

**Co-ordination of discharge from hospital between
medical and mental health teams
(07HDC08795, 25 June 2008)**

District health board ~ Mental health ~ Substance abuse ~ Methadone ~ Addison's disease ~ Hashimoto's disease ~ Community care ~ Hospital discharge ~ Self-discharge ~ Rights 4(3), 4(5)

A woman complained about the services provided to her 27-year-old son by a District Health Board (DHB). The man had a long history of mental health and medical problems and also suffered from substance abuse. Consequently, he posed many complex challenges for his health care providers.

During the seven-month period he was a client of the DHB mental health services, he was admitted to hospital on a number of occasions with medical problems. He was admitted suffering from the effects of an overdose of opiates, and he was discharged after only a few hours. He was readmitted three hours later, in the early hours of the following day, still suffering from the overdose, and pneumonia was diagnosed. He remained in hospital until discharge four days later, but did not take his medications, including antibiotics, with him. He was found dead a few days later.

It was held that the DHB failed to advise the man of the risks posed by the continuing effects of the methadone overdose in his body at the time of his discharge, and to document accordingly. Furthermore, by failing to plan his discharge adequately, and to ensure that the mental health team and the physical health team discussed his ongoing care after discharge, the DHB failed to provide properly co-ordinated services in a manner consistent with his needs. In these circumstances, the DHB breached Rights 4(3) and 4(5).