Southern District Health Board
Consultant Psychiatrist, Dr B

A Report by the
Mental Health Commissioner

(Case 16HDC00195)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. Ms A had been a consumer of mental health services since the mid-1990s. Ms A had been diagnosed with bipolar affective disorder and admitted to mental health services a number of times, including an admission in late 2013 under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA).

2. In February 2015, Ms A's mother, Mrs C, contacted Southern DHB's (SDHB's) Mental Health Emergency Team (MHET) about her concerns for Ms A's mental health, and requested that Ms A be admitted under the MHA. Dr B undertook a psychiatric assessment of Ms A, concluding that hospital admission was not necessary and that Ms A could be managed by the community mental health team. MHET made regular contact with Ms A and Mrs C following this assessment.

3. In March 2015, Mrs C told MHET that Ms A had hunting knives in her possession, which she confiscated. Mrs C also reported that Ms A's highs and lows were more extreme.

4. A short time later, Ms A was taken into Police custody after harming a woman unknown to her.

Findings

SDHB

5. The Mental Health Commissioner was critical that SDHB did not have an adequate care plan in place for Ms A, which was contributed to by a lack of psychiatric review over a protracted time. In the Mental Health Commissioner's view, this issue was compounded by the absence of a cultural care plan, and the lack of elementary factors of Māori communication and care in SDHB's engagement with Ms A. SDHB was found to have failed to provide services to Ms A with reasonable care and skill, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[1]

Dr B

6. Individual criticism of Dr B was made for his inadequate documentation, and for failing to discuss Ms A's mental health with Mrs C at the time of the psychiatric assessment in February 2015.

Recommendations

7. It was recommended that SDHB assess how its cultural and clinical care can be best coordinated and integrated, in collaboration with local Māori communities, and with input from consumer and family/whānau advisors. It was also recommended that SDHB provide a further update to HDC in relation to the changes it has made since this complaint, and in relation to the outstanding recommendations made following SDHB's Serious Adverse Event Review.

8. SDHB provided letters of apology to Ms A and her family in response to the provisional opinion, and these were forwarded on by this Office.

[1] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her by Southern District Health Board (SDHB). The following issues were identified for investigation:

- *Whether Southern District Health Board provided Ms A with an appropriate standard of care between June 2014 and March 2015.*
- *Whether Dr B provided Ms A with an appropriate standard of care between February 2015 and March 2015.*

10. This report is the opinion of Kevin Allan, Mental Health Commissioner, and is made in accordance with the power delegated to him by the Commissioner.

11. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Southern District Health Board	District health board/provider
Dr B	Consultant psychiatrist/provider

Also mentioned in this report:

Mrs C	Ms A's mother
RN D	Registered nurse
RN F	Registered nurse/Māori Mental Health Services Clinical Leader
RN G	Registered nurse
RN H	Registered nurse
Mr I	Cultural support worker
Ms J	Ms A's sister

12. Further information was received from Dr E, a consultant psychiatrist who was engaged by Dr B's legal counsel to provide a peer review of these matters.

13. Independent expert advice was obtained from a psychiatrist, Dr Wayne Miles (Appendix A), and a nursing specialist, Dr Jacqueline Kidd (Appendix B).

Information gathered during investigation

Background

14. Ms A had been a consumer of mental health services at various times since the mid-nineties. Her symptoms were predominantly low mood, anxiety, and low self-esteem. She had also been diagnosed with bipolar affective disorder. Ms A had had several mental

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health services admissions, often in the context of drug and alcohol use. In 2013, Ms A was admitted for five days as a mental health inpatient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA). She was taking psychiatric medications to help to manage her symptoms.

Timeline of events

15. The focus of this report is in relation to events that occurred in 2014 and 2015.

16. On 4 June 2014, Ms A ceased taking her psychiatric medications due to what she referred to as "significant side effects". She updated an advance directive (of 18 December 2013) for health care, consenting to her mother and sister being fully involved and consulted if she became partially or fully unable to make an informed choice about her treatment preferences.[2]

17. On 16 June 2014, a referral was made to Māori Mental Health Services (Māori MHS)[3] from the Mental Health Emergency Team (MHET) seeking a key worker for follow-up care and cultural support for Ms A. Registered nurse (RN) D was the Māori MHS key worker assigned to Ms A's care. Following the referral, RN D saw Ms A twice, and assessed her as mentally stable. RN D discharged Ms A back to the care of her general practitioner (GP).[4] On 25 July 2014, Ms A discharged herself completely from SDHB's mental health services, and declined any further follow-up.

18. On 9 February 2015, Ms A's mother, Mrs C, contacted MHET. She spoke with a registered nurse and reported deterioration in Ms A's mental health. Mrs C told the nurse that her daughter had not been taking her medications, and that she had experienced a huge weight loss. Mrs C thought that Ms A's young child might be at risk. The MHA process was discussed, and Mrs C was encouraged to contact Child Youth and Family services (now known as Oranga Tamariki — Ministry for Children). Mrs C told the nurse that she would keep in contact with MHET.

19. At 10.10am on 16 February 2015, Mrs C contacted MHET and reported ongoing concerns for Ms A, and said that she had now uplifted Ms A's child. Mrs C asked for input from Māori MHS, and said that Ms A had agreed to talk with MHET. At 11.10am, Māori MHS contacted Mrs C. Mrs C was told to liaise with MHET if she chose to proceed with trying to have her daughter admitted compulsorily under the MHA. At this stage, no safety concerns were voiced by Mrs C. MHET told Mrs C that it would contact her when it had a plan in place. Māori MHS kept in contact with Mrs C while staff attempted to contact Ms A.

20. On 18 February 2015, Ms A was seen at her home by Māori MHS's Clinical Leader, RN F, and RN G from MHET. A cultural assessment was undertaken and some cultural issues were identified. The following was noted: "Very strong cultural identity ? bordering on

[2] The last reference to the advance directive seen is on 3 July 2014, as noted by RN D during a home visit.
[3] Māori MHS provides specialist and clinical support specific to Māori.
[4] It is noted that Ms A did not have a regular GP.

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delusion." The risk assessment toolkit completed by RN G noted that Ms A remained at risk owing to her extreme views regarding her medications, hospitalisation, diet, and exercise. The extent of this risk was not noted, but it was documented that the criteria for compulsory admission under the MHA were not met. A plan was made to refer Ms A to the Community Mental Health Team (CMHT) and Māori MHS. It is documented that Mrs C was updated and was happy with the plan. RN G also sent a referral to Māori MHS.

21. On 19 February, a file review of Ms A's case was carried out by an SDHB Adult Community Mental Health Services consultant psychiatrist, Dr B, in his role as an emergency psychiatrist for MHET that day. Dr B stated that he was made aware of the full extent of RN G's concerns, and that the primary area of potential risk at the time, i.e., child neglect, was well contained following Ms A's "willing surrender of her [child]" to Mrs C's care. Dr B said that Ms A's nutrition was a matter of concern, but not of an imminently life-threatening nature.

22. MHET proposed to re-engage Ms A with CMHT as soon as possible on a voluntary basis by means of a referral to CMHT, which would involve the allocation of an allied health professional key worker and a psychiatrist, as well as continued cultural input with Māori MHS. Dr B agreed to the plan and signed the file review.

After-hours compulsory assessment

23. On the morning of 20 February 2015, Ms A refused Māori MHS input and dismissed her existing Māori MHS key worker, as she was unhappy with the clinical component of the proposed plan. Māori MHS informed Mrs C, and at 1pm Mrs C requested MHET input and asked that Ms A be admitted under the MHA.

24. RN G made an application for Ms A's compulsory assessment at 1.55pm. By 3pm the appropriate medical certificate had been completed, and at 4.15pm the application was served. Dr B, as the after-hours emergency duty psychiatrist, assessed Ms A between 6–7pm.

25. SDHB told HDC that the assessment occurred after hours because of the acuity of workload for the service on 20 February. Dr B had seen scheduled outpatients in the afternoon, and prior to seeing Ms A had been assessing an acute patient.

26. In making the application, RN G referred to Ms A's sarcastic, irritable, and dismissive attitude. RN G noted "extreme views" regarding diet, exercise, and cultural matters. RN G recorded Mrs C's request for assessment for involuntary treatment, and her concerns about the management of Ms A's child's needs. RN G also referred to Ms A having fallen out with neighbours and agencies. RN G's application states: "It is in my opinion that [Ms A] has an elevated mood and may come to physical harm secondary to extreme diet/exercise views."

27. Dr B's clinical impression, however, was that there were no safety concerns. He considered that Ms A could be managed safely with community support. He documented that Ms A

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had good self cares, that productive dialogue was possible, her thought processes were logical, and that "she was willing to engage". His plan was to follow her up as a voluntary community client with Māori MHS and CMHT. The formal concluding notes for this assessment state: "Admission might be helpful but is not essential. Current pressure on beds and high degree of acuity in Mental Health Unit would hinder this."

28. Dr B told HDC:

> "[Had I considered that [Ms A] needed to be admitted] it would have required a long-distance staff-escorted transfer to [a hospital in another centre], which I did not believe to be warranted at the time, given my view that she would be best treated within the community setting for at least the foreseeable future."

29. SDHB told HDC that SDHB has a 16-bed unit with some flexibility to "flex up". The average bed occupancy at the time of these events was 110%.

30. Dr B acknowledged the perceived ambiguity in the notes (his clinical impression of no safety concerns compared to RN G's application noting concerns as to physical harm). He told HDC:

> "Of importance for me at the time was that the client did not pose risks that would have contraindicated follow-up in the community and I believe the latter to be a viable option."

31. Dr B said that he was aware of Ms A's "objection to intrusion by mental health services" earlier that day. He stated:

> "[I]t did not entirely surprise me that she would have expressed her annoyance at the arrival of MHET.
>
> …
>
> [T]he assessing colleagues also appeared comfortable to arrange follow-up with [Māori MHS] and [CMHT] on the basis of the said findings, including her outward behaviours.
>
> …
>
> I agree that I could have documented this thinking more fully; however I do not believe that I did this assessment in a void."

32. Dr B told HDC that at the time of the assessment he had a comprehensive dialogue with RN G and a Duly Authorised Officer (under the MHA) from MHET. He said that they were happy to refer Ms A to the CMHT. Dr B stated:

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> "I can confirm that no concerns [as to the proposed plan] were voiced by staff to me at the time … I had been appraised of the prevailing concerns and known trends and was acting in that context as part of the after-hours management team."

33. Dr B acknowledged that he had not spoken to Mrs C, and that not to do so was not best practice. He also acknowledged that his notes were somewhat "condensed", and attributes this in part to the fact that it was an after-hours assessment.

34. Dr B stated that he "perused salient information in selected documents and entries in the most recent volume of files". He said that owing to the sheer volume of documents, it would have been outside the scope of this urgent assessment to undertake a detailed critical historical review of all file material dating back to Ms A's first contacts with the services. I note Dr B's submission that his care should not be judged on his clinical notes alone.

35. During the course of this investigation, Dr B's legal counsel obtained an independent peer review of these matters from a consultant psychiatrist, Dr E. Dr E is of the view that Dr B's documentation for an after-hours assessment was adequate.

36. Dr B told HDC that he spent approximately an hour speaking to Ms A, and explored all the areas relevant to the referral, "such as psychotic phenomena, mood status, insight, and judgment and likely behavioural sequelae of same". He considered that although Ms A was hypomanic, "the risks were sufficiently containable and would likely continue to be if she were followed up in the community".

37. Dr B stated that at the time of his assessment, no imminent safety concerns were elicited (i.e., Ms A did not express any current intent to harm herself or others). He said that although Ms A had been involved in verbal disputes, the prevailing level of actual threat at the time was considered low.

38. Dr B stated that Ms A was happy with the plan to be managed in the community setting, and that "given [his] assessment, becoming an inpatient was not discussed".

39. Dr E stated that the MHA requires the least restrictive approach in relation to treating patients, and he considers this approach to be appropriate if a patient is expressing a willingness to engage in a community setting. I further note Dr E's comments that the patient's perspective is fundamental to engagement. Dr E noted:

> "My understanding of the clinical notes provided is that as at 20 February 2015 [Ms A] was hypomanic, but criteria were not met for compulsory treatment under the [MHA], hence ongoing attempts to engage her by the crisis team, the local community mental health team and the Māori mental health team were the most appropriate course of action."

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40. The referral to Māori MHS was made on the same day as the assessment, and RN D again took on the role of key worker. As it was a Friday, follow-up by MHET was to occur over the weekend.

Serious Adverse Event Review of the Mental Health Act assessment

41. A Serious Adverse Event Review (SAER)[5] undertaken after these events notes that the Duly Authorised Officer told the review team that she would have preferred Ms A to be sectioned under the MHA. The Duly Authorised Officer also noted that Ms A was very clever and able to mask her mental ill health, and that the point was whether Ms A met the second limb of the MHA — "the 'seriously' diminished capacity to self care".

42. RN D told the review team that she was surprised that Dr B did not place Ms A under the Act. However, in a later statement, she told the review team:

> "[O]n discussion with [Dr B] I could see the reason he had not placed her under the MHA because there was no sense of her being a danger, other than the risk she posed of neglect to her [child] which was mitigated through her mother having the care of the child."

Events following the MHA assessment

43. On 21 and 22 February 2015, MHET made follow-up telephone calls to Ms A and Mrs C, and no risks or clinical concerns were identified.

44. RN D visited Ms A on 24 February 2015. RN D was not invited into the home, but sat outside and talked to Ms A for some time. It is documented that Ms A appeared superficially engaging, and denied thoughts of harm to self or others.

45. RN D visited Ms A again on 3 March 2015. Ms A was noted to have spoken loudly, and was not as well groomed as on previous visits. She denied any thoughts of harm to self or others. Ms A said that she would be moving to another town, and that rather than seeing Dr B at the appointment scheduled for 13 March, she would prefer to wait until she was settled.[6] RN D said that she informed Dr B of this, and stated:

> "[He was] ok with this, encouraging me to follow up with her as I could, and as she would allow. This was also discussed with Clinical coordinator [CMHT] and the Team Leader, and MDT [the multidisciplinary team] of [Māori MHS]."

46. Dr B told HDC that "this delay did not seem ideal at the time", but that he was still anticipating having the opportunity to review Ms A at some stage. He noted that Ms A's mother could reapply for a reassessment under the MHA "should concerns escalate".

[5] "Review into the Serious Adverse Event involving [Ms A]", completed March 2016.
[6] SDHB told HDC that Ms A's care was to become "planned outreach" (a service provided by Māori MHS and falling under the Māori Health Directorate) when she moved.

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47. On 5 March 2015, RN D contacted Mrs C, who reported that Ms A was isolating herself and was obsessed with being healthy. Mrs C remained concerned, and thought that her daughter was doing what she needed to (such as interacting and communicating with Māori MHS) to remain off the MHA. It was agreed that Mrs C would call RN D if necessary.

48. Between 10 and 14 March 2015, RN D attempted to contact Ms A. At this stage, Ms A was in the process of getting ready to move. On 14 March, Ms A emailed RN D stating that once settled she would contact her when she was in a position to be able to meet.

49. On 15 March 2015 at 7.20pm, Mrs C contacted MHET. She spoke with RN H and reported that Ms A had large hunting knives. RN H told HDC that Mrs C did not indicate that Ms A had voiced any intention to use these items to harm herself or anyone else, and that Mrs C said that the knives had been purchased over the past two months. RN H told HDC that she was aware that Ms A was willing to engage with Māori MHS staff but not clinical staff. RN H felt that the information disclosed by Mrs C did not require follow-up that night. An action point was made to liaise with Māori MHS (RN D) and suggest that Māori MHS contact Mrs C. Ms A's refusal of the 13 March 2015 review was noted, and RN H documented that the plan should include consideration of a review by a psychiatrist prior to Ms A shifting. Information relating to Mrs C's call was relayed to RN D.

50. On 16 March 2015, RN D spoke with Mrs C and noted: "[A]ll going well so far", "[N]il concerns for safety", and "[N]ot feel there are grounds for MHA". There is an action plan to review "ASAP in MDT with [Dr B]".

51. On 19 March 2015, RN D and a Māori MHS cultural support worker, Mr I, visited Mrs C and then Ms A. Mrs C had confiscated Ms A's knives, but felt that Ms A was not a risk to anyone. Mrs C said that she would call the Police or complete section 8A of the MHA if she felt that there was a risk. However, it is further documented that Mrs C reported that Ms A's highs and lows were more extreme.

52. RN D told HDC that Mrs C felt that she had insufficient information to complete an MHA request for compulsory treatment, but that she did voice the absolute desire for her daughter to have treatment. RN D said that she fully agreed with Mrs C and wanted this too.

53. During the 19 March visit, RN D and Mr I carried out a risk assessment of Ms A. RN D told HDC that initially Ms A was reluctant to engage. However, Ms A denied all thoughts of harming herself or others, and did not appear to be hearing voices. Ms A still would not agree to see a psychiatrist, although she did want to have a cultural assessment "down the track". She agreed that once she was settled in her new home, RN D could visit again. The plan was to see Ms A in one month's time, or sooner if willing, and to review her in a multidisciplinary team meeting for a plan moving forward.

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Dealing with lack of engagement

54. RN D told HDC that it is the practice at SDHB that key workers should not "key-work" people who are not willing to engage with a psychiatrist as well. She said that she wanted guidance and support around this, and "did not want [Ms A] to fall through the cracks". She said that she was seeking permission to continue to try to get Ms A to engage, and that she wanted to review Ms A in a multidisciplinary team meeting to obtain ideas from others on how to engage with Ms A more productively. RN D stated that the general consensus was that she was doing what she could.

55. In relation to RN D's comment, SDHB told HDC that when dealing with complex cases, key workers can access team support through the MDT meeting, which is held twice weekly. SDHB told HDC that the MDT terms of reference were that clinical teams review the current management plan, situation, and history, and that the decision/plans moving forward are based on this information, which is presented by the consumer's clinical team.

56. SDHB said that key workers also have the ability to raise issues directly with their team manager/clinical leader and the psychiatrists. They can also complete a MHET alert and begin the MHA process.

57. SDHB told HDC that the team manager can raise with the Clinical Governance Team any issues of concern brought to the team manager's attention, and that meetings to discuss patients who are causing concern are held once a fortnight. SDHB told HDC that no concerns regarding Ms A were raised at the Clinical Governance Meetings.

58. RN D told HDC that she attempted to have Ms A's case reviewed at an MDT meeting on 26 March 2015, but that this particular meeting was not attended by a psychiatrist, and therefore the actual review component of the meeting did not occur. RN D said that it was not unusual for a psychiatrist to be unavailable for the MDT meeting, although she noted that she did have other informal conversations with Dr B regarding Ms A. RN D said that Dr B's advice to her was to continue to try to get Ms A to engage.

59. Although Ms A's case was not reviewed with a psychiatrist at the MDT meeting, her case was discussed with other people present at the meeting. The documented plan was to attempt to engage Ms A with Mental Health Services, and to review her at least monthly with MDT support. It was also planned to continue contact with Mrs C and encourage her to contact Police and MHET if required. At this time, Ms A's risk of harming others was considered to be moderate if she was in her mother's care, and it was noted that Ms A remained in Mrs C's care. It was also noted that Ms A had denied thoughts of harming herself or others. A referral to Supporting Families was to be completed for additional support for Mrs C.[7] It was also decided that RN D would continue to attempt to engage with Ms A, with a low threshold for involvement from MHET and the Police.

[7] This was sent on 10 April 2015, and re-sent on 26 May, as the original had not been received.

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60. A few days later, SDHB Mental Health Service was informed by the Police that Ms A was in custody after harming a woman unknown to her. The following day, RN D contacted Mrs C, who told her that Ms A had been up and down in the last ten days, but that at no time had she felt that she or anyone else was at risk. Mrs C had thought that her daughter had been doing better.

Other information

61. SDHB told HDC:

> "The team have reflected with the benefit of hindsight, and acknowledge that a different approach and interventions may have achieved different outcomes. Our records note that at the time, [Ms A] appeared to be engaging with the service and it was hoped that taking time to establish a therapeutic relationship would bring better acceptance and participation in her treatment. At each point of contact her immediate risk was assessed and a plan made for on-going reassessment of [her] mental health disorder."

62. Recently, SDHB underwent a substantive independent review of its governance, management, and delivery of Māori health services. Māori MHS was part of this review. This led to the appointment of a new Māori Health Leadership Team with recommendations that the current Māori Health Directorate, which includes Māori MHS, be re-integrated and under the management of SDHB Mental Health, Addiction and Intellectual Disability Services (MHAID). SDHB stated: "[T]he re-integration of services will provide clear policies and standards, [and] support for improved cultural and clinical care to ensure tāngata whaiora and their whānau stay well."

63. SDHB's SAER found that overall the care provided to Ms A was reasonable. However, a number of recommendations were made (some of which are discussed below):

1. Ms A's history could have been considered more carefully.

   SDHB reported that staff have been reminded of the importance of the collection of collateral history that may contribute toward the identification of risk and the care and treatment of the individual. SDHB is also reviewing its clinical risk management systems and triage processes across the service. Risk identification and management workshops are mandatory for all staff.

2. SDHB Mental Health Service staff are to be reminded of the importance of family/whānau/significant others.

   Family education/working with families workshops are now embedded in the DHB's training schedule.

   The Mental Health Service ensures that the family/whānau and/or close social network of a consumer participate in the client's assessment process, and it enables family/whānau to share their experience with staff through feedback surveys and focus meetings.

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3. The structure and service delivered by Māori MHS should be evaluated against the needs of the population it serves.

   Since these events, an extra registered nurse has been assigned to Māori MHS, and daily meetings are carried out to discuss shared client caseloads, improved referral pathways, etc. In addition, training has taken place as part of the new district-wide cultural assessment form that will be used with all clients/whānau referrals.

   Māori MHS staff now review their consumer caseloads weekly. This is to identify any risk for the consumer/tāngata whaiora, with strategies and resourcing put in place to address this.

   In addition to mental health assessments, Māori MHS staff undertake cultural assessment in partnership with consumer tāngata whaiora, to identify cultural needs and issues.

64. Other changes being considered also include a review of the use of senior medical officers to aid the MDT process, and SDHB is looking at how it can use video-conferencing and other technology remotely to aid patient/family communication.

65. Dr B told HDC that the above events highlighted for him the need to provide a fuller context in his notes, especially with regard to information provided by others prior to an assessment.

Responses to provisional opinion

66. The parties were all given the opportunity to respond to relevant sections of my provisional opinion.

67. Dr B accepted the findings. SDHB accepted the opinion and recommendations, and stated that it would implement the recommendations with urgency. It advised that it had already commenced a programme of work to implement the recommendations made by the SAER.

68. Ms A stated: "[T]here were huge red flags that should have signalled to SDHB that I needed help." She further stated: "I feel dreadful for what I did and the hurt & pain I have caused the victim of my offence. My life has been turned upside down. I lost my [child], I lost my house and I could no longer work. I feel SDHB failed me and I definitely slipped through the cracks."

Opinion: Southern District Health Board — breach

69. A specialist mental health nurse, Dr Jacqueline Kidd, provided expert advice during the course of this investigation. Dr Kidd reviewed the nursing care and the care provided by the DHB overall, from a nursing systems perspective.

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70. Psychiatrist Professor Wayne Miles also provided expert advice. Professor Miles focused on the psychiatric care provided to Ms A by psychiatrist Dr B, and the care provided by the DHB overall, from a mental health services systems perspective.

Level of engagement with Ms A

71. It is apparent that generally Ms A was happy to engage with Māori MHS but not clinical staff. On occasions, Ms A was reluctant to engage at all. For example, during Ms A's risk assessment on 20 March 2015, Ms A displayed a reluctance to talk or to see a psychiatrist or engage with her community worker. However, it is noted that she was open to a cultural assessment "down the track".

72. Dr Kidd noted that whether the services and the individual nurses had engaged appropriately with Ms A depends "a great deal" on whether Ms A wanted to engage with them. Dr Kidd advised: "It is not a one-sided process."

73. Dr Kidd noted Ms A's increasing interest in her Māori heritage, and advised that this indicated that "there could have been an opportunity to engage with [Ms A] more fully through Te Ao Māori". Dr Kidd advised:

> "[I]t can be complex to work as a nurse across the clinical and Māori worlds, but in my view [Māori MHS] seemed in this case to abandon the Māori world in favour of the clinical one."

74. Dr Kidd notes that there is no evidence that the Māori MHS cultural worker had any involvement with Ms A. Although an urgent cultural assessment was carried out on 18 February by RN F (Māori MHS), it is noted that there is no evidence that this was followed up, or a cultural care plan created. Dr Kidd advised that "the lack of a documented cultural care plan was a departure from best practice in the Māori mental health context", but that there are no specific standards against which to measure this.

75. It is noted that RN D (Māori MHS) conducted risk assessments at each contact, and documented these. Dr Kidd advised that this met the expected standard of care, but that RN D should have worked with Ms A on her cultural needs. Dr Kidd noted that this "may have allowed their relationship to progress more rapidly".

76. Dr Kidd advised that overall the level of engagement with Ms A did not breach any Nursing Council competencies, but that it was lacking the most elementary factors of Māori communication and care.

77. I note that since these events, SDHB has increased its staffing levels and made changes to the format of its cultural assessments. Dr Kidd advised that this "is a great deal more comprehensive and includes cultural care planning and ongoing evaluation of care".

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Level of engagement with Mrs C

78. Dr Kidd advised:

> "[T]he RNs at MHET responded in a timely way to concerns raised by [Mrs C]. They organised assessments and referrals, and made contact to remotely assess risk during out-of-hours times when requested."

79. I note that the progress notes of both Māori MHS and MHET demonstrate that Mrs C was responded to when she contacted them, and was proactively kept informed of Ms A's mental state and the management plan. However, Dr Kidd advised that the registered nurses appeared to focus primarily on risk assessment and evaluation of Mrs C's position with regard to initiating the MHA, and did not identify or attend to Mrs C's fears as well as they could have. Dr Kidd notes that Mrs C's requests for help were responded to but that her perspective was not explored fully or recorded in the notes, and nor was she engaged with in a collaborative way. For example, Dr Kidd notes:

> "[I]t is emotionally very difficult for whānau to initiate contact with mental health services, and I expect that it was also a difficult decision for [Mrs C] to uplift [Ms A's] child. This does not appear to be taken into account in the service's interactions with [Mrs C]."

80. Professor Miles noted the large responsibility placed on Ms A's mother to monitor the situation, to evaluate her daughter's risk, and to initiate Police involvement or the Mental Health Act if she was concerned.

Ms A's management plans

81. Dr Kidd notes that the management plans documented in the progress notes and MDT record show that the main priority for the key workers and MHET in 2015 was to maintain contact with Ms A and her mother, and establish a relationship with Ms A that would support ongoing engagement and risk assessment. Dr Kidd advised:

> "This would not usually constitute an adequate management plan because it does not contain information about [Ms A's] recovery goals or plans for how to achieve them. However, [Ms A's] reluctance to engage in anything she perceived as 'clinical' and the relatively short period of time [RN D] had been involved with [Ms A's] care are mitigating factors."

82. As outlined above, Dr Kidd advised that the cultural aspects of Ms A's care did not feature in the management plan, which she advised was a missed opportunity to provide full and effective care. However, Dr Kidd said that MHET, RN D, and the MDT developed an appropriate management plan for Ms A "in the context of the early stage of relationship building with [Ms A]".

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RN H's handling of notification of knives

83. RN H (MHET) received a telephone call from Mrs C about Ms A having knives. Dr Kidd advised:

> "[I]n my view it would have been prudent to arrange an immediate face to face risk assessment. There is no rationale given in the notes for not arranging an urgent assessment for [Ms A]."

84. Dr Kidd notes, however, that Mrs C appeared to reassure MHET that Ms A's risk of harming herself or others was low. In addition, I note that RN H told HDC that she was aware of Ms A's reluctance to engage with clinicians. Dr Kidd advised that if RN H had been reassured by Mrs C and was aware of Ms A's reluctance to answer clinical questions, then RN H's response of only notifying Māori MHS "could be viewed as adequate".

Dealing with Ms A's reluctance to engage

85. Although Dr Kidd notes the lack of engagement as a mitigating factor for the individual nurses involved in Ms A's care, Professor Miles advised that from a systems perspective, what was apparent to him was the lack of any plan on how to deal with Ms A's lack of engagement. He advised: "The awareness that [Ms A] was difficult to engage was well recognised but there is an absence of a concerted and agreed plan to address that issue." I note that RN D told HDC that often a psychiatrist was absent from MDT meetings. Professor Miles advised that this difficulty in obtaining a thorough and complete team review points to "a lack of structured ways to deal with complex cases".

86. Professor Miles noted that engaging with a client who has "an underlying negative attitude to service engagement and to treatment is a considerable problem". Overall, however, he was concerned that "the care offered seemed to be of wait and see rather than a careful structured plan that sought to create engagement and the gathering of sufficient information to know the depth and severity of the illness effect".

Lack of a clear leader in Ms A's care planning

87. Professor Miles advised that there was not a clear leader in Ms A's care planning. He stated: "Especially absent from this planning overview is the specialist psychiatrist." Professor Miles advised that "[w]hat is never addressed is what actual planning and support might be anticipated from a consultant psychiatrist with such a complex case".

Lack of information in clinical notes

88. Professor Miles advised that Ms A's clinical notes for this period "have no comprehensive longitudinal view". In addition, he noted:

> "One sees quite different reports and interpretations by differing assessors over quite short time periods … What I would have expected though would be some acknowledgement of these differing pictures and attempts to understand those differences."

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Conclusion

89. Professor Miles advised:

> "The threads I see running through the available notes, the internal reviews and the responses to my comments would make me think that we are more likely to be looking at a system wide problem rather than the deficiency being linked to one or two practitioners."

90. Dr Kidd noted:

> "[B]ased on the progress notes, risk assessments and MDT assessment … SDHB appeared to hold a narrow view of what care could and should be offered to [Ms A] and her whānau. It seems from the documents that the focus was on risk and whether [Ms A] met the criteria for the Mental Health Act. … [T]he responsibility of mental health services and staff involves holistic, recovery focused care that considers a range of interventions and treatments that meet the full range of people's needs."

91. Dr Kidd further noted that Ms A had made good progress in the changes she had made at her own initiative (around June/July 2014 prior to re-engaging with mental health services), including a significant reduction in her alcohol and drug use. Focus on this progress could have been a way to engage with Ms A in an appropriate treatment plan. There is no evidence that these strengths-based aspects were considered when attempting to build engagement with Ms A.

92. From a psychiatric perspective, Professor Miles advised that he had "considerable concerns about the standard of care". However, he noted several mitigating factors, including Ms A being at times difficult to engage, her ability to give her assessors "a false sense of well being", and the statements from Mrs C when communicating with the nurses that she felt that her daughter was not a risk to herself or others.

93. I accept that this was a complex case with several mitigating factors. Overall, however, I am of the view that the failings exhibited are systems issues for which SDHB is accountable.

94. The level of engagement with Ms A was described by Dr Kidd as lacking the most elementary factors of Māori communication and care. I am concerned by this, as well as by the lack of a cultural care plan.

95. Although I note that at times it was difficult to engage with Ms A, no structured plan was put in place to address this. RN D refers to the difficulty of obtaining a thorough and complete team review, and the difficulty of obtaining input from psychiatrists at MDT meetings.

96. In addition, reliance was largely placed on Ms A's mother to monitor and evaluate Ms A and initiate the MHA if she felt it necessary, while at the same time, little support was

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being provided to her. As noted by Dr Kidd, it is a "big ask" for a mother to initiate the MHA.

97. Professor Miles noted the lack of a comprehensive longitudinal view, and the differences in assessment by different individuals and/or at different visits, as well as the lack of acknowledgement of this or of any attempt to understand these differences. Professor Miles also noted that there was not a clear leader in Ms A's care planning. As outlined above, Professor Miles further noted the delay in reviewing Ms A following the request by Mrs C on 20 February that her daughter be admitted. I agree with Professor Miles' concerns.

98. In reviewing Ms A's care, my fundamental concern is the lack of an adequate care plan, contributed to by the lack of psychiatric review over a protracted time. This is aptly summarised by Professor Miles' comment that the care offered "seemed to be of wait and see rather than a careful structured plan that sought to create engagement and the gathering of sufficient information to know the depth and severity of the illness effect". This was further compounded by the lack of an adequate cultural plan.

99. In summary, I find that SDHB failed to provide services with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[8]

Opinion: Dr B — adverse comment

100. Professor Miles advised that overall the care provided by Dr B was "significantly short of that expected". It is further noted, however, that Professor Miles also advised: "[I]n my view [Dr B's] failings are a small part of a bigger picture of less than satisfactory care". In addition, Professor Miles stated:

> "The threads I see running through the available notes, the internal reviews and the responses to my comments would make me think that we are more likely to be looking at a system wide problem rather than the deficiency being linked to one or two practitioners."

Documentation

101. Professor Miles was particularly critical of Dr B's notes from the 20 February 2015 assessment of Ms A, and advised that the notes "lack a full account of the clinical assessment and thinking". Professor Miles further advised that he was unable to ascertain what information Dr B actually considered, and how this influenced his evaluation. However, I note that Professor Miles also advised that Dr B's written response to HDC suggests that a more thorough mental state evaluation was actually performed than was recorded in the notes.

[8] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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102. My interpretation of Professor Miles' advice is that he is critical not of the approach that was taken (i.e., a return to being treated in a community setting), but that there was nothing to back up why that approach was being taken, and that generally there was poor documentation, which made it difficult to comment on the standard of care provided by Dr B. I have therefore decided to focus primarily on the documentation issues identified by Professor Miles, including the following:

- The notes include only a "very cursory mention" of the concerns leading to the request to assess, and no reference to the major concerns of others.
- The notes provide only a brief summary of Ms A's past mental health episodes, which gives the reader the impression of a "minimally impacting mental illness". Professor Miles advised that therefore it is very difficult to know what impact Ms A's longitudinal history had on Dr B's decisions regarding a treatment plan, as little is mentioned in his notes.
- The notes include only bullet points regarding the mental state examination undertaken by Dr B, and provide only a summary judgement and do not describe the phenomena being presented/observed. Professor Miles advised: "I have no way of knowing which components of the mental state assessment and their possible impacts were considered."
- There is a brief statement that Ms A was "[p]hysically healthy", but there is nothing to base this on. Given the expressed concerns about her weight loss, Professor Miles advised that "such assessment would be worthy of comment".
- Dr B's plan was to follow up Ms A as a voluntary community client. Professor Miles advised that there is little explanation as to why Dr B felt that Ms A would commit to such a plan despite the fact that her refusal to follow that plan was a reason why he was seeing her.
- There was no ongoing plan of management that took into account the differing concerns of others, nor any guidance on how to deal with Ms A's noted issues.

103. Dr B submitted that his care should not be judged on his clinical notes alone. I accept this, but also accept Professor Miles' advice that "clinical notes have as one primary purpose the provision of information to others that will help guide current and future care for the client". This was the first time a psychiatrist had engaged with Ms A for a considerable time, and the first time she was seen by Dr B. Professor Miles advised that therefore "a full account of the clinical assessment and thinking" was important. I note that Dr B informed HDC that the incident has highlighted the need to provide a fuller context in his notes, especially with regard to the information provided by others prior to an assessment.

104. During the course of this investigation, Dr B's legal counsel obtained an independent peer review of these matters from a consultant psychiatrist, Dr E.

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105. Contrary to Professor Miles' opinion, Dr E is of the view that Dr B's documentation was adequate, particularly for an after-hours assessment.

106. Although this was an emergency after-hours visit, I note Dr B's acknowledgement that his notes were somewhat condensed, particularly given that this was the first time he had engaged with Ms A, and that a significant time had elapsed since Ms A's previous engagement with a psychiatrist.

107. I conclude that Dr B's documentation should have been more comprehensive in order to provide guidance for Ms A's on-going care.

Communication

108. Dr B acknowledged that although it was Mrs C who initiated the assessment, he had no discussion with her, and that this was not best practice. Professor Miles advised:

> "I would expect that when [an assessing psychiatrist's] findings were at variance with the collateral, especially from family members, they would have a dialogue about that, that they would have made some notes about the difference and they would ensure the ongoing plan of management took that into account."

109. As acknowledged by Dr B, despite the assessment occurring after hours, the lack of a discussion with Mrs C was not best practice, and was inconsistent with the Ministry of Health and the Royal Australian and New Zealand College of Psychiatrists guidance about family engagement.

110. Professor Miles stressed that in his view, Dr B's failings were a small part of a bigger picture of less than satisfactory care. Professor Miles advised: "The absence of any psychiatric review over a protracted period of time drives the focus on his one off review; that absence is to me a more serious issue." I agree.

Conclusion

111. Although I note the mitigating factors in relation to an after-hours assessment, including the systems issues, and also note the differences in clinical opinion, overall I am critical of Dr B's documentation and family engagement.

Recommendations

112. Following consideration of the actions SDHB has taken in response to the issues arising from this complaint, I recommend that SDHB:

a) Assess how its cultural and clinical care can be best coordinated and integrated, with reference to the standards and guidelines referred to in Dr Kidd's advice, and in collaboration with local Māori communities, and with input from consumer and

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family/whānau advisors. SDHB is to report back to this Office on the outcome of its review, and outline the actions it has taken as a result of the review, within six months of the date of this report.

b) Provide a further update to this Office in relation to the changes SDHB has made since this complaint and in relation to the outstanding recommendations made following the SAER. SDHB is to provide a plan to this Office outlining how and when it intends to action any recommendations that have not been implemented, within six months of the date of this report.

113. In response to the provisional opinion, SDHB provided letters of apology to Ms A and her family. These have been forwarded on to them by this Office.

Follow-up actions

114. A copy of this report with details identifying the parties removed, except SDHB and the experts who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

115. A copy of this report with details identifying the parties removed, except SDHB and the experts who advised on this case, will be sent to the Royal Australian and New Zealand College of Psychiatrists, the Health Quality & Safety Commission, Te Ao Māramatanga New Zealand College of Mental Health Nurses, the Director of Mental Health, and the Mental Health Foundation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Associate Professor Sylvester Miles:

"In providing this advice for the Commissioner I have examined:

- The complaint of [Ms A] dated […]
- [The SDHB response] dated […]
- Copies of clinical notes relevant to the complaint [dates]
- Police summary of facts (printed draft and undated)
- SDHB Adverse Event review written by [RN D] (undated)
- Confidential Review into Serious Adverse Event completed March 2016 commissioned by SDHB.

I was requested to focus on three questions

The appropriateness of [Dr B's] assessment and management on 20 February 2015.

The appropriateness of [RN D] and [Mr I's] assessment and management of [Ms A] on 15 March 2015 given that her mother reported she had two knives in her possession, and she was reluctant to engage.

The overall standard of care provided to [Ms A].

And to consider

a) What is the standard care/accepted practice?
b) If there has been a departure from the standard of care or accepted practice how significant do you consider it is?
c) How would it be viewed by your peers?

The appropriateness of [Dr B's] assessment and management on 20 February 2015

This was evaluated by means of

- Handwritten notes of that assessment (4 pages).
- A type written note prepared 20.11.2015.
- A further typewritten note, undated in preparation time with header 'some minor modifications for clarification'.
- A clinical report to Director of Area Mental Health Services dated 20/02/2015.

To put this assessment in perspective it is important to note that this was an assessment arranged under the Mental Health Act following the application (s 8A) by [RN G] supported by a medical certificate (s 8B) by Dr […]. In making the application [RN G] refers to the sarcastic, irritable and dismissive attitude of [Ms A]. She notes

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'extreme views' re diet, exercise and cultural matters. The concern of [Ms A's] mother is referenced as is her request for assessment for involuntary treatment. There is also reference to [Ms A] having fallings out with neighbours and agencies. There is concern that she has an elevated mood and is possible risk from her extreme views.

a) What is the standard care/accepted practice?
Standard practice in such a situation would be to:

— Gather information from those with concerns finding out why they think the patient may be mentally unwell and what worries they have about the proposed patient.

— Consider the longitudinal picture available about the person's past mental health issues, and risks related to that, what treatments and hospitalisations were required, what was [the] outcome of that.

— Carefully explore with the patient their current situation, including their perceptions of the concerns of others. Explore past episodes of mental health issues, patient's views of these, degree of awareness of previous problems.

— Do a detailed mental state examination.

— Where indicated assess physical contributions that might relate to the mental health issues.

— Assemble the above to create a diagnostic formulation and then use that formulation to develop an indicated approach to treatment. The place of involuntary assessment and treatment under the Mental Health Act would be considered as part of that overall management plan.

— Where the doctor's assessment is quite different from that of others there should be careful discussion of why it is different and careful planning of intervention that takes those differences into account.

b) If there has been a departure from the standard of care or accepted practice how significant do you consider it is?
The practice of [Dr B] as judged by appraisal of the above mentioned records is significantly short of that expected as follows:

— *Gather information from those with concerns finding out why they think the patient may be mentally unwell and what worries they have about the proposed patient.*

There is very cursory mention of the concerns leading to [the] request to assess. Eg 'concerns raised about elevation of mood', 'possibly neglecting health and diet'. The concerns as expressed in the application for assessment and in the available reports from the patient's mother are of much greater concern than would be seen in the brief report of [Dr B]. He makes no reference to the major concerns of others.

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— *Consider the longitudinal picture available about the person's past mental health issues, and risks related to that, what treatments and hospitalisations were required, what was [the] outcome of that.*

There is a brief summary of past episodes that give the reader the impression of a minimally impacting mental illness. There is more in the notes from others that I read that does give some picture but all this is in stark contrast to that which is summarised in the Forensic Report attached to the SDHB Commissioned Serious Incident Review. It seems unlikely that these facts were not known or at least available to [Dr B] when he was completing the assessment and management plan. If such detail was truly not available that is a major system failure.

— *Carefully explore with the patient their current situation, including their perceptions of the concerns of others. Explore past episodes of mental health issues, patient's views of these, degree of awareness of previous problems.*

The recent changes in values and practices are referenced as 'new cultural/spiritual avenues' and 'a sense of renewal and awareness …'. This seems to indicate that he took her explanation as being more relevant than that collateral information that he should have been aware of. The end result would be a considerable diminishment of the significance of such issues as her recent changes of attitude, belief and behaviour.

— *Do a detailed mental state examination.*

This is only reported as a series of brief bullet points that do not describe the phenomena being presented/observed but purely give the summary judgement. Where there are any details they do not seem totally consistent with what I have gleaned from the notes, for example 'possible mild impairment of reality testing (pertaining to own sense of spiritual renewal) but not delusional'.

'[W]illing to engage and use support advice' does not fit with all the collateral available.

— *Where indicated assess physical contributions that might relate to the mental health issues.*

I doubt this occurred. There is a brief statement that she is 'Physically healthy' but nothing to base that on. Given expressed concerns about weight loss such assessment would be worthy of comment.

— *Assemble the above to create a diagnostic formulation and then use that formulation to develop an indicated approach to treatment. The place of involuntary assessment and treatment under the Mental Health Act would be considered as part of that overall management plan.*

Diagnostic formulation is limited to 'Hypomanic' or 'Hypomanic but behaviourally contained and open to reason'. The only plan is 'follow up as voluntary/Common client …'. He also notes 'Admission might be helpful but not essential. Current

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pressure on beds and high degree of acuity in Mental Health Unit would hinder this.' It is not possible to know from what is written if he was aware of the concerns of others and the collateral that suggested she indeed had others concerned about her behaviour.

There is no plan around the ongoing care and treatment apart from '[Māori MHS] and SMHT to provide support/advice/monitoring of mood state'. This does not give those who are charged with the responsibility for ongoing care any guidance about how to deal with the mood issues, what to do with her beliefs that appear to be driving behaviours of concern and the like.

— *Where the doctor's assessment is quite different from that of others there should be careful discussion of why it is different and careful planning of intervention that takes those differences into account.*

This aspect of the assessment/management process is totally absent. In part the absence of any recording in [Dr B's] notes of the concerns of others and the different interpretations between the patient and her caregivers makes it hard to even know if he was aware of that. I think however he should have been and that it would be incumbent upon him as the assessing and treating psychiatrist to have had communication with other team members and also with her mother about how his impressions differed from theirs, why he was less concerned than they were and how he felt there could be ongoing support and monitoring in these circumstances.

To illustrate the difference between the way [Dr B] summarised and interpreted findings on 20.02.15 and the way she was seen by others I quote some key points of an assessment on 18.02.15

> 'expansive, irritable, sarcastic. Labile, overly talkative. Not like relaxing. Increased physical activity. Distractible Views bordering on extreme at times. Multiple fallings out. Fixation on nutrition and exercise. Is at risk due to her extreme views.'

Compared with, on 20.02.15

> 'engaging well and a productive dialogue possible.
>
> Increased speech volume but no pressure
>
> ?mild impairment reality testing but not delusional'

There is no explanation of these marked differences nor is there any recording of discussion with other parties about the differences.

c) How would it be viewed by your peers?

It is my opinion that most of my peers would have a similar reaction to the situation as apparent in the available notes. There seems to be a minimisation of concern and a serious difference in the assessment of [Dr B] as compared to others. Whilst I would not expect an assessing psychiatrist to make their diagnostic formulation and

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management plan based solely on the collateral information they receive and the concerns of others I would expect that when their findings were at variance with the collateral, especially from family members, they would have a dialogue about that, that they would have made some notes about the difference and they would ensure the ongoing plan of management took that into account.

An assessment under the Mental Health Act should be about more than 'do they satisfy the requirements for involuntary treatment or not' but I suspect that these notes indicate the 20.02.15 assessment was only about that.

I also suspect that expression in the notes of that admission without any indication of how that was discussed and worked through would be seen as less than standard care.

The appropriateness of [RN D] and [Mr I's] assessment and management of [Ms A] on 15 March 2015 given that her mother reported she had two knives in her possession, and she was reluctant to engage.

I have made an assumption that the assessment in question was actually that of 20 March 2015[1]. This assessment follows two phone contacts with the mother of [Ms A].

The first was on 15 March where [RN H] of [MHET] received the information about the finding of knives, knife sharpener, rope and baseball bat. Mother expressed concern and raised previous violence toward her. She also described a 'weird' self photo on Facebook. There were action plans to liaise with [Māori MHS] to suggest they contact mother, and also to consider a 'psych' (one assumes psychiatrist) review occurs before [shifting] (noting her refusal for such review that was set up on 13.03).

The second was initiated by [RN D] of [Māori MHS] on 16 March. What is recorded from mother is quite different from that the day before; 'all going well so far', 'nil concerns for safety', 'not feel there are grounds for MHA'. There is also reference to [Ms A's] response to an email which it is said is copied in the file, but I cannot find that email copy. There is an action plan to review 'ASAP in MDT (multi disciplinary team) with [Dr B]'. This review did not occur before the home visit of 20 March[2].

a) What is the standard care/accepted practice

An evaluation of a community mental health client who is suspected of having a serious mental illness and who is showing signs suggesting a reduced awareness/acceptance of that illness and a consequent diffidence to engage with treatment services would involve

- Evaluation of the current mental state.
- Exploration of the possible impact of this mental state on their day to day function.

[1] Please note that the home assessment was 19 March not 20 March. It was retrospectively documented on 20 March hence why it can appear in the notes as if it occurred on 20 March.
[2] 19 March.

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— Consideration on risks to self or others that may be part of that.

— Gathering collateral information from significant others re the above.

b) If there has been a departure from the standard of care or accepted practice how significant do you consider it is?

This can only be assessed based on a page and a half report from [RN D]; there is no account from [Mr I].

The notes would suggest there is a departure from the desired standard regarding the first three items. The meeting with [Ms A] is summarised by her reluctance to talk, to see a psychiatrist and to engage with community worker. There was some dialogue but I assume quite limited. She is reported to be 'polite and pleasant' and 'denies thoughts of harm to self or others'.

It is quite possible that the departure from the desired standard may not have been due to the practitioner not attempting to conduct the usual assessment but was largely due to the inability to engage with the client. This is, I acknowledge, quite speculative. What is clear though is that we do not have access to a full mental state and that states impact.

The fourth component, gathering collateral, did explore relevant areas. The knives were discussed with an interpretation that explained it in a 'normalising' framework ('like to go diving and hunting'). It is not stated if that was something she has always done or is another new plan. It is clear mother had considerable concern about mental state ('all over the place') and mother recounting the suicide of [a close family member] and saying [Ms A's] highs and lows were more extreme than [that]. There is however a statement from the nurse that mother feels 'she is not a risk to anyone'. This in some ways negates mother's expressed concerns about her daughter's mental wellbeing.

The management plan following this assessment was:

— Mother will contact police if feels there is a risk; will complete section 8A at that time.

— See [Ms A] in 1/12 or sooner if she is willing.

— Review [Ms A] in MDT for plan moving forward.

I have concerns that this management plan is below the standard I would expect for the type of client [Ms A] appears to be from the notes. There is a large responsibility placed on [Ms A's] mother to monitor the situation, to evaluate risk and to initiate police/Mental Health Act if concerned. There is no mention of the support for mother from the services.

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There appears to be a decision about lack of risk based on a very minimal engagement with a client who has a known history of recurrent episodes of care, some that needed Mental Health Act, and a reported incident of violence against mother. Equally ignored is the engagement difficulty and the refusal of any treatment for her illness; the management plan does not have any steps to address (purely a one month follow up).

The action to have case reviewed by MDT is very appropriate and might indicate that the assessor was concerned; however that concern is not expressed in the notes and there is no evidence that it was passed on to the MDT.

c) How would it be viewed by your peers?
I would think that there would be shared concerns from peers; though I acknowledge that there are issues of work pressure and the like that might influence some to see this differently. It is also obvious that [Ms A] is difficult to engage and maybe gives her assessors a false sense of well being.

The overall standard of care provided to [Ms A].
I have considerable concerns about the standard of care as is outlined in the clinical notes.

I must acknowledge that this concern might be biased by my awareness of the subsequent actions of [Ms A], the hindsight bias problem.

I also acknowledge that having read the post incident reports from SDHB and the Forensic report could have affected how I see the situation.

A further factor that could bias my review is the reports provided by her sister and mother to the incident review.

I also wish to state quite directly that although I have been critical of service offered I am in no way implying that the incident that happened could have been avoided if a higher standard of care pertained.

The notes I reviewed (from 10.10.14 up to 26.03.15) have no comprehensive longitudinal view (in stark contrast to the forensic report of 18 November 2015). It may be that this longitudinal history was known by the treating teams but even if it was it seems to have minimal impact on decision making.

One sees quite different reports and interpretations by differing assessors over quite short time periods. It is clearly impossible for me to know which of these assessments represented a truer picture of the mental wellbeing of [Ms A]. What I would have expected though would be some acknowledgement of these differing pictures and attempts to understand those differences.

Examples include

— The reports of mother's concerns of [RN H] of [MHET] on 15 March compared with that of [RN D] ([Māori MHS]) on 16 March.

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— The assessment of [Ms A] of [RN G] on 18.02.15 and that of [Dr B] on 20.02.15.

The overall impression I have is that there was not a clear leader in the care planning. Especially absent from this planning overview is the specialist psychiatrist. This is a client with a known history of serious mental illness whose family continue to express concerns re her wellbeing and who has a known history of non-engagement with services and for whom there has been need for use of the MHA, yet there is only one note from a psychiatrist in nearly six months. This note is a brief summary of an assessment to decide about use of the MHA. There are a couple of brief summaries of clinical reviews that say the psychiatrist was present but these do not add to the plan.

I am also concerned that there seems to be very little recording of basic mental state observations and those phenomena that are recorded seem to be largely dismissed in the ongoing planning. It seems clear to me that this young woman has formed views and is acting on these in ways that are for her unusual. They appear to coincide with family's concerns for her. They are not seen as possible indicators of an underlying delusional system but are explained in a way as to make them understandable and thus acceptable.

I note there is a reference to an advanced directive drawn up when she discharged herself during a previous episode of care, not wanting follow up. I did not see this in the notes but more importantly there was no direct mention of it during the period in question. There was however repeated mention of her reluctance for care and her reluctance to take medication. It is possible that this 'advanced directive' had a greater impact on the care planning than is apparent from the notes.

In summarising though I appreciate that engaging a client with a hypomanic episode who has an underlying negative attitude to service engagement and to treatment is a considerable problem. I am concerned that the care offered seemed to be of wait and see rather than a careful structured plan that sought to create engagement and the gathering of sufficient information to know the depth and severity of the illness effect.

S W Miles 20.06.2016."

Further advice was provided by Professor Miles on 21 October 2016:

"This report is based on review of the additional material provided by the Southern District Health Board which included:

— response from [Southern DHB], accompanied by information about workshops on working with families, Cultural Assessment and Plan, Adverse Event Review ([Authors]), Review of Serious Adverse Event completed March 2016, Advance Directive for healthcare for [Ms A];

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— response from [Dr B];

— response from [RN D] via NZNO.

I was requested to report whether the information provided would lead me to reconsider my previous advice (of 22 June 2016).

I reviewed the above reports and my advice of 22 June alongside the available clinical notes for the period in question.

I acknowledge the considerable thought and effort that Southern DHB has put into understanding and addressing issues raised in [the complaint].

I will first address the rebuttal points raised by the respondents then address the impact on my advice.

Consideration of responses

Response of [The CEO]

[The CEO] observes that with [Ms A] moving to [another town] the distance factor required her care to become 'planned outreach'; I accept the distance imposes constraints but would have thought that there would still be the same obligations for a thorough assessment of treatment need that would take into account changing circumstances and indicators. She also mentions that [Mrs C] was often the first point of contact and her views were sought; again I accept that but this response from [the CEO] does not address the manner in which her ([Mrs C]) views were addressed and the support she had in making her decisions. The fact that services knew [Ms A] was historically 'hard to engage' and this episode was showing strong hints of replicating that difficulty might, as [the CEO] acknowledges, have suggested a different approach (without having to wait to apply the 'benefit of hindsight').

I note the steps being taken to address the recommendations from the serious incident report which one hopes will add to the service's effectiveness. They are not relevant to my opinions about the incidents in question however.

The inserts from clinical notes about contact with [Mrs C] reaffirm my views from initial reading of case notes that [Mrs C] had for the period in question considerable concern re her daughter.

> 'very much aware of [Ms A's] extreme views', 'requesting that MHA be instigated', 'remains concerned about [Ms A] … isolating self … obsessed with being healthy', 'reports rapid changes in [Ms A's] thought processes', '[Ms A] is saying what she thinks we need to hear to remain out of the unit and off the MHA', '[Ms A] has purchased hunting and diving knives, knife sharpeners, rope and baseball bat. Not cheap imitations. [Mrs C] is concerned … acknowledges previous domestic violence'

Viewing the Advance Directive was helpful. It confirms that [Ms A] had an awareness of her propensity for mental illness episodes and also that these might affect her capacity to make informed choice. It also gives very clear permission for the

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involvement of her mother and sister if there should be such concerns re her capacity. This directive underlines that when unwell a period of time in hospital to de-stress works best for her, she believes.

[The CEO] concludes that services were trying to build a therapeutic relationship with [Ms A], and this was an important part of her treatment plan. Unfortunately what I have available to me in reports and notes does not spell out what that engagement plan was nor who and how it was to be achieved.

Response of NZNO/[RN D]

I note the NZNO response and the fact that I am not being asked to provide advice on the nursing care provided. I would say, however, that in my view mental health care relies on a well-functioning multi-disciplinary team with good clinical leadership and clear goals and reviews. Siloing of professional groups and activities of different team members is a common contributor to poor outcomes. I believe my years of participation in the provision of care for clients and their families does give me a mandate to comment on the roles and functions of members of those multi-disciplinary teams.

The response does not alter my opinion and if anything highlights an important service wide issue namely the difficulty in getting a through and compete team review. [RN D] refers to that difficulty, especially in relation to [the 19] March assessment, but probably on other occasions. She was keen to get the advice and assistance of other team members and particularly the psychiatrist but it seems this help was limited to 'informal conversations'. Her report confirms her awareness of the difficulty in getting a full assessment due to engagement difficulty.

Response of [Dr B]

A strong point is made about how the clinical notes are insufficient to judge what actually happened on the day. The hindsight bias is also raised. I acknowledge that hindsight bias and have referred to that in reporting. I consider that clinical notes have as one primary purpose the provision of information to others that will help guide current and future care for the client.

The notion that we are seeking perfection is not one that I believe is required. What I would want, however, is sufficient in the notes for me to know why a decision has been made about diagnosis and care planning, what is that care and how will the outcome of that care be monitored. The incident in question was an assessment of a person to decide if care under the Mental Health Act was required. This was from all reports the first time a psychiatrist had engaged with [Ms A] for a considerable time and was the first time she had been seen by [Dr B]. I would have thought then that it would therefore be quite important that there was a full account of the clinical assessment and thinking.

It is apparent that [Dr B] had involvement in care discussions before [Ms A] was seen by him. He states SMHT said home was very good which does not fit well with reports

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in notes that [Ms A] did not give access to her home. He signed a form about the community plan.

[Dr B] underlines the processes and the issues of concern that resulted in [Ms A] being brought for assessment. He was aware that mother had made the request for [MHET]. The notes suggest this request from mother occurred on morning of 20 [February] (10 am). [Dr B] says that he saw her as the after-hours emergency psychiatrist; one wonders why the delay and did that impact on process. He suggests in his response that his notes may have been condensed due to it being an after-hours assessment.

[Dr B] brings to notice the fact that nursing members of the team accompanied him in the assessment on 20 February to show there should have been awareness of decisions and plans. He goes on to state that he had been apprised of the prevailing concerns. He opines that staff concerns that she might be admitted were 'retrospective reflections'. I have reviewed the notes and it is quite clear that these concerns were held and expressed by team members ahead of that assessment. He makes it clear he was aware that her mother was the person requesting assessment for admission under the MHA but acknowledges he did not speak with her.

There is a comment about 'operational paradigms differing in larger urban services' and reference to registrars and MOSS. I must point out that the MHA pertains across the country and that there is a statutory requirement that the assessment is by a psychiatrist (or if not available some other medical practitioner approved by the DAMHS) that does not change from rural to city.

I am pleased that he acknowledges he might have more fully documented interactions. I think that is particularly crucial if as he suggests the verbal descriptions of team members were at variance to those made on paper.

[Dr B] had access to the same material re her past that I saw. There is in my mind sufficient available material to raise levels of concern. I did not have an expectation that he would look through all the files for entries whose salience was lost. The past notes would highlight the difficulty with engagement.

He reaffirms that a prime reason for her being assessed was the decision she had made to discontinue the contacts with services planned a few days before. He has clear awareness of difficulty with engagement. Neither of these appear to have been considered when accepting from [Ms A] 'a willingness to re-engage'.

In his rebuttal [Dr B] has altered the statement about reality testing; the 'pertaining to own sense of spiritual renewal' was not previously in evidence. He gives expansion of a number of mental phenomena in his response. He concludes the section about possible disorder of mood with quite a different description of phenomenology.

[Dr B] mentions 'verbal disputes' in his response which were not referenced in his notes. By comparison the notes state 'no problems with behavioural issues'. Becoming irritable or challenging does have significance for evaluation of possible impact of emerging elevated mood. Likewise the expansions on such things as insight and judgement would have been valuable at the time, not as these addendums.

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He states that [Ms A] agreed to a previously made plan that she defaulted on to lead to his seeing her and that he would see her again in 2 to 3 weeks for clinical review. That time frame seems quite long given the recent experiences with her. He gives a mixed response re hospitalisation from she did not need it to there was no voluntary bed due to bed pressures to would need long-distance escort to [another centre]. Though he concludes his view was she was best treated in the community it is worth noting that it was actually his own notes that said 'admission might be helpful'.

I found the remaining sections regarding care planning did not clarify issues. There is mention of her engagement with service providers being 'rather complex'. He notes the plan was a return to that plan that had been put in place prior to his review (despite the fact that her refusal of that plan was a part reason for him being requested to assess). He says he did not believe workers would require 'a revision of basic guidelines'. What is never addressed is what actual planning and support might be anticipated from a consultant psychiatrist with such a complex case.

Finally there is once again the statement that the services had an enduring expectation that any further consideration of use of the Mental Health Act would be the responsibility of mother.

Impact of the responses to my advice

Question 1 the appropriateness of [Dr B's] assessment and management on 20 February 2015

a) The accepted practice is not affected.

b) If there has been a departure from the standard of care or accepted practice how significant do you consider it is?

The practice of [Dr B] as judged by appraisal of the above mentioned records is significantly short of that expected as follows:

Gather information from those with concerns finding out why they think the patient may be mentally unwell and what worries they have about the proposed patient.

The response does suggest more awareness of others concerns and that would reduce my concerns. There is however a persistent inability to ascertain what information he actually considered and how that impacted his evaluation. I agree with his statement that he should have documented the interactions. I am worried that he appears to be suggesting that the written reports of others are at variance to their verbal statements.

Thus I continue to opine the practice was short of expected.

Consider the longitudinal picture available about the person's past mental health issues, and risks related to that, what treatments and hospitalisations were required, what was outcome of that.

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The response does not explain for me why the brief report from him contained so much less than in the forensic report (though one assumes the base material would have been available at both times; if it were not then the service has a serious issue). I do not think that the details of relevance such as multiple admissions, difficulty to engage and the like need 'a detailed critical review of all file material dating back to first contact'. Indeed in his response [Dr B] outlines many issues re her longitudinal history that are not mentioned in his notes and therefore it is very difficult to know what impact those facts had on his decisions re treatment plan.

Carefully explore with the patient their current situation, including their perceptions of the concerns of others. Explore past episodes of mental health issues, patient's views of these, degree of awareness of previous problems.

The response does not reassure me that matters such as her dismissal of the follow up team, her reasons for not wanting to let people in to her house and the like were actually explored with her. I have difficulty with the idea that a one off statement of willingness to engage should be accepted without apparent question when there is such a long term pattern of difficulty to engage. I would expect a psychiatrist to have awareness of the likelihood someone will 'feign relative wellness' at the time of an assessment interview.

Do a detailed mental state examination.

The response suggests that a more thorough mental state evaluation was actually performed than was recorded in the notes. Some of this new material in my opinion gives quite a different slant than was obtained from reading the original summary. I have no way of knowing which components of the mental state assessment and their possible impacts were considered. An example is the added statement about her judgement and its relationship to making complex choices. If there was concern about this I would want to know how that was seen as consistent with believing she could and would follow a management plan.

Where indicated assess physical contributions that might relate to the mental health issues.

The response does suggest some consideration of this that is beyond 'Physically healthy'.

Assemble the above to create a diagnostic formulation and then use that formulation to develop an indicated approach to treatment. The place of involuntary assessment and treatment under the Mental Health Act would be considered as part of that overall management plan.

The response does little to allay my concerns here. I have referred above to the added details that are in the response that might have had relevance in both a formulation and in management planning (the judgement issues being just one of those). The response appears to say that [Dr B] accepted that [Ms A] committed herself to a

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treatment plan despite the fact that her refusal to follow that plan was a reason why he was asked to see her, and there is little explanation for why he accepted that. The response also serves to increase my concerns about issues influencing the formulation and management planning. He describes how admission to hospital would have been very difficult to achieve then follows that saying his view was she was best treated in the community setting. He seems in his response to ignore the fact that in his notes after the assessment he says that 'admission might be helpful'.

The response appears to minimise the psychiatrist role in care planning and team support; this complex case would seem to me to need more than 'revision of basic guidelines'.

Where the doctor's assessment is quite different from that of others there should be careful discussion of why it is different and careful planning of intervention that takes those differences into account.

The response does not alter concerns.

c) How would it be viewed by your peers?
The response does not alter my views here.

Question 2

I note that you are not requesting advice on nursing care provided.

I also note that this component of the teams' service delivery is crucial and has relevance to question 3.

Question 3 The overall standard of care provided to [Ms A]
The responses do not reduce my concern that the overall care was less than desirable. If anything the extended information seems to highlight the lack of structured ways to deal with complex cases. The awareness that [Ms A] was difficult to engage was well recognised but there is, as was previously noted, an absence of a concerted and agreed plan to address that issue. The response of [RN D] does suggest that it was difficult to get the sort of team support for such planning.

The response focusses on the family involvement. It summarises contacts with [Mrs C]. These point to the place that [Mrs C] appears to have been given as the person who is ultimately charged with the actions to ensure there is urgent review and reassessment if situations should change. It is very clear that [Mrs C] voiced considerable concerns and did so recurrently. I would have thought the spirit of the family support and involvement that is part of the DHB workshop would include clinician action in the decision making re care.

The probable significance of differences in reports about [Ms A] from family and from clinicians at different times seem to have been missed. These would appear to indicate considerable fluctuations in her mental state and function but the responses

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tend to focus more on explaining possible observer reasons. I previously underlined some particular examples of these differences and the responses would confirm their existence and the absence of planning to account for these differences.

There were hints that resource issues had impacted on ability to deliver care in the notes that are reinforced by some of the responses (community team numbers through to available hospital beds). The question of why the Mental Health Act assessment was conducted as an 'out of hours' process needs question and may have influenced the adequacy and its apparent lack of link to overall care planning. It is of course only possible from the material I have to speculate on the possible links between these resource issues and the sub-standard care.

I would conclude by suggesting to the Commissioner that if further review is deemed indicated that I would strongly advise that such a review take into account the totality of the care that was offered to [Ms A] and her family. The threads I see running through the available notes, the internal reviews and the responses to my comments would make me think that we are more likely to be looking at a system wide problem rather than the deficiency being linked to one or two practitioners.

The focus of the questions put to me (the assessment of [Dr B] on 20 February 2015, the assessment of [RN D] and [Mr I] on 15 March) and therefore the responses and my response to those put a particular focus on small parts of the overall care episode, but I am sure the underlying issues that related to the standard of her care are much wider than those two particular points of care.

S W Miles

21.10.2016."

Further advice was provided by Professor Miles on 23 August 2018:

"**Further Report for the Health and Disability Commissioner**
Reference C16HDC00195
Complaint of [Ms A] re Southern District Health Board
Prepared by Assoc Prof S W Miles MDChB, Dip Psychiat, FRANZCP.

This response follows request from [HDC] (13.08.2018)

I have read through the material that was forwarded in relation to [the complaint] including

1. Letter of 6 April 2018 from [Dr B]

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2. Letter of 6 April 2018 from [lawyer]
3. Opinion from Dr E dated 4 September 2017
4. Opinion of Dr E dated 15 February 2018
5. Review into the Serious Adverse Event completed March 2016
6. Letter of 18 August 2017 from [SDHB]
7. Letter of 18 September from [SDHB]

I note that in some of these reports and letters there is reference to attached material that I did not have access to.

— In [the lawyer's] letter reference to a comparative table (not attached).

  This would probably not affect my view.

— Letter of [SDHB] lists attachments that are not available.

  I assume there is not new clinical information in the attachments.

— Appx G refers to MDT meetings; I assume this is not specific material re this case.

I have then re-examined my initial and follow up reports to consider if the material that was now presented substantially alters my view. I must stress that I did not re-examine the entire set of notes that I initially reviewed in preparation of the report.

I do not find anything in the submitted additional material that substantially alters the views that I put forward in the two previous reports. I will give a few more details about each separately.

1. Letter of 6 April 2018 from [Dr B]. I entirely agree there is a need for fuller note taking. The problem throughout is I have no other way to judge the adequacy of assessment. I am also pleased to hear he considers seeking information from MDT workers more robustly.

2. Letter of 6 April 2016 from [the lawyer]. I do not intend to rebuff all that is said. They have made incorrect assumptions about my credentials and experience and also about 'implications' conveyed in my report. I appreciate the lawyer's job is to attempt to undermine a witness's credibility, so will not take a personal offence at how they say things. The claim of 'lack of impartiality', and assertions of not meeting standards are quite offensive.

   It appears to me that their response (and indeed the opinion of [Dr E]) are somewhat predicated on an assertion that the patient should have been put under the Mental Health Act. I must point out that was not my opinion and that was never stated by me. What I am commenting about is the adequate process for a psychiatrist assessment of a new presentation. May I also remind the

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Commissioner I did question why the assessment should have become an out of hours urgent assessment when the need for her assessment was known in the morning (that is in ordinary working time).

3. [Dr E] notes the patient was showing signs of a relapse of mood disorder, that there were concerns from community workers and family about her and that assessment 'developed a plan regarding ongoing voluntary care'. Where she and I depart is the adequacy of the recorded assessments and intervention plans. I contest that 'an impression' following acute assessment is sufficient and would expect consideration of bio-psycho-social factors.

   My point in raising the Forensic Report is not to compare [Dr B's] documentation with it but to point out that there was a rich detail re the patient and her past that was not mentioned by him but one might have expected at least some was known to him.

   I am not sure why [Dr E] believes I saw the patient as 'seriously unwell'; the point is she was, as [Dr E] says, a person with a long history of a serious mental illness that was clearly becoming unwell again.

   The detailed section about when and how to apply the Mental Health Act is not relevant to my consideration of the case; as said before the question is not should or should she not have been put under the Act but is there evidence of a satisfactory assessment and plan for intervention.

   On a number of occasions [Dr E] opines that I 'inferred' things. On each occasion I disagree with her elaborations of my statements and do not believe the Commissioner should ascribe to the statements in my report the 'inferences' [Dr E] is ascribing.

4. The only additional point I would highlight is [Dr E's] supposition that [Ms A's] clinical presentation changed considerably subsequent to her assessment with [Dr B]. I am not sure where she gets the evidence for this supposition, though it might be true. As I think I said clearly in my reports I am critical of the overall care provided to [Ms A] not just the assessment and planning by the doctor.

   She proffers a potentially different set of standards for an on call assessment by a busy psychiatrist than might be expected in usual hours. I am not sure I agree but also I consider the fact that this was an out of usual hours assessment is a sign of deficiency in the SDHB's provision of care given her need for assessment was known in usual working time. Is it a problem of insufficient workforce or of failure of prioritisation ability?

5. This report continues to raise similar issues as in the previous one, the ongoing family concerns, the after the event surprise of some MDT that she was not admitted under the Mental Health Act. They note historical factors and family

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concerns 'could' have been more carefully considered. I would entirely agree. They continue to not recognise the influence of what could and perhaps should have been a normal working day assessment being deferred until out of usual working hours.

The only possible issue here is if there is additional clinically relevant data I have not seen. This seems unlikely and I suspect the appendices refer to policy and procedure for the service. Though there are assertions regarding MDT review availability I saw little impact of this in the case notes of the patient.

This letter does not have direct relevance.

In concluding may I again stress that in my opinion based on the available clinical notes the overall clinical care that was delivered to [Ms A] does not meet what I would consider to be a reasonable expectation for a person with a known history of serious mental illness who was clearly becoming unwell again and who was known to be difficult to engage and who exhibited adherence issues when unwell. Much of this additional material has a particular focus on the assessment provided by [Dr B] and accordingly I would wish to stress to the Commissioner that in my view his failings are a small part of a bigger picture of less than satisfactory care. The absence of any psychiatric review over a protracted period of time drives the focus on his one off review; that absence is to me a more serious issue.

Assoc Prof Wayne Miles
Clinical Director
Research and Knowledge

23.08.2018"

Further advice was provided by Professor Miles on 30 November 2018:

"**Further Report for the Health and Disability Commissioner**
Reference C16HDC00195
Complaint of [Ms A] re Southern District Health Board
Prepared by Assoc Prof S W Miles MDChB, Dip Psychiat, FRANZCP.

This response follows request from [HDC] (28.11.2018).

I have read through the additional material that was forwarded in relation to [the complaint] namely a table prepared by [Dr B] and his legal team. The actual date of

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the submission was not annotated but clearly it is a summary prepared well after the original event.

I have then re-examined my initial and follow up reports to consider if the material that was now presented substantially alters my view. My report is about findings and opinion based on what was available in the clinical notes pertinent to care and assessment.

Much of the comments from [Dr B] give further explanation about the encounter with her and the interaction with services.

I have previously stated that the fact that this was an urgent out of hours assessment (and that is used often as justification for brevity) was to my mind a systemic failure given that there were ongoing concerns and desire for assessment early on the day in question.

The material does not change my view that based on the available clinical notes the overall clinical care that was delivered to [Ms A] does not meet what I would consider to be a reasonable expectation for a person with a known history of serious mental illness who was clearly becoming unwell again and who was known to be difficult to engage and who exhibited adherence issues when unwell. Particular focus on the one off Mental Health Act assessment could serve as a distraction from what is in my opinion a wider system failure in care.

Assoc Prof Wayne Miles
Clinical Director
Research and Knowledge

30.11.2018”

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Appendix B: Independent advice to the Commissioner

The following expert advice was obtained from Dr Jacqueline Kidd:

"I have been asked to provide an opinion to the Commissioner on case number 16HDC00195.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Ko Te Ahuahu tōku maunga. Ko Omapere tōku roto. Ko Ngapuhi tōku iwi. Ko Ngāti Hineira me Te Uri Taniwha ōku hapū. Ko Parawhenua me Ngāwhā ōku marae. Ko Pehiriri, […] ōku whānau. Ko Jacquie Kidd tōku ingoa.

I first qualified to be a Registered Nurse in 1990, gaining a diploma in comprehensive nursing from Hawke's Bay Polytechnic. I gained my Bachelor of Nursing and Master of Nursing from Otago Polytechnic in 1998 and 2002 respectively, and my PhD in Nursing from the University of Auckland in 2008. I also have a certificate in Māori mental health from Te Ngaru Learning Systems.

Between 1990 and 2002 I practised primarily as a mental health nurse in a variety of long term, acute inpatient, crisis, community and Māori mental health/kaiwhakaora Māori positions. I became a mental health nursing academic and have worked in the tertiary education sector since 2002. My current role involves research, and teaching specialty practice to new graduate and post graduate mental health nurses.

My instructions from the Commissioner are to provide my opinion on the care provided by Southern District Health Board to [Ms A] ([Ms A] at the time of these events) during June 2014 and March 2015. My advice is to focus on the care provided by the DHB as a service, and by the individual Registered Nurses. I understand that the Commissioner has obtained separate advice about the Psychiatric care provided to [Ms A]. I am asked to advise whether I consider her care was reasonable in the circumstances, and why. In particular I have been asked to comment on:

1. Whether the management plans in place during June 2014 and March 2015 were appropriate
2. Whether [Ms A's] Advanced Directive should have had any impact on the management of [Ms A], from the perspective of SDHB as a service and from the individual RN's point of view
3. The adequacy of the overall level of engagement with [Ms A's] mother
4. The adequacy of the overall level of engagement with [Ms A]
5. The adequacy of the care provided to [Ms A] by each of the individual RNs involved in her care
6. The adequacy of the care provided to [Ms A] by SDHB as a service
7. Any other matters in this case that I consider warrant comment

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For each question I have been asked to advise:

(a) What is the standard of care/accepted practice?

(b) If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider it is?

(c) How would it be viewed by my peers?

I have been provided with the following information:

- The letter of complaint received […]
- [RN D's] response dated […]
- Clinical records from Southern District Health Board (relating to [Ms A] during the time of the events complained of)
- SDHB's Serious Adverse Event review completed March 2016
- SDHB's responses received […, …, …, …]

Summary of events, derived from progress notes and associated clinical documents

[Ms A] has been a client of Mental Health Services intermittently since the mid-1990s. She has had several diagnoses including Major Depressive Disorder, Dependent Traits, Bipolar Affective Disorder, Borderline Personality Disorder and alcohol abuse.

On 6th June 2014 [Ms A] updated her advance directive of 18th December 2013. The document requests that her mother [Mrs C] and sister [Ms J] be informed of and involved in her care and treatment, and details her wishes regarding care of her daughter and her treatment preferences.

[Ms A's] advance directive notes that she has had significant adverse effects from some psychiatric medications. She and her sister [Ms J] further state that she suffered a stroke that they believe was possibly associated with her medications. It seems that from about this time she has focused on eating unprocessed foods, veganism, and stopping the use of tobacco, alcohol and drugs.

[Ms A] was assessed as mentally stable and at her request was discharged from mental health services to the care of her GP in July 2014.

On 9th February 2015 [Ms A's] mother, [Mrs C], phoned the Southern DHB mental health emergency team ([MHET]) with concerns about [Ms A's] deteriorating mental health over previous months, and about potential risk to [Ms A's child]. She reported that [Ms A] was not taking her medication and had lost a significant amount of weight. She had not seen [Ms A] for a week, so was not able to initiate a section 8a. The plan was for [Mrs C] to contact CYF re the child and to consider instigating the MHA once she had seen [Ms A] again. [MHET] would await further contact.

On 16th February 2015 [Mrs C] phoned [MHET] to say that she had removed the child from [Ms A's] home and would care for her. [Ms A] was (according to [Mrs C]) happy

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with this as the child had been 'annoying' her. [Mrs C] expressed concern for [Ms A] and requested urgent [Māori MHS] involvement. [Ms A] had agreed that she would talk with them. [Mrs C] would consider completing a section 8a to start the MHA process. [MHET] would contact [Mrs C] when a plan has been established by the service.

[Māori MHS] registered nurse and team leader [RN F] made multiple attempts to contact [Ms A] that same day, and maintained contact with [Mrs C] who reported that she had no safety concerns for [Ms A].

On 18th February 2015 [Ms A] made contact with [RN F] and agreed to a home visit from her and a nurse from [MHET]. A cultural assessment was conducted which included several reports of [Ms A's] passion about being Māori and achieving a 'balance' in her life, but also a rejection of clinically focused questions along with irritability when these were asked. A follow up phone call to [Mrs C] was made to report the outcomes of the assessment. Support phone numbers and encouragement were given about reaching out for help as needed.

The clinical assessment recorded from the home visit reported that [Ms A] was irritable and dismissive of clinical content. Elevated mood was noted, but criteria for the MHA was unmet.

The risk assessment recorded from the home visit found that she was a risk to herself due to her 'extreme views re medications/hospitalisation/diet & exercise'. The extent of the risk was not noted.

The HoNOS quick rating sheet completed from the home visit notes a mild irritability and anxiety, and a moderate impact on her relationships.

A referral to [Māori MHS] was made later that day.

On 20th February 2015 [Ms A] contacted [RN F] to ask about the outcome of the assessment. When she was told that [Māori MHS] would provide cultural and clinical support [Ms A] became irritable about the clinical component. [RN F's] notes report that [Ms A] 'became aggressive in her tone and started to manipulate the conversation, then sabotaged the korero'. Finally, [Ms A] said she no longer wanted follow up from [Māori MHS] and would seek help in the community.

[Mrs C] was phoned about this interaction, and subsequently contacted [MHET] to request their input. She requested that the MHA process be commenced.

In the evening of 20th February 2015 a psychiatrist assessed [Ms A]. His impression was that she was hypomanic and his plan was to follow her up as a voluntary community client with [Māori MHS] and [the] Community Mental Health Team to provide support and advice. He noted in the assessment that [Ms A] was 'able to reason' and was 'willing to engage'. The MHA was not continued, and although admission was considered it was not initiated due to [Ms A's] presentation and possibly the pressure on beds at that time.

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On 20th February 2015 [RN D] from [Māori MHS] accepted the referral and took on the key worker role, supported by [a cultural worker] as level 2 cultural support. As this was a Friday, it was arranged for follow up by [MHET] over the weekend.

On the 21st and 22nd February 2015 the [MHET] made phone contact daily. Some pressured speech but no clinical concerns were noted.

On 23rd February 2015 [RN D] made phone contact with [Ms A] for the first time as her key worker. No changes to her presentation or concerns were noted. An appointment was made for a home visit the following day.

On 24th February 2015 [RN D] visited [Ms A] at home. She was not invited inside, but [RN D] was able to see a well organised home and the Māori flag on display in the garage/sitting room. [Ms A] was receptive to [RN D] and answered her questions. [Ms A] was reminded that her involvement with [Māori MHS] also meant that she would be in the care of a psychiatrist, which she agreed with. She indicated that she planned to move [towns] to be closer to her mother and [child]. Plan from this meeting was for another home visit on 3rd March.

On 3rd March 2015 [RN D] visited [Ms A] again. She was not invited inside, and the curtains were pulled so she could not see inside. [RN D] noted that [Ms A] was 'superficial in interactions', 'spoke loudly, mild pressure of speech'. [Ms A] confirmed that she would be moving to [another town]. She declined to attend an appointment with the psychiatrist scheduled for 13th March, preferring instead to wait until a month after she is settled in [the new town]. Agreed to another home visit next week, and for [RN D] to share information with mother [Mrs C].

On 5th March 2015 [RN D] contacted [Mrs C] to discuss [Ms A]. [Mrs C] 'remains concerned' about [Ms A], particularly about her isolating herself and not allowing people into the house. [Mrs C] confirmed that [Ms A] has lost a great deal of weight over the previous 6 months, and reported that she had rapid changes in her thought processes currently. [RN D] recorded [Mrs C] as saying '[Ms A] is saying what she thinks we need to hear to remain out of the unit and off the MHA'. [Mrs C] will phone [RN D] if she needs to.

The planned meeting on 13th March did not go ahead as [RN D] was busy. She was unable to contact [Ms A] as the phone seemed to be disconnected. [RN D] contacted [Mrs C] to let her know, and was given [Ms A's] email address. She sent an email and planned to wait for [Ms A] to contact her.

On 15th March 2015 [Mrs C] contacted [MHET] with further concerns. She had been to [Ms A's] [home] and planned to take her back to [her own home]. She became aware that [Ms A] had hunting and diving knives, a knife sharpener, rope and a baseball bat. [Mrs C] relates that there has been 'previous domestic violence by [Ms A] towards herself'. She also says that [Ms A] is posting 'weird' photos of herself on Facebook but this is not elaborated on in the notes. The plan from this phone call was to ask [RN D] to contact [Mrs C] to discuss this. It was also noted that [Ms A] had 'declined psych

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evaluation planned for 13/03/15' and querying the need to arrange a psychiatric assessment before [Ms A] leaves for [the new town].

On 16th March 2015 [RN D] phoned [Mrs C], who was with [Ms A]. [RN D's] notes indicate that [Mrs C] was not concerned about anyone's safety, and would contact the police if she became worried. No grounds for section 8a. Plan was to visit [Ms A] in [the new town] on 19th March.

On 19th March 2015 [RN D] and another cultural support worker visited [Mrs C]. She said she had taken the knives off [Ms A] the day before (18th March), before she moved. [Ms A's] explanation for having them was that she wanted to get involved with hunting and diving. [Mrs C] remained concerned about [Ms A] being 'all over the place', but did not feel that there were risks to anyone. [Mrs C] confirmed that she would phone the police if necessary and would also complete a section 8a form, but did not currently feel able to.

[RN D] also visited [Ms A] that day, and found her 'unwilling to engage'. She was not willing to see a psychiatrist in the near future. [RN D] and the cultural support worker helped [Ms A] with her new phone and internet connections, during which time [Ms A] became more conversational. She agreed that she would like help, but wanted to settle in first. A risk assessment was carried out by [RN D], identifying [Ms A's] history of self-harm, destroying property and 'irritability' with family which was later expanded upon to say 'verbal abuse of mother'. The plan from this home visit is to meet again in one month or sooner if [Ms A] agrees, and to review [Ms A] in the next MDT to establish a plan.

On 26th March [Ms A] was reviewed, in her absence, at the MDT meeting. The decision was made for [RN D] to continue to attempt to engage with [Ms A] with a low threshold for involvement of [MHET] and police. Monthly reviews were planned, and contact with [Mrs C] would continue.

[A short time later] [Ms A] […] assaulted a young woman […].

[Ms A] was arrested the following morning. The court found her not guilty by reason of insanity. [Ms A] is currently in the Forensic Unit at […].

[Ms A] has complained to the HDC that her mother's concerns about her deteriorating mental health during 2014 and 2015 were not taken seriously by [the] Community Mental Health Team (SDHB).

OPINION

National documents informing my opinion

My opinion in relation to the nursing care in these questions has drawn on three key national documents: The *Nursing Council of New Zealand (NCNZ) competencies for registered nurses* [1] describes the fundamental standard of care expected; *Let's Get Real* [2] is a framework from Te Pou that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services; and Te Ao Māramatanga (New Zealand College of Mental Health Nurses) *Standards of practice*

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for mental health nursing in New Zealand which provides specialty guidelines for nursing practice [3].

I also considered *Huarahi Whakatū*, Te Rau Matatini's dual competency professional development and recognition programme framework for Māori nurses [4] as a potential indicator of Māori nursing standards, and include it here cautiously. Māori mental health nurses bring an additional dimension to their work which can be enriching and powerful for the nurse, service user and whānau. However it is a delicate space to negotiate for those on the outside of the relationship such as employers and reviewers. 'Being Māori' is not a standard for nursing practice, and bringing one's own culture into nursing practice cannot be compelled by an employer. Equally, the use of Māori knowledge in nursing practice is not a suitable focus for an external review unless the nurse has opted to be a part of the dual competency framework and thereby indicated that their practice is open to being judged. Of equal importance is the understanding that the dual competencies are evaluated by Māori mental health nursing peers who have been trained and are supported to undertake evaluations safely. I am not a trained and supported portfolio evaluator, and I do not know whether any of the nurses who work in [Māori MHS] are a part of Te Rau Matatini's dual competency programme. However, their framework constitutes the only document I am aware of that could give an indication of how a Māori mental health nurse in [Māori MHS] might be expected to practise and therefore also what kind of service [Māori MHS] might be expected to provide to their community. Therefore I am presenting it here as context, rather than as a practice standard.

Huarahi Whakatū has been accredited by the Nursing Council of New Zealand. The framework includes the NCNZ competencies and adds six Māori specific competencies to assist the Māori nurse in the delivery of care based upon Māori methods and knowledge. The competencies are

1. Wairuatanga influences the way people relate to each other and to the surrounding environment. Wairuatanga is more than just karakia; although karakia aims to strengthen taha wairua, taha whānau, and taha hinengaro and taha tinana. The Māori nurse demonstrates an understanding and incorporation of taha wairua as an integral part of practice.
2. Pupuri ki te Arikitanga: It is important the Māori nurse understands and practises in adherence to Māori beliefs and values that maintain a balance and minimise risk.
3. Tuakiri: The Māori nurse recognises the importance of a sense of belonging and identity and incorporates these principles into practice.
4. Te Reo me ona Tikanga: Māori nursing requires a high level of communication skills; advantageous are a knowledge of Te Reo and Tikanga. These enable the Māori nurse to relate to client and whānau within a Māori context.
5. Whakawhanaungatanga is viewed as a Māori process of building a relationship through the strengthening of kinship ties. This deliberate process promotes a

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connectedness and foundation for the culturally therapeutic relationship. The Māori nurse understands this process and purposely utilises processes to work in partnership with client and whānau.

6. Hauora Māori relies upon a number of approaches that address client needs in a comprehensive way. The Māori nurse will utilise Māori models of practice placing Hauora in a broad and holistic context.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 [5] has informed my opinion in relation to the role of SDHB in [Ms A's] care.

I have also drawn on other resources as needed. A full reference list is appended.

I have re-ordered the questions in this section because the levels of engagement and care provided to [Ms A] provide some of the information needed to evaluate the adequacy of her management plan.

The overall level of engagement with [Ms A]

Whether the services and individuals involved had engaged with [Ms A] also depends a great deal on whether [Ms A] wanted to engage with the nurses; it is not a one-sided process. [Ms A] had made it clear from the time of her last involvement with mental health services in 2014 that she was reluctant to be involved with mental health services, and she was irritable if the RNs were too inquisitive during February and March. The progress notes show that the relationship between [RN D] and [Ms A] had remained tenuous during this period, with [RN D] not being permitted to enter [Ms A's] home or to ask questions that [Ms A] did not agree with. [Ms A's] ongoing deflection of [RN D's] request that she meet with the psychiatrist also indicated [Ms A's] ambivalence or reluctance to engage with mental health services.

It is important to note that the period of time between [Mrs C's] first contact with [MHET] and the events of 29th March spans only seven weeks. In the context of the community setting and the absence of high risk (discussed further below), my clinical experience suggests that taking this time to develop a trusting relationship is not unusual or unreasonable.

The relevant standards of accepted practice in relation to the level of engagement with [Ms A] are:

NCNZ Competency 3.2 which states that the nurse practises nursing in a negotiated partnership with the health consumer where and when possible … in a manner that facilitates the independence, self-esteem and safety of the health consumer and an understanding of therapeutic and partnership principles; and *Te Ao Māramatanga Standard Two* which states that the mental health nurse establishes collaborative partnerships as the basis for therapeutic relationships.

These standards prioritise the development of a collaborative relationship, particularly one that supports and protects the independence and safety of the service user. In this situation it seems that the relationship between [RN D] and [Ms A] was being

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carefully negotiated by both of them, and it is my view that it would have been invasive and probably alienating for [Ms A] if [RN D] had insisted on having access to her home or pressed [Ms A] to reveal her thoughts.

However, the progress notes and cultural assessment say that [Ms A] was intensely interested in her Māori heritage, and report her display of the Māori flag, and [Ms A's] willingness to be involved with [Māori MHS]. These indicate that there could have been an opportunity to engage with [Ms A] more fully through Te Ao Māori. Further, the progress note of 18th February by [RN F] clearly states that [Ms A] was willing to engage with [Māori MHS] but not 'clinical' staff.

In my experience and in the literature [6, 7] it can be complex to work as a nurse across the clinical and Māori worlds, but in my view [Māori MHS] seemed in this case to abandon the Māori world in favour of the clinical one. There is no evidence that [the cultural worker] had any involvement with [Ms A], and similarly there is no evidence in the notes that the cultural assessment was followed up on or a cultural care plan created. While [Mr I] attended an appointment with [RN D] and [Ms A], there is no record of any cultural input because he was not the nominated cultural support person for [Ms A].

It also seems that a major contributing factor to [Ms A's] involuntary Mental Health Act assessment on 20th February was [RN F's] phone conversation when she informed [Ms A] that [Māori MHS] would provide both cultural and clinical support. Upon hearing that news, [Ms A] became angry and indicated that she no longer wanted mental health service support, resulting in a section 8a application by [Mrs C]. Based on the progress note written by [RN F] about that conversation, it appears that [RN F] may have also been annoyed as she wrote that [Ms A] 'became aggressive in her tone and started to manipulate the conversation, then sabotaged the korero'. This language is contrary to recovery focused language as described in *Let's Get Real* particularly in relation to an experienced health professional.

I regard [RN F's] contact with [Ms A] as an important missed opportunity to facilitate engagement, and consider that communication with [Ms A] about [Māori MHS's] role may have been confrontational. The lack of a documented cultural care plan was a departure from best practice in the Māori mental health context, but there are no specific standards against which to measure this. Further, there is an apparent lack of documentation covering any discussions about [Ms A] in the [Māori MHS] daily meetings.

In relation to how [Māori MHS] functions, SDHB state that the service works 'within a holistic model of care that enables consumers to have access to wrap-around, whānau centred services'. In my view [Ms A] did not receive a service that is consistent with that statement.

I note that the serious adverse event review recommended that the structure and service of [Māori MHS] be evaluated against the needs of Māori. In the SDHB responses of 8th August 2016 and 18th August 2017 they report an increase in clinical staffing and a new cultural assessment format.

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Opinion: The level of engagement with [Ms A] does not breach the fundamental NCNZ competencies, however it is not consistent with *Let's Get Real* or with *Te Ao Māramatanga standards for practice*.

My peers in Māori mental health services would regard the overall engagement with [Ms A] as lacking the most elementary factors of Māori communication and care.

The overall level of engagement with [Ms A's] mother

The progress notes from the [MHET] and [Māori MHS] demonstrate that [Mrs C] was responded to when she phoned and proactively kept informed of [Ms A's] mental state and management plan.

NCNZ competency 3.2 includes the acknowledgement of whānau perspectives and support for their participation in services. Similarly, *Let's Get Real* advises that 'every person working in a mental health and addiction treatment service encourages and supports families/whānau to participate in the recovery of service users and ensures that families/whānau, including the children of service users, have access to information, education and support (p.8)' and *Te Ao Māramatanga standard two* has whānau collaboration as a practice outcome.

Based on the frequency and timeliness of the communications with [Mrs C] I initially felt that the RNs involved in [Ms A's] care were diligent in their communications with [Mrs C] and kept her informed. However, I have some concerns about the depth of engagement.

I acknowledge that it is easy to be wise with hindsight, but I want to comment on the apparently different experiences of the RNs and the whānau. Based on the progress notes it seems that the RNs responded appropriately to the facts that [Mrs C] presented, but based on [Ms A's] complaint, [Mrs C's] interview with the serious adverse event review team, and the undated email from her sister [Ms J] to the review team it appears that the RNs under-estimated the severity of [Mrs C's] concerns. In my experience it is emotionally very difficult for whānau to initiate contact with mental health services, and I expect that it was also a difficult decision for [Mrs C] to uplift [Ms A's] child. This does not appear to be taken into account in the service's interactions with [Mrs C].

The service responded rapidly to [Mrs C's] requests for contact, so appeared to be responsive to her concerns. However there is no evidence that they asked her about her feelings about frequently 'reporting on' her daughter or that they evaluated the frequency of [Mrs C's] contact rather than only the content of her calls. This is also the case in the service's reaction to the news about [Ms A's] knives; although there were now weapons associated with [Ms A], and [Mrs C] made an apparently new disclosure about previous domestic violence by [Ms A] towards [Mrs C], the RNs appeared to completely accept [Mrs C's] reassurance that the level of risk remained low despite these new facts. The initial interaction between [Mrs C] and [RN H] about the knives does not appear to have included any inquiry about where the knives were and who

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had access to them. There is no rationale given for not arranging an urgent assessment for [Ms A].

It also seems from the progress notes that alternatives to the enforced care of [Ms A] and additional supports for [Mrs C] were not discussed with her until after [Ms A] had been arrested.

In my view, during their conversations with [Mrs C] the RNs were focused primarily on risk assessment and evaluating [Mrs C's] position with regard to initiating the Mental Health Act, so they did not identify or attend to [Mrs C's] fears as well as they could have.

I note that the serious adverse event review recommended the development of in-service training on working with whānau, and that the SDHB has acted on this already.

Opinion: If the testimony from [Mrs C], [Ms A] and [Ms J] is correct then the level of engagement by mental health services was inadequate.

If the progress notes are accurate that [Mrs C] made contact but then reassured the service that [Ms A] presented no or low risk, then the level of engagement is barely adequate in that [Mrs C's] requests were responded to but her perspective was not fully explored, recorded in the notes, and engaged with in a collaborative way.

My peers in mental health services would regard the level of engagement with [Mrs C] as adequate, but not at the level of best practice.

The management plans in place during June 2014 and March 2015

There is little information in the documents I have about [Ms A's] management plan around the time of her discharge from services in 2014, other than a note that a referral had been sent to her GP. However, her mother informed [MHET] on 9th February that [Ms A] had stopped taking her medication and progress notes from the current admission state that she does not have a GP. It is not clear when she stopped the medication, or whether she ever had contact with her GP.

[Mrs C's] testimony to the serious adverse event review included her view that [Ms A] was 'doing OK' in early 2014 around the time that she was discharged. She also notes that at that time [Ms A] was refusing all contact from mental health services and had threatened legal action 'against everyone' (p.9). It is not clear what effect those threats may have had in [Ms A's] discharge and subsequent readmission.

June 2014 opinion: [Ms A's] management plan would have been adequate if the service had followed up to ensure that the referral had been received and that the GP had been in contact with [Ms A]. This may in fact have been the case, but not included in the documents I received. If no follow up occurred then the management plan was inadequate.

The management plans documented in the progress notes and MDT record show that the main priority for the keyworkers and [MHET] in 2015 was to maintain contact with [Ms A] and her mother, and establish a relationship with [Ms A] that would support

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ongoing engagement and risk assessment. This would not usually constitute an adequate management plan because it does not contain information about [Ms A's] recovery goals or plans for how to achieve them. However, [Ms A's] reluctance to engage in anything she perceived as 'clinical' and the relatively short period of time [RN D] had been involved with [Ms A's] care are mitigating factors.

Moreover the cultural aspects of [Ms A's] care did not feature in her management plan which was a missed opportunity to provide full and effective care.

Risk assessments were undertaken twice during the seven weeks, once on 20th February by [MHET] and once by [RN D] on 19th March. A further assessment was carried out by [Dr B] on 20th February. None of these assessments identified risks to [Ms A] or those around her apart from the risk to her child which was managed by her mother's custody, and concern about her possibly extreme diet and resulting weight loss.

Let's Get Real (p.8) states that every person working in a mental health and addiction treatment service utilises strategies to engage meaningfully and work in partnership with service users, and focuses on service users' strengths to support recovery.

March 2015 opinion: The registered nurses in [MHET], [RN D] and the MDT developed an appropriate management plan in the context of the early stage of relationship building with [Ms A].

My peers would view the management plan as reflecting the beginning stage of the relationship between [Ms A] and the community mental health service.

[Ms A's] Advanced Directive

[Ms A's] advance directive was initially written in December 2013 and updated on 6th June 2014. It requests that her mother [Mrs C] and sister [Ms J] be informed of and involved in her care and treatment, states her wishes regarding care of her [child], and her treatment preferences. [Ms A's] advance directive notes that she has had significant adverse effects from some psychiatric medications.

In my view the advance directive enabled frequent and open communication between the various nurses involved in [Ms A's] care and her mother, and provided clear instructions about the care of [Ms A's] [child].

The advance directive does not state that [Ms A] rejects the notion of hospitalisation or medication, rather it provides guidance about her preferences if either of those treatment options are chosen by the service. In my view the content of the advance directive is consistent with the mental health and addiction national strategic direction of care in the least restrictive environment and service user input into treatment decisions [5, 8, 9].

Opinion: Based on the documents provided and the information in the Health and Disability Commissioner's leaflet on advance directives [10] [Ms A's] advance directive had a helpful impact on how the services engaged with her.

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The care provided to [Ms A] by each of the individual RNs involved in her care

The RNs involved in [Ms A's] care during February and March 2015 were:

- [RN D], key worker/case manager at [Māori MHS]
- [RN F], team leader [Māori MHS] who conducted [Ms A's] cultural assessment in collaboration with [RN G]
- [RN G] , DAO at [MHET], conducted urgent assessment and made referral to [Māori MHS]
- [A] DAO at [MHET], took [Mrs C's] initial phone call
- [A] DAO at [MHET], took [Mrs C's] second phone call and arranged urgent [Māori MHS] assessment
- [A] DAO at [MHET], arranged MHA assessment
- [RN H] , DAO at [MHET], made most of the weekend calls to [Ms A] and [Mrs C]

The type of service provided by mental health emergency teams is not standardised across Aotearoa New Zealand. In my experience such teams have local expectations of their role that range from short term therapeutic care to only being involved in situations where there is considerable risk and the actual or potential involvement of the Mental Health Act. Nurses in mental health emergency teams usually also provide 'stop-gap' care to cover weekends and nights when a service user is in the care of a community mental health team. I do not know which model the [MHET] follows, but in my view there is enough information in the documents provided to assume that in [Ms A's] case their roles were to be responsive to initial contact, and to provide out-of-hours contact when [Māori MHS] were not available.

Collectively the RNs at [MHET] responded in a timely way to concerns raised by [Mrs C]. They organised assessments and referrals, and made contact to remotely assess risk during out-of-hours times when requested.

[RN H] received the phone call on 15th March from [Mrs C] about [Ms A] having knives. In my experience this would usually have prompted an urgent visit and risk assessment because of the new factors of weapons and a report of previous domestic violence that appears to have been new information. The initial interaction between [Mrs C] and [RN H] about the knives does not appear to have included any inquiry about where the knives were and who had access to them, and from [RN D's] progress notes it seems that [Ms A] remained in possession of the knives until the 18th March. However, although [Mrs C] had phoned [MHET] with concerns about the knives, she also appeared to reassure [RN H] that [Ms A's] risk of harming herself or others was low (although the notes do not state this explicitly); she only asked for contact and support with [Ms A's] [move]. However, despite [Mrs C's] reassurance, the risk assessments in [Ms A's] file that consistently note that her risk to herself and others has not been a concern recently, and that [Ms A's] previous drug and alcohol abuse were not a feature of her current presentation, in my view it would have been

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prudent to arrange an immediate face to face risk assessment. There is no rationale given in the notes for not arranging an urgent assessment for [Ms A].

[MHET] opinion: that the care provided to [Ms A] by the registered nurses in the [MHET] was generally adequate given the involvement of [Māori MHS] as the primary care team, [Ms A's] risk assessment, and [Mrs C's] responses to their questions about risk. The exception to this is the lack of a risk assessment initiated by [RN H], however I am mindful that the benefit of hindsight may be inflating this perspective. If [RN H] was reassured by [Mrs C] and was aware of [Ms A's] reluctance to answer clinical questions then her response of notifying [RN D] could be viewed as adequate.

[Māori MHS] was clearly expected to deliver both clinical and cultural care. The absence of a cultural care plan is a significant issue. My expectations are that it would have been initiated at the time of the first cultural assessment, and refined by the key worker over time.

[RN F's] involvement in [Ms A's] care was to perform an urgent cultural assessment on 18th February which was handwritten into the progress notes using a basic Whare Tapa Wha format [11]. However, there was no guidance given in the notes regarding the way forward for [Ms A], and no cultural care plan although she stated that [Ms A] has 'some cultural needs'. [RN F's] notes say that [Ms A's] 'cultural needs will be discussed later today' but do not say who with. The SDHB letter of 8th August 2016 states that the [Māori MHS] team meets daily, but the relevant discussions are not recorded in the file notes that I have access to.

[RN F] opinion: [RN F] was the team leader and senior RN in [Māori MHS] as well as the RN who conducted the cultural assessment. Whether she completed the care plan herself or liaised with [RN D] to do so, the lack of a documented cultural care plan was a departure from best practice in the Māori mental health context, but there are no specific standards against which to measure this.

[RN D] was assigned as [Ms A's] key worker between the 18th February when the referral was generated and 20th February when she accepted the role. The progress notes show that [RN D] made prompt contact with [Ms A], and maintained contact throughout the subsequent weeks. She conducted risk assessments at each contact, communicated her finding to [Ms A's] mother and documented them in [Ms A's] file. I note that [RN D] documented her plan to involve a psychiatrist in [Ms A's] care and that [Ms A's] own reluctance and/or refusal to make an appointment played a big part in this being delayed. [RN D] also attempted to have an MDT clinical review done which would have included the psychiatrist, but this was also delayed as he was not present at the meeting.

In her role as [Māori MHS] nurse [RN D] should have worked with [Ms A] on her cultural needs, which may have allowed their relationship to progress more rapidly. However it is not clear from the documents I have whether [RN D] is Māori, and even if she is I am unable to comment on her capacity to deliver culturally specific care. It

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does not appear that [RN D] was well supported by her team leader or the cultural support worker.

[RN D] identified on 19th March that [Ms A] should be reviewed by the MDT, which I assume from my own experience means that she wanted the psychiatrist primarily but also other experienced clinicians to discuss her approach and advise her about the next steps. In my view this was a reasonable nursing response to the information about the knives and previous domestic violence, and [Mrs C's] ongoing concerns. She did not achieve the review until 26th March, and then there was no change to her plan to continue making contact and assessing [Ms A]. With hindsight it is clear that [RN D] should have escalated her concerns and had [Ms A] reviewed earlier, but in my view there were no reasons at the time to do so. This is also evidenced by the MDT conclusions to continue trying to establish a relationship with [Ms A].

I note that [RN D] wrote in response to [Ms A's] complaint on […], outlining her concerns about her work environment and her perceived lack of support as well as adding detail about [Ms A's] care. The content of her letter is consistent with the progress notes.

[RN D] opinion: [RN D] has met the standard of care required by *NCNZ* and *Te Ao Māramatanga*, providing adequate care within the bounds of the context at the time. [RN D] managed a challenging situation very well when she maintained contact and communication with [Ms A], although there were significant opportunities to improve her cultural care.

My mental health nursing peers would recognise the challenge of working respectfully with a service user who could easily refuse contact but clearly needed ongoing support, and would see [RN D's] initial approach as adequate nursing care.

In relation to the overall care received by [Māori MHS], I acknowledge that the serious adverse event review recommended that the structure and service of [Māori MHS] be reviewed. It was reported by the SDHB in their letter of 8th August that a new format for cultural assessments was in the process of being implemented from 28th July 2016. The new format, which they provided, is a great deal more comprehensive and includes cultural care planning and ongoing evaluation of care.

The care provided to [Ms A] by SDHB as a service

Rising to the Challenge [5] states 'New Zealanders with mental health or addiction issues must lead their own recovery, have personal power and take up a valued place in their family or whānau and communities' (p.6), which is in my view a position that the registered nurses involved in [Ms A's] care took as they followed her lead regarding how they should work with her. However, as noted above, the care tended to stop at the point of identifying [Ms A's] relatively low risk and did not include cultural or other non-medical approaches to care.

Rising to the Challenge also states (p.6) that 'hapū, iwi and the Māori community have an important role in shaping the way in which communities and services respond to people experiencing mental health or addiction issues and in supporting recovery for

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Māori who use services'. This highlights what, in my opinion, is a problem with service delivery by SDHB. The combining of cultural and clinical care in one team creates a set of issues, for people like [Ms A] and for the nursing staff, which would benefit from further analysis and planning in collaboration with local Māori communities.

I have a further concern based on the progress notes, risk assessments and MDT assessment, which is that the SDHB appeared to hold a narrow view of what care could and should be offered to [Ms A] and her whānau. It seems from the documents that the focus was on risk and whether [Ms A] met the criteria for the Mental Health Act. My own experience and guidance from *Let's Get Real* [2, 12] clearly shows that the responsibility of mental health services and staff involves holistic, recovery focused care that considers a range of interventions and treatments that meet the full range of people's needs.

I note that testimony to the serious adverse event review included information about referrals that were offered to [Ms A] and which she refused. However there was scope within the care delivered by [Māori MHS] to meet some of [Ms A's] non-medical needs without further referral.

My final comment on [Ms A's] care is to express my concern about the level of contact that was going to be possible if the relationship had progressed further. The need for 2 health care workers to be present at out-of-town home visits, and the time and distance involved in visiting service users so far from [the area] would, I believe, have put great pressure on the care [Ms A] received. [Ms A's] ambiguity about being involved with [Māori MHS] and [Mrs C's] concerns about [Ms A's] health seemed to indicate that this was unlikely to be adequate. I am mindful that this is an issue for many DHBs, and that resolving it is an ongoing challenge for our national healthcare service.

Opinion: the service provided by SDHB was barely adequate. They met the most obvious and pressing needs presented by [Ms A] and her whānau, but did not provide care that included [Ms A's] cultural and whānau needs.

My peers would regard the service provided to [Ms A] and her whānau as maintaining a risk averse focus and missing the opportunity to care for them.

Other matters

My scope for this review is with the RNs and service only, and this final matter may lie more properly with the psychiatrist primarily. However, around the time of [Ms A's] discharge in 2014 she embarked on a very significant lifestyle change regarding her diet, exercise and opinions about how she should treat her body. [Ms A's] notes indicated that she had a previous history of drug and alcohol abuse, and this had stopped as well. This is reported in her notes as 'extreme views', but apparently no attention was given to the events that prompted such substantial personal changes.

[Ms A's] reluctance to take medication and her stopping medication prior to her readmission in February 2015 is consistently reported in the documents, including both serious incident reviews, as 'non-compliance'. This gives the impression that [Ms

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A] was disobedient, and does not examine her reasons for choosing to change her life. There is mention by [Ms A] and her sister of a stroke event, but there is no reference to this at all in the documentation I have access to.

Based on the documents I have, and acknowledging that there may be further documents that I do not have access to, it seems that [Ms A's] physical health was not attended to and that the impact of her physical history on her current presentation was not considered.

My overall view of the care [Ms A] and her whānau received during this timeframe is that of a barely adequate level of service that has missed opportunities to provide holistic, recovery focused care. However, even had the care been of a very high standard, it seems likely that this event would not have been prevented due to the nature of [Ms A's] thoughts and beliefs at that time.

Ngā mihi nui

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