Psychiatric assessment of a young man
14HDC01268, 20 October 2016

Psychiatrist ~ District health board ~ Risk assessment ~ Management plan ~ Mental health ~ Right 4(1)

A man, aged 20 years at the time of these events, presented to the Emergency Department (ED) at a public hospital complaining of testicular pain. The man had no significant mental health history. On assessment, no source for the testicular pain was found, and the impression was "Anxiety and depressed mood — suicidal ideation." An acute mental health review was requested.

The man was assessed first by two community psychiatric nurses who assessed the man's risk to himself as low–moderate and risk to others as low and requested an urgent psychiatric assessment "for possible ward admission."

A psychiatrist completed the assessment. His impression was that of "Major Depression". His management plan was for the man to return home with his parents (who were present at the assessment) and to return for a further assessment the following morning.

The following morning the man, accompanied by his father, attended a further assessment with the psychiatrist. During the assessment the psychiatrist had difficulty engaging with the man. At the completion of his assessment, the psychiatrist concluded that the man was experiencing a major depressive disorder, with no imminent risk of self-harm.

The psychiatrist made the decision to discharge the man with suggested follow-up with his GP for his testicular pain, and consideration for counselling in the community. The man returned home with his father. He subsequently left the house and was later involved in an incident that resulted in injuries causing his death.

It was held that the psychiatrist did not provide services to the man with reasonable care and skill, and, accordingly, breached Right 4(1) by failing to:

- ascertain and take into account the parents' opinions on risk and their views on the proposed management plan at the initial assessment;
- assess the man's level of risk adequately at the second assessment;
- admit the man, either voluntarily or compulsorily under the Mental Health (Compulsory Assessment and Treatment) Act 1992 and, having decided not to admit the man, failing to offer him ongoing specialist follow-up, or to provide clear, specific guidelines to the man's GP; and
- provide sufficient information to the man's father about his son's condition, and not discussing the proposed management plan adequately or providing clear information about that management plan during the second assessment.

The psychiatrist was also criticised for not documenting the formulation of his risk assessment adequately in the clinical notes.

The district health board was found not to have breached the Code.

It was recommended that the psychiatrist undertake further training on communication with patients, that he undertake further professional development in relation to clinical assessment, and that he provide a letter of apology to the family for his breach of the Code.

In accordance with the recommendation of the provisional opinion, the DHB agreed to undertake a review of all patients seen and discharged by mental health services during a one-month period, looking at short-term outcome, to assess whether risk assessments have been assigned appropriately.