Care provided to mentally unwell man
14HDC01390, 23 June 2017

District health board ~ Psychiatric in-patient unit ~
Mental health ~ Risk assessment ~ Monitoring ~ Right 4(1)

Police found a man wandering outside an airport following an international flight. The man appeared dazed and confused. He was taken to a police station, where he was seen by a consultant psychiatrist and a Duly Authorised Officer/social worker.

The psychiatrist recorded her impression as: "Psychosis NOS [not otherwise specified] — possibly associated with mood disorder, possibly drug induced. History of polysubstance abuse." The plan was to admit the man to a psychiatric inpatient unit after he had been cleared medically.

The man was admitted directly to a ward, and placed on observations every 15 minutes. A second psychiatrist recorded that he believed that the man was mentally disordered. The man was given notice of a period of compulsory assessment and treatment under section 11 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.

At 2pm, the man was reviewed by a consultant psychiatrist, who decided on a plan that included further assessment and monitoring for signs of withdrawal. She recorded a request that the man be reviewed by a registrar the following day (Saturday) and on Sunday if necessary. However, the man was not reviewed again by a psychiatrist during his admission.

At 5pm, a house officer conducted the man's admission physical examination. The house officer recorded a history of substance abuse, chronic pain, and anxiety. There is no record of a risk assessment.

On Saturday the man's mood appeared low, and he was subdued and kept to himself, but approached staff to have his needs met. He is recorded as showing no signs or symptoms of withdrawal. The house officer reviewed him again, but did not request a review by the on-call psychiatrist or undertake a risk assessment.

On Sunday afternoon the man was visited by two friends. When the friends left the ward, they spoke to the ward clerk and expressed concerns about the man. The ward clerk telephoned the man's allocated nurse for the day, and relayed the friends' concerns. The man's allocated nurse came from the ward and spoke to them.

The friends told the man's allocated nurse that they thought the man was "low and distressed as he was expressing thoughts of wanting to make a will as he believed that he would not be able to make [it] out of the hospital". The nurse said she asked if the friends knew whether the man had any suicidal intention or plans. They were unable to identify any, but said that he was dissatisfied with his recent trip. The friends also told the nurse that the man had had a psychiatric admission two years ago, had been using LSD for the previous two weeks, and had begun to identify

himself as the "Messiah". The nurse mentioned the conversation to another nurse and recorded it in the progress notes, but did not seek a medical review.

At around 5.30am the next day, a psychiatric assistant saw the man standing by his open door acting unusually.

At around 8am, two nursing students found the man unconscious in his room. Sadly, the man could not be resuscitated.

Findings

The DHB did not provide services to the man with reasonable care and skill, and breached Right 4(1) as follows:

- Staff failed to arrange a psychiatric review of the man on the Saturday and Sunday.
- The man's risk was not assessed sufficiently following his admission.
- Staff failed to respond adequately to his changing presentation.
- Staff failed to monitor him for signs of withdrawal after Saturday, as required by the plan made by the psychiatrist.
- Staff failed to respond adequately to the concerns expressed by the man's friends and the information that he was talking about making a will.

Recommendations

It was recommended that the District Health Board:

- Report back to HDC on the implementation of the recommendations of the Serious Incident Review Triage Team.
- Conduct audits of the new standard operating processes and policies and procedures.
- Provide further training to staff on patient risk assessment, and the clinical documentation of patient presentation.
- Audit the use of risk assessment documentation for patients presenting with possible substance withdrawal, significant risks, or suicidal ideation, or who are receiving compulsory care under the Mental Health (Compulsory Assessment and Treatment) Act 1992, to ensure that the documentation meets professional standards.
- Consider whether a registrar or consultant should attend the inpatient unit each day over the weekend and on public holidays.
- At the next meeting of the Mental Health Clinical Directors of the DHBs, include a discussion of psychiatrist input into inpatients at weekends.