Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 19HDC01187)

Introduction

1. This report is the opinion of Deborah James, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Mr A by Health New Zealand|Te Whatu Ora (Health NZ)[1] and two psychiatric social workers, Ms B and Ms C.

3. Initially, the following issue was identified for investigation:

- *The appropriateness of the care provided to Mr A by Health NZ from 29 to 31 Month2[2] 2016 (inclusive).*

[1] 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 Health NZ. All references in this report to the DHB now refer to Health NZ.
[2] Relevant months are referred to as Months 1–3 to protect privacy.

4. Following the receipt of information gathered from various parties, I decided to extend my investigation to include the care provided to Mr A by psychiatric social workers Ms B and Ms C. This report therefore also includes the following issues:

- *The appropriateness of the care provided to Mr A by Ms B from 29 to 31 Month2 2016 (inclusive).*
- *The appropriateness of the care provided to Mr A by Ms C from 29 to 31 Month2 2016 (inclusive).*

5. The parties directly involved in the investigation were:

Mrs A	Mr A's wife
Ms B	Psychiatric social worker
Ms C	Psychiatric social worker

6. Further information was received from:

Dr D	Psychiatrist
Mr E	Support worker

Executive summary

7. Mr A suffered from schizophrenia. Over the course of two months in 2016, his mental health worsened to the extent that he attempted suicide, but he was prevented from completing suicide by a support worker. He was taken to a police station, where he was assessed by two psychiatric social workers, Ms B and Ms C, who concluded that he was a low risk to himself and others and returned him to his family home. Mr A died by suicide later that day.

8. This report examines the actions of the psychiatric social workers on 31 Month2, and in particular whether the mental health assessment of Mr A was adequate. The report also considers whether Health NZ's policies and procedures in place at the time of events were adequate and appropriate, and whether Health NZ had provided the psychiatric social workers with adequate training prior to their assessment of Mr A.

Findings

9. The Deputy Commssioner considered that the psychiatric social workers' assessment of Mr A was inadequate, as they failed to elicit vital facts or to consider these adequately, failed to obtain information from third parties, and failed to consult an appropriate medical practitioner or senior colleague. The Deputy Commissioner also considered that the psychiatric social workers returned Mr A to his family home when he should have been admitted to hospital for compulsory treatment, and they failed to communicate adequately with Mr A's whānau about the assessment or the plan to return Mr A to his family home, and there was inadequate safety planning.

10. The Deputy Commissioner considered that these failures represented serious departures from the standard of care and found both psychiatric social workers in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

11. The Deputy Commissioner was also critical that Health NZ did not ensure that psychiatric social workers who were conducting mental state examinations had the appropriate training, and that its policy on Inservice Training did not include a required frequency of attendance at vital training sessions.

Recommendations

12. In her provisional opinion, the Deputy Commissioner made several recommendations in respect of the psychiatric social workers and Health NZ. In response to the provisional opinion, these parties confirmed that they had completed those recommendations (see the sections of this report titled 'Changes made since events' and 'Recommendations' below). The Deputy Commissioner also noted the time elapsed since the events, the significant extra training undertaken by the psychiatric social workers, and the appropriate and effective changes made to their practice, and the detailed and insightful reflections provided to HDC. Health NZ had also made appropriate changes to its training policy. Accordingly, the Deputy Commissioner made no further recommendations.

Summary of events

13. At the time of events, Mr A was under the care of Health NZ's Māori mental health service. He had a diagnosis of paranoid schizophrenia and was known to use cannabis and alcohol, and occasionally other drugs. Mr A had also been involved in several incidents of violence towards his wife, Mrs A, for which he was not held criminally responsible due to his mental health.

14. On 19 Month1, Mr A attended a medical review with a psychiatrist from the mental health service, Dr D. Mr A's key worker, psychiatric social worker Ms B, also attended. Dr D noted that Mr A reported significant stressors on his mental health. Mr A also reported having auditory and visual hallucinations, and anxiety.

15. Dr D's report records that Mr A was experiencing a recent mild risk increase regarding his mental health and that Ms B was to contact Mr A weekly. There was no change in his treatment plan at that stage.

16. On 18 Month2, Mr A attended another review with Dr D. Dr D noted that Mr A was experiencing some breakthrough psychotic symptoms and increased anger and irritability towards others, which are recorded as being his early warning signs of mental health relapse. His three-weekly paliperidone[3] injection was increased from 100mg to 150mg at this appointment and was next due on 1 Month3. Again, Dr D was to be contacted weekly by Ms B. Ms B was also present at this appointment.

17. Between 29 and 31 Month2, Mrs A became concerned by Mr A's behaviour, which included threats of self harm. On 30 Month2, she called Ms B and advised her of Mr A's threats. Ms B spoke with Mr A, who told her that he was feeling stressed from a house move and had felt suicidal that morning but was now fine.

[3] An antipsychotic medication.

18. On 31 Month2 Mrs A called Mr A's support worker, Mr E. Mr E drove to their home and found Mr A sitting on his deck having coffee and a cigarette. Mr A appeared calm, and Mr E went inside the house with Mrs A to discuss Mr A's behaviour.

19. When Mr E went outside again, Mr A had left the property. Mr E drove around looking for him. Mr E persuaded Mr A to get into his car. Mr A told Mr E that he wanted to harm Mrs A and that he wanted to harm himself. Mr E drove them both to his office and went to make them some coffee.

20. While Mr E was making the coffee, Mr A left the premises. Mr E called the Police and the mental health service and drove to their home. Mr A appeared at the house and tried to leave in his car, but he was blocked from doing so by Mr E's car. When the Police arrived, they detained Mr A for a mental health assessment, and he was transported to the police station, where an officer contacted Health NZ's mental health service and requested a mental health assessment. At the police station, Mr A was detained under section 109 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHCATA).[4]

Mental health assessment

21. Ms B and another psychiatric social worker, Ms C, carried out the mental health assessment on Mr A on 31 Month2. Ms C had not had any prior involvement with Mr A, but she told HDC that prior to the assessment she took time to read his file and prepare for the assessment. At the time of the assessment, Ms B was employed by the mental health service as a provisionally registered junior psychiatric social worker with about two years' experience. Ms C was employed by the mental health service as a psychiatric social worker and had been a registered social worker for about four years. Ms B led the assessment and Ms C attended in an assisting capacity. Ms C told HDC that she acted as the assistant despite being the senior because she had had no prior experience working with Mr A and had been involved that day only because of staffing shortages. Ms C said that Ms B had an existing rapport with Mr A and had already worked with him on multiple occasions.

22. Mr A's patient notes, completed by Ms B, record that at 10.45am on 31 Month2, Mr E called the mental health service and informed staff that he had stopped Mr A from taking his own life. The notes record that the mental health service advised Mr E to call the Police. Ms B told HDC that this note represents an error in her record-keeping, and that in fact she had been advised only that he had expressed suicidal ideation.

23. Prior to the assessment, Ms B called Mrs A, who told her that she (Mrs A) had had a breakdown that morning from the stress of moving house, and her child was also unwell.

24. Ms B recounted the working conditions at the mental health service on 31 Month2 in a statement to HDC. She said that two mental health service child and adolescent team members were on leave that day, and she was covering for both. The adult community mental health team was also short staffed, as the senior registered nurse and treating doctor

[4] https://www.legislation.govt.nz/act/public/1992/0046/latest/whole.html#DLM263882. Accessed 8 June 2023. Section 109 grants the Police powers to detain any person appearing mentally disordered in a public place, and have that person examined by a mental health practitioner.

were appearing in Court on that day, and there were no other medical practitioners available. The cellphone in the mental health service car taken by the psychiatric social workers was also not operational. Ms B also recounted that the reception from police at the station was 'not warming'.

25. Ms C also described the staffing issues with the mental health service and said that she assisted Ms B because no other staff members were available, and she had had to cancel her scheduled keyworker appointment with another individual to do so.

26. Ms C also told HDC that the reception they received at the police station was 'not very warming'. She said that the handover from Police to Ms B was very brief, and a police officer told Ms B only that Mr A was calm and had requested his paliperidone injection. Ms C said that the officer was not happy when she and Ms B told him that they could not administer the injection, as they were not medical practitioners. Ms C said that no information was offered as to the events of 31 Month2, and therefore she was unaware of the severity of the situation, and the fact that Mr A had been detained under section 109 of the MHCATA. Ms C later clarified that she was not sure (especially given the passage of a significant amount of time) what information she had overheard during the handover and what Ms B had relayed to her later.

27. The Health NZ Root Cause Analysis completed following these events records that on arrival at the police station and prior to assessing Mr A, a police officer informed Ms B and Ms C that Mr A had been threatening to harm himself, and his support worker had stopped him from doing so, and that Mr A needed a mental health assessment. However, both Ms B and Ms C deny that the officer gave them any information about Mr A's suicidal ideation, so it is unclear on what basis the Root Cause Analysis reached the conclusion that the officer provided that information.

Paliperidone injection

28. Ms C told HDC that during the assessment, Mr A requested that his paliperidone injection be administered that day. She said that she and Ms B advised that they could look into getting this done the next day, and they all agreed that Ms B and a registered nurse would return the next day to administer it.

Risk assessment form

29. The risk assessment form completed by Ms B states that the rationale for the assessment was: '[Mr A] was in police cells … due to wife [Mrs A] raising concerns about risk.'

30. A section on the form titled 'Points of treatment at which risk assessment should occur' has a tick box for 'accommodation change', which was not ticked despite Mr A and his family having just moved house. Ms C told HDC that although they forgot to check this box, they listened to Mr A's concerns and took them seriously.

31. Another section on the same page titled 'Current Risks' has a tick box for 'current suicidal ideation', which was marked as absent. The subsequent sections dealing with intent, lethality, plan, and access are not completed. The historical risks section also records that there was no history of either suicidal ideation or suicide attempts, despite Mr A having

attempted suicide previously (both on that day and a previous attempt). Ms B told HDC that she was unaware of any previous suicide attempts.

32. There is also a section titled 'Factors that may increase risk in the consumer/tangata whaiora and others'. Boxes are ticked for mental health symptoms, impulsivity, individual's attitude, insight, substance use, intoxication, withdrawal, relationship issues, tendency to hide truth, and vulnerability.

33. The next page of the risk assessment form contains guidelines for assessing the current level of risk. The guidelines include a direction to take into account 'reports from other relevant people'.

34. The last page of the assessment form has a section to detail recent relevant events. 'Moved house', and 'used [drugs] @...weekend' are recorded here. There is also a section to detail cultural issues that influenced the risk assessment, in which nothing is recorded.

35. Also on the last page of the assessment form is a section titled 'Identified protective factors by consumer, family/whānau, clinician and/or others'. Recorded here is 'Mrs A', that Mr A was 'cooperative and engaging with mental health services', and that he agreed to the safety plan. The section on the treatment plan records that olanzapine had been prescribed, that Mr A should refrain from consuming alcohol and drugs, and that he should call the Police or the Mental Health Emergency Team if he 'feels sad, crys [sic] or feels suicidal'.

Other notes

36. The following is recorded in the patient notes by Ms B in respect of the mental health assessment:

> '[Mr A] denied current suicidal ideation … [Mr A] reported walking down the street this morning and the staff from … picked him up and brought [Mr A] home. [Mr A] then reported then being picked up by police. [Mr A] reported consuming [drugs] over [the weekend] and described it as "a lot". [Mr A] described only sleeping for one hour at a time since [the weekend]. [Mr A] expressed his mood as stressed due to moving homes. [Mr A] reported at times crying but would not give specific details, [Mr A] would not give dates when he has been crying or how long [he] has felt sad. [Mr A] denied feeling sad over the past week. [Mr A] denied suicidal ideation on the 30th [Month2], reporting that he just wanted to sleep. [Mr A] reported using "a lot" of [drugs] but would not give specific details, ie: dates and amounts. [Mr A] denied experiencing hallucinations, paranoid thoughts and aggressive behaviours/intimidating behaviours, which is displayed when [Mr A] becomes unwell. [Mr A] was orientated to time, person and place. [Mr A] continues to have little insight of the effect [drugs] [have] on his mental health. [Mr A] denied suicidal ideation, expressed wanting to go home to see his wife, Mrs A. [Mr A] agreed to the plan for him to contact [the mental health emergency team]. The number was given to [Mr A] if [he] felt sad, isolated himself or had thoughts of suicide. [Mr A] was to take 10mg of Olanzapine prior to 9.30pm to aid his sleep.'

Subsequent events

37. The psychiatric social workers assessed Mr A as being low risk to himself and others, and the overnight safety plan was for him to take olanzapine,[5] to refrain from alcohol and drugs, and to call the crisis team if required. Mr A was offered respite care for the night and for the weekend, but he declined it. The psychiatric social workers also offered to contact Mr A's father, which he also declined. Ms C and Ms B did not consult a psychiatrist or other clinician during or after the assessment, nor did they contact Mrs A or Mr E. It also appears that they did not refer to any relevant Health NZ guidance for the assessment or the decision to send Mr A home.

38. Ms C told HDC that she recalls discussing the plan with a police officer, but they were interrupted by a police staff member, and as the corridor was not big enough for all of them, she left with Mr A, and Ms B stayed to discuss the assessment with the officer.

39. The psychiatric social workers drove Mr A home. Mrs A was very surprised to see her husband, as she had expected him to be admitted to hospital. Mr A's patient notes record that Mrs A told Ms B at that time that she was 'feeling stressed and anxious due to the move to the new house,' and that she was suffering panic attacks.

40. Ms B told HDC that she discussed the safety plan with Mrs A, and it was her 'understanding that [Mrs A] was accepting of the safety plan'.

41. In relation to the safety plan, Ms C told HDC: '[I]n hindsight we understand [Mr A] was not in a position to agree/give consent to the safety plan as proposed.'

42. At approximately 5.30pm on that day, Mr A died by suicide.

Complaint

43. Mrs A complained that Mr A should have been admitted to hospital and not returned to the family home. She also told HDC that Mr A requested his paliperidone injection at the mental health assessment on 31 Month2[6] and he was told that he would have to wait until the next day despite the injection being three days overdue.[7]

Serious Adverse Event Review

44. Following Mr A's death, Health NZ carried out a Serious Adverse Event Review (SAER), which identified several failures with the mental health assessment carried out by the psychiatric social workers. In particular, the SAER identified the following:

a) The psychiatric social workers failed to take into account Mr A's earlier suicide attempt that had been interrupted by Mr E;

[5] An antipsychotic medication.
[6] It is recorded in patient notes made by Ms B that Mr A said 'Need my injection' to them on 31 Month2.
[7] It is unclear whether the injection was overdue — see paragraph 16.

b) The risk assessment was lacking — in particular, Mr A had a plan to end his life, had identified the means to carry it out, and had intent (however, the sections on the risk assessment form dealing with intent, lethality, plan, and access were not completed);

c) There was a lack of multi-disciplinary team consultation, community collaboration, and communication;

d) The risk management plan was inadequate; and

e) The documentation and records were inadequate.

45. The SAER also reviewed the DHB policies, procedures, and forms that were relevant to Mr A's care. Although the SAER made some recommendations in respect of improvements to some policies, it identified the root cause as the competence (or rather lack of competence) of the psychiatric social workers and found that they had not met the expectations of basic standards of care. Details of the improvements recommended by the SAER are included in the 'changes made' section of the report below (see paragraphs 155–156).

46. The SAER also noted the following in relation to the training provided to the psychiatric social workers:

> 'Job descriptions were appropriate and training available. It was noted from information available, that not all training opportunities were taken up by the staff concerned. At that time, [Ms B] had attended QPR Advanced Training Suicide Risk Assessment in … 2014, Mental Health Act introduction and Med Led in … 2015. No Mental Status Examination, which is compulsory for all clinical Mental Health staff, was attended.
>
> There is no evidence of staff member [Ms C] attending QPR Advanced Training Suicide Risk Assessment, for which she was booked in … 2015. The Mental Health Act for Beginners and Mental Status Examination session was attended by [Ms C] in 2007. Due to [Ms C's] clinical management role, there is no evidence of on-going clinical training since 2013.'

47. Ms B told HDC that she was not able to complete this training as she was required to complete other acute clinical tasks and cover other staff due to resourcing issues on the day of the training. She said that Health NZ did not offer her another opportunity to complete this training or otherwise support her.

Further information

48. Despite having made all reasonable efforts, HDC has been unable to contact Mrs A prior to issuing this opinion.

49. Both Ms B and Ms C provided further information to HDC.

Ms B

50. Ms B reflected on the events of 31 Month2. She told HDC:

> '[O]n refection a detailed handover from the Police Officer in [the] Station would have outlined that the Mental Health Act Section 109 had been [enacted]. Therefore a Duly Authorized Officer and Medical Officer would have attended the Police Station for the assessment of [Mr A].
>
> [O]n reflection the Treating Psychiatrist should have been consulted before attending the Police Cells to gather further information. [O]n further reflection the Clinical Manager should have been contacted and the plan discussed with both the treating Psychiatrist and Clinical Manager before departing … It would also have been valuable to have spoken to [the support worker] upon arrival at the Police station which would have allowed further information gathering to inform the assessment.'

51. Ms B also apologised to Mr A's whānau in her statement and wrote that she accepted responsibility for her role and continued to reflect on her practice daily.

Ms C

52. Ms C also reflected on the mental health assessment. She told HDC:

> 'In hindsight, the psychiatrist or the clinical manager should have been contacted to discuss the plan and request the assessment that had been conducted. My reflection is that I should have taken the time to ensure that I had all of the relevant information required and that all processes had been considered, such as, informing the psychiatrist of the request from the Police. This could have assisted with the plan forward following assessment.'

53. Ms C also told HDC that discussions with her managers and colleagues following Mr A's death highlighted flaws in her understanding of the situation — namely, the events leading to Mr A's detention, the need for police intervention, and psychiatrist knowledge of Mr A's situation.

54. Ms C wrote:

> 'There is a possibility that if I had all the information prior to engaging with [Mr A] at the Police Station the whole process could have been different … My recollection is that this information was not provided at the time nor during the time at the police station.'

55. Ms C also apologised to Mr A's whānau in her statement and wrote that not a day goes by when she does not consider the tragic loss of Mr A and the impact this has had on the changes she has made to her practice and the mental health service she provides. Ms C accepted responsibility for the care she provided to Mr A on the day he died and said that she understands that there were things that could have been done better.

Health NZ

56. Health NZ also apologised unreservedly to Mr A's whānau for the shortcomings in its service that contributed to Mr A's death.

57. Health NZ provided HDC with copies of relevant policies and procedures that were in place at the time of events. Of particular note is the Health NZ document 'Partner Abuse (Family Violence) Policy and Procedure', which contained [8] guidance on the assessment, identification, and safety planning for family violence. The policy also contained details of other agencies that specialise in dealing with family violence.

58. The policy 'Inservice Training Packages for Mental Health Staff (Compulsory and Recommended)' (dated 2015) in effect at the time of these events contains the training requirements for all mental health and addiction services clinical staff. The policy states that mental health status examination training is compulsory for all social workers. It does not state the required frequency of the training, or any other compulsory training.

Responses to provisional opinion

59. Health NZ, Ms B, and Ms C were given the opportunity to respond to the relevant sections of my provisional opinion. Where appropriate, their responses have been incorporated into this report.

Opinion: Introduction

60. As part of my assessment of this complaint, I obtained independent advice from a psychiatrist, Dr Alma Rae (Appendix A), and a psychiatric social worker, Ms Nicole Begley (Appendix B).

Opinion: Ms C and Ms B — breach

Mental health assessment

61. Ms B and Ms C carried out the mental health assessment on Mr A on 31 Month2. Ms C noted that she was asked to recollect events that happened eight years ago, and that delay has made responding an extremely difficult task. I accept that the significant delay will have made remembering these events accurately difficult for the psychiatric social workers, and I have taken that difficulty into account in my decision.

62. Ms Begley identified several failures with respect to the assessment and advised HDC that it did not meet the standard of acceptable practice. Dr Rae agreed and stated that the assessment was 'woefully inadequate'.

Rationale for assessment

63. The risk assessment form states that the rationale for the assessment was that '[Mr A] was in police cells … due to wife [Mrs A] raising concerns about risk'. Ms Begley considered that this was incorrect and noted that the psychiatric social workers overlooked the fact that Mr A had been brought to the Police station following a suicide attempt earlier that day.

64. Dr Rae also noted the error in the rationale for the assessment and pointed out that Mr A had in fact just been physically prevented from taking action to end his life. Dr Rae stated that this could have been established by talking to Mr E, although I note that the psychiatric

[8] The policy was reviewed in 2020, but substantially the updated version is the same.

social workers appear to have been aware of this, having been advised by a police officer on arrival at the police station. It is also noted in Mr A's patient notes at 10.45am on 31 Month2, an entry that was written by Ms B. In any event, I agree that this was not captured on the risk assessment form as being the reason for Mr A's assessment.

65. I agree with my advisors that recording the rationale for the assessment as being due to concerns raised by Mr A's wife raises concerns about whether the psychiatric social workers appreciated the seriousness of the situation, and consequently the degree of risk. However, it appears that they were at least aware of Mr A's suicide attempt that day, even if it was not recorded as the rationale for the assessment. I remain concerned that Mr A's suicide attempt that day was not given appropriate weight by the psychiatric social workers in their assessment, and I discuss this further below.

Risk factors

66. Both advisors noted several errors and omissions in the risk assessment completed by Ms B.

67. Ms Begley noted that Mr A was open about his recent heavy drug use, and the risk assessment documents this and his alcohol use. However, Ms Begley said that the psychiatric social workers appear not to have understood the impact of Mr A's substance use and its relevance to his presentation. Ms Begley advised that this was a missed opportunity to consult with the treating psychiatrist to help them understand how the substance use may have been affecting Mr A's mental health. Dr Rae agreed and noted that although the box for 'substance use, intoxication, withdrawal' on the assessment form is ticked, there is no evidence that the psychiatric social workers appreciated the effect that days of [drug] intoxication and insomnia would have had on Mr A given his mental illness. Dr Rae noted that these issues had been documented by his psychiatrist to be early warning signs.

68. Ms Begley also noted that stress and lack of sleep were Mr A's self-reported relapse indicators, and that Mr A was suffering from both at the time of the assessment.

69. Ms Begley also criticised the psychiatric social workers' over-reliance on Mr A's self-reporting rather than other critical information that suggested he was in fact suicidal. Ms Begley advised that the prior suicidal ideation and attempt, and the fact that Mr A had attempted suicide that same day evidenced an increase in risk, as Mr A had developed suicidal thoughts, a plan, and then made a suicide attempt. Dr Rae agreed and noted that a section in the assessment form titled 'Current Risks' has a tick box for 'current suicidal ideation', which was marked as absent despite the fact that Mr A had expressed suicidal ideation several times to Mrs A and others, including mental health service staff, over the preceding three days. Both Mr A and Mrs A had reported to Ms B that Mr A had been feeling suicidal the day before his death, on 30 Month2. The historical risks section of the assessment form also incorrectly records that there was no history of either suicidal ideation or suicide attempts.

70. The result of the failure to recognise that suicidal ideation was present led to a further failure by the psychiatric social workers to complete the parts of the assessment form that dealt with suicidal ideation (ie, those parts dealing with intent, lethality, plan, and access).

71. Ms Begley noted also that psychiatric reviews referred to an increase in Mr A's suicide risk. I note that Ms B was present at Mr A's most recent psychiatric reviews.

72. Dr Rae noted that a section in the assessment form titled 'Points of treatment at which risk assessment should occur' has a tick box for 'accommodation change', which was not ticked despite the fact that Mr A and his family had just moved house. Dr Rae noted that Mrs A was exhibiting considerable stress from the move.

73. In her response to the provisional opinion, Ms B told HDC that she was not aware that Mr A had attempted suicide previously, and that information was not communicated to her either within Health NZ, or by Dr D. She said that, having no knowledge of the historical suicide attempt, she could not have appreciated this as a risk factor in the assessment. Although it is unclear whether that information was readily available to the psychiatric social workers, there is also no evidence that they sought it out. That information, and other relevant information, could have been obtained by seeking input from other parties with involvement in Mr A's mental health care. The lack of involvement of third parties is considered in more detail below.

Section 109 MHCATA

74. In response to the provisional opinion, Health NZ submitted that it should not be assumed that Mr A was detained under section 109 of the MHCATA. However, it is difficult to imagine what other power he could have been detained under, as his removal to the Police Station was clearly not voluntary. I note in particular that the Coroner's report records that '[w]hen Police arrived, the decision was made to detain him for a mental health assessment … and [the Sgt] contacted the mental health service and requested a Duly Authorised Officer attend the Police Station to perform an assessment'. That is the language of section 109. The Coroner's report also records that '[Mr A] was arrested at his home, and transported to the Police Station for a mental health assessment'. I see no reason to doubt that Mr A was detained under section 109, and I have made my decision on that basis.

Involvement of third parties

75. Section 109 of the MHCATA empowers the Police to take a person to a Police station (or other appropriate place) to arrange for a mental health examination in circumstances where that person is acting in a manner that gives rise to a reasonable belief that the person is mentally disordered. Dr Rae discussed the procedures set out in section 109 of the MHCATA.[9] Dr Rae noted that section 109(1)(b) requires that the mental health examination be carried out by a medical practitioner, and she advised that it is 'incomprehensible' that a medical practitioner did not attend.

[9] https://www.legislation.govt.nz/act/public/1992/0046/latest/whole.html#DLM263882. Accessed 8 June 2023.

76. Ms Begley noted that the psychiatric social workers did not appear to be aware that Mr A was being held at the Police station under section 109 of the MHCATA, and it appears that they felt that this was because of an inadequate handover from the Police. The psychiatric social workers said that if they had been aware that Mr A was being held under section 109 of the MHCATA, they would have followed the procedure of contacting a duly authorised officer and a medical officer to attend and complete the assessment.

77. Dr Rae also advised that it is a Police responsibility to arrange for the attendance of a medical practitioner, but the psychiatric social workers should have contacted a psychiatrist to discuss their findings, whether or not they thought the risks were significant.

78. I note the psychiatric social workers' comments that they were unaware of the fact that Mr A was being held under section 109 of the MHCATA, and also Ms B's comment that it was the responsibility of the Police to arrange for the attendance of a medical practitioner. However, the psychiatric social workers failed to engage with third parties to obtain vital supporting information to assist with the assessment. Had they done so, they may have discovered that Mr A had been detained under the MHCATA, and this may have prompted them to call for the attendance of a medical practitioner. An important opportunity was lost for vital medical support to have been provided to Mr A.

79. Dr Rae also advised that the usual standard of care would involve consultation with colleagues more senior than the psychiatric social workers and would also involve arranging further assessment. The indicators for the use of the MHCATA were the high level of risk and Mr A's 'plainly disingenuous denial of suicidality in the teeth of much evidence to the contrary'. Dr Rae advised that the psychiatric social workers' assessment of low risk did not excuse their decision not to consult anyone else, and their failure to do so was a severe departure from the standard of care. I agree and find it very concerning that Ms B and Ms C did not involve other clinicians in the assessment of Mr A.

80. Ms Begley advised that the risk assessment tool should have been used in conjunction with critical thinking and in consultation with other relevant people, including the police officers involved, the treating psychiatrist, and Mrs A, which was not done.

81. Ms Begley noted that both psychiatric social workers accepted that other parties should have been consulted about Mr A's assessment. In addition to medical professionals (see above) and the other parties identified above, Ms Begley advised that Mr E should have been consulted to obtain a full background to the assessment, as he was the person who intercepted Mr A and reported his concerns to the Police. There is a reference in the clinical notes to a conversation between Ms B and Mr E at 11.45am on that day, and this would have been an appropriate time to gather information about Mr A's attempt to end his own life.

82. In response to my provisional opinion, Ms B submitted that an inadequate handover from Police should be a significant mitigating factor in my assessment of whether the assessment of risk she and Ms C undertook was adequate. Ms B said that she 'knew that section 109 requires the mental health assessment to be conducted by a medical practitioner', and '[Police] did not convey critical information … nor did the interaction suggest there was

additional information to be enquired further about'. Ms B stated: [My] engagement with the Police was reasonable and appropriate in these circumstances.'

83. I put these comments to Ms Begley, who advised that these submissions did not change her criticisms about the psychiatric social workers' failure to enquire about the events that led Mr A to be at the police station. Ms Begley stated:

> 'After consultation with my senior social work colleagues … we could not comprehend a scenario in which we were tasked to meet a current client at a police station, where we would not query the circumstances that brought them into contact with the police, and the reason for them being brought into the police station. Factors such as the current risk of the client need to be considered, as do risks to staff when transporting or being alone with a client.'

84. I agree with these comments. I remain of the view that, while I accept that the Police handover may not have been as thorough as ideally it could have been, this does not absolve the psychiatric social workers of the obligation to seek information as to why Mr A was being held at the police station or to consult with others to obtain the necessary information upon which to base the assessment.

Assessment conclusion

85. My independent advisors noted serious failings in Mr A's mental health assessment. In particular, the fact that Mr A had attempted suicide earlier that day appears to have been disregarded, and his contemporaneous statement that he was not suicidal was taken at face value over his expressions and actions demonstrating suicidal ideation over the previous days.

86. In response to the provisional opinion, Ms B told HDC that, to the best of her recollection, the information provided by Mr E was that Mr A had suicidal ideation, and not that suicidal ideation had transitioned to a suicide attempt. Although the telephone note she made on the morning of 31 Month2 records that Mr E 'called reporting that [he had] stopped [Mr A] from [taking his own life]', Ms B told HDC that this represents an error in her clinical record keeping. However, I note that Ms C told HDC that during their assessment of Mr A, '[Ms B] asked [Mr A] about attempting to [take his own life]', and during the assessment they 'discussed the suicide attempt with [Mr A]'. I also note the Coroner's finding that 'it was only the intervention of [Mr E] which likely prevented [Mr A] from [taking his own life]'.

87. I consider that, other than Ms B's statement about this in her response to the provisional opinion, the evidence points to the psychiatric social workers being aware that Mr A had attempted suicide earlier that day. In any event, I note the following comments from Ms Begley, which I agree with:

> 'There is a discrepancy between [Ms B's] recollection of the phone call and the details of this recorded in her case note, yet both accounts confirm that [Ms B] was aware of [Mr A] having suicidal ideation several hours prior to her and [Ms C] completing the mental health risk assessment, therefore it is my belief that "current suicidal ideation" should have been considered as a "current risk" on the risk assessment form.'

88. I also note that the SAER found that, 'regardless of which information was accurate, both scenarios present a significant risk which should have been taken into account'. Whether or not Mr A had made a suicide attempt, he had demonstrated suicidal ideation on 31 Month2, and that went unrecognised by the psychiatric social workers.

89. Other risk factors were also ignored, or the impact of those factors was underestimated. Mr A was suffering from drug withdrawal and insomnia, and he was experiencing stress from a house move, and the psychiatric social workers failed to obtain information from vital third parties, most notably Mrs A, Mr E, and Dr D.

90. Ms B was also aware from her attendance at Mr A's mental health reviews and her position as Mr A's key worker, that Mr A's mental health had been worsening over the past few months, yet this does not seem to have factored into the risk assessment.

91. Dr Rae advised that the factors noted above, plus Mr A's gender and ethnicity (both of which are associated with a higher risk of suicide) should have been taken into account by the psychiatric social workers, and the failure to do so resulted in an error in the judgement of Mr A's risk to himself. Dr Rae considered Mr A's risk to himself to have been serious, and his risk to others to have been moderate.

92. Ms Begley advised that Ms B overlooked the knowledge she had as Mr A's key worker, and she failed to consider the information held by other people.

93. I agree with my advisors that the mental health assessment undertaken by both psychiatric social workers represents a serious departure from the accepted standard of care.

Discharge home

Decision to send Mr A home

94. Ms Begley was critical of the decision to take Mr A home. She advised that there was a lack of evidence that important relevant factors were considered, including that Mrs A had told Ms B that she was feeling stressed, Mrs A had described herself as having had a breakdown, Mrs A's child was unwell, and Mr A had a history of violence towards Mrs A. Ms Begley advised that given these factors, it was unreasonable to expect Mrs A to take on the task of managing her husband's mental health, his abstinence from drugs and alcohol, and compliance with the safety plan.

95. Dr Rae was similarly critical of the decision to send Mr A home and noted similar factors to Ms Begley. Dr Rae also noted that although Mr A was referred to the mental health emergency team, this was done for information purposes only, and the team was not asked proactively to call Mr or Mrs A. Dr Rae advised that the psychiatric social workers' instructions to Mr A to take olanzapine in addition to his usual medication, not to use alcohol or illicit drugs, and to telephone the emergency mental health team if he was feeling 'sad, [cries], or feels suicidal' was 'tragically naïve', and there was little chance that Mr A could or would comply with those instructions.

96. Mr A refused respite care, which Dr Rae noted is common, and she advised that this should not have led the psychiatric social workers to resort to a lesser level of care. Dr Rae also

advised that Mr A should have been admitted to hospital as a compulsory patient. Dr Rae described the decision to send Mr A home as 'misguided, unsafe, and inappropriate' and advised that it was a severe departure from the standard of care.

97. I agree with Dr Rae's and Ms Begley's advice and consider that the decision to send Mr A home, in light of the circumstances, was entirely inappropriate.

Communication with whānau before Mr A's discharge home

98. Dr Rae and Ms Begley were also critical of the communication with Mr A's whānau. Ms Begley noted that contacting Mrs A before taking Mr A home would have given the psychiatric social workers the opportunity to obtain Mrs A's views on it without the pressures of having her husband present for the discussion. Dr Rae characterised the communication as poor, noting that Mrs A had had no involvement in Mr A's assessment and had no warning or input into the plan to return him to the family home. Dr Rae advised:

> 'The power dynamics at play when she found two mental health professionals and her abusive husband on the doorstep could hardly have disadvantaged her more. It would be a very unusual woman in such circumstances who could or would turn her husband away, however much she wanted to. Mental health professionals are supposed to know these things and behave accordingly.'

99. Ms Begley also advised that it is standard social work practice to explore a client's support networks, and she noted that a police officer offered to contact Mr A's father and brother (which Mr A declined). I also note that the psychiatric social workers offered to contact Mr A's father (which he also declined). Ms Begley advised that this omission was a mild departure from the standard of care.

100. I agree with my advisors that not consulting Mr A's whānau about his discharge home, and not exploring his support networks, was a departure from the standard of care.

Safety planning

101. Ms Begley also noted that on Mr A's return to the family home, Mrs A advised Ms B that she was having panic attacks. Ms Begley is critical that there is no mention in the clinical notes of any consideration of Mrs A's mental health or the family's safety, no reference to a safety plan on the risk of family violence, and no mention of Mr A's supports. Ms Begley noted that Health NZ's policy, 'Partner Abuse (Family Violence)', contained guidance on identification and safety planning for family violence, including details of specialised family violence agencies that the psychiatric social workers could have consulted. Ms Begley considered that the psychiatric social workers did not follow the policy.

102. Ms Begley also advised that it was imperative that the plan to return Mr A home was signed off by a senior colleague. Ms Begley considered that Ms B's failure to do this was a moderate departure from acceptable social work practice.

103. I accept Ms Begley's advice. Once the decision had been made to discharge Mr A to his home, substantial safety planning should have occurred, including planning for the safety of

Mr A's family. The failure to do so was a departure from the standard of care, in addition to the failure to follow the Health NZ policy on family violence.

Discharge home conclusion

104. Mr A should not have gone home on 31 Month2. Clearly, he was unwell, given that he had attempted suicide the same day and (as discussed above) there were multiple risk factors that were not given appropriate consideration by the psychiatric social workers. Against this background, it was inappropriate to expect Mrs A to take responsibility for her husband's mental health and safety. Mrs A was potentially at risk herself, given Mr A's history of family violence, and she had her own concerns and other problems to manage. It is inexcusable that no input on the decision to send Mr A home was sought from Mrs A or Mr A's wider support network. The decision to send Mr A home was a serious departure from the standard of care. As noted above, the psychiatric social workers also failed to follow the Health NZ policy on family violence.

Mitigating factors

105. The psychiatric social workers have both commented that there were resourcing issues at Health NZ on 31 Month2, which affected their ability to provide care to Mr A on that day. Those issues included:

a) No mental health service medical practitioners or other senior social workers were available on 31 Month2;

b) The mental health service cell phone was not operational;

c) The psychiatric social workers were unaware that Mr A was being held under section 109 of the MHCATA because the Police handover was inadequate; and

d) Without access to other senior colleagues and without appreciating that Mr A was being held under section 109 of the MHCATA, it was reasonable for the psychiatric social workers to proceed with the mental health assessment without advising the Police to transfer Mr A to hospital for an assessment by an appropriate medical practitioner.

106. Whilst I recognise that there were challenging working conditions on that day, it is my opinion that these issues were not a significant mitigating factor for the events that occurred. Unfortunately, there will always be the possibility of resourcing issues in a healthcare setting, and healthcare professionals need to act appropriately when that occurs. Although, according to Ms C's evidence, there was no duly authorised officer available to attend the assessment with them, they made no attempt to reach out to any senior mental health service staff member or appropriate clinician (or, in fact, anyone else), and insufficient attention was paid to the risk to (and burden on) Mr A's whānau. As my advisors have noted, the circumstances pointed to a man who was actively suicidal despite his statements that he was not, and this was not recognised or acted upon with the care required.

107. There was also a lack of clarity about the respective roles of the psychiatric social workers at the assessment. In response to the provisional opinion, Ms B told HDC that she was inadequately trained and qualified to undertake the assessment, and Ms C told HDC that

she was attending in an assistant capacity only and had been asked to attend at the last minute because the assistant Ms B had lined up to work with her that day was occupied with a court hearing. I comment on the psychiatric social workers' individual responsibility below. However, as a preliminary issue, I note that Ms B's team leader appears to have regarded Ms B's skills and training as sufficient for her to undertake the assessment of Mr A with the support of Ms C. That decision has not been criticised by my independent advisors, and I do not think that it warrants criticism.

108. I wish to acknowledge the impact of these tragic events on everyone involved, including the psychiatric social workers. A death in these circumstances no doubt continues to have a deep impact on those individuals long after the event. I also acknowledge the time that has passed since these events, and the significant training undertaken and the insightful reflections provided by the psychiatric social workers. I also wish to make it clear that the shortcomings in the care identified in this report are in no way intended to indicate that the social workers wanted anything other than to ensure that Mr A and his whānau remained safe.

Ms B — conclusion

109. Both Ms Begley and Dr Rae advised that the failures discussed above constituted departures from the standard of care. I agree with that advice. I am particularly critical that Ms B does not appear to have taken into account in the risk assessment her knowledge of Mr A's deteriorating mental health over the months prior to Month2.

110. In response to the provisional opinion, Ms B told HDC:

> '[I] was employed by [Health NZ] as a provisionally registered junior psychiatric social worker in the mental health service Adult Community Mental Health team. [I] had commenced employment with [Health NZ] in February 2014, two years before the event. This was [my] first role as a social worker after completing [my] qualifications. [I] had insufficient training in carrying out mental health risk assessments at the time.'

111. Ms B submitted that the fact that she was placed in a position in which she had to carry out a mental health assessment without the necessary training or experience was a substantial mitigating factor, and my other provisional findings, or criticisms of her care, were consequential from her proceeding to carry out the mental health assessment without the necessary training or experience.

112. Ms B also told HDC that she had attended mental health assessments with senior colleagues prior to 31 Month2, and that it was only in Month2, around the time of these events, that she started to lead mental health risk assessments under the supervision of senior colleagues. She also said that she had not completed the compulsory 'Mental Status Examination' training as she had been required to complete other acute clinical tasks and cover other staff due to resourcing issues, and she had not been given another opportunity to attend that training.

113. Ms B also said that she involved Ms C as a senior colleague to provide oversight guidance and it was reasonable for her to do so. I note that I have been similarly critical of the role Ms C played in these events in the opinion section about her below.

114. I put Ms B's comments to my independent advisor, Ms Begley. Ms Begley noted that although there was a lack of clarity as to the respective roles of Ms B and Ms C, the psychiatric social workers' supervisor had clearly assessed that there was a satisfactory level of competence between both psychiatric social workers to complete the task. Ms Begley also advised that two years of observing senior colleagues complete mental health assessments and safety plans could be regarded as 'on the job training'. In response, Ms B disputed that 'on the job' observations could amount to formal training. I accept that there is a difference between formal structured training, and experiential or observational on-the-job training. However, I agree with Ms Begley that Ms B would have gained some experience and knowledge with respect to assessments and safety plans during her two years in the role.

115. Ms Begley advised that she would consider it a departure from the acceptable standard of practice if Ms B agreed to complete social work practice outside the scope of work she felt qualified or trained to complete. In response, Ms B stated that it was reasonable for her to rely on her supervisor's judgement that it was appropriate for her to attend. I acknowledge that the supervisor's assessment was relevant, but I consider that if Ms B did not have the requisite skills and training, once she recognised this while assessing Mr A, she should have sought further support, rather than continuing.

116. In my opinion, either Ms B continued with an assignment she did not feel qualified or trained to complete, or she was sufficiently trained to carry out the assessment and did so inadequately. In either case, the result was that there were several deficiencies in the care Ms B provided to Mr A (as summarised in the next paragraph), such that a finding that she breached Right 4(1) of the Code is warranted.

117. In conclusion, I find that Ms B:

a) Failed to elicit vital facts, or failed to consider them adequately, when conducting the risk assessment;

b) Failed to complete the risk assessment form adequately to include all relevant information;

c) Failed to obtain information from any other party, including Mr E, Mrs A, and Mr A's psychiatrist, to inform the risk assessment carried out on 31 Month2;

d) Failed to consult an appropriate medical practitioner or senior colleague to assist in the assessment of Mr A;

e) Returned Mr A to his family home when he should have been admitted to hospital for compulsory treatment, his family was under-equipped to handle his mental health difficulties, and there was inadequate safety planning; and

f) Failed to communicate with Mrs A about the assessment or the plan to return Mr A to his family home.

118. Accordingly, Ms B failed to provide Mr A with health services with reasonable care and skill and breached Right 4(1) of the Code.[10] In reaching this conclusion, I have carefully considered and taken into account the difficult circumstances faced by the psychiatric social workers on 31 Month2.

Ms C — conclusion

119. Both Ms Begley and Dr Rae advised that the failures discussed above constituted departures from the standard of care. I agree with that advice.

120. Ms B was Mr A's key worker and took the lead on 31 Month2. Ms C told HDC that she was assisting during the assessment of Mr A, and that she was not familiar with Mr A or Mr E, or Mr A's mental health history. She said that, as the assistant worker, and not the key worker, she bore a lesser level of responsibility for the mental health assessment. I note that Ms C has accepted some responsibility for her part in the errors of 31 Month2, but she believes that her conduct did not amount to a breach of the Code.

121. Despite these arguments, Ms C remains responsible for the care she provided. Ms C was engaged as a psychiatric social worker to attend and assist with Mr A's assessment, she was party to most of the relevant information, and was more experienced and more appropriately trained than Ms B. Ms C, in response to the provisional opinion, added that she was not aware that Ms B had not completed her mental status examination training, or that she felt that she was not properly qualified or trained to undertake the mental health assessment. I accept that Ms C had no reason to doubt Ms B's ability to assess Mr A, but I remain of the view that, as she was present and assisting with the assessment, she could have acted at any point to remedy the failures identified.

122. In conclusion, I find that Ms C:

a) Failed to elicit vital facts, or failed to consider them adequately, when conducting the risk assessment;

b) Failed to obtain information from any other party, including Mr E, Mrs A, and Mr A's psychiatrist, to inform the risk assessment carried out on 31 Month2;

c) Failed to consult an appropriate medical practitioner or senior colleague to assist in the assessment of Mr A;

d) Returned Mr A to his family home when he should have been admitted to hospital for compulsory treatment, his family was under-equipped to handle his mental health difficulties, and there was inadequate safety planning; and

e) Failed to communicate with Mrs A about the assessment or the plan to return Mr A to his family home.

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

123. Accordingly, Ms C failed to provide Mr A with health services with reasonable care and skill and breached Right 4(1) of the Code. In reaching this conclusion, I have carefully considered and taken into account the difficult circumstances faced by the psychiatric social workers on 31 Month2, as noted by Ms C in her response to the provisional opinion.

Clinical records — adverse comment

124. Ms Begley also raised concerns about the quality of the clinical record-keeping by Ms B and Ms C. Ms Begley advised that there was a lack of information about:

a) What was discussed with Mrs A when they returned Mr A home;

b) The details of the handover from the Police; and

c) The rationale for the decisions made about Mr A's mental health management and his discharge home.

125. In particular, Ms Begley noted that Mrs A believed that Mr A would be admitted to hospital on 31 Month2, but there is no reference in the clinical record to this having been considered as an option. Ms Begley advised that the inadequacy of the psychiatric social workers' clinical notes constitutes a mild departure from the standard of acceptable social work practice. I agree that there are deficiencies in the patient notes.

126. In response to Ms B's comment that her case note recording that Mr A had attempted suicide on 31 Month2 was an error, Ms Begley advised me that, if the case note did not correctly record what Mr E told her, Ms B's case note represented a severe departure from the standard of acceptable practice. In light of my comments in paragraph 87, I do not consider that a finding on this is necessary.

127. The notes were largely made by Ms B, who appears to have taken the lead, and I am critical of the inadequacies in her documentation. In response to the provisional opinion, Ms B told HDC that she accepted that her clinical record-keeping in relation to this event could have been improved. She acknowledged that she should have engaged in training and supervision in this area at the time.

128. I also remind Ms C of her obligations to keep full and accurate patient notes, and I remain concerned that she did not take the opportunity to assist with the documentation of Mr A's assessment.

Paliperidone injection — other comment

129. Mrs A complained that Mr A was not administered his paliperidone depot injection on 31 Month2 despite asking for it. Ms Begley appropriately did not comment on the effect of the delay in administering Mr A's paliperidone injection, but she was critical that the psychiatric social workers did not consult with medically trained colleagues about whether the injection should have been administered on the day of the assessment. She advised that it is standard practice for social workers to advocate for a client to have his or her medical needs met and said that if the psychiatric social workers had taken that course of action, this may have allowed for further observation and assessment of Mr A by an appropriately trained medical professional. Ms Begley noted that it was not the role of the psychiatric social workers to

decide whether the paliperidone injection should be administered, but the failure to consult with a colleague with the appropriate level of medical training was a moderate departure from the standard of care.

130. In response to my provisional opinion, Ms C told HDC that she wanted to emphasise that it is not a social worker's job to administer an injection. She said that she and Ms B talked to Mr A about the injection and advised that they could look into getting it done the next day, agreeing with Mr A that a registered nurse would return the next day to administer the injection. Ms C said that, as she understood things, it was not possible to arrange for a registered nurse to administer the injection the same day. Ms C also stressed that she understood in hindsight that administering the injection on 31 Month2 would not have made a difference to Mr A's mental state.

131. I am not critical of the fact the psychiatric social workers did not administer the injection on that day — I agree that it was not their job. I note Ms Begley's advice that they should have consulted with a colleague with the appropriate level of medical training, rather than agreeing to return with a registered nurse the following day. I have considered Ms Begley's advice, Ms C's submissions, the submissions of both psychiatric social workers regarding the resourcing issues that day (in particular the absence of a working cellphone and the lack of available mental health service clinical staff), and the fact that Dr Rae has advised that the delay in Mr A receiving his paliperidone injection is unlikely to have affected his mental state significantly.

132. I am satisfied that, although ideally the psychiatric social workers would have consulted an appropriate medical professional, they did consult with Mr A, consider his wishes, and form a plan for his injection to be administered the following day. In those circumstances, I do not find that the psychiatric social workers breached the Code.

Opinion: Health NZ — adverse comment

133. I asked Ms Begley to consider whether the applicable Health NZ policies and procedures in place at the time of events were adequate and appropriate. Ms Begley advised that the policies and procedures in place in Month2 were adequate and appropriate. She also commented that Health NZ made changes to its policies in response to the circumstances surrounding Mr A's death, to ensure that there is no room for misinterpretation.

134. Except as I discuss below, I agree with that advice. As stated above, I consider that the failures in this case stem from the failure of the psychiatric social workers to follow standard and reasonable psychiatric social work practice, and in my view these failures were individual and not a result of systems issues at Health NZ. However, I wish to comment on the assertions by the psychiatric social workers that there were resourcing issues at Health NZ on 31 Month2, and the implication that these issues contributed to the failures described above. It is an unfortunate fact of the health system in New Zealand that available resources sometimes fall short of consumer need, and I note with approval the improvements made by Health NZ. Ideally, a duly authorised officer would have attended the mental health assessment with the psychiatric social workers on 31 Month2, but circumstances meant that

a duly authorised officer was not available. I am pleased to note that it is now a requirement for a registered mental health nurse to attend emergency calls.

135. Dr Rae said that generally the policies and procedures were appropriate, but identified several points where there was room for improvement. I make no criticism of Health NZ in this respect, but I will recommend that Health NZ consider whether these recommendations can be implemented.

Staff training

136. Ms Begley advised that Ms B's training was less than adequate at the time of these events. She noted that Ms B's training in Mental Status Examination (MSE) occurred eight months after Mr A's death. Ms Begley advised that it is challenging to understand how Ms B was able to undertake mental state examinations to the standard accepted by Health NZ prior to having received MSE training, and, on that basis, Ms Begley considered that Ms B's training was insufficient.

137. In response to the provisional opinion, Ms B gave further details of her training, including attendance at several mental health assessments with more senior colleagues. She also told HDC that she was not able to complete the training for Mental Status Examination due to acute clinical tasks and covering other staff on the day of training, and she was not offered another opportunity to complete this training. Ms Begley reviewed that further information and advised that it did not change her advice that Ms B's training was inadequate.

138. Dr Rae also commented on staff training. She advised that the Health NZ policy on Inservice Training was disappointing. Dr Rae stated:

> 'It has not been updated since 2015 and does not appear to include required frequency of attendance even at "compulsory" sessions. Instead, as far as I can see, it merely states that individual needs should be identified at annual appraisals; this seems to me an unreliable method of maintaining standards.'

139. I accept Ms Begley's and Dr Rae's advice. I remain concerned that Health NZ did not ensure that psychiatric social workers who were conducting mental state examinations had the appropriate training, although I note that in this case Ms C was present and had received training in MSE. I also remain concerned that the Health NZ policy on Inservice Training did not include the required frequency of attendance at vital training sessions.

Cultural issues — other comment

140. Mr A was Māori and I sought input from my Māori advisors, who wish to highlight one particular issue — the importance of whānau support.

141. Delivering culturally safe care focuses on the consumer experience and considered decision-making that enables quality of care (manaakitanga and tautikanga) and improved health outcomes. From a culturally responsive perspective, whānau support is paramount. Consultation and effective communication with Mrs A and Mr E as key partners in Mr A's

suicide risk assessment, safe release arrangements, environment considerations, as well as whānau needs to support his safety plan, is not evident (as discussed above).

142. Failure to recognise whānau as important partners in care planning, and to deny whānau the opportunity to be involved and participate in the decision-making of safety plans, is a practice that leads to inequalities in the health system for Māori.

Changes made since events

143. Ms B and Ms C both set out their reflections on the events detailed in this report, including the errors made and further training undertaken. Ms Begley advised that she agrees with those reflections, and I commend Ms B and Ms C on the steps they have taken to improve their practice since the tragic events described in this report.

Ms B

144. Ms B told HDC that after Health NZ carried out the SAER:

> 'I was placed under safety precautions for my clinical practice, I completed all assessments with a registered Nurse. I did not work collaboratively with a social worker since the incident. I had weekly clinical supervision with [the] Clinical Manager, my files were audited and I had to present comprehensive cases to the clinical manager and multidisciplinary team. I completed the mandatory training including QPR training and MSE Training. I was not responding to crisis assessments, acute assessments and was limited to working within the … Area. I had clinical supervision with a senior social worker working in [the] District Health Board. To further reflection and professional development at this time I engaged with Employee Assistance Program.'

145. Ms B also recounted a meeting in July 2019, at which Mr A's whānau, including Mrs A, were present. The whānau had the opportunity to ask questions, and Ms B apologised in person to the whānau.

146. Ms B also described her current practice, which involves working with a diverse multi-disciplinary team and includes daily debrief appointments, reviews, and multi-disciplinary team reviews. In particular, she described working closely with a psychiatrist, monthly supervision with a clinical nurse specialist or team leader, and monthly social work supervision. She is also supervised by a consultant psychiatrist and has weekly peer supervision.

147. Ms B told HDC that since 2016, she has endeavoured to keep her mandatory training up to date, and has completed further training, including (among other activities) training on psychosis, suicide risk management, care coordination, clinical handover, broader training in engaging with people who may be suicidal, open disclosure, cognitive behavioural therapy, trauma informed care, and early psychosis.

148. Ms B's statement contains substantial reflections on her practice and how she has sought to improve it.

149. In response to the provisional opinion, Ms B also told HDC that she has included clinical record-keeping as an area of her supervision and that she appreciates the importance of clear clinical documentation in ensuring high quality care outcomes. She said that she will continue to engage in available training and supervision opportunities to improve her clinical record-keeping skills.

Ms C

150. Ms C said that she also took measures to improve her practice after Mr A's death. She told HDC that she began working with a registered nurse, ensured that crisis and acute cases were managed by the wider team, worked closely with the multi-disciplinary team, engaged with a professional advisor, and engaged with clinical supervision and manager supervision. A review and audit of her caseload and clinical documentation was also carried out.

151. Ms C also described her attendance at the meeting with Mr A's whānau in July 2019, at which the whānau were given the opportunity to ask questions. Ms C stated:

> 'The emotional impact for [Mr A's] wife's and his whānau's ongoing grief and loss has continued to remain with me. My reflection of this process was to acknowledge the passing of [Mr A] and the whānau collective voice to ensure that his death is honoured and the learning and subsequent changes are used as [a] guide to my practice.'

152. Ms C listed training she has undertaken since the events described above. The training included (among other activities) being seconded to the Acute Care Team, which involved participating in crisis assessments involving suicidal ideation, and which Ms C describes as enhancing her practice as a mental health clinician and enriching her experiences in mental health services. She also completed courses in assessment and management of risk, management planning, case management, education by kaumātua for practice and participation with tangata whaiora and their whānau, mental status examinations, cross-cultural communication, dialectical behavioural therapy, speaking up for safety in the workplace, and distress tolerance. She also attended several conferences and seminars dealing specifically with Māori social work practices, and organised professional development workshops for Māori social workers.

Health NZ

153. Ms C and Health NZ described some changes in mental health service policies and care delivery, including that mental health service staff are now embedded in the community mental health team, which allows for greater collaboration and also access for mental health service staff to the skills of a greater pool of staff, and allows for local responses to requests by police, including attendance of duly authorised officers for the purposes of the MHCATA and input from a consultant psychiatrist.

154. Health NZ said that it recognised its system failings and sought to address them — primarily by ensuring that there are medical officers based in the region full time and ensuring that all the mental health service teams have access to after-hours medical support. As identified by the psychiatric social workers, Health NZ policy now requires duty teams responding to

emergency calls to include a registered mental health nurse who can act as a duly authorised officer (for the purposes of the MHCATA) and initiate compulsory treatment if necessary.

155. The SAER also details some changes made to the mental health service since these events. Health NZ's SAER stated:

> 'The [mental health] service is implementing a development plan to address standards of service provision and practice standards. The plan includes auditing of files, direct intervention with standards in MDT processes, increase in consultant resource and reallocation of team resource and coverage. For instance, more consistent allocation of staff to cover the … area from [the mental health service]. Staff visiting the … area are integrated with the local community mental health team and service delivery is now locally coordinated.'

156. The SAER also recorded that the psychiatric social workers participated in a development plan before returning to full duties, the detail of which was described by the psychiatric social workers (see above). The SAER also described increased clinical manager involvement, including regular updates by the psychiatric social workers to the clinical manager and ensuring that all patient documentation is completed by the end of each day, the abovementioned requirement for a registered nurse to attend all assessments, improved performance appraisal processes, and individual staff cell phones.

157. In response to the provisional opinion, which contained provisional recommendations about including competencies attained or compulsory training units for psychiatric social workers in their job descriptions, Health NZ provided HDC with a copy of its Allied Health Scientific and Technical Knowledge and Skills Checklist, which includes required training in mental status examination and risk detection and management, and a copy of its psychiatric social workers job description, which includes 'acceptance and experience of working with people with mental illness and alcohol and other drug problems' in its list of core competencies. Health NZ confirmed that training is monitored using the Checklist and during annual performance appraisals.

158. The provisional opinion also contained a proposed recommendation about the inclusion of frequency of attendance at compulsory training sessions in the Health NZ Inservice Training Policy. The Health NZ Allied Health Scientific and Technical Knowledge and Skills Checklist also now identifies the frequency with which each skills training is required.

159. Health NZ also confirmed that since 2019, an allied health documentation audit has been put in place, which is helpful in improving and maintaining standards of record-keeping.

160. In my provisional opinion, I also asked Health NZ to consider how it could improve (or how it had improved) its cultural safety practices by ensuring whānau support and involvement for Māori consumers, especially in respect of mental health assessments and safety planning. Health NZ told HDC that it has included Whānau Ora Hauora Māori roles to support and assist whānau to navigate through its service and offer connection to Iwi and NGO services within their locality. It said that these roles were put in place to improve cultural

safety practices by increasing involvement of Māori consumers and support available to whānau. Health NZ also noted that it had included a Tikanga Rua Bicultural Approach as part of key accountabilities in its allied health job description.

161. Health NZ also outlined several other training, education, and monitoring initiatives it has introduced since the events described in this report, and I commend it for the initiatives and improvements noted in this report.

Recommendations

162. In a case of this severity, where a man has died in potentially avoidable circumstances, I would ordinarily make several recommendations. However, Health NZ, Ms B, and Ms C have clearly reflected on the circumstances that led to Mr A's death and have made appropriate and effective changes to their practice. Ms B and Ms C have also undertaken significant extra training. I also acknowledge that a significant amount of time has passed since the events described in this report, and Ms B and Ms C are now more experienced and have progressed in their careers.

163. In my provisional opinion, I noted Dr Rae's comment that she was disappointed to see that Ms C had undertaken only one session on mental status examination, in 2016, only one on risk detection and management, and only a grand round in the addiction area. I therefore recommended that Ms C update HDC on further training she has undertaken in these areas. In her response to my provisional opinion, Ms C told HDC:

> '[I am] intent on continuing to learn and enhance my social worker skills all throughout my career, so am happy to continue to engage in training. I have worked extremely hard so far and taken part in many relevant trainings (I have counted 11 trainings which relate to mental status examination, risk detection and management and addiction.'

164. I commend Ms C for taking up these further training opportunities.

165. I also recommended that Ms B and Ms C consider this report, and the advice of Ms Begley, and reflect on their failings in this case, and that each provide a written report to HDC on their reflections, any further training they have undertaken, and any further changes to their practice they have instigated as a result of this case and as a result of further training they have undertaken. Annexed to their responses to my provisional opinion, Ms C and Ms B provided substantial and thorough reports covering those topics. I therefore have no further recommendations in respect of Ms C and Ms B.

166. In my provisional report, I also made several recommendations that Health NZ consider whether the policy and procedures recommendations made by Ms Begley and Dr Rae could be incorporated into its suite of policies and procedures, and also consider how it could improve (or how it has improved) its cultural safety practices by ensuring whānau support and involvement for Māori consumers. I have noted above in the section about changes made that Health NZ made several relevant and appropriate improvements to its policies and procedures, and therefore I have no further recommendations to make in respect of Health NZ.

Follow-up actions

167. A copy of this report with details identifying the parties removed, except the advisors on this case, will be sent to the Social Workers Registration Board, and they will be advised of Ms B's and Ms C's names.

168. A copy of this report with details identifying the parties removed, except the advisors on this case, will be sent to the New Zealand Police, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from a psychiatrist, Dr Alma Rae:

'Thank you for referring this case for an expert opinion.

My qualifications for commenting on it are a career in general adult psychiatry, much of it in the community, including work in various emergency mental health teams. Please see attached CV for further details.

In preparing this report I have received and read:

1. Letter of complaint 28 June 2019
2. [DHB's] response 27 November 2019
3. [Mr A's] clinical records from [the DHB]

I have been asked to comment on:

1. The assessment of [Mr A's] condition;
2. The appropriateness of care provided and whether further review was warranted (also on the coordination of [Mr A's] care);
3. The appropriateness of the safety netting advice and follow-up instructions provided;
4. The safety and appropriateness of [Mr A's] discharge home;
5. [Mr A's] depot injection being overdue;
6. Whether appropriate consideration was given to [Mr A's] substance use;
7. [The DHB's] communication with [Mr A] and his family; and
8. Any other matters that I consider warrant comment.

For each question, my advice is requested on:

a. The standard of care/accepted practice;
b. If there has been a departure from the standard of care/accepted practice, how significant is that departure;
c. How my peers would view this case;
d. Any recommendations I may have for improvement so as to prevent a similar occurrence.

1. The assessment of [Mr A's] condition

This was woefully inadequate. My first reading of it made me wonder if the staff concerned … had even had proper training in risk assessment. In respect of their documentation, the risk assessment form completed by [Ms B] exposed a range of errors:

- The rationale for the assessment was documented as "[Mr A] was in police cells … due to wife [Mrs A] raising concerns about risk." This was wrong. In fact, he was there because he had just been physically stopped from committing suicide.

> The mental health social worker (whom [Mrs A] had told about her husband's statement that he intended to [end his life] and who knew [Mr A] well) had gone looking for him and found him … When asked by the social worker what he was doing, [Mr A] stated that he was going to [end his life]. This information appears not to have been known by the assessing key workers, and it should have been. It is not clear what information they were given on arrival at the police station. Whatever that was, they should most definitely have contacted the staff member who had found [Mr A] … to establish a first-hand account of those all-important details necessary for a thorough risk assessment. Thus, the assessment was begun without vital information and in the context of a misapprehension of why it was being conducted at all.

- Under *Points of treatment at which RISK ASSESSMENT should occur*, only "significant change in mental state" is ticked, ignoring the fact that the tick box above included "accommodation change" and [Mr A] and family had just moved house, leading to his wife having a "breakdown" that very morning. Also, his [child] was sick.

- Under CURRENT RISKS, helpfully subsumed under the heading *Factors that may influence assessment of the Current Risk,* "Current Suicidal Ideation" was ticked as absent when on the 29th, 30th and 31st of [Month2] suicidal ideation had been expressed by [Mr A] to his probation officer and to his wife. On all three days appropriate contact was made with mental health services about this. [Mr A's] denial of suicidal ideation in the police station should not have been taken at face value nor allowed to trump all the other compelling evidence that he was indeed suicidal. The injunction under *Current level of risk* to "*take into account reports from other relevant people"* was ignored. It followed from the initial clinical failure to realise that suicidal ideation was obviously present, that none of the other factors listed on the form (*intent, lethality, plan, access*) were assessed at all.

- Under HISTORICAL RISKS [Mr A's] previous suicide attempt … was not noted. [Dr D] was aware of it, but he was not consulted at any stage of the assessment. Thus, another risk factor was missed.

- Under *Factors that may increase risk in the consumer/tangata whaiora and others "substance use, intoxication, withdrawal"* is ticked but there is no evidence of an appreciation on the part of the assessing staff of the ill effects of days of [drug] intoxication and insomnia on a man who already has a serious and enduring mental illness, and has been documented by his psychiatrist over the previous six weeks to be exhibiting early warning signs. [Mr A's] report that he had "spent most of [the previous] night crying" was indicative of [drug] withdrawal and should also have been taken into account, as should his gender and ethnicity, both of which are well known to be associated with a higher risk of suicide.

- Judgment of the overall risk was greatly impeded by all of the above failures.
- On my reading of the information, [Mr A's] current risk to self was "Serious" and his risk to others "Moderate".

In my opinion an adequate standard of care was not reached in this assessment, and accepted practice not observed. A Mental Status Examination was haphazardly recorded but far from complete. While some relevant questions were asked, the answers were not assessed according to other information, vital facts were glossed over or not enquired into at all, while the clinical acumen displayed fell well short of that expected of all mental health staff. Given that a s109 was in place the failure of a medical practitioner to attend the police station, as required by s109(1)(b), is incomprehensible. The Act is clear that this is a police responsibility. A medical practitioner may well have considered that initiating the Mental Health Act was advisable and [Mr A's] death prevented by a more skilled assessment by a psychiatrist. Failing that, the two assessing clinicians should have discussed their findings with a psychiatrist whether or not they themselves thought the risks were significant.

This was a severe departure from expected standards and I have no doubt my peers would agree.

My recommendations coincide with those made in the Root Cause Analysis (RCA) document prepared by [Health NZ]. It is an excellent, clearly presented, analysis demonstrating a refreshing willingness on the part of [Health NZ] to identify and remedy shortcomings in their staff and procedures.

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

The care provided was not appropriate, because the assessment was so poor. [Mr A] should have been admitted to hospital as a compulsory patient. I am sure that any psychiatrist in possession of the facts as they were known, or should have been known, on the afternoon of 31 [Month2] would have taken this course of action.

Essentially there was no coordination of care. Communication with the police was almost nil. No consultations were held by the two assessors with any other clinicians whatsoever. Their willingness to take so much responsibility on their own shoulders is in my view inexplicable and most certainly wrong. Further review was warranted and should have occurred.

The usual standard of care would have involved consultation with more senior colleagues and arranging further assessment using the Mental Health Act. A Duly Authorised Officer could have assisted but one was not contacted. The indicators for use of the Act were the high level of risk and [Mr A's] plainly disingenuous denial of suicidality in the teeth of much evidence to the contrary. The fact that the two [social workers] did not think the risk was high in no way excuses their decision not to consult anyone else.

I would reckon this a severe departure from usual standards and would expect my peers to agree. These [social workers] needed much more education and training in order to do effective risk assessment and to know when and how to invoke the Mental Health Act.

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

The referral (a FYI only) to the Mental Health Emergency Team (MHET) was perfunctory and inadequate given [Mr A's] presentation. At the VERY least MHET should have been asked to contact [Mr and Mrs A] assertively and not wait for [Mr and Mrs A] to ring them. More information should have been given to MHET to assist with this.

Instructing [Mr A] to take olanzapine in addition to his usual medication, not to take alcohol or illicit substances and to phone MHET if he was feeling "sad, cries or feels suicidal" was tragically naïve. [Mr A] was a distressed man with a distressed family and a drug habit, not to mention [drug] withdrawal and a destabilised psychotic illness. The chances that he would or even could comply with these instructions were vanishingly small. Also, refusal of respite is very common for a range of reasons and should not have led the [social workers] to default to a lesser level of care.

4. The safety and appropriateness of [Mr A's] discharge home

[Mr A's] discharge home was misguided, unsafe and inappropriate, as I hope my comments above have explained. Even if there had been no history of serious domestic violence, and his wife not so stressed that she described herself as having a "breakdown" that morning, it would have been unwise and unfair to expect her or any family to handle this level of risk. That is what mental health services are for. Of course she said he could stay; what abused wife would dare to refuse? Especially one who had explicitly blamed herself for a previous assault he made on her. [Mr A] should never have been taken home in these circumstances.

This represents a severe departure from the norm. Also see question 7.

5. [Mr A's] depot injection being overdue

I agree with the advice given to the RCA team (p8) that the lateness of [Mr A's] depot paliperidone injection is unlikely to have affected his mental state to any significant extent. This is a fairly trivial departure from expected standards of care, and I am sure my peers would agree. Obviously, it is not desirable, but there is considerable flexibility in pharmacological and clinical terms in the administration of long-acting depot medication and I do not find this particular example, by itself, problematic, except inasmuch as it may indicate a more general level of disorganisation in the service.

In my view this is only a mild departure from usual standards; I believe my peers would agree. [Health NZ] has already taken steps to remedy the gaps exposed in medication prescribing and administration.

6. Whether appropriate consideration was given to [Mr A's] substance use

It was not. [Mr A] was clearly describing the very unpleasant symptoms of [drug] withdrawal after a heavy binge over [25 Month2] to [28 Month2]. As well as leading to low mood, [drug] withdrawal causes marked feelings of agitation, which are known *sui generis* to be associated with suicide. Also, his insight and judgment would be more impaired than usual in this condition, and impulsivity increased. As well as their association with poor self-management and suicide, these factors go to my comment in question 3 regarding [Mr A's] likely inability to comply with the instructions he received at the end of his assessment. We also know that he was abusing alcohol in an attempt to manage his insomnia, which raised his risk still further.

Failing to take these factors into consideration was a severe departure from expected and usual standards and practice; I have no doubt my peers would agree.

The RCA recommendations do not specifically include better education about the adverse effects of substance use disorders in relation to risk; if such education is not already being attended to by [Health NZ] then I recommend that it should.

7. The DHB's communication with [Mr A] and his family

In relation to [Mrs A], this was extremely poor, verging on outrageous. Staff did not involve her in [Mr A's] assessment (which could have been done by phone conferencing during the assessment, or by discussion afterwards) and nor did she have any warning of the plan formed without her input to deposit [Mr A] at home, which is really quite astonishing, and inexcusable regardless of the phone situation. The power dynamics at play when she found two mental health professionals and her abusive husband on the doorstep could hardly have disadvantaged her more. It would be a very unusual woman in such circumstances who could or would turn her husband away, however much she wanted to. Mental health professionals are supposed to know these things and behave accordingly.

Summary

This was a tragic and avoidable death brought about by incompetence and by failure to follow basic processes and procedures common to all mental health services. The two [social workers] did a very poor assessment and failed to communicate effectively with anyone at all. They demonstrated a serious lack of knowledge about either the science or the art of risk assessment. They did not consult colleagues. They effectively dumped [Mr A] on his wife without any prior discussion.

Overall, this sad event represented a travesty of usual standards and expected practice. However, the RCA was first rate and I take the liberty of congratulating [Health NZ] on its response.

May I extend my sincere sympathy to [Mrs A] and all the whānau.

Dr Alma Rae
MBChB FRANZCP MBHL

5 June 2020'

The following further advice was obtained from Dr Rae:

> 'Thank you for allowing me to read and comment on [Health NZ's] responses, dated 8 October 2020. I apologise for my delay in doing so.
>
> The responses do not change my initial report, as obviously that pertains to the events of 2016.
>
> However, it is clear that [Health NZ] has taken this event seriously and put considerable work into improving their mental health services in both practical ways and via updated policies and procedures.
>
> I was impressed by the genuine regret and obvious sincerity expressed in the letters from the two keyworkers. [Ms B] especially has been inspired to do more training. [Ms C] has also, but seemingly to a lesser extent: on viewing the list of formal training that she has done since the event (Appendix 5 in the [Health NZ] response) I am disappointed to see one session on Mental Status Examination, in 2016, only one on risk detection and management and that not until 2020, and only a Grand Round in the addiction area. I do not blame [Ms C] for this; seeing that all mental health staff attend more regular and timely training in these areas is the responsibility of management. In my opinion, social workers in mental health need these skills and knowledge to practise safely. The documents in Appendix 3 do not satisfactorily address this, in my view, including as they do a requirement only for two years' experience in mental health rather than evidence of actual competence or a list of compulsory training units that must be accomplished after being appointed. To her credit [Ms C] has done a huge amount of extra training specific to her role with [the] mental health service, which is entirely appropriate.
>
> The updated policies in Appendix 4 are generally good. It is particularly pleasing to see the requirement for a Registered Nurse at all police cell assessments ([the DHB]); a comprehensive policy on engagement with whānau ([the DHB]); a policy on staff safety ([the DHB]) recognising the desirability of having two clinicians attending home visits; policy on provision of and attendance at supervision ([the DHB]).
>
> The Keyworker Roles and Responsibilities policy ([the DHB]) lists many roles and a huge amount of responsibility. I would comment that, while recognising that the HDC legislation does not provide for lack of resources being an excuse for inadequate standards of care, and while knowing that mental health is chronically and ubiquitously under-resourced, it is *extremely* important that keyworker caseloads be accordingly constrained. In practice, in my experience, this is pretty rare.
>
> The policy on Inservice Training ([the DHB]) is disappointing. It has not been updated since 2015 and does not appear to include required frequency of attendance even at "compulsory" sessions. Instead, as far as I can see, it merely states that individual needs should be identified at annual appraisals; this seems to me an unreliable method of maintaining standards. If I have missed something, I withdraw this comment.

Regarding the question asked by the HDC office about contact with [Mrs A] after the initial event (see [the DHB] reply no. 11) I was sad to see that apart from apologising at the inquest, which I assume [Mrs A] attended, [the DHB] has not had any contact with her.

> "There were no meetings held, this was addressed at the Coroners meeting [at] which [the DHB] apologized for not having any contact."

In [the DHB's] response no. 8 they state that "The policies at the time were carried out (Appendix 4)" which is odd because some of them were not. Perhaps this is some sort of typo.

In summary, in my opinion [the DHB] has responded constructively and honestly to the event concerned.

I offer again my sincere condolences to the whānau.

Dr Alma Rae
FRANZCP MBHL
Consultant Psychiatrist

21 January 2021'

Appendix B: Independent clinical advice to Commissioner

The following independent advice was obtained from a psychiatric social worker, Ms Nicole Begley:

'To whom it may concern,

I have been asked to provide an opinion to the Commissioner on case number 19HDC01187 ([Ms B]/[Ms C]/[the DHB] (now [Health NZ])). I have read and agree to follow the Commissioner's Guidelines for Independent Advisors, and I am not aware of any conflicts of interest with any of the parties involved in this complaint.

I am a registered clinical social worker with a Bachelor of Social Work (BSW), and a Post Graduate Diploma in Health Sciences (PGDipHealSc) with Distinction, endorsed in Mental Health. I am a level 2 accredited ACC Sensitive Claims Counsellor, and ACC accredited social worker and group work facilitator. I have completed training in family violence risk assessment and working collaboratively, as well as refuge advocacy and peer support training. I am trained in Cognitive Behavioural Therapy, Corrections and Stopping Violence Services nonviolence programs, and the Incredible Years and Tuning into Kids parenting programs. My training in the field of mental health includes papers in assessment and treatment of mental health disorders as well as papers in forensic and perinatal mental health. I have worked for Women's Refuge and the Christchurch Family Safety Team where the focus has been with high-risk victims of family violence, and with perpetrators of family violence at Stopping Violence Services. I am currently employed as a team leader at Presbyterian Support Upper South Island where I lead 10 psychologists, counsellors and social workers. We work with tamariki, rangatahi and whānau.

I have been asked to answer the following questions in relation to the above-mentioned complaint:

1. The adequacy of the training received by [Ms C] and [Ms B];
2. The assessment of [Mr A] by [Ms B] and [Ms C] at [the] Police Station on 31 [Month2];
3. The safety and appropriateness of [Mr A's] discharge home on 31 [Month2];
4. Whether all relevant factors, including [Mr A's] drug use, were properly considered.
5. Whether information or opinions should have been sought from other parties for the purposes of [Mr A's] assessment on 31 [Month2].
6. Whether the assessment and treatment of [Mr A] reflected appropriate principles of cultural safety.
7. Whether [Mr A's] Paliperidone depot injection being overdue was a problem and, if it was, whose responsibility was it, and should it have been offered either at the time of the assessment on 31 [Month2] or at another time.
8. Whether communication with [Mr A's] whānau was sufficient and appropriate.
9. The adequacy and appropriateness of [the DHB's] policies and procedures in place both at the time of these events, and as revised since the events.

10. The reasonableness of the care provided by [Ms B] and [Ms C]; and
11. Any other matters in this case that you consider warrant comment.

For each question I have been asked to advise on the following points:

a) What is the standard of care/accepted practice?
b) If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?
c) How would it be viewed by your peers?
d) Recommendations for improvement that may help to prevent a similar occurrence in future.

I have reviewed the following information to formulate my advice.

1. Letter of complaint via referral from the Nationwide Health and Disability Advocacy Service, dated 28 June 2019;
2. [DHB's] responses dated 27 November 2019 and 8 October 2020;
3. Clinical records from [the DHB] covering the period 31 [Month2];
4. Timeline of events provided by [the DHB];
5. Statements of [Ms B] and [Ms C];
6. [DHB] psychiatric social worker employment agreement and position description;
7. The [DHB's] policies in effect in 2016 and as amended;
    a. Triage;
    b. Key Worker Roles and Responsibilities;
    c. Clinical Assessment;
    d. Administration of Medications in the Community Mental Health Services;
    e. Partner Abuse (Family Violence) Policy and Procedure;
    f. Risk Assessment Documentation;
    g. Safety of Community Mental Health Staff;
    h. Service User and Family/Whānau Participation;
    i. Clinical and Professional Supervision; and
    j. Inservice Training Packages for Mental Health Staff (Compulsory and Recommended);
8. Training records for [Ms B] and [Ms C]; and
9. The Improvements Made and Recommendations sections of [the DHB's] Serious Adverse Event Review dated … 2016.

I have clarified with [the HDC investigator] that I have received all of the information available to me, therefore I complete my report based solely on this.

Brief summary

[Mr A] was a [man in his thirties] under the care of the Māori Mental Health Service … [Mr A] had a diagnosis of paranoid schizophrenia and was also a regular user of [drugs] and alcohol.

On 30 [Month2], [Mr A's] wife rang [the mental health service] and spoke to [Ms B], saying that [Mr A] was feeling down and wanted to [end his own life] that morning. [Ms B] then spoke to [Mr A] who reported that he had felt stressed and suicidal and had taken Zopiclone, slept and now felt fine. On 31 [Month2], [Mr A] attempted to [end his own life], but his social worker, [Mr E] intercepted him and called the Police. [Mr A] was assessed by [Ms B] and [Ms C] in [the] Police Station. He was offered crisis respite care for the night, but declined it. He was released home with a plan for Olanzapine for sleep, to contact mental health services if he needed, and for his Paliperidone depot injection to be administered on 1 [Month3].

[Mr A] returned home and, within a few hours, he died by suicide …

The Complainant, [Mrs A's] account of events differs from those outlined above. [Mrs A] states in her 28 June 2019 complaint that [Mr A] was to be admitted to [hospital] following the mental health assessment by the [DHB's] Māori Mental Health Service … team at [the] Police Station, and that this did not occur.

1. The adequacy of the training received by [Ms C] and [Ms B];

It is my opinion based on information contained in the training record that [Ms C's] training prior to the 31 [Month2] is adequate as it covers general areas of practice relevant to the field of mental health including suicide risk assessment and management, psychosis, mental state examination, DBT, CBT, the mental health act and other areas relevant to her role as a social worker. It is unclear from the information provided to me if [Ms C] undertook formal training in social work, but this is listed as an essential qualification in the psychiatric social worker job description.

It is my opinion based on information contained in the training record that [Ms B's] training prior to the 31 [Month2] is less than adequate. [Ms B's] training does cover general areas of practice relevant to the field of mental health including suicide risk assessment, DBT, CBT and the mental health act which are areas relevant to her role as a social worker.

[Ms B] completed her training in Mental Status Examination (MSE) in …, eight months after [Mr A's] death. It is unclear from the information provided if [Ms B] undertook any informal/in-service training on MSE prior to [Month2]. It is challenging to understand how [Ms B] was able to undertake mental state examinations to the standard accepted by [the DHB] prior to receiving this training, and on this basis I have formed my opinion that [Ms B's] training was less than adequate. It is unclear from the information provided to me if [Ms B] undertook formal training in social work studies, but this is listed as an essential qualification in the psychiatric social worker job description.

I am unclear if [Ms C] or [Ms B] were practising as registered social workers during 2016, as there is no information provided around their practising certificates. Mandatory social work registration was not implemented until 2021, however many social work practitioners chose to voluntarily register prior to this date, either with the Social Work Registration Board, or the Aotearoa New Zealand Association of Social Workers. Voluntary registration ensured social workers achieved a minimum standard of practice competence. (Social Workers Registration Board, accessed November 2022.)

2. The assessment of [Mr A] by [Ms B] and [Ms C] at [the] Police Station on 31 [Month2];

After thoroughly considering the information provided to me in the form of clinical records and the timeline of events it is my opinion that the mental health assessment of [Mr A] on the 31st of [Month2] does not meet a standard of acceptable practice.

When undertaking the risk assessment [Ms B] overlooked the information referenced in the timeline of events, that she had received a phone call from [Mrs A] on the 30th [Month2] stating that [Mr A] was feeling down and had reported wanting to [end his own life]. Additionally, [Ms B] overlooked the information that [Mr A] was brought to [the] Police station by the police after a suicide attempt earlier that day … It is my opinion that this information is evidence of an increase in risk as [Mr A] has developed suicidal thoughts, developed a suicide plan and then made a suicide attempt. The document which outlines the Timeline of events references an increase in [Mr A's] risk noted at psychiatric reviews by [Dr D] on the 19th of [Month1] and the 18th of [Month2], which [Ms B] attended with [Mr and Mrs A]. [Ms B] appears to have relied too heavily on the self reports from [Mr A] when completing the risk assessment document that he was not experiencing suicidal ideation during the assessment, and dismissed the other information she held, which was critical to an accurate assessment of [Mr A].

[Ms B's] assessment on the 31st of [Month2] does not appear to account for [Mr A's] self disclosure during a phone call on 22nd [Month1] that stress and sleep were his relapse indicators. [Mr A] reported that stress from a recent move and a significant lack of sleep was present during the assessment at [the] Police Station. It is my opinion that when [Ms B] completed the risk assessment document she focused too heavily on that moment in time, and in doing so minimised the importance of the additional information that she was privy to.

Caution should be observed around the reliance upon suicide risk assessment tools alone (Mulder, 2011) and therefore these should be used in conjunction with practitioner critical thinking, prior knowledge of the patient, by consulting with multi-disciplinary colleagues and other relevant people; in this case these people were [Mr E], the police officer …, and [Mrs A].

I have consulted the facts of this case with [two of my colleagues] (personal communication, 16 November 2022) one a registered social worker, the other a registered psychologist, and they were both of the opinion that [Ms B's] assessment

overlooks the knowledge she had as [Mr A's] key worker, and fails to consider information held by other people such as the police, [Mr A's] support worker and the treating psychiatrist.

It is my opinion that as [Mr A's] key worker [Ms B's] assessment of [Mr A] was a severe departure from the standard of acceptable practice due to [Ms B's] failure to consider [Mr A's] recent suicidal plan, and attempt that same day, and the presence of [Mr A's] relapse indicators.

3. The safety and appropriateness of [Mr A's] discharge home on 31 [Month2].

After consideration of the information provided to me in the form of clinical records, the timeline of events and [Ms B] and [Ms C's] statements to the Health and Disability Commissioner, it is my opinion that [Mr A's] discharge home was not an appropriate plan, as there is a lack of evidence that the following factors were considered:

- [Mrs A] had disclosed to [Ms B] during a phone call earlier on the 31st of [Month2] that she was feeling stressed due to the move of house and that she had had a breakdown earlier that day
- [Mrs A] had disclosed to [Ms B] during a phone call earlier on 31st of [Month2] that [her child] was unwell
- [Ms B] noted during her assessment of [Mr A] at [the] police station that [Mr A] had a history of assaulting [Mrs A] when he is unwell
- [Mr A] was on bail for a charge of assaulting [Mrs A] during [Month1].

When considering the above-mentioned factors, it is my opinion that it was unreasonable to expect that [Mrs A] was the sole person tasked with managing her husband's mental health, his abstinence from drugs and alcohol, and compliance with the mental health safety plan alongside managing the risk of family violence, her own mental health, and the health of her [child].

By her own disclosure at the time of dropping [Mr A] home, [Mrs A] advised [Ms B] that she was having panic attacks. There is no mention in the clinical notes whether consideration was given to [Mrs A's] mental health, [Mrs A] and her children's safety, no reference of a safety plan regarding the risk of family violence, and no mention of [Mrs A's] supports, whether formal or informal. [The DHB's] 2016 policy on Partner Abuse (Family Violence) provided guidance around identification and safety planning of Family Violence, and the contact details of specialised Family Violence agencies that could have been consulted with. It is my opinion that [Ms B] and [Ms C] did not follow [the DHB's] policy on Partner Abuse (Family Violence).

According to the provided training records, [Ms C] and [Ms B] had both completed training in family violence, however [Ms C] was not present during the conversations between [Ms B] and [Mrs A].

It is my recommendation that all staff who are provided training in family violence can gain an understanding of the power and control dynamics of relationships where family

violence has occurred or is occurring. It would also be my recommendation for clinicians who are unsure about the appropriateness of a family violence safety plan, or how to develop one, make direct contact with an organisation that is able to assist with this E.G. a local women's refuge, or local family violence police officers, and are provided these contact numbers in the form of a wallet card, or other easily retrievable document.

4. Whether all relevant factors, including [Mr A's] drug use, were properly considered

After reviewing the information in the clinical notes it is evident that [Mr A] was forthcoming with disclosures around his use of [drugs] … no more than one week prior to his assessment on [31 Month2]. [Mr A] describes the quantity that he used as being "quite a lot", the risk assessment document states that [Mr A] was "coming down" from his use of [drugs], and there is also mention of alcohol use during [the weekend].

It is my opinion that [Ms C] and [Ms B] practising as psychiatric social workers were not able to understand the impact of [Mr A's] drug use, and to make a decision on its relevance or nonrelevance to his current presentation. It is my opinion that there was a missed opportunity to consult with the treating psychiatrist to gain their specialised understanding of how [Mr A's] [drug] use may have been impacting his mental health, lack of sleep and mood. This is expanded upon in point 5.

5. Whether information or opinions should have been sought from other parties for the purposes of [Mr A's] assessment on 31 [Month2]

[Ms B's] statement to the Health and Disability Commissioner reports that she requested a hand over from [the police] prior to her assessment of [Mr A] on 31 [Month2], and the reception was not warming. [Ms B] has reflected in her statement to the Health and Disability Commissioner that this handover from police was critical as she would have then known [Mr A] was being held under section 109 of the Mental Health Act, which would have enacted the procedure of a Duly Authorised Officer and a Medical Officer attending and completing [Mr A's] assessment.

[Ms C] reflected in her statement to the Health and Disability Commissioner that the clinical manager or treating psychiatrist should have been consulted about the plan, and it is necessary that time is given to gather all information relevant to an assessment. I agree with [Ms C's] reflection that it would have been useful to have consulted with her manager or the treating psychiatrist.

[Ms B] has reflected in her statement to the Health and Disability Commissioner that consultation with her manager and [support worker] [Mr E] was lacking, and that this information was critical to her formulating a plan. From the information provided to me in the timeline of events and clinical notes, it is my opinion that further consultation with [Mr E] at the time of the assessment was critical as [Mr E] intercepted [Mr A] … and he was the person who reported his concerns for [Mr A] to the police.

There is reference to an 11:45AM phone call between [Ms B] and [Mr E] on [Month2] 31st, which would have been an appropriate opportunity to gather details about the

circumstances of [Mr A's] suicide attempt …, [Mr E's] assessment of [Mr A's] presentation, and what if any concerns he had for [Mr A's] wellbeing. It is my opinion that as [Mr A's] key worker, and as the clinical notes state was the person completing the assessment of [Mr A] that the responsibility to seek this information and guidance from others was the primary responsibility of [Ms B].

I agree with [Ms B's] reflection that it was necessary for her to have had a detailed handover from the police, and to have consulted with the treating psychiatrist and her clinical manager prior to enacting the plan to return [Mr A] home.

It is my opinion that it was imperative that [Ms B's] plan to return [Mr A] home was signed off by a senior colleague, and that [Ms B's] failure to do this was a moderate departure from acceptable social work practice. There is no explanation given in either [Ms B's] or [Ms C's] statements, or the clinical notes as to any barriers which prevented consultation with key people in this case, and it is my opinion that while [Mr A] was being held in a secure location, that consultation with the police, [Mr E], the clinical manager and the treating psychiatrist should have been prioritised.

6. Whether the assessment and treatment of [Mr A] reflected appropriate principles of cultural safety

After reviewing the documentation provided to me, there is no record of [Mr A's] ethnicity, however it is my assumption that he identified as Māori as he was a patient under [the] Māori Mental Health Service … As a pākehā woman, it is my opinion that I am not able to provide expert advice on the cultural safety of [Mr A's] assessment and treatment.

7. Whether [Mr A's] Paliperidone depot injection being overdue was a problem and, if it was, whose responsibility was it, and should it have been offered either at the time of the assessment on 31 [Month2] or at another time

When reviewing the clinical notes of [Ms B] and the timeline of events it is noted that [Mr A] requested his injection, or states "need my injection" at the time of the assessment at [the] police station. It is my opinion that this request was an opportunity for [Ms B] and [Ms C] to consult with their colleagues about the possibility of [Mr A] having his injection administered at [the] police station, or at another suitable venue. It is standard social work practice to advocate for a client to have their medical needs met, and it is my opinion that [Ms B] or [Ms C] were in a position to support [Mr A] to receive his Paliperidone injection on the day of his request. The information in the psychiatric social worker job description describes this as a key responsibility of the role. This course of action may have allowed for further observation and assessment of [Mr A] by an appropriately trained medical professional.

As a social worker without training in the field of medicine, I am unable to comment on what effect [Mr A's] overdue Paliperidone injection had on his presentation at the time of assessment. After reviewing the training records of [Ms C] and [Ms B] it is my opinion that they were not in a position to make a decision about the appropriateness to delay [Mr A's] Paliperidone injection to the 1st [Month3] due to a lack of medical training, or

training in psychiatric drug administration. It is my opinion that this decision should have been made in consultation with a colleague with the appropriate level of medical training, as per [the] 2016 policy on Administration of Medications in the Community Mental Health Services. It is my opinion that [Ms B's] decision was based on a lack of knowledge, departing from the responsibilities and policies of her position, and is a moderate departure from the standard of practice acceptable from a psychiatric social worker.

8. Whether communication with [Mr A's] whānau was sufficient and appropriate

After review of the clinical notes, and in reference to the conclusions I made in point 3, it is my opinion that [Mrs A] should have been contacted prior to [Ms B] and [Ms C] enacting the plan of returning [Mr A] home. This contact would have created an opportunity to gather [Mrs A's] views on the proposed plan, without the presence of [Mr A], and the pressures that may have come with the factors outlined in point 3.

It is standard social work practice to explore a client's support networks (formal and informal) and contact these if the client requests. It is noted that [a police officer] offered to contact [Mr A's] father and brothers and this offer was declined. It is unclear from the clinical notes if any other supports were explored with [Mr A]. It is my opinion that this lack of communication with [Mrs A] is a mild departure from the standard of acceptable social work practice.

9. The adequacy and appropriateness of [the DHB's] policies in place both at the time of these events, and as revised since the events

After a detailed review of [the DHB's] policies in place at the time of [Mr A's] death it is my opinion that the policies in place at the time were adequate and appropriate. It is my opinion that the updated policies have been revised in such a way as to ensure there is no room for misinterpretation and include changes made which appear to have been added in response to the circumstances surrounding [Mr A's] death. As I have mentioned in previous points, it is my opinion that [Ms C] and [Ms B] have not strictly adhered to [the DHB] policies that were in place at the time of [Mr A's] death, and as this relates to several [DHB] policies it is my opinion that this is a moderate departure from the acceptable standard of social work practice.

10. The reasonableness of the care provided by [Ms B] and [Ms C]

I have detailed in several instances during this report that it is my opinion that [Ms B] and [Ms C's] actions were a departure from acceptable standards of social work practice, and therefore on this basis I do not consider their care of [Mr A] reasonable.

With the benefit of hindsight [Ms B] and [Ms C] have both outlined in their statements to the Health and Disability Commissioner some of the errors they have identified in their practice, and I agree with these reflections.

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

After considering the information provided to me for the purposes of writing this report, it would be remiss of me to not raise my concerns with the commissioner about the quality of the clinical records provided. There is a lack of information in the clinical records as to what was discussed between [Ms B] and [Mrs A] at the time of returning [Mr A] home, other than details of the overnight plan for the management of [Mr A's] mental health. There is a lack of information about the details provided during a hand over from the police, which is referenced in both [Ms B] and [Ms C's] statements, and a lack of case noted rationale regarding the decisions made around the plan for [Mr A's] mental health management and [Mr A's] discharge home.

Significantly, [Mrs A] states in her complaint that [Mr A] was to be admitted to [hospital]. There is no reference to this being considered in the clinical records from the day, however with the lack of detail provided in these, it is unclear if this was discussed or explored as an option.

The job description of a psychiatric social worker at [the DHB] states that all documentation is to be completed concisely, accurately and objectively, and it is my hope that this is outlined for new staff during their orientation. It is my opinion that [Ms B] and [Ms C's] clinical notes are a mild departure from the standard of acceptable social work practice. It is my recommendation that as part of [the DHB's] induction training for mental health staff that this include a component of acceptable standards of record keeping and writing of case notes.

Reference List

- Mulder R. Problems with Suicide Risk Assessment. Australian & New Zealand Journal of Psychiatry. 2011;45(8):605–607. doi:10.3109/00048674.2011.594786
- Social Workers Registration Board, Rehitatanga ā-ture Mandatory registration, https://swrb.govt.ndabout-us/legislation/mandatorv-the-nextstep/accessed November 2022

Should you require any further information please do not hesitate to contact me.

Ngā mihi

Nicole Begley BSW, PGDipHealSc (Mental Health)'

Following my provisional opinion, the following independent advice was obtained from Ms Begley:

'I have been asked to review [Ms B's] response, dated the 23 April 2024, [Ms C's] response, dated 7 May 2024, and [Health NZ's] response, dated 3 May 2024 to the Health and Disability Commissioner's provisional decision for the above-mentioned

complaint. These responses include new information that was not contained in the original documents provided to me on which I formulated my advice.

For ease of reference, I will set out my comments using headings, referencing the response, paragraph number, and the information provided I consider as "new information". I have been asked by the Health and Disability Commissioner to answer the following questions:

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

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?

c. How would it be viewed by your peers?

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

Training

[Ms B] explains in paragraph 18 of her response that she had spent two years in her role observing senior colleagues complete mental health risk assessments and safety plans. I believe this could be considered as "on the job" training. Paragraph 19 states that [Ms B] was not able to complete the training for "Mental Status Examination" due to acute clinical tasks and covering other staff on the day of training. The context of [Ms B] not completing this training, and the "on the job" training she has completed was not available to me when I formulated my original advice, however this does not change my advice that [Ms B's] training was inadequate.

Role Clarity

Paragraph 21 of [Ms B's] response explains that she discussed the request for a mental health assessment for [Mr A] with [her team leader]. [The team leader's] agreeance with this proposal, and the plan to complete this with the support of [Ms C] would suggest that [the team leader] assessed a satisfactory level of competence between both social workers to complete the task. [Ms B's] response states that she was not "properly qualified or trained to undertake the mental health assessment". It is my assessment that if [Ms B] agreed to complete social work practice outside of the scope of work that she felt qualified or trained to complete, then this is a moderate departure from the acceptable standard of practice. It is my recommendation that should [Ms B] find herself in a scenario in her future social work practice where she is asked to engage in tasks that are outside her skillset, that she voices this with her supervisor immediately.

[Ms C's] response, at paragraph 17.1, references that her role was to assist [Ms B] to complete the mental health assessment, rather than to lead this. After reading both social workers' responses, there appears to be a lack of role clarity between [Ms B] and [Ms C] during [Ms B's] mental health assessment, as in their reflections [Ms B] has

referenced being underqualified, and [Ms C] has referred to undertaking an assistant role.

[Mr A's suicide attempt]

Paragraph 23 of [Ms B's] response states that her case note dated the 31 [Month2], where it is recorded that [Mr E] phoned to say he had stopped [Mr A] from [ending his own life] is not an accurate reflection of the phone call. [Ms B] states that [Mr E] had in fact reported that [Mr A] had suicidal ideation. Based on [Ms B's] comments in paragraph 23 of her response it is my conclusion that [Ms B's] case note for this contact is a severe departure from the standard of acceptable practice. [Ms B] has acknowledged in her response that her clinical record keeping could have been improved. It is my recommendation that [Ms B] complete formal training in clinical case noting.

At paragraph 25 [Ms B] states that she was not made aware of [Mr A's] suicidal ideation over the three days prior to completing the mental health assessment, and this was the reason for [Ms B] and [Ms C] to accept that [Mr A] did not have any current suicidal ideation. [Ms B's] case note from several hours prior to completing the mental health assessment with [Mr A] states that she took a call from [Mr E] where he had stopped [Mr A] from [ending his own life]. [Ms B] states in paragraph 23 of her response that this case note is not an accurate reflection of the information [Mr E] gave her, and that she was made aware that [Mr A] had suicidal ideation. There is a discrepancy between [Ms B's] recollection of the phone call and the details of this recorded in her case note, yet both accounts confirm that [Ms B] was aware of [Mr A] having suicidal ideation several hours prior to her and [Ms C] completing the mental health risk assessment, therefore it is my belief that "current suicidal ideation" should have been considered as a "current risk" on the risk assessment form. It is my view that not considering [Mr A's] suicidal ideation when completing the risk assessment form is a moderate departure from the standard of acceptable social work practice.

Paragraph 17.5 of [Ms C's] response states that [Ms B] asked [Mr A] about attempting to [end his own life]. [Ms C] states that [Mr A] denied any attempt to [end his own life] and that his support worker had picked him up. [Ms C] states that [Mr A] denied he was suicidal, … his support worker had picked him up and not long after the police arrived and took him to the station. This information is in contrast to the information [Ms B] had received from [Mr E] via phone earlier that day. This differing information that [Ms B] presented was an opportunity for both social workers to seek clarification from [Mr E] and the police who had brought him in to [the] police station.

[Mr A's] Mental Health Assessment

Paragraph 24 of [Ms B's] response states that she was unaware of [Mr A's] previous suicide attempt and therefore did not consider this as a risk factor when completing the mental health risk assessment. It is unclear from [Ms B's] response if she did not have access to all of [Mr A's] file and previous assessments by other clinicians, or if this was not documented by other clinicians. As I am unclear on the details of why [Ms B] was

not aware of this information, I feel that I am not able to advise if this is a departure from the standard of acceptable practice.

Paragraph 32 of [Ms B's] response states that she was not aware of [Mr A] being detained under section 109 of the Mental Health (Compulsory Assessment and Treatment) Act 1992. After consultation with [my senior social work colleagues] we could not comprehend a scenario in which we were tasked to meet a current client at a police station, where we would not query the circumstances that brought them into contact with the police, and the reason for them being brought into the police station. Factors such as the current risk of the client need to be considered, as do risk to staff when transporting or being alone with a client. It is my assessment that [Ms B] and [Ms C] not enquiring about the events that led to [Mr A] being at the police station is a severe departure from the acceptable standard of social work practice.

Paragraph 17.4 of [Ms C's] response states that [Mr A] went off topic during the conversation, often talking about stray dogs making noise outside his house. This information could be considered clinically relevant when considered with [Mr A's] denial of suicidal ideation despite information from [Mr E] stating otherwise. Critical thinking to inform professional judgements is number 7 of the core competence standards of the Social Workers Registration Board. Not applying critical thinking to [Mr A's] presentation and the differing information he was presenting could be considered as a moderate departure from the acceptable standard of care.

It is my assessment that the response provided by [Health NZ], dated the 3rd of May 2024 does not include any new information pertaining to the social work practice of [Ms B] and [Ms C], and is therefore outside of my scope of advice.

[HDC] has asked me to consider this specific question: If [Ms C's] comment that they "talked about the injection with [Mr A] and advised that we could look into getting this done the next day, and we all agreed that [Ms B] and a registered nurse would return the following day to administer the injection", is correct, does this change your view that the failure to consult with a colleague with the appropriate level of medical training was a moderate departure from the standard of care?

It is my view that while this is new information, it does not change my initial advice that this was a moderate departure from the standard of acceptable social work practice. [Mr A] advised [Ms B] and [Ms C] that he was overdue to have his paliperidone injection. It is my belief that [Ms C] and [Ms B] were not appropriately trained to decide on the administration of [Mr A's] paliperidone injection, and it would have been more appropriate at this stage for [Ms B] and [Ms C] to consult with a medically trained colleague on the plan to have this administered the following day.

Should you require any further information please do not hesitate to contact me.

Nga Mihi,

Nicole Begley BSW, PGDipHealSc (Mental Health).'