Registered Nurse, RN D

District Health Board

Mental Health Service

A Report by the

Deputy Health and Disability Commissioner

(Case 18HDC00971)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a man in 2018 by a registered nurse, a district health board (DHB) and a mental health and addiction advocacy and peer support service (the service).

2. The man contacted DHB Mental Health Services and attended a mental health assessment at the DHB with his parents the next day. The assessment was led by the registered nurse. The man presented with low mood and was withdrawn, and the nurse's clinical impression was of depression. The nurse scored the man as low risk and made an urgent referral to a mental health pilot project. The transition to the pilot project was inadequate and there were delays in responding to the urgent referral.

3. The pilot project was established by the DHB in response to a 2016 Ministry of Health request for proposals. Commencing in 2017, it was a single point of entry for all mental health services in the region and was designed with a Te Ao Māori[1] framework. The DHB and the service worked in partnership in the delivery of the pilot project's service.

4. The report highlights the importance of documenting important details of a comprehensive assessment to support patient care and safety, ensuring that the urgency of referral and assessment of risk concur, appropriately implementing pilot projects, and ensuring that the referral process is adequate and understood by the services involved.

5. The report also highlights the confusion caused and lack of accuracy in using predictive risk profiling for determining risk of self-harm (low/medium/high).

Findings

6. The Deputy Commissioner commended the intention behind the pilot project in adopting a Te Ao Māori framework to meet the needs of the local community.

7. However, the Deputy Commissioner found the pilot project (the DHB and the service) in breach of Right 4(5) of the Code. She considered that the man's care was poorly coordinated and lacked continuity, resulting in missed opportunities to provide a prompt and effective response. The Deputy Commissioner criticised the implementation of the pilot project, and considered that there was a significant gap in guidance about responsibility for consumers in transition to the pilot project, and there was no consensus across services on what an "urgent referral" meant. There was also a disconnect between the DHB and the service regarding expectations for the referrer to maintain contact with the case, and inadequate follow-up when the man could not be contacted.

8. The Deputy Commissioner was concerned that the nurse did not document important details of the comprehensive assessment adequately, and that the urgency of referral and the assessment of risk assigned caused confusion. The Deputy Commissioner was also

[1] A Māori world view.

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concerned that the DHB had no formal system for recording the content of telephone conversations.

Recommendations

9. The Deputy Commissioner recommended that the DHB develop a more formal system of recording the content of telephone conversations; review and replace the risk prediction process with risk management and safety planning protocols; ensure that clinical assessments include clinicians' reasoning about admission decisions and use of the Mental Health Act; clarify who holds clinical responsibility for the patient's care at the point of referral and escalation pathways; provide training on compassionate communication; report back to HDC on the actions taken and any outstanding issues from the recommendations in the Serious Incident Review; and provide a written apology to the man's whānau.

10. The Deputy Commissioner recommended that the service collaborate with the DHB on reporting to HDC on the recommendations in the Serious Incident Review that relate to the pilot project, and provide a written apology to the man's whānau.

11. The Deputy Commissioner recommended that the nurse undertake training on keeping clear and accurate patient records, and provide evidence of this to HDC within six months of returning to practise as a registered nurse, if and when that occurs.

12. The Deputy Commissioner also wrote to the Ministry of Health to request that providers are advised to cease using risk prediction in determining self-harm, and to adopt a consistent approach to risk management and safety planning.

Complaint and investigation

13. The Health and Disability Commissioner (HDC) received a complaint from Ms B and Mr C about the services provided to their son, Mr A, by RN D, the DHB, and the service. The following issues were identified for investigation:

- *Whether RN D provided Mr A with an appropriate standard of care in 2018.*
- *Whether the DHB provided Mr A with an appropriate standard of care in 2018.*
- *Whether the service provided Mr A with an appropriate standard of care in 2018.*

14. This report is the opinion of Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

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15. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's mother
Mr C	Complainant/consumer's father
RN D	Provider/registered mental health professional
The DHB	Provider/district health board
The service	Provider/mental health and addiction advocacy and peer support service

16. Further information was received from:

Ms E	Kaiaromatawai/cultural worker/kaiāwhina
RN F	Registered mental health professional
RN G	Registered mental health professional
Ms H	Kaiaromatawai/cultural worker/kaiāwhina
The tertiary institute	
The Coroner	

17. Also mentioned in this report:

Law Firm 1	Law firm representing nurses
Law Firm 2	Law firm representing the service

18. Independent expert advice was obtained from a registered nurse, Dr Anthony O'Brien (Appendix A).

Information gathered during investigation

Introduction

19. Mr A, aged in his twenties at the time of events, identified as Māori. He lived with his whānau, and was studying in another region. From 2016 to 2017, his whānau noticed changes in his behaviour and mental health. This case relates to the adequacy of a mental health assessment in 2018, and the management of a referral to a mental health service provider, the pilot project. Sadly, Mr A died of a suspected suicide.

Pilot project

20. The district health board is responsible for providing mental health services in the region.

21. In September 2017, the DHB commenced a pilot project. The pilot project is the DHB's response to a 2016 Ministry of Health request for proposals. The Ministry of Health allocated funding to the DHB for 16 months to provide the pilot project as a single point of entry for mental health services in the region (primary and secondary) and was in addition to the

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services already available. The pilot project was designed with a Te Ao Māori[2] framework to meet the needs of the local community, and promote equitable mental health outcomes for Māori.

22. The contract for the pilot project describes it as a joint venture governance structure[3] with the DHB, the PHO, the service,[4] and a training organisation.[5] However, the only two parties to the contract are the DHB and the service. A key objective was to actively work towards obtaining a joint venture transformation of mental health service delivery in the region. The contract describes the pilot project as laying "the pathway for significant system change for whānau receiving services in the region", and "prioritising Kaupapa Māori methodology to shape and develop the 'usual care approach' for the region".

The service's description of the pilot project

23. The service told HDC:

> "[The pilot project] was initiated as a tri-partite service provision arrangement between [the DHB], [the PHO] and [the service]. Under that arrangement [the DHB] hold[s] the exclusive responsibility for clinical care. [The service] provides cultural care and tikanga based solutions, based in [the region's] indigenous pedagogy, where appropriate."

24. The service stated:

> "[The PHO] were to provide support services and contribute to secondary care, but that never eventuated during the course of the contract, and [in] 2019 they were formally exited from the arrangement for non participation. … In 2018, during the time of the incident, only [the DHB] and [the service] actively worked with wh[ā]nau as part of the [pilot project] contract delivery."

The DHB's description of the pilot project

25. The DHB stated:

> "[The service] has a service agreement with [the DHB] in order to provide [the pilot project] service and, as part of that contracted responsibility, provides the administrative functions to ensure adequate service delivery. Those functions include ensuring that referrals to [the pilot project] are responded to in the right way within the right timeframe … [The service] is responsible for the overall running of [the pilot project] service."

26. The DHB disagrees that it exclusively holds the clinical responsibility for services provided through the pilot project.

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[2] A Māori world view.

[3] In practice, the DHB and the service were the active parties in the pilot project. Initially the PHO was a party to the pilot project but was not actively involved.

[4] A consumer-led organisation that provides cultural care and tikanga-based solutions and peer support.

[5] For workforce development and kaitiakitanga (guardianship and protection).

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27. The DHB told HDC that the pilot project was a combination of the DHB's and the service's employees working in partnership, and the DHB seconded staff to the pilot project. The DHB stated that it "does not have an involvement in the operation or day-to-day management [of the pilot project]".

Day 1[6] — telephone call to DHB

28. On the evening of Day 1, Mr A's whānau were concerned about his behaviour and telephoned the DHB's Assessment and Triage Team (the team)[7] for advice and assistance. RN F spoke to whānau for 45 minutes and entered a brief summary of the conversation in the team contact book. The book had only a small space to document contacts.

29. Mr A's mother, Ms B, told HDC that the whānau described to RN F Mr A's behaviours of anxiety, fixed glaze, paranoia, being isolated/withdrawn, depression, illusions of grandeur/grandiose thoughts, anger, and self-righteousness.

30. RN F told HDC that she informed whānau of the options available, including contacting Mr A's general practitioner, being assessed by the team,[8] or contacting the Police.[9] RN F said that she discussed admission to the acute inpatient mental health unit at the public hospital through the Mental Health Act,[10] and explained the importance of the principle of the least restrictive intervention.[11]

31. Ms B's understanding from the telephone call was that the team could assess Mr A if he initiated the call and asked for help, and that after an assessment Mr A might be admitted to the acute inpatient unit for five days. However, RN F told HDC that referrals to the team can come from a number of sources, not just from the individual.

Day 2 — mental health assessment

32. On the morning of Day 2, Mr A and his whānau agreed that he needed help urgently. Mr A telephoned the team, and a meeting for him and his whānau was arranged for 2pm that day at the acute inpatient unit.

33. At 2pm, Mr A and his parents met with RN D[12] (the duly authorised officer[13]), who conducted an assessment with support from RN G and cultural worker Ms E (the cultural assessment team (CAT)). The assessment took two hours. RN D completed the DHB's mental health comprehensive assessment form, and a cultural assessment form was completed by Ms E.

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[6] Relevant dates are referred to as Days 1–11 to protect privacy.
[7] A 24-hour crisis mental health service.
[8] Depending on the risk assessment, the team could refer to the pilot project, admit to the ward, or formally admit under the Mental Health Act.
[9] If immediate support is required, such as voicing suicidal ideation, or if there is an imminent risk to the individual.
[10] The Mental Health (Compulsory Assessment and Treatment) Act 1992.
[11] An approach to a person's treatment and care that minimises the use of compulsory treatment and coercive practice and is consistent with both rights-based and recovery approaches to providing mental health services.
[12] RN D was considered a senior member of the team by the DHB.
[13] A health professional who can perform certain functions and use certain powers under the MHA.

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34. RN G commented that she was present as an observer.[14] Ms E told HDC that she offered Mr A a cultural assessment[15] but "it was declined by [Mr A's] whānau, who wanted to proceed with the clinical assessment". She told HDC that she felt that it was important that the assessment was focused on Mr A's clinical needs, given the concerns that had been raised by his whānau.

Documentation of assessment

Cultural assessment form (Te Aromatawai Māori)

35. Although Ms E did not undertake a cultural assessment, she documented her observations on the cultural assessment form that Mr A presented as "very tired", "couldn't think", "reluctant to converse", "his brain was not computing", not eating and sleeping well, he had "lapsed into a deep black hole", and that Mr A was "totally overwhelmed and depressed", with low mood rated 0 out of 10. She commented that Mr A was not saying "how much he had delved into drugs". Ms E recorded that Mr A and his parents were willing to be referred to the pilot project to have "further help with coun[sel]ling and other medium[s]".

Mental health comprehensive assessment form

36. RN D documented the following information on the assessment form.

37. The reason for referral was: "[W]hānau concerned re[garding] [Mr A's] m[ental] s[tate], isolative & withdrawn, had low mood."

38. The history of presenting illness was recorded as:

> "Parents report significant change in [Mr A's] behaviour, from friendly & outgoing to isolative & w[ith]drawn. This has occurred over the last 2 y[ea]rs becoming more guarded and suspicious of others. Broke up [with] G[irl]FRIEND of 1 y[ea]r about 2 y[ea]rs ago. Moved into a flat around the same time, felt lonely. Feels split between his friends from [home] & his friends in [the city] when they visit [the city]. [Mr A] use[d] to feel like a leader but now feel[s] like [he's] pushing people away. Engaged w[ith] counselling services in [the city] which [Mr A] found 'helpful' during a previous episode of depression."

39. The sections for "history of psychiatric diagnosis/treatment" and "developmental issues/ history" were left blank on the form.

40. It was documented under "family history of mental illness" that a family member had experienced manic depression. Under "alcohol and other drug history", it was documented that Mr A used alcohol, cannabis, and ecstasy socially and regularly.

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[14] RN G told HDC that she took charge of the crises telephone and recalled leaving the assessment twice to take calls.

[15] Cultural assessment refers to a holistic approach to ascertaining the collective cultural engagement or experiences of consumers and their connections to their cultural base, with the main objective of supporting consumers on their journey towards better health and well-being. It is underpinned by an awareness of Māori values.

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41. The mental state examination documented Mr A's appearance as: "[A]ppropriately and casually attired, appears tired, reports unrestful sleep. Parents report a poor sleep pattern." The section for behaviour recorded: "[V]ariable eye contact, difficult to establish rapport due to poverty of thought. Has a habit of rolling his eyes back." The section for speech recorded: "[V]olume OK, rate OK, amount and flow ↓."

42. Mr A's mood was recorded as: "[S]elf-rates 0/10, presents as low in mood … occasional spontaneous smile but generally feels 'horrible'. Fearful on occasions." His thought process was recorded as: "[I]mpoverished/slumped but logical. Difficulty in decision making." His thought content was recorded as:

> "[N]o evidence of a delusional or grandiose thinking … Occasional suicidal ideation (when alone) … no plan or intent … No perception issues observed or expressed … Memory appears intact, good intelligence … Expresses good insight and judgment [into requirement for treatment]."

43. The "social history" documents that Mr A was studying and planned to return to the city to complete his study. Under "relationships with others", Mr A's parents reported that he was becoming "more isolative". Mr A's "current support available" was described as whānau and friends.

44. The section on "clinical impression" contains the single word "depression", and RN D scored Mr A as "low risk"[16] to himself and others. The management plan was first, "urgent referral to [the pilot project]", secondly, "advice given on nutrition, exercise and sleep", and thirdly, "given contact details and encouraged to phone should situation deteriorate".

45. RN D told HDC that "[a]t the end of the assessment everyone[17] agreed that [Mr A] would be referred to [the pilot project]".

Subsequent comments about assessment

46. In addition to what was documented on the assessment forms, Ms B, Mr C, RN D, Ms E, and RN G provided HDC with the following information about the assessment. None of the below was documented at the time of the assessment.

Depression

47. Ms B gave RN D a list of the concerning behaviours Mr A had been portraying, alongside a list of his typical behaviours. RN D said that the list facilitated a lengthy discussion about symptoms, and Mr A identified depression as an issue, and said that Talking Therapy had been effective for him in 2017, and he wanted to pursue this as a first option. RN D said that the discussion about depression involved education with regard to symptoms,[18] prognosis, and treatment options.

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[16] Modifiable risk factors, with strong protective factors and/or support. May have thoughts of death, no plan, intent, or behaviour. Unlikely to injure self or others.

[17] This is confirmed by Ms E and RN G.

[18] Including sleep, concentration, eye contact, and energy levels.

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48. Ms E told HDC that she observed Mr A to be "in a fragile and vulnerable way", and said that RN D talked about depression and anxiety, which had been raised as concerns by Ms B. Ms E said that she felt that RN D "was definitely listening to these concerns and addressing them". Ms B told HDC that RN D "mentioned that [Mr A] was depressed and talked about Bi Polar [disorder][19] and medication. But nothing more was done about this."

Suicidal thoughts

49. RN D told HDC that Mr A reported having experienced occasional thoughts of suicide in 2017 but not at this time, and his suicidal ideation was not intrusive, and he did not dwell on it and had not thought about how he might attempt suicide. RN D commented that suicidal ideation, intent, and planning were assessed continually during the assessment.

50. Ms B said that when asked if he had planned his suicide, her son grunted and shrugged. She told HDC that when Mr A said that he had suicidal thoughts, this should have been "an alarm bell for the professionals". Mr C told HDC that his son "was having severe difficulty articulating answers" to RN D's questions.

51. RN D told HDC that Mr A's 0/10 score was "somewhat incongruent with [Mr A's] presentation[20]". RN D stated that Mr A was able to respond to questions rationally, and was future focused to finish his degree. RN D said that Mr A's limited communication, body language, and zero mood rating were concerning, but were balanced by other factors.[21]

52. RN D told HDC that he spoke about strategies that could help, such as engaging with the pilot project to access Talking Therapies, a resident psychiatrist, alcohol and drug input, and other services. RN D said that he took into account whānau views, which he acknowledged as important, and also considered other information.

53. RN G said that RN D assessed Mr A to be low risk because of his supportive whānau, his plan to return to his relative's house, and no plan to harm himself. She said that it was clear that Mr A would benefit from further mental health support, which was the reason for the urgent referral to the pilot project. Ms E said that she trusted the assessment completed by RN D, and stated: "If I had thought that there was a greater risk for [Mr A], I would have said something at the assessment."

Alcohol and other drug history

54. Ms B told HDC that Mr A said that he used recreational drugs. She thought that RN D "down played [Mr A's] drug use and brushed it off as if [Mr A's] drug use was normal and acceptable".

55. RN D told HDC that Mr A was reluctant to disclose any substance use, but did disclose regular cannabis and alcohol use. RN D said that Mr A did not want to share specific details about

[19] Bipolar disorder causes extreme mood shifts ranging from mania to depression.

[20] Such as maintaining his daily activities and personal cares, attending work and the assessment, plans for the future (studies), and being willing to re-engage with therapies.

[21] Including agreeing to stay in his home town with a relative, seeking assistance and identifying Talking Therapies as beneficial, performing at work and being determined to finish his studies, and supportive whānau and friends.

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the quantity of substance use or how frequently it was used, and he expected the pilot project to identify and monitor substance use further.

56. RN D said that he encouraged Mr A to preferably abstain or reduce the use of drugs, and discussed the services at the pilot project, including peer support, whānau support, Talking Therapies, and alcohol and drug counselling. RN G told HDC that the extent of Mr A's alcohol and drug use became known only with hindsight after his passing, and said that it was expected that the pilot project would identify Mr A's needs in the following days, including alcohol and drug counselling.

57. RN D and RN G told HDC that in addition to the initial offer to Mr A and his parents to discuss their concerns individually, Mr A was offered an opportunity to discuss his substance use without his parents present, but he declined. RN D acknowledged that it was not recorded in the notes that Mr A was offered an opportunity to be seen alone.

Psychiatric review/admission

58. RN D considered that a psychiatrist[22] review was not warranted at the time, as Mr A had expressed a preference for Talking Therapies through the pilot project, did not want medication, and his risk of harm was assessed as low. RN D added that Mr A was already tired after the two-hour assessment, and "another round of questioning" from a psychiatrist "would likely have been exhausting and distressing".

59. There is no record that admitting Mr A to hospital, either voluntarily or under the Mental Health Act 1992, was discussed on Day 2, and Mr A's father told HDC that inpatient admission was not offered. RN D told HDC that he did not admit Mr A to hospital as there was a low risk of harm to himself or others, and he had an obligation to treat Mr A in the least restrictive manner. Ms E said that she recalls that Mr A did not want to be admitted. RN G agreed that Mr A did not meet the criteria for compulsory admission and did not want a voluntary admission. She told HDC that a psychiatrist assessment was not indicated.

Return to the city

60. Mr A's parents identified Mr A returning to the city as a primary concern for them. RN D told HDC:

> "It was agreed by everyone that it would not be in [Mr A's] best interests to return to [the city] at that time. Critically [Mr A] agreed to delay his return to [the city] and remain in [his home town] to engage with the pilot project for the commencement of treatment and ongoing support."

61. RN G recalled specifically encouraging Mr A not to return to the city.

Choice of urgent referral

62. RN D told HDC that he assessed Mr A's short-term risk as low, but made an urgent referral to the pilot project as "risk is not static and there was a need for urgent engagement with

[22] The DHB told HDC: "A psychiatrist is always available on call and can be contacted 24/7 for advice and are required to be available on site within 20 minutes of a request to do so."

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mental health services to monitor [Mr A's] risk" and to access quick and responsive ongoing support for Mr A. In an interview with the DHB, RN D said that he made an urgent referral on low risk because he could see other stressors with Mr A and his parents.

Engagement and communication

63. Mr A's father told HDC that his impression was that the interview was "impersonal", "cold and clinical", with "no empathy or compassion shown". The DHB told HDC that feedback from whānau indicated that the assessment "displayed little thoughtfulness about the information that was being gathered and was inadequate in terms of listening to the whānau".

64. RN D stated that it was difficult to establish a rapport with Mr A, and he tried to create an atmosphere and environment where Mr A was comfortable enough to discuss his concerns and those of his parents. RN D said that he felt that eventually he was able to connect with Mr A.

65. Ms E and RN G agreed that eventually RN D was able to build a rapport with Mr A. RN G said she believed that RN D's manner of assessment was professional throughout the assessment.

66. RN D told HDC that all parties were offered an opportunity to discuss their concerns individually, but Mr A and his whānau declined. RN D commented that he observed strain between Mr A and his parents, and, with hindsight, RN G considered that Mr A would have benefited from the less clinical and threatening environment offered by wānanga.

Documentation

67. RN D acknowledged that during the assessment he could have documented the discussion more extensively, and that it was his professional responsibility to ensure that the notes were up to standard.

68. RN D stated that although the documentation may not have reflected the level of detail considered and discussed, in his view, "all aspects of the static[23] and dynamic risk factors were considered along with protective factors for [Mr A]". RN G said she thought that RN D captured the main points of concern of the whānau adequately, and believed that this was enough to support the referral to the pilot project.

69. RN D said that in documenting the assessment, "[t]he objective is to obtain enough information to establish the best way forward for the individual, whilst maintaining safety". He added that he did not want his note-taking to interfere with building a rapport with Mr A.

[23] Age, gender, and ethnicity.

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Day 3 — referral to pilot project received

Handover

70. The team and the DHB told HDC that a nurse handed over the referral and comprehensive assessment to the pilot project[24] at a face-to-face meeting at 9am on Day 3. This was in line with the accepted handover process[25] to hand over to team leader and Matataki[26] at 9.30[am]" after the hui at 8.30am. RN F told HDC: "On a weekday, referrals can occur the same day. On a weekend, a referral would be handed over from the team on the following Monday."

71. In response to the provisional opinion, the service told HDC that it was the role and responsibility of the clinical team leader (seconded from the DHB) to receive referrals and triage them "using [DHB] approved clinical triage tools/guidelines, information sharing protocols including [DHB] clinical documentation procedures in combination with [DHB] approved clinical based performance audit and monitoring tools".

72. There are no clinical notes regarding receipt of the handover. The service told HDC that the handover was not at 9am but during the course of that day. The Matataki process states that the list of whānau who need to be triaged each day will be updated continually and checked each morning, at midday, and in the afternoon.

73. The referral was entered into the pilot project's computer system later in the afternoon. The registration form states: "[Mr A] appears to be experiencing a depressive episode this is also negatively impacting upon his whānau." Pilot project staff read the Matataki notes but not the comprehensive assessment by RN D.[27]

74. RN D commented that he "expected that [Mr A's] risk would be assessed again on Day 3 because [he] had referred [Mr A] for an urgent tono[28]".

Day 4 — telephone calls

75. On Day 4, the client case notes record telephone calls at 10.47am and 1.04pm from the pilot project staff to Mr A and then his mother, and that there was no answer, but messages were left. Ms B returned the telephone call, and the wānanga for Mr A was arranged for 10am on Day 6 at the home of Mr A's relative.

76. The service said that Day 6 was the earliest day on which the multidisciplinary team at the pilot project could see Mr A. RN F told HDC that if there is a delay in the referral being processed, such as a problem with service capacity, the agency (such as the pilot project) would usually contact the team, and the patient would continue to be followed up by the team. However, when a referral is accepted, the team will hand over the care.

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[24] The pilot project staff involved in managing Mr A's referral were employed by the DHB.
[25] Minutes of a meeting two months prior to these events.
[26] The triage assessment and documentation process for tono/referrals.
[27] The DHB's Serious Incident Review.
[28] Referral.

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Management of an urgent referral

77. Guidelines[29] current at the time for management of an urgent referral (see Appendix B) were as follows:

a) The DHB's Triage Guidelines:

- an urgent referral should be responded to in 2–3 hours
- a semi-urgent referral should be responded to in 3–24 hours.

b) Mental health service Matataki process for triaging tono:

- "All urgent tono must have contact on the day the tono is entered."

78. The service told HDC:

> "[S]ervice delivery specifications for [the pilot project] are for a referral to be picked up and actioned within 72 hours of receipt. It is unclear whether [RN D] or [RN E] knew that at the time they made their decision to refer."

79. No evidence of these specifications was provided by the service.

80. In response to the provisional opinion, the DHB stated that the DHB's triage guidelines do not apply to referral out of the service to the pilot project, and that the information that the service provided met its expectations.

81. RN F's understanding was that an urgent referral to the pilot project needs to be responded to in 2–3 hours, and staff at Matataki in the pilot project had the role of triaging referrals and organising wānanga. RN G's understanding was that because Mr A was a low risk, urgent referral, he should have been managed by the pilot project as semi-urgent to urgent and contacted within 3–24 hours to confirm a wānanga. Ms E believed an urgent referral meant that Mr A would receive further input as soon as the following day.

82. RN D said that prior to the formation of the pilot project, an urgent referral would be followed up with a telephone call as soon as possible (usually within 24 hours). The DHB stated that an urgent referral to the pilot project means "being seen on the same day or ASAP within 24 hours".

83. The service told HDC that "sending the confusion of 'urgent' [referral] and 'low clinical risk' within the same documentation" was unclear communication to the pilot project. RN D told HDC that mental health staff were familiar with the assessment forms and the language and terms he used, including the terms "low risk" and "urgent referral".

Follow-up

84. The DHB Triage Guidelines place the obligation on the service receiving the referral (the pilot project) to inform the referrer (the team) of the outcome of the referral. RN D said that prior

[29] The DHB's Triage Guidelines Single Point of Entry Pathway.

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to the formation of the pilot project, any concerns would be referred directly back to the team without delay for the team to follow up.

85. The service told HDC:

> "It is the agreed protocol when making a referral that [the team] maintain contact with the file for at least 72 hours *after referral* to ensure that the referral is being dealt with (effectively to stop any potential 'slipping through the gaps' type errors, or to pick up matters that may require a revision in management plan/further referral)."

86. No evidence of this protocol was provided by the service.

Day 6 — wānanga

87. At 10am, pilot project staff attended Mr A's relative's house for the wānanga, but Mr A did not attend. The client case notes record that Mr A's relative told staff that Mr A believed the wānanga was to be held at the pilot project, that Mr A would "attend this wānanga from his place of work", and that Mr A would be leaving for the city on Day 9 to continue his studies. Pilot project staff telephoned Mr A (but received no reply) and sent him a text message that they would meet him at the pilot project (but received no reply). Staff then contacted Ms B and advised her that they "are flexible and would see [Mr A] if he is able to come in". Although Mr A had engaged with counselling services at the tertiary institute previously, the pilot project staff did not attempt to contact the service.

88. The DHB's Serious Incident Review noted that Ms B confirmed that Mr A was returning to the city, and that the pilot project staff offered to wait until Mr A had settled before following up on his well-being.

89. The service said that attendance at a wānanga is voluntary, and commented that it is not unusual for whānau in distress to alter their decision to seek help, or to not attend appointments, and this is always followed up. RN D stated: "If [the pilot project] weren't able to make contact with [Mr A] then this should have triggered a referral back to [the team] to follow up but this did not happen."

90. Ms B told HDC that Mr A did not attend the wānanga as he had decided to return to the city to finish his studies.

Day 9 — return to city

91. Mr A returned to the city on Day 9. Sadly, Mr A died of a suspected suicide on Day 11. Pilot project staff contacted Ms B on Day 12 to follow up on Mr A, and were informed of his death.

Further information

Ms B

92. Ms B commented on "the lack of support and treatment" Mr A and his whānau received from mental health services. Ms B told HDC: "The system and the professionals responded poorly to the needs of [Mr A] who was in obvious mental distress, and failed us and especially [Mr A]."

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93. Ms B stated: "Whānau need to be listened to as we know our whānau/children best and are the ones who see the change in their behaviours."

The DHB

94. The DHB apologised "that when [Mr A] and his whānau sought help, the Service did not provide this to the standard expected".

95. The DHB provided HDC with four investigations/reports relating to Mr A's care and/or the pilot project (see Appendix C).

RN D

96. RN D told HDC that he is "deeply sorry for the loss felt by [Mr A's] whānau", and added that "[Mr A's] wellbeing was first and foremost in [his] mind at the assessment, not only for [Mr A's] sake but his whānau's sake as well".

97. In response to issues raised in the Serious Incident Review, RN D stated that the team is a crises triage team, and Mr A was referred to the pilot project for help in developing specific strategies. RN D disagrees that he missed key red flags, and noted that risk assessment considers a multitude of factors that are weighed against identifiable protective factors, and are subject to forces and influences that cannot be foreseen.

System concerns

98. RN D's view is that the pilot project was rolled out without any structure or planning for integration into current systems. He told HDC that the team repeatedly raised concerns about patient safety, but the DHB failed to act to alleviate these concerns. He referred to an "overriding atmosphere of uncertainty", poor management, and poor oversight of mental health services, and said that "practices and procedures were changing on an almost daily basis at times".

99. RN F said that the changes to mental health services in recent times had created a negative work environment. She stated that the team were not consulted adequately or prepared for change. RN F commented that there were no new policies or procedures in place, and said that the team received no guidance about how to fit in with the pilot project service, except to refer patients to the pilot project instead of directly to DHB mental health services.

100. RN G said that the team identified concerns about clinical risk and gaps in the pilot project's service in 2017. RN G told HDC that the team staff were not adequately informed about how the team and the pilot project should be integrated, and described the work environment as chaotic and unsupportive.

101. Ms E commented that in her opinion the referral process between the DHB and the pilot project "was flawed". She said that it was not clear how the team/CAT were to fit into the pilot project model. She said that the team/CAT were told to keep doing what it had always been doing, but instead of referring patients to the DHB's mental health service, to refer them to the pilot project as a single point of entry.

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102. The service told HDC that systems and processes between the DHB and the service were tested and reviewed during the pilot phase of the pilot project, and identified issues with clinical resistance and collaborative working.

The service

103. The service acknowledged Mr A's mana and his tapu, and the pain and burden of grief upon his whānau. The service offered for its staff to meet with Mr A's whānau on their terms, and within their timeframes, if they wished to.

The pilot project

104. The pilot project ended in 2019, and the Ministry of Health extended funding for a further three years. The DHB and the service entered into a service level agreement to deliver services within the pilot project under a joint venture partnership.

The tertiary institute

105. Mr A was seen by a counsellor at the tertiary institute four times — once in 2015 and three times in 2017. The counsellor told HDC that she was first contacted by the community mental health and addictions service in Mr A's home town in 2018 [after Mr A's death].

Responses to provisional opinion

Ms B and Mr C

106. Ms B and Mr C were given an opportunity to respond to the provisional opinion. They accepted the proposed recommendations and follow-up actions.

The DHB

107. The DHB was given an opportunity to respond to the provisional opinion. Where appropriate, changes have been made to the "information gathered" section in response to the DHB's comments.

108. The DHB acknowledged that it "has always considered that the care provided to [Mr A] and his wh[ā]nau was substandard" and it has apologised for this.

109. The DHB commented that there were tensions between the pilot project and the rest of the service in the region, which in the most part related to differing views on the value of the Kaupapa Māori approach fitting with western clinical practice. The DHB told HDC that it considers that the main issue in this case was the adequacy of the assessment by RN D and the irreconcilable urgent referral on an assessment of low risk. The DHB commented that a range of options was available to the team, but it elected to refer Mr A to the pilot project, which is a primary level service. The fact that the team decided to refer to a primary service is indicative of its view that Mr A was of low risk. Any statement of urgency needs to be considered in the context of that level of risk. The DHB considers that in the circumstances, it is unreasonable to find the pilot project in breach of the Code of Health and Disability Services Consumers' Rights (the Code).

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The service

110. The service was given an opportunity to respond to the provisional opinion and agreed to the proposed recommendations. Where appropriate, changes have been made to the "information gathered" section in response to the service's comments.

111. The service told HDC:

> "It was expected [that a DHB-designated clinical Team Leader (T/L)] would advise [the DHB] Clinical Head of Department MH&AS, line manager who at the time was Group manager [of the DHB] and the service manager of their concerns, who worked together to minimise/eliminate harm risks wherever the threat(s) were identified."

112. The service acknowledged that the DHB does not agree with the service's view that "[the DHB] exclusively holds clinical responsibility for services provided through the pilot project". The service reiterated its view that the contract and the service level agreement show that "clinical responsibility and duty of care sits with [DHB] services and cultural care and tikanga based solutions workforce sits with the service".

RN D

113. RN D was given an opportunity to respond to the provisional opinion. RN D's lawyer told HDC that RN D was unable to be reached for comment. The lawyer told HDC that RN D is not currently practising as a registered nurse and is not listed as holding a practising certificate.

Opinion: Introduction

114. This report highlights the confusion caused and lack of accuracy in using predictive risk profiling for determining risk of self-harm. It also highlights the importance of providers undertaking comprehensive and systematic mental health assessments, and the importance of ensuring that the assessments are documented adequately. The report also emphasises the need to have in place adequate systems for managing referrals between different teams and providers, and the importance of resourcing the implementation of new ways of working adequately to enable co-operation among providers to ensure continuity of care. In my opinion, a number of issues in Mr A's care contributed to a delay in his referral being actioned, and a lack of appropriate follow-up. These issues are set out below.

115. I note that Mr A contacted mental health services during a time of service change and considerable upheaval. In September 2017, The DHB commenced a pilot project as a single point of entry for all referrals to mental health services. It was designed with a Te Ao Māori framework to meet the needs of the local community, and to promote equitable mental health outcomes for Māori. This is commendable. However, I have concerns about the implementation of the pilot project and the effect this had on Mr A's care.

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Opinion: RN D — adverse comment

116. On Day 2, RN D assessed Mr A. RN D documented the assessment on the DHB's "mental health comprehensive assessment form".

Documentation of assessment

117. The DHB's policy[30] and the assessment form indicate that the assessment should be "comprehensive".

118. My nursing advisor, Dr O'Brien, considered that the documentation of RN D's assessment was not at the appropriate standard,[31] with "too little detail in many of the sections of the assessment". He advised that a mental health assessment by the team should not be abbreviated or limited, unless made under extreme urgency, which was not the case for Mr A's assessment, which took two hours. Dr O'Brien advised:

> "When a consumer is being seen for the first time with whānau concerns for safety, and under urgency (i.e. at the weekend rather than by routine referral) it is important the assessment is not abridged or abbreviated."

119. I note that as outlined above in the "information gathered" section of this report, several additional matters were assessed and considered but not documented. These included the development of symptoms over time, protective factors, and whānau concerns. The documentation of social history, depressive symptoms, assessment of alcohol and other drug use, and risk assessment, is limited. There is also no record of thought content or suicidal thoughts, although RN D did state that there was some discussion around those matters.

120. RN D documented that Mr A planned to return to the city to complete his studies, but did not record that Mr A's parents identified his returning to the city as a primary concern for them. If whānau concerns are not documented adequately, it is difficult to demonstrate that they were considered adequately. I endorse Ms B's comment that whānau need to be listened to as they know their whānau/children best. I note that the DHB's policy on assessment specifically states that "the person and their family/wh[ā]nau are seen by the Service as the experts in their care".

121. RN D stated that he was concentrating on building a rapport with Mr A, and that this affected the detail in his documentation of the assessment. RN D also stated that some information was not forthcoming from Mr A. Mr A may have been more forthcoming if he had been seen alone, but I note that this option was offered to him and he declined.

[30] The DHB's Assessments: Single Point of Entry Pathway policy (see Appendix B).
[31] Te Ao Māramatanga (New Zealand College of Mental Health Nurses) Standards of Practice for Mental Health Nursing in Aotearoa New Zealand (2012).

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122. I accept that RN D undertook a more comprehensive assessment than was documented, but I am concerned that his documentation is not a full and accurate representation of the assessment. As Dr O'Brien advised:

> "[I]t must be remembered that [RN D's] assessment is all subsequent clinicians and services have to inform their response, especially following referral to another service. From their perspective the documented assessment is the assessment."

Urgent referral on low risk

123. Dr O'Brien commented on the tension or contradiction between the term "urgent" referral with an assessment of "low risk". In the DHB's Triage Guidelines, the term "lower risk" is used for Triage Code 4, which is considered non-urgent, and needing assessment within 1–7 days. Dr O'Brien advised: "There is a real mismatch between the statement of 'urgent' and 'low risk'." I agree and I am concerned that there is a disconnect between the low level of risk and the urgency of response sought by RN D. This disconnect created the potential for confusion when the referral was handed to the service and, as is discussed below, this added to the lack of clarity around how speedily Mr A's referral should be progressed. Further, although I accept that the use of the term "low risk" was still being used by some practitioners at the time of this assessment, I understand that this approach of trying to predict future self-harm causes confusion and has little to no validity,[32] and, as such, I have asked the Ministry of Health to give guidance to providers to cease using this approach.

Decision not to admit

124. In Dr O'Brien's opinion, the decision not to admit Mr A was acceptable in the circumstances of whānau support being available and a referral made for further care, and he advised that he did not expect to see Mr A's care escalated to a psychiatrist by the team as there was no change in his presentation throughout the assessment.

125. Dr O'Brien advised that "[a]ssessment by a psychiatrist, especially in relation to whether [Mr A's] depression should be treated with medication, could still have been arranged by the pilot project". He advised that discharging Mr A home with whānau support, and a referral to the pilot project, was appropriate and safe, and a plan was in place that was agreed to by those present at the assessment. Safety-netting advice of contacting the team again if the situation deteriorated was also provided.

Conclusion

126. I note Dr O'Brien's advice that based on the documentation, the assessment by RN D was a moderate departure from the accepted standard. I accept that RN D undertook a more comprehensive assessment than was documented, but share Dr O'Brien's concern that RN D did not document important details of the two-hour comprehensive assessment, including the concern Mr A's parents had around Mr A returning to the city, symptom development over time, a substantial review of depressive symptoms, thought content or suicidal thoughts, social history, and a limited assessment of alcohol and other drug use and risk

[32] Mulder, R, Newton-Howes, G, and Coid, J (2016). The Futility of Risk Prediction in Psychiatry, BJP 2016, 209: 271–272 DOI: 10.1192/bjp.bp.116.184960.

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assessment. I am also concerned about the potential for confusion for the pilot project in receiving an "urgent" referral with an assessment of "low risk".

Opinion: Pilot project (the DHB and the service) — breach

Background

127. "The pilot project" is a joint venture between the DHB and the service that commenced in 2017. The pilot project was in the pilot stage when Mr A was referred to it, and I note comments from RN D and other staff at the DHB that this was a period of significant organisational upheaval and challenge.

128. The service is the contract holder, and provides cultural care and tikanga-based solutions to consumers. The staff at the pilot project are a combination of DHB and mental health service employees working in partnership. The pilot for the project ended in 2019, and funding was extended for a further three years, following evaluation of the service. The DHB and the service entered into another service level agreement to deliver services under a joint venture partnership.

129. Although I recognise the specific legal entities responsible for this service, in recognition of their partnership in the delivery of the pilot project's service, for the purposes of this opinion I will be referring to them as "the pilot project".

Referral to the pilot project

Timeline

130. The outcome of Mr A's mental health assessment on Day 2 was an urgent referral to the pilot project. The referral, and responsibility for Mr A's care, was handed over to the pilot project by the team at a meeting on the morning of Day 3, and entered into the computer system that afternoon. On Day 4, telephone calls were made to Mr A and his mother and messages left. Ms B returned the call, and a wānanga was arranged for Day 6.

131. Mr A did not attend the wānanga, and staff telephoned and texted Mr A, with no reply. Staff then telephoned Ms B, who advised that Mr A was returning to the city on Day 9. Pilot project staff offered to wait until Mr A had settled before following up on his well-being. When pilot project staff next telephoned Ms B on Day 12, they were informed that Mr A had died of a suspected suicide on Day 11.

Management of an urgent referral

132. I have been presented with different views from the DHB and the service on what an "urgent referral" means, especially in the context of the low-risk category assigned to Mr A in the assessment. Guidelines current at the time were the DHB's Triage Guidelines and the service's Matataki process for triaging tono (referrals) (see Appendix B). The DHB's guidelines stated that an urgent referral should be responded to in 2–3 hours, and a semi-

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urgent referral responded to in 3–24 hours. The service's process stated: "All urgent tono must have contact on the day the tono is entered."

133. Pilot project staff did not contact Mr A on the day the tono was entered (Day 3), nor did they contact him or his whānau within 24 hours of receiving the referral. There was a delay in making first contact (on Day 4 with Mr A's whānau) and a further delay for the wānanga (Day 6), as this was the earliest that the multidisciplinary team at the pilot project could see Mr A.

134. RN G, RN D, and Ms E all believed that the urgent referral for Mr A meant that he would be contacted as soon as possible and within 24 hours. The DHB went further, and said that an urgent referral to the pilot project meant that Mr A should have been seen as soon as possible within 24 hours. However, there is an obvious disconnect between the DHB and its staff's expectations and those of the service, as the service held the view that a referral would be picked up and actioned within 72 hours of receipt. This disconnect between services is concerning.

135. Dr O'Brien advised that there is a real mismatch between the statement of "urgent referral" and "low risk", with the term "lower risk" used for non-urgent referrals, and needing assessment within one to seven days. The service also commented that an urgent referral with low risk was unclear communication to the pilot project. I accept Dr O'Brien's advice that if "there was any confusion about the level of risk or the urgency of response sought by [the team], [the pilot project] needed to seek clarification of that from [the team]".

136. I accept Dr O'Brien's view that the low risk on an urgent referral was misleading for pilot project staff to determine an appropriate response. The confusion was compounded by the lack of consensus in the policies between the DHB and the service, with neither entity holding the same understanding of what an urgent referral meant, even without considering the low risk rating. I am critical of this lack of clarity and consensus. I also note that pilot project staff read the registration form, which states, "[Mr A] appears to be experiencing a depressive episode this is also negatively impacting upon his whānau," but did not read the mental health assessment by RN D, which provided more information. Dr O'Brien advised that the transition to the pilot project (including the response to the referral) was a moderate departure from the accepted standard of practice. I agree with this advice.

Follow-up

137. The DHB Triage Guidelines place the obligation on the service receiving the referral (the pilot project) to inform the referrer (the team) of the outcome of the referral (see Appendix B). RN D said that prior to the pilot project, any concerns would be referred directly back to the team without delay, for the team to follow up. RN F said that if there was a delay in the referral being processed, the team would be contacted and would follow up the consumer. Again, there is a disconnect between the DHB and the service. The service told HDC that it expected the team to maintain contact with the file for at least 72 hours after referral, to ensure that the referral was being dealt with.

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138. Pilot project staff did not contact the team when the pilot project was unable to see Mr A until Day 6. Nor did pilot project staff refer Mr A back to the team when he did not attend the wānanga and could not be contacted directly. As Dr O'Brien comments, "direct contact with [Mr A] would have been helpful as part of the pilot project's response". However, after his assessment by the team on Day 2, the pilot project had no direct contact with Mr A, which Dr O'Brien describes as "a long gap for someone in crisis". I acknowledge Dr O'Brien's comments about the pilot project implementing a Kaupapa Māori service model, with whānau the smallest unit of engagement, so he is not critical of the pilot project working through the whānau. However, I am concerned that pilot project staff did not communicate with the team staff to manage Mr A's risk.

139. When Mr A returned to the city he had not been seen since his initial assessment on Day 2. Pilot project staff did not contact counselling services at the tertiary institute (where Mr A had attended counselling previously), and there was no attempt to arrange follow-up care in the city. Dr O'Brien refers to the Ministry of Health's guideline (*Preventing suicide: Guidance for emergency departments)* and advised that "if a person who is suicidal does not receive follow up care following assessment that is likely to increase risk by making the person feel unsafe".

140. Dr O'Brien advised that the lack of direct contact with Mr A and lack of contact with mental health services at the tertiary institute was a departure from the accepted standard of practice. I agree that there were missed opportunities for the pilot project to contact the team and the services in the city to provide continuity of care for Mr A, and I am concerned that pilot project staff did not recognise that Mr A required an urgent response.

Conclusion

141. As I have stated in my overall introduction, I commend the intention behind the pilot project in adopting a Te Ao Māori framework to meet the needs of the local community. However, I am concerned about the implementation of the pilot. The DHB has submitted, in response to my provisional opinion, that there were tensions between the pilot project and the rest of the service in the region around the value of a Kaupapa Māori approach. With such tensions between staff, the need for a robust implementation process was paramount. There was a significant gap in guidance about responsibility for consumers in transition from the team to the pilot project. There was no consensus across services as to what the term "urgent referral" meant in Mr A's case, and this contributed to the delay in responding to the urgent referral. There was also a disconnect between the DHB and the service regarding expectations for the team to maintain contact with the file after referral to the pilot project.

142. I note that the DHB has told HDC that it believes the dominant issue is the inadequate assessment and irreconcilable referral by RN D. I have considered the assessment and accept that RN D undertook a more comprehensive assessment than was documented. I am concerned about the disconnect between the low level of risk and the urgency of response sought by RN D. However, I am not critical of the decision not to admit Mr A. I believe that the main issue was the poor coordination and continuity of care for Mr A on transition to the pilot project.

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143. I accept Dr O'Brien's advice that "[t]he transition to [the pilot project] was inadequate and unsafe and led to no follow up being provided for four days". There was no attempt to contact the team when there was no direct contact with Mr A, or to arrange follow-up care in the city for Mr A. I am critical that there were missed opportunities to provide a prompt and effective response to Mr A, indicative of a disconnect between DHB staff and the service in the pilot project referral process, which resulted in poor coordination and continuity of care for Mr A. Accordingly, I find that the pilot project (the DHB and the service) breached Right 4(5) of the Code.[33]

Opinion: DHB — adverse comment

Day 1 — telephone call

144. On Day 1, Ms B telephoned the team for advice and assistance, and spoke to RN F. The telephone call led to an appointment for assessment the next day. Dr O'Brien commented that the documentation of this 45-minute call was minimal and was a mild departure from expected standards. He advised that a more extensive note should have been made, a case opened, and the call recorded in formal clinical records, especially as the telephone call resulted in a decision that Mr A or his whānau could call back for further support. I note that the book used to record telephone calls had only a small space to document contacts, and I have made a recommendation for the DHB to develop a more formal system for recording the content of telephone conversations.

Changes made

RN D

145. RN D has reflected on his practice, and stated that he will record more in-depth documentation in clinical notes and assessments. He believes his practice will be positively influenced with renewed empathy for service users and their families, and more checking that they are comfortable and confident to express any concerns. Where possible, he will ensure that collaboration and coordination of supports and services culminate in a solid and sound plan for service users, and will evaluate the outcome. RN D said that he will continue to consult with colleagues and encourage their feedback and suggestions on ways to improve how he practises, and will take opportunities to further his postgraduate studies and update his skills, knowledge, and clinical experience.

[33] Right 4(5) states: "Every consumer has the right to co-operation among providers to ensure quality and continuity of services."

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DHB

146. The DHB met with Ms B and Mr C and shared the DHB's Serious Incident Review and investigation report (see Appendix C). Since the review, the team and CAT have been assigned a Team Leader to support the team to integrate into the pilot project's model of care. In addition, a formal process related to professional conduct and practice was undertaken with staff to address the issues identified in the investigation.

147. The DHB told HDC:

- A system for recording information on initial telephone calls is being considered.
- An updated comprehensive assessment is being used.
- The team has been strengthened with more clinicians on the roster, clinicians working in mentoring relationships, structured handovers, and built-in education and supervision.
- Work is ongoing around the quality and recording practices of the team and CAT, ensuring that the team records are now being held within the DHB Community Mental Health Services clinical records as well as the new project (formerly the pilot project) recording system.
- The managerial and clinical oversight of the team, CAT, and clinical team members currently working within the new project has been strengthened, including a new nursing clinical coach role to build capability.
- Clinical governance within mental health is being reviewed and re-established.

Mental health service

148. The service acknowledged that "[t]he pilot was not without its challenges; and key staffing changes were made, as well as renewed commitments to working together collaboratively and in the best interests of whānau at risk". The service stated that the new joint venture between the DHB and the service "is intended to structurally set out reporting lines, role, function and strengthen any areas identified by the reviews of the service. The referral system, and the procedures … will be formali[s]ed within the joint venture documentation (and all staff now receive full induction and training …)."

149. The service told HDC:

- Referral protocols have been re-confirmed with all staff working within the pilot project, including protocols for addressing incomplete or inadequate referral documentation. These are to be escalated immediately to the operations manager and addressed immediately with the corresponding colleague in the DHB.
- Staff have been reminded of procedural requirements in taking file notes and documenting progress in Excess,[34] and additional training has been provided.
- Senior staff from the service undertake regular auditing of the entries into the database to ensure consistency, quality control, and accuracy.

[34] The client management database.

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- Mental health service staff (and the governance Board) have undertaken training, including on the development of systems and Te Tiriti o Waitangi.
- Kawa[35] and tikanga[36] have been agreed for the pilot project.
- A senior team has been established to work on realigning behaviours and practices in the pilot project. Another team has been established to work on operational best practice.
- The service has reviewed all its policies and procedures.

Recommendations

150. In light of the changes already made (as noted above), I recommend that the DHB:

a) Provide a formal written apology to Mr A's whānau for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this opinion, for forwarding to the whānau.

b) Develop a more formal system of recording the content of telephone conversations (beyond the current template for initial telephone interviews), especially for calls that involve triage of urgency and that result in appointments for face-to-face assessment.

c) Broaden the focus of training on suicide risk assessment to include comprehensive clinical assessment, and involve clinicians in developing a supportive model for any training.

d) Review and update the risk assessment and safety management protocols, as use of high/medium/low risk ratings have been found to be low predictors of harm and to create confusion relative to urgency of care, as occurred in this case.

e) Ensure that clinical assessments include clinicians' reasoning about admission decisions and use of the Mental Health Act, with reference to whānau views on this.

f) Clarify who holds clinical responsibility for the patient care at the point of referral and escalation pathways.

g) Provide training for the team staff on compassionate communication with consumers and whānau.

h) Consider the recommendations in the Serious Incident Review, and report back to HDC on the actions taken and any outstanding issues, with a plan on how these will be addressed. Where the recommendations relate to the pilot project, coordinate the response with the service.

151. The information requested in points (b) to (h) above is to be provided to HDC within three months of the date of this opinion.

[35] Māori protocol and etiquette.
[36] Incorporating practices and values from mātauranga Māori.

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152. In light of the changes already made (as noted above), I recommend that the service:

a) Provide a formal written apology to Mr A's whānau for the deficiencies of care identified in this report. The apology should be sent to HDC within three weeks of the date of this opinion, for forwarding to the whānau.

b) Collaborate with the DHB on addressing the recommendations that relate to the pilot project in the Serious Incident Review, within three months of the date of this opinion.

In response to the provisional opinion, the service told HDC that it has "taken assertive steps to address and implement all relevant recommendations identified in the Serious Incident Review in partnership with the DHB Senior clinical and senior management staff". The recommendation in point (b) has been retained, as the DHB will be considering the recommendations in the Serious Incident Review and will report back to HDC on actions taken and any outstanding issues, and, where this relates to the pilot project, the DHB is to coordinate the response with the service.

153. I recommend that RN D undertake training on keeping clear and accurate patient records, in particular regarding risk assessment in mental health comprehensive assessments, and provide evidence of this to HDC within six months of him returning to practise as a registered nurse, if and when that occurs.

Follow-up actions

154. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN D's name.

155. A copy of this report will be sent to the Coroner.

156. I wrote to the Ministry of Health on 12 January 2022 (see Appendix D) to request an update on its guidance to providers that incorporates updated models of risk assessment, formulation, and safety planning, and that provides advice on replacing terms such as "low/medium/high risk" in order to reduce confusion, such as occurred in this case.

157. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Director of Mental Health and Addiction Services, the New Zealand Nurses Organisation, the Mental Health and Wellbeing Commission, and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from registered nurse Dr Anthony O'Brien:

"August 2019

Report prepared by Anthony O'Brien, RN, PhD, FANZCMHN

Preamble

I have been asked by the Commissioner to provide expert advice on case number C18HDC00971. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

I qualified as a registered male nurse in in 1977 and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow and board member of Te Ao Māramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and a Senior Lecturer in Mental Health Nursing with the University of Auckland. My current clinical role involves assessment and care of people in acute mental health crisis and liaison in relation to people with mental illness in the general hospital. My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. In the course of my career as a mental health nurse I have been closely involved with professional development issues, including development of the College of Mental Health Nurses *Standards of Practice*. I have previously acted as an external advisor to mental health services following critical incidents and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice on matters related to the care provided to [Mr A] by [the DHB] in … 2018. I do not have any personal or professional conflict of interest in this case.

Instructions from the Commissioner are:

Please review the enclosed documentation and advise whether you consider the care provided to [Mr A] by [the DHB] was reasonable in the circumstances, and why.

In particular I have been asked to address the following questions:

1. Did [the team] appropriately respond to [Ms B's] phone call of [Day 1]?
2. Did [the team] adequately assess [Mr A] on [Day 2]? In particular please comment on whether:

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a) [The team's] 'low risk finding' following meeting was appropriate, including whether all relevant information was considered to make this assessment;

b) The decision to not admit [Mr A] as an inpatient following his assessment was appropriate;

c) Suicide Prevention Guidelines were appropriately followed;

3. Was [Mr A's] care appropriately escalated in a timely manner and in accordance with relevant policies?
4. Are there any concerns regarding the coordination of [Mr A's] care between [the team] and the pilot project
5. Any other matters in this case that you consider warrant comment.

In relation to the above issues I have been asked to advise on:

a) What the standard of care/accepted practice is;

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

c) How the care provided would be viewed by your peers

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

I have had the following documents available to me for the purpose of writing this report:

1. Letters of complaint from [Mr A's mother] dated [2018] and [Mr A's father], dated [2018].
2. Family's comments on the Reportable Event Investigation Report.
3. [The DHB's] response to the Commissioner dated [2018] (and appendices).
4. Reportable Event Investigation Report dated [2018] (with embedded documents).
5. Clinical records from [the DHB].
6. [The DHB's] triage, assessment and risk policies.
7. Covering letter from [Law Firm 1] dated [2019] with individual responses from [RN F], [RN G] and [RN D], and from [Ms E].
8. DHB questionnaires completed based on interviews with [RN F] ([2018]), [RN G] ([2018]) and [RN D] ([2018]).
9. Minutes of a meeting held by [the DHB] Mental Health and Addictions service, [two months prior to these events].
10. [DHB] admission criteria and admission checklist for [the] (acute inpatient unit).
11. [DHB] Triage Guidelines.

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12. Generic questionnaire completed with [RN G] dated 22 May 2015 (but would have been 2018 or 2019).
13. Letter from [the Public Service Association] to [the] CEO, [the DHB], [2018].
14. Draft of report to CE, [the DHB], [2018] (Author: …).
15. Responses from [RN F] to complaints to HDC.
16. Interview transcript, Serious incident, [2018], interview with [RN F].
17. Letter from [the DHB] to [RN F]
18. Response from [Ms E] to complaints to HDC.
19. Further response from [the DHB] to HDC, dated [2019].
20. Further email from [Law Firm 1] to [the DHB] [2019] including a new [DHB] policy document (… for [the pilot project], [2019]).

Context

I feel I should make a comment on the context for the opinions provided in this report. The letter from [the CEO] on [date] states that [the DHB's] complaint investigator did not have an opportunity to interview staff named in the complaint due to them being on extended leave and receiving medical treatment. There are, however, statements from staff made via their legal representative [in] 2019 (and the generic questionnaires noted above). There are a number of documents, including statements from the four named staff, that show considerable conflict within [the DHB] before and following the adverse event. There are some serious allegations made about some staff, and some serious criticisms of [the DHB's] management process. The events that are subject to this investigation took place at a time of major changes in the configuration and delivery of mental health services at [the DHB]. The changes, and the impact of change, are outlined in [the external report] to the [CEO of the DHB].

Outline of events

[Mr A's] whānau had become concerned about [Mr A's] mental health in 2016 following a trip [overseas], with increasing concern in 2017 while [Mr A] was living away from his whānau studying in [the city]. [Mr A's flatmate] had contacted his mother [Ms B] expressing concern at [Mr A's] increasing isolation, difficulties with communication and other uncharacteristic behaviours. In 2017 [Ms B] sought help and information from various sources about how to get help for [Mr A]. When [Mr A] returned home over the [holiday] period whānau noticed significant changes in his behaviour, including [Mr A's] marked paranoia at a family dinner, at which [Mr A] had shown a fixed glazed look and asked people 'why are you looking at me?'.

On [Day 1] [RN F] took a phone call from [Mr A's] whānau expressing concerns for [Mr A's] mental health. [RN F] provided advice about how the whānau could access mental health care for [Mr A]. The phone call lasted 45 minutes. [RN F] made written notes of this phone call. On [Day 2] [RN F] passed on information about the phone call to [RN D] who held the crisis phone that day. [RN D] took a phone call about [Mr A] from [Mr C]

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during which he spoke to several whānau members. [RN D] arranged for the whānau to attend a face to face meeting at 2pm at the acute inpatient unit, the inpatient mental health unit at [the DHB]. Present at the assessment were [Mr A], his mother [Ms B], his father [Mr C], and with [DHB] team staff [RN G], [RN D] (duly authorised office under the Mental Health Act) and cultural worker [Ms E]. [RN D] led the assessment. The assessment took two hours and is recorded in two documents, the standard [DHB] Comprehensive Assessment form completed by [RN D], and a cultural assessment form completed by [Ms E]. The outcome of the assessment was that [Mr A] was assessed as low risk with a clinical impression of depression. He was given education about sleep, nutrition and exercise and encouraged to phone [the team] should his situation deteriorate. A decision was made for urgent referral to another [DHB] service, [the pilot project]. The date of referral is not shown in records made at the time, but the letter from [Law Firm 1] [in] 2019 states that the referral was passed to [the pilot project] at 9am the following day, [Day 3]. [Pilot project] staff arranged a wānanga (meeting) for [Mr A] and his whānau for [Day 6]. Clinical notes record a phone call from [the pilot project] to [Mr A's] whānau on [Day 4] (no answer) and a phone call from [Ms B] to [the pilot project] the same day, confirming the time and place of the wānanga (10am at [a relative's] place). [Mr A] did not attend the wānanga. His [relative] told [pilot project] staff that [Mr A] believed the wānanga was to be held at [the pilot project] premises. [Mr A's relative] informed [pilot project] staff that [Mr A] had made plans to return to [the city] on [Day 9]. Phone and text messages on [Day 6] were unsuccessful in communicating with [Mr A]. [Mr A] left for [the city] on [Day 9]. He took his own life in [the city] on [Day 11], nine days after his first and only contact with mental health services.

The following section of this report responds to the Commissioner's questions.

1. Did [the team] appropriately respond to [Ms B's] phone call of [Day 1]?

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

Responses to phone calls should be polite and supportive, and should focus on clarifying the reason for the call, what the clinical issues are, what actions if any are to be taken by the clinical service, and whether further contact with the service is required. Risk issues should also be clarified. An accurate record of phone calls should be maintained.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

There is limited information available about [Ms B's] call. The call is recorded in a series of brief handwritten notes. There is fairly minimal information recorded given that the phone call lasted 45 minutes. Some of these notes are not completely legible, however I feel I have been able to glean most of the pertinent content. On the basis of the handwritten notes I am unable to comment on the manner in which this phone call was conducted. I note that [Ms B] is very critical of [RN F's] telephone manner, and of some questions that were asked. One issue raised by [Ms B] was [RN F's] suggestion that if [Mr A] were involved with Police this would enable him to get help quicker. There is

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reference to [Mr A's] involvement with Police in the notes, and this is an appropriate area to explore in a phone call as it may reflect safety concerns. The note records that on an earlier occasion Police had been called in response to [Mr A's] 'threatening behaviour towards parents'. It would not be appropriate, as [Ms B's] complaint seems to suggest, that Police involvement should be sought specifically for the purposes of leveraging access to mental health care. However I cannot see evidence in the written note that [RN F] did suggest that the family should seek Police involvement for this reason. [Ms B's] complaint also mentions that the possibility of a 5 day admission to hospital was discussed. This seems to suggest admission under the Mental Health Act which is for a maximum of 5 days in the first instance. However there is also the possibility of voluntary admission to hospital, so I would expect that possibility to be canvassed in a phone call. It is not possible from the recorded notes to comment on whether [RN F's] statements about admission were about voluntary or involuntary admission, or both.

It is my view that during the phone call from [Ms B] pertinent information was collected about [Ms B's] concerns for [Mr A's] mental state. The phone call led to an appointment for assessment the next day and so [Ms B's] concerns appear to have been adequately addressed. However the written record is very brief, making it difficult to fully answer the question about the standard of care provided. It is my opinion that a more extensive note should have been made, especially as the phone call resulted in a decision that [Mr A] or his family could call back to request further support. It would be good practice to open a case for [Mr A] and enter the information from the phone call in the formal clinical records, rather than maintain only a very brief handwritten note.

As noted above I am not able to comment on [RN F's] telephone manner based on the information available to me.

In relation to recording of information from the telephone call I believe this is a mild departure from expected standards.

c) How the care provided would be viewed by your peers

I believe my peers would regard this as a mild departure from expected standards.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

I recommend that a more formal system of recording the content of telephone conversations be initiated, especially for calls that involve triage of urgency and which result in appointments for face to face assessment. These calls should be treated as 'clinical contacts' with the appropriate level of emphasis on assessment and documentation. I note that [the DHB] have since developed a template for initial telephone interviews (Matataki process). However this template is not adequate for crisis calls such as that made by [Ms B]. It is also not clear that the template is intended to apply to calls made to [the team]. While the template addresses some of the issues

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about record keeping, it remains incumbent on clinicians to record an adequate amount of information on the form.

2. Did [the team] adequately assess [Mr A] on [Day 2]?

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

Consumers should receive a timely comprehensive assessment using a recognised model, and with a clear and complete record of the presenting issues, clinical and social history, cultural issues, current mental state, risk formulation, clinical impression and a plan of intervention. Corroborative information from family and other sources should be considered where it is available.

Assessment provided

It is my impression that [Mr A] was provided with a reasonable assessment in some respects, although there are some aspects in which the assessment was not at the expected standard. [Mr A] was seen by three clinicians including a cultural worker and his family, at their request, were included in the assessment. This is good clinical practice, especially for initial assessments, as it enables clinicians to draw on more than one perspective. In the case in question the assessment included cultural assessment, which is also good clinical practice. The assessment seems to have taken an appropriate amount of time, and the clinicians seem to have gained some understanding of the concerns that led [Mr A] and his parents to seek help.

However there were several aspects of the assessment that were not adequate, judging from the written record and from [RN D's] letter of [2019]. The history of presenting illness does not describe the development of symptoms over time, for example since [Mr A's] return home. There is no substantial review of depressive symptoms such as sleep, appetite, weight, concentration, energy and depressive thoughts. The assessment of substance use is very limited and does not quantify use of substances, or record use of substances in response to changes in mood or thinking. In particular there is no specific inquiry about cannabis use, including whether [Mr A] used natural or synthetic substances. There is no comment on [Mr A's] thought content other than to say there were no delusions or grandiose ideas. This section of the mental state assessment should also record the themes of thought, and the main ideas the consumer is concerned with. There needed to be more exploration of [Mr A's] suicidal thoughts, for example when these thoughts occurred, how specific were they, did they include thoughts of means of suicide, what stopped [Mr A] from acting on these thoughts. The risk assessment is also very limited, with no exploration of how [Mr A] managed his thoughts of self-harm, or how those thoughts were related to substance use. There is no record of what protective factors were operating, and there is no exploration (beyond a brief not in the history of presenting illness) of [Mr A's] parents' concerns, which were the reasons for the initial phone contact with [the team] on [Day 1] (and expressed at the assessment interview). Risk assessment should also comment on long term and short term risk and that distinction is not noted in this case. On the important issue of [Mr A's] intention to return to [the city] to study there is nothing documented

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in the assessment, apart from [Mr A's] intention to return to [the city]. The social history records little new information apart from information already recorded in the history of presenting illness. There is nothing about [Mr A's] siblings, social life in [the city], current friendships or early development.

[Mr A] was seen with his whānau, which is consistent with the accepted standard of involving family in care. There was also a cultural worker present at the assessment which is consistent with the requirement to consider cultural issues in an assessment. However [Mr A] was not seen alone, and there is no indication in the assessment notes that he was offered time alone with [the team], or one of its members. Not seeing [Mr A] alone could have inhibited him from expressing concerns or communicating openly, for example about substance use and suicidal thoughts. There is a balance to be struck between involving family and giving consumers the opportunity to speak without being constrained by the presence of family members.

Finally, an area of assessment that was not at the expected standard is documentation. Although the assessment is documented on the appropriate [DHB] form, the content is not adequate for an initial assessment of someone in crisis. This applies to most areas of the assessment. In particular, there is nothing recorded in the field for psychiatric history, the history of substance use does not mention use of cannabis or any changes in substance use related to [Mr A's] recent mental health problems, the clinical impression is a single word 'depression', and the risk assessment consists of two ticks with no narrative statement of risk factors. The management plan documents the urgent referral to [the pilot project], and encouragement to phone [the team] if needed. Given the information about what was covered in the assessment (in the letters from [Law Firm 1]) there was room for a much more comprehensive documentation of the assessment that took place.

The plan to refer to [the pilot project] was appropriate given the expectation that [the pilot project] would be providing further care and treatment, [Mr A] had whānau support in the interim, and there was a plan for [Mr A] or the whānau to contact [the team] if there was a deterioration in [Mr A's] mental state. However there was a gap in the system at this stage, and it is unclear who was holding clinical responsibility for [Mr A] from [Day 3]. This is further discussed in the section on service coordination below.

I am not able to comment on the manner in which the assessment was conducted, except to say that [Ms B's] and [RN D's] statements about this are at variance.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

I believe the departures from the expected standard of care noted above are a moderate to severe departure from the expected standards. This is discussed in the section above (assessment provided). However there are also [the DHB's] statement of assessment and risk assessment policy and it is my opinion that the assessment provided, including the risk assessment, are not fully compliant with [the DHB's] policies. The whānau were involved and there was a cultural assessment provided

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(which are part of [the DHB's] policies). But the assessment was not sufficiently detailed and did not adequately describe the risk issues.

c) How the care provided would be viewed by your peers

I believe the care provided would be viewed by my peers as a moderate to severe departure from the expected standards.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

I note that [the DHB's] Reportable Event Investigation recommended training for all frontline staff in suicide risk assessment and management. While that is commendable, I think the focus needs to be on comprehensive mental health assessment, of which suicide risk assessment is part. Good risk assessment requires good clinical assessment. My recommendation is that the focus on suicide risk assessment is broadened to comprehensive clinical assessment, and that clinicians are involved in developing a supportive model for any training.

In particular please comment on whether:

a) [The team's] 'low risk finding' following meeting was appropriate, including whether all relevant information was considered to make this assessment;

As will be seen from the comments above I think there were some aspects of the assessment which were not at the expected standard. Without a comprehensive assessment it is not possible to make a sound assessment of risk, which involves weighing up static factors (such as gender, age etc, family history etc, which do not change) and dynamic (or modifiable) factors (e.g. mental state, substance use, engagement with treatment and support, which do change). Because of inadequacies in the assessment it is not possible to have confidence in the finding of low risk. [Mr A] rated his mood as 0/10 on a mood scale where 0=as low as possible. This is an extreme rating and is hard to reconcile with an overall finding of low risk. While the rating of 0 does not in itself determine risk, together with [Mr A's] history of suicidal thoughts and his parents' obvious concern, a rating of 'low', in the absence of further qualification, seems to be at odds with his clinical picture at the time of his assessment. In particular the lack of a narrative formulation of risk supports [Ms B's] complaint that some factors reported to the assessing clinicians were not adequately considered. A single tick in a box is not an adequate risk assessment unless it is supported by a narrative formulation that outlines factors likely to increase risk in the near future, and protective factors. [Mr A] presented with several modifiable risk factors (in addition to static factors) had strong protective factors (a supportive whānau). He had not harmed himself and expressed no intent to harm himself at the time of the assessment. He did, however, report suicidal thoughts when he was alone. The nature and intensity of these thoughts is not recorded in the assessment. It needs to be noted that the protective factor whānau support only applied if [Mr A] stayed with his whānau. That protective factor became much less prominent if [Mr A] were to move away from home.

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The [DHB's] Triage Guidelines document describes an 'urgent' case as needing assessment within 2–3 hours, although this was not [the team's] expectation of [the pilot project]. The term 'lower risk' is used for Triage Code 4, which is considered non-urgent, and needing assessment within 1–7 days. There is a real mismatch between the statement of 'urgent' and 'low risk'.

b) The decision to not admit [Mr A] as an inpatient following his assessment was appropriate;

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

Decisions to admit to inpatient care are made on the basis of clinical acuity and risk, both of which are influenced by available supports. Community care is the preferred option if that can be done safely. The accepted standard of care is that voluntary admission is sought if there is no viable community based option for the consumer. If there is no viable community option and the consumer does not agree to voluntary admission, inpatient admission can be provided according to criteria set out in the Mental Health (Compulsory Assessment and Treatment) Act. Services are expected to work to the least restrictive standard, and to avoid inpatient admission, especially compulsory admission, if a less restrictive community alternative can be negotiated. Admission decisions should also consider family perspectives, although these are only one factor in the decision making process.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

I do not believe there has been a departure from the expected standard of care in relation to the decision not to admit [Mr A] to the inpatient unit. It is not clear to me that [Mr A] met the criteria for compulsory admission. It is also apparent that there was a viable option for community care for [Mr A], there was a plan for further care from [the pilot project], and an option provided for further phone contact with [the team]. However that opinion must be qualified in light of my opinion given above that the assessment was not at the expected standard. A more comprehensive and complete assessment may have revealed factors that would support admission to hospital, either voluntarily or under the Mental Health Act.

c) How the care provided would be viewed by your peers

I believe that my peers would regard the care provided, in respect of the decision not to admit, as acceptable in the circumstances of whānau support being available and of there being a referral for further care.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

Clinical assessments should include clinicians' reasoning about admission decisions and use of the Mental Health Act, with reference to whānau views on this.

Suicide Prevention Guidelines and other policies were appropriately followed.

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The 2016 Ministry of Health document *Preventing suicide: Guidance for emergency departments* is not fully applicable to mental health service responses to people with suicidal thoughts in community settings. In particular, the Australian Mental Health Triage Scale is designed for emergency department settings, where the least urgent level (level 5) requires a response within 2 hours. Nevertheless, the document does contain some general principles that can be applied in any setting. I note [the DHB] report makes reference to the Ministry's guideline. The Guidelines were followed in involving whānau and responding to [Mr A's] cultural needs through the involvement of a cultural support worker. Other aspects of the Ministry's guideline, which can be applied to this case, were not followed. These are: assessment, documentation and arranging follow up. In my opinion the assessment showed significant gaps as noted above, documentation was inadequate (also noted above) and arranging follow up (also noted above). In relation to arranging follow up, it is apparent that [the DHB's] processes of handover and follow up were not adequate. The Short Term Action Plan outlined in the Ministry guideline has much to commend it as a guide to actions following assessment. The Ministry's guideline notes that if a person who is suicidal does not receive follow up care following assessment that is likely to increase risk by making the person feel unsafe. After his assessment by [the team] on [Day 2] [Mr A] had no contact with mental health services. There was a 6 day period in which [the DHB] made no direct contact with [Mr A]. Responsibility for this gap is shared between [the team] and [the pilot project], and the inadequate protocols in place at [the DHB] which allowed this gap to occur.

e) Was [Mr A's] care appropriately escalated in a timely manner and in accordance with relevant policies?

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

The expected standard of care is that in the event of a significant change in a consumer's presentation steps are taken to escalate care, such as review of the case, consultation with colleagues, or referral to a senior clinician.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

In this case there was no change in [Mr A's] presentation throughout the assessment and so no question of escalating the level of care. Assessment by a psychiatrist, especially in relation to whether [Mr A's] depression should be treated with medication, could still have been arranged by [the pilot project].

c) How the care provided would be viewed by your peers

I believe my peers would not expect to see an escalation of care in this case.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations.

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e) Are there any concerns regarding the coordination of [Mr A's] care between [the team] and [the pilot project].

There is a tension between an 'urgent' referral and [the team's] assessment of [Mr A] as low risk. It is not entirely clear what response is expected from [the pilot project], and whether 'urgent' referral requires a faster response than a standard referral. It is also not clear that making the referral 'urgent' meant that [the team] should remain responsible for [Mr A] until they knew [the pilot project] had taken over care. There appears to have been, at the time of this event, a significant gap in guidance for both [the team] and [the pilot project] about responsibility for consumers in transition from one service to the other.

It is not clear exactly when [the pilot project] assume[s] clinical responsibility for newly referred consumers, whether it is at the time the referral is made, when the referral is entered into [the pilot project's] clinical records, or when [the pilot project] makes contact with the consumer. There appears to have been no category of 'urgent' that would trigger a more assertive response. A concerning aspect of this case is that after [Day 2] there was no further direct contact with [Mr A]. At some point this became the responsibility of [the pilot project] but it is not clear exactly where that point is. The [pilot project's] systems for response to referrals do not appear to be have been adequate at this time.

f) Any other matters in this case that you consider warrant comment.

[Mr A] presented to [DHB] mental health services on [Day 2], the day after a phone call from his mother [Ms B]. [Mr A] died by suicide in [the city] nine days later, without any further contact with mental health services. There is clearly a significant gap in [Mr A's] care. In my opinion there were gaps in [Mr A's] assessment on [Day 2] which may have adversely impacted on decision making. In particular there is conflict between the assessment of 'low risk' and the classification of [Mr A's] referral as 'urgent'. Following the assessment, the process of handover to [the pilot project] was unclear. There was no communication about who would hold clinical responsibility for [Mr A's] care until his referral was actioned by [the pilot project]. There was a significant delay of three days in processing the referral and in setting up a wānanga for [Mr A]. During that time no-one from [the DHB] was directly in touch with [Mr A]. This is a long gap for someone in crisis. The planned wānanga with [Mr A] on [Day 6] did not occur, and there was no subsequent contact with [Mr A] before he left for [the city]. There was no contact with [city] mental health services to attempt to arrange an assessment for [Mr A] in [the city] and this is a significant omission.

Summary

[The DHB's] response to [Mr A] and his whānau was inadequate in multiple respects. Beginning with the initial phone call on [Day 1] the documentation was minimal. There was a timely response to the whānau when [Mr A] made contact again on [Day 2], with an assessment arranged for that day. Two clinicians and a cultural support worker (Kai Awhina) attended the assessment. [Mr A's] whānau were involved, but [Mr A] was not seen alone. The assessment on [Day 2] was inadequate with many sections of the

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assessment document poorly completed. There is a mismatch between the terms 'urgent' and 'low risk'. I think the decision for [Mr A] to return to stay with his family was reasonable; it is not clear that compulsory admission was indicated and it appears [Mr A] did not consent to a voluntary admission. The transition to [the pilot project] was inadequate and unsafe and led to no follow up being provided for four days. Finally, when [Mr A] returned to [the city] on [Day 9] there was no attempt to arrange follow up care in [the city].

In my opinion there was a significant service failure on the part of [the DHB] to engage [Mr A] in care, and to ensure that he received appropriate referral when he moved out of the area.

Documents consulted

Ministry of Health (2016). *Preventing suicide. Guidance for emergency departments*. Wellington: Ministry of Health.

Te Ao Māramatanga *Standards of practice for mental health nursing in Aotearoa New Zealand* (3rd Edition) Auckland, Te Ao Māramatanga."

Further advice

"14 February 2021

Report prepared by Anthony O'Brien, RN, PhD, FANZCMHN

Preamble

I have been asked by the Commissioner to provide further advice on case number C18HDC00971. This follows my initial advice provided in August 2019. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications

My qualifications are outlined in my previous report.

The purpose of this report is to provide further advice on matters related to the care provided to [Mr A] by [the DHB] in … 2018. This follows receipt by the Commissioner of responses to my initial advice. I do not have any personal or professional conflict of interest in this case.

Instructions from the Commissioner are:

Please review the enclosed documentation and advise on the following matters. Where there is an overlap with providers, such as the transition to [the pilot project], it would be helpful if you could identify where the responsibility lay for any departures from accepted practice.

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[The DHB]

1. Whether the further advice and information provided by [the DHB] changes your previous advice and if so, why. In particular, please consider:

a) The adequacy of the assessment on [Day 2].

b) The adequacy of the transition to [the pilot project] and the system for response to referrals.

c) The adequacy of guidance about responsibility for consumers in transition from one service to another.

d) That there was no direct contact with [Mr A].

e) That there was no contact with [city] mental health services.

2. Any other matters in this case that you consider warrant comment.

[The service]

1. Whether the further advice and information provided by [the service] changes your previous advice and if so, why. In particular, please consider:

a) The adequacy of the assessment on [Day 2].

b) The adequacy of the transition to [the pilot project] and the system for response to referrals.

c) The adequacy of guidance about responsibility for consumers in transition from one service to another.

d) That there was no direct contact with [Mr A].

e) That there was no contact with [city] mental health services.

2. Any other matters in this case that you consider warrant comment.

[RN D]

1. Whether the further response and information provided by [RN D] changes your previous advice and if so, why. In particular, please consider:

a) The adequacy of the assessment by [RN D] on [Day 2].

2. Any other matters in this case that you consider warrant comment.

I have had the following documents available to me for the purpose of writing this report:

1. [The DHB's] response dated 27 October 2020.

2. Position descriptions for:
    a. Casual Kai Awhina (relevant to [Ms E's] role).

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b. Registered Mental Health Professional, Psychiatric Assessment Team 2015 (relevant to [RN F's] role).

c. Registered Mental Health Professional, Psychiatric Assessment Team 2016 (Relevant to [RN G's] role)

d. Registered Mental Health Professional, Psychiatric Assessment Team 2017 (relevant to [RN D's] role).

3. The following sections of the Contact between [the DHB] and [the service] for '… [the pilot project]').

a. Section F service specification.

b. Appendix 1. [Pilot project] whānau pathway.

c. Mental Health and Addiction Services Tier Level One service specification.

d. Mental Health and Addiction Services Kaupapa Māori Mental Health and Addiction Services Specification Tier level two.

e. Kaupapa Māori Mental Health Services Kaupapa Māori Community Based Clinical and Support Service, tier level 3.

4. [The lawyer's] response on behalf of [RN D] dated June 10th 2020.

5. [RN D's] letter dated 10th June 2020.

6. Documents provided by [Law Firm 1] on behalf of [RN D]:

   a. [Ms H's] letter date 7 June 2020.
   b. Emails from Dr … dated 10 July 2017 and 13 July 2020.
   c. Email from … 28 August 2017.
   d. Invite to [the pilot project] launch.

7. [Law Firm 2] response on behalf of [the service] dated 26 May 2020.

8. Documents provided by [the service] including client case notes and Maruaaitu (incident) reporting form.

9. Letter from [the tertiary institute] dated 18 May 2020, with correspondence relating to [Mr A].

I have read the above documents and my own initial report. I have also read relevant documents provided for my initial report, including records of [Mr A's] assessment and referral to [the pilot project], [the pilot project's] response and other documents.

The following section of this report responds to the Commissioner's questions.

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[DHB]

Whether the further advice and information provided by [the DHB] changes your previous advice and if so, why. In particular, please consider:

a. The adequacy of the assessment on [Day 2].

The assessment was conducted by [RN D] with support from [RN G] and Kai Awhina [Ms E]. I have discussed this in my comments on [RN D's] assessment below.

b. The adequacy of the transition to [the pilot project] and the system for response to referrals.

The transition to [the pilot project] and their subsequent response are not the same issue, so I have commented on each separately.

Transition to [the pilot project]. As far as I can tell the transfer to [the pilot project] followed an established process for handovers from one service to another. None of the documentation has stated that the referral should not have been made. I have not seen a written document that fully describes this process. The written referral was physically handed over at a face to face meeting of [the team] and [pilot project] staff at around 9am on [Day 3]. That is the time given in [the DHB's] Reportable Investigation Report of [2018]. I note that in their response on behalf of [the service] [Law Firm 2] (page 3) describe the referral as delayed by [the DHB]. However I can see no evidence that the referral was delayed. From that point (9am on [Day 3]) further care for [Mr A] was clearly the responsibility of [the pilot project].

System of response to referrals. This refers to what processes [the pilot project] subsequently follow in response to referrals once they are received. I have not seen a document that clearly sets out what the process of response is. In the case of [Mr A] the response does not seem to me to have been adequate. I accept the point made by [Law Firm 2] that [the pilot project] initiated a response on [Day 4], and that [the pilot project], despite making efforts to contact [Mr A] and his whānau were not always able to do that.

c. The adequacy of guidance about responsibility for consumers in transition from one service to another.

In my initial report I commented that it was not clear who held clinical responsibility for [Mr A] following his assessment on [Day 2]. Having read the various responses to my initial report, and having re-read the original documents it seems clear that this responsibility was held by [the pilot project]. I note that there is provision for [the team] to provide further support to consumers referred to [the pilot project] following referral, although in this case there seems to have been no understanding that [the team] would continue to be involved. [RN G's] letter states that [the pilot project] could have asked [the team] to help in establishing contact with [Mr A], but no such request was made. I have made a further comment about referrals from [the team] to [the pilot project] below.

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d. That there was no direct contact with [Mr A].

There should have been some direct contact with [Mr A]. I have discussed this in the section of this report that relates to [the service].

e. That there was no contact with [city] mental health services.

It was known that [Mr A] had previously sought help from mental health services in [the city]. This is documented in [RN D's] assessment. There was, therefore, reason to communicate with [city] services (DHB mental health services or [the tertiary institute's] student health services) and ask them to follow up with [Mr A]. This is another responsibility that falls to [the service] and is devolved to [the pilot project].

Standard of care

In regard to the transition to [the pilot project] (including the response to the referral) there was a moderate departure from the accepted standard of practice. From the point of referral there should be a prompt and effective response to the client, including the whānau. In regard to lack of direct contact with [Mr A] and lack of contact with [the city] mental health services there has been a mild departure from the accepted standard of practice. Although [Mr A] was described in the referral as 'low risk' part of his reason for presenting was suicidal thoughts, and this requires face to face contact for further assessment and to engage support services. Similarly, after having had no direct contact with [Mr A] there was an onus on [the pilot project] to ensure that gap was closed by advising [the city] mental health services.

2. Any other matters in this case that you consider warrant comment.

Referrals between services can be problematic. Established practice in [the DHB] has been that once the referral is made [the team] receiving the referral assumes clinical responsibility for further care. Consideration could be given to reviewing this practice to have the referring team continue to hold responsibility until the referral is accepted. This would allow for any questions about the initial assessment to be addressed.

[The service]

1. Whether the further advice and information provided by [the service] changes your previous advice and if so, why. In particular, please consider:

a. The adequacy of the assessment on [Day 2].

The assessment on [Day 2] was provided by [RN D] from [the DHB's] [team] service and I have commented on that below. At the assessment stage responsibility for the assessment falls to [the DHB]. [Law Firm 2] have commented on the adequacy of the risk assessment and on the comment in my initial report on what I saw as a tension between the assessment of 'low risk' and the classification of the referral as 'urgent'. I have made additional comment on this issue in my further advice on [RN D's] assessment (below).

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b. The adequacy of the transition to [the pilot project] and the system for response to referrals.

This comment needs to be read in conjunction with the comment above in response to the same question in relation to [the DHB]. There are clearly two parties to a transition in care. As I noted above, once the referral was physically handed over to [the pilot project] at 9am on the morning of [Day 3], the responsibility for follow up care fell to that service. This was early on the first business day following [Mr A's] assessment on [Day 2], so I cannot agree with the statement by [Law Firm 2] that the referral was made one full day following the assessment. Considering the assessment took place on the afternoon of a [day] (outside [the pilot project's] hours of service) and the referral was made the following morning, the referral seems to me to have been made at the earliest opportunity. I do accept [Law Firm 2's] statement that my comment that there was a three-day delay in setting up a wānanga for [Mr A] was incorrect. In fact the attempt to set up the wānanga began on [Day 4], the day after the referral was received. If, as suggested by [Law Firm 2], there was any confusion about the level of risk or the urgency of response sought by [the team], [the pilot project] needed to seek clarification of that from [the team]. [Law Firm 2] state that it was unclear in [Ms E's] cultural assessment whether [Mr A] was in agreement with being referred to [the pilot project], but this is clear in [Ms E's] assessment which states: 'Willing as well as mum and dad to refer to [the pilot project] to have further help …'. In any case [the pilot project] did act on the referral. I accept the arguments made by [Law Firm 2] that [Mr A] did not respond to the attempts by [the pilot project] to contact him, and this was a factor in his not being seen by their service. I agree that this was not a case that warranted compulsory intervention. Voluntary engagement was appropriate in this case and I note that communication with [Mr A's] family left it open for [Mr A] to engage. Overall it remains my opinion that the system of response to [Mr A] was not adequate in this case.

c. The adequacy of guidance about responsibility for consumers in transition from one service to another.

My comments above in relation to [the DHB] also apply here.

d. That there was no direct contact with [Mr A].

This is clearly an area of deficit in this case. In my opinion responsibility for any direct contact with [Mr A] falls to [the pilot project]. [The pilot project] did contact members of [Mr A's] whānau who initiated the assessment on [Day 2]. I am mindful that [the pilot project] is a service that was endeavouring to implement a Kaupapa Māori service model, in particular the statement that 'Whānau is the smallest unit' [of engagement]. When contacted, whānau members did appear to want to engage with [the pilot project], and [Mr A] had obviously accepted a whānau-focussed model of care, as exemplified by his consent to have whānau present at his assessment. For those reasons [the pilot project] should not be criticised for working through the whānau. I note that in addition to working through the whānau, staff of [the pilot project] did attempt to contact [Mr A] individually. [Mr A] did not respond to these attempts. There seems to have been no other plan to contact [Mr A] individually, for example by asking for

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involvement from [the team]. Direct contact with [Mr A] would have been helpful as part of [the pilot project's] response, however I think it is important to recognise that [the pilot project] did make attempts to contact [Mr A] directly.

d) That there was no contact with [city] mental health services.

I have commented on this issue above, and that comment also applies to [the service]. In my opinion there should have been an attempt to contact mental health services in [the city]. Responsibility for that contact fell to [the pilot project] and is the more important as [Mr A] had not been seen since his initial assessment. I note [Law Firm 2's] comment that [the pilot project] would attempt to help [Mr A] access support in [the city] once he has settled there. [Law Firm 2] further note that if [Mr A] had been deemed to be at medium or high risk this plan (accessing mental health care in [the city]) would not have 'been the landing point for further follow up'. I assume [Law Firm 2] mean that a more assertive approach would have been followed if [RN D's] assessment had indicated a higher level of risk. However there is no reason to think that [RN D's] assessment of 'low risk' means that there should be no communication with [city] services. [Mr A] was due to leave for [the city] on [Day 6], and would have had only one full business day in [the city] prior to the weekend. While there might be some merit in giving [Mr A] time to settle in to [the city] he would then be at least a week on from his initial assessment on [Day 2] with no further direct contact. It would have at least been helpful to have sent information to [city] mental health services as soon as it was known [Mr A] intended to travel there.

Standard of care

In regard to the transition to [the pilot project] (including the response to the referral) there was a moderate departure from the accepted standard of practice. From the point of referral there should be a prompt and effective response to the client, including the whānau. In regard to lack of direct contact with [Mr A] and lack of contact with [city] mental health services there has been a mild departure from the accepted standard of practice. Although [Mr A] was described in the referral as 'low risk' part of his reason for presenting was suicidal thoughts, and this requires face to face contact for further assessment and to engage support services. Similarly, after having had no direct contact with [Mr A] there was an onus on [the pilot project] to ensure that gap was closed by advising [the city] mental health services.

d. Any other matters in this case that you consider warrant comment. No other matters to comment on.

[RN D]

1. Whether the further response and information provided by [RN D] changes your previous advice and if so, why. In particular, please consider:

a. The adequacy of the assessment by [RN D] on [Day 2].

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I have read over [RN D's] assessment several times. I have also read [RN D's] response to my initial report, the response from [Law Firm 1], and at [Law Firm 1's] suggestion the original letter from [RN G].

It remains my opinion, despite reading these documents, that [RN D's] assessment was not at the appropriate standard. In my opinion there is too little detail in many of the sections of the assessment. I do not agree with [Law Firm 1's] (or [RN D's]) suggestion that a crisis assessment is in some sense an abbreviated or limited assessment. This might apply in situations of extreme urgency, for example when immediate admission to hospital is necessary. In circumstances of extreme urgency it might not be possible to cover all the components of an assessment. This can be noted in the documentation. But this does not seem to have been the case with [Mr A]. The assessment lasted two hours ([RN G's] letter of [2019]) and [Mr A] seemed to have engaged in the assessment process, albeit he was not forthcoming on some issues. The [DHB] policy and assessment form clearly indicate that the assessment should be 'comprehensive' which means covering all the relevant areas (set out in the form) in sufficient depth. When a consumer is being seen for the first time with whānau concerns for safety, and under urgency (i.e. at the weekend rather than by routine referral) it is important the assessment is not abridged or abbreviated as [Law Firm 1] seem to suggest.

I note that [RN D's] colleague [RN G] felt that [RN D's] assessment was adequate, and I accept her opinion, assuming she is not referring to the documentation. I also accept [RN D's] statement that his documented assessment did not capture all the information from [Mr A] and his whānau and perhaps did not reflect his full understanding of [Mr A's] presentation. However it must be remembered that [RN D's] assessment is all subsequent clinicians and services have to inform their response, especially following referral to another service. From their perspective the documented assessment is the assessment. They do not have access to any other information. This comment also responds to the statement from [Law Firm 1] that the brevity of records is not indicative of the quality of assessment. I do not accept that statement. I also do not accept [Law Firm 1's] statement that 'assessment and documentation are two distinct elements of care that should be considered separately.' That is simply wrong. Documentation (of an assessment) involves interpreting and describing a consumer's clinical presentation and is part of the assessment process, not something separate. I accept that [Mr A] was offered an opportunity to be seen alone, but declined that opportunity. I also accept that [RN D's] assessment of risk can only be seen in the context of the risk factors known on [Day 2], not those that came into play later. My opinion about [RN D's] assessment is based solely on the assessment on [Day 2], not on subsequent events. In my opinion the outcome of the assessment (discharge home with whānau, referral to [the pilot project], and advice to contact [the team] again if the situation deteriorated) was an appropriate and safe plan.

Having read comments by [RN D], [Law Firm 1] and [Law Firm 2] on the issue of an 'urgent' referral with an assessment of 'low risk' it remains my opinion that there is a tension, even a contradiction in this language. To an outsider these terms seem to imply

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different meanings. The documents available also show that there is no consensus across services as to what these terms mean in [Mr A's] case.

[The lawyer] ha[s] urged that any departure from the accepted standard of practice should be regarded as 'mild' rather than 'moderate to severe'. After reviewing all the relevant documents I would rate the departure from the accepted standard as moderate rather than moderate to severe. This takes into account [RN G's] opinion of the assessment and [RN D's] explanation that the documentation did not fully capture the quality of the assessment.

[The lawyer] asked what standard I referred to in my initial opinion. The relevant standard is the Te Ao Māramatanga (New Zealand College of Mental Health Nurses) *Standards of Practice for Mental Health Nursing in Aotearoa New Zealand* (2012), referred at the end of my initial opinion. [The lawyer] also ask[s] what is meant by an accepted model of comprehensive assessment. The [DHB] template provides an accepted model. The [DHB] policy on assessment makes it clear that a *detailed* assessment must be undertaken at first contact. The policy document sets out the components of assessment, including the required standard for risk assessments. In addition there is a separate risk assessment policy with a good level of detail of the standard required.

b. Any other matters in this case that you consider warrant comment. No other matters to comment on.

Overall, in relation to my original advice, my opinion remains that [Mr A's] initial assessment was not adequate although I have revised that opinion to say that the departure from the expected standard is moderate rather than moderate to severe. In every other respect my opinion about the standard of care provided is unchanged.

Please get in touch if there are any issues in this report that require further explanation."

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Appendix B: Relevant standards

1 Te Ao Māramatanga (New Zealand College of Mental Health Nurses) Standards of Practice for Mental Health Nursing in Aotearoa New Zealand (2012)

"Attributes

… (b) Skills

The Mental Health Nurse:

… 3 Makes appropriate clinical decisions based on comprehensive nursing assessments."

2 Preventing suicide: Guidance for emergency departments (2016)

"Step 7: Arrange follow-up
It is important that follow-up is arranged for the person who is discharged from the emergency department. Continuity of care is very important because discontinuities and gaps in care can significantly increase suicide risk and are known to make people experiencing mental distress feel unsafe.[1]"

3 The DHB's Assessments: Single Point of Entry Pathway policy

"…

POLICY STATEMENT
People and their family/whānau will be actively engaged and encouraged to participate fully as partners in their care. A person centred approach will be central to the model of care and the person and their family/whānau are seen by the Service as the experts in their care and supported as such with self determination and self management being key principles that guide engagement.

…

Assessment Standards
…

The assessment is comprehensive, appropriate for the purpose and is conducted using accepted evidence based and culturally safe methods and tools."

4 The DHB's Triage Guidelines Single Point of Entry Pathway (April 2015)

"…

This document provides guidance to clinicians, in relation to the process of triaging referrals received into the Service and determining an appropriate response.

[1] The Assessment and Management of Risk for Suicide Working Group. 2013. *Assessment and Management of Patients at Risk for Suicide (Full Version)*. VA/DOD. Arlington, VA.

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…

Decision Making

The triage decision making process is based around four key interrelated factors

- The level of risk to the person/or others.
- The person's need for specialist mental health/AOD services.
- The urgency of the response required from Mental Health or others.
- The cultural identity of the person (to be correctly assessed and noted)

The challenge for clinicians is in assessing and weighing up the factors to make a safe and appropriate decision.

The urgency of the response will be influenced by both the assessment of risk and through an evaluation of other contextual factors, and is focused more immediately on the short term risk:

- The nature and severity of risk.
- Whether the situation is stable or deteriorating.
- Will the opportunity to engage the person be lost if action is not taken quickly
- Are family or whānau members/supports able to manage the situation; if so how long can they manage this safely?
- Relevant information should be requested to be faxed or forwarded through to the Single Point of Entry Team.
- All referrers, service users, and whānau shall be informed of the outcome of the triage process and the next steps that will occur.

…

Mental Health Triage Tool

…

Triage code 2. Response needed: Urgent 2–3 hours

Assessment findings:

- Acute suicidal ideation or risk of harm to others with clear plan/means
- High risk behaviour associated with psychosis delirium disinhibitions
- Severe distress.
- MHA assessment requested by concerned others/police

Triage code 3. Response needed: Semi Urgent Face to Face within 3–24 hours

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Assessment findings:

- Highly distressed person, but in a safe place or with support overnight or this is able to be arranged.
- Rapidly increasing symptoms mood disorder/psychosis/anxiety
- Suicidal ideation without immediate intent
- Current service user at risk of relapse requiring semi urgent response.

Triage code 4. Response needed: Non Urgent Mental Health Face to Face within 1–7 days

Assessment findings:

- Requires specialist mental health assessment but is stable and low risk able to wait.
- Other service providers are able to manage the person until MHS appointment is arranged
- Existing service user of MHS needing nonurgent review, e.g. follow up new prescription"

5 The service's Matataki process (the triage assessment and documentation process for tono), July 2017

"RESPONSIBILITIES
[The service's] Board is responsible for developing, adopting and reviewing this policy.

[The service's] Chair is responsible for the implementation of this policy, and for advising on the need to review or revise this policy as and when the need arises.

PROCESSES
Matataki is the triage assessment and documentation process for tono. It is both the role and the task.

All BPAC will [be] assessed by team leader to assess for urgency risk prior to commencement of Matataki process as per Kaituhi process.

The Matataki list of whānau who need to be triaged each day will be provided and prioritised in discussion with team leader and using my outcomes group lists.

My outcomes checklist will be updated continually through the day as new tono come in. This is to be checked each morning, midday and afternoon for new tono that needs to be matataki.

All urgent tono must have contact on the day the tono is entered."

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Appendix C: Investigations/reports

The DHB provided HDC with four investigations/reports relating to Mr A's care and/or the pilot project:

a) Serious Incident Review, 2018

The Serious Incident Review (SIR) was an internal review of systems and processes. It identified issues in the assessment process and that the pilot project urgent pathway needed reviewing.[2] Assessment issues included that red flags were missed and should have triggered consultation with the on-call psychiatrist, risk assessment appeared to rely heavily on the here and now, lack of specific strategies to address symptoms, gaps in the documentation, engagement not led by CAT, an urgent tono made on low clinical risk of suicide was inconsistent. The recommendations were:

1. Training for frontline staff in suicide risk assessment/management.[3]
2. Reviewing and improving the approach to assessment in the Crisis Model.[4]
3. Reviewing and improving the approach to urgent referral in the pilot project.
4. Clarifying pathways between services and transition points to community.
5. The provision of information to whānau.
6. The DHB to review workplace factors.

b) Investigation report, undated

The DHB prepared a short internal investigation report, and RN D raised concerns that the report did not include input from staff.[5] The findings included the professional practice of staff named in the complaint to be addressed by the DHB, issues with the assessment and response on Day 2, inadequate documentation,[6] a significant disconnect between Mental Health providers, inadequate handover process, and no defining parameter around what constitutes an "urgent" referral.

c) Report of external investigation, 2018

An external report, following a complaint from staff[7] to the Chief Executive of the DHB. It noted there is widespread support for the pilot project as an important Kaupapa Māori service, and acknowledged the significant service changes and effects on staff since the pilot project commenced in 2017. Recommendations included strengthening governance,

[2] There was a delay in processing the urgent tono, the process needs review, urgency not being clear on the tono form, gaps in documentation.
[3] To include interviewing techniques for exploring risk of suicide and intent, ensuring empathetic and compassionate quality interactions, and understanding significant non-verbal communication.
[4] A structured model for crisis assessment and intervention.
[5] The DHB stated that the investigation was based on the documentation, and responses to questions to the lead reviewers of the serious incident review. There was no opportunity to interview staff.
[6] Inadequate for the length of the interview, incomplete sections, did not demonstrate the rationale for decisions made, did not detail whānau concerns, little reference to drug taking and impact.
[7] Through New Zealand Public Service Association.

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training and development, clarity of scope and focus, and appointing an experienced change team, resourcing and supporting the WAKA[8] values, and improving cultural capability.

d) The pilot project Evaluation Final Report, 2019

An external evaluation of the pilot project was completed in 2019 as part of the funding arrangement with the Ministry of Health. The evaluation presented a range of learnings and potential next steps, including continuing to co-design the single point of entry bringing all partners increasingly together, completing the development of the pilot project policy and procedure documents, developing a formal quality improvement process, developing the cultural competency of mental health staff across the DHB, and ensuring that there is expert specialist change management for the implementation of the pilot project.

[8] **W**hakarangatira/enrich — Enriching the health of our community by doing our very best, **A**whi/support — Supporting our turoro/patients their whānau/families, our community partners and each other. **K**otahitanga/togetherness — Together we can achieve more. **A**roha/compassion — Empathy, we care for people and people want to be cared for by us.

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Appendix D: Letter to the Ministry of Health

12 January 2022

Philip Grady
Acting Deputy Director-General
Mental Health and Addiction
Ministry of Health

By email: philip.grady@health.govt.nz

Dear Phil

As briefly discussed, I wish to draw your attention to an issue relating to the ongoing use of risk prediction profiles "low/medium/high risk" in summarizing suicidal risk in mental health crisis assessments.

In the trend data report for complaints received by the Health & Disability Commissioner in 2020, issues with assessments comprise 22% of the mental health complaints. While issues with risk assessments per se are not specifically counted, since my arrival in the role of Deputy Commissioner three months ago, I have already reviewed 3 cases involving the use of risk prediction in assessing suicide risk undertaken by mental health crisis teams.

In these cases, consumers and families are confused about how the risk profile of low-medium-high risk is being applied, and how this relates to their experience. Further, in one instance, the crisis team had made an assessment of "low risk" of suicide but at the same time made an urgent referral to an NGO for follow up which presented a confusing picture of what was required by the receiving service and which indicator they should follow.

The lack of accuracy of risk-prediction with the outcome of a "low-medium-high" profile was commented on in the NZ Guidelines for Assessment and Management of People at Risk of Suicide (2003) and has been shown to have a validity of "close to zero" (Mulder et al, 2016; 271). Whilst a number of services have ceased this practice I consider that continuing to utilise a practice that has shown to have no validity in this area specifically should no longer be supported.

The Health and Disability Commissioner's ability to make adverse comment about this outdated practice is somewhat compromised as practitioners currently continue to believe it is acceptable practice. The most recent guidelines (2003) specifically explains risk prediction for individuals (p27) and although makes comment about the lack of accuracy (p45) it is stated as a caution rather than an indicator to not use this approach. In this regard, I would request the Ministry of Health make a written statement to providers to cease the practice of summarizing suicidal risk prediction as low/medium/high and to move to adopt risk management and safety planning protocols which are widely available.

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I am aware that the Health Quality and Safety Commission has established a clinical leadership network and this would be a useful forum to also convey this message and would seek consideration of the Ministry funding a programme of change through HQSC to enable the implementation of a consistent best practice approach in crisis assessment and formulation across New Zealand. This would also be in line with key recommendations approved by Government in He Ara Oranga.

Many thanks for your consideration of these issues.

Ngā mihi

Dr Vanessa Caldwell
Deputy Health & Disability Commissioner

cc: Janice Wilson, Health, Quality & Safety Commission

References:

Mulder, R, Newton-Howes, G, & Coid, J (2016) The Futility of Risk Prediction in Psychiatry, BJP 2016, 209: 271–272 DOI: 10.1192/bjp.bp.116.184960

New Zealand Guidelines Group (NZGG) and Ministry of Health (2003) The Assessment and Management of People at Risk of Suicide — For Emergency Departments and Mental Health Service Acute Assessment Settings, Ministry of Health, Wellington.

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