and inter-service relationships. These issues appear to have distracted them from providing a client-centred service, focused on the needs of Ms A. While it is easy to blame individuals for their failings, this is a case where primarily the lack of clear systems and well-functioning inter-service relationships led to Ms A receiving suboptimal care with tragic consequences.

Opinion: Breach — Serenity Trust Home

As a provider of health care services, Serenity Trust Home (STH) is bound by the Code and had a duty to provide Ms A with a safe environment. Under Rights 4(1) and 4(2) of the Code, Ms A had the right to mental health services provided with reasonable care and skill and that complied with legal, professional, ethical and other relevant standards. Ms A also had the right to cooperation between her providers to ensure quality and continuity of care (Right 4(5)).

STH provides residential rehabilitation for women with borderline personality disorder (BPD). It accommodates five women and carefully selects as its clients those who will most benefit from its therapies and from living in the home for long periods of time. STH's programme is aimed at women aged twenty years or over. However, Dr G, clinical psychologist at CAMHS 2, requested that they make an exception and accept

Ms A, who was then aged seventeen years. While Ms E argues that accepting Ms A was not an "exception", it is clear that STH did not have a working relationship with CAMHS. Ms A was younger than STH's usual clients, and Ms E acknowledges that Ms A was the first CAMHS aged client they had accepted since she became manager.

BPD is characterised by chronic self-harming behaviour and attempts at suicide. STH aims to teach residents to recognise emotions likely to induce such action and adopt less harmful coping strategies. STH is not a secure unit. Residents are voluntary and may leave at any time.

BPD is complex and difficult to treat. Dr F, in his report to the Coroner, said that it is not a mental health illness but a chronic personality deficit controlled with medication and psychotherapy. Admitting BPD sufferers every time they self-harm or attempt suicide (as would be done with an acute situation) has been shown to be counter-productive, often escalating their harmful actions. However, there may be times when admission to an acute mental health facility for 24 to 48 hours is necessary to keep the patient safe. BPD sufferers may also have co-morbidities, such as depression, which benefit from admission during the acute phase. To define the differences between chronic self-harming and when a patient is entering the acute phase of his or her illness takes careful assessment of risk, employing the skills of a multidisciplinary team.

At the end of the month, Ms E informed CAMHS that Ms A would be residing at STH and needed a key worker assigned to her care. STH appears to have requested a key worker as staff understood it was necessary to enable them to access CAMHS psychiatric services and HBDHB after-hours emergency services. There was no established protocol or understanding between STH and CAMHS as STH clients were not usually within the CAMHS age range. STH did not raise any concerns about this with the HBDHB or undertake any consultation with the HBDHB prior to accepting Ms A. It appears that STH did not have a productive working relationship with the HBDHB adult services or CATT prior to Ms A's arrival, and this seems to have affected how STH interacted with CAMHS. Unfortunately, there was also no formal referral or communication between CAMHS 2 and HBDHB CAMHS.

Ms B and Ms L met with Ms A and Ms H at STH. STH has not provided any records or notes of that meeting. Ms B's records indicate that STH did not want the CAMHS key worker to be involved in therapeutic care of Ms A, and all that STH wanted Ms B to do was to arrange for a non-urgent psychiatric review. Ms B was informed by STH that Ms A was settling in well, exhibited no symptoms or signs of self-harming and A herself. According to Ms B, STH and Ms A rejected her two requests to make a further appointment to undertake a full risk assessment. Ms B also asked to be informed of when Ms A's monthly review meetings at STH would be held so that she could attend these, but STH did not contact her about these. I agree with Ms E's view that simply feeling uncomfortable or unwelcome is not a justification for not doing

your job. However, there is an obligation on all providers to work cooperatively together, and it is not appropriate for a provider to make another provider feel unwelcome or uncomfortable. In addition, Ms B's request to return to undertake a risk assessment was refused, and she did not have Ms A's consent to undertake this.

The records indicate that Ms A's mental health was deteriorating, as evidenced by her smoking cannabis, arguments with her mother and her boyfriend, two incidents of self-harm, agitation, withdrawal, isolation, panic and distress, concluding with her death by suicide. During this period her lorazepam had to be increased from half a tablet to four tablets a day if needed. Ms A was expressing some impulsivity in her self-harming, was unable to talk about her feelings to staff or fellow residents, and "could not guarantee her own safety". STH did not inform Ms B or anyone else at CAMHS of these incidents and did not contact CAMHS again until after Ms A's first suicide attempt.

On the two occasions when Ms A harmed herself, Ms E sat with her, talking through the feelings that were overwhelming her. The day before Ms A died, Ms E asked STH staff to contact CATT to undertake a risk assessment with a view to Ms A being admitted. STH obtained some assistance from their general practitioner and the CAMHS 2 medical team. My nursing advisor commented:

> "The service provided by Serenity Home staff was appropriate. The contract they have with the HBDHB and Accident Compensation Corporation (ACC) is to provide a long-term residential therapeutic community for women with a diagnosis of personality disorder.[4] They are not equipped to deal with people who may be entering an acute phase of their illness. They do appear to be equipped to manage people at chronic risk of self-harm/suicide."

When Ms A attempted to commit suicide on the first occasion, Ms E spent one and a half hours with her and informed CAMHS Hawke's Bay the following day. My advisor said that this delay was not unreasonable. Given that this was Ms A's second incident of self-harm it would have been reasonable for someone to monitor her throughout the night, but this was beyond the capacity of STH's contract. However, STH staff had been supporting Ms A for several days, sleeping in the lounge with her prior to her death.

In my opinion the day-to-day care and treatment provided by STH to Ms A was of an adequate standard and did not breach Rights 4(1) or 4(2) of the Code.

However, I have serious concerns about the relationship between STH and HBDHB. I am concerned that STH decided to accept a seventeen-year-old client without consulting with HBDHB CAMHS first. While I acknowledge that Ms E informed

[4] Ibid p82

CAMHS that they were accepting Ms A, this is not the same as consulting. STH should have clarified their relationship and expectations with HBDHB CAMHS and established how they intended to work together prior to accepting Ms A. It would have been appropriate for STH to address this with the HBDHB before a crisis situation occurred. Ms E has indicated that there was a Memorandum of Understanding between STH and HBDHB and this included CAMHS. However, what is clear from the information received is that CAMHS and STH did not have an established working relationship, and that neither party understood the other's expectations and requirements. Neither STH or HBDHB have provided a copy of this document, and in any case a Memorandum of Understanding is of little use if staff are unfamiliar with it, or when providers do not know what other providers expect and do not communicate and cooperate with each other.

Comments made by Ms E indicate that she had not been satisfied with STH's relationship with the HBDHB adult services for some time. It is very clear that this coloured STH's relationship with CAMHS. Ms B and Ms L both state that they felt uncomfortable and unwelcome during their meeting. STH was resistant to input from CAMHS and made it very difficult for Ms B to undertake the role and duties normally expected of a CAMHS key worker. Ms B twice offered to return to STH to undertake a full assessment of Ms A but STH declined these offers.

STH did not keep Ms B (or CAMHS) informed of what were indicators of Ms A's serious mental deterioration, and consequently all staff at the HBDHB, including Mr I, Dr J, the CATT staff and Ms B had an incomplete picture of how Ms A was. Ms B had asked to be informed of when Ms A's monthly review meetings would occur so that she could attend but STH did not contact her about this.

Even when Ms B specifically asked what may have triggered Ms A's first suicide attempt she was not informed of the earlier incidents and was told that Ms A was doing well, and that the trigger may have been a television programme.

STH's willingness to discontinue the CAMHS key worker role when Ms A's mental state was deteriorating, and their failure to seek to have this decision reviewed as Ms A entered into a repeated crisis phase is also concerning.

Relationships between agencies are not a one-way path. Both providers need to be proactive in ensuring that there is a clear understanding of what is expected, and that avenues for communication are well established. Ms A was entitled to have providers who worked co-operatively together to ensure that she received the best care possible. STH was the provider with the expert knowledge on borderline personality disorders and with a close relationship with Ms A. It had an obligation to share this knowledge with others involved with Ms A's care. STH and the HBDHB had an obligation to work together to ensure that all involved in her care were aware of Ms A's risk factors and her care needs. This did not occur. Specifically STH:

- Failed to consult with CAMHS prior to accepting a CAMHS aged client;
- Did not encourage or facilitate CAMHS involvement in Ms A's care; and
- Did not keep CAMHS informed about critical incidents and indicators that Ms A's mental state was deteriorating.

In my opinion STH's conduct amounted to a breach of Right 4(5) of the Code.

Opinion: Breach — Hawke's Bay District Health Board

As a provider of health services Hawkes Bay District Health Board is bound by the Code and had a duty to provide Ms A with appropriate services. Under Rights 4(1) and 4(2) of the Code, Ms A had the right to mental health services provided with reasonable care and skill and that complied with legal, professional, ethical and other relevant standards. Ms A also had the right to cooperation between her providers to ensure quality and continuity of care (Right 4(5)).

CAMHS / STH interface
The services Ms A received involved two health care providers. CAMHS provides a community-based mental health service for children and adolescents. STH provides residential rehabilitation and therapy for women with BPD who are referred from six DHBs. The HBDHB Mental Health Services provides out-patient services such as psychiatric assessments and care co-ordination for out-patients like Ms A, and also provides inpatient psychiatric care when required. However, following Ms A's transfer to STH, STH and CAMHS had different expectations of their respective roles, and no protocols were in place to facilitate this. As already discussed, this was the first time that STH had accepted a client who was within the CAMHS age range. They did this without discussing care arrangements with CAMHS and without a formal referral from CAMHS 2 to HBDHB CAMHS.

Dr F said that BPD is not a mental illness as such, and treating every episode of self-harm as an acute event could result in escalation of this behaviour. However, to assess whether this was chronic self-harming or a manifestation of acute mental illness takes the skills of a multidisciplinary team. My social work advisor, Mr Orovwuje, was critical of HBDHB's lack of a clear policy for the interface between CAMHS and STH. In his view, this set in train a series of events that disrupted the continuity of care for Ms A. It led to unacceptable delays in her receiving appropriate psychiatric assessment. Mr Orovwuje stated:

> "The absence of clear interface polices, protocols and guidelines by the HBDHB at its service interface with STH appears to have disrupted the continuity and timeliness of clinical care delivery to [Ms A]."

Mr Orovwuje also stated:

> "Given that a contract exists between Hawkes Bay DHB (Funder) and Serenity Trust Home (Provider) — although the substance of the contract is not available to the writer — it stands to reason that the inter-face between both services should have had a detailed Memorandum of Understanding and/or Guidelines to deal with the day-to-day relationships between the organisations. It is a given that most specialised Non-Government agencies lack the full range of supportive clinical services to meet the complex needs of some of the clients they manage and [Ms A] falls into the group of clients with complex needs and on-going at-risk behaviour.
>
> There appears to be a failure to clearly enunciate the character and quality of clinical input as well as the roles and responsibilities of staff in the provision of care at the service inter-face between Hawkes Bay DHB and Serenity Trust Home. This appears to have justified what seems to be an ad hoc approach to policy making at the meeting between [Mr I] and Serenity Trust Home. It invariably compromised the quality of clinical care delivery for [Ms A]."

The absence of appropriate protocols and policies not only meant that staff were uncertain about their roles but also led to the provision of suboptimal care and poor decision-making. The lack of policies and procedures directly contributed to:

- Ms B's role not being clearly defined and consequently no care coordination or proper risk assessment of Ms A occurred. It resulted in Ms A not having an advocate within the HBDHB's Mental Health Services;

- A delay in obtaining a psychiatric review. Dr J was unsure how the relationship between STH and the HBDHB operated, and consequently delayed making an appointment;

- The decision to close Ms A's CAMHS file and to no longer have a key worker — this was a direct result of the failure of HBDHB and STH to have established protocols. This decision coincided with Ms A's attempt to self-harm and led to further fragmentation of her care.

The delay in getting a CATT assessment was partially due to the CATT not knowing what protocols CAMHS had established with STH.

There is ample evidence to support Ms B's assertion that she was concerned about her role and that she sought clarification about this from her supervisor at the HBDHB.

HBDHB should have had guidelines and protocols in place for Ms B and other staff to follow. I acknowledge that HBDHB was in a difficult position as STH had accepted Ms A without consulting them, and no proper referral between DHB 2 and HBDHB had occurred. However, this should have been dealt with immediately.

Mr I said that CAMHS dealt with crises in the community every day but there were simply inadequate resources to cope with demand. CAMHS patients in crisis took priority over those receiving support in residential facilities such as STH. He also attributed the delays that occurred to inadequate resources. On the other hand, the Sentinel Event Review team found a number of errors stemming from a lack of understanding of roles and responsibilities between CAMHS and STH, which impacted on the clinical decisions made by individual staff. It concluded that inadequate polices and procedures led to delays.

The Sentinel Event Review team noted that staff did not follow HBDHB policy in regard to completing a risk assessment and consulting medical personnel. However, at the time of this incident HBDHB had not clearly defined CAMHS's role and responsibilities to STH staff and residents. Staff were confused about what was required of them. My advisor, Mr Orovwuje, attributes the lack of policy and guidelines as being the primary cause for the delay in Ms A receiving a psychiatric assessment. In my opinion the delays can also be attributed to STH's reluctance to accept CAMHS involvement.

In my opinion, HBDHB did not have adequate policies and procedures regarding its relationship with STH. It failed to define the roles and responsibilities of staff when interacting with clients and staff at STH. This amounted to a failure to ensure cooperation and continuity of care. It also led to Ms A's standard of care being compromised by a lack of coordination, delays in obtaining a psychiatric review and appropriate risk assessments, and management plans not being undertaken. Accordingly, the HBDHB breached Rights 4(1) and (5) of the Code.

Opinion: No breach — Ms B

Ms B was Ms A's CAMHS Hawke's Bay key worker. She had a duty of care to her, regardless of the confusion in her relationship with STH.

Mr Orovwuje is critical of Ms B. He stated:

> "The role of a CAMHS key worker is to work collaboratively with Serenity Trust Home key worker so as to ensure continuity of care, coordination of care, a single person for [Ms A] to refer to, and a bridge between Serenity team and clinical

> team at CAMHS. Key workers sometimes deploy their therapeutic skills in working with clients but this does not override the support, coordination and continuity of service provision which is equally critical for effective clinical care."

Ms B raised these matters with her supervisor and expressed her concerns about STH's and Ms A's refusal to allow her to work with them. I accept that in some respects Ms B did not provide a standard of care that is usually expected from a key worker. However, I am satisfied that she took reasonable steps in the circumstances to fulfil her obligations. In particular I am aware that she attempted to undertake a full risk assessment of Ms A and requested on two occasions to return to STH to do this, but her services were declined. Mr Orovwuje's comments were made without the benefit of this information and, while his advice offers some guidance as to what the usual applicable standards are, I do not accept that his advice remains applicable in this case.

Risk assessment

Ms B was in an unenviable position. She had been given the responsibility by CAMHS to be Ms A's "key worker" and she understood what this role usually required but she was not able to perform her role owing to the lack of cooperation between STH and HBDHB.

Ms B met with Ms A and STH staff. As this was the first time that CAMHS had worked with STH she was unsure what they were expecting from her. She went with her colleague, Ms L, to this initial meeting to clarify how it was envisaged CAMHS would work with STH.

Ms B knew it was her job to complete a new risk assessment for Ms A but was unable to do this without the cooperation of Ms A and STH staff. Ms B was told by STH staff and Ms A that she had settled in well since she arrived and apparently did not pose any current risk of self-harm. Ms B has stated that she was "very concerned" about Ms A as the move to STH had meant leaving behind her support networks such as her mother and boyfriend. However, Ms B was told that her clinical and therapeutic input was not required. Her offer to return to undertake a more comprehensive assessment was declined twice. Consequently Ms B and STH staff agreed that Dr G's risk assessment and management plan should remain current and that Ms B or CATT could be contacted if necessary. In the meantime, Ms B would contact Dr G for more information about Ms A and make a non-urgent outpatient appointment with the psychiatrist.

Mr Orovwuje advised that Ms B's initial assessment "lacked purpose". Although Dr G's risk assessment and management plan was thorough, it was signed off. I accept that it was unsatisfactory to rely on it three months later, particularly considering how Ms A's circumstances had changed. Ms B should initially have recorded Ms A's psychosocial history and considered what it meant to Ms A to have contact with her

mother, and what a "risk-free" period at STH meant in terms of her past history of risk-free periods. I also acknowledge that a further assessment was required to take into account, amongst other things, what it meant for Ms A coming to STH to live, possibly for a long period of time, and the impact of this on her relationship with her mother and boyfriend. However, I accept that without Ms A's and STH staff's cooperation Ms B could not perform these tasks. She could not undertake a full risk assessment without Ms A's consent. It did not assist Ms B that STH staff told her, in front of Ms A, that her input was not required. I acknowledge that Ms B was concerned about this and raised her concerns with her co-worker, Ms L, and her team leader and supervisor, Mr I. While I consider that Ms B could also have raised her concerns with senior staff at STH, I acknowledge that in the climate that existed between the HBDHB and STH, this would have been very difficult to do.

The HBDHB role description for a key worker lists functional relationships with community agencies to provide a variety of treatment and care options for the client. Ms B completed a clinical alert factors form which identified previous but not current risks.

Mr Orovwuje regarded Ms B's failure to thoroughly assess Ms A's risk factors as "severe". In the circumstances I do not accept Mr Orovwuje's advice. At the time of writing his report he was not aware that Ms A had declined Ms B's services and that Ms B did not have the opportunity to fully assess Ms A.

I am aware that BPD, although not a mental illness in itself, can co-exist with mental health problems that benefit from short-term inpatient management. I accept that there is a fine line between chronic self-harm and acute episodes, and that assessing the difference is difficult, but this highlights the need for in-depth assessment at the first consultation and listening to those who deal with BPD on a daily basis. STH was the organisation with this expertise but they did not share their knowledge and skills with Ms B or act collaboratively. Nor did they give Ms B the opportunity to undertake her own assessment.

According to HBDHB policy the assessment should have been completed in three visits. While Ms B did not undertake a risk assessment and failed to document "what her next two interviews would focus on in terms of her clinical objectives and priorities", this must be seen in light of the fact that her request to undertake further assessment was declined by Ms A and STH. In my opinion, while failing to complete a risk assessment as required by the HBDHB Clinical Review Policy and the Ministry of Health guidelines suggests that Ms B provided less than optimal care, I accept that she was not solely responsible for this. This failing was a result of the poor or non-existent relationship between STH and HBDHB CAMHS and STH's reluctance to have CAMHS involved in therapeutic and clinical care of their clients. Without STH's cooperation and Ms A's consent, Ms B was unable to undertake a full risk assessment.

Ms B was unfortunately "caught in the middle" of this unsatisfactory situation, which resulted in Ms A not receiving the care she was entitled to.

Delays in psychiatric assessment
A number of failures led to Ms A not receiving a timely appointment for a psychiatric assessment. By failing to undertake a risk assessment and not fulfilling her role as a key worker, Ms B contributed to these delays. She did not recognise the urgent need for a psychiatric assessment.

Ms B tried but had trouble contacting Dr G. It took two weeks before she was able to talk to him, and nine days before she contacted Dr J to make an appointment. Due to the lack of policies and guidelines, Dr J did not know how the relationship between HBDHB and STH worked and sought clarification from Mr I. My advisor, Mr Orovwuje, attributes the primary cause of the delay in offering a review appointment to this lack of policy and guidelines. I also note that STH clearly stated to Ms B that the psychiatric review was non-urgent and that they would contact her if needed.

Although Ms B had difficulty contacting Dr G and Dr J for what she had been told was a "non-urgent" psychiatric assessment, she made no further effort to ascertain whether Ms A's assessment remained "non-urgent". However, I acknowledge that STH had made it clear to Ms B that they would contact her if they needed her, and that they did not want her input into the treatment and care provided to Ms A. Clearly an urgent review was needed following Ms A's first attempt to commit suicide. However, STH failed to tell Ms B about a number of critical incidents and events that would have alerted her to Ms A's deteriorating mental state. STH assured Ms B that Ms A was "settling well" and that there was "no conflict with her boyfriend". Ms B also responded by immediately contacting Dr J and Mr I.

Ms B ceased to be Ms A's key worker. In my opinion, if Ms B had been able to undertake her key worker role, had been able to undertake a full risk assessment, and had been fully informed by STH about events prior to this suicide attempt she may possibly have been more aware of the true nature of Ms A's mental state and of the urgency of seeking a psychiatric assessment. Unfortunately this was not the case. Ms B was not the primary cause for the delay or solely responsible for it. Numerous other factors impacted on this delay, including the length of time it took Dr G to return Ms B's calls, STH staff assurance that Ms A was doing well, the failure of STH to inform Ms B of critical incidents, Dr J's lack of understanding of his role in relation to STH clients who had transferred from other DHBs and the subsequent delay this caused, and the removal of Ms B from the key worker role. Consequently I do not intend to take any further action in relation to this issue and do not consider that Ms B breached the Code.

Failure to visit and closure of CAMHS file

On the morning following the suicide attempt, STH telephoned Ms B to inform her of Ms A's suicide attempt during the night and requested a medication review. According to STH records, Ms B did not seem interested. However, Ms B recorded over a page of notes following the incident, recommended that STH take Ms A to their GP, and immediately telephoned Dr J to request a medication review. She then spoke in person to her clinical team leader, Mr I, calling him out of a meeting to do so. Her notes record that STH "feel they are able to manage risk, would like med review". In my opinion this does not equate to a lack of interest. She did not, however, arrange to visit Ms A. Mr Orovwuje commented:

> "[Ms B] appropriately dealt with the information Serenity Home gave to her regarding [Ms A's] first suicide attempt by alerting the clinical leader and the psychiatrist at CAMHS to the critical event and by seeking action and additional clinical information. [Ms B] however failed to visit [Ms A] and Serenity Staff in the absence of the clinical leader taking initiative."

Ms B received the call from STH while her relationship with Ms A remained uncertain. According to my experts she should have arranged to assess Ms A or "prevailed on her team leader to act promptly to Serenity's request". In my opinion, given the circumstances that prevailed at the time, Ms B took appropriate steps. When she told her clinical leader that Ms A had attempted to commit suicide, she was told that he was meeting with STH that day to clarify policies and expectations. This meeting led to the decision that Ms A would not have a CAMHS key worker and the CAMHS file was closed. Given the overall confusion surrounding this matter, referring STH to the general practitioner who had been involved in Ms A's care and seeking a medication review seems to have been a reasonable response in the short term. While under optimal circumstances Ms B should have also visited Ms A, STH had made it clear that they did not want her involved in Ms A's therapeutic care. In view of this, combined with the lack of cooperation between STH and CAMHS and the fact that her clinical team leader was meeting that day with STH staff, I do not consider Ms B's failure to visit Ms A to be a breach of the Code.

When asked what Ms B and HBDHB should have done under these circumstances, Mr Orovwuje said that there should have been an inter-disciplinary clinical review of Ms A to identify key clinical management issues and to revisit the decision to withdraw the CAMHS key worker. He suggested that Ms B should have called for a review of the decision to remove her as key worker and, if unsuccessful, discussed this matter and the delays in the provision of a psychiatric review with her social worker supervisor.

The closure of the file meant that Ms A did not have a key worker within HBDHB Mental Health Services to advocate on her behalf. However, arrangements had been

made for STH to access the services they required. In my view Ms B was in a difficult position, as the decision to remove her as Ms A's key worker and to close the file coincided with Ms A's first attempt to self-harm. Her supervision was a line supervision provided by the CAMHS Clinical Leader, Mr I, who was a psychologist. This left Ms B with no independent professional supervisor with whom to discuss these difficulties.

Although I accept Mr Orovwuje's opinion that it was Ms B's role to advocate on Ms A's behalf for her file not to be closed and to remain as her key worker, I do not consider that in the circumstances Ms B's failure to do so amounted to a breach of the Code. The Code requires health care providers to take "reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in [the] Code".[5] The decision was in fact made by her then social work supervisor (Mr I); STH had consented to the decision; and alternative arrangements (although in retrospect unsatisfactory) had been made.

Opinion: No Breach — Ms D

Ms K from STH rang HBDHB CATT late in the morning requesting a risk assessment for Ms A. The request was assessed as "semi urgent". The records show that there was some initial confusion as to why STH had contacted CATT directly rather than coming through a key worker, as CATT had not been informed of the decision to remove the key worker role from this case.

At about 3pm that day, the CATT clinical leader told Ms D that STH had requested a CATT assessment for Ms A but CAMHS Hawke's Bay did not have an "open" file for her. Ms D was not made aware that the request had been made at 11.40am that day.

At about 6pm, Ms D arrived at STH and met with Ms K (Ms A's psychotherapist), Ms A and Ms P, who was the STH staff member on sleepover that night. Ms D's notes record that her assessment took two hours (6–8pm).

Ms A told Ms D that the laceration on her wrist, which she had inflicted at 9pm the night before, was not a suicide attempt, but was because she wanted to "feel pain". She acknowledged acting impulsively and was unsure she could maintain her own safety, but was unlikely to be overwhelmed by these feelings if she had one-on-one support from STH and other residents. Ms A stated that once settled she usually slept through the night with medication, and Ms D's notes record that STH staff "observed the

[5] Code of Health and Disability Services Consumers' Rights — Clause 3

same". Furthermore, Ms A did not want to be admitted to a the hospital psychiatric unit but wanted to remain at STH.

Ms E states that STH staff asked CATT to admit Ms A to the IPU, but this is not recorded in the contemporaneous notes taken by either Ms D or Ms P, the sleepover staff. After completing the assessment and taking Ms A's wishes into account, an alternative plan was formulated and she was not admitted. In Ms D's view, this was not a "crisis", as Ms A had cut herself almost 24 hours previously and she had no current plans to harm herself. STH staff would sleep in the lounge with Ms A overnight. To expedite the psychiatric appointment, Ms D faxed the STH documentation to CAMHS so it would have this information early the following week. Ms D recorded Ms A as a "client of concern" for the CATT over the weekend and discussed with STH staff the importance of contacting the CAT team if Ms A's mental health deteriorated.

Ms D said that STH staff agreed to the plan. Ms E denies that, and points to her note "must be admitted" in her records made earlier that day. However, the notes recorded contemporaneously by both Ms D and by the sleepover staff present during Ms D's assessment do not record any dissent.

While I acknowledge that Ms E has stated in response to my first opinion that "at no time" did STH staff agree with Ms D's decision, I am not convinced that STH staff expressed their views as strongly as Ms E alleges. While STH staff may have respected Ms D's "expert" position as suggested by Ms E, the contemporaneous notes in the STH records state: "CATT team arrived at 1830 hours. Met with [Ms A], and [Ms K] and this staff, discussed ways of keeping safe with support from myself and o/c and [Ms K] if necessary." The record continues to describe how the staff member was relieved by Ms A's improved mood. There is no record of dissent or concerns about the plan. Neither are there any comments to this effect recorded in Ms D's relatively full record. Ms D is adamant that the STH staff agreed to the plan and confirmed that they were able to continue to offer Ms A one-to-one supervision.

Ms E has responded by stating that Ms D did not have a relationship with Ms A, like that of staff at STH, so knew nothing about her history or pervasive thoughts of dying. This is true. However, STH must accept some responsibility for this because it was STH who declined CAMHS involvement. If CAMHS had actively been involved, this information would have been available to Ms D and CATT. Ultimately Ms D made her clinical judgment based on the information provided by STH staff alone.

Ms E was also critical of Ms D taking Ms A's desire to remain at STH into account. In my view, Ms D was obliged to take Ms A's views into account. This is consistent with Right 7(3) of the Code, which deals with the rights of consumers with diminished competence. Without her consent, Ms D could not have admitted Ms A without

invoking the compulsory care provisions in the Mental Health (Compulsory Assessment and Treatment) Act 1992.

My nursing advisor, Ms Lyall, said that Ms D's decision not to admit Ms A was incorrect. Ms Lyall listed a number of reasons; for example, Ms D used Dr G's risk assessment, which had not been updated; Ms A had an increased need for antidepressant medication in the preceding days and stated that she could not guarantee her own safety. Ms Lyall also noted that STH was not equipped to safely care for Ms A, who probably needed constant monitoring by IPU staff and access to appropriate medical intervention, and that Ms D made the decision without discussing it with on-call medical staff.

Ms D was required to make a very difficult decision about whether Ms A's self-harming remained at the chronic stage or whether her mental state had deteriorated to acute depression requiring admission. She was disadvantaged by not having a CAMHS file and because there was no up-to-date risk management plan or psychiatric report. Had these things been available, Ms D would have had a greater understanding of the background and context with which to assess Ms A. There also appears to be no clear policy as to when CAT team members should discuss assessments and plans with on-call medical staff. This was left to the clinical judgment of the assessor. Ms D also states that she specifically considered the increased use of lorazepam, noting that it was within the range of what would likely be prescribed by any on-call doctors.

While with hindsight Ms D's decision not to admit Ms A can be criticised, having considered all the circumstances, the expert advice, Ms E's comments and Ms D's response, I have reached the view that Ms D exercised her clinical judgement appropriately in very difficult circumstances and did not breach the Code of Health and Disability Services Consumers' Rights.

Other Comment

This report has focused on the importance of providers working together and cooperating with each other. Whether improved relationships between STH and HBDHB would have prevented Ms A's death will never be determined. What is clear is that if the providers had cooperated and communicated with each other and worked in collaboration, Ms A would have received better care. While Ms A may have wished to die at that moment, other comments reveal a vibrant, intelligent young woman who was loved by her family and who wanted to get well. Simply suggesting that because she wished to die her care was therefore adequate is unacceptable.

This report is intended to be a catalyst for change. It is intended to help STH and HBDHB to identify how they can improve their relationship and prevent incidents like this occurring again. This will take more than policies and procedures. It will involve on-going dialogue and a commitment from all involved to ensure communication and cooperation.

Recommendations

I recommend that Serenity Trust House take the following actions:

- apologise to Mrs C for their breach of the Code in relation to the care provided to Ms A. This apology is to be sent to this Office to forward to Mrs C.
- undertake a full review of its practice and its relationships with any other mental health providers in Hawke's Bay with which it works; and
- advise the Commissioner, by 31 June 2007, of the steps taken as a result of the above review.

I recommend that Hawke's Bay DHB take the following action:

- apologise to Mrs C for its breach of the Code in relation to the care provided to Ms A. This apology is to be sent to this Office to forward to Mrs C.
- undertake a full review of its practice and its relationships with other mental health providers in Hawke's Bay;
- advise the Commissioner, by 31 June 2007, of the steps taken as a result of the above review.

I also recommend that the Hawke's Bay DHB and Serenity Trust Home provide the Commissioner with a joint written report by 31 June 2007, detailing how their working relationship is now functioning, and the steps they have both taken to improve this relationship.

Follow-up actions

- A copy of this report will be sent to the Coroner.

- A copy of this report, with details identifying the parties removed (other than Hawke's Bay DHB and Serenity Trust Home), will be sent to the Director-

General of Health, the Mental Health Commission, the New Zealand Association of Social Workers Inc, the Australian and New Zealand College of Mental Health Nurses Inc, Te Ao Maramatanga (New Zealand College of Mental Health Nurses), and to all District Health Boards, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Hawke's Bay DHB and Serenity Trust Home) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's name.

Appendix I: Excerpts from Dr F's report to the Coroner

"As is usual practice for Hawke's Bay District Health Board Mental Health & Addiction Service following any critical incident, the care and treatment provided to [Ms A] has been subject to a Sentinel Event Review process. This review process identified a number of areas of suboptimal service response in [Ms A's] case, all of which related to the need to improve the systems of care for people with complex needs relating to Borderline Personality Disorder —

- the need to have a clear agreement with Serenity House about processes to be followed relating to referrals coming from out of area;

- the need for clinical staff to be involved in the Serenity House assessment and decision regarding admission;

- the need to have a clear plan relating to acute situations/self-harm or suicidal thinking or actions, which is agreed to and in the possession of CATT;

- the need to involve the on call Consultant Psychiatrist and/or Clinical Director in decisions regarding high risk situations with people with complex needs as a result of Borderline Personality Disorder — in particular decisions regarding admission or not.

Since [Ms A's] death these actions have been followed up on, within the overall umbrella of the Hawke's Bay District Health Board Mental Health & Addiction Service quality process. The outcomes have included a clearly agreed procedure between the Mental Health Service and Serenity House, which provide clearer guidance for all involved and addresses areas of suboptimal practice identified.

It should be noted that this Sentinel Event Review [by HBDHB], conducted with the clinical and the other staff involved in [Ms A's] care but undertaken by senior leadership of the Mental Health Service, did not identify any deficiencies in the clinical assessment, or care and treatment provided by the Mental Health Service. With the information to hand, and in the light of the assessment of [Ms A] at the time, (including in particular the fact that neither of these attempts of self-harm had been disclosed by [Ms A] as being attempted suicide), the plan agreed was in keeping with the management plan, and was documented to have been with the agreement of Serenity House staff. Serenity House staff have subsequently expressed their strong views that [Ms A] should have been admitted on the night; this was not strongly communicated to the CAT staff involved in her assessment at the time and they did not agree to the proposed plan which included close support and follow-up with the contingency plan regarding admission, should there be further escalation of distress or self-harm."

Appendix II: Services offered by Serenity Trust Home

Serenity Trust Home (STH) accepts residents referred by six DHBs in the central North Island region. STH is a residential facility for women. It provides rehabilitation and a supportive supervised environment for women with personality disorders. STH is a certified facility complying with Mental Health and Disability Standards.

Women who qualify for entry to STH have personality disorders resulting from sexual, physical, emotional and verbal abuse. These include post traumatic stress disorder, borderline personality disorder (BPD), and clinical depression. The disorders can result in unsafe behaviour, such as suicide attempts, self-harm, depression, isolation and low level of function.

Most of the women have well-established "unsafe behaviours" such as previous suicide attempts and self harm. Intensive psychotherapy and self responsibility are used to try and prevent them from harming themselves again. It is important that they want to cease to self-harm. STH is a sleep-over unit, meaning that a staff member sleeps in the home and another is on call if required. It does not have staff awake to constantly monitor the actions of clients at night, nor does it have a "lock-up" unit available for clients at risk. All clients are voluntary and STH cannot prevent them from leaving.

STH may not be the appropriate placement for all clients referred. STH accommodates only five women; aged 20 years or older. It does not provide specialist services for clients with eating disorders and drug and alcohol addictions. Clients who are potentially violent or have a long criminal history are also not accepted. Once accepted clients spend varying periods of time in therapy, ranging from three months to two years, depending on their needs.

Each woman has an initial settling-in period of two weeks, then it is decided whether STH is the appropriate placement for that individual. Once accepted, progress meetings involving the client, the client's liaison at STH and other health professionals involved in care are held every 12 weeks, to ensure the goals remain appropriate, realistic and achievable.

Clients are taught to explore and document what happens when anxiety and stress levels begin to rise. This enables both staff and client to assess the level of support and supervision required. A recovery support plan, relevant to the individual client, is then developed. All members of the client's recovery support team are involved in this process, and include the client, the community mental health care worker, the client liaison worker, a therapist and other support people the client identifies. It may also include family/whanau.

Therapy progresses through four steps to independence; safety and containment, support and growth, independence and reclaiming, and support for independence. Psychotherapy begins when the client has finished the two week settling-in period.

In summary, STH is a residential community. It provides long-term, intensive rehabilitation for women diagnosed with personality disorder. The rehabilitation is in the form of a day programme, facilitated by various mental health professionals, and psychotherapy facilitated by psychotherapists, the focus of which is self assessment and learning appropriate coping strategies.

Appendix III: Position description — Social worker

The HBDHB role description for a social worker with the mental health service states (page 3):

> "The Child & Adolescent Mental Health Service (CAMHS) is part of the Mental Health & Addiction Service. It offers a wide variety of therapeutic services to children, adolescents and their families. Staff is allocated in Napier and Hastings with limited visiting services to Wairoa and Central Hawke's Bay. Services are delivered in people's homes as well as Mental Health & Addiction facilities. …
>
> This position is part of an existing team of Nurses, Social Workers, Kaimanaaki, Psychiatrists, Psychologists, Occupational Therapist and Clinical Leader. This position will also involve working at times as part of the wider multidisciplinary team within the Mental Health & Addiction Service. …
>
> This team works in close association with GPs and community agencies to provide a variety of treatment and care options, with the aim of enabling consumer/tangata whaiora and their family/whanau to have choice and control over their return to health. …
>
> MANAGEMENT
> a) To arrange the delivery of assessment, therapeutic and support services to consumers/tangata whaiora as allocated on a daily and ongoing basis.
>
> …
>
> CLINICAL
> a) Assessment
> To provide a quality and responsive nursing assessment for people referred.
>
> …
>
> d) Networking
> To ensure linkages with families, community agencies, services and support networks are made and maintained for the benefit of consumer/tangata whaiora."

HBDHB Mental Health and Addiction Service *Child & Adolescent Mental Health Service Client Care Pathway* (January 2004) states:

"**RESPONSIBILITIES**

Clinical Leader

The clinical leader is responsible for appointing the interim/assessing Key Worker referrals along with the allocation team.

Interim Key Worker

The interim/assessing Keyworker holds responsibility for the initial comprehensive assessment and the clinical safety and care of the client and their family.

Key Worker

The Keyworker is responsible for coordinating the care plan of the client, providing active treatment and working in collaboration with other clinicians, NGOs [Non-Governmental Organisations], Iwi providers and Governmental Organisations that provide relevant services."[6]

[6] The interim/assessing Key Worker is required to complete the comprehensive assessment (within three visits) and Risk Assessment (p 2). (See also appendix 1 HBDHB CAMHS Continuum flowchart.)

Appendix IV: Hawkes Bay District Health Board Sentinel Event Review

"Conclusion and Corrective Actions

Referral Process:

- The referral process was being reviewed to ensure that NASC [Needs Assessment Service Coordinator] was involved to broker the referral to the correct MH&AS [Mental Health and Addiction Service] business unit. In this case the referral went directly to the residential home, who forwarded it to NASC [Needs Assessment Service Coordinator], who then forwarded it to CAMHS, which resulted in a delay.

- The assessment of the client with the residential staff did not involve CAMHS, CATT or the MHIPU [Mental Health Inpatient Unit], which could have provided joint care planning around managing the client's risk factors and allow for a similar management plan to be put in place as that of the transferring DHB's prior to her arrival. It would have also allowed the client the opportunity to meet other members of the service who would be involved in her ongoing care.

- Clarity around roles and responsibilities would have been identified well before the client was accepted into the service and additional information requests would have been facilitated. This would have allowed Dr's appointments to be scheduled.

Lead Services

- The residential staff hold the expertise in providing residential care, support work and programmes for people diagnosed with borderline personality disorder in the Hawkes Bay.

- Contracts require that MH&AS [Mental Health and Addiction Service] clinical services provide joint services for this client group to enhance the care packages provided. This is usually brokered through NASC [Needs Assessment Service Coordinator].

- The residential service provided the lead provider role in the client's care with MH&AS [Mental Health and Addiction Service] providing clinical support as needed.

- A key worker was allocated through CAMHS. The residential service identified that their request was driven by the need to be able to access CATT

when they needed to as in the past they had experienced difficulty in getting CATT to respond.

- It was agreed that CAMHS would close the client's file and that if a Dr's appointment was required contact would be made with the CAMHS Clinical Leader.

CATT Intervention

- The first phone call was received by CATT from the residential service and logged at 1140 hours. The referral form identifies that the residential service were informed that during working hours key workers respond to crisis work. Also informed that the Team Leader would be back to them.

- CATT Team Leader contacted the residential staff and questioned their staff's competency to make the decision around admission and crisis.

- The CATT Team Leader discussed the case with CAMHS Clinical Leader and it was agreed that as the client was closed to CAMHS CATT would undertake the assessment.

- CATT were notified at 1240 of this expectation by the CATT Team Leader.

- CATT responded at 1800 hours according to documentation. The residential service however, logged the arrival as being at 1900 hours.

- A total of 6 hours and 20 minutes elapsed before CATT responded.

- CATT staff had separated so only one staff member responded.

- There was no evidence that indicated that the 1st oncall Dr was consulted around the decision.

Inpatient Unit Admission versus Community Treatment

- The residential service was left with the impression that the client's admission to the East Wing was not conducive of her overall treatment and that IPCU [Intensive Psychiatric Care Unit] was full and not accepting admissions. Decision-making regarding admissions when any part of the MHIPU [Mental Health Inpatient Unit] is full, sits with the Clinical Director. The Clinical Director and the 2nd oncall were not consulted regarding admission options.

Chronic versus Acute Impulsivity

- There is significant evidence and research that supports that chronic suicidality and acute impulsivity is difficult to assess and at times calculated risks need to be taken. Decisions of this magnitude should be made with the Consultant involvement to ensure that risk is shared and staff are supported in the treatment plan arrived at.

- The management plan provided by the transferring DHB's Mental Health Services identified early warning signs, contributing factors and steps to be taken for addressing risk-taking behaviour:

    1. Attempts of suicide or self harm ring the Crisis Team
    2. Coping strategies are discussed with the Crisis Team if not resolved over the phone then the Crisis Team to visit
    3. Elective informal admission is offered after being seen by the Registrar who feels that she remains unsafe for up to 3 days
    4. To ensure that the inpatient unit remains a safe place if an attempt of self harm occurs then she will be discharged
    5. If after a period of admission she feels safe then she can request to see the Registrar to discuss discharge
    6. If she requires discharge and is not deemed safe and still decides to leave she will be discharged against medical advice.

- Although Serenity agreed to the plan following CAT assessment they felt that she should have been admitted to the MHIPU as they had been specialling her with a 1:1 staff member and staff and clients have been sleeping with her in the lounge since the attempted [suicide].

After Hours Contact

- The residential services manager had a number of concerns regarding the length of time taken and the outcome of the assessment but due to the lateness of the hour did not know whom to contact. The manager was unaware of the MH&AS [Mental Health and Addiction Service] Oncall Manager, 1st and 2nd Oncall system in place.

Acute Respite Care

- Options were limited to meet the acute needs of the client. Crisis Respite does not allow for actively suicidal people to be placed in the facility and admission to [another] Unit could not have been facilitated until after the weekend.

- There is a growing need for a Crisis Respite facility for Rangitahi/Youth with high acuity needs and risk taking behaviour.

Lessons Learnt

1. The client pathway for the residential service has been reviewed and has NASC [Needs Assessment Service Coordinator] brokering all referrals, includes joint assessments with the appropriate business unit/s to ensure that a recovery plan is agreed, roles and responsibilities assigned and access to Dr's appointment and crisis response is facilitated.

2. The Clinical Leadership team will need to arrive at an agreement that the residential service holds the expertise in borderline personality disorder and accept that when a request for Crisis Assessment is made that it is responded to.

3. Implementation of the Interim Support recommendations regarding the review of CATT service delivery and model of care has been put on hold until the MHIPU [Mental Health Inpatient Unit] refurbishment have been completed and CATT is relocated back to [the city]. The recommendations suggest that if crisis work is being provided by the community teams Mon-Fri then CATT as an after-hours, weekends and public holiday service to be considered.

4. The lengthy delay in CATT responding to the call requires further investigation.

5. After-hours complex decision-making should be made in conjunction with the 1st and/or 2nd Oncall and not made by a sole clinician.

6. The decision to admit when the MHIPU is full rests with the Clinical Director who has implemented an open admission procedure.

7. Oncall Manager policy, Doctor Oncall policy and Crisis Assessment and Treatment policy to be disseminated to the NGO [Non-Governmental Organisations] and Iwi providers so they are aware of our after-hours procedures.

8. Presentation to Planning & Funding regarding the growing need for residential options for Rangitahi/Youth with high acuity and high-risk behaviour."

Implementation of corrective actions
HBDHB advised the following progress in implementing the corrective actions identified above.

"The status of the recommended actions is as follows:

1. I confirm that NASC [Needs Assessment Service Coordinator] brokers referrals for supported accommodation and personal care packages and NASC tracks referrals to ensure ongoing services are being provided as appropriate. The Client Pathway has been reviewed by NASC and HBDHB's clinical leaders to ensure that all service users referred to NGO (Non-Government Organisations) and Iwi providers involve the appropriate clinical team(s) in the development of the initial recovery care plan.

   All routine referrals from other health services providers are triaged and a clinician appointed as key worker. All crisis referrals are triaged by the Crisis Assessment and Treatment Team (CATT) and responded to appropriately.A key working policy (for provider arm of the DHB) is in place. A Care Coordination policy is currently under consideration by mental health and addiction service providers in the district (to also include other mental health providers in the district so that care is coordinated across providers). This will improve coordination across all mental health & addiction providers in Hawke's Bay.

2. Serenity House's expertise in providing residential treatment to people with Borderline Personality Disorder is acknowledged, and when Serenity House requests access to HBDHB's CATT it is responded to appropriately.

3. HBDHB's CATT has been relocated back to [the city] (August 2004) and the recommendation that crisis work is provided by the community teams Monday to Friday and CATT after hours, weekends and public holidays, has been implemented. During the day community teams are encouraged to provide crisis response for known consumers to ensure there is continuity of care. CATT provides back up where necessary.

4. HBDHB has further investigated CATT's response time. Due to the nature of crisis work demand varies and work has to be prioritised. CATT triages referrals, prioritises and responds accordingly and HBDHB considers that [Ms A] was appropriately triaged and prioritised according to CATT's caseload at the time. The provision for crisis work to be undertaken in the first instance by community key workers during working hours, Monday to Friday, has assisted with crisis response times.

5. After-hours complex decision making is made with the Medical Officers who are 1st and/or 2nd on call. CATT is supported by the 1st and 2nd on call medical officers and access these persons as appropriate.

6. HBDHB's mental health inpatient unit has an open admission policy and all mental health staff, in particular CATT, is aware of this policy.

7. All mental health and addiction service policies, including the CATT, 1st and 2nd Medical Officers on call policy and on call manager policy, are made available to all mental health and addiction service providers in the district.

8. HBDHB acknowledges the growing need for residential options for rangitahi/youth with high acuity and high-risk behaviour. Residential options that currently exist for this group include inpatient admission to the adolescent mental health inpatient unit in Wellington, temporary admission to HBDHB's mental health inpatient unit, and individualised packages of care for crisis response and community accommodation in the community. HBDHB is also in the process of redesigning its mental health inpatient unit and the design includes flexibility to accommodate young people experiencing acute mental disorder."

Appendix V: Independent expert advice from Ms Christine Lyall, psychiatric nurse

Ms Lyall provided the following report:

> "I have been requested by the Commissioner to provide an opinion on case number 05/05329/WS. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a Registered Nurse (Registration number 069024), gaining registration in 1980 with mental health nursing defined as my scope of practice. I have a Bachelor of Nursing degree (Otago Polytechnic, 1999) and a Master of Arts (Applied) in Nursing (Victoria University of Wellington, 2004).
>
> The majority of my almost thirty-year career has been spent in general adult mental health. The last five of these have been in either senior clinical or managerial positions. My previous position was that of Unit Manger in an acute inpatient mental health unit. Since June of this year I have been working within a Primary Health Organisation as a specialist mental health nurse. A component of this position is that of liaison with general practitioners, non-government organisations and District Health Board provider arm services.
>
> I have been requested by the Commissioner to provide expert advice on a number of questions. These are:
>
> 1. *In your professional opinion, was the service the staff at Serenity House and Hawkes Bay District Board provided to [Ms A] appropriate? Please give reasons for your opinion, with reference to the individual staff members involved.*

[Ms A] was transferred to Serenity Home from the Child Adolescent Mental Health Service (CAMHS) team [in another city]. An initial assessment was completed by Ms B (social worker), Hawkes Bay District Health Board (HBDHB). The initial assessment form completed at that time suggests that a mental state examination was not completed and that a risk management plan was not required.[7] This is evidenced by circling of the prompts in the left margin of the page. The *Guidelines for clinical risk assessment and management in mental health services* (1998)[8] suggest that 'Risk assessment is an integral part of *every* clinical observation or assessment. Risk

[7] Health and Disability Commissioner supporting information p35.
[8] Guidelines for clinical risk assessment and management in mental health services (1998) Ministry of Health.

assessment does not occur on a 'one off' basis, but is ongoing, with a particular emphasis at 'critical points', such as:

- first contact with a service
- change or transfer of care
- change in legal status
- change in life events (eg, loss)
- significant change in mental state
- discharge, or move to a less restrictive environment.

All individuals presenting to, or under the care of a mental health service should be assessed for risk. The detail and specificity of such assessment will vary according to circumstance and past behaviours, but every individual should at least be screened for risk.

[Ms B] proceeded to say that there was an appropriate risk management plan which had been developed by [Dr G, psychologist]. This plan was completed on the [date].[9] The plan would remain the same and no risks were to be added.[10] A clinical risk alerts factors form[11] was completed by [Ms B], it identified that [Ms A] had a previous risk of suicide and self harm but current risk was not present. [Ms A's] circumstances had altered considerably since the risk management plan [was completed], not least her move to Serenity Home.

The plan from this initial meeting was that [Ms B] would arrange a non-urgent psychiatric appointment and liaise with [CAMHS 2]. There was a two week delay before [Ms B] contacted [Dr G] and also requested [Ms A's] [notes]. It was a further nine days before she spoke with [Dr J] regarding [Ms A]. The doctor said he would like to speak with [Ms A's] previous psychiatrist before making an appointment. The delay in contacting [CAMHS 2] and arranging a psychiatrist appointment is, in my opinion, unacceptable. [Ms B] visited [Ms A] once at Serenity Home in the time from the initial appointment until [Ms A's] death. As her key worker I would expect there to have been a more concerted effort to develop a relationship with [Ms A] given her history and presenting problems.

In my opinion a complete mental state examination, including risk assessment and management plan should have been completed as soon as possible by HBDHB Mental Health Services following [Ms A's] admission to Serenity Home.

[9] Health and Disability Commissioner supporting information p106–109.
[10] Ibid p36.
[11] Ibid p27–28.

The staff at Serenity Home requested a medical review [following Ms A] attempting to [commit suicide] the previous night. This review was not made available and in fact later that day [Ms A's] file was closed to key worker intervention at the suggestion of the HBDHB clinical leader, [Mr I]. It appears from the Serenity Home progress notes that [Ms A's] mental health was deteriorating.[12] The referral information [from DHB 2] states that '[Ms A's] distress may escalate to crisis proportions and her safety may be in question.'[13] Taking these factors into account it is inappropriate that the keyworker's intervention file was closed without some other arrangement having been made for follow-up.

The service provided by Serenity Home staff was appropriate. The contract they have with the HBDHB and Accident Compensation Corporation (ACC) is to provide a long-term residential therapeutic community for women with a diagnosis of personality disorder.[14] They are not equipped to deal with people who may be entering an acute phase of their illness. They do appear to be equipped to manage people at chronic risk of self-harm/suicide.

It is usual practice within residential programmes that not all staff have a recognised professional registration. Serenity Home had systems in place to always have a professional either on duty or on-call to provide support when untrained staff was on duty.[15] [After Ms A's] attempted [suicide] the on-call staff member was called and attended the home. On-call staff was again called to the home [following Ms A] cutting her wrist. This wound was reported as being superficial[16] and would not on its own have been a reason to contact the CAT team.

2. What standards apply in this case?

6 Safety
13 Access
14 Entry
15 Assessment
16 Quality treatment and support

[12] Health and Disability Commissioner supporting information p137–141.
[13] Ibid p107.
[14] Ibid p82.
[15] Ibid p59.
[16] Ibid p145.

3. Were those standards complied with?

While all eighteen National Mental Health Sector Standards apply to all mental health service providers the Standards most relevant to the complaint under investigation are noted above.

6 Safety
6.3 Treatment and support offered by the mental health service will strive to protect the person from all forms of neglect, abuse and exploitation.
6.5 Staff are regularly trained to assess and respond appropriately to situations that may compromise the safety of the person receiving the service or others.

13 Access
13.1 the mental health service is accessible to the defined community, is conveniently located and operates at appropriate times.

This may include and is not limited to:
a Psychiatric assessment, acute treatment and support, day programmes and home visiting can be accessed.

14 Entry
14.2 The mental health service has a system for prioritizing referrals according to risk, urgency, distress, dysfunction and disability, and not excluding people with other disabilities or needs.

This may include and is not limited to:
a management of waiting lists
b suicide risk assessment protocol
c crisis intervention service
d emergency psychiatric triage scale.

15 Assessment
15.2 The assessment is comprehensive, appropriate for the purpose, and is conducted using accepted evidence based and culturally safe methods and tools.

15.5 Each person using the service should be re-assessed regularly using the above criteria.

16 Quality treatment and support
16.3 An individual plan is developed collaboratively with each person receiving the service and other persons as nominated by them. A copy is provided to the person receiving the service.

16.4 The identification of early warning signs and relapse prevention is included in the individual plan. Each person receiving the service and their family, whanau

receives assistance to develop a plan that identifies early detection or warning signs of a relapse and the appropriate action to take.

16.5 Each person within the service has an individual plan that is based on a comprehensive assessment and identified needs, and is specific to that individual's stage in the recovery process.

16.9 Mental health service staff review the outcomes of treatment and support for each person receiving the service.

16.10 The review is comprehensive, appropriate for the purpose, and is conducted using accepted evidence based and culturally safe methods and tools.

16.11 a review of the individual plan shall be completed when significant changes for the person receiving the service occur.

This shall include and is not limited to ensuring reviews are conducted when the person receiving the service:

a requests a review
b has a decline in his/her health
c Self-injures or injures another person
d declines treatment and/or support.[17]

The documentation provided does not reflect compliance with these standards.

If not covered above, please answer the following:

4. *Should Serenity House staff have contacted CATT after [Ms A] attempted to self harm [the first time]?*

The notes[18] reflect that [Ms E] who was on-call was contacted and spent 1½ hours with [Ms A] and other residents. Following this assessment Serenity Home staff contacted the key worker, [Ms B], the following day to apprise her of the incident.

This delay in contacting the mental health service was not unreasonable.

5. *In view of [this] self harming attempt, should [Ms A] have been seen by a psychiatrist [when the request for a psychiatrist review was made], rather than be put on the waiting list?*

It would not be unreasonable as a minimum to expect the key worker or crisis worker to attend and assess following such an incident. An urgent medical review

[17] National Mental Health Sector Standards NZS8143:2001.
[18] Health and Disability Commissioner supporting information p 147.

may subsequently be requested. Staff in residential Homes generally know the people in their care well and do not request a medical review without cause.

6. Was it appropriate for [Ms B's] key worker intervention file to be [closed]?

See above page 5.

7. Was [Ms D's] assessment of [Ms A] appropriate?

The New Zealand Nursing Council Competencies for Entry to the Register of Comprehensive Nurses (2002)[19] recognises that nurses make professional judgements that will enhance nursing practice. There are specific mental health performance criteria related to the professional judgement competency. Three of these criteria are: assesses situations in a mental health setting in a manner that reflects an understanding of safety issues and patient/consumer needs; identifies the mental health care needs of the patient/consumer in partnership with the patient/consumer, their family and whanau; makes clinical nursing judgements based on current nursing knowledge, psychotherapeutic principles and critical reflection (p 11). Another of the competencies, management of the environment, states the nurse assesses risk factors and identifies strategies that maintain own, patient/consumer and others' safety (p 15).

[Ms D] accessed the notes from DHB 2 [dated …].[20] I have some concerns regarding using these notes to form an opinion and as the basis for the assessment. These are:

the length of time since that assessment; Serenity Home staff's concerns; [Ms A] stating that she was unsure if she could maintain her safety; increased use of PRN medication; chronic suicidal ideation/impulsive acting on same.[21]

[Ms D] states that [Ms A] declined admission and that Serenity Home had equivalent level of supervision. The staff member on duty at Serenity Home that night was a support worker working on her own with the support of other residents and the ability to contact the on-call person. An in-patient unit would have registered nursing staff and access to medical staff.

8. Was the plan for [Ms A's] care made after Ms D's assessment appropriate?

[19] New Zealand Nursing Council (Amended 8 February, 2002) Competencies for Entry to the Register of Comprehensive Nurses p 10.
[20] Health and Disability Commissioner supporting information p43.
[21] Ibid p43.

The third standards of practice for mental health nursing in New Zealand[22] is the 'mental health nurse provides nursing care that reflects contemporary nursing practice and is consistent with therapeutic plan.

The mental health nurse is able to:

iv Facilitate the process of comprehensive nursing assessment
v Assess the contextual factors which are impacting on the consumer and therapeutic relationship
vi Identify and interpret recurrent patterns of behaviour
vii Collaborate with consumer, family or whanau, and other colleagues to develop a nursing plan for care
vii Document assessment outcomes, nursing management plan, strategies for care and outcomes.'

Faxing notes to CAMHS seeking an out-patient appointment and follow-up late [in the evening] would not result in a medical review occurring in a timely manner. To have [Ms A] noted as a client of concern and for the CAT team to be available[23] over the long weekend indicates that [Ms D] was concerned for [Ms A's] health and wellbeing.

[Ms D] did not discuss her assessment and plan with other CAT team staff or the on-call medical staff. She states 'that the assessment was conducted 5 days post the attempted [suicide] rather than in response to an acute presentation.'[24] This decision does not take into account the use of PRN medication prescribed by [Dr N] (GP) and the Serenity Home staff's concern at [Ms A's] impulsivity and the decline in her ability to maintain her safety.

9. Should [Ms A] have been admitted to the Intensive Psychiatric Care Unit (IPCU)?

Admission would appear to have been indicated given the reasons outlined above in the responses to questions 7 and 8.

[22] Australian and New Zealand College of Mental Health Nurses (1995) Standards of practice for mental health nursing in New Zealand p11.
[23] Health and Disability Commissioner supporting information p44.
[24] Health and Disability Commissioner supporting information p 255.

10. Was Serenity House's 1:1 support on the evening [prior to Ms A's death] appropriate?

It was noted by [Ms D] that 1:1 staff supervision was in place. 'staff to sleep in the same room as [Ms A].'[25]

11. Should Serenity House have done anything further [that evening] to support [Ms A]?

Taking into account [Ms A's] impulsivity and that there had been two previous incidents it may have been appropriate for staff to be awake and able to observe [Ms A]. This would appear to be beyond the staffing requirements for Serenity Home. Their contract with the DHB quotes the following 'one staff member will be directly available from the hours of 10pm to 6am to respond to the identified needs of the consumers.' The staff member is not required to remain awake, but is available for support on the request of the client.[26] Serenity Home had been supporting and maintaining [Ms A] for several days prior to the incident which resulted in [Ms A's] death.

The Blueprint for Mental Health Services in New Zealand [27] is clear with regard to an individual's safety while accessing mental health services.

5.10.3 Clinical responsibilities for reducing the risk of harm

The potential for an individual to harm themselves or others, or to be harmed by others, is sometimes increased as a result of a mental illness and the change in life circumstances it may create. For this reason, procedures designed to reduce the risk of harm are an integral part of clinical practice (and the recovery approach); they should be stated as formal requirements for the provision of any clinical service in any setting, in order to maximise safety for all people. Services should implement the *Guidelines for clinical risk assessment and management in mental health services* (1998) which have been developed by Ministry of Health in partnership with the Health Funding Authority specifically to provide a basic framework to guide and aid mental health clinicians to better assess and manage clinical risk.

Guidelines for community and hospital services need to cover the following:

[25] Ibid p255.
[26] Ibid p152.
[27] The Blueprint for Mental Health Services in New Zealand (1998) Mental Health Commission, p 53–54.

• ***Individual assessment of the potential for harm***

Services require clear protocols for assessing the risk of harm for all people on first contact with mental health services and then regularly as part of their ongoing treatment. This assessment should be based on all available information about past and present harmful behaviour.

Are there any aspects of the care provided by Serenity House or Hawkes Bay District Health Board that you consider warrant additional comment?

It is clear from the documentation provided that tensions exist between Serenity Home and the HBDHB. It would be desirable for the organisations to attempt to resolve the issues and tensions to ensure both parties can assist the people in their care to the optimal level."

Appendix VI: Independent expert advice from Mr Reg Orovwuje, social worker

Mr Orovwuje provided the following report:

> "In preparing this report, I have read the supporting documents as outlined above. I also reviewed pertinent professional articles and publications on best practice and evidenced based assessment and management of people at risk of suicide, and current publications on clinical care/case/key management functions in mental health service delivery, including the following:
>
> - The Health and Disability Code of Rights for consumers.
> - Competent Social Work Practice (The Code of Ethical Standards and Principles) of the Aotearoa New Zealand Association of Social Workers.
> - The New Zealand Mental Health Standards.
> - The Assessment and Management of People at risk of Suicide, Ministry of Health 2003.
> - Guidelines for Clinical Risk Assessment and Management in Mental Health Services, NZ Ministry of Health 1998.
> - Redesigning Mental Health Access and Choice Service Improvement Guide, National Institute for Mental Health in England, 2003.
> - Care Management and Assessment; Practitioners Guide. Department of Health and Social Services Directorate, Scottish Office, Social Work Services Group, HMSO, London, UK.
> - Caring for People in the Community: The New Welfare, edited Michael Titter and Jessica Kingsley.
>
> I requested additional information from the Health and Disability Commissioner on 29 May 2006, concerning supervision provisions, job descriptions, certificate of competency to practice and an explanation of the implications of a 'Closed File' at Hawkes Bay DHB. I also sought information on the nature and role of the Needs Assessment and Service Coordination ('NASC'). I sought clarification on the non-attendance of a particular CAT Team practitioner at the Sentinel Review Report on (P 052).
>
> I have read and accepted the Health and Disability Commissioner's Guidelines for Independent Advisors.
>
> I am currently employed as Consultant Social Worker at the Central Regional Forensic, Rehabilitation and Intellectual Disability Service, Porirua Hospital. I am also the Professional Advisor (Social Work) for Capital and Coast District Health Board, Wellington.

I have worked as a mental health practitioner for over 30 years in developing and developed countries. I have presented and published professional papers in my area of specialism.

I hold full membership of the Aotearoa New Zealand Association of Social Workers and before this, the British Association of Social Workers Certificate of Qualification in Social Work. My academic/professional qualifications are as follows:

- Diploma in Social Work (University of Birmingham)
- BSc (Hons) Sociology (London School of Economics)
- Diploma in Social Administration (London School of Economics)
- RMN England and Wales
- MANASW

Opinion: [Ms B]:

1. In your professional opinion, was the service [Ms B] and Hawkes Bay DHB provided to [Ms A] appropriate? Please give reasons for your opinion.

The following summation of critical events, and the extent of [Ms B's] involvement in the provision of clinical care for [Ms A], provides the context for the 'Opinion' offered.

[Ms A], a 17 year old woman, was twice referred to Serenity Trust Home (P 103 &104): by [Dr G] of [Mental Health Services], Child and Adolescent Mental Health Service [of DHB 2], and by [consultant psychiatrist and psychiatric registrar] of [DHB 2] ([Acute Mental Health Service]).

Both referrals were addressed directly to Serenity Home Trust who forwarded the referral to Hawkes Bay DHB NASC [Needs Assessment Service Coordinator], who in turn sent it to Hawkes Bay DHB CAMHS (P 031).

The referral by [the consultant psychiatrist and psychiatric registrar] identified [Ms A] as a person with long psychiatric history with a number of diagnoses including: depression with anxiety, associative disorder, post traumatic stress disorder, borderline personality disorder with deliberate self-harm and chronic suicidal ideation. [Ms A] was reported to have an extensive drug history including using cannabis and psychedelics and was 'currently using cannabis' at the time of the referral from [DHB 2] (P 104). [Ms A] was reported to have suffered multiple losses within her friends and family, multiple stresses within her family and chaotic family dynamics.

[Ms A] presented to DHB 2 Mental Health Services [after] she slashed her forearms and was alarmed when she saw blood. She was reported to be concerned regarding 'the enemy who tried to influence her mind but did not protect her'. [Ms A] was also reported to be displaying depressive symptoms such as insomnia, anorexia, hopelessness, suicidal ideation, and had plans to take an overdose of Paracetamol and slash her wrist sometime later that week.

During her time in hospital [Ms A] was found in her room [attempting to harm herself] while feeling anxious and distressed, and admitted that it was a regular occurrence: she would use a variety of objects, [to harm herself] without intending suicide (P 104 to 105).

At the time of the referral from [DHB 2] to Serenity Trust Home [Ms A] had had three admissions to [the Acute Mental Health Unit], [DHB 2]. [The consultant psychiatrist and psychiatric registrar] noted in their letter of referral to Serenity Trust Home that in view of the nature of [Ms A's] history and symptoms it would be 'more beneficial for [Ms A] where there is more expertise involving people with grief, trauma, depression, borderline personality traits, deliberate self harm etc' (P 105).

[Dr G] in completing the referral form for Serenity Trust Home noted [Ms A's] current diagnosis as:

Axis 1: Depression, panic attacks, PTSD, Dissociative Disorder.
Axis 2: Borderline Personality Traits
Axis 3: Hyperventilation.
Axis 4: Multiple Losses, multiple stresses within family, raped.
Axis 5: GAF 50

[Dr G's] reasons for referral was because [Ms A] was 'suffering from a variety of difficulties (depression, anxiety, mood changes, perceptual sensory distortions, frightening dreams, a presence which she calls 'the enemy') which has led her to despair about her future and her on-going existence' and [Ms A] had sought solutions through dysfunctional tactics — [self-harm], occasional cannabis use, attempting suicide by various means — […] (P 087).

[Dr G] in his letter of referral to Serenity Trust Home noted that he found [Ms A] to be 'an intelligent and creative person to work with but feel that her environment here is not sufficiently supportive and the emotional attrition which she would undergo if she waits until she is older before gaining access to a therapeutic environment may overwhelm her and remove her hope of a meaningful life trajectory' (P 104).

[Dr G] prepared and forwarded to Serenity Trust Home a comprehensive, detailed and updated Risk Management Plan dated […]. (P 106). The Risk Management Plan focused on historical background clinical issues, safety issues, elective admissions and emergency department episodes.

[Ms A] was on a range of prescribed medications for her condition.

Serenity staff noted that [Ms A] was gang raped twice in 2002 and 2003 — and conceived from one of these rape incidents (P 89).

[Ms A] had had previous admissions in 2003, to [DHB 2], [a children's hospital] CFU in [July/August], [DHB 2] [October], [DHB 2] [December], and 2004 [DHB 2] [February].

[Ms A's] expectations of her placement at Serenity Home were 'To get my sickness sorted out, my depression and harming myself. I have a lot of aspirations and goals I want to achieve and to do something meaningful and productive with my life'. [Ms A] rated her motivation to recover from her illness as 7 on a scale of 1 to 10 'because I really want to get better and get a normal life back'. [Ms A's] aspirations/needs are itemised on P101 of the [Psychiatric Residential Support Needs Assessment report] (P 101). On P 100 of the Needs Assessment under reference the amount of support needed for [Ms A's] illness/disability were as follows on a scale of 1 to 4:

Address symptoms of psychosis (4).
Address symptoms of mood disorder (4).
Address symptoms of alcohol abuse (N/A).
Address symptoms of substance abuse (N/A).
Address symptoms of anxiety disorder (4).
Manages medication requirements including side effects (4).
Manage socially embarrassing/disruptive behaviour (4).
Manages suicidal thoughts/impulses (4).
Manages risk of self-harm (4).
Manages risk of harm to others (3).
Able to recognise early warning signs (3).

The [Psychiatric Residential Support Needs Assessment] expected 'CAMHS can continue to offer med reviews & therapy' and that 'CAMHS would recommend [a residential home] for [Ms A]' (P 101) presumably in the city of DHB 2 since the needs assessment was dated 16 September. [Ms A's] support level at that time was level 3.

The general pattern of activities and mental state that characterised her initial stay at Serenity Trust Home [dates]: repeated lateness in getting out of bed, lacking

energy, cooking good meals, chilling out, helping with house chores, retiring to her room for space, seeking changes in her condition, adhering to medication regime, occasionally 'chatty' with fellow clients/staff, participating in programmes, sleeping well, well grounded at times, having relaxing baths, listening to music alone in her room, occasional outings with staff, making telephone calls in her room or watching television with clients and staff.

The [following period] (P 127 to 148) was also characterised by similar activities and mental state, except that there were developing issues relating to [Ms A] and her boyfriend, occasional upsets from telephone discussions with her mother, cannabis use, experiencing migraine and the fear of losing her place at Serenity Trust Home, attempted suicide, self harm and a successful suicide.

[Ms B] had her first personal contact with [Ms A] for assessment purposes on [date]. (P 256 & 257).

[Ms B] is a qualified Social Worker who holds an Aotearoa New Zealand Association of Social Workers (ANZASW) certificate of competency to practice (dated 26/11/04). [Ms B] also holds an annual practising certificate (Expiry date 30 June 2006), and certificate of registration from the Social Workers Registration Board (dated 17/6/2005). [Ms B] has been practising as a social worker in New Zealand and overseas for about six and a half years.

[Ms B], in response to the Health & Disability Commissioner's questions on the risk assessment of [Ms A] , states that 'I completed a risk assessment of [Ms A] on my initial meeting with her at Serenity Home [when I met with her] and her Serenity Home Key Worker, [Ms H]. This assessment was based on [Ms A's] presentation at that time and the information that I had available to me from the initial CAMHS triage, [Ms A] herself and Serenity Key Worker, [Ms H]'. [Ms B] referred readers to the clinical Risk Alert/Factor assessment in [Ms A's] mental health file (P 256).

[Ms B] referred to the fact that [Ms H] and [Ms A] had reported to her ([Ms B]) that [Ms A] 'had settled well into the Serenity environment and that she had not presented with any risk to herself or others in the [time that she had been at Serenity Home]'. [Ms B] noted that both [Ms A] and [Ms H] were very positive about her progress and the initial assessment concentrated on how well [Ms A] had adjusted to her new therapeutic environment. [Ms B] noted that [Ms H] was very aware of [Ms A's] history of risk and had extensive supporting documentation from CAMHS 2 including a copy of psychologist [Dr G's] existing management plan for [Ms A] (P 256).

[Ms B] believed that 'At that time, as no current risk was being presented, we agreed that [Ms A's] existing risk management plan was appropriate, particularly

while [Ms A] continued to undertake the extensive assessment and treatment programme being offered to her at Serenity Home. Keeping existing risk management plan also allowed Serenity time to become more familiar with her presentation before adjustments to the plan would be made'.

[Ms B] noted that she had her first involvement with [Ms A] when she 'triaged a referral from [Ms E] at Serenity (see triage document in file)'. She was informed by [Ms E] that '[Ms A] would be moving [to Serenity]' and that Serenity was requesting Key Worker support within the Child and Adolescent Mental Health Service (CAMHS). [Ms B] noted that she was informed that [Ms A] was 'currently' neither suicidal nor a danger to herself. [Ms B] recorded that referral information had been received — copies of correspondence of referral from [Child and Adolescence Mental Health 2] Specialist Service to Serenity. [Ms B] itemised the referral documents she received.

[Ms B] noted that CAMHS referral/triage was processed by [Mr I], Clinical Leader of HBDHB's CAMHS. [Ms B] was subsequently assigned the position of [Ms A's] Key Worker by [Mr I].

[Ms B] noted that she was unsure of what her role was to be since she (Ms B) understood Serenity Home would provide 'full treatment including their own therapists, day programme and 24 hour support for residents'. [Ms B] noted she agreed to meet with [Ms A] and her Serenity Key Worker' to determine what it was that they required from our service'.

[Ms B] met with [Ms A] and her Key Worker [a few days later than initially intended] because [Ms B] was sick (P257). [Ms B] was accompanied by [Ms L] (CAMHS Key Worker and Kaimaanaki). [Ms B] completed an initial risk assessment which was set out in [Ms A's] Mental Health file — the Clinical Risk Alert Factor assessment. [Ms A] and [Ms H] confirmed [Ms A's] movement to Serenity on [date]. They noted that she had settled in well in her progress at Serenity — and that [Ms A] had shown no symptoms or signs of risk since her stay in Serenity. [Ms A] had stated her desire to get better (P258).

[Ms B], in discussing her role with [Ms H], noted that she was informed by the Serenity Key Worker that Serenity would 'be responsible for overseeing [Ms A's] clinical care' and that [Ms B] 'would not be undertaking any therapeutic work with [Ms A]', nor having clinical input into the treatment programme at Serenity. They agreed that the current risk management plan for [Ms A] would remain until Serenity staff further re-assessed [Ms A].

[Ms B] expected Serenity Home to arrange a review meeting to coincide with Serenity Homes' regular monthly review meetings, which [Ms H] accepted.

[Ms B] noted that [Ms H] perceived her role as 'a person outside of Serenity for [Ms A] to liaise with' and who would arrange non-urgent appointments for [Ms A] to see a CAMHS psychiatrist. [Ms B] expressed her concern at being excluded from having input into [Ms A's] care and treatment (P258) and mentioned this to [Mr I]. [Ms B] noted that it was agreed at the meeting that she ([Ms B]) would liaise with [Dr G] 'to get a further sense of [Ms A] and some further clarification'. [Ms B] noted difficulty in accessing [Dr G] and noted that Serenity was already in contact with [Dr G] and [Ms A] was able to speak with [Dr G] on phone.

[Ms B] noted (P 259) that she and [Ms H], the Serenity Key Worker, agreed that '[Ms H] to key-work and [Ms A] to contact writer should she need to. Non-urgent medical review to be arranged'. [Ms B] noted that 'This was the only occasion that I met with [Ms A].

It is pertinent to put in perspective and to note that a series of systemic failures, confusion/distortion of roles, lack of attention and delayed actions from HBDHB CATT and CAMHS converged to compromise [Ms A's] quality of care at Serenity Trust Home.

The absence of clear interface policies, protocols and guidelines by Hawkes Bay DHB at its service inter-face with Serenity Trust Home appears to have disrupted the continuity and timeliness of clinical care delivery for [Ms A]. This may have implications for evidenced based practice and good risk management for [Ms A].

Examples of service fragmentation are inferred from the letter (dated 2 June 2006) by [Ms B's Legal Advisor], to the Health and Disability Commissioner in which it was noted that 'Needs Assessment and Service Coordination ("NASC") is not an independent service jointly used by HBDHB and Serenity House. NASC is a service funded by HBDHB and operates within the adult mental health and addiction service ("MHAS"). NASC works with adult clients of MHAS; it does not work with adolescent clients (and therefore CAMHS clients)'.

The CAT Team had no overall knowledge across the service of when, who and what services were involved with [Ms A] at HBDHB when [Ms D] assessed [Ms A]. The [lawyer] (representing Ms D) in his letter to the Health and Disability Commissioner dated 1 March 2006, noted that: 'Despite being responsible for the initial CATT Assessment, [Ms D] did not have available to her the CAMHS file. [Ms D] was not aware that [Ms A] had been seen by CAMHS or that her Risk Management Plan from [DHB 2] was amongst documentation in the possession of CAMHS. Had the CAMHS file been made available, [Ms D] would have had a greater understanding of the background and context in which she was assessing [Ms A]' (P 320).

In her brief intervention with [Ms A], [Ms B] appears to have predominantly documented contents of already existing records on [Ms A] — except for the documented assurances [Ms B] received from [Ms H] (Key Worker for [Ms A]) and [Ms A] on the good progress and risk free stay at Serenity House.

The initial assessment of risk lacked purpose and disregarded Hawkes Bay DHB policies, even as an initial assessment. The Hawkes Bay DHB Child and Adolescent Mental Health Service Job Description for Social Workers states that 'The DHB will foster an environment, which values and encourages innovation and learning, for its own staff, for clients, and for health organisations in the district" … and that it would step outside traditional approaches and find new ways, and new opportunities'. The HBDHB strives 'to meet the needs of patients, clients and the community; and to pursue clinical standards and excellence'. The job description under clinical assessment details the following:

> 'Consumer Tangata/Whaiora will be seen for an assessment at the earliest available appointment.
>
> A comprehensive assessment to meet service policies and procedures will be taken and recorded.
>
> Significant others will be involved in the assessment process where appropriate (e.g. family/whanau, caregiver).
>
> Clinical risk will be assessed and managed according to service policies and procedures'. (Additional document obtained on request).

The HBDHB Discharge Plan form (P 048) was not completed, except the entry that states 'Please see initial assessment and Risk Plan'.

The HBDHB Mental Health Services Clinical Risk Alert Factors (P027) was completed by [Ms B]. All risk factors were rated under 'Previous Risk' and 'Previous History of.' There was no current risk identified.

The risk assessment outcome is not consonant with the Ministry of Health Guidelines for Clinical Risk Assessment or the Ministry of Health Best Practice Evidence-Based Guideline for the Assessment and Management of People at Risk of Suicide (see 28, 29, 30 below).

The risk assessment by [Ms B] failed to meet Standard 1 of the Aotearoa New Zealand Competent Social Work Practice which states that 'The social worker establishes an appropriate and purposeful working relationship with clients taking into account individual differences and the cultural and social context of the client's situation'.

[Ms B] appears not to have met some of the requirements by not establishing, sustaining and concluding her relationship with [Ms A] in a planned way. [Ms B] appears not to have focused on the development of personality, life stages and crisis, normal and abnormal psychology and behaviour, relationships, inter-personal behaviour, socialisation, cause and consequences of illness and disability and divergent/dysfunctional behaviour.

The assessment of risk by [Ms B] failed to focus on psychosocial, clinical and environmental issues by working systematically from the past to the present. The assessment [conducted before] CAMHS closed [Ms A's] file, appears not to have commenced the process of a Mini Mental State examination. There was no indication of what plans were in place to complete the mandatory number of interviews as specified in HBDHB CAMHS policies on clinical assessment.

[Ms B] noted that [Ms A] and [Ms H] gave her assurances of a risk free stay at Serenity. Given the clinical history of [Ms A], these assurances do not change the significance of the serious omissions in the assessment process.

The service [Ms B] and Hawkes Bay DHB provided to [Ms A] appears to be sub-optimal and therefore not appropriate for the following reasons:

It was acknowledged in the 'Report for Coroner' by Hawkes Bay DHB that Needs Assessment Service Coordination (NASC) received the referral and copied it to Child and Adolescent Mental Health Service (CAMHS) for Key Worker allocation prior to [Ms A's] admission to Serenity Trust Home (P 013).

It has to be noted that at the time of the referral NASC was responsible only for the adult section of mental health services and not CAMHS.

The referral papers contained sufficient clinical information to alert CAMHS to [Ms A's] complex needs and on-going at-risk behaviour.

The referral papers are listed as follows:

- Two letters to Serenity from [Dr G] (clinical psychologist, dated […]).
- Letter to Serenity from ([referring psychiatric registrar], dated […]).
- SNAP assessment.
- Serenity form completed by [Dr G].
- An existing risk management plan completed by [Dr G] (previous therapist at Child and Youth Mental Health Service, [CAHMS 2]).
- Serenity form completed by [Dr G].
- An existing risk management plan completed by [Dr G] (previous therapist at CAHMS 2).

The Social Worker, [Ms B], triaged the referral papers on [date] (twelve days before [Ms A] was admitted to Serenity Trust Home). [Ms B] informed [Mr I], Clinical Leader, of the referral papers on [Ms A]. It is unclear whether [Mr I] presented the referral papers to the multidisciplinary team at CAMHS for review and action before assigning a Key Worker. [Mr I] subsequently assigned [Ms B] as Key Worker on [date] — 20 days after [Ms B] triaged the referral papers at CAMHS, and 9 days after [Ms A] was admitted to Serenity Trust Home. [Ms B's] first face-to-face contact with [Ms A] for initial assessment was [16 days] after [Ms A] was admitted to Serenity Trust Home.

It would appear that a relaxed/delayed clinical approach to assessing and addressing [Ms A's] needs impacted on [Ms B's] initial clinical assessment — resulting in lost opportunities and distortions in collaborative working between Serenity Trust Home and Hawkes Bay DHB to determine appropriate treatment pathways for [Ms A].

[Ms B] was uncertain of her role and raised concerns with her team leader after a meeting with Serenity Trust Home (with [Ms H]) where she sought clarification of her role as Key Worker (presumably in the absence of definitive policies/Memorandum of Understanding and/or guidelines for engagement at the service inter-face between Hawkes Bay DHB and Serenity Trust Home).

The sequel to [Ms B's] meeting with [Ms H] was [Mr I's] meeting (on [date]) with Serenity Trust Home and the decision to close [Ms A's] file at CAMHS. [Ms A] attempted to [self-harm on [date]. The closure of the file and the abrupt termination of the Key Worker input, (ostensibly for reasons of possible risk to CAMHS Key Worker) further compounded the confusion/uncertainty surrounding the clinical management of [Ms A]. In the event, [Ms A] commenced the series of crises that culminated in the successful suicide on [date].

The response to Serenity's request for clinical support was an appointment which came too late. The absence of a Key Worker meant that no advocacy existed at HBDHB for [Ms A]. This was subsequently reflected in [Dr J's] hesitation and doubts in responding to [Ms B's] request for a clinical /medication review at critical periods for [Ms A] and her care givers at Serenity Trust Home.

The confusion and delay in responding to requests from Serenity Trust Home appears to have marred Hawkes Bay DHB CAT Team's subsequent interventions at critical times for [Ms A] and staff at Serenity Trust Home. The internal confusion and debate in HBDHB about which service should respond to Serenity's request for CATT involvement appeared to lead to the delay in CATT's response ([date]).

Controversies, lack of trust and frustrations intensified between staff from both services. This culminated in recriminations between staff at Hawkes Bay DHB and Serenity Trust Home. Outcomes at inter-departmental clinical meetings in times of crisis became open disputes with implications for clear client pathways and good risk management (P 060, 140, 144).

The consequence was that [Ms A's] clinical care was compromised. The diagnoses were never re-visited and confirmed. The Hawkes Bay DHB 'Report For Coroner' dated […] (P 003) excluded 'Depression' in the list of diagnosed conditions for [Ms A]. Rather, much emphasis was placed on 'Borderline Personality Disorder' which was described as a condition that 'is not a mental illness as such'. The classification would appear to place [Ms A] in a DSM 1V Axis 11 classification — thus implying the assumption that all of the expertise in providing clinical care for [Ms A] rested with Serenity Trust Home.

Such reasoning detracts from the fact that people with borderline personality disorder also sometimes manifest symptoms of mental illness especially when there are co-morbidities. [Dr G] included 'Depression' as Axis 1 on DSM 1V and [the consultant psychiatrist and psychiatric registrar from the] in-patient Unit also included 'depression' in their list of diagnosed conditions. [Ms B] in her assessment noted depression as 'current' and 'ongoing'.

[Ms A's] escalating crisis involving cannabis use and migraine on [date] (P128), [Ms A's] letter (dated … P 129) on the subject of cannabis use and guilt, the emerging problems with her boyfriend, the attempted [self harm] at Serenity House on [date], the self harm by cutting her wrist on [date], the disturbing telephone discussions with her mother — all received only delayed crisis intervention from Hawkes Bay DHB and CAT Team. The placement on the waiting list for psychiatric review at Hawkes Bay DHB CAMHS on [date] was overtaken by events of the successful suicide.

The general practitioner became the main continuous provider of clinical/medication reviews and treatment during the crisis period for [Ms A]. Serenity staff and [Ms B] had made requests for psychiatric consultations and expressed concern at the delay in effecting a psychiatric review of [Ms A]. Serenity Trust Home staff had expressed their concern at the 'unpredictability/showing no warning signs/unable to talk to staff about her feelings of wanting to die' (P 141).

Following the second self-harm [Ms A] was observed by staff to be 'stressing out' about the phone call she made to her mother (P 142). The frequently occurring difficulty [Ms A] found in getting out of bed until late mornings and with promptings from staff — suggesting an on-going struggle with her depressive symptoms. All of these experiences and behaviours appear to be evidence of

changes and deterioration in [Ms A's] mental state which progressed into a rapid descent into crisis mode.

It appears [Ms A's] condition failed to attract a psychiatric assessment or treatment, and a review of care /risk management plans by CAMHS to support the initiatives taken by Serenity Trust Home. For persons with complex needs and on-going at-risk behaviour, comprehensive frequent assessments and care/risk plans are an essential part of good clinical management. 'Clinical risk assessment and management occurs in the context of broader risk management — organisation, financial, political, legal, and so on' (Ministry of Health Risk Assessment).

[Ms B] and HBDHB failed to provide appropriate care for [Ms A], and failure to do so was severe.

2. If the care provided was not appropriate, please explain why.

Hawkes Bay DHB in the Sentinel Review Report (P052) noted the limitations placed on the service through [CAMHS 2] direct referral of [Ms A] to Serenity Trust Home. The documents triaged by [Ms B] on [date] contained sufficient clinical information to warrant attention from Hawkes Bay DHB Children and Adolescent Mental Health Service (CAMHS) and subsequently by CAT Team.

The information contained in the referral documents triaged by [Ms B] should have prompted Hawkes Bay DHB CAMHS to directly contact Serenity Trust Home and the referrers at [DHB 2] and [another community group] for further information on at-risk behaviour and treatment priorities. Such initiative could have helped to clarify additional clinical issues in the management of [Ms A] before her admission to Serenity Trust Home.

Additionally, such an initiative would have helped Hawkes Bay DHB CAMHS in coping with the requests for additional clinical input from Serenity staff in working with [Ms A]. Furthermore, it would have encouraged a collaborative working relationship between Hawkes Bay DHB CAMHS and Serenity Trust staff in formulating a more robust current care/risk management plan for [Ms A's] clinical care — especially in the period of [Ms A's] descent into crisis.

Given that a contract exists between Hawkes Bay DHB (Funder) and Serenity Trust Home (Provider) — although the substance of the contract is not available to the writer — it stands to reason that the inter-face between both services should have had a detailed Memorandum of Understanding and/or Guidelines to deal with the day-to-day relationships between the organisations. It is a given that most specialised Non-Government agencies lack the full range of supportive clinical services to meet the complex needs of some of the clients they manage and [Ms A] falls into the group of clients with complex needs and on-going at-risk behaviour.

There appears to be a failure to clearly enunciate the character and quality of clinical input as well as the roles and responsibilities of staff in the provision of care at the service inter-face between Hawkes Bay DHB and Serenity Trust Home. This appears to have justified what seems to be an ad hoc approach to policy making at the meeting between [Mr I] and Serenity Trust Home (on [date]). It invariably compromised the quality of clinical care delivery for [Ms A].

[Mr I's] subsequent decision to close [Ms A's] CAMHS clinical file further compounded the problem in providing appropriate care for [Ms A] at Serenity Trust Home. The closure of [Ms A's] file by HBDHB virtually coincided with [Ms A's] attempted [self-harm] on [date]. It seems ironic that [Ms B], in her discussions with [Dr G], responded positively to [CAMHS 2] files to be kept open for consultation, while concurrently, HBDHB CAMHS was closing [Ms A's] file. The fact that [Ms H] was seeking clinical advice from a [DHB 2] psychiatrist and clinical psychologist appears to demonstrate/justify the need for extra clinical support in managing [Ms A].

Because of the apparent lack of clarity in the relationship between Serenity Trust Home and Hawkes Bay DHB, clinical decisions and processes were compromised and long periods elapsed before an action, or no action, was taken.

[Ms D's] legal representative in the letter (dated […]) in response to questions from the Health and Disability Commissioner explained that 'Despite being responsible for the initial CATT Assessment, [Ms D] did not have the CAMHS file available to her. [Ms D] was not aware that [Ms A] had been seen by CAMHS or that her Risk Management Plan from [DHB 2] was among documentation in the possession of CAMHS. Had the CAMHS file been made available, [Ms D] would have had a greater understanding of the background and context in which she was assessing [Ms A]'.

[Ms B's] involvement appears to be compromised for similar reasons, with telling clinical consequences for effective initial assessment, re-confirmation of diagnosis, and revision of care and risk plans. The omission seems to be oblivious of the fact that risk is contextual and dynamic and that [Ms A] had a long complex and clinical history of at-risk-behaviour.

[Ms A] had moved from [the city] where she lived with her mother and brother to Serenity Trust Home, a therapeutic facility. [Ms B] wrote that on [date] (P036) an appointment was 'attended by [Ms A], [Ms H] ([Ms A's] Key Worker at Serenity Home), Writer & [Ms L], CAMHS Kaimanaaki for an initial assessment of [Ms A]'. The assessment noted the following:

> [Ms A] moved to Serenity home on [date]

[Ms A] had settled well although she talked of missing her mother and boyfriend.

[Ms A] has had an extensive involvement with [CAMHS 2] and had a long psychiatric history, 'and a number of diagnosis including depression with anxiety, associative disorder, PTSD, borderline personality disorder with deliberate self-harm & chronic suicidal ideation'

[Ms A] had 'suffered multiple losses, multiple stressors within her family & chaotic family dynamics'.

[Ms A's] mother was 'currently on methadone programme'.

[Ms A] described her relationship to her mother as 'friendly' and lacking parental support.

[Ms A] was gang raped at a young age.

[Ms A] had an extensive drug history and currently used cannabis occasionally.

[Ms A] 'has an appropriate risk management plan developed by [Dr G], psychologist in [the city where her mother lived]. Liaison required. Plan remains same. No risks to be added'.

'Meds: Citalopram 40 mgs morning, Olanzapine 2.5 mg nocte, Doxepin 50 mg nocte. She also takes Nozinan & movane on a prn basis. [Ms A] would like a medication review'.

'[Ms A] has shown no symptoms and signs since being at Serenity & wants to get better & is now in an environment where she believes she can'.

'Purpose of intervention: a person outside of Serenity for [Ms A] to liaise with

Arrange non-urgent psychiatric appt. [Ms B] to transport

Attend progress meetings at Serenity. Liaise with [CAMHS 2]. [Ms A] has our contact details.

END of Assessment.'

[Ms B] in her response to the Health & Disability Commissioner's request for information dated […] (P 256) explained the type of risk assessment she carried out during the period she was the Key Worker for [Ms A] . [Ms B] stated that she 'completed a risk assessment of [Ms A] on my initial meeting with her at Serenity Home on [date]'. The assessment was 'based on [Ms A's] presentation at the time and the information I had available to me from the initial CAMHS triage'. [Ms B] noted the following:

[Ms B] says she was informed by [Ms H] and [Ms A] that the latter had settled well at Serenity Home and had presented no current risk to herself or other people.

[Ms B] noted that she and [Ms H] agreed that [Ms A's] 'existing management plan was appropriate, particularly while [Ms A] continued to undertake the extensive assessment and treatment programme being offered at Serenity Home'. The keeping of the existing risk management plan was justified by [Ms B] as offering more time for Serenity Trust Home staff to be more familiar with [Ms A's] presentation and management.

[Ms B] noted that she triaged [Ms A] on [date] following a referral from [Ms E] at Serenity. [Ms E] informed [Ms B] that [Ms A] would be moving from [the city where she lived] to Serenity Home on [date] and that Serenity Home was requesting a CAMHS Key Worker.

Advised by Serenity that [Ms A] 'was not currently suicidal and not currently a danger to her self'.

Recorded referral information received from [DHB 2].

[Mr I], clinical leader HBDHB's CAMHS processed referral/triage and assigned Key Worker role to [Ms B] on [date] after an initial failed attempt to assign a Key Worker.

[Ms B] informed [Mr I] that she was 'unsure what my role would be as I understood Serenity Home provided full treatment including their own therapists, day programme and twenty four hour support for residents'. A meeting between Serenity Home and [Ms B] was agreed to determine 'what it was that they required from our service'.

[Ms B] noted that it was agreed that '[Ms H] to key-work & [Ms A] to contact writer should she need to. Non-urgent medical review to be arranged'.

[Ms B] noted that 'This was the only occasion that I met [Ms A]. I did not meet her subsequently as it was agreed with [Ms H] and [Ms A] that I would only do so at their request'.

[Ms B] noted that she 'did not undertake further risk assessment as it did not seem appropriate'.

[Ms B] felt that for the reasons set out above she did not complete a mental state examination because she had no concerns about [Ms A's] mental state during her

assessment on [date]. [Ms B] expected [Ms H] 'to contact CAMHS should they have concerns about her as an outcome of their assessment or treatment'.

In explaining why a new updated risk management plan was not required for [Ms A] on her move to Hawkes Bay, [Ms B] referred to her previous involvements and noted as follows:

That it was not her specific role to develop an updated risk management plan but 'rather all parties involved with [Ms A's] care, particularly her therapist who would have a more in-depth understanding of any risk [Ms A] was presenting and the appropriate ways to manage these'.

Serenity Home were aware they could contact CAMHS or crisis assessment and treatment team (CATT) if they had concerns.

Serenity had a copy of the current risk management plan.

There were no new risks for [Ms A] when [Ms B] assessed [Ms A] on [date] when [Ms A] was said to be progressing 'really well'.

Serenity was in contact with [Dr G] and therefore [Ms B] believed it was appropriate to maintain the current plan.

[Ms B] accounted for the delays before contacting [Dr G] on [Ms A's] records and in arranging the appointments as follows:

Made numerous unsuccessful phone calls to [Dr G] after the [date] meeting with Serenity.

Was aware that Serenity was liaising directly with [Dr G] — therefore the purpose of her contacting [Dr G] was to obtain additional psychiatric notes for CAMHS psychiatrist when reviewing [Ms A].

[Ms B] was aware that the triage notes previously recorded were already available to Serenity.

[Ms B] spoke with [Dr J], CAMHS psychiatrist (who works part-time at CAMHS), on [date], 6 days after meeting [Ms A]. [Ms B] considered the appointment for review non-urgent since [Ms A] was under the care of Serenity Home.

[Ms B] explained to [Dr J] about [Ms A] being at Serenity Home and she being Key Worker for [Ms A], and of Serenity having their own Key Worker, and that she was not involved in the day-to-day clinical management of [Ms A], but that she had been asked by Serenity to arrange an appointment for [Ms A] to see him.

[Dr J] was unsure of the procedures with Serenity Home and promised to explore this with [Mr I], Clinical Leader. An appointment would not be made until the issues were clarified. [Dr J] was also 'unsure about reviewing without having better understanding of [Ms A's] history and previous prescribing' (P 260).

[Ms B] spoke to [Dr G] on [date] who agreed to fax through the last psychiatric consultation. [Ms B] informed [Dr G] of Serenity seeking psychiatric consultation and [Dr G] agreed to leave open [CAMHS 2's] clinical file and that he would liaise directly with [Ms A] at Serenity Home.

[Ms B] spoke to [Dr J] on [date] and informed him of her conversation with [Dr G]. [Dr J] wanted to speak with [Ms A's] previous psychiatrist before making an appointment to review [Ms A]. [Ms B] noted that [Dr J] had not heard from [Mr I] regarding the clarification of roles with Serenity or policies or memorandum of understanding — which was the primary cause for the delay in offering review appointment to [Ms A]. [Ms B] requested that [Dr J] reviewed [Ms A's] file and arranged an appointment to review her.

In response to the Commissioner's question as to whether [Ms B] reviewed [Ms A] after her attempt to commit suicide on [date], [Ms B's] main responses were as follows:

'Received information from [Ms H] on [date] giving details of [Ms A's] attempted suicide but was assured [Ms A] was "settling well".' A psychiatric/medication review for PRN, was requested by [Ms H], Serenity Home because [Ms A] was 'having fleeting thoughts of wanting to die'. At that time [Ms H] felt able to monitor [Ms A] and did not feel she was an immediate risk of a repeated attempt as she was 'remorseful about her attempt'. [Ms B] recommended a consultation with the general practitioner as soon as possible, and that she would try and arrange a psychiatric review for [Ms A].

[Ms B] spoke to [Mr I] about the delay in offering a psychiatric appointment being 'inappropriate' and the need for 'more immediate clarification'. [Ms B] noted that she also informed [Mr I] of [Ms A's] attempted suicide and Serenity's subsequent request for psychiatric review. [Ms B] discussed her role and the discomfort she felt — having no clinical in-put to [Ms A's] care, yet receiving disturbing information about her and being expected to arrange a psychiatric review for [Ms A]. [Ms B] informed [Mr I] of the difficulties she was experiencing.

[Mr I] agreed with [Ms B's] statement that 'it was inappropriate for me to be involved if my role was just to secure a psychiatrist appointment'. [Mr I] said 'he and other HBDHB staff had arranged to meet with Serenity that day to discuss this very matter' in view of expressed concerns by [Dr J] and [Ms B], and promised to give feed back on outcome of the meeting on staff roles and

responsibilities to [Ms B] (P261). [Mr I] phoned [Ms B] the same day to give feedback on the meeting with Serenity and confirmed that 'it had been agreed with Serenity that CAMHS would close [Ms A's] file to my Key Worker intervention on [date]' and asked [Ms B] 'to close' the file on [Ms A]. [Dr J] being part-time could not see [Ms A] after [Ms A's] attempt to [commit suicide], but would meet with [Ms B] the following day to arrange an appointment. [Ms B] was informed by [Mr I] on the same day to close the file, and that he ([Mr I]) would be responsible for arranging reviews with [Dr J]. (P 262).

[Mr I] in the Sentinel Event Individual/Team Report dated [date] (P 033) noted that 'the involvement of the clinical leader was to address the risk of the Key Worker when a client was treated at Serenity Home'. [Mr I] recorded the facts of the meeting with Serenity which was attended by CAMHS and Adult Community Mental Health Services, and Serenity as follows:

'Agreement that the involvement of Key Workers in the service was unnecessary if the service users are primarily receiving treatment at Serenity House. As such, a situation would for Key Workers enhance risk.

Agreement that if Serenity Home required psychiatric services, they would access the clinical leader, who would set up an appointment with the psychiatrist.

Agreement that if anyone entering or exiting Serenity Home from outside the DHB area, then Serenity would inform the clinical leaders of the relevant DHB services.'

The clinical leader CAMHS ([Mr I]) telephoned [Ms B] on [date] to inform her 'about the new agreement, and that she was to close the file, as she was no longer the Key Worker … The agreement was activated when Serenity House left a telephone message [date] in order to make an appointment with the psychiatrist.'

Before the appointment could be communicated, [Ms K] from Serenity House called and expressed her concern that CATT was not responding to her concerns. She was told that [Mr O], clinical leader CATT would be contacted. This was done immediately afterwards, and [Mr O] stated that he understood the predicament, and that he would respond immediately and would contact Serenity House.

Serenity Home had emphasised that their reason for seeking a Key Worker was to access CATT and psychiatric assessments.

Apparently nothing happened until [date] when the Clinical Leader CAMHS [was informed of] the death of [Ms A].

Hawkes Bay DHB Child and Adolescent Mental Health Service Client Pathway policy (P277) describes the role of the interim/assessing Key Worker as holding 'responsibility for the initial comprehensive assessment and the clinical safety and care of the client and their family'. The Key Worker was 'responsible for coordinating the care plan of the client, providing active treatment and working in collaboration with other clinicians, NGO's, Iwi providers and Government Organisation that provide relevant services'.

[Ms B] as Key Worker and HBDHB CAMHS would appear to have interpreted the role of the Key Worker too narrowly and in favour of therapeutic involvement. The care coordination aspect of the Key Worker for clients with complex needs is equally as important as therapeutic aspects. The absence of therapeutic input does not nullify the importance of the Key Worker whose primary task is ensuring that a client's care needs are maximised using available resources.

Key Workers in the community operate in a variety of settings including a client's home, all clinical facilities and with other providers. Key Workers are responsible for ensuring that all appropriate clinicians are involved in the treatment of an individual client. Key Workers could at times deploy their clinical skills in working with a client. At other times the coordinating functions take precedence. Assisting Serenity Trust Home to access CATT team and arranging psychiatric reviews for clients are important aspects of care. [Ms A] had complex needs and changeable mood states, and her history would suggest caution because of the variability and unpredictability of her behaviour on the day-to-day basis.

Firstly, the decision taken at the meeting between [Mr I] and Serenity Home on [date] appears to be hasty and inappropriate. Secondly, as [Ms A] entered into repeated crisis phases HBDHB CAMHS and Serenity Trust Home should have re-visited the exclusion of a CAMHS Key Worker, which did not occur. HBDHB CAMHS response to [Ms A's] first attempt to commit suicide was tepid to non-existent, partly due to the absence of a CAMHS Key Worker collaborating closely with the Serenity Trust Home Key Worker to provide a comprehensive care/risk management plan for [Ms A].

[Ms B] appropriately dealt with the information Serenity Home gave to her regarding [Ms A's] first suicide attempt by alerting the clinical leader and the psychiatrist at CAMHS to the critical event, and by seeking action and additional clinical information. [Ms B] however failed to visit [Ms A] and Serenity staff in the absence of the clinical leader taking that initiative.

Serenity Trust Home has as its philosophy the provision of a safe and therapeutic community where clients can learn and develop understanding towards themselves (P 62). The brochure states referrals should go through Needs Assessment Service Coordination (P 063). Serenity expects support as stated on 'The Pathway in

Serenity Home, with support of other health professionals, endeavours to equip the client to live a life that they want for themselves' (P 068). Serenity stated its interest in the safety of staff and clients. Serenity procedures (P074) accept referrals from health professionals and request current psychiatrist report and risk management plan (P074) and forward referrals to Service Coordination for SNAPS. Serenity works in collaboration with Hawkes Bay DHB. Any health professional may initiate a referral to Serenity and applications are sent to Needs Assessment Service Coordination to ensure eligibility (P 083).

In her response to the Health & Disability Commissioner ([date]) on [Ms A's] care at Serenity (P058), [Ms E], Manager, Serenity Trust Home raised issues about not having policies regarding HBDHB CATT protocols before the suicide, and that there had been 'battles with CATT from day one'.

[Ms E] suspected the client group was unattractive to Mental Health Services. She believed that Serenity Trust Home have the understanding that Serenity have to contain complex clients in need at Serenity when MHIPU [Mental Health Inpatient Unit] is full. She believes the decision on [date] to leave [Ms A] at Serenity was solely driven by 'a single staff at CATT', and that the decision was 'not agreed to by Serenity at Serenity'. Serenity was 'dealing with an entity not able to make collaborative decisions'. [Ms E] believed that the onus of consulting with 1 & 2 clinical leaders on-call and the Clinical Director lies with CATT members conducting assessments of the client in crisis. CATT's policies and protocols 'are not were not' adhered to in this instance and practice was not consistent with policy.

[Date] In the Hawkes Bay DHB Mental Health Services Clinical Alert Factors form (P 027) [Ms B] recorded under 'Alerts', 'Suicide Risk' and 'Self Harm' as previous risks. [Ms B] also recorded the following under 'Previous History of':

> Self harm ([…])
> Suicide plan — (Chronic)
> Drug/Alcohol abuse — (cannabis, psychedelics)
> Physical harm — (chaotic family dynamics)
> Psychological harm — (Mother — D&A issues — friendship rather than parents)
> Sexual abuse — (Gang raped)
> Impulsiveness — (Anxious, distressed)
> Rational thinking impaired — (correct)
> Depression — ('current' and 'Pevious History of' — On meds. No.)
> Events (loss, conflict, etc) — (multiple losses and grief, chaotic family, sexual abuse)
> Relapse — ('Previous history of'. Wants to get better)

Psychosis/mania — ('Current' and 'Previous History of' — When 'unwell')

[Ms B] made the following additional comments:

> 'Extensive involvement with [CAMHS 2] including five hospitalisations in last 12 months. Moved to HB with a determination to "get better".'

A barely completed undated Hawkes Bay Discharge Plan form was signed by [Ms B] (P 048) who referred readers to her 'Initial assess & Risk Plan'.

Hawkes Bay Child and Adolescent Mental Health Services Client Pathway states under 'Allocation' that 'All referrals received are allocated to an interim/assessing Key Worker, by the Clinical Leader and CAMHS Allocation Team on a case by case basis' and that 'The referral is allocated to an interim/assessing Key Worker to complete the Comprehensive Assessment (within 3 weeks) and Risk Assessment' (P 278). The policy stipulates under 'Goals Have Been Met' (P 279) that 'Mutual agreement between the client, family and the Key Worker that therapeutic interventions goals have been met and discharge arrangements have been made' (P279). Under CAMHS Service Continuum the response time for routine new referrals is 'five working days' (P280). Referrals would involve MDT review and recommendation (P 281).

The Hawkes Bay District Health Board Clinical Review Policy has as one of its Principles 'The safety of the Service User/Tangata Whaiora will be paramount and barriers to manage Service Users/Tangata Whaiora/family care are minimised' (P294). The policy stipulates that reviews should occur on 'Completion of the comprehensive Assessment/Aromatawai Tikanga a Maori within three days of admission to Mental Health In Patient Unit, and 3 visits within the community'. The policy recommends that reviews should occur where there are 'significant changes in Risk Factors' and 'Following any self harm attempt' (P295).

Hawkes Bay DHB Recovery Discharge Planning Policy has as some of its purpose the providing of 'services appropriate to the changing needs of Service Users/Tangata Whaiora'.

'Encouraging Service Users/Tangata Whaiora to maximise opportunities across the mental health services continuum to improve their independence and quality of life.'

'Giving people the best help available whoever they are and wherever they are' (P296).

The policy defined the role of the Key Worker as 'responsible for the general role of overseeing the coordination of a service users care to ensure that the needs of the Service User/Tangata Whaiora are met' (P297).

Hawkes Bay DHB Recovery/Discharge Planning Procedures stipulates standard documentation forms in which recovery/discharge planning is recorded. These include Comprehensive assessment, Risk Alerts, Aromatawai Tikanga Maori, Recovery/Discharge plan, relevant progress notes and a recovery/discharge summary (P 301).

Hawkes Bay DHB Crisis Assessment and Treatment Roles and Responsibilities Guidelines state that 'Key Worker will address their Service Users/Tangata Whaiora's acute presentation during normal working hours'. If the Key Worker is unavailable and/or unable to address the acute presentation, the Clinical Leader, Team Leader/Duty Person will coordinate access to appropriate levels of care (P 312).

The Ministry of Health Best Practice Evidence Based Guideline: The Assessment and Management of People at Risk of Suicide. May 2003 recognised 'Suicide risk to be substantially higher among people with co-morbid substance abuse, depression and hopelessness' (P4). The Guideline states that:

> Assessment should be made as quickly as possible.
>
> Appropriate arrangements to be made where transfer to a psychiatric facility by completing any further required medical procedures.
>
> 'No person who has attempted deliberate self harm or who is expressing suicidal ideation should be categorised to triage category 5 i.e. waiting beyond one hour to be seen by a doctor.'
>
> Case notes should be augmented with structured assessments and the information should include — relevant suicide risk assessments, whanau/family member's concerns, previous psychiatric history, previous treatment received, risk benefit assessments of key clinical decisions (P13).
>
> Management plans are only a guide to usual presentations. They should be over-ridden if the person has made a medically serious potentially lethal attempt or is in an acute distress. In such circumstances consultation with specialist mental health services is essential and a brief admission may need to be considered, irrespective of the directives in the management plan (P16).
>
> A key part of any assessment is a mental state examination — by focusing on appearance, feelings of hopelessness/distress/self dislike/helplessness,

evidence of self-denigration, evidence of change in circumstances, pre-occupation with escape and suicide as the only option.

There is a link between personality disorders and suicidal risk, especially with Borderline Personality Disorder and Anti-Social Personality Disorder (P 20).

Be mindful of Major Depression — acute risk factors: severe ahedonia, insomnia, anxiety, substance abuse, co-morbid depression, recent inter-personal loss or disruption, Borderline Personality Disorder or Anti-Social Personality Disorder — acute risk factors: co-morbid Axis 1 disorders, particularly depression. (P 21).

Basing assessment on the accumulation of risk factors alone is not realistic.

There is an awareness that the key contextual triggering factors and the person's current mental state are more immediately important factors (P22) in the assessment of risk factors (P 22).

Managing people with 'green cards' (24 hours access to crisis team) is a useful but insufficient treatment strategy, and other interventions should also be provided (P25).

Factors that strongly suggest that an admission is required include: the need for medical management of an attempt, more intensive psychiatric management, psychosocial support, the establishment of a therapeutic alliance and crisis intervention fails and the person remains acutely unwell.

In order to reduce the person's risk of suicide, admission should be for more than four days.

For a chronically suicidal person short admissions (1–4 days) may be sufficient.

If the person is not admitted, appropriate arrangements must be made for follow-up with the relevant health provider (e.g. care manager, therapist etc) within 24 hours.

The reasons for not admitting should be clearly documented in the person's file (P 26).

Whether a person meant to die or engaged in self harming behaviour for other reasons, both are dangerous scenarios and are associated with a high risk of death by suicide (P50).

> A major predictor of future suicidality is previous suicidality and 60 to 70 percent of people who die by suicide do so after their first attempt (P52).

The Ministry of Health Guidelines for Clinical Risk Assessment and management in Mental Health Services 1998, considers risk assessment as an integral part of every clinical observation or assessment and that risk assessment does not occur on a 'one off' basis, but is on-going with a particular emphasis at critical points such as first contact with a service, change or transfer of care, change in legal status, change in life events, significant change in mental state, discharge or move to a less restrictive environment (P4).

All individuals presenting to or under the care of mental health service should be assessed for risk — every individual should at least be screened for risk (P4).

Factors to consider when assessing risk are mental state environmental/current factors, and historical information (P5).

3. What standards apply in this case? Were these standards satisfactorily applied by [Ms B] and/or Hawkes Bay DHB?

Standards include:

> Ministry of Health Guidelines Clinical Risk Assessment and Management in Mental Health Services. 1998.
>
> Aoteaoroa New Zealand Association of Social Workers Competent Social Work Practice. July 1993.
>
> Ministry of Health, Best Practice Evidence Based Guideline. The Assessment and Management of People at Risk of Suicide. May 2003.
>
> Hawkes Bay DHB, Foundation Client Pathway Policy (P268).
>
> Hawkes Bay DHB, Policy on Service User/Tangata Whaiora Care Pathway Procedure (P 271).
>
> Hawkes Bay DHB Child Adolescent Mental Health Service, Client Care Pathway (P 277).
>
> Hawkes Bay DHB, Service User/Tangata Whaiora Care Pathway Procedure Policy (P282).
>
> Hawkes Bay DHB Clinical Review Policy (P 294).
>
> Hawkes Bay DHB, Recovery/Discharge Planning Policy (P 296).

Hawkes Bay DHB, Recovery/Discharge Planning Roles and Responsibilities Policy (P299).

Hawkes Bay DHB, Recovery/Discharge Planning Process Policy (P 301).

Hawkes Bay DHB, Crisis Assessment & Treatment Policy (P 307).

Hawkes Bay DHB, Crisis Assessment and Treatment Procedural Guidelines Policy (P 309).

Hawkes Bay DHB, Crisis Assessment and Treatment Roles and Responsibilities Guidelines Policy (P 311).

Hawkes Bay DHB, Job Description for Child & Adolescent Mental Health Service Social Worker. July 2003 (Requested document by writer on 29 May 2006.)

These standards appear not have been adhered to by [Ms B] or by HBDHB — see more detail above.

If not covered above, please answer the following, giving reasons for your opinion:

4. Was [Ms B's] assessment of [Ms A] appropriate?

No. The assessment was a repetition of already existing documentation and she omitted to come to grips with [Ms A's] history of risk, her diagnoses, the contextual triggering factors in her presentation, and an initial approach to psychosocial history. [Ms B] appears to have taken the re-assurance by [Ms H] and [Ms A] at face value and appears not have tried to analyse what the risk-free period of stay at Serenity Home may mean for a person with Borderline Personality Disorder, and did not compare the risk free period with past history of at-risk behaviours in deciding against further probing of [Ms A]. This omission is severe.

5. Should [Ms B] have performed a mental state examination during her assessment?

Yes. A minimum to expect is a mini mental state examination. [Ms B] should have indicated in her first report what her next two interviews would focus on in terms of her clinical objectives and priorities within the next two interviews. The omission is severe.

6. Was it appropriate that [Ms B] did not prepare a new or updated risk management plan for [Ms A] when she moved to Hawkes Bay?

No. Although the risk care management plan from [Dr G] was comprehensive, and updated, it could not be assumed to be current because risk is dynamic and contextual and therefore changes constantly. [Ms A's] movement from [a family home] to a therapeutic organisation meant that this should have been revisited and reviewed. The care/risk plan from [Dr G] was in part prescriptive but it fails to identify who bears responsibility for an adverse event arising from the implementation of the prescriptive aspects of the care/risk management plan. It is unclear whether the CAMHS Multidisciplinary Team was consulted on the maintenance of [Dr G's] care/risk plans without adjustments to suit the new conditions for [Ms A]. The failure to review risk management plans is severe.

7. Was [Ms B's] role in [Ms A's] care appropriate? If not, please explain.

The role of a CAMHS Key Worker is to work collaboratively with Serenity Trust Home Key Worker so as to ensure continuity of care, coordination of care, a single person for [Ms A] to refer to, and a bridge between Serenity team and clinical team at CAMHS. Key Workers sometimes deploy their therapeutic skills in working with clients but this does not override the support, coordination and continuity of service provision which is equally critical for effective clinical care. The CAMHS Clinical Leader could not possibly undertake the CAMHS Key Worker role and this was evidenced in the difficulties Serenity Trust subsequently experienced in accessing critical specialist clinical input into [Ms A's] care. The failure to fully fulfil the Key Worker role is moderate.

8. Were [Ms B's] actions after [Ms A] attempted to [commit suicide the first time] appropriate?

Yes, in as much as she communicated the event to her clinical leader and the psychiatrist and urged them to act.

No, in that she did not call or visit [Ms A], or propose a review of the decision to remove the Key Worker. Her failure to visit [Ms A] is moderate because of other contending issues.

9. Should there have been a more urgent review arranged when [Dr J] was unavailable?

Yes. An attempt to [self harm in this way] can not be rated as a non-urgent clinical occurrence, and she should have prevailed on her team leader to act promptly to Serenity's request. Additionally, [Ms B] could have taken her dilemma to a Social Work supervisor for discussion — unfortunately, her supervision was a line supervision by the CAMHS Clinical Leader who was a psychologist and unlikely to be conversant with the ethical standards of the Aotearoa New Zealand

Association of Social Workers. This left [Ms B] with no choices for independent professional consultation. This is a severe deviation by HBDHB.

10. Should any other action have been taken by [Ms B] or Hawkes Bay DHB after [Ms A's] attempt to [commit suicide]?

Yes. There should have been an inter-disciplinary clinical review of [Ms A] to identify key clinical management issues and to revisit the decision to withdraw the CAMHS Key Worker. Such an attempt by [Ms A] to [commit suicide] should have received immediate attention and a place of safety, possibly an acute mental health ward for a brief admission for a clinical re-assessment, a review of care/risk management plans and a discussion with Serenity Trust Home of strategies for managing [Ms A]. This is a severe omission by Hawkes Bay DHB and [Ms B].

11. Should [Ms B] have closed her intervention file for [Ms A] on [date]?

No. The closure of the file the day after a suicide attempt was ill-advised because the Key Worker role is pivotal for maintenance of good clinical care and risk management. The closure of the file by CAMHS while CAT remained involved with [Ms A's] care was a contradiction which fragmented services with HBDHB and equally fragmented clinical input into [Ms A's] care — partly accounting for some of the systemic failures. [Ms B] was instructed to close the file by her Clinical Leader. Hawkes Bay DHB's decision to close the file is severe.

12. Were the arrangements for follow-up for [Ms A] made by Hawkes Bay DHB after [Ms B] had closed her file appropriate?

No. The discharge process was flawed and the discharge plan was barely completed and therefore did not meet the protocols of HBDHB's policies on discharge procedures. The failure by [Ms B] in maintaining the integrity of HBDHB's Discharge policy and procedures is severe.

13. Are the changes to Hawkes Bay DHB processes, including triage and patient allocation, that [Ms B] describes appropriate?

Yes — triage and patient allocation processes should always have gone through a multi-disciplinary team; roles of CAMHS staff are defined and agreed before patient allocation.

No — I do not agree that a CAMHS Key Worker is not allocated to a patient who already has a Key Worker. Some clarifying statements here are incomprehensible, and roles between services still remain undefined.

14. Are there any aspects of the care provided by [Ms B] and/or Hawkes Bay DHB that you consider warrant additional comment?

The Key Worker role should, in my opinion, be a Care Manager role because Care Managers work ecologically in communities away from institutions. Care Managers work in the community harnessing resources, ensuring appropriate service delivery to clients, supporting clients and working collaboratively with other Key Workers and Care Managers. Occasionally Care Managers or Key Workers would use their professional therapeutic skills within their roles but these do not supersede the other roles as specified.

The interface between Serenity and HBDHB needs clear contractual relationships, clear policies, and guidelines for day to day engagement in the form of a Memorandum of Understanding. The same process should apply to all Iwi and Non-Government providers who inter-face with Hawkes Bay DHB.

Hawkes Bay DHB need to ensure that its policies and procedures (which are advanced and enlightened) are made available to all Iwi and Non-Government providers with which the DHB interface.

Hawkes Bay DHB should endeavour to ensure that appropriate professional clinical supervision provisions exist for social workers in their service, by appropriately qualified and experienced social workers. There should be clear delineation of line manager supervision and professional supervision.

The CAT Team is being reviewed and needs to consider response times, on-going professional development, resources and the implications of geographical cover for effective service delivery.

From all indications, a part-time psychiatrist may not be adequate for meeting the needs and demands of HBDHB CAMHS.

It is common knowledge internationally that clinicians in Mental Health Services are often wary of clients with Borderline Personality Disorder because of their enduring, complex and challenging presentations. Hawkes Bay DHB need to explore avenues for educating/equipping clinical staff by providing training in understanding clients like [Ms A] with complex needs and the treatment choices available.

In view of the fact that the [nearest suitable unit is in a distant city] and therefore not useful in local acute situations, facilities for the Hawkes Bay area need to be developed for clients of [Ms A's] age and presentation."

Appendix VII: Expert advice commissioned by the HBDHB from Mr Andrew Malone, social worker

Re: Health and Disability Commissioner Provisional Opinion Reference: 05/05329

Thank you for approaching me to undertake an independent peer review of the Health and Disability Commissioner's (HDC) expert report set out in the above provisional opinion.

My instructions from you were to review Mr Orovwuje's report in relation to his comments and findings concerning [Ms B], my opinion on each of the Commissioner's 14 questions listed and answered by Mr Orovwuje, and whether or not I agreed with his conclusions.

In preparing this report, I have reviewed the following:

- **[Ms A's] health record;**
- **A chronology of events summarised from the health record;**
- **Letter from Coroner to HBDHB re adjournment of inquest, dated [09 November 2004];**
- **Report of Dr F, on behalf of HBHDB, to the Coroner, dated [18 February 2005];**
- **Letter from HDC to HBDHB enclosing [Mrs C's] (mother of [Ms A]) complaint to the Commissioner, dated [01 June 2005];**
- **Letter from HDC to HBDHB enclosing independent advice from expert, Ms Christine Lyall, and notice of extension of investigation to include [Ms B], dated [25 November 2005];**
- **Provisional report by the Health and Disability Commissioner on case 05HDC05329, dated [13th December 2006];**
- **HBDHB Health Record Policy;**
- **Letter from [Ms B] to the Commissioner, dated [12 December 2005];**
- **Letter from HBDHB to the Commissioner enclosing information re [Ms B], dated [25 May 2006];**
- **Letter from [Ms L], kaimanaaki social worker, HBDHB's CAMHS, to the Commissioner, dated [21 December 2006];** [+]
- **Letter from [Mr I], then Clinical Leader for HBDHB CAMHS, dated [8th January 2007];** [+]

[+] I note that these documents would not have been available to either the Commissioner at the time he completed his provisional report, nor to Mr Reg Orovwuje and Ms Christine Lyall at the time they prepared their respective expert opinions.

- **Letter from [the] Chief Executive Officer HBDHB, dated 15th January 2007.** [+]

I am currently employed as the Team Leader for the Regional Youth Forensic & Child and Adolescent Liaison Services, at the Kari Centre (CAMHS) with the Auckland District Health Board. I am a qualified Senior Social Worker, and have worked in the field of Child & Adolescent Mental Health for 9 years, in a variety of settings (both at CMDHB, and now ADHB), working as a case manager, family therapist, and for several years as the coordinator for the Duty Team, managing the process of incoming referrals, triage, crisis assessments and interventions. I am also a Duly Authorised Officer for the purposes of the Mental Health Act.

My academic/professional qualifications include:

Bachelor of Social Work — Massey University

Post Graduate Certificate in Health (Child & Adolescent Mental Health) — Auckland University

Foundations of Clinical Supervision — CMDHB and Auckland University.

In the interests of clarity I have where possible focused on the care provided by [Ms B] and matters impacting on this. HBDHB has already provided feedback to the HDC on the broader issues of HBDHB's care for [Ms A].

1. In your professional opinion, was the service [Ms B] and Hawkes Bay DHB provided to [Ms A] appropriate? Please give reasons for your opinion.

In my opinion the care provided to [Ms A] was compromised, however it is not as simple as suggesting that this was a result of failings by the HBDHB CAMHS, in particular [Ms B]. Rather the result of multiple factors including:

Poor referral process — [CAMHS 2] was the responsible CAMHS for [Ms A] at the time that she moved to Serenity Trust Home. It would normally be the responsibility of the original DHB to initiate a referral/ transfer of care to the local CAMHS in order to properly establish [Ms A's] clinical needs with a like service, and to clearly delineate clinical responsibility. At no stage did [CAMHS 2] initiate a referral/transfer of care to HBDHB CAMHS. In fact the referral letter [Dr G] sent Serenity Trust House requests a transfer of care to Serenity Trust House, rather than to another CAMHS.

The referral that was made to HBDHB was by Serenity Trust House, who while quite capable of making a referral, were not able to present [Ms A's] clinical needs in a manner which [CAMHS 2] could have if dealing with a like mental health service like

HBDHB CAMHS. This is evidenced by the referral from Serenity Trust House which was made "to get a key worker assigned" from CAMHS — a some what vague request, rather than identifying specific needs or issues the CAMHS was being asked to attend to.

This contributed to delays in the process of referral to HBDHB CAMHS, and confusion over what HBDHB CAMHS role would be.

Difficulties in the allocation process — HBDHB received the referral for [Ms A] on [date], and it was triaged by [Ms B] that same day. I note [Ms B] made prompt phone contact with the referrer [Ms E] at Serenity Trust House, and collaboratively with [Ms E] determined the level of urgency for the referral, and current risks for [Ms A]. The referral was then passed to [Mr I] (Team Leader, HBDHB CAMHS) for processing and allocation. The case was initially allocated to a [Ms M] to key work, however due to [Ms M's] caseload she indicated she would be unable to be key worker. The case was then reassigned to [Ms B] on [date]. The sequence of events after the triage had been completed is concerning and suggests systemic problems with: (i) inadequate oversight of [Ms M's] case load to recognise she was not able to carry out the role of key worker, and (ii) a delay in recognising the caseload issue and then reallocating the case to [Ms B]. These delays were unhelpful and meant [Ms A] had been at Serenity Trust House for more than a week before the case was allocated to [Ms B], and thus reduced some opportunities to collaborate between services, or establish a clear role early in [Ms A's] stay at Serenity Trust House. Mr Orovwuje suggests this delayed/relaxed approach to [Ms A's] needs impacted on [Ms B's] initial assessment.

I note however these delays arose out of a systemic issue within the CAMHS referral allocation and caseload management process, and therefore should not reflect on [Ms B]. In fact [Ms B's] work in triaging the case was appropriate and performed in a timely fashion. Once allocated the case she made prompt contact with Serenity Trust House, and arranged an appointment within 2 days (although due to illness this was [postponed]).

Lack of role clarity between HBDHB CAMHS, [CAMHS 2], and

Serenity Trust Home — As discussed above, [CAMHS 2] at no stage initiated a referral or transfer of care to HBDHB CAMHS, nor is it apparent from documentation available that they intended to. Instead the referral to HBDHB was made by Serenity Trust House. The only contact between [CAMHS 2] and HBDHB came as a result of [Ms B's] efforts to clarify the role expected of HBDHB CAMHS, and occurred after several messages were left with [Dr G] [over a period of nine days]. Even after the telephone contact between [Ms B] and Dr G, responsibility for [Ms B's] care was not clarified as [Dr G] indicated that the [CAMHS 2] would hold [Ms A's] file open, and no arrangement was reached to forward transfer of care documentation or to arrange a hand over meeting/discussion between the CAMHS. I believe this led to confusion and

fragmentation on the parts of HBDHB and Serenity Trust House as to [CAMHS 2] role, evidenced by Serenity Trust House contacting [Dr G] for advice on [Ms A's] care rather than working with HBDHB (HDC report, page 7).

The referral Serenity Trust House made to HBDHB on [date] requested a key worker be assigned to [Ms A]. The referral did not elaborate on the specific tasks this role would include. It is worth noting that Serenity Trust House normally does not accept clients under 20 years of age (in [Ms A's] case Serenity Trust House made an exception for her after an appeal by [Dr G]). Therefore Serenity Trust House and HBDHB CAMHS did not have a previous experience of working together, and it is not unreasonable that an MOU had not previously been established of how they could work together given there was no expectation they would do so. I believe in the absence of a previous working relationship, or MOU with CAMHS, that Serenity Trust House was hasty in its decision to accept [Ms A] as a client without first approaching HBDHB CAMHS to explore how they could work together, ensure that roles were properly understood so that they would be confident that accepting [Ms A] as a client would work. Instead of initiating a dialogue with HBDHB CAMHS, they accepted [Ms A] as a client, and then made referral to HBDHB CAMHS asking for a key worker to be assigned, without elaborating what role they envisaged a CAMHS key worker would have in [Ms A's] care. It might be Serenity Trust House had an idea what a key worker could provide (possibly from experience with adult services), however this was certainly not communicated to HBDHB CAMHS at the time of referral.

[Ms B] has been criticised for interpreting the role of key worker too narrowly, and therefore failing to provide appropriate services to [Ms A]. I believe this criticism is unreasonable and fails to take into account the efforts [Ms B] took to clarify the role expected of her both with [Ms A], with [Ms H] of Serenity Trust House, with [Dr G] of [CAMHS 2], and within her HBDHB CAMHS's clinical and managerial structure. On being allocated the case, [Ms B] recognised that the request for a key worker from Serenity Trust House was vague and fraught with potential pitfalls, and raised this concern with her colleagues (letter from [Ms L], page 1), and with her team leader [Mr I] before meeting with [Ms A] and Serenity Trust House. [Mr I] suggested she meet with Serenity Trust House and [Ms A] to try and clarify roles. [At this meeting] it appeared that Serenity Trust House's desire for a key worker from CAMHS was limited to having some one to liaise with, and to arrange non urgent psychiatrist appointments. It was specifically agreed that [Ms H] of Serenity Trust House would be providing for [Ms A's] therapeutic needs and 'general key working'. On leaving this meeting, [Ms B] was sufficiently uncomfortable with the role proposed for her as key worker, that she needed to stop the car to discuss the matter on the roadside with her colleague [Ms L] (letter from [Ms L], page 2). She subsequently raised the matter again with [Mr I], and on advice of [Dr J] attempted to find out whether any policies or procedures existed for working with Serenity Trust House. [Dr J] himself was

sufficiently uncomfortable with the lack of clarity around HBDHB's role that he asked for a proper transfer of care from [CAMHS 2] occur before he met with [Ms A] to review her. [Ms B] left a number of phone messages for [Dr G], but was not able to speak to him [for nine days]. The clinical notes record that a discussion of roles occurred and that [CAMHS 2] would be holding their file for [Ms A] open. Throughout this period [Ms B] makes repeated reference in her the clinical notes to having sought clarification from [Mr I], and not receiving support or advice as yet from him over the roles between CAMHS and Serenity Trust House. From this I believe [Ms B] clearly had concern over the role of key worker as she understood it, took repeated steps to clarify this role, and elevated her concerns to her team leader. Having done so I do not think she should be criticised for interpreting the role too narrowly, nor for not providing services arising from this. Also at this time [Mr I] was [Ms B's] clinical supervisor (in addition to being her team leader). As her clinical supervisor I would expect that he would have been intimately aware of her caseload, in particular [Ms A] given the level of concern the case was causing [Ms B]. Having been aware of the issue, there was clearly a responsibility on [Mr I] to ensure the role of key worker was clarified.

A meeting was arranged on [date] between [Mr I] (CAMHS), [Ms E], [Ms K], & [Ms H] from Serenity Trust House, [two staff from] (NASC), [two staff from] (CMHS) to discuss this issue and attempt to clarify roles. From this meeting it appeared that Serenity Trust House had been under the understanding that [Ms A] would have required a CAMHS key worker allocated in order to receive services from CATT — should their services be required in a crisis. It was not apparent that Serenity Trust House would want anything else from CAMHS, other than access to non urgent psychiatry appointments. It was decided with Serenity Trust House staff that that a CAMHS key worker was not actually required as (i) any person in need of crisis services from CATT would be eligible for service whether they were known to CAMHS or not, and (ii) non urgent psychiatry appointments could be arranged through [Mr I] on request. [Mr I] then instructed [Ms B] to close [Ms A's] key worker file.

At this stage the responsibility for deciding the role of a CAMHS key worker, and what services CAMHS would provide to [Ms A] was clearly [Mr I's], and he reached this decision in consultation with Serenity Trust House, and representatives from both CMHS (Adult Mental Health Services) and NASC present. It is therefore unreasonable that [Ms B] be criticized for failing in her interpretation of this role.

Absence of cooperation between Serenity Trust House and HBDHB

I am concerned that there was a lack of cooperation between Serenity Trust House and HBDHB, as described in letters written by [the HBDHB CEO], [Ms L] (Kaimanaaki).

[Ms B's] and [Ms L's] meetings with [Ms A] and [Ms H] on [date] was ostensibly to establish what services they wished to receive from CAMHS and how [Ms B] could work with them ([CEO's] letter, page 1). This was the clear purpose, and it was in line with earlier instructions [Mr I] had given [Ms B]. I therefore disagree with Mr Orovwuje's suggestion that this meeting lacked purpose.

During this initial meeting the staff from HBDHB were made to feel uncomfortable and unwelcome by [Ms H]. [Ms H] went on to inform them that there was no role for CAMHS other than arranging a psychiatry review ([Ms L's] letter, page 1). [Ms H] would be the "main and only" person needed to intervene in the care for [Ms A].

[Ms B] explained the role of a key worker, that this would include carrying out a full assessment and that this would be a first step before arranging a psychiatrist review. During their attempt to conduct an interview with [Ms A], [Ms H] continued to answer questions for [Ms A], which interfered with both the assessment process and engagement with [Ms A] to the point where an assessment could not be properly completed. [Ms B] then offered to make another appointment time to go through the assessment process properly. [Ms H] at that stage told [Ms B] that this was not desired, and just to arrange an appointment with a psychiatrist. Later in the conversation [Ms B] again tried to arrange a follow up appointment, which [Ms H] declined. The clear impression received by [Ms B] and [Ms L] was of hostility from [Ms H], and that [Ms B] and [Ms L's] involvement was not wanted or needed by [Ms A] or Serenity Trust House. ([Ms L's] letter, page 3, and [the CEO's] letter page 2.)

This lack of interest in working cooperatively with HBDHB is curious in that it was Serenity Trust House who made the request to HBDHB for a key worker, and worrisome and in that given [Ms A's] history it seemed prudent to have ongoing mental health service's input into her care. One cannot help but wonder whether the tensions between Serenity Trust House and HBDHB adult services (described elsewhere in the reviewed documentation) had an impact on [Ms H's] attitude towards the CAMHS staff and her preparedness to work with them. Nonetheless it is clear to me that [Ms B] attempted to form a purposeful working relationship, however did not have [Ms H] & [Ms A's] cooperation. [Ms B] has been criticized by Mr Orovwjue for failing to arrange follow up appointments, or to properly complete an assessment. I disagree with this criticism and note that [Ms B] made two separate attempts to arrange further appointments, clearly outlined the purpose for these, and need to complete a proper assessment. These offers were declined by [Ms H] and [Ms A].

Further lack of cooperation between Serenity Trust House and HBDHB CAMHS is evident in Serenity Trust House's failure to alert HBDHB CAMHS to significant information affecting [Ms A's] risk, including her cannabis use on [date], her letter of [date], emerging problems with her boyfriend, disturbing phone conversations with her mother, and deterioration of her mood from [date]. This information was not provided to HBDHB CAMHS either at the time that Serenity Trust House noted these problems, and was contrary to information provided to [Ms B] by [Ms H] on [date]. In fact HBDHB was not informed of these developments until after [Ms A's] death.

Additionally [Ms B] asked to be invited to Serenity Trust House's review meetings concerning [Ms A]. [Ms H] agreed to phone her with the date and time for this meeting, but subsequently did not. (Letter from [Ms B], page 3.)

Issue of Initial assessment and review of risk assessment

[Ms B] has been severely criticised by Mr Orovwuje for not carrying out an adequate initial assessment, nor an adequate risk assessment of [Ms A], and that any assessment "lacked purpose" was contrary to the Social Work job description for HBDHB C&A MH services.

On reviewing letters from [the] (CEO HBDHB), [Mr I] (Team Leader, HBDHB CAMHS) and [Ms L] (HBDHB CAMHS), I believe that this criticism is unreasonable. It is clear from this correspondence that [Ms B] met with [Ms A] and [Ms H] to establish what is it they wanted from CAMHS, and to clarify roles, as per [Ms B's] instructions from [Mr I] (letter from [Mr I], page 1). The purpose of this meeting was not to carry out an initial assessment nor a risk assessment. [Ms B] notes that at the time of the meeting there was nothing obvious from [Ms A's] demeanour suggesting that an urgent assessment needed to occur at that moment; and information provided by both [Ms H] and [Ms A] suggested that [Ms A] was settling in well and they were not presently concerned for any current risk issues. (Letter from [Ms B], page 3.)

During this meeting [Ms B] explained the role she could provide, and outlined the need for a full assessment. [Ms H] and [Ms A] declined [Ms B's] offer to work with them beyond simply arranging a non urgent psychiatrist appointment. [Ms H] interfered with [Ms B's] attempts to interview [Ms A] by continuing to answer questions for her, making it impossible to carry out an adequate assessment at the time. [Ms H] and [Ms A] then went on to decline [Ms B's] two offers to make further appointments to properly conduct a full assessment — including an updated risk assessment (letter from [Ms L], page 3). [Ms B] was clearly uncomfortable with this, and there is evidence that she discussed this concern with colleagues (letter from [Ms L], page 4). I therefore do not think that [Ms B] is deserving of the amount of criticism she has received on this issue.

Mr Orovwuje also suggests [Ms B's] risk assessment failed to meet Standard 1 of the Aotearoa New Zealand Competent Social Work Practice which states: "The Social Worker establishes an appropriate and purposeful relationship with clients taking into account individual differences and the cultural and social context of the client's situation." Mr Orovwuje goes on to criticise [Ms B] for not focusing on psychosocial, clinical, and environmental issues, and not carrying out a mini mental state examination as part of her risk assessment. I feel it important to reiterate that the purpose of the meeting was not to carry out a risk assessment, and efforts to conduct an interview with [Ms A] were interfered with by [Ms H]. I believe Mr Orovwuje is mistaken in suggesting Standard 1 of the Aotearoa New Zealand Competent Social Work Practice applies to the risk assessment — given the wording clearly describes the process of engagement between social worker and client. It was not possible to engage with [Ms A] without her consent, nor with [Ms H] continually interjecting herself into the process. Therefore the absence of engagement is not due to a failing on [Ms B's] part and she is not in breach of Standard 1. Additionally [Ms B] explained the process of assessment (which includes engagement) to [Ms H] and [Ms A], and made two offers to arrange appointments to carry out the assessment properly. Both offers were refused by [Ms A] and [Ms H].

Clinical documentation of this meeting however is inappropriate. I believe that the offers of assessment being declined, the efforts to interview [Ms A] being hampered by [Ms H], and the level of professional concern [Ms B] had in regard of this should have been properly documented in the HBDHB clinical notes. Nor should [Ms B] have completed the initial assessment form in a manner which might lead a reader to believe that a full initial assessment had indeed been carried out. It was also inappropriate to circle a prompt on the initial assessment form indicating that a risk management plan was not needed. [Ms B] instead should have noted:

i. More clearly that the purpose of the meeting with [Ms A] and [Ms H] on [date] being to establish what was needed from CAMHS and to negotiate roles.
ii. That an initial assessment was not properly completed at the time — and the reasons why
iii. That offers to return and complete the assessment were declined by [Ms H] and [Ms A].
iv. It would have also been appropriate for [Ms B] to indicate that an updated risk management plan would be required, however this could not be prepared at the time of the meeting;
v. That based on the information from [Ms A] and [Ms H] suggesting that [Ms A] was settled and not presented additional risk factors since arriving at Serenity Trust House,
vi. That preparing the Risk Management Plan would occur in a planned manner with Serenity Trust Home. For this purpose [Ms B] had agreed with [Ms H]

that she would be invited to Serenity Trust House's next planned review of [Ms A]. ([Ms B's] letter to the Commissioner, page 3.)

vii. I believe it also would have been sensible to have written to [Ms H] and [Ms A], cc'ing a copy to [Dr G], summarising the meeting, that the offer to carry out a full assessment was recommended and remained open, and detailing [Ms B's] understanding of what Serenity Trust House and [Ms A] expected from her (which was at that stage only to be available to arrange non urgent psychiatrist appointments).

[Ms B's] record keeping in regard of this meeting (and therefore initial and risk assessment) was incomplete, confusing, and not in keeping with HBDHB's internal guidelines for clinical documentation. While [Ms B] is in error on this issue, it is important to note without condoning her error, that this mistake would not itself have affected the tragedy that later occurred.

Certainly had [Ms B's] records been more complete, this would have offered her some protection from the criticism which has since been directed towards her.

I note that Mr Orovwuje was not in possession of the letters from [the CEO], [Mr I], or [Ms L] at the time he prepared his expert opinion for the HDC, and so would have based his findings primarily on the clinical notes. Had he had opportunity to review these letters, or had he interviewed [Ms B], I believe that he would have come to a different conclusion and been less critical of [Ms B].

Delays in psychiatric assessment.

[Ms B] has been criticised by Mr Orovwuje for delays in the process of arranging a psychiatric review with [Dr J], stating '[Ms B] considered the appointment for review non urgent since [Ms A] was under the care of Serenity Trust House'. This is not the case, as it was [Ms H] who asked for a non urgent psychiatrist appointment, and not [Ms B] who decided the non urgency. Additionally at the time of meeting with [Ms H] and [Ms A], [Ms B] was informed that [Ms A] had settled in well over the past two weeks, and denied any new risk factor.

Regardless of this, [Ms B] did recognise the need for a review with [Dr J] as soon as possible, as seen from the clinical notes she had discussions with [Dr J] to further this process.

[Dr J] was at the time a part time consultant at HBDHB CAMHS, and so it is quite understandable that the process of arranging an appointment with him took some time, particularly as (i) [Dr J] had not received a formal transfer of care or referral from [Ms A's] previous psychiatrist, (ii) the request from Serenity Trust House was for a non-urgent appointment, and no information had been provided by Serenity Trust House to suggest [Ms A's] needs had become more urgent.

It is also worth noting that [Ms B] herself had specifically offered to conduct a full assessment, which was declined by [Ms H] and [Ms A]. [Ms B] is an experienced Mental Health Social Worker, and would be capable of providing a comprehensive mental health assessment, including assessment of risk. Although a review with a psychiatrist was indicated in light of [Ms A's] history and medication, an assessment by [Ms B] would have been extremely valuable in understanding [Ms A's] needs and risks, and would have contributed to her care plan as an interim until a review with [Dr J] was possible. It is unfortunate that [Ms H] and [Ms A] did not accept [Ms B's] offer for such an assessment.

Level of response to [Ms A's] [suicide] attempt on [date].

Mr Orovwuje has criticised [Ms B] for not arranging to assess [Ms A], or prevailing on her team leader to respond to Serenity Trust House's request. This criticism is unreasonable. [Ms B] had earlier offered to make an appointment to carry out a full assessment (on [date]) and made the same offer again on [date]. These offers were refused by Serenity Trust House, and [Ms B] was informed that all that was wanted was a psychiatrist's appointment. It is not reasonable to expect [Ms B] to attempt an assessment or intervention without [Ms A's] consent or Serenity Trust House's cooperation.

[Ms B] immediately began the process of arranging this with [Dr J]. [Ms B] also brought the situation to the attention of [Mr I], calling him out of a meeting to do so. [Mr I] was also concerned at the situation and that CAMHS was being asked to provide such a limited role in [Ms A's] care, and fortuitously was due to meet with Serenity Trust House that afternoon to address this issue. I therefore feel that the steps [Ms B] took were quite reasonable, and her documentation of the timeframe of events on the day comprehensive and thorough.

Mr Orovwuje has also criticised [Ms B] for not calling for a review of the decision to remove her as key worker, and if unsuccessful discussed the matter and delays with her social work supervisor. This criticism does not account for the fact that [Mr I] was both Team Leader, and Supervisor for [Ms B]. He had advised her the matter was in hand, that the decision to close the key worker file was made in consultation with Serenity Trust House, and that he ([Mr I]) would be arranging a psychiatrist review as requested for Serenity Trust House. It is therefore unreasonable to expect that [Ms B] should have defied his instructions. HBDHB has acknowledged that it was not ideal for [Mr I] to be supervising [Ms B] given he is not a social worker, and has taken steps to remedy this. I note that the practice of supervision by other disciplines, although not ideal, is not uncommon in organisations or areas where there are fewer senior social workers available.

I believe that [Ms A's] care was compromised, however this was as a result of multiple systemic failures as highlighted above, most specifically the absence of role clarity

between Serenity Trust House and HBDHB CAMHS, despite [Ms B's] efforts, and the lack of cooperation between Serenity Trust House and HBDHB CAMHS. [Ms B] did not have either [Ms A's] consent, nor Serenity Trust House's cooperation to play a larger role in her care. I believe that [Ms B's] efforts to try and highlight these issues and clarify roles is commendable, and undeserving of the amount of criticism she has received.

2. If the care provided was not appropriate, please explain why.

In discussing the reasons that he felt the care provided to [Ms A] was not appropriate, Mr Orovwuje again makes reference to [Ms B] interpreting the role of key worker too narrowly 'in favour of therapeutic involvement' and highlights the care coordination aspect of a key worker role as being as important as therapeutic role. I agree with Mr Orovwuje that the care coordination aspect of the key worker role is as important as therapeutic aspect of a client's care. However it is unsound practice for any clinician to provide care coordination without some insight/input into therapeutic care being provided, in order that the clinician can coordinate care, services, and resources in the most sensible and informed manner. This requires a collaborative relationship between key worker and whom ever is providing therapy. Such a relationship clearly did not exist between Serenity Trust House and HBDHB CAMHS given [Ms H] and [Ms A's] refusal to proceed with a full assessment of [Ms A], and when [Ms B] attempted to work out what was required, was told all that was wanted from HBDHB CAMHS was for access to non urgent psychiatrist appointments. [Ms B] was therefore correct in feeling concerned at being attached to a case where she had no input into decision making, could not establish for herself what [Ms A's] clinical needs and risks at that time were, and was reduced to only arranging appointments. I believe that [Ms B] was fully aware of the range of responsibilities normally included in the role of key worker, and in seeing Serenity Trust House's apparent desire to have a key worker for CAMHS only to arrange appointments, correctly raised this issue with her colleagues and team leader [Mr I]. [Ms B] therefore should not be criticised for her interpretation of the key worker role, when in fact this was the role requested of her by Serenity Trust House and [Ms A] (despite her efforts to offer a full assessment and additional services), and that she brought this issue to the attention of her manager requesting support. This later led to [Mr I's] meeting on [date] with Serenity Trust House, NASC, and representatives from adult MH services to clarify the issue of the key worker role. Rather than defining a larger role for [Ms B], or CAMHS, this meeting concluded that CAMHS role at that stage was only to arrange psychiatrists appointments on request by Serenity Trust House, and that this did not require a key worker to be allocated as Serenity Trust House did not wish to have any other services from CAMHS.

Mr Orowvuje has criticised [Ms B] for not visiting [Ms A] and Serenity Trust House on the day of her attempted [suicide], "in the absence of the clinical leader taking that

initiative". Serenity Trust House clearly indicated to [Ms B] that they wished to have a psychiatrist appointment to "review [Ms A's] medication". [Ms B] then took steps to arrange exactly this by contacting [Dr J], and her notes indicate they intended to compare diaries the following day (as [Dr J] was not at CAMHS that day), with the intention of arranging an appointment for [Ms A]. [Ms B] had previously offered to visit and assess [Ms A], an offer which Serenity Trust House refused. [Ms A] could not intervene without Serenity Trust House cooperation or [Ms A's] consent. Also [Ms B] was aware that [Mr I] was visiting Serenity Trust House that afternoon, and that had he thought an assessment by her was appropriate, or requested by Serenity Trust House, then he would have instructed her to do this.

I note also from [the CEO's] letter to the commissioner, that there is concern over the confusing and contradictory records kept by [Ms H] of Serenity Trust House on this day. They do not match up with the account and timeframes recorded by [Ms B], and suggest additional conversations that day between [Ms H] and [Ms B], which did not occur. ([CEO's] letter, page 5.)

Mr Orowvuje makes reference to HBDHB CAMHS's Client Pathway, and it stipulating that all referrals will be allocated to an interim/assessing key worker to complete the comprehensive assessment (within three weeks) and risk assessment. He makes further reference to "mutual agreement between client, family, and the key worker over therapeutic goals being met". I again point out that [Ms B] explained the role of key worker to [Ms A] and [Ms H], along with the need for a full assessment; made two offers to make additional appointments to properly conduct said assessments; and that these offers were turned down by [Ms H] and [Ms A]. That the initial assessment and risk assessment could not be properly completed within the three weeks outlined in the policy, was clearly beyond [Ms B's] control. Also there was clearly not a mutual agreement between Serenity Trust House, [Ms A] and HBDHB over therapeutic goals being met, evidenced by [Ms B's] efforts to further clarify her role, and seek support in it from her colleagues and management, and that a meeting was needed between [Mr I] and Serenity Trust House to discuss this issue.

Mr Orovwuje makes reference to HBDHB's policy for defining the role of key worker as "responsible for the general role of overseeing the coordination of a service user's are to ensure that the needs of the service user/tangata whaiora are met". [Ms B] was clearly unable to provide the breadth of care this description called for, without the cooperation and consent of [Ms A] and Serenity Trust House — who repeatedly stated they only wished for [Ms B] to arrange a non urgent psychiatric review, and declined her offers for assessment and other input into her care. [Ms B] was aware that she was unable to execute the role of key worker as defined in HBDHB policy, and appropriately raised this issue with her team leader [Mr I].

Mr Orovwuje discusses the guidelines for initial assessment as outlined in the Ministry of Health Best Practice Evidence Based Guideline: The Assessment and Management of People At Risk of Suicide (May 2003), and the Ministry of Health Guidelines for the Clinical Risk Assessment and Management in Mental Health Services 1998. These guidelines are only useful in that they assume that the client has either given consent to participate in an assessment, or may be subject to compulsory assessment under the Mental Health Act 1993. [Ms A] had not given consent for any assessment to occur, nor was there any request for her to be assessed under the Mental Health Act. In fact when offered an assessment earlier by [Ms B], [Ms A] and [Ms H] declined this offer. Although it is difficult to second guess, I suspect from the material available that [Ms A's] decision not to participate in an assessment by [Ms B] was at least in part due to influence from [Ms H]. Had [Ms H] supported the assessment proposed by [Ms B], it is possible that [Ms A] would have consented to participate. [Ms B] could not attempt to carry out an assessment without [Ms A's] consent, and without cooperation from Serenity Trust House.

3. What standards apply in this case? Were these standards satisfactorily applied by [Ms B] and/or Hawkes Bay DHB?

Mr Orovwuje lists many standards he felt applicable to this case including:

- Ministry of Health Guidelines Clinical Risk Assessment and management in Mental Health Services. 1998
- Aotearoa New Zealand Association of Social Workers Competent Social Work Practice. July 1993.
- Ministry of Health, Best Practice Evidence Based Guidelines. The Assessment and Management of people at risk of suicide. May 2003.
- Hawkes Bay DHB, Foundation Client Pathway Policy.
- Hawkes Bay DHB, Policy on Service User, Tangata Whaiora Care Pathway Procedure.
- Hawkes Bay DHB Child and Adolescent Mental Health Service, Client Care pathway.
- Hawkes Bay DHB Clinical Review Policy.
    - Hawkes Bay DHB, Recovery/discharge planning policy.
    - Hawkes Bay DHB, Recovery/discharge planning process policy.
    - Hawkes Bay DHB, Job Description for Child and Adolescent Mental Health Service Social Worker. July 2003.

Mr Orovwuje suggests that [Ms B] does not appear to have adhered to these policies and standards in her care towards [Ms A]. I suggest that the circumstances of the case (in particular the lack of preparedness of [Ms A] and Serenity Trust House to either participate in a full assessment or take up offers of support beyond simply arranging non urgent psychiatrist appointments) have prevented [Ms B] from providing a level of

care consistent with the above standards and policies. [Ms B] did not neglect her responsibility to provide the standard of care required, rather once she realised that the position she had been placed in by Serenity Trust House and [Ms A], she immediately raised this issue with her team leader [Mr I]. This was the appropriate course of action, given [Mr I] as Team Leader held responsibility for [Ms B's] work, and the overall services provided by the CAMHS team. [Mr I] then arranged a meeting with Serenity Trust House management, adult services, and NASC to discuss the issue of CAMHS being asked to take such a narrow brief in [Ms A's] care.

4. Was [Ms B's] assessment of [Ms A] appropriate?

Mr Orovwuje notes that the documentation of [Ms B's] assessment of [Ms A] appears to be repetition of existing information, and that she failed to come to grips with [Ms A's] history of risk, diagnosis, contextual triggering factors, and psychosocial history, and that [Ms B] appeared to accept [Ms H] and [Ms A's] assurances that she was doing well at face value. Mr Orovwuje describes these omissions as severe.

I agree with Mr Orovwuje that any sound assessment would include cover of these areas. However in this case, [Ms B] was unable to satisfactorily carry out an assessment either on [date] due to [Ms H's] constant interjections into her attempted interview of [Ms A], nor was [Ms B] able to convince [Ms A] or [Ms H] of the need to make further appointments to properly conduct a full assessment (Letter from [Ms L]). That she could not complete the assessment on [date], and was not able to return to complete the assessment as she had offered to do, was beyond [Ms B's] control.

As discussed earlier, I believe that it was an error on [Ms B's] part not to document this more clearly in [Ms A's] clinical notes. One must read correspondence from [Ms B], [Ms L], [Mr I], and [the CEO] in order to properly understand the sequence of events and that the assessment was not considered complete or appropriate by [Ms B]; hence the reason she had offered to return to continue it (an offer declined by [Ms H] and [Ms A]), and one of the reasons she raised the issue of [Ms A's] care with [Mr I].

[Ms B's] error was in her clinical documentation, rather than her direct practice or services she proposed to provide for [Ms A]. I believe this distinction is important as although her documentation was not in line with HBDHB's internal guidelines, this error does not warrant the level of criticisim made by the Commisioner and Mr Orovwuje, nor could it have contributed to or averted the tragedy that later occurred.

5. Should [Ms B] have performed a mental state examination during her assessment?

I agree with Mr Orovwuje that a full assessment should include a mental state examination. Mr Orovwuje describes this omission as severe.

As discussed above, [Ms B] was not able to properly complete an assessment of [Ms A], despite her best efforts. At the time of the meeting based on [Ms B's] observations of [Ms A], and based on information provided to [Ms B] by [Ms A] and [Ms H], there was no reason to have heightened concerns for [Ms A's] mental state. The decision not to complete the assessment or revisit it was [Ms H] and [Ms A's].

Also as noted above I feel that [Ms B] was in error in not documenting that the assessment was not considered complete, and the reasons for this more clearly in her notes.

Although one cannot complete a mental state examination without specific questioning, some aspects of a mental state examination can be gathered through skilled observation and regular conversation with a client (for instance appearance, affect, behaviour, speech, and to a limited degree mood and orientation). I suspect that [Ms B] therefore may have been able to describe [Ms A's] mental state at least in part from her limited contact with her on [date] (and so should have documented these observations while noting their limitations). She also would have formed a view of whether a more detailed and full mental state examination was needed at the time of this meeting. She did make offers to return to carry out a full assessment, which were declined by [Ms H] and [Ms A].

6. Was it appropriate that [Ms B] did not prepare a new or updated risk management plan for [Ms A] when she moved to the Hawkes Bay?

Mr Orovwuje describes the omission of an updated risk management plan for [Ms A] as severe. I agree that an updated risk management plan should have been completed. That it was not completed was out of [Ms B's] control given she was unable to carry out a full assessment, and that Serenity Trust House staff did not follow through with agreements to collaborate with her on this issue.

I believe it was a mistake by [Ms B] to circle a prompt on the initial assessment form indicating a risk management plan was not necessary. She should have instead recorded that the risk management plan was considered necessary, but that [Ms A's] presentation and apparent risk at the time of the initial meeting on [date] (based on reports from [Ms H], [Ms A], and [Ms B's] observations) did not indicate that it needed to be completed as matter of urgency at that meeting; and that there had been an agreement reached between [Ms B] and [Ms H] that [Ms H] would invite [Ms B] to Serenity Trust House's next review meeting for [Ms A]. [Ms B] indicates in her letter to the Commissioner (Page 3), that it was at such a meeting that she intended to collaborate with Serenity Trust House staff on a risk management plan for [Ms B]. Given no reports of additional risk issues and assurances from [Ms A] and [Ms H] that

all was well, the risk management plan prepared by [CAMHS 2] was felt sufficient until the updated plan could be developed in collaboration between [Ms B] and Serenity Trust House. [Ms B] in good faith believed that Serenity Trust House intended to make good on their offer to include her in review meetings, and that they could collaborate on a risk management plan. Serenity Trust House did not recontact [Ms B] to advise her of the timing of review meetings, and later failed to make her [aware] of information relevant to [Ms A's] presentation and risk (including her cannabis use on [date], her letter of [date], emerging problems with her boyfriend, disturbing phone conversations with her mother, and deterioration of her mood from [date]).

[Ms B] responsibly raised the issue of the incomplete assessment and risk management plan, with concerns over her key worker role, with her team leader [Mr I]. Therefore management within CAMHS was aware of these problems, and that [Ms B] had sought support for them.

7. Was [Ms B's] role in [Ms A's] care appropriate? If not, please explain.

Mr Orovwuje indicates in his report that he believes [Ms B] failed to fulfil the role of key worker, and goes on to discuss the importance of working collaboratively with Serenity Trust House, and the aspect of a key worker's role, that is care coordination.

As discussed previously, [Ms B] was well aware the role of key worker was broader than simply a therapeutic one. However on meeting with [Ms A] and Serenity Trust House, she was repeatedly informed that all that was wanted from her was to arrange non urgent psychiatric appointments. This was not [Ms B's] interpretation of what a key worker role should be, it was Serenity Trust House's and [Ms A's]. [Ms B] realised this narrow interpretation of the key worker role was not sensible, nor in keeping with best practice, and so raised this issue with [Mr I], and [Dr G] at [CAMHS 2].

I agree with Mr Orovwuje that working collaboratively with the Serenity Trust House key worker ([Ms H]) was part of the key worker role. It appears that [Ms B] attempted to provide such a collaborative approach to working with Serenity Trust House. However her offers to work with [Ms H] were met with dismissal, and near hostility (Letter from [Ms L]). [Ms B] explained her role to [Ms H] and [Ms A], and the need to carry out a full assessment prior to arranging a psychiatric appointment. [Ms H] continually interjected into [Ms B's] attempts to interview [Ms A] on [date], and dismissed [Ms B's] offers to make further appointments to return and complete the assessment.

I believe that [Ms B] attempted to provide appropriate care to [Ms A], however was unable to given the narrow role that [Ms H] and [Ms A] were prepared for her to take. The relationship between [Ms H] and [Ms B] was clearly not collaborative, however

this was not due to any failing on [Ms B's] part. [Ms B] then took the appropriate course of action and raised the issue to the attention of her team leader [Mr I], who then arranged a meeting with the management of Serenity Trust House, adult MH services, and NASC, to discuss the issue of case management between Serenity Trust House and HBDHB CAMHS.

8. Were [Ms B's] actions after [Ms A] attempted to [commit suicide] on [date] appropriate?

[Ms B's] notes from [date] indicate that during her phone conversation with [Ms H] she established what had occurred, and was informed that [Ms A] had settled, was remorseful of having attempted to harm herself, and that [Ms H] felt comfortable monitoring [Ms A] at that time. [Ms B] responded to the news of [Ms A's] attempted [suicide] by immediately contacting her team leader, and then [Dr J] to ascertain when an appointment could be made. [Ms B] then established with [Mr I] that he would be visiting Serenity Trust House that afternoon to discuss the role that CAMHS should have in [Ms A's] care, and that decisions over the level of response to [Ms A] would arise from this meeting.

I believe that [Ms B's] work at this stage was appropriate and commendable.

While I feel the decision by [Mr I] to close the key worker file after [Ms A's] [suicide] attempt without first attempting to review her, was a highly dubious one, this decision was [Mr I's] and not [Ms B's] . It would not have been appropriate for [Ms B] to act contrary to [Mr I's] instructions, and given [Mr I] informed her that he would take on the role of arranging for [Dr J] to review [Ms A], [Ms B] would not have anticipated the need to challenge [Mr I's] instructions.

9. Should there have been a more urgent review when [Dr J] was unavailable?

Whether a more urgent review should have been arranged is a matter for debate. Mr Orovwuje notes that an "attempt to [harm] can not be rated as a non urgent clinical occurrence". I agree with this statement to the extent that all potentially life threatening attempts should be responded to appropriately. At the same time when dealing with patients with borderline personality disorder, established practice is to provide a response appropriate to the circumstances, without over responding. [Dr F] in his report for the coroner ([Feb 2005]) emphasises that "responding to chronic suicidal thinking and self harming behaviour as if it was acute illness-based suicidal thinking and behaviour results in an escalation of both frequency and lethality of self harming behaviours, along with an escalation of dependence and acting out behaviours". So whilst it was appropriate for CAMHS to respond to [Ms A's] attempted suicide, it was also appropriate for them to take care to not over respond. Such a response did not necessarily need to take the form of an acute mental health assessment on [date].

The response that CAMHS did provide was as follows:

[Ms B] gathered sufficient information on the phone to understand the circumstances of [Ms A's] [suicide] attempt, that the situation was now settled, that Serenity Trust House did not have any imminent concerns for [Ms A's] safety, and felt able to monitor [Ms A] for the time being. Thus CAMHS had evaluated the immediate risk and Serenity Trust House's capacity to manage the situation. [Ms B] recommended that Serenity Trust House have [Ms A] reviewed by a general practitioner — again a sensible precaution to assess whether [Ms A] had injured herself during her attempted [suicide] or in need of immediate medical intervention, and a course of action which would be at the same time responsive, but less likely to reinforce the self harming behaviour in the same way that a reactive acute mental health assessment might.

[Ms B] then immediately took steps to inform her team leader — pulling him out of a MDT meeting, and also made phone contact with [Dr J] who was off site. It does not appear from these consultations that there was any suggestion that [Ms B] should attend [Ms A] in person that day, and provisions were in place to arrange an appointment with [Dr J] when he returned to CAMHS the following day.

Later that day [Mr I] met with Serenity Trust House, Adult services, and NASC, to discuss [Ms A's] care, and CAMHS role in it. At that meeting [Mr I] agreed to arrange a psychiatric review on request by Serenity Trust House. Adult services also agreed that CATT would respond to any request for service that Serenity Trust House made for [Ms A].

Mr Orovwuje also suggests that [Ms B] should have been able to take her dilemma to her social work supervisor for advice, and faults HBDHB for not providing [Ms B] with a social work supervisor (at the time [Ms B] was being supervised by [Mr I], a Clinical Psychologist). Although I agree that it is less than ideal for [Ms B] to not have access to a social work supervisor, this is not so unusual in small services or provincial areas with a smaller pool of senior social workers available. That her supervisor was a clinical psychologist in this instance was not as significant an issue as Mr Orovwuje suggests. Having worked with many social workers and psychologists, and having familiarity with both disciplines training and codes of ethical practice, I do not believe that a social work supervisor would have provided significantly different advice than a psychologist supervisor.

I believe the greater issue was that her supervisor and team leader were one in the same person, hence she did not have a supervisor who could provide an alternate point of view from her team leader. This issue has since been addressed, and [Ms B] is receiving external supervision.

10. Should any other action have been taken by [Ms B] or Hawkes Bay DHB after [Ms A's] attempt to [commit suicide] on [date]?

Mr Orovwuje suggests that an interdisciplinary clinical review of [Ms A] should have been carried out, and the decision to withdraw the role of key worker revisited. In this I agree with Mr Orovwuje. I find the decision to close [Ms A's] case without first reviewing her unsound. I also believe the decision to close the file should have been discussed at an multidisciplinary meeting to ensure that decisions about CAMHS's role in [Ms A's] care were in line with best practice and in her best interests.

However while the outcome of such discussions should ideally have been for CAMHS to remain involved (with a redefined role than that proposed for them by Serenity Trust House to one which allowed for greater input into [Ms A's] care), if CAMHS could not have a role which was clinically sound and allowed input into [Ms A's] care (as [Ms B's] earlier role clearly had not) then this position should have been confirmed in writing to Serenity Trust House, [Ms A], and [Dr G] at [CAMHS 2].

That this did not occur reflects on processes undertaken by the HBDHB and Serenity Trust House staff at the meeting rather than [Ms B] in my opinion.

11. Should [Ms B] have closed her intervention file for [Ms A] on [date]?

The decision to close the intervention file was made as a result of the meeting on the [date] between [Mr I], Serenity Trust House Management, [Ms H], Adult MH services, and NASC. At this meeting it was agreed that Serenity Trust House remain the main care provider, that a key worker from CAMHS was not necessary, and that Serenity Trust House could access psychiatric appointments via CAMHS and access to CATT on request (Sentinel Event individual report by [Mr I]).

I agree with Mr Orovwuje that the closure of the intervention file was incorrect, but for different reasons. I believe that the decision to close the file was premature, in that the process should have included multidispinary review, correspondence with [Ms A], Serenity Trust House, and [Dr G] at [CAMHS 2] to ensure all understood the decision and had opportunity to comment on it.

I believe that the timing of the decision — made the same day that [Ms A] had attempted to commit suicide was particularly poor, especially given at the time the decision was made by those at the meeting no arrangement had been made for an appointment to review [Ms A].

Additionally while I understand from [a staff member] at HBDHB that it is possible to close an intervention file while still keeping the case open for psychiatric review, I am puzzled that any psychiatrist working in a public service (especially a part time psychiatrist) would agree to an arrangement where they would be responsible for providing psychiatric reviews for patients under the care of Serenity Trust House (but only at Serenity Trust House's request), and without the additional support and coordination offered by the involvement of a key worker. In my view such a proposal

seems as unworkable as the earlier idea of only having a CAMHS key worker involved to arrange psychiatrist reviews. Similar to the key worker issue, it would not provide the psychiatrist sufficient input into [Ms A's] care, but would expose them to considerable clinical risk as being the clinician of record should anything go wrong.

Given flaws in the plan made by [Mr I] and Serenity Trust House over access to psychiatrist appointments, I believe that more time should have been spent working through these issues before closing the intervention file.

I note that [Ms B] was not involved in the decision to close the intervention file.

12. Were the arrangements for follow up for [Ms A] made by Hawkes Bay DHB after [Ms B] had closed her file appropriate?

In his report Mr Orovwuje faults the arrangements for follow up for [Ms A] after [Ms B] had closed the file, highlighting an incomplete discharge process being followed by [Ms B], and describing the flawed process as "severe". I disagree with this criticism as the documented chronology provided clearly notes that [Ms B] was still in the process of completing [Ms A's] discharge "paper work" at the time of [Ms A's] death. Once [Ms A] died, it was not appropriate for [Ms B] to make further additions or alterations to [Ms A's] records. Therefore she was unable to properly complete the discharge process, and her work on this should be considered incomplete.

Although I do not fault the arrangements for follow up made by [Ms B], I am concerned that the follow up arrangements agreed on [date] were for [Mr I] to arrange a psychiatrist review on a future request by Serenity Trust House, rather than an urgent review being requested and secured at that meeting. A request by Serenity Trust House was made on [date], however the appointment arranged by [Mr I] was for [date] (two and half weeks away), and was never communicated to Serenity Trust House. This does not seem sufficiently responsive given [Ms A's] attempted [suicide] four days earlier.

Also on [date], [Ms K] of Serenity Trust House advised [one] of the CATT team, that [Ms A] was "open to CAMHS". This statement should have been further explored with [Ms A] as to whether she meant by this that she would like to have greater input from CAMHS.

13. Are the changes to Hawkes Bay DHB processes, including triage and patient allocation, that [Ms B] describes appropriate?

I believe that the changes described by [Ms B] are appropriate. Mr Orovwuje in part agrees with [Ms B's] description of these changes, but finds fault with the policy of not allocating a key worker where a key worker (from another organisation) is already allocated, unless or until the role for the CAMHS key worker is clarified, and there is a

defined process in relation to requesting assistance. Mr Orovwuje suggests that these statements are incomprehensible and that roles between services remain undefined. I disagree with his statements, and find [Ms B's] description of the policy straight forward to understand. In essence it will mean that where a case is referred to CAMHS and another service is already providing a key worker, that a process will occur to clarify roles and to specify responsibilities before a CAMHS key worker will be allocated. Such a policy would have been enormously useful in [Ms A's] case, and it is unfortunate that the tragedy of her death was needed as the catalyst to create such a policy.

[Ms B] goes on to describe client care pathways which have been established between Serenity Trust House and CAMHS to provide a greater collaboration between services, and clarification of roles and expectations between services. This again sounds appropriate.

14. Are there any aspects of the care provided by [Ms B] and/or Hawkes Bay DHB that you consider warrant additional comment?

Mr Orovwuje discuses his opinion that the role of key worker be transformed into that of case managers. I do not find that his rationale for such a change would be useful to CAMHS or DHBs as a whole, and believe that any alteration in definition or change in the role of key worker should be left to the DHBs to set policy around.

I agree with Mr Orovwuje that the interface between Serenity Trust House and HBDHB needs to be remedied. This case has highlighted long standing tensions between Serenity Trust House and HBDHB, some of which appear to have spilled over into the relationship between Serenity Trust House and HBDHB CAMHS — who have previously had no dealings with Serenity Trust House. There is a clear need to sort out these issues, and create a relationship of greater collaboration and mutual respect. This should be underpinned with a formal Memorandum of Understanding, protocols on how joint clients will be managed, and the responsibilities of all specifically outlined.

The care [Ms B] was able provide to [Ms A] was largely compromised through inadequate willingness to collaborate on the part of Serenity Trust House, particularly [Ms H]. In light of correspondence to the commissioner from [Ms B], [Ms L], and [the CEO] highlighting this problem, I submit that this issue should be taken into account by the commissioner.

Given confusion between CATT and CAMHS over the status of clients, whether they have been seen by CAMHS or remain open to them, a shared or accessible electronic record system should be set up as the DHB's infrastructure allows (assuming this has not already been set up in the prevailing period). This would mean that CATT staff could potentially check clients' most recent notes, risk plans, medications, and other

relevant information before leaving to assess a client, and would allow ease of hand over back to CAMHS. Examples of such systems can be found in other DHBs.

Although it is sensible to advocate for supervision within the same discipline, this will not always be practical. On the one hand social workers require supervision from another social worker for professional development, role clarity, and registration purposes. At the same time recognition should be made for areas with a smaller pool of senior practitioners, or instances where a social work practitioner was interested in supervision best provided by another discipline (an example might be a social work practitioner who wished to have specific supervision around the development of cognitive behavioural therapy skills, and so might seek a psychologist skilled in such a technique to provide them with supervision). Ideally where possible however supervision should be available within the same professional group. I think that the issue of having a clinical supervisor, who is also the line manager for an employee is problematic, and creates a conflict of interest for the supervisor. The supervisee cannot hope to receive supervision which is wholly independent of the supervisor's views as the line manager/team leader, and does not have a forum to raise views or issues which might be contrary to the point of view of the team leader/line manager. I suggest that this issue be considered by the DHB, with a view to establishing a policy of keeping the roles of clinical supervisor and line manager separate where ever practicable.

Conclusions

[Ms B] is an experienced and competent Social Worker, and from the letters provided by her peers and managers, a respected clinician. She was fully aware of the scope of the key worker role, and relevant standards impacting upon her practice. She was prevented from doing her job by Serenity Trust House, and there was no consent from [Ms A] for the services [Ms B] offered to provide.

[Ms B] did make an error in her documentation regarding the content of the meeting on [date], the initial assessment, and mistakenly circled a prompt indicating that a risk management plan was not required. There is sufficient corroborating documentation to conclude that [Ms B] did not believe that the initial assessment was complete, that she wished to revisit this, and to complete a risk management plan in collaboration with Serenity Trust House. [Ms B's] poor record keeping of this meeting is inconsistent with HBDHB's internal guidelines, and made it necessary to review information from other sources to properly understand the sequence of events. However in my opinion this error was not a significant error in the context of this case and the significant systemic failings, or could the error in documentation in of itself have contributed to or averted the tragedy of [Ms A's] death. I therefore suggest that [Ms B's] documentation error should be viewed in this light and the consequences (if any) be aligned with the degree of her error.

It is worth noting that had [Ms B] properly completed her documentation as she should have, she would not find herself in the position she is now in.

It is my opinion that otherwise most of the criticisms directed at [Ms B] in Mr Orovwuje's report are unreasonable or unfounded. It is unfortunate that Mr Orovwuje did not have access to the same documentation as has been provided to me, or that he did not seek to speak with [Ms B] or others involved in the case, as he might have then better understood and explained the sequence of events, and may have arrived at different conclusions.

HBDHB has already conceded systemic breakdowns in the relationship with Serenity Trust Home. I suggest that these issues, particularly in this case, were significantly complicated by the stance that Serenity Trust House adopted in their dealings with HBDHB and [Ms B].

I hope that my report will be of benefit to both you and [Ms B]. I am happy to be contacted should you require further comment.

Yours sincerely

Andrew Malone
BSW, PG Cert Health