(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF AGGRIEVED PERSON

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2022] NZHRRT 5**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 065/2021
UNDER	**SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**BAY OF PLENTY DISTRICT HEALTH BOARD**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms Jane Foster, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Ms S Stewart, Member

REPRESENTATION:
Mr G Robins, Acting Director of Proceedings
Ms AD Brown, Senior Advisor Governance and Quality, for Bay of Plenty District Health Board

DATE OF HEARING: **Heard on the papers**

DATE OF DECISION: **8 February 2022**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v Bay of Plenty District Health Board* [2022] NZHRRT 5. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 23 November 2021.

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make a consent declaration. The parties have filed:

[2.1] A Consent Memorandum dated 15 November 2021.

[2.2] An Agreed Summary of Facts, a copy of which is annexed and marked 'A'.

[3] In the Consent Memorandum, the parties requested that the Tribunal exercise its jurisdiction in respect of the following matters:

> 3. (a) A declaration pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of:
>
> (i) Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and
>
> (ii) Right 4(5) by failing to co-operate with other providers to ensure quality and continuity of services.
>
> (b) The plaintiff seeks a final order under s 107(3)(b) of the Human Rights Act 1993 prohibiting publication of the name of the aggrieved person in this matter (Mr A, (deceased)) and all identifying details. The defendant consents to such final orders being granted.

[4] Having considered the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 3(a) of the Consent Memorandum.

[5] The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of Mr A, the aggrieved person in this matter, for the following reasons.

[6] The Tribunal may order final name suppression under s 107(3) of the Human Rights Act 1993 if it is "satisfied it is desirable to do so". In this context "desirable" is considered from the point of view of the proper administration of justice; a phrase that must be construed broadly to accommodate the particular circumstances of individual cases as well as the broader public interests. Any name suppression order should do no more than is necessary to achieve the proper administration of justice. For an order to be made there must be some material before the Tribunal to show specific adverse consequences that are sufficient to justify an exception to the fundamental rule of open justice; see *Waxman v Pal (Application for Non-Publication Orders)* [2017] NZHRRT 4 and *Director of Proceedings v Brooks (Application for Final Non-Publication Orders)* [2019] NZHRRT 33.

[7] This case arises from Mr A being a consumer of the services provided by Bay of Plenty District Health Board and its failures to provide him services with reasonable care and skill and to co-operate with other providers to ensure quality and continuity of services. There is public interest in the details of Bay of Plenty District Health Board's failures being published, as set out in the detailed Agreed Summary of Facts. This, however, involves

Mr A's sensitive and private health information. There is little or no public interest in the publication of Mr A's name nor in him being identified in connection with this case.

[8] Publication of Mr A's name alongside the very detailed Agreed Summary of Facts (involving his sensitive and private health information as well as information about his family) would cause significant distress to his parents and brothers. In these circumstances the Tribunal is satisfied the specific adverse consequences (harm to Mr A's family) are sufficient to justify an exception to the fundamental rule of open justice.

[9] Further, publication of the Tribunal's decision that includes the detailed Agreed Summary of Facts, with Mr A's name and identifying details redacted, impacts on open justice to a limited degree only. The redaction of Mr A's name and identifying details does no more than is necessary to achieve the proper administration of justice.

[10] Accordingly, the Tribunal is satisfied the order sought by the parties in paragraph 3(b) of the Consent Memorandum should be made.

DECISION

[11] The decision of the Tribunal is that:

[11.1] A declaration is to be made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the Bay of Plenty District Health Board breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of:

[11.1.1] Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and

[11.1.2] Right 4(5) by failing to co-operate with other providers to ensure quality and continuity of services.

[11.2] A final order is made prohibiting publication of the name and any other details which might lead to the identification of the aggrieved person (Mr A (deceased)). There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms Jane Foster	**Dr SJ Hickey MNZM**	**Ms S Stewart**
Chairperson	**Member**	**Member**

'A'

This is the Agreed Summary of Facts marked with the letter 'A' referred to in the annexed decision of the Tribunal delivered on 8 February 2022

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT No.

UNDER	Section 50 of the Health and Disability Commissioner Act 1994
BETWEEN	**DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994 **Plaintiff**
AND	**BAY OF PLENTY DISTRICT HEALTH BOARD** **Defendant**

REDACTED AGREED SUMMARY OF FACTS

REDACTED AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings exercising statutory functions under sections 15 and 49 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The "aggrieved person" in these proceedings is Mr A (deceased).

3. At all material times the defendant, Bay of Plenty District Health Board ("BOPDHB"), was a healthcare provider within the meaning of s 3 of the Act, and was providing health services to the consumer.

4. At all material times, the defendant managed and operated Place A Hospital ("the Hospital"), and was responsible for the services the Hospital provided.

5. In February 2018, the aggrieved person's father complained to the Health and Disability Commissioner about services provided to his son by the defendant.

6. On 7 December 2020 the Deputy Health and Disability Commissioner (appointed under s 9 of the Act) finalised his opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Service Consumers' Rights) Regulations 1996 ("the Code") and, in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

CHRONOLOGY OF EVENTS

Background

7. The aggrieved person (who, for the purposes of this summary of facts will be referred to as "Mr A") first had contact with BOPDHB Mental Health and Addiction Services (MHAS) in July 2014, after his parents and his GP developed concerns about his low mood and behaviour.[1]

8. Mr A had further contact with MHAS in July 2015, after using recreational drugs and suffering a particularly bad response, including self-harm attempts, hallucinations, and admissions that he was suffering from low mood, social anxiety and fleeting suicidal thoughts.[2] He was briefly monitored by BOPDHB's Community Mental Health Service (CMHS), before being discharged to GP care. Upon discharge, Mr A began taking anti-depressant medication as prescribed by his GP.[3]

9. At the start of 2016, Mr A moved to Place B for university. On 16 and 18 August 2016, Mr A was taken to the emergency department at Place B Hospital after self-harming. At the time, Mr A was already taking fluoxetine as prescribed by his GP in Place B. The hospital prescribed lorazepam to assist Mr A with sleeping and ruminative thoughts.

10. Mr A subsequently left Place B and returned to live with his parents in Place A.

[1] CAMHS – Routine notes from 20 July 2014, completed by RN A.
[2] Consult Liaison Psychiatry – CMH Place A notes from 2 July 2015, completed by Mr B.
[3] 20mg Fluoxetine.

Admission to Place A Hospital, August 2016

11. On the evening of 20 August 2016, Mr A phoned a mental health line to report that he had been self-harming and feeling low.[4] The mental health professional discussed a safety plan with Mr A and arranged for CMHS to follow up with Mr A the next day.

12. At 6.20pm on 21 August 2016, a member of the CMHS crisis team phoned Mr A to follow up with him.[5] During this follow-up call, Mr A reported that he was suffering from low mood and depression, but said he was not suicidal.

13. Later in the evening on 21 August 2016, Mr A was found by his parents intending to harm himself. He was subsequently voluntarily admitted to the Place A Hospital Mental Health Ward (Ward 8) at just before midnight on 21 August 2016.

BOPDHB inpatient care

14. Upon admission, Mr A was placed under observation and assessed. Psychiatric registrar Dr C recorded in Mr A's clinical notes that Mr A was suffering from anxiety, low mood, rumination and suicidal ideation.[6] During his admission, Mr A's regular fluoxetine prescription was reduced and he was prescribed quetiapine for treating his anxiety and insomnia.

15. According to BOPDHB, consultant psychiatrist Dr D had primary responsibility for Mr A's care during his admission to Ward 8. This is noted on Mr A's admission checklist, which lists Dr D as Mr A's "admitting Medical Officer" and "Psychiatrist and/or Responsible

[4] Mental Health Line Handover Report, printed 20 August 2016, 11:00pm, completed by Ms E.
[5] Crisis Assessment Form – CMH Place A, completed by Ms F.

Clinician."[7] However, Dr D does not recall being notified about Mr A's admission or treating Mr A at any point during his time in Ward 8.

16. BOPDHB's policy at the time of Mr A's admission required all psychiatric inpatients to be seen by a senior medical officer within 24 hours of admission. However Mr A was not seen by a senior medical officer at any point during his time as an inpatient from 21 August 2016 to 24 August 2016, or following his discharge. BOPDHB told HDC that it was "unusual" that this did not occur.

Discharge from inpatient care

17. On 23 August 2016, the MHAS multi-disciplinary team (MDT) discussed Mr A's care and decided Mr A should remain as an inpatient for a further two days until 25 August 2016. According to Mr A's clinical notes, Dr C met with Mr A's parents on 23 August 2016 and reassured them that Mr A could stay on at Ward 8 for another 1 – 2 nights for medication monitoring.[8]

18. Despite the MDT's decision and Dr C's discussion with Mr A's parents, Mr A was discharged from Ward 8 on 24 August 2016. It is unclear who was responsible for this decision. Mr A's Discharge Summary, which was signed by a house officer, listed Dr D as Mr A's doctor, and Mr A's Discharge Checklist (Checklist) also listed Dr D as Mr A's responsible clinician. However, Mr A was never reviewed by Dr D prior to discharge (or at any point, as outlined above). The clinical notes for 24 August 2016 do not show any other senior medical staff involvement in the discharge decision.

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[6] Clinical Notes, entry at 1230 on 22 August 2016 by Dr C.
[7] Admission & Discharge Checklist.
[8] Mr A's Inpatient Clinical Notes, entry made 1500 on 23 August 2016 by Dr C.

19. Mr A's Discharge Summary recorded the MDT's plan for Mr A following discharge, which included a review in outpatient clinic by Dr D on 22 September 2016, psychiatric nursing follow-up in one week, referral to counselling through the CMHS team, and discharge to his parents' home and GP care.

20. Mr A's family told the HDC that they were not told about the MDT's plan for Mr A to see Dr D on 22 September 2016 following Mr A's discharge.

BOPDHB CMHS care

21. On 31 August 2016, Mr A had an appointment with his regular GP. Following this appointment, Mr A's GP made a semi-urgent request to CMHS for a review of his medication and treatment. There is no evidence that this request was actioned or followed up by BOPDHB.

22. On 12 September 2016, Mr A had his first appointment with BOPDHB's CMHS psychologist Mr G, as directed by the MDT. Mr G completed a Comprehensive Assessment of Mr A, which recorded that Mr A had depression and anxiety but denied current suicidal intent.[9] Mr A was not assigned a CMHS case manager separate from Mr G. Mr G saw Mr A for a follow up appointment on 19 September 2016, where he reported that he was "still feeling shit", ruminating a lot and experiencing some social anxiety.[10]

[9] Clinical notes by Mr G, 12 September 2016.
[10] Clinical notes by Mr G, 19 September 2016.

Discharge from psychiatric care

23. Mr A was scheduled to attend an appointment with Dr D on 22 September 2016 however Mr A did not attend this appointment. Mr A's family told HDC that Mr A did not attend because they did not receive information about the appointment from the hospital when Mr A was discharged.

24. On 23 September 2016, Dr D wrote a letter to Mr A in which he said:

> "You did not attend my appointment today. However I did speak to [Mr G] who will be of utmost importance in your progress to better well-being. He is prepared to offer counselling on a regular basis and hence there is no real need for any other psychiatric input at this present moment in time. I will therefore transfer your care to [Mr G] and we will obviously monitor the situation as it progresses in out[sic] Multi-Disciplinary Meeting."

25. BOPDHB's policy[11] at the time stated that if a consumer misses two appointments and has a current risk assessment that indicates unknown/low risk, a decision should be made based on clinical judgement and/or the referrer's level of concern whether a third appointment should be attempted or whether a letter should be sent advising the consumer of discharge from the service if they do not contact the service within 14 days.

26. At the time that Dr D wrote to Mr A and transferred him to Mr G's care, Mr A had only missed one psychiatric appointment. Dr D never had an in-person consultation with Mr A and was therefore unable to perform his own physical assessment of Mr A's clinical requirements.

[11] Protocol MHAS.C1.4 Active Follow-Up of Consumers who do not attend pre-arranged appointments at [4.1].

Transfer to CMHS psychologist

27. Mr A had further appointments with Mr G on 26 September 2016 and 17 October 2016. While clinical notes from these appointments record that Mr A was not self-harming, they indicated some concerns such as loss of appetite, feelings of worthlessness, insomnia and low mood.

28. On 3 October 2016, Mr A's care was discussed at a MDT meeting. Notes from this session are brief, and the extent of any discussion is unclear. Dr D was present at this meeting. On 7 November 2016, Mr A's care was discussed again at a MDT. It was noted that Mr A was "presenting as depressed/obsessional" and requesting psychiatric/psychological input. Dr D was not present at this meeting.

29. On 8 November 2016, Mr A was assessed by Mr G and a CMHS nurse practitioner/crisis worker, Mr H, after Mr A's mother reported that Mr A's mood was very low. Mr A met with Mr G again on 15 November 2016, where Mr A discussed his travel and work plans for the future.

30. Mr A missed his next three appointments[12] with Mr G, due to his work schedule. From the documents available, there was minimal engagement between CMHS and Mr A over the Christmas and New Year period.

[12] Scheduled for 21 November, 4 November and 19 December 2016.

Early 2017

31. On 16 January 2017, Mr G met with Mr A after Mr A's mother reported that Mr A had been struggling over the holiday period. At this appointment, Mr A revealed he had been self-harming over the summer break.

32. On 1 February 2017, Mr A had another appointment with Mr G and a CMHS social worker, where Mr A admitted to thinking about self-harm but denied suicidal ideation.

33. On 8 February 2017, Mr A's GP referred him to CMHS for a crisis assessment after Mr A expressed suicidal thoughts, including during a doctor appointment. Two members of the CMHS crisis team carried out a crisis assessment which recorded that Mr A said he often thought about ending his life but "has not done anything to date, explained that he just gets these moods" and that Mr A was "currently getting support from Mr G."[13]

34. Following the assessment, Mr A was prescribed venlafaxine by his GP on advice from the CMHS crisis team. Two days later on 10 February 2017, the CMHS crisis team followed up with Mr A, who reported feeling better after commencing venlafaxine.

35. On 17 February 2017, Mr A's mother wrote to Mr G after she discovered Mr A had been visiting suicide websites. Mr G took Mr A's mother's letter to a CMHS crisis team meeting, but the team "did not think it was severe enough to warrant a call out at that moment." Mr G had an appointment with Mr A that same day, where Mr A admitted to visiting the websites but denied current suicidal ideation.

[13] Crisis Assessment Form, 8 February 2017, by Ms I.

36. Mr G had a further appointment with Mr A on 20 February 2017, and reported an improvement to Mr A's mood.

Involvement of private psychologist

37. On 10 February 2017, Mr A's family requested a meeting with a private psychologist, Ms J. Mr A's parents say they sought appointments with Ms J because they felt dissatisfied with the progress made with Mr G.

38. Mr A's parents arranged a meeting with Ms J on 24 February 2017. At this meeting, Mr A gave Ms J permission to speak with Mr G, as she was shortly taking annual leave and wanted to see if Mr G could see Mr A while she was away.

39. On 6 March 2017, Ms J contacted Mr G to explain that she was seeing Mr A and ask whether Mr G could keep an eye on him while she was on leave from 10 to 21 March 2017. Ms J's handwritten file note of her phone call with Mr G recorded:

> "…Mood is still low but has presented better…. [Mr G] will look after him while im away on holiday. I'll see [Mr A] on Wed, [Mr G] has offered an appt. too around the same time. Ill contact [Mr G] after I've seen [Mr A]."

40. Mr G told HDC that Ms J asked him to take care of Mr A during her upcoming planned absence on annual leave. He did not say whether he agreed to her request, but instead noted his concern that "once a patient is discharged into the care of another outside clinician, the MDT ceases to be the vehicle of care for that person" and that Ms J knew that she could refer Mr A back to CMHS if anything escalated.

Discharge from CMHS

41. Also on 6 March 2017, Mr A's mother rang Mr G to request an urgent appointment for Mr A. Mr G told Mr A's mother that he was concerned about ethical issues and a conflict of interest, as working with another clinicians' client was (in his view) a breach of ethics.

42. Following this call, Mr G raised the issue with the MDT, and the MDT agreed that Mr A could be discharged to Ms J's private care.

43. Mr A was subsequently discharged to Ms J's private care on 8 March 2017. There was no discharge plan made and/or shared between Mr A, Mr G, Ms J, Mr A's GP, or his family.

44. On 8 March 2017, Mr A had an appointment with Ms J, during which she advised Mr A that Mr G would be available while she was on leave.

45. On 15 March 2017, Mr A saw his GP who recorded that Mr A was no longer suicidal and was doing better following the changes to his medication.

46. On 27 March 2017, Mr A had another appointment with his GP after Mr A's mood had "slipped again" and he reported feeling suicidal.

47. The following day, Mr A's mother took him to the CMHS where he was assessed by nurse practitioner/crisis worker, Mr H. During this assessment, Mr A said he was no longer suicidal but did admit that he had thought about self-harming, but decided it was a dumb idea.[14] Following the assessment, Mr H offered Mr A admission to Ward 8 but Mr A declined. It was agreed that Mr H would contact Mr A daily until the end of the week in order to decide whether further support over the

[14] Crisis Assessment Form, 28 March 2017, by Mr H.

weekend was necessary. Mr H also referred Mr A back to CMHS for immediate case management follow up.[15]

48. On 30 March 2017, Mr H attempted to follow up with Mr A but was unable to contact him as Mr A had changed his phone number. Instead, Mr H spoke with Mr A's mother, who said she would find Mr A's new number and provide it to Mr H.

49. Later that evening, after Mr A's mother gave Mr A's new number to Mr H, Mr H phoned and spoke with Mr A. Notes from this phone call record that Mr A sounded "reasonably cheerful" and talked about work the next day. Mr H again offered Mr A an admission to Ward 8, but Mr A again declined.

50. At around 1am on 31 March 2017, Mr A left his home whilst his family was sleeping.

51. At around 10:00am on 31 March 2017, Mr A was found deceased near his home.

BOPDHB'S RESPONSE TO EVENTS

52. BOPDHB has acknowledged that this was a tragic case involving a number of failures in its care of Mr A. BOPDHB has apologised to Mr A's family and expressed deep regret over its failings to ensure Mr A received the support and treatment necessary to maintain his mental wellbeing and prevent his death.[16]

53. On 19 April 2018, BOPDHB carried out a Serious Incident Review (SIR). Mr G and Mr H were on the SIR team. The SIR acknowledged a number

[15] Internal Referral Community Mental Health Services, 28 March 2017, by Mr H.
[16] Letter of apology, dated 5 March 2021.

of issues with Mr A's care and made recommendations. BOPDHB has introduced changes following the SIR and the HDC process, including:

a) Amending its Mental Health and Addiction Service protocol A1.22 Admission to Inpatient Psychiatric Care, which now requires all mental health inpatients to have a consultant psychiatrist review within 24 hours of admission;

b) Introducing a new requirement for a separation between case manager and therapist/psychologist in cases where a psychologist is providing complex therapeutic services; and

c) Introducing a MDT protocol which sets the standards for MDT meetings, including the standard of record keeping and a requirement that a three-monthly review of client progress is documented.

54. As at the date of agreeing this summary of facts, BOPDHB has complied with many of the recommendations made by the Deputy Commissioner in his report dated 4 February 2021, and is in the process of complying with the remaining recommendations.

EXPERT ADVICE

55. Dr Alma Rae, consultant psychiatrist, provided expert advice on the care provided to Mr A by BOPDHB. In particular, Dr Rae advised that:

a) Dr D's decision to discharge Mr A to Mr G following Mr A's failure to attend his first appointment represented a serious departure from accepted standards of practice. The usual practice is to discharge after three missed appointments, if there are no

good reasons for it being missed. In this case, Mr A was discharged after missing only one appointment.

b) The failure to organise a psychiatry review between September 2016 and March 2017 represented a severe departure from accepted standards.

c) The lack of involvement by a consultant psychiatrist represented a severe departure from accepted standards. The accepted practice for an inpatient is review by a consultant psychiatrist within 24 hours, which did not occur. The accepted practice for an outpatient is review every 3 months, unless they are extremely stable and under a mental health team because they are subject to a compulsory treatment order or taking clozapine. This did not occur, nor was there any evidence to support that Mr A was extremely stable. If anything, the evidence supported the opposite.

d) The use of the two health professionals most involved in Mr A's care in the Serious Incident Review Team represented a serious departure from accepted standards.

56. The HDC also obtained expert advice from psychologist Tina Earles on the care provided by BOPDHB psychologist, Mr G. Ms Earles identified a number of failures, particularly:

a) Mr G's failure to document and implement a discharge/transfer of care plan. The record of contact between CMHS clinicians and Mr A / his family over February and March 2017 show that Mr A had a high level of risk and service intervention. There were indicators of the need for comprehensive discharge/transfer of care, such as

Mr A's inconsistency of attending appointments, his mother's high level of concern for Mr A's safety, and Mr A's recent discharge from Mr G's care. Despite these indicators, there was no discharge/transfer of plan on file, and there was no contact with or by CMHS services documented for the period 8 to 21 March 2017.

b) The unclear process for care while Ms J was on leave. CMHS should have stayed actively involved in Mr A's care given Mr A's high acuity with severe depression and high risk of suicide; ongoing previous high level of contact by CMHS; and that Ms J was going to be on leave.

c) While most of the practice concerning Mr A's care was well managed, there were systemic issues with the CMHS discharge and transfer of care process, and ongoing care plan, where it could have been better explicated and managed.

BREACH OF RIGHTS 4(1) AND 4(5) OF THE CODE

57. BOPDHB accepts that the care provided to Mr A fell below the standard expected of a healthcare provider in New Zealand. There was a lack of attention to the basic aspects of assessment, monitoring, communication and clinical decision making, and a failure to adequately consider the level and type of care that Mr A required. This was a collective failure of the system, and the people operating in it, for which BOPDHB was ultimately responsible.

58. BOPDHB accepts that it breached Right 4(1) of the Code in that it failed to provide care to Mr A with reasonable care and skill and Right 4(5) of the Code in that it failed to ensure that there was effective collaboration

among providers to ensure quality and continuity of services. In particular, BOPDHB accepts the following failures in care:

a) Mr A was not seen by a senior medical officer within 24 hours of admission to Place A Hospital in August 2016, or at all before being discharged from inpatient care, which was inconsistent with BOPDHB's policies and protocols;

b) In August 2016, Mr A was discharged from Place A Hospital a day earlier than previously agreed by the MDT, in circumstances where the relevant decision-making lacked input from appropriate medical professionals. In particular, there was no senior psychiatric input into the discharge process or decision;

c) Mr A's family were not told on discharge about the MDT's plan for Mr A to have an appointment with Dr D in September 2016, which likely contributed to the family's lack of knowledge of the treatment plan and Mr A's subsequent absence from that scheduled appointment;

d) There was poor clinical judgement by Dr D, who discharged Mr A from his psychiatric care after Mr A missed one appointment, despite BOPDHB's policy and protocol which requires a minimum of two consecutive missed appointments before discharge from psychiatric care. Dr D discharged Mr A despite not having had an in-person consultation with Mr A and therefore no opportunity to perform his own assessment of Mr A's clinical requirements. This decision was also made at a time when the MDT was aware that Mr A was particularly depressed/obsessional;

e) there was no psychiatry review of Mr A between August 2016 and March 2017, and little documented discussion of Mr A's condition by the MDT in the same timeframe;

f) Mr A was not assigned a case manager separate from his treating psychologist, Mr G;

g) Two of the four members of the Serious Incident Review Team were directly involved in the care provided to Mr A, which was inappropriate; and

h) Mr G declined to schedule an appointment with Mr A in March 2017 due to a perceived conflict of interest, which contradicts Mr G's duty to provide co-ordinated services under the Code of Ethics for psychologists working in Aotearoa/ New Zealand.

_____

Greg Robins
Acting Director of Proceedings

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Date

I, Angela Debra (Debbie) Brown, Senior Advisor Governance and Quality, acting on behalf of **Bay of Plenty District Health Board**, agree that the facts set out in this Summary of Facts are true and correct.

_____

Debbie Brown
For and on behalf of **Bay of Plenty District Health Board**

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Date