Psychiatric assessment and granting of home leave (**06HDC04783, 31 March 2008**)

Psychiatrist ~ District health board ~ Assessment and treatment ~ Risk assessment ~ Suicide ~ Home leave ~ Right 4(1)

A 36-year-old woman's mental health was perceived by her family and friends to be deteriorating. After assessment by a district health board (DHB) community mental health team, the woman was compulsorily detained in an intensive care unit in a public hospital under the Mental Health (Compulsory Assessment and Treatment) Act. The team recorded serious concerns about her condition and unpredictable behaviour.

The following day, after assessment by a psychiatrist, the patient was authorised to go on home leave, to be further reviewed the following day. Having talked to her in a multidisciplinary assessment meeting, the psychiatrist considered that the woman was at low risk of self-harm and was able to go home overnight. The psychiatrist did not discuss his differing view of the patient's condition with the more junior clinicians in the community team. The patient committed suicide early the following morning at home.

Although the woman had assured staff at the clinic that she had no suicidal ideation and her suicide could not have been predicted, she did have a recent history of unpredictable behaviour which placed her at risk. It was held that the psychiatrist failed to adequately assess the risk of self-harm before deciding to grant the patient home leave. He did not give adequate consideration to the concerns of the community team who admitted the patient. The patient's complex presentation and recent impulsive behaviour were not adequately explored and the patient's husband was not provided with adequate instructions for observing her behaviour. A patient placed under compulsory care should be assessed and provided with a diagnosis and a treatment plan before any home leave is granted. Accordingly, the psychiatrist breached Right 4(1). The psychiatrist was referred to the Medical Council with the recommendation that a competence review be undertaken.

It was held that the community mental health team had provided the patient with appropriate assessments and management, and her family with appropriate advice, prior to her admission under the Mental Health Act. Although it would have been preferable for the medical staff from the community team to have provided a verbal handover to the medical staff from the inpatient team, the documentation made it clear that the community team had a high level of concern about the patient's condition and safety. It was noted that the community team's lack of diagnosis was indicative of the complexity of the presentation rather than the absence of a proper evaluation.

Although the community team provided appropriate care, it was recommended that the DHB review the communication systems between the community and inpatient teams. The DHB made significant changes to its systems as a result of this case.