

**Te Whatu Ora | Health New Zealand  
Capital, Coast and Hutt Valley**

**Psychiatrist, Dr B**

**Psychiatrist, Dr D**

**A Report by the  
Deputy Health and Disability Commissioner**

**(Case 19HDC02030)**

## Contents

Executive summary .....	1
Complaint and investigation .....	2
Information gathered during investigation .....	3
Further information.....	12
Opinion .....	15
Te Whatu Ora Capital Coast and Hutt Valley — breach.....	15
Opinion: Dr B — breach.....	21
Opinion: Dr D — adverse comment .....	24
Changes made .....	25
Recommendations.....	26
Follow-up actions .....	27
Appendix A: Independent clinical advice to Commissioner .....	28
Appendix B: Relevant standards .....	54

## Executive summary

1. This report concerns the care provided to a man in his sixties by Te Whatu Ora Capital, Coast and Hutt Valley. The man had a long history of engagement with community mental health services, and was supported by his parents and a family friend. The man had been under the care of a psychiatrist and the Community Mental Health Team (CMHT) for many years. A locum psychiatrist took over the responsibilities of the man's psychiatrist during a planned absence from the service. The man also received support from a contact centre<sup>1</sup> (run in part by the DHB). In 2019, the man's parents became concerned about their son's depressive state, agitation, panic attacks, mood swings, inability to sleep, and talk of suicide. Sadly, the man harmed himself and died in hospital.

## Findings

2. The Deputy Commissioner found Te Whatu Ora Capital, Coast and Hutt Valley in breach of Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code) for several shortcomings in the care provided to the man. In particular, that inadequate documentation kept by the contact centre and CMHT contributed to inconsistent approaches to the man's care, and culminated in the collective failure by several clinicians at a whānau hui to offer appropriate support to the man following his predictable distress.
3. The Deputy Commissioner also found that the psychiatrist breached Right 4(5) of the Code for the lack of co-operation with the man's general practitioner to ensure the quality and continuity of care to the man.
4. The Deputy Commissioner was also critical of the locum psychiatrist for the lack of support provided to the man following a whānau hui.

## Recommendations

5. The Deputy Commissioner recommended that Te Whatu Ora Capital, Coast and Hutt Valley provide a written apology to the man's whānau. The Deputy Commissioner also recommended that Te Whatu Ora Capital, Coast and Hutt Valley provide evidence that it has updated its internal policies to include a requirement for CMHT psychiatrists to provide regular written updates to other treating clinicians; that it provide feedback on the implementation of the recommendations made in its SER; and that it circulate a copy of the anonymised version of this report across all of the MHAIDS psychiatrists and relevant staff, for continuing education.
6. The Deputy Commissioner recommended that the psychiatrist provide a written apology to the man's whānau, and provide a written reflection about his care of the man and any learnings that have occurred as a result of the events.

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<sup>1</sup> A contact centre for people who are in crisis or are experiencing moderate to severe mental health or addiction problems. By contacting the contact centre, an individual can request help or a referral to a mental health or addiction service, or they may have questions that they want answered by a mental health or a substance dependence professional.

## Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mrs C about the services provided to her son, Mr A, by psychiatrists Dr D and Dr B at a district health board (DHB)<sup>2</sup> (now Te Whatu Ora|Health New Zealand Capital, Coast and Hutt Valley). The following issues were identified for investigation:
- *Whether the DHB provided Mr A with an appropriate standard of care between 1 Month<sup>1</sup><sup>3</sup> and 1 Month<sup>11</sup> 2019 (inclusive).*
  - *Whether Dr B provided Mr A with an appropriate standard of care between 1 Month<sup>1</sup> and 24 Month<sup>7</sup> 2019 (inclusive).*
  - *Whether Dr D provided Mr A with an appropriate standard of care between 24 Month<sup>7</sup> and 1 Month<sup>11</sup> 2019 (inclusive).*
8. This report is the opinion of Dr Vanessa Caldwell, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.
9. The parties directly involved in the investigation were:
- |                  |                                |
|------------------|--------------------------------|
| DHB <sup>4</sup> | Provider/district health board |
| Dr B             | Provider/psychiatrist          |
| Dr D             | Provider/locum psychiatrist    |
| Mrs C            | Complainant/consumer's mother  |
10. Further information was received from:
- |                  |                           |
|------------------|---------------------------|
| Dr E             | General practitioner (GP) |
| General practice |                           |
11. Ms F, a family friend, is also mentioned in this report
12. Independent advice was obtained from a psychiatrist, Dr Murray Patton (Appendix A).
13. I extend to Mr A's whānau my condolences for their loss.

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<sup>2</sup> On 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to the DHB now refer to Te Whatu Ora Capital, Coast and Hutt Valley.

<sup>3</sup> Relevant months are referred to as Months 1–11 to protect privacy.

<sup>4</sup> See footnote 2.

## Information gathered during investigation

### Introduction

14. This report concerns the care provided by a DHB (now Te Whatu Ora Capital, Coast and Hutt Valley) to Mr A (aged in his sixties at the time of these events).
15. Mr A was under the care of a psychiatrist, Dr B, at the DHB from 2011 until approximately 24 Month7,<sup>5</sup> and Mr A's care was transferred to Dr D, a locum psychiatrist at the DHB, on approximately 11 Month8.<sup>6</sup> During Dr B's absence while on leave, Dr D covered the Senior Medical Officer (SMO) responsibilities at the Community Mental Health Team (CMHT). Mr A also received care from his GP, Dr E at the medical centre.
16. In early 2019, Mr A's parents became concerned about their son's depressive state, agitation, panic attacks, mood swings, inability to sleep, and talk of suicide. Mrs C told HDC: "[2019 was] a struggle and a battle with [CMHT] to get the help and care [that Mr A] needed." Throughout 2019 the whānau remained concerned about whether the DHB was treating Mr A for a chronic serious psychotic illness or a disorder of his mood. Mr A's parents, Dr E, and a family friend, Ms F (who was also a medical practitioner), raised concerns with the DHB about Mr A's health on a number of occasions during 2019.
17. Mr A had a long history of engagement with community mental health services, and was supported by his parents and Ms F. Mr A's whānau raised concerns about the repercussions of Mr A's diagnosis being changed from schizophrenia<sup>7</sup> to dependent personality disorder.<sup>8</sup> They felt that despite frequent warnings of Mr A's increasing suicidal thoughts and general mental health deterioration, his care was being withdrawn.
18. Sadly, on 1 Month11 Mr A harmed himself and died in hospital the following day.
19. This report relates to the standard of care that Mr A received from the DHB, Dr B, and Dr D from Month1 until 2 Month11. At the outset, it is important to note that it is not the role of this Office to make a finding on Mr A's diagnosis.

<sup>5</sup> The DHB advised that Dr B took a planned period of leave from his position at the DHB from 19 to 29 Month8 and then from 23 Month9 to 6 Month11.

<sup>6</sup> Dr D advised that he was not substantively involved in Mr A's care until 21 Month9.

<sup>7</sup> Schizophrenia is a serious mental disorder in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and extremely disordered thinking and behaviour that impairs daily functioning and can be disabling.

<sup>8</sup> Dependent personality disorder is characterised by clingy and submissive behaviour. Individuals are passive and allow others to direct their lives because they are unable to do so themselves. Other people such as spouses or parents make all the major life decisions, including where to live and what type of employment to obtain. These patients fear separation and tend to be indecisive and unable to take initiative. Often they are preoccupied with the thought of being left to fend for themselves, and want others to assume responsibility for all major decision-making.

*Community Mental Health Team (CMHT)*

20. The CMHT is part of the Mental Health, Addiction and Intellectual Disability Service (MHAIDS). Mr A began to receive care from the CMHT in 2011.
21. As well as monthly psychiatric appointments with Dr B and (later) Dr D, Mr A received support from his care manager (a registered nurse). Mr A's engagement with the CMHT was primarily through reviews and through visits from his care manager, which occurred on a weekly basis. The clinical staff of CMHT (including Dr B and Dr D) prescribed and supervised Mr A's psychiatric medication in the form of a monthly depot injection of paliperidone.<sup>9</sup> His last dose was administered on 30 Month10.

*MHAIDS contact centre*

22. The MHAIDS contact centre (the contact centre) is for people who are in crisis or are experiencing moderate to severe mental health or addiction problems. By contacting the contact centre, an individual can request help or a referral to a mental health or addiction service, or they may have questions that they want answered by a mental health or a substance dependence professional.
23. Throughout 2019 Mr A presented in crisis or otherwise contacted the contact centre approximately nine times. Emergency care was provided to Mr A through this service, and often he received telephone counselling assistance.
24. In summary, the care provided to Mr A by both CMHT and the contact centre was the responsibility of the DHB as the district in which Mr A resided.

**Summary of care**

*Month2*

25. Mr A's mother told HDC that in Month2 the whānau were very worried about Mr A's "depression, agitation, panic attacks, mood swings, inability to sleep and talk of suicide".
26. Mr A telephoned the contact centre on one occasion in Month2. On 18 Month2, Mrs C contacted the contact centre concerned about Mr A's mental state, and was advised to get Mr A to telephone the contact centre if he was in crisis, or to take him to the Emergency Department (ED).
27. Mrs C told HDC that on 24 Month2 she attended an appointment with Dr B and Mr A as she and Mr A's whānau were very concerned about Mr A's mental health. Mrs C said that they requested a review of Mr A's medication and a second opinion (from another psychiatrist), but felt that they were not taken seriously during the appointment, and "months went by and nothing was done". Dr B wrote a letter to another psychiatrist (who historically had been involved in the care of Mr A) requesting a second opinion. Dr B wrote: "Our own

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<sup>9</sup> Paliperidone is used to treat schizophrenia, psychosis and similar conditions. A paliperidone injection is given once a month, and is administered into the muscle at the top of the arm. Antipsychotics do not work immediately, and it may take several days or even weeks for some symptoms to reduce.

feeling, namely my own and his longstanding [care manager], have a slightly different view and think [Mr A] is doing reasonably well given his circumstances.”

28. Mrs C telephoned Dr B on 24 Month2 (following the meeting) as she was concerned about Mr A. Dr B documented that he told Mrs C that Mr A’s care manager would follow up with him the following day. Dr B noted that he said that it was his view that both Mr A and his whānau could be concerned about who would look after Mr A in the event his parents died. Dr B documented: “Until this is more closely addressed and accepted, [there] may be increase[d] frequency and increasingly anxious telephone calls for help.”

### *Month3*

29. Mr A telephoned the contact centre on one occasion in Month3. The clinical notes document “nil acute risks identified”, and the contact centre sent an “FYI” email to the CMHT.
30. On 13 Month3, Mr A requested a reduction in the dose of his paliperidone.<sup>10</sup> Mr A’s care manager documented that Mr A said that “he would refuse it if not reduced”, and subsequently his medication was reduced<sup>11</sup> on 18 Month3 (as approved by Dr B). However, there is no evidence that this reduction in medication was communicated to Mr A’s primary care provider (his GP).
31. In response to the provisional opinion, the DHB stated that Dr B’s management was guided by a formulation that sought to balance the risk of harm to Mr A from unnecessary exposure to adverse effects of medication against the risk of harm from perceived withdrawal of support. It stated:

“[W]e believe the clinical record does document the rationale for the change in dose which occurred during Month3, and that there were reasonable grounds for respecting [Mr A’s] preference for a reduced dose of Paliperidone.”

32. Mr A also saw Dr B on 27 Month3 for Mr A’s monthly review.

### *Month4 to Month6*

33. Mr A contacted the contact centre on three occasions during this period. An entry in Mr A’s clinical notes (made by Dr B) on 26 Month4 states: “Seen with [Dr D] — supportive work continues.” However, it is unclear the extent to which Dr D assessed Mr A on this date.
34. On 29 Month5, Dr B documented that he received a “second opinion” from Dr D. However, Dr D told HDC that he was visiting the DHB as a locum psychiatrist and “professional visitor” when he saw Mr A (with Dr B as the attending doctor), and did not provide a “comprehensive second opinion” on this date.
35. On 25 Month6, Mr A contacted the contact centre as he was feeling overwhelmed. The nurse who took the call documented that she reassured Mr A and transferred him to

<sup>10</sup> His next dose was due on 19 Month3.

<sup>11</sup> From 150mg to 100mg.

another telephone counselling service. On 27 Month6, Mr A attended an appointment with Dr B, who documented that Mr A was “worried” and that this was likely to continue given the significant events that were occurring in his life at that time.<sup>12</sup> The “plan” was documented as “Re-framing, positive thinking ...”.

#### *Month7*

36. The clinical notes indicate that throughout Month7 there was increased contact by Mr A with both the contact centre (Mr A contacted the contact centre on four occasions in Month7) and his care manager.
37. The DHB told HDC that on 5 Month7, Ms F emailed Dr B with concerns about Mr A, including concerns about his medication. Dr B documented that he discussed these concerns with Ms F, but it was his view that changing medication would not address the underlying issues. On 24 Month7, Mr A attended an appointment with Dr B and his care manager. Dr B’s notes from the session are brief but show a discussion of Mr A’s ongoing concerns and that there was a plan for a further review in one month’s time.

#### Reviews by GP

38. On 25 Month7, Mr A attended an appointment with his GP, Dr E. Dr E documented that various concerns were discussed during this appointment, and that he spoke to Ms F, who advised that Dr B did not feel that an antidepressant medication would be helpful at that time, but that Ms F’s view was to “[c]onsider 25mg [quetiapine] for sleep [and] [a]sk for [a] second opinion”.
39. Mr A saw Dr E again on 27 Month7. Dr E documented that Mr A “[r]eally need[ed] to be managed by [CMHT]”, and Mr A was advised to contact his care manager.

#### *Month8*

40. On 1 Month8, Mr A’s care manager had a telephone conversation with Ms F, who advised that she had noticed an increase in Mr A’s requests to be taken to see the Crisis Team, and that he had been attending his GP requesting help.

#### Further review by GP

41. On 4 Month8, Mr A and Ms F attended a consultation with Dr E. Dr E documented that Mr A no longer wanted to see Dr B or his care manager and that he was “unhappy with his psychiatric care — feels relationship has broken down with [Dr B] and [his care manager]. Says he doesn’t want to see him again.” Dr E prescribed Mr A mirtazapine<sup>13</sup> and sent a referral to CMHT<sup>14</sup> to request a “reassessment/2<sup>nd</sup> opinion”. Dr E told HDC that he felt that Mr A was becoming more depressed at this time.
42. The DHB said that it was its view that by prescribing Mr A an antidepressant, “[Dr E] effectively undermined the deliberate approach which had been maintained by [Dr B] and

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<sup>12</sup> Dr B noted that Mr A was concerned about how he would manage once his parents were gone, as they had supported him his entire life, but he was not suicidal at that time.

<sup>13</sup> Mirtazapine is used to treat moderate to severe depression.

<sup>14</sup> Received by the contact centre on 4 Month8.



by [the care manager] during the previous five years”, and that Dr E did not make contact with CMHT prior to making the medication addition. However, in response to the provisional opinion, the DHB added that after commencing the antidepressant, Dr E wrote to the contact centre to advise of the change and to request a second opinion and a reassessment of Mr A’s medication regimen.

43. On this date, Dr E also documented that correspondence from CMHT had been “poor” and that he had received no correspondence from Mr A’s treating team since 2018.

Transfer of care from Dr B to Dr D

44. On 11 Month8, Mr A met with Dr D for a second opinion. The details of this meeting are in the form of a letter to Dr E in response to his request for a second opinion.

45. In summary, Dr D wrote to Dr E that he had met Mr A “briefly a few month[s] ago” as a locum at CMHT but that he had had no input into his care or access to his notes until “today”. Dr D wrote that he drew most of his conclusions on Mr A’s presentation from his meeting, including that it was his view that Mr A’s presentation was much more in line with a significant disorder of personality with features of dependency being “paramount”. Dr D wrote:

“It must be acknowledged that [Mr A] has been in psychiatric services a very long time and therefore large changes in his treatment will cause him stress ... Whatever [Mr A’s] treatment plan, because of his suggestibility, I would suggest that the parameters and roles and responsibilities in his future treatment be nice and clear — i.e the role of GP, the role of the mental health services and the role of friends.”

46. Dr D wrote that he had been dictating the letter in front of Mr A during the meeting, but that Mr A “got annoyed” half way through and left the meeting. Dr D told HDC that it was his view from the meeting that Mr A was confused about Ms F’s role, specifically whether she was a friend or a medical practitioner who would give medical advice. Following this meeting, Dr D had a telephone conversation with Ms F about Mr A’s future treatment, for which he obtained Mr A’s consent.<sup>15</sup>

47. Dr D told HDC:

“I made it clear in my contact with [Mr A] and then again with [Ms F] — also a trained medical practitioner and thus aware of the role of second opinion doctors — that I did not set the treatment plan.”

48. Dr D emphasised that at this time he was a non-treating assessing doctor and was “distinct from [Mr A’s] treating team”, and that he advised both Mr A and Ms F that Mr A’s treating

<sup>15</sup> Dr D documented a summary of his discussion with Ms F, including Mr A’s diagnosis, medication, psychological work, roles, family, symptoms and relationships, and that Mr A’s GP was to focus on physical health only.

team would make the final decision about treatment, which was mirrored by the language used in his letter to Dr E.

49. Dr D told HDC that following the telephone call with Ms F, he saw Mr A with his care manager in the reception area. Dr D said that he ensured that Mr A was OK and spoke briefly with Mr A's care manager about the meeting, and was of the view at that time that there was no need for community follow-up and that "the duty of care remained with his team".
50. It is unclear from the documentation when the therapeutic relationship between Mr A and Dr B ended and when Mr A's care was transferred to Dr D. However, Mr A had complained to Dr E on 4 Month8 that he felt that his relationship with Dr B had broken down and that he did not want to see Dr B again. The DHB also told HDC that following Dr D's meeting with Mr A of 11 Month8, "[Mr A] remained under the care of [Dr D]". In addition, as noted above, the DHB advised that Dr B was on planned leave from 19 until 29 Month8 and then from 23 Month9 until 6 Month11 (during which periods Dr D covered SMO<sup>16</sup> responsibilities at CMHT).

#### Crisis Team assessment

51. On 13 Month8, Mr A made a 23-minute-long telephone call to the contact centre at 3.05pm. Mr A expressed that he was struggling with a number of issues. The notes record that Mr A said that he wanted to end his life and was suicidal, but there is no record that a mental state examination was undertaken. The DHB told HDC that this telephone call was "at times difficult" and that "there are limitations to what can be achieved with regards to mental state assessment over the telephone, particularly when a person is in crisis". An ambulance was called for Mr A and he was taken to ED. In relation to this phone call to the contact centre, the DHB told HDC:

"Given this was the outcome of [the call taker's] assessment of [Mr A], that the conversation with [Mr A] had been 'at times difficult', and that [the call taker] would expect further assessment of [Mr A's] presentation to take place at ED, we consider that [the call taker's] note from 13 [Month8] was appropriately detailed."

52. Mr A was seen by the Crisis Resolution service (the Crisis Team) clinicians at around 2am on 14 Month8. The assessment notes are brief and state that Mr A was "[u]nclear why he had actually presented to ED" and that he did not express thoughts of self-harm, was future focused in talking about plans for the following day, and that he asked the Crisis Team to call Ms F to advise her of his attendance at ED. There is no record of an exploration of Mr A's symptoms, and no conclusions were drawn about the presentation. The Crisis Team documented that they would advise CMHT of Mr A's contact with the service.
53. Mrs C made two telephone calls to Mr A's care manager, on 15 and 18 Month8, expressing concerns about Mr A. In her telephone call of 18 Month8, Mrs C asked for Mr A's medication to be reviewed, but was advised that he had received a second opinion the previous week. The care manager documented: "[Mrs C] thought the outcome of the assessment was

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<sup>16</sup> Senior Medical Officer.

wrong, and that [Mr A's] depend[ent] behaviour was a response to his illness and not a personality issue."

#### 21 Month9

54. The DHB and Dr D told HDC that Mr A had an appointment with Dr D on 21 Month9. No entry was made in the clinical record, but a clinic letter from Dr D on this date outlines his consultation with Mr A. The letter states:

"Whilst the relationship with [Mr A's care manager] is good, other agencies are more attuned to the problems [Mr A] brings. Like all clients of the psychiatric services, transfer to lesser intensity services is not a rejection but more a success. Thus I have suggested a goal of assessing his needs and working on a transition to a more appropriate service. This will take 6 months to a year in my experience."

55. Dr D told HDC that he did not receive any official handover prior to this appointment, "nor any indication that [Mr A's choice to see him instead of Dr B] indicated that [he] automatically became [Mr A's] doctor". Dr D stated: "[I]n my case I was a part time locum supporting a well-established team." Dr D said that he did not consider that he needed to see Mr A again, given that the issue of medication had been resolved (in that Dr D had deferred to the decisions already made by Dr B), and he recalls telling Mr A that he should continue to see his care manager.
56. The DHB told HDC that during this appointment there was a discussion with Mr A regarding whether or not he should remain under the care of CMHT, or begin a transition towards services outside secondary mental health care. The DHB stated:

"Unfortunately, it appears [Mr A] understood from this conversation that he had been discharged from [CMHT]. [Mr A] made contact with his parents shortly after the appointment with [Dr D] and was reportedly distraught as a consequence of believing he had been discharged."

57. Mrs C telephoned Mr A's care manager on 22 Month9, concerned that Mr A had been discharged from CMHT, as he had been "distraught [on 21 Month9] following his consultation". Subsequently, Ms F contacted the CMHT team leader to organise a whānau hui to discuss their concerns.

#### Month10

58. On 1 Month10, the contact centre received a telephone call from the ED advising that Mr A had harmed himself, and that he had called an ambulance to take him to hospital. On 2 Month10, Mr A was reviewed in ED by his care manager and another nurse. It was documented that Mr A had expressed his irritation at his mother's involvement in his life and "told [the care manager] ... not [to] talk to her". However, the notes of this assessment do not record a clear exploration of Mr A's psychiatric symptoms or a clearly structured mental state examination. Mr A's care manager accompanied him to CMHT and he was seen by Dr D for his scheduled paliperidone injection.

59. On 11 Month10, the contact centre received a call from the ED at another hospital stating that Mr A had presented to the department concerned about his medication and that he could not guarantee his safety. Mr A was escorted to the main centre ED and arrived in the early hours of 12 Month10. The brief ED notes record that Mr A expressed no plans or intent to harm himself in the near future, but that he felt that CMHT did not help him. The documented “impression” was of chronic pain and chronic low mood, but that Mr A had “future focus”. The documented “plan” was for Mr A to return home and for the Crisis Team to discuss follow-up with CMHT. However, there is no detailed exploration of psychiatric symptoms or a record of a full mental state examination.

Assessment by another district health board (DHB2)

60. DHB2 told HDC that its Mental Health Services Acute Care Team assessed Mr A once on 17 Month10 at the request of the police following a welfare check, and clinical notes document the following impression:

“No evidence of major affective or psychotic disorder. [Increase] in behaviours seems to correspond with recent change in diagnosis and management plan re [personality disorder] and reducing some support re services. Ongoing report of [suicidal ideation] but risk felt to be chronic and best managed with ongoing community support.”

61. DHB2 recommended to the DHB that a whānau hui be arranged to discuss Mr A’s diagnosis and ongoing plan for crisis management.

Whānau hui on 30 Month10

62. On 30 Month10, a whānau hui took place, attended by Mr A, his parents, Ms F, the CMHT team leader, Dr D, and Mr A’s care manager. Dr D told HDC that he was surprised to find Mr A in attendance, as he had been under the impression that prior to the hui the treating team had agreed that Mr A should not attend because he had found previous similar discussions about his change in treatment approach to be upsetting.

63. Mrs C told HDC that the whānau asked for a management plan for both Mr A and themselves, and for some emergency medication that could be given to Mr A when he was in crisis. Mrs C told HDC: “[Dr D] made it quite clear that he felt [Mr A] was behaving like a spoilt child and he should just grow up.” In response to the provisional opinion, Mrs C advised that they were not provided with a management plan or emergency medication.

64. An MHAIDS clinic letter (written by Dr D to Mr A) notes that it is a “brief summary” of the meeting, which lasted for about an hour and a half. The clinic letter is the only record of the meeting.

65. The letter outlines what was discussed and agreed on in the meeting. The matters discussed include the following:

- Medication had been important (and would continue to be important) but the focus should now be on other ways of helping Mr A;
- There were two main areas where clarity was needed, including the response to sleep problems and crises;

- The implementation of a care plan with appropriate interventions;
- Mr A providing written consent so that his clinic letters could be passed on to his parents and Ms F; and
- The importance of clarity of roles, in particular the role of Ms F.

66. The letter also outlines the importance of communication, and that if there were any significant changes in Mr A's treatment plan, this should be discussed with others involved in Mr A's care before any major action was taken.

67. The DHB told HDC that the direction of the meeting and care plan were aimed at gradually reducing Mr A's overdependence on CMHT.

68. Mr A found the meeting distressing and left early. Dr D said that in the meeting he made it clear that Mr A was not to be discharged from CMHT imminently, but he mentioned that he (Dr D) would be at CMHT for only a further two weeks, at which point Dr B would be returning. Dr D stated that after leaving the meeting, Mr A waited in the reception area. Dr D said that his impression was that Mr A was no longer in distress. Dr D acknowledged that this observation was not documented in the clinical notes by any party, but said that this was because the meeting had run over time, and his view was that the other parties at the meeting knew Mr A well and agreed that Mr A was not in distress. Dr D said that he did not deem it necessary to document this observation, as he considered that it had been resolved. He told HDC:

"Remaining even longer behind in an empty building to make a plan for what was taken to be a temporary and resolved distress in a man with a long history of the same was not considered. Instead, a [multidisciplinary team meeting] discussion was planned for the next day. We had no cause to make an urgent follow up plan and I cannot imagine what service or plan that would be in the circumstances, given he was back to baseline."

#### *1 Month11*

69. Mrs C told HDC that on 1 Month11, she became particularly concerned for Mr A's wellbeing as he was sitting in an almost catatonic state. Mrs C contacted the CMHT team leader at 3pm to express concern for Mr A. The CMHT team leader documented:

"I suspect that this is a reaction to yesterday's Family meeting where things were spoken about openly which did lead to [Mr A] walking out of the meeting ... I explained that I would discuss the matter with [the care manager] and come up with a plan around how best to respond to this."

70. Subsequently, the care manager and team leader visited Mr A's home and discovered that he had harmed himself. Dr D told HDC that he does not believe that the events of 30 Month10 were the trigger for Mr A's self-harm, rather that the self-harm was part of a tendency to become distressed and engage in self-harming behaviour to bring support closer to him. Dr D does not believe that the self-harm was secondary to depression.

71. Sadly, Mr A passed away in the early hours of the following day.

## Further information

### DHB

#### *Mr A's diagnosis*

##### Change in diagnosis

72. The DHB told HDC that owing to concerns about the possible harm that would be caused by sharing Mr A's change in diagnosis with Mr A and his whānau in early 2019, Dr B decided to allow his formulation to guide the support offered to Mr A. The DHB stated:

“In particular, the formulation provided a compelling rationale for resisting adjustments to medication in response to [Mr A's] episodic distress, and for protecting [Mr A] from potentially harmful adverse effects of medication.”

73. The DHB also told HDC that Dr B wrote to Mr A's GP (Dr E) annually.

##### Emergent depressive disorder

74. The DHB told HDC that the possibility of an emergent depressive disorder was raised and explored with clinical staff, but that none had the impression that Mr A was severely depressed. The DHB said that Mr A's care manager's documentation of his observations of Mr A were not consistent with an emergent depressive episode.

#### *Guidelines on medication monitoring*

75. The DHB's guidelines on medication monitoring are contained in its “Community Mental Health Medication” policy. The policy states that “consumers receiving medication are observed for its effects, expected benefits, side effects, and are advised of any precautions required and potential interactions of any other medication”.

#### *Serious Event Review (SER)*

76. The DHB conducted an SER as a result of these events. The review identified the following areas of concern:

- The difficulties that occurred in the triangular relationship between Mr A, his whānau, and CMHT.
- Mr A's whānau not feeling heard by CMHT.
- Mr A had a four-decade-long history of engagement with mental health services and, consequently, he became dependent on mental health services, and this formed a core component of his identity. Accordingly, Mr A would have felt distressed when this part of his identity was challenged by the clinical team.
- On the day of Mr A's self-harm, he was facing a significant care transition. Mr A had been given a message (on several occasions over the preceding few months) that his care would be transferred (gradually) from a mental health service setting to a primary care setting, and Mr A and his whānau had found this alarming.

77. The DHB also told HDC that the contact centre’s approach in Mr A’s case was discussed at the MHAIDS Operations Centre Clinical Governance Committee meeting in 2021, and recommendations for improvement were made (see “Changes made” section below).

### **Dr B**

#### *Mr A’s diagnosis*

#### Communication with Mr A’s whānau

78. Dr B told HDC that it is usual for the “keyworker” (care manager) to have the predominant contact with families.
79. Dr B stated that he began to doubt Mr A’s longstanding diagnosis of a psychotic illness (schizophrenia) as far back as 2012. He said that by Month2, he was of the view that Mr A was suffering from a personality disorder. Dr B stated that he was cautious about sharing this information with Mr A and his whānau, in part because some of Mr A’s concerns were intimate in nature, and Mr A had specifically asked him not to share that information with his parents. Dr B told HDC:

“I acknowledge that despite being a long-standing service user whose family had much contact with services over the years, that if there were significant changes in his diagnosis and management then it would be preferable to discuss this with them in an open and meaningful way ... [T]he dilemma was how this could be shared with those involved in [Mr A’s] care without having a profound negative impact on [Mr A’s] mental wellbeing.”

80. Dr B also told HDC that the decision not to share the change in diagnosis directly with Mr A and his whānau was discussed anonymously in his peer review group and explicitly in the CMHT multidisciplinary meeting “as to how to manage this revised conceptualisation of [Mr A’s] difficulties”.

#### Contact with Mr A’s GP

81. Dr B told HDC that he wrote approximately two letters per year to update Mr A’s GP (Dr E), and that he would do this directly, or accompanied by copies of other relevant communication. Dr B stated that it was his usual practice with patients who were “long standing service users” to provide periodic updates to the primary care provider to advise of any changes in presentation, formulation or treatment. In response to the provisional opinion, Dr B said that the revised diagnosis was first raised with Dr E in 2012 when there was a shift in his thinking away from Mr A having schizophrenia, “but rather that he had a mood disorder”. Dr B said that when there was a further significant shift (in 2014) this was also conveyed to Dr E. Dr B said that he did so again in 2015, and that the “reformulation continued to be communicated to Dr E up to and including [2017] and [2018]”.
82. Dr B stated that he was happy to communicate with Dr E at any time, and was always happy for Dr E to telephone him with any concerns. Dr B considers that more frequent letters advising that there had been “no change” to Mr A’s care would not have enhanced Dr E’s care of Mr A, and is of the view that the important changes were “well documented and conveyed”.

### Responses to provisional opinion

83. Mrs C, Dr B, Dr D and Te Whatu Ora Capital, Coast and Hutt Valley were all given an opportunity to comment on relevant sections of the provisional opinion. Their comments have been incorporated into the report where relevant. In addition, I note the following:

#### *Mrs C*

84. Mrs C told HDC: “I have found it very difficult to go back and recall all that occurred during the years of [Mr A’s] illness and particularly the last year.” She said that although there was a “sudden change” in Mr A’s diagnosis after 47 years in the mental health system, “[t]his was not relayed or discussed with [Mr A’s] support people and family”. Mrs C said that her whānau felt unheard and ignored when they expressed alarm at Mr A’s increasing distress. She stated:

“We disagree that [Mr A’s] death was not the result of his depression. He was extremely upset and felt unheard (as we all felt) after that meeting and after months of expressing our concerns.”

85. Mrs C added that Mr A’s GP was “caring compassionate and made himself available when [Mr A] was in crisis”.

#### *Dr B*

86. Dr B told HDC: “I have spent much time reflecting on my communication in this case, your expert advisor’s opinion, and provisional findings.” He accepted that he could have corresponded more frequently with Dr E from 1 Month1 to 24 Month7, and following the reduction in paliperidone.

87. In relation to Mr A’s change in diagnosis, Dr B told HDC:

“[W]hile I agree it is good practice for any formulation to be shared with the patient’s GP and note there were detailed descriptions of my formulation or understanding of his difficulties, on reflection I accept it would have been good practice for this to have been reiterated with [Dr E] at the time as I had done so in the past.”

88. Dr B agreed to the proposed recommendation that he provide a written apology to Mr A’s whānau, and a reflection about his care of Mr A. Dr B confirmed that he has retired from practice.

#### *Dr D*

89. Dr D accepted the findings in the provisional opinion.

#### *Te Whatu Ora Capital Coast and Hutt Valley*

90. Te Whatu Ora Capital Coast and Hutt Valley disagreed with the findings in the provisional report. In particular, it disagreed that Mr A and his whānau had increased contact with CMHT and the contact centre in Month2. However, it accepted the proposed recommendations and stated that it would “work to implement any recommendations made”.



## Opinion

### Introduction

91. This report considers whether the care provided to Mr A from Month1 and up to the date of his death was of an appropriate standard. Mr A was entitled to co-operation among providers to ensure the quality and continuity of the services he received.
92. The provision of supportive and therapeutic mental health care relies on input from various parties, including the service provider, individual clinicians, community support, and the consumer's GP and support system. This collaborative approach means that it is crucial that all parties operate within a system that encourages continuity of care through robust documentation and clear and open communication between service providers and whānau.
93. As part of my assessment of this complaint, I sought internal clinical advice from GP Dr David Maplesden. Dr Maplesden assessed the care provided by Mr A's GP, Dr E, and identified no concerns. Accordingly, the focus of this report is on the care provided by psychiatrists Dr D and Dr B, and the DHB.

## Te Whatu Ora Capital Coast and Hutt Valley — breach

### Introduction

94. Mr A was under the care of the CMHT (part of MHAIDS). Accordingly, the care provided to Mr A by CMHT was the responsibility of the DHB. In 2019, Mr A predominantly received care from two psychiatrists, Dr B<sup>17</sup> and Dr D,<sup>18</sup> and his care manager.<sup>19</sup> Mr A also presented to ED in crisis, or otherwise made contact with the contact centre a number of times in 2019. The contact centre provided accessible support to Mr A when he became preoccupied with negative thoughts.
95. As part of my assessment of the care provided by Dr B, Dr D, and the DHB, I sought independent advice from psychiatrist Dr Murray Patton.
96. As discussed above, the provision of community mental health support, particularly in a DHB setting, relies on a robust collaborative approach. Dr Patton advised:

“[I]ndividual practitioners operate, at least in an environment like the DHB, within the context of relationships with teams and colleagues, and of people in roles that might offer an opportunity for oversight/overview of decisions and of practice ... A ‘just culture’ orientation attends to both individual and organisational contributions to practice and a file review alone is insufficient basis to know where the balance of

<sup>17</sup> Mr A was under the care of Dr B from 2011 until 24 Month7.

<sup>18</sup> Mr A was under the care of Dr D from 24 Month7 until the day of Mr A's passing.

<sup>19</sup> The care manager saw Mr A weekly in 2019.

responsibility for perceived departures lies. Without further exploration of a range of factors, it would be improper for me to try to attribute responsibility more closely.”

97. I have taken this advice into consideration in my assessment of this complaint.

### **Documentation**

98. On a number of occasions, various staff at the DHB kept poor clinical documentation.
99. In Month3, Mr A’s medication dose was reduced, which the DHB advised was at Mr A’s request. This reduction in medication followed a period of increased concern by both Mr A and his mother and repeated contact with the contact centre and CMHT, particularly in Month2. The documentation in the clinical record outlines the rationale for the change in dose — that Mr A had requested it and would refuse it altogether if it was not reduced. However, there is no record of a discussion with Mr A about the implications of this reduction, the clinical recommendation, or the safety-netting advice provided to Mr A, his family, or Dr E (his GP).
100. On 29 Month5, Dr B received a second opinion from Dr D regarding Mr A’s care, evidenced by a letter to Mr A’s GP on 12 Month8, which notes that Dr D had met Mr A “a few months before”. However, no record of this visit was recorded in Dr D’s notes.
101. On 13 Month8, Mr A telephoned the contact centre, and the call lasted for over 23 minutes. It was documented that Mr A was in crisis, suicidal and unable to think positively, and appropriately an ambulance was called to take Mr A to ED for further assessment. Subsequently, Mr A was transported to ED via ambulance and was assessed by the Crisis Team in the early hours of 14 Month8. However, the documentation is brief and there is no evidence that Mr A’s symptoms were explored, and no conclusions were drawn about his presentation.
102. On 1 Month10, Mr A was transported by ambulance to ED in crisis, having harmed himself. The following day Mr A was seen by the CMHT team (including his care manager), but the clinical documentation of this assessment does not show any clear exploration of his psychiatric symptoms, and the mental state findings were recorded in an unstructured manner with no formulation evident.
103. On 11 Month10, Mr A presented to the ED at another hospital (part of Te Whatu Ora Capital, Coast and Hutt Valley) and eventually was escorted to the main centre ED in the early hours of 12 Month10, where he was assessed by the Crisis Team. However, the clinical documentation of that presentation is brief and lacks any record of a detailed exploration of Mr A’s psychiatric symptoms.
104. It is clear from the information available that Mr A relied heavily on support from the contact centre and Crisis Team services, and that in 2019 his contact with the services became increasingly frequent. Mr A’s medication was also reduced in Month3 at his request, despite a period of increased contact with both the contact centre and CMHT by both Mr A and his mother, particularly in Month2. I acknowledge Te Whatu Ora Capital Coast and Hutt Valley’s view that there was not increased contact by Mr A with CMHT or with the contact centre

during this time. However, I note that in reaching this conclusion I have considered a variety of information, including comments from Mr A's whānau, contact with both CMHT and the contact centre by both Mr A and his mother, and the concerns raised by Mr A with his care manager during this time. In my view, it is clear that during this time Mr A's whānau was becoming increasingly concerned about his wellbeing.

105. I am also concerned that given the circumstances, Dr B did not document the clinical rationale for Mr A's change in dose of paliperidone.
106. My independent advisor, Dr Patton, advised that considering Mr A's significantly increased engagement with the contact centre and the Crisis Team in 2019, his psychiatric symptoms should have been documented each time he sought help from these services. Dr Patton said that this would have also allowed the DHB to ascertain whether another disorder had developed (discussed further below). I am concerned about the lack of documentation of Mr A's presenting symptoms by various staff at the contact centre and the Crisis Team who spoke to Mr A throughout 2019, particularly when his contact with the service became increasingly frequent. Dr Patton advised that although the contact centre staff may have relied on the conclusions already drawn by clinical staff, the documentation of such symptoms is important. He stated:

“[I]t is typically helpful for at least some outline to be provided of the information that was considered in reaching that conclusion, to not just enable an assessment to be made by a practitioner ... but also to enable a comparison of the future presentation (symptoms and mental state) with what had been seen previously.”

107. I note that the DHB has accepted that the clinical documentation by the contact centre staff did not meet the DHB's expected standard, and that risk assessments conducted via telephone calls with Mr A were not documented by the service adequately.
108. Dr Patton advised that such lack of detail “would generally be regarded as below a reasonable standard and viewed with at least a moderate level of disapproval by peers”. I accept Dr Patton's advice in this regard.
109. Various staff in both the CMHT and the contact centre services were involved in the care of Mr A throughout 2019. I have found deficiencies in the standard of documentation kept by the contact centre, the Crisis Team, and between Dr B and Dr D. Accordingly, I consider that the pattern of poor record-keeping as outlined above highlights deficiencies at an organisational level, for which ultimately the DHB is accountable.

### **Support following whānau hui**

110. The DHB held a whānau hui on 30 Month10, attended by Mr A, his parents, Ms F, and several members of Mr A's treating team, including Dr D and Mr A's care manager. Dr D advised that he was surprised to see Mr A in attendance, as he had been under the impression that the treating team had agreed that it was best for Mr A not to attend such meetings because of the stress it caused if he felt that his treatment approach was being changed.

111. From the information supplied by the DHB, the contemporaneous notes in the clinical letter, and the information provided by Mr A's whānau, it is clear that there was a disconnect between the views of the DHB treating team and Mr A and his whānau, and this culminated in Mr A leaving the hui prematurely.
112. Dr D told HDC that Mr A withdrew to the reception area and waited for the meeting to end, and it was his view that Mr A was no longer in distress by the end of the hui. However, this was not documented by any of the attendees at the hui. Dr D told HDC that a multidisciplinary team (MDT) discussion was planned for the following day. He stated: "We had no cause to make an urgent follow-up plan and I cannot imagine what service or plan that would be in the circumstances, given [Mr A] was back to his baseline."
113. Dr Patton advised:
- "It is not clear from the clinical records or from the correspondence from the DHB whether there was consideration of any additional support being made available to [Mr A] in the immediate aftermath of that meeting, or whether there was any discussion with [Mr A's] parents about any additional steps that might be needed to assist him with his distress associated with the meeting."
114. The evidence does not suggest that Mr A's care team offered Mr A further support at that stage, or discussed with his family how to assist him following the hui. First, the clinical records contain no discussion of any further support, and secondly, Dr D indicated that considering that Mr A had returned to his baseline (by which he meant that Mr A was no longer distressed), according to Mr A's treating team, no further support was warranted. I am concerned that despite being aware of Mr A's response to such situations, having experienced a similar incident during the previous hui (and as evidenced by Dr D's surprise that in light of past events Mr A had attended the hui), no plan was formulated by the DHB to mitigate the risks associated with Mr A becoming distressed.
115. Dr Patton advised:
- "In my view these matters should have been canvassed. [Mr A's] reaction was predictable. There was evidence of him having been at increased risk of self-harm when his fears of being left unsupported had been prominent. This further discussion seems highly likely to have challenged his views about himself and was likely to leave him feeling his support system was being dissolved. In my view, this lack of consideration of the need for added support was a significant failure and is one that would be regarded with moderate disapproval by peers."
116. I accept Dr Patton's advice, and agree that given Mr A's known history of distress following such meetings, and that the hui was called because of concerns about his level of distress at perceptions of not being supported, consideration should have been given to offering further support to Mr A and engaging with his whānau, who by this point were clearly struggling with Mr A's situation.

117. I am further concerned that there is no evidence that Mr A and his whānau were presented with a clear actionable plan for Mr A as part of the hui, including information about what community support would be available to him and his whānau moving forward. It was also clear from the CMHT and the contact centre documentation that Mr A had significant concerns about what would happen to him in the future when his parents died, but this does not appear to have been addressed or considered in the whānau hui. In my view, this is a significant shortcoming, particularly given Mr A's known history of distress when he felt his support was being withdrawn.
118. I acknowledge that as the senior clinician responsible for Mr A's care at this time, Dr D had a responsibility for ensuring that adequate support was offered by him to Mr A and his whānau, and I discuss this further below. However, I note that several other members of Mr A's treating team, including his care manager, were present at the hui. I also acknowledge that at the time of these events, Dr D was a locum psychiatrist at the DHB, and he had only recently taken over the care of Mr A from Dr B, during which there was no official handover from Dr B. As discussed above, the provision of community mental health support in a DHB setting relies on robust communication and collaboration between staff. Accordingly, I consider that the DHB was, in part, responsible for the failure to ensure that adequate support was provided to Mr A following the hui on 30 Month10.

### Conclusion

119. In my view, there were significant areas in which the DHB failed to provide services of an appropriate standard to Mr A. I note Dr Patton's comments:
- "[A]n individual[s] record is the product of the practice of the author of that record, and the author has the responsibility, to some extent, for its quality ... However, individual practitioners operate, at least in an environment like [the DHB], within the context of relationships with teams and colleagues, and of people in roles that might offer an opportunity for oversight/overview of decisions and of practice."
120. Dr Patton's comments highlight the collaborative approach to the provision of community mental health care. I also note Dr Patton's comments about the importance of documentation of symptoms and mental state examinations for use in any future comparison of a patient's presentation, particularly by other providers. Although individual practitioners are responsible for the standard of care they provide, I consider that the documentation failings by multiple staff within the contact centre and CMHT represent a systemic failure for which the DHB must take responsibility. In particular, I am concerned that the contact centre and CMHT failed to keep adequate and fulsome records of Mr A's contact with the services. I mirror Dr Patton's comments that robust documentation plays a pivotal role in ensuring cooperation among providers and, in turn, continuity of care for patients in a community mental health service setting.
121. I am also concerned that multiple DHB staff present at the whānau hui failed to plan appropriately to provide adequate support to Mr A following the meeting. Given that multiple staff present were aware of Mr A's previous reactions to such situations, I consider that there was a collective failure to plan appropriately for Mr A's predictable distress

following the meeting. Although I acknowledge that Dr D was the senior treating clinician present at the hui, it must be noted that he was a locum psychiatrist and did not receive a handover of Mr A's care from Dr B. In my view, this indicates a failing of the DHB to ensure cooperation and coordination of care among treating clinicians to plan Mr A's care appropriately.

122. Right 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to cooperation among providers to ensure quality and continuity of services. The DHB held ultimate responsibility for ensuring cooperation among staff to provide appropriate care and support to patients. In my view, the inadequate documentation kept by the contact centre and CMHT contributed to a distinct lack of clarity and action amongst teams about the change in Mr A's care, treatment plans, and expectations, including the possibility of the re-emergence of symptoms, and this culminated in the collective failure by several clinicians at various points of crisis contact and at the hui to offer appropriate support to Mr A following his predictable distress. In addition, there was inadequate contact with Mr A's GP by Dr B (discussed below), which contributed to the failure by the DHB to coordinate Mr A's care appropriately.
123. Accordingly, I find that the DHB breached Right 4(5) of the Code.

#### **Communication with Mr A and his whānau — adverse comment**

124. It is clear that Mr A was supported by his whānau, including his parents and his family friend Ms F. I discuss below the decision made by Dr B not to advise Mr A and his whānau that his view of Mr A's diagnosis had changed to a personality disorder, and the direction of Mr A's treatment plan. Guided by Dr Patton's advice, I have accepted that the decision to withhold this information from Mr A and his whānau was, at that time, appropriate and well reasoned.
125. However, Dr Patton advised that in the face of escalating concerns from the whānau, resulting in several complaints to the DHB, and with the increasing number of contacts made by Mr A to the contact centre and CMHT in the second half of 2019, it was necessary for this decision to be revisited. Mr A's care transferred from Dr B to locum psychiatrist Dr D in Month7, and by that time it was clear that Mr A's whānau were struggling with Mr A's deteriorating health and were of the belief that the DHB was withdrawing care.
126. Dr Patton advised that Mr A's whānau could have benefited from more frequent contact by the DHB, and a recognition and acknowledgement of the emotional impact on them. Dr Patton advised:

“[Mr A] had parents who were clearly concerned about him and with whom it appears he had a close relationship and from whom he got a significant degree of support. The records available to me for 2019 do not demonstrate a substantial degree of proactive contact with these family members by the clinical team, although there does seem to have been good responsiveness to concerns expressed by [Mr A's] parents.”

127. Dr Patton considered that the care provided by the DHB could have been improved with regard to the more active involvement of Mr A's whānau, including Ms F as a medical

professional, in the diagnostic formulation and consequent approach to care. This was particularly so given that Mr A's family could have been unknowingly reinforcing Mr A's dependency on the mental health service.

128. Dr D did begin to attempt this in late 2019. However, Dr Patton advised that "the consequences of this taking place so late in the course of [Mr A's] contact with services appears likely to have triggered the increased distress that [Dr B] forecast some years earlier".
129. I accept Dr Patton's advice. I also acknowledge the unique situation of the clinicians when considering whether or not to communicate the change in diagnosis and management with Mr A and his whānau. I also acknowledge that throughout the period of Mr A's increased contact with the contact centre and CMHT, Mr A's care was transitioning from Dr B to Dr D.
130. In any event, I consider that in the second half of 2019, the DHB should have communicated more clearly with Mr A and his whānau about the change in diagnosis and, given the transfer of care from Mr A's long-standing treating clinician (Dr B) to locum psychiatrist Dr D, I consider that some responsibility for this breakdown in cooperation sits with the DHB. I encourage the DHB to reflect on my comments and those of my independent advisor, and ensure that adequate systems are in place to allow clinicians to foster relationships with patients and whānau that encourage open, honest and effective communication.

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## Opinion: Dr B — breach

### Introduction

131. Mr A was under the care of psychiatrist Dr B from 2011 until 24 Month7, when his care was transferred to locum psychiatrist Dr D following the end of the therapeutic relationship between Dr B and Mr A. Although there is documentation to suggest that Dr D provided a second opinion as far back as 29 Month5, Dr B was the senior clinician in charge of Mr A's care until 24 Month7. It is of note that when Mr A's care was transferred from Dr B to Dr D, there was no official handover of care.

### Communication with Mr A's GP

132. Mr A had a well-established positive relationship with his GP, Dr E, and saw Dr E relatively frequently in a primary care setting.
133. I have concerns about the infrequent contact between Dr B and Dr E throughout the first half of 2019, whilst Mr A was under Dr B's care. My independent advisor, psychiatrist Dr Murray Patton, advised that it would have been appropriate for Dr B to update Dr E after each contact with Mr A, even if it was to advise that there had been no significant change to the treatment approach.

134. The DHB told HDC that Dr B wrote to Dr E annually. Conversely, Dr B told HDC that he wrote approximately two letters per year to update Dr E, and that he would do this directly, or accompanied by copies of other relevant communication. Dr B said that it was his usual practice with patients who were “long standing service users” to provide periodic updates to the primary care provider to advise of any changes in presentation, formulation or treatment. He said that he was happy to communicate with Dr E at any time, and was always happy for Dr E to telephone him with any concerns.
135. Dr B considered that more frequent letters advising that there had been no change to Mr A’s care would not have enhanced Dr E’s care of Mr A. Dr B is of the view that the important changes were “well documented and conveyed”. I acknowledge Dr B’s comments in this regard and am inclined to agree that in a patient with a long history of engagement with community mental health services, it may not always be possible or necessary to contact primary care providers following every contact with a service user, particularly if there has been no change to the care being provided. However, it is critical that important information, including any change in diagnosis or medication, is communicated between the treating psychiatrist and the primary healthcare provider. I acknowledge Dr B’s comments that he considers that the important changes were “well documented and conveyed” to Dr E. However, I disagree.
136. On 4 Month8, Dr E recorded that he had not heard from the DHB since 2018, and that correspondence had been “poor”. I note that neither the DHB nor Dr B provided HDC with copies of any letters sent to Dr E by Dr B, nor were they contained in the records provided to HDC by the medical centre and Dr E.
137. On 18 Month3 a significant change in Mr A’s medication took place when his paliperidone injection was decreased from 150mg to 100mg. However, this was not communicated to Dr E by Dr B.
138. The DHB’s guidelines on medication monitoring are contained in its “Community Mental Health Medication” policy. The policy states that “consumers receiving medication are observed for its effects, expected benefits, side effects, and are advised of any precautions required and potential interactions of any other medication”.
139. Dr Patton advised that there was a possibility that a reduction in the dose of Mr A’s medication might risk a re-emergence of symptoms that had been treated effectively by the higher dose, and it is not clear that the recommendations as outlined in the “Community Mental Health Medication” policy were followed by the clinical team systematically. Dr Patton noted that Mr A did appear to be in contact with his GP regarding aspects of his general health care relevant to the possible complications of antipsychotic medication, but there does not appear to have been communication between the CMHT (including Dr B as Mr A’s treating clinician) and Dr E about these issues.
140. I accept Dr Patton’s advice in this regard. It is clear that Mr A’s clinical team, and Dr B in particular, as a senior treating clinician, did not adhere to the guidelines set by the DHB. I am also concerned that there was no communication with Mr A’s primary health clinician, Dr E, regarding the monitoring of any potential effects or side effects following the reduction



of Mr A's dose of paliperidone, and also in light of Dr E's additional prescription of medication.

141. I also have residual concerns about the sharing of Mr A's change in diagnosis as concluded by Dr B. It is clear that once the diagnosis of dependent personality had been reached, the approach to Mr A's care also changed. Dr B and the DHB have explained the rationale for the change in diagnosis. Guided by Dr Patton's comments, I accept that this was reasonable. However, this meant that changes were being made to how Mr A was managed by Dr B and his treating team, and particular importance was placed on moving Mr A towards independence with less reliance on medication and constant contact with the service.
142. With the above in mind, I am concerned that this information was not communicated clearly to Dr E by Dr B. Dr Patton advised that it would have been good practice for the formulation reached by Dr B to be shared with Dr E so that the clinicians within both the DHB and the general practice setting were "operating as much as possible with a shared understanding of the approach to be taken to responding to [Mr A]". Dr Patton advised:

"I believe that this very limited communication with the GP falls short of commonly accepted standards [including] the Medical Council of New Zealand 'Good Medical Practice' 2016, '... work with colleagues in ways that best serve patients' interests') and would be viewed with a moderate level of disapproval by peers."

143. I accept Dr Patton's advice and am concerned about Dr B's lack of engagement with Dr E in 2019, particularly regarding Dr B's clear change in management of Mr A and his reduction of antipsychotic medication. I consider that Dr B's lack of engagement amounted to a failure to co-operate with Dr E to ensure the quality and continuity of care to Mr A. Accordingly, I find that Dr B breached Right 4(5) of the Code.

#### **Communication with Mr A's whānau — no breach**

144. Throughout 2019 Mr A's whānau remained concerned about whether the DHB was treating him for a chronic serious psychotic illness, or a disorder of his mood. From the information available to me, it is clear that Mr A had a strong support system, and that both his parents and his friend, Ms F, were heavily involved in his care, and would advocate on his behalf frequently.
145. Dr B told HDC that he began to doubt Mr A's longstanding diagnosis of a psychotic illness, as far back as 2012. By Month2, Dr B was of the view that Mr A was suffering from a personality disorder, but was cautious about sharing this information with Mr A or his whānau as he believed that it would do more harm than good. Dr B told HDC that he discussed this decision anonymously in the CMHT multidisciplinary meetings. Dr B also advised that some of Mr A's prominent concerns were intimate in nature, and that also impeded his willingness to disclose such information to Mr A's parents, as Mr A had specifically asked him not to do so.
146. The DHB told HDC that instead, Dr B decided to allow his formulation to guide the support offered to Mr A. The DHB stated:

“In particular, the formulation provided a compelling rationale for resisting adjustments to medication in response to [Mr A’s] episodic distress, and for protecting [Mr A] from potentially harmful adverse effects of medication.”

147. Dr Patton advised that overall he accepted Dr B’s rationale for the changing diagnosis and for not discussing this with Mr A and his whānau in early 2019. Dr Patton stated:

“Whilst typically there would be an expectation, indeed even an obligation on doctors to discuss their assessment conclusions and the rationale for treatment with patients and their families, in the circumstances the decision reached seems to have been reasonable as there appears to have been some concern that harm might be caused by doing so. There does seem to have been some weighing up of risks and benefits.”

148. I accept Dr Patton’s advice in this regard, and I acknowledge Dr B’s explanation for why this information, particularly the more intimate aspects of Mr A’s struggles, were not shared with Mr A’s parents proactively in early 2019. Accordingly, I am not critical of this aspect of Dr B’s care.
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## **Opinion: Dr D — adverse comment**

### **Support following whānau hui**

149. Dr D was a locum psychiatrist at the DHB when he took over the care of Mr A from Dr B on approximately 11 Month8. Dr D was the treating clinician present for the whānau hui that took place on 30 Month10, which ultimately culminated in Mr A becoming distressed and leaving the meeting prematurely.
150. My independent advisor, psychiatrist Dr Murray Patton, advised that there was a lack of precautions taken by the DHB during the hui, and that there appears to have been a lack of consideration for how Mr A would react in the meeting, considering his known history of self-harm when he feared that he was being left unsupported.
151. Dr D told HDC that although Mr A left the meeting room, he did not leave the building, and he was seen by his care manager and another member of the clinical team in the corridors of the building following the meeting. Dr D said that he was assured that Mr A was no longer distressed. However, this was not documented by Dr D.
152. Dr Patton advised that the lack of support offered to Mr A and his whānau during the hui would constitute a moderate departure from accepted practice, and I have accepted this advice (discussed above). However, in the case of Dr D, I note the following mitigating factors: Dr D was a locum psychiatrist at the time of these events and has reinforced that he was not Mr A’s sole treating clinician; Dr D did not receive an official handover from Dr B, who had been treating Mr A for the past eight years; and Dr D was supported in the hui by other clinical staff from the CMHT, who also failed to offer support and safety-netting to Mr A and his whānau, or adequately plan for the likely event that Mr A would leave the meeting

in distress. In my view, the failures identified by my independent advisor represent systemic issues within the service, and it would be unduly harsh to single out Dr D as responsible for the lack of support offered to Mr A and his whānau following the hui.

153. However, it is apparent that Mr A was of the view that Dr D was his treating clinician at that time, and the DHB also appears to have been of the view that Dr D had taken over the care of Mr A in Dr B's absence. Accordingly, I consider that Dr D, as the most senior clinician present at the hui, could have taken adequate steps to ensure that support was provided to Mr A, and to document any observations (of distress, or resolved distress) and any steps taken to mitigate that distress. I encourage Dr D to reflect on my comments and those of my advisor.

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## Changes made

### DHB

154. The DHB referred to the SER recommendations and confirmed that the MHAIDS Improvements Committee was overseeing the implementation of two recommendations from the review:
1. A review of the Whānau/Family Participation policy to ensure that care, transition planning and exit processes incorporate practices that support collaborative planning and outcomes. The review was to be completed within six months of the date of the SER.
  2. A review of transitions from care (in particular, exit from specialist mental health support) at the next team planning day, with a focus on how to maintain good communication, collaboration and management of client and whānau anxieties that may occur during care transitions. The outcomes of the review were to be presented to the Adult Community Clinical Governance meeting for wider consideration, within six months of the date of the SER.
155. The DHB told HDC that it had made internal recommendations that a reminder be sent to all contact centre staff, via email and verbal communication at the contact centre's monthly business meeting, that clinical documentation needs to reflect the content of a telephone call with a patient.
156. The DHB stated that it was finalising an audit of calls to the contact centre. The DHB noted that one possible outcome of the audit was a recommendation that all staff must document the mental state and assessment of risk at the time of a call with a patient. The DHB said that this recommendation would be communicated, and the final audit report would be presented to the wider MHAIDS Clinical Governance Committee in early 2022.
157. The DHB also noted that following the events it took steps to upskill its Crisis Team clinicians to address documentation needs, including in-service training workshops focusing on risk

assessment and mental state examinations. The DHB assured HDC that all staff have attended these workshops, and new clinicians are expected to attend this training.

**Dr D**

158. Dr D told HDC that he made the following changes as a result of these events:
- a) He established a formalised pathway for when he is asked for a second opinion from a colleague, in that he asks for a formal written request.
  - b) He gives sufficient notice to a patient under review that the patient may bring a support person to meetings.
  - c) His reports written as a result of meetings are no longer dictated in front of the patient, but are written only to the requestor.
  - d) He explains the process of dictation and will no longer dictate if there is any substantial change to treatment that may distress a patient, or if the patient has responded negatively to this in the past.
  - e) He establishes roles/responsibilities/duty of care with any new employer.
  - f) He ensures that he understands the policies of his employer more clearly.
- 

## **Recommendations**

### **Te Whatu Ora Capital Coast and Hutt Valley**

159. I recommend that Te Whatu Ora Capital, Coast and Hutt Valley:
- a) Provide a written apology to Mr A's whānau for the failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's whānau.
  - b) Provide evidence that the below has occurred, within three months of the date of this report:
    - i. Update its internal policies to include a requirement for CMHT psychiatrists to provide regular written updates to other treating clinicians (in particular, primary care providers) within an appropriate time frame.
    - ii. Provide feedback on the implementation of the recommendations made in its SER.
    - iii. Circulate a copy of the anonymised version of this report across all of the MHAIDS psychiatrists and relevant staff, for continuing education.

**Dr B**

160. I recommend that Dr B:
- a) Provide a written apology to Mr A's whānau for the failings identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's whānau.
  - b) Provide a written reflection about his care of Mr A and any learnings that have occurred as a result of these events. This is to be provided to HDC within three months of the date of this report.
  - c) In my provisional opinion it was recommended that Dr B update HDC with evidence of steps taken to ensure that relevant communications and information are supplied to his patients' primary care providers in a consistent and timely manner. However, it is noted that Dr B has since retired from practice and, accordingly, this recommendation is no longer required.
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**Follow-up actions**

161. A copy of this report will be sent to the Coroner.
162. A copy of this report with details identifying the parties removed, except Te Whatu Ora Capital, Coast and Hutt Valley and the advisor on this case, will be sent to the Director of Mental Health and Addiction Services, 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](http://www.hdc.org.nz), for educational purposes.
163. A copy of this report with details identifying the parties removed, except Te Whatu Ora Capital, Coast and Hutt Valley and the advisor on this case, will be sent to the Medical Council of New Zealand, and it will be advised of the names of Dr D and Dr B.

## Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Murray Patton dated 9 August 2021:

“Dear Ms Thompson

**Complaint: [Mr A] (deceased)/[DHB]**  
**Your ref: C19HDCO2030**

You wrote on 20 October asking for my opinion in respect of several matters related to the care of [Mr A]. In March 2021 you asked me to quantify the severity of the criticisms I made in my report dated 17 November. Those clarifications have been added to this updated report.

Subsequently in July you asked for me to clarify some further elements in respect of these criticisms. I have added some further commentary in respect of these additional questions.

You provided with your original letter a bundle of documents to assist me in providing an opinion, being:

Letter of complaint dated 23 [Month11]

[The DHB’s] response dated 30 July 2021

Clinical records from [the DHB]

Clinical records from [the medical centre]

Clinical records from [DHB2].

On 27 October 2021 I sought some additional information, being any information in respect of a serious adverse event investigation carried out by [the DHB]. That report was made available to me in July 2021, along with a request to clarify whether that changed my view in any way.

I am a psychiatrist holding vocational registration with the New Zealand Medical Council. I have held clinical and leadership roles in public sector mental health and addiction services in New Zealand and Australia. These roles have included clinical responsibilities in acute adult psychiatry inpatient services and community mental health services.

I have worked previously for [the DHB]. I was the Clinical Director for the service between May 2004 and June 2008. Subsequently I also held locum leadership and clinical roles in the service, in 2019, between March and May then again briefly in a clinical role in June/July. I have also assisted with providing expert opinion on some matters in a private consulting capacity.

I have no current employment or other contractual relationship with [the DHB].

I do not believe that these roles create any conflict of interest. I had no direct or (as far as I am aware) indirect roles in the care of [Mr A] nor did I have a direct supervisory or close collegial relationship or other personal relationship with any of the staff identified in the care of [Mr A].

I am familiar with and agree to adhere to the HDC Guidelines for Independent Advisors.

### **1. The assessment of [Mr A's] condition from 2019 onwards.**

[The DHB's] letter of 30 July 2020 to [HDC] notes the second opinion provided by [Dr D] in [Month8] and identifies that this reached a conclusion congruent with that reached by [Dr B] as long before as 2014.

The date of this second opinion is a little hard to pin down. A file note by [Dr B] on 29 [Month5] records '*received a second opinion from [Dr D] ...*'. There is no file note from [Dr D] at that time nor does there appear to be any communication with the GP.

There is however a file note '*written on behalf of [Dr D]*' on 12 [Month8], apparently reflecting an appointment on 11 [Month8]. That note, recorded as a letter to the GP, identifies that [Dr D] had met [Mr A] briefly previously, a few months before.

This letter does not outline details of prior symptoms but does appear to indicate some exploration of these ('... *his explanation of psychotic symptoms did not entice me to that diagnosis ...*') and does describe in some detail the way [Mr A] presented. It shows consideration of whether features that might ordinarily be evident in someone with a long history of psychosis were present in [Mr A].

Although appropriately noting the limitations of conclusions drawn from a single assessment, [Dr D] concluded that [Mr A's] presentation was more in line with a personality disorder than schizophrenia or bipolar affective disorder.

The nature of any further contact by [Dr D] is a little unclear. The material provided by [the DHB] in the letter of 30 [Month8] appears to indicate that there was to be an appointment on 21 [Month9]. A clinical file entry on 22 [Month9] appears to reflect that an appointment did take place. The clinical file entry of 2 [Month10] reflects that [Dr D] saw [Mr A] that day also. I do not appear to have been provided records of those contacts. There do not appear to be corresponding entries in the electronic clinical record. There is however a further record of contact in the context of a family meeting on 30 [Month10].

Through 2019 assessments took place by various other staff. His key worker was often in contact with [Mr A] as well as having some contact with his family, often when family rang with concerns. There appears to have been reasonable responsiveness to these concerns as well as to the anxieties expressed by [Mr A]. Overall though there is not a pattern of repeated detailed exploration of phenomena.

There is reasonable attention to [Mr A's] mental state, and this is accompanied by appropriate guidance about managing the concerns.

Crisis team staff assessed [Mr A] in [Month8]. The record of that contact in the early hours of the morning on 14 [Month8] is brief and there is no evidence of exploration of symptoms. Self-harm ideas had been expressed in a telephone contact with another staff member in the afternoon of the 13th [Month8] and the record shows there was some exploration (without much detail) of these again, but with no further thoughts of self-harm being expressed.

There is no mental state examination recorded and no conclusions drawn about the presentation.

[Mr A] was again seen by [the] crisis staff on 12 [Month10]. This record does not identify exploration of psychiatric symptoms in any detail nor does it record a full mental state examination.

Although it is possibly reasonable to base further actions on a conclusion drawn by an experienced colleague, it is typically helpful for at least some outline to be provided of the information that was considered in reaching that conclusion, to not just enable an assessment to be made by a practitioner involved in future care whether the conclusion was sound, but also to enable a comparison of the future presentation (symptoms and mental state) with what had been seen previously.

Such a lack of detail would generally be regarded as below a reasonable standard and viewed with at least a moderate level of disapproval by peers.

In your letter of July 2021 you ask if this departure from standards is in relation to or whether this is a system error, or perhaps attributable to individual and system factors. This is not possible to answer with certainty on the information available to me. I expand further on that in my closing remarks at the end of this report.

In contrast to the records from the [DHB's] crisis service, the records of the contact with crisis staff in [DHB2] on 17 [Month8] are well structured and reasonably comprehensive. There is evidence of exploration of psychiatric symptoms relevant to the crisis presentation as well as t[he] documentation of a mental state examination. Conclusions are drawn with a good formulation of the presentation outlined.

Overall, although the records from the MHAIDS crisis staff are generally lacking in detail, there does seem to have been reasonable attention in the [CMHT] team to [Mr A's] presentation with attention to his symptoms, his mental state and his functional capabilities. The conclusion drawn by [Dr D] in his assessment in [Month8] seems reasonable. I shall address that further below.

## **2. The appropriateness of care provided and whether further review was warranted (including the coordination of [Mr A's] care).**

The overall approach to [Mr A] is set out in the letter of 30 July 2020 from [the DHB], as well as in the letter of [Dr D] to the GP in [Month8].



There appears to have been reasonable consideration given to the diagnosis by [Dr B], with a second opinion sought from [a psychiatrist] and then subsequently obtained from [Dr D] who largely confirmed the view held by [Dr B].

I accept that there is concern amongst [Mr A's] carers about whether he was optimally treated for a chronic serious psychotic illness or disorder of his mood.

I do not feel there is compelling evidence of a sustained disorder of mood requiring antidepressant or other mood stabilising medication. The pattern of mood disturbance demonstrated appears to have been one of reactions to life events, possibly exacerbated by a growing concern regarding his future should his parents' health fail or he lost other supportive relationships.

Whether or not he had a chronic psychotic illness or mood disorder however, attention to psychosocial responses was appropriate. Efforts to encourage his own coping strategies were an important part of building resilience and self-confidence, aimed at minimising further crisis episodes.

Consideration could arguably have been given to whether additional health-based services oriented toward community engagement may have been necessary. A community support worker might commonly be considered in such a situation however [Mr A] appears already to have had good community connections and a range of activities with which he was very capable of engaging. A further health-based resource may potentially have reinforced a lack of self-efficacy, thus countering the treatment direction being taken by the clinical team.

I note the rationale set out in [the DHB's] letter of 30 July 2020 for [Dr B] not discussing his understanding of [Mr A's] difficulties with [Mr A] or his family. Whilst typically there would be an expectation, indeed even an obligation on doctors to discuss their assessment conclusions and the rationale for treatment with patients and with families, in the circumstances the decision reached seems to have been reasonable as there appears to have been some concern that harm might be caused by doing so. There does seem to have been some weighing of the risks and benefits.

I wonder however whether more consideration could have been given to sharing the formulation with [Ms F], much earlier than when this finally appears to have happened (as far as I can tell in the notes available to me) on 11 [Month8]. She appears to have been closely involved as a support and advocate for [Mr A] and could potentially have been a support for the clinical team in reinforcing messages encouraging [Mr A's] self-reliance and non-pharmacological interventions. I accept however that her role was not that of a treating medical practitioner for [Mr A] or his family and was therefore not subject to the usual information sharing expectations between health care providers, so caution would have been needed in approaching any discussion of that nature.

However, it is not clear that this formulation was shared with [Mr A's] usual GP in a manner that enabled the GP to adopt a similar approach to the mental health team,

rather than the GP adding in medication that may not have been indicated, or at least not doing so until after consultation with the community mental health team.

[Dr B's] communication with the GP seems to have been infrequent. In my view it would have been appropriate to update the GP after each contact with [Mr A], even if just to note that there was no significant change to the treatment approach. Although I find the GP records provided a little difficult to follow, it is not clear that even a significant change in medication, the reduction in paliperidone dose in early 2019, was communicated to the GP.

Additionally, although I appreciate I have only a limited portion of the records, it would have been good practice for the formulation reached by [Dr B] to be shared with the GP so that each set of clinicians, within [the DHB] and General Practice setting, were operating as much as possible with a shared understanding of the approach to be taken to responding to [Mr A].

I believe that this very limited communication with the GP falls short of commonly accepted standards (Health and Disability Code of Rights — especially Right 4(5); General Medical Council (UK) 'Good Medical Practice' 2013, paragraph 44 — 'Must share all relevant information with colleagues involved in patient's care'; Medical Council of New Zealand 'Good Medical Practice' 2016, '... work with colleagues in ways that best serve patients' interests') and would be viewed with a moderate level of disapproval by peers.

[The DHB's] policy 'Community Mental Health Medication' ([2016]) sets out expectations for monitoring for side effects of medication in people on antipsychotic medication.

From the records available to me it is not clear that these recommendations were systematically followed by the clinical team. I note however there was attention intermittently to his observations about weight and exercise as well as some attention to diet and to foodstuffs available to him. It is also clear that [Mr A] was in contact with his own GP regarding aspects of his general health care relevant to the possible complications of antipsychotic medication, although there does not appear to have been communication between the mental health care team and the GP in either direction about these issues.

[Mr A] had parents who were clearly concerned about him and with whom it appears he had a close relationship and from whom he got a significant degree of support. The records available to me for 2019 do not demonstrate a substantial degree of proactive contact with these family members by the clinical team, although there does seem to have been good responsiveness to concerns expressed by [Mr A's] parents. When the clinical team was contacted, typically there would be review of [Mr A] to review his situation and the need for a change in the treatment approach.

The only further area (other than improved communication with the GP) in which care could have been improved would have been the more active involvement of carers

(including [Ms F]) in the diagnostic formulation and the consequent approach to care. It does appear that [Dr D] was beginning to attempt this, carefully, but tragically the consequences of this taking place so late in the course of [Mr A's] contact with services appears likely to have triggered the increased distress that [Dr B] forecast some years earlier.

### **3. The appropriateness of the safety netting advice and follow-up instructions provided.**

[Mr A] presented in crisis or otherwise contacted [the contact centre] a number of times through 2019.

He called reporting chronic loneliness on [2 Month2]. Symptoms and other phenomena are not explored in detail. Staff provided some advice regarding simple strategies to 'ground' him to prevent fears escalating.

His mother made contact concerned regarding his panic attacks on [18 Month2]. Advice was given to his mother, including for [Mr A] to attend ED if in crisis.

On 13 [Month3] [Mr A] rang worried about his medication and wanting to discuss reduction in dose with the psychiatrist. An appointment was agreed, and medication dose reduced.

On 7 [Month4] [Mr A] contacted [the contact centre] again. He was worried about his thinking. He had plans for future activity and it appears he was assisted in finding ways to calm himself.

On 13 [Month6] [Mr A] reported feeling suicidal to a visitor, who phoned the service. His key worker visited, and [Mr A] recounted general difficulties although was not suicidal. He appears to have been assisted in re-orienting his thoughts to an assessment of his progress, with some apparent relief of his level of distress. He later that same day phoned [the contact centre] again with similar concerns and he was transferred to a telephone counselling service.

A similar interaction took place with [the contact centre] on 25 [Month6] and he was again transferred to the phone counselling service.

Less than a week later, on 30 [Month6], [Mr A] phoned the community mental health service multiple times. His key worker visited, and some guidance was provided on his patterns of thought leading to increased distress, with some support provided to reframe his responses to other people to assist with reducing the adverse emotional impact of these interactions.

On 3 [Month7] [Mr A] rang [the contact centre] reporting feeling scared. He was encouraged to focus on simple tasks that he could manage. He was followed up by his key worker the following day.

A phone conversation took place with his key worker again the following day following a series of phone messages of concern about him. He was assisted in analysing his pattern of behaviour and the negative consequences of those patterns and some alternative approaches were discussed. This was followed by further conversation with the psychiatrist and his key worker in the following days.

[Mr A] rang [the contact centre] again on 8 [Month7]. Similar concerns to those previously raised were discussed. Distraction techniques were explored but [Mr A] felt they would be unhelpful and requested that his key worker be informed of the contact. The key worker made contact again 2 days later.

He rang [the contact centre] again on 13 [Month7], worrying about worrying. The note suggests he responded to distraction techniques.

On 29 [Month7] the ambulance service contacted [the contact centre]. There had been some contact with police and there was distress about a trespass order being served. Some possible approaches to reduce his agitation and distress were discussed although [Mr A] was not keen on the suggested direction. He subsequently rang the national helpline and was put through again to [the contact centre]. In conversation with staff there it appeared that his level of distress had reduced somewhat after some help reducing his rate of breathing and he resolved to take some sleeping medication and go to bed.

On 13 [Month8] [Mr A] appears to have made contact with [the contact centre]. An ambulance was arranged, and he attended ED where he was assessed by crisis staff. When seen, [Mr A] voiced various concerns about his community team. He was focussed on attending church that day. He wanted staff to contact [Ms F] to tell of his presentation, but this request was declined. No specific intervention was offered, nor was one clearly indicated.

Two days later his mother contacted the community mental health team after a long conversation with [Mr A] in which he had indicated he wished to kill himself. She spoke of her son previously being administered a sedating medication in similar circumstances, although it is not clear when this had been. She was encouraged to ask her son to attend the centre, but he appears not to have done so.

She contacted the key worker again on 18 [Month8] following a conversation with her son in which he had expressed multiple concerns. She felt his medication should be changed. She expressed disagreement with the conclusions of the recent second opinion. The key worker said he would contact [Mr A] and visited but did not find him at home or at a place he commonly visited. He followed this up the following day.

On 20 [Month9] [Mr A] contacted his key worker again, expressing concerns including what he might do when his mother died. Apparently frustrated that the key worker was not responding in the manner he was hoping, [Mr A] sought an appointment with a psychiatrist. The call was transferred to administration staff to arrange that appointment.

The information provided by [the DHB] setting out the list of contacts appears to identify that an appointment was arranged for 21 [Month9] but there does not seem to be a medical record matching that date in the records made available to me. [The DHB] summary information provided to the Commissioner however identifies the content of that discussion, including consideration of whether there was evidence of matters requiring the expertise of the mental health service and whether gradually commencing a transition to his care being managed 'outside of secondary mental health care' would be appropriate.

This conversation appears to have been understood by [Mr A] as indicating that a decision had been made to discharge him from secondary care, resulting in a conversation between the key worker and [Mr A's] parents on 22 [Month9]. The key worker reassured them that [Mr A] would continue to be seen as usual. [Mr A] was contacted with the same assurance.

On 27 [Month9] [Ms F] rang the community mental health team expressing concern reported by [Mr A's] parents that he was not being provided enough to support him. A meeting with family was sought and the same was to be set up.

On 1 [Month10] [Mr A] [harmed himself] and was seen in crisis in the Emergency Department. He had been worried who would look after him when his mother died and had other concerns regarding his status in life.

There was no clear exploration of psychiatric symptoms other than the material apparently conveyed by [Mr A], but the mental state findings as recorded (albeit in an unstructured manner) do not suggest the presence of acute relapse of a major psychiatric illness.

[Mr A] contacted his key worker late in the afternoon of 5 [Month10], concerned about his circumstances. Suggestions were made about strategies to distract him from his negative cognitions and a visit was planned, although the following day [Mr A] phoned and indicated he did not wish for that visit to take place.

On the night of 11 [Month10] there were several phone contacts about [Mr A] eventually resulting in him attending ED at the emergency department. He was seen by crisis staff. The notes are brief. No acute features of illness were identified, and he was to return home for follow-up by his usual clinical team.

On 17 [Month10] [Mr A's] mother made contact concerned that [Mr A] was in his car making threats to end his life. This resulted in an assessment by the [DHB2] team. That assessment did identify some features that could have been congruent with a disordered (depressed) mood although the conclusion was that there was no evidence of a major affective or psychotic disorder.

[Mr A] returned home and was followed up by his key worker a few days later.

A meeting with family and with [Ms F] took place at the end of the month. This meeting appears to have led to increased distress being experienced by [Mr A], prompting his mother to call the service. Staff from the community team attended [Mr A's] home and found that he had [harmed himself]. He was transported to hospital but did not recover from the effects of this [self-harm].

Overall there appears to have been good responsiveness to [Mr A's] multiple contacts outlining concerns of various sorts. Plans for follow-up were enacted reliably and advice offered on strategies to manage the difficulties he described.

The pattern of contact through 2019 appears to have been of [Mr A] becoming preoccupied with negative aspects of his psychosocial circumstances, with thought patterns that led to negative emotions and anxieties for which he (and his parents apparently) sought medical intervention. In reality, bio-medical intervention however was unlikely to help and in general the efforts made to help [Mr A] not rely upon a health service response and to help him develop strategies to manage his own anxieties and re-orient his thought processes were appropriate and most likely to make a difference to the pattern of repeated crisis or other help-seeking presentations.

However, greater confidence in an independent assessor that this was indeed the right approach would have been enabled by more detailed exploration, and documentation of this, of symptoms that might confirm (or otherwise) whether in addition to the aspects of his personality that were thought to be behind his ongoing help-seeking, another major disorder had developed.

It is not unknown for people with significant problems with living arising from their patterns of thought and interactions (their personality) to develop an acute mental illness. The possibility that this may have occurred should typically be considered when someone is presenting in crisis, particularly if there is a change in nature or frequency of the contact with a service.

It is also apparent that there were stresses for [Mr A] that were likely to have contributed to more troubling thoughts, particularly when facing the reality of ageing parents no longer being available to support him. It appears that this escalating series of concerns led to increased crisis presentations and intermittent suicidal ideas and that the efforts of the community team to encourage methods of coping were insufficient to curtail the mounting distress.

Nonetheless, consideration of the possibility of an emergent disorder of another type would have been good practice and there is no evidence (in the form of detailed exploration of symptoms and mental state phenomena) that this was carefully considered by the [CMH] team or crisis staff despite the increasing contact with the service.

The records such as they are however do not clearly suggest that such a development (that is, a further major psychiatric disorder developing) had occurred. The more

detailed assessment in [DHB2] does seem to have considered this possibility and found no such concern.

Overall, with one exception outlined below, there does seem to have been good responsiveness by the service to [Mr A's] repeated presentations. Guidance was provided to him regarding managing his concerns, with good attention to further follow-up of him typically over the following days. He was encouraged, appropriately in my view, to engage in his already well-developed activities to refocus his thoughts away from his repeated and unhelpful preoccupations with negative matters.

#### **4. Comments on the medications prescribed to [Mr A] and whether this was appropriate.**

Amongst the records provided to me are copies of two prescriptions issued by [the DHB]. One dated 15 [Month3] is for a three-month supply of paliperidone in a dose of 100mg to be administered by IM injection. The other is dated 1 [Month11] and is for quetiapine in a dose of 25–50mg as required for insomnia and anxiety. Although the document has copied poorly, it appears to be for a quantity of eight 25mg tablets.

A prescription and administration record in the files reflects regular dosing of paliperidone in a dose of 150mg over [a two-year period], at intervals of approximately each 4 to 5 weeks, some doses being given a little later than the record suggests was planned. The longest interval between doses appears to have been close to 6 weeks [in] 2018.

From [Month2] it appears the paliperidone dose was reduced to 100mg monthly and the administration record documents this being given generally at intervals of about one month, apparently from 22 [Month2] onward. This is a little difficult to reconcile with the prescription record, the only prescription in the file copied to me for 100mg paliperidone is dated 15 [Month3]. That [Month3] date also is congruent with the file entry of 13 [Month3] in which the key worker records a call from [Mr A] insistent that his medication be reduced.

There is no medical note outlining the rationale for the change in dose, but [the DHB] letter of 30 July 2020 notes that this change arose from [Mr A] requesting a reduced dose.

This was probably a reasonable decision. There appears to have been doubt about whether antipsychotic medication was required at all. It appears that [Mr A] had not demonstrated positive features of psychosis for some time (if at all). Stopping medication completely, as [Mr A] appears to have indicated he would if the dose was not reduced, could have had greater potential to cause a relapse of illness than a negotiated decrease.

Paliperidone is an effective antipsychotic medication. Its use in someone with a diagnosis of schizophrenia is appropriate. It is thought possibly to have particular benefit for people who are experiencing negative symptoms (such as withdrawal and

reduced drive, motivation and energy) associated with a psychotic illness. The 150mg dose prescribed to [Mr A] is at the upper end of the generally accepted range of dosing although there is variation in response and tolerability which will also guide dosing decisions. I have insufficient information in respect of prior treatment history to comment on the use of this upper range dose.

I note the question that emerged of whether [Mr A] actually had a psychotic illness at all and therefore whether antipsychotic medication was required.

It is difficult to comment with certainty on this matter with the limited information available to me. The absence of positive psychotic symptoms is not a clear indication of incorrect diagnosis of schizophrenia in someone with a long-established illness and in the presence of ongoing use of antipsychotic medication. The absence of symptoms such as hallucinations or delusions or thought disorder may simply be evidence of effective pharmacological treatment.

If that was the case for [Mr A], there was the possibility that a reduction in dose might risk re-emergence of symptoms that has been effectively treated with the prior dose. In such situations, ongoing close attention to evidence of returning symptoms is good practice.

It is evident in the records that [Mr A] did experience periods of increased anxiety and distress in the period after [Month2], on the lower dose of depot antipsychotic medication. This in itself however does not necessarily indicate that previously treated psychotic symptoms were returning. There seems to have been attention to evidence of emergent psychotic symptoms and none were clearly evident, and no justification was clear therefore for re-instating the prior dose regimen.

It might be that on the lower dose of medication [Mr A] was more emotionally reactive to events, had the prior dose been blunting his affective response in an abnormal manner (as may occur on excessive doses). If this was the situation, the response would not necessarily be to increase the dose again, but to assist [Mr A] to find non-pharmacological ways to address anxiety and distress arising from the range of psychosocial matters about which he was concerned.

It is also evident, at least as reported in [the DHB's] letter, that [Mr A] is reported to have had intermittent periods of anxiety over a number of years arising from concerns about his circumstances. It is not evident that these concerns were different in their nature or severity following the reduction in medication early in 2019, nor that they were concerns for which medication would likely to have been helpful.

It is evident, as outlined in [the DHB] letter of 30 [Month8] as well as in the clinical records available to me, that efforts were made to encourage [Mr A] to use non-medication approaches to manage anxiety.

There does not appear to have been a clear indication for the use of antidepressant medication. However, apparently in [Month7] Mirtazapine was prescribed by the GP



and this was thought to have led to some benefit. The GP records however do not detail exploration of features typical of depression and it is not clear to me whether the apparent benefit was due to a genuine and direct effect on biological features of depression or whether the improvement, which appears to have fluctuated in response to various stresses and life events, was a psychological response based in a belief that medication was the solution to his life's concerns.

There was some use of zopiclone and of quetiapine to assist with sleep disturbance and with anxiety symptoms. There seems to have been appropriate caution regarding these and efforts to reserve them for use as a last resort when other attempts to manage with non-medication approaches had been unsuccessful.

I have no particular concerns regarding medication use and do not believe it would be out of line with the practice of many other psychiatrists.

#### **5. Comments on [the DHB's] communication with [Mr A] and his family.**

I note the weighing up of what information would best be provided to the family, at least as outlined in [the DHB's] letter of 30 July 2020. I have commented on that decision already.

It does seem that in the face of escalating concerns from family in the second half of 2019 and the number of unplanned contacts made by [Mr A], it was necessary to revisit this decision. It was clear that his family were concerned and were potentially contributing to [Mr A's] belief that the health system had the solutions for his life that he was seeking. Although there was responsiveness to the family (and [Ms F's]) concerns when they made contact with the service, there is little evidence of proactive engagement with these support people as part of a treatment approach, nor is there evidence of recognition that they also could have benefitted from consideration of the emotional impact on them of the lifelong care of their adult son who had still not achieved complete independence.

This was attempted in late [Month10]. As noted above, sadly this appears to have triggered the reaction that had been predicted some years before. There does appear to be evidence that [Mr A] was upset by the discussion, as measured by him leaving the meeting before it ended.

It is not clear from the clinical records or from the correspondence from [the DHB] whether there was consideration of any additional support being made available to [Mr A] in the immediate aftermath of that meeting, or whether there was any discussion with his parents about any additional steps that might be needed to assist him with his distress associated with the meeting.

In my view these matters should have been canvassed. [Mr A's] reaction was predictable. There was evidence of him having been at increased risk of self-harm when his fears of being left unsupported had been prominent. This further discussion seems

highly likely to have challenged his views about himself and was likely to leave him feeling his support system was being dissolved.

In my view, this lack of consideration of the need for added support was a significant failure and is one that would be regarded with moderate disapproval by peers.

#### **6. Any other matters that warrant consideration.**

The further information provided by [the DHB] in the form of the SER report does not prompt me to change my opinion. Overall it appears [the DHB's] views and my own are broadly in accord with each other.

As noted earlier, in your letter in July 2021 you have asked me to consider whether, in respect of those areas where I note a departure from standards, the departure is attributable to an individual or to system factors, or to both. As also noted earlier, this is difficult to determine for the following reasons.

Firstly, there are in many circumstances no clear criteria against which practice can be assessed. Although documents such as those referred to in places in this report (EG the 'Good Medical Practice' publications, or the Code of Rights) set out good practice, these do not contain objective criteria for what constitutes a mild, moderate or severe deviation. My comments therefore are based not on such clear criteria and thresholds, but instead are based upon years of experience and discussions with colleagues, and familiarity with the practice of peers.

You have also asked whether the departures from standards can be attributed to individual or to systemic factors. That too is impossible to tease out fully. Clearly an individual record is the product of the practice of the author of that record, and the author has the responsibility, to some extent, for its quality. Similarly, an individual practitioner determining a particular course of action has some responsibility directly for the action taken. However, individual practitioners operate, at least in an environment like [the DHB], within the context of relationships with teams and colleagues, and of people in roles that might offer an opportunity for oversight/overview of decisions and of practice.

Realistically there are trade-offs that occur every day in systems like [the DHB]. Workloads will have an impact on time available to make fulsome records. Workloads will also have an impact on ability to follow through with someone about whom there might be reasonable cause to believe that additional support was required.

Training and orientation have important roles in shaping expectations of practice, as do service policies (for example, what is expected in respect of the nature of documentation, or the frequency of communication with other practitioners, or the involvement of carers).

Was the apparent absence of consideration of the possibility of other emergent disorders a failure of practice, or was it a failure of documentation? [The DHB] itself in its review appears to note the meeting of 30 [Month10] and the distress [Mr A]

experienced at that time as being significant, with no evidence of a plan to follow him up. But that DHB review adds nothing more to my understanding of why that was — whether a need was not recognised; or whether a need was recognised but not enacted (or documented). It is not possible to determine that in a file review alone.

Without also knowing whether these file entries were typical of entries made in respect of many other people and by other clinicians, it is not possible to determine whether what I observed is typical or not of other practice, and therefore possibly indicating something about the overall culture of record-keeping and representing a broader system issue. And without assessing or otherwise having knowledge of the mechanisms available to supervise and review practice and the documentation associated with it, it is not possible to determine whether the lack of attention to the quality of the records was a failure of the system to ensure a mechanism to periodically sample the records, or a failure of the operation of such a system should one exist. A ‘just culture’ orientation attends to both individual and organisational contributions to practice and a file review alone is insufficient basis to know where the balance of responsibility for perceived departures lies. Without further exploration of a range of factors, it would be improper for me to try to attribute responsibility more closely.

Yours sincerely

M D Patton”

The following advice was obtained from Dr Murray Patton dated 9 August 2021:

**“Complaint: [Mr A] (deceased)/[the DHB]**

**Your ref: C19HDC02030**

You wrote on 20 October asking for my opinion in respect of several matters related to the care of [Mr A]. In March 2021 you asked me to quantify the severity of the criticisms I made in my report dated 17 November. Those clarifications have been added to this updated report.

You provided a bundle of documents to assist me in providing an opinion, being:

Letter of complaint dated [2019]

[The DHB’s] response dated 30 July 2021

Clinical records from [the DHB]

Clinical records from [the medical centre]

Clinical records from [DHB2].

On 27 October I sought some additional information, being any information in respect of a serious adverse event investigation carried out by [the DHB].

At time of this report being completed that further information has not been provided.

I am a psychiatrist holding vocational registration with the New Zealand Medical Council. I have held clinical and leadership roles in public sector mental health and addiction services in New Zealand and Australia. These roles have included clinical responsibilities in acute adult psychiatry inpatient services and community mental health services.

I have worked previously for [the DHB]. I was the Clinical Director for the service between May 2004 and June 2008. Subsequently I also held locum leadership and clinical roles in the service, in 2019, between March and May then again briefly in a clinical role in June/July and have assisted with providing expert opinion on some matters in a private consulting capacity.

I have no current employment or other contractual relationship with [the DHB].

I do not believe that these roles create any conflict of interest. I had no direct or (as far as I am aware) indirect roles in the care of [Mr A] nor did I have a direct supervisory or close collegial relationship or other personal relationship with any of the staff identified in the care of [Mr A].

I am familiar with and agree to adhere to the HDC Guidelines for Independent Advisors.

### **1. The assessment of [Mr A's] condition from 2019 onwards.**

[The DHB's] letter of 30 July 2020 to [HDC] notes the second opinion provided by [Dr D] in [Month8] and identifies that this reached a conclusion congruent with that reached by [Dr B] as long before as 2014.

The date of this second opinion is a little hard to pin down. A file note by [Dr B] on 29 [Month5] records '*received a second opinion from [Dr D] ...*'. There is no file note from [Dr D] at that time nor does there appear to be any communication with the GP.

There is however a file note '*written on behalf of [Dr D]*' on 12 [Month8], apparently reflecting an appointment on 11 [Month8]. That note, recorded as a letter to the GP, identifies that [Dr D] had met [Mr A] briefly previously, a few months before.

This letter does not outline details of prior symptoms but does appear to indicate some exploration of these ('... *his explanation of psychotic symptoms did not entice me to that diagnosis ...*') and does describe in some detail the way [Mr A] presented. It shows consideration of whether features that might ordinarily be evident in someone with a long history of psychosis were present in [Mr A].

Although appropriately noting the limitations of conclusions drawn from a single assessment, [Dr D] concluded that [Mr A's] presentation was more in line with a personality disorder than schizophrenia or bipolar affective disorder.

The nature of any further contact by [Dr D] is a little unclear. The material provided by [the DHB] in the letter of 30 July appears to indicate that there was to be an appointment on 21 [Month9]. A clinical file entry on 22 [Month9] appears to reflect that

an appointment did take place. The clinical file entry of 2 [Month10] reflects that [Dr D] saw [Mr A] that day also. I do not appear to have been provided records of those contacts. There do not appear to be corresponding entries in the electronic clinical record. There is however a further record of contact in the context of a family meeting on 30 [Month10].

Through 2019 assessments took place by various other staff. His key worker was often in contact with [Mr A] as well as having some contact with his family, often when family rang with concerns. There appears to have been reasonable responsiveness to these concerns as well as to the anxieties expressed by [Mr A]. Overall although there is not a pattern of repeated detailed exploration of phenomena there is reasonable attention to [Mr A's] mental state and this is accompanied by appropriate guidance about managing the concerns.

Crisis team staff assessed [Mr A] in [Month8]. The record of that contact in the early hours of the morning on 14 [Month8] is brief and there is no evidence of exploration of symptoms. Self-harm ideas had been expressed in a telephone contact with another staff member in the afternoon of the 13th [Month8] and the record shows there was some exploration (without much detail) of these again, but with no further thoughts of self-harm being expressed.

There is no mental state examination recorded and no conclusions drawn about the presentation.

[Mr A] was again seen by [the] crisis staff on 12 [Month10]. This record does not identify exploration of psychiatric symptoms in any detail nor does it record a full mental state examination.

Although it is possibly reasonable to base further actions on a conclusion drawn by an experienced colleague, it is typically helpful for at least some outline to be provided of the information that was considered in reaching that conclusion, to not just enable an assessment to be made by a practitioner involved in future care whether the conclusion was sound, but also to enable a comparison of the future presentation (symptoms and mental state) with what had been seen previously.

Such a lack of detail would generally be regarded as below a reasonable standard and viewed with at least a moderate level of disapproval by peers.

In contrast to the records from the [DHB's] crisis service, the records of the contact with crisis staff in [DHB2] on 17 [Month8] are well structured and reasonably comprehensive. There is evidence of exploration of psychiatric symptoms relevant to the crisis presentation as well as to documentation of a mental state examination. Conclusions are drawn with a good formulation of the presentation outlined.

Overall, although the records from the MHAIDS crisis staff are generally lacking in detail, there does seem to have been reasonable attention in the [CMH] team to [Mr A's] presentation with attention to his symptoms, his mental state and his functional

capabilities. The conclusion drawn by [Dr D] in his assessment in [Month8] seems reasonable. I shall address that further below.

## **2. The appropriateness of care provided and whether further review was warranted (including the coordination of [Mr A's] care).**

The overall approach to [Mr A] is set out in the letter of 30 July 2020 from [the DHB], as well as in the letter of [Dr D] to the GP in [Month8].

There appears to have been reasonable consideration given to the diagnosis by [Dr B], with a second opinion sought from [a psychiatrist] and then subsequently obtained from [Dr D] who largely confirmed the view held by [Dr B].

I accept that there is concern amongst [Mr A's] carers about whether he was optimally treated for a chronic serious psychotic illness or disorder of his mood.

I do not feel there is compelling evidence of a sustained disorder of mood requiring antidepressant or mood stabilising medication. The pattern of mood disturbance demonstrated appears to have been one of reactions to life events, possibly exacerbated by a growing concern regarding his future should his parents' health fail or he lost other supportive relationships.

Whether or not he had a chronic psychotic illness or mood disorder however, attention to psychosocial responses was appropriate. Efforts to encourage his own coping strategies were an important part of building resilience and self-confidence, aimed at minimising further crisis episodes.

Consideration could arguably have been given to whether additional health-based services oriented toward community engagement may have been necessary. A community support worker might commonly be considered in such a situation however [Mr A] appears already to have had good community connections and a range of activities with which he was very capable of engaging. A further health-based resource may potentially have reinforced a lack of self-efficacy, thus countering the treatment direction being taken by the clinical team.

I note the rationale set out in [the DHB] letter of 30 July 2020 for [Dr B] not discussing his understanding of [Mr A's] difficulties with [Mr A] or his family. Whilst typically there would be an expectation, indeed even an obligation on doctors to discuss their assessment conclusions and the rationale for treatment with patients and with families, in the circumstances the decision reached seems to have been reasonable as there appears to have been some concern that harm might be caused by doing so. There does seem to have been some weighing of the risks and benefits.

I wonder however whether more consideration could have been given to sharing the formulation with [Ms F], much earlier than when this finally appears to have happened (as far as I can tell in the notes available to me) on 11 [Month8]. She appears to have been closely involved as a support and advocate for [Mr A] and could potentially have been a support for the clinical team in reinforcing messages encouraging [Mr A's] self-

reliance and non-pharmacological interventions. I accept however that her role was not that of a treating medical practitioner for [Mr A] or his family and therefore was not subject to the usual information sharing expectations between clinical services, so caution would have been needed in approaching any discussion of that nature.

However, it is not clear that this formulation was shared with [Mr A's] usual GP in a manner that enabled the GP to adopt a similar approach, rather than the GP adding in medication that may not have been indicated, or at least not doing so until after consultation with the community mental health team.

[Dr B's] communication with the GP seems to have been infrequent. In my view it would have been appropriate to update the GP after each contact with [Mr A], even if just to note that there was no significant change to the treatment approach. Although I find the GP records provided a little difficult to follow, it is not clear that even a significant change in medication, the reduction in paliperidone dose in early 2019, was communicated to the GP.

Additionally, although I appreciate I have only a limited portion of the records, it would have been good practice for the formulation reached by [Dr B] to be shared with the GP so that each set of clinicians, within [the DHB] and General Practice setting, were operating as much as possible with a shared understanding of the approach to be taken to responding to [Mr A].

I believe that this very limited communication with the GP falls short of commonly accepted standards (Health and Disability Code of Rights — especially Right 4(5); General Medical Council (UK) 'Good Medical Practice' 2013, paragraph 44 — 'Must share all relevant information with colleagues involved in patient's care'; Medical Council of New Zealand 'Good Medical Practice' 2016, '... work with colleagues in ways that best serve patients' interests') and would be viewed with a moderate level of disapproval by peers.

[The DHB's] policy 'Community Mental Health Medication' ([2016]) sets out expectations for monitoring for side effects of medication in people on antipsychotic medication.

From the records available to me it is not clear that these recommendations were systematically followed by the clinical team. I note however there was attention intermittently to his observations about weight and exercise as well as some attention to diet and to foodstuffs available to him. It is also clear that [Mr A] was in contact with his own GP regarding aspects of his general health care relevant to the possible complications of antipsychotic medication, although there does not appear to have been communication between the mental health care team and the GP in either direction about these issues.

[Mr A] had parents who were clearly concerned about him and with whom it appears he had a close relationship and from whom he got a significant degree of support. The records available to me for 2019 do not demonstrate a substantial degree of proactive

contact with these family members by the clinical team, although there does seem to have been good responsiveness to concerns expressed by [Mr A's] parents. When the clinical team was contacted, typically there would be review of [Mr A] to review his situation and the need for a change in the treatment approach.

Overall I feel that the care provided was in accord with the diagnostic formulation, which itself also seemed reasonably considered.

The only further area (other than improved communication with the GP) in which care could have been improved would have been the more active involvement of carers (including [Ms F]) in the diagnostic formulation and the consequent approach to care. It does appear that [Dr D] was beginning to attempt this, carefully, but tragically the consequences of this taking place so late in the course of [Mr A's] contact with services appears likely to have triggered the increased distress that [Dr B] forecast some years earlier.

### **3. The appropriateness of the safety netting advice and follow-up instructions provided.**

[Mr A] presented in crisis or otherwise made contact with [the contact centre] a number of times through 2019.

He called reporting chronic loneliness on 2 [Month2]. Symptoms and other phenomena are not explored in detail. Staff provided some advice regarding simple strategies to 'ground' him to prevent fears escalating.

His mother made contact concerned regarding his panic attacks on 18 [Month2]. Advice was given to his mother, including for [Mr A] to attend ED if in crisis.

On 13 [Month3] [Mr A] rang worried about his medication and wanting to discuss reduction in dose with the psychiatrist. An appointment was agreed and medication dose reduced.

On 7 [Month4] [Mr A] contacted [the contact centre] again. He was worried about his thinking. He had plans for future activity and it appears he was assisted in finding ways to calm himself.

On 13 [Month6] [Mr A] reported feeling suicidal to a visitor who phoned the service. His key worker visited and [Mr A] recounted general difficulties although was not suicidal. He appears to have been assisted in re-orienting his thoughts to an assessment of his progress, with some apparent relief of his level of distress. He later that same day phoned [the contact centre] again with similar concerns and he was transferred to a telephone counselling service.

A similar interaction took place with [the contact centre] on 25 [Month6] and he was again transferred to the phone counselling service.



Less than a week later, on 30 [Month6], [Mr A] phoned the community mental health service multiple times. His key worker visited and some guidance was provided on his patterns of thought leading to increased distress, with some support provided to reframe his responses to other people to assist with reducing the adverse emotional impact of these interactions.

On 3 [Month7] [Mr A] rang [the contact centre] reporting feeling scared. He was encouraged to focus on simple tasks that he could manage. He was followed up by his key worker the following day.

A phone conversation took place with his key worker again the following day following a series of phone messages of concern about him. He was assisted in analysing his pattern of behaviour and the negative consequences of those patterns and some alternative approaches were discussed. This was followed by further conversation with the psychiatrist and his key worker in the following days.

[Mr A] rang [the contact centre] again on 8 [Month7]. Similar concerns to those previously raised were discussed. Distraction techniques were explored but [Mr A] felt they would be unhelpful and requested that his key worker be informed of the contact. The key worker made contact again 2 days later.

He rang [the contact centre] again on 13 [Month7], worrying about worrying. The note suggests he responded to distraction techniques.

On 29 [Month7] the ambulance service contacted [the contact centre]. There had been some contact with police and there was distress about a trespass order being served. Some possible approaches to reduce his agitation and distress were discussed although [Mr A] was not keen on the suggested direction. He subsequently rang the national help-line and was put through again to [the contact centre]. In conversation with staff there it appeared that his level of distress had reduced somewhat after some help reducing his rate of breathing and he resolved to take some sleeping medication and go to bed.

On 13 [Month8] [Mr A] appears to have made contact with [the contact centre]. An ambulance was arranged and he attended ED where he was assessed by crisis staff. When seen, [Mr A] voiced various concerns about his community team. He was focussed on attending church that day. He wanted staff to contact [Ms F] to tell of his presentation but this request was declined. No specific intervention was offered, nor was one clearly indicated.

Two days later his mother contacted the community mental health team after a long conversation with [Mr A] in which he had indicated he wished to kill himself. She spoke of her son previously being administered a sedating medication in similar circumstances, although it is not clear when this had been. She was encouraged to ask her son to attend the centre, but he appears not to have done so.

She contacted the key worker again on 18 [Month8] following a conversation with her son in which he had expressed multiple concerns. She felt his medication should be changed. She expressed disagreement with the conclusions of the recent second opinion. The key worker said he would contact [Mr A] and visited but did not find him at home or at a place he commonly visited. He followed this up the following day.

On 20 [Month9] [Mr A] contacted his key worker again, expressing concerns including what he might do when his mother died. Apparently frustrated that the key worker was not responding in the manner he was hoping, [Mr A] sought an appointment with a psychiatrist. The call was transferred to administration staff to arrange that appointment.

The information provided by [the DHB] setting out the list of contacts appears to identify that an appointment was arranged for 21 [Month9] but there does not seem to be a medical record matching that date in the records made available to me. [The DHB's] summary information provided to the Commissioner however identifies the content of that discussion, including consideration of whether there was evidence of matters requiring the expertise of the mental health service and whether gradually commencing a transition to his care being managed 'outside of secondary mental health care' would be appropriate.

This conversation appears to have been understood by [Mr A] as indicating that a decision had been made to discharge him from secondary care, resulting in a conversation between the key worker and [Mr A's] parents on 22 [Month9]. The key worker reassured them that [Mr A] would continue to be seen as usual. [Mr A] was contacted with the same assurance.

On 27 [Month9] [Ms F] rang the community mental health team expressing concern reported by [Mr A's] parents that he was not being given enough to support him. A meeting with family was sought and the same was to be set up.

On 1 [Month10] [Mr A] [harmed himself] and was seen in crisis in the Emergency Department. He had been worried who would look after him when his mother died and had other concerns regarding his status in life.

There was no clear exploration of psychiatric symptoms other than the material apparently conveyed by [Mr A], but the mental state findings as recorded (albeit in an unstructured manner) do not suggest the presence of acute relapse of a major psychiatric illness.

[Mr A] contacted his key worker late in the afternoon of 5 [Month10], concerned about his circumstances. Suggestions were made about strategies to distract him from his negative cognitions and a visit was planned, although the following day [Mr A] phoned and indicated he did not wish for that visit to take place.

On the night of 11 [Month10] there were a number of phone contacts about [Mr A] eventually resulting in him attending ED at the emergency department. He was seen by

crisis staff. The notes are brief. No acute features of illness were identified and he was to return home for follow-up by his usual clinical team.

On 17 [Month10] [Mr A's] mother made contact concerned that [Mr A] was in his car making threats to end his life. This resulted in an assessment by the [DHB2] team. That assessment did identify some features that could have been congruent with a disordered (depressed) mood although the conclusion was that there was no evidence of a major affective or psychotic disorder.

[Mr A] returned home and was followed up by his key worker a few days later.

A meeting with family and with [Ms F] took place at the end of the month. This meeting appears to have prompted increased distress to be experienced by [Mr A], prompting his mother to call the service. Staff from the community team attended [Mr A's] home and found that he had [harmed himself]. He was transported to hospital but did not recover from the effects of this [self-harm].

Overall there appears to have been good responsiveness to [Mr A's] multiple contacts outlining concerns of various sorts. Plans for follow-up were enacted reliably and advice offered on strategies to manage the difficulties he described.

The pattern of contact through 2019 appears to have been of [Mr A] becoming preoccupied with negative aspects of his psychosocial circumstances, with thought patterns that led to negative emotions and anxieties for which he (and his parents apparently) sought medical intervention. In reality, bio-medical intervention however was unlikely to help and in general the efforts made to help [Mr A] not rely upon a health service response and to help him develop strategies to manage his own anxieties and re-orient his thought processes were appropriate and most likely to make a difference to the pattern of repeated crisis or other help-seeking presentations.

However, greater confidence that this was indeed the right approach would have been enabled by more detailed exploration, and documentation of this, of symptoms that might confirm (or otherwise) whether in addition to the aspects of his personality that were thought to be behind his ongoing help-seeking, another major disorder had developed.

It is not unknown for people with significant problems with living on the basis of their patterns of thought and interactions (their personality) to develop an acute mental illness. The possibility that this may have occurred should typically be considered when someone is presenting in crisis, particularly if there is a change in nature or frequency of the contact with a service.

It is also apparent that there were stresses for [Mr A] that were likely to have contributed to more troubling thoughts, particularly when facing the reality of ageing parents no longer being available to support him. It appears that this escalating series of concerns led to increased crisis presentations and intermittent suicidal ideas and that

the efforts of the community team to encourage methods of coping were insufficient to curtail the mounting distress.

Nonetheless, consideration of the possibility of an emergent disorder of another type would have been good practice and there is no evidence (in the form of detailed exploration of symptoms and mental state phenomena) that this was carefully considered by the [CMH] team or crisis staff despite the increasing contact with the service.

Failure to do so, at least as evidenced by the documentation available, would be viewed with mild disapproval by peers.

The records such as they are however do not clearly suggest that such a development had occurred. The more detailed assessment in [DHB2] does seem to have considered this possibility and found no such concern. It would be reasonable for some reliance to be placed upon such recent reasonably fulsome assessment.

Overall, with one exception outlined below, there does seem to have been good responsiveness by the service to [Mr A's] repeated presentations. Guidance was provided to him regarding managing his concerns, with good attention to further follow-up of him typically over the following days. He was encouraged, appropriately in my view, to engage in his already well-developed activities to refocus his thoughts away from his repeated and unhelpful preoccupations with negative matters.

#### **4. Comments on the medications prescribed to [Mr A] and whether this was appropriate.**

Amongst the records provided to me are copies of two prescriptions issued by [the DHB]. One dated 15 [Month3] is for a three-month supply of paliperidone in a dose of 100mg to be administered by IM injection. The other is dated 1 [Month11] and is for quetiapine in a dose of 25–50mg as required for insomnia and anxiety. Although the document has copied poorly, it appears to be for a quantity of eight 25mg tablets.

A prescription and administration record in the files records regular dosing of paliperidone in a dose of 150mg over [a two-year period], at intervals of approximately each 4 to 5 weeks, some doses being given a little later than the record suggests was planned. The longest interval between doses appears to have been close to 6 weeks [in] 2018.

From [Month2] it appears the paliperidone dose was reduced to 100mg monthly and the administration record documents this being given generally at intervals of about one month, apparently from 22 [Month2] onward. This is a little difficult to reconcile with the prescription record, the only prescription in the file copied to me for 100mg paliperidone is dated 15 [Month3]. That [Month3] date also is congruent with the file entry of 13 [Month3] in which the key worker records a call from [Mr A] insistent that his medication be reduced.

There is no medical note outlining the rationale for the change in dose, but [the DHB's] letter of 30 July 2020 notes that this change arose from [Mr A] requesting a reduced dose.

This was probably a reasonable decision. There appears to have been doubt about whether antipsychotic medication was required at all. It appears that [Mr A] had not demonstrated positive features of psychosis for some time (if at all). Stopping medication completely, as [Mr A] appears to have indicated he would if the dose was not reduced, could have had greater potential to cause a relapse of illness than a negotiated decrease.

Paliperidone is an effective antipsychotic medication. Its use in someone with a diagnosis of schizophrenia is appropriate. It is thought possibly to have particular benefit for people who are experiencing negative symptoms (such as withdrawal and reduced drive, motivation and energy) associated with a psychotic illness. The 150mg dose prescribed to [Mr A] is at the upper end of the generally accepted range of dosing although there is variation in response and tolerability which will also guide dosing decisions. I have insufficient information in respect of prior treatment history to comment on the use of this upper range dose.

I note the question that emerged of whether [Mr A] actually had a psychotic illness at all and therefore whether antipsychotic medication was required.

It is difficult to comment with certainty on this matter with the limited information available to me. The absence of positive psychotic symptoms is not a clear indication of incorrect diagnosis of schizophrenia in someone with a long-established illness and in the presence of ongoing use of antipsychotic medication. The absence of symptoms such as hallucinations or delusions or thought disorder may simply be evidence of effective pharmacological treatment.

If that was the case for [Mr A], there was the possibility that a reduction in dose might risk re-emergence of symptoms that has been effectively treated with the prior dose. In such situations, ongoing close attention to evidence of returning symptoms is good practice.

It is evident in the records that [Mr A] did experience periods of increased anxiety and distress in the period after [Month2], on the lower dose of depot antipsychotic medication. This in itself however does not necessarily indicate that previously treated psychotic symptoms were returning. There seems to have been attention to evidence of emergent psychotic symptoms and none were clearly evident, and no justification was clear therefore for re-instating the prior dose regimen.

It might be that on the lower dose of medication [Mr A] was more emotionally reactive to events, had the prior dose been blunting his affective response in an abnormal manner (as may occur on excessive doses). If this was the situation, the response would not necessarily be to increase the dose again, but to assist [Mr A] to find non-

pharmacological ways to address anxiety and distress arising from the range of psychosocial matters about which he was concerned.

It is also evident, at least as reported in [the DHB's] letter, that [Mr A] is reported to have had intermittent periods of anxiety over a number of years arising from concerns about his circumstances. It is not evident that these concerns were different in their nature or severity following the reduction in medication early in 2019, nor that they were concerns for which medication would likely have been helpful.

It is evident, as outlined in [the DHB's] letter of 30 July as well as in the clinical records available to me, that efforts were made to encourage [Mr A] to use non-medication approaches to manage anxiety.

There does not appear to have been a clear indication for the use of antidepressant medication. However, apparently in [Month7] Mirtazapine was prescribed by the GP and this was thought to have led to some benefit. The GP records however do not detail exploration of features typical of depression and it is not clear to me whether the apparent benefit was due to a genuine and direct effect on biological features of depression or whether the improvement, which appears to have fluctuated in response to various stresses and life events, was a psychological response based in a belief that medication was the solution to his life's concerns.

There was some use of zopiclone and of quetiapine to assist with sleep disturbance and with anxiety symptoms. There seems to have been appropriate caution regarding these and efforts to reserve them for use as a last resort when other attempts to manage with non-medication approaches had been unsuccessful.

I have no particular concerns regarding medication use and do not believe it would be out of line with the practice of many other psychiatrists.

#### **5. Comments on [the DHB's] communication with [Mr A] and his family.**

I note the weighing up of what information would best be provided to the family, at least as outlined in [the DHB's] letter of 30 July 2020. I have commented on that decision already.

It does seem that in the face of escalating concerns from family in the second half of 2019 and the number of unplanned contacts made by [Mr A], it was necessary to revisit this decision. It was clear that his family were concerned and were potentially contributing to [Mr A's] belief that the health system had the solutions for his life that he was seeking. Although there was responsiveness to the family (and [Ms F's]) concerns when they made contact with the service, there is little evidence of proactive engagement with these support people as part of a treatment approach, nor is there evidence of recognition that they also could have benefitted from consideration of the emotional impact on them of the lifelong care of their adult son who had still not achieved complete independence.

This was attempted in late [Month10]. As noted above, sadly this appears to have triggered the reaction that had been predicted some years before. There does appear to be evidence that [Mr A] was upset by the discussion, as measured by him leaving the meeting before it ended.

It is not clear from the clinical records or from the correspondence from [the DHB] whether there was consideration of any additional support being made available to [Mr A] in the immediate aftermath of that meeting, or whether there was any discussion with his parents about any additional steps that might be needed to assist him with his distress associated with the meeting.

In my view these matters should have been canvassed. [Mr A's] reaction was predictable. There was evidence of him having been at increased risk of self harm when his fears of being left unsupported had been prominent. This further discussion seems highly likely to have challenged his views about himself and was likely to leave him feeling his support system was being dissolved.

In my view, this lack of consideration of the need for added support at this time that he was especially likely to be in distress was a significant failure and is one that would be regarded with moderate disapproval by peers.

**6. Any other matters that warrant consideration.**

I have no additional comments.

Yours sincerely

M D Patton"

## Appendix B: Relevant standards

### **The DHB's Operation and Procedures Manual, Adult Community Mental Health and Addictions Services**

The policy states:

#### "1 Purpose

1.1 This manual provides a set of standard operating procedures for staff to follow, other than in exceptional circumstances. Exceptional circumstances related to clinical care must be discussed with a senior staff member, team leader or delegate.

1.2 The primary aims of this manual are to:

Provide a set of procedures for Adult Community Mental Health Team (CMH) and Addictions staff to follow when undertaking their clinical duties."

A section titled "21 Documentation" discusses the following:

"21.1 Accurate, timely and complete documentation is critical to ensuring effective communication and for promoting continuity of care for people/whānau.

21.5 The standard of documentation will be audited six monthly as part of the MHAIDS internal audit programme."

### **The DHB's ISBAR (Identify, Situation, Background, Assessment and Recommendation) Clinical Communication Guideline (November 2018)**

The policy states:

#### "Purpose

The purpose of this guideline is to provide a consistent clinical communication method using the ISBAR tool for use in verbal exchanges between staff, for requests for assistance, for patient transfers across wards or settings, shift handovers and in deteriorating patient situations. The aim is to ensure patient safety through effective and efficient communication.

#### Definitions

Clinical communication is any situation where there is a discussion and transfer of information in order to progress the patient's care. This can occur between health professionals, administration or support staff.

#### Guideline

[The DHB] recommends clinical communication between all staff be structured using the ISBAR ... tool.

It is recommended that the ISBAR tool is used by all staff when verbally requesting clinical advice, patient review and/or escalation of clinical care. This can occur through



different exchanges such as telephone conversations, face to face discussions or within team/shift handovers.”

The policy states that ISBAR can also be used in written communication such as clinic letters.

### **The DHB's Medical Records (electronic and hard copy) policy**

The policy states that the documentation entries must be written according to standards/guidelines set by the Medical Council. The policy further states that medical records should be reliable, accurate, complete and timely to support (as far as relevant):

Continuity of care

Multidisciplinary working

Risk mitigating

Decision making

Legal requirements

The Medical Council of New Zealand publication *Good Medical Practice* (November 2021) states: “Work with colleagues in ways that best serve patients’ interests.”

The General Medical Council (UK) publication *Good Medical Practice* (March 2013) states:

“You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must:

- (a) share all relevant information with colleagues involved in your patients’ care within and outside the team, including when you hand over care as you go off duty, and when you delegate care or refer patients to other health or social care providers.
- (b) check where practical, that a named clinician or a team has taken over responsibility when your role in providing a patient’s care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.”