Director of Mental Health's Consideration of the Findings of an Inquiry under Section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992

An Inquiry into Hutt Valley District Health Board Mental Health Service Including the Clinical Management of Certain Patients and the Operation of the Office of the Director of Area Mental Health Services

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Introduction

I received the Findings of an Inquiry under Section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 on 31 January 2012. Subsequent to the receipt of the Findings I have carefully considered them. It should be noted that prior to considering the Findings I deliberately did not seek information about the Inquiry or the events leading up to commissioning of the Inquiry. Because of contention surrounding the Inquiry I deemed it best that I approach the consideration of the findings without any prior knowledge so that my deliberations could be seen to be impartial. Subsequent to my consideration of the findings it became clear I needed to clarify the sequence of events leading to the commissioning of the Inquiry and sought advice from my office around details if this. I also decided I needed advice from the Chief Medical Officer and Chief Nurse of the Ministry of Health around matters of professional practice and clinical governance. I have also sought legal advice from the Ministry's Chief Legal Advisor over certain actions that might be necessary for me to take.

In my opinion the District Inspector (and his advisors) undertook an appropriate formal process to conduct the Inquiry. I note that independent peer review was undertaken with Helen Cull QC (Senior Advisory District Inspector). Legal representation was available to affected parties and I have been supplied with a list of counsel representing the various parties. Parties likely to perceive the findings as adverse were supplied with those findings in draft form for comment. Representation was made on their behalf and the District Inspector and his advisors carefully considered those representations prior to finalisation of the Findings. I am satisfied that principles of natural justice were followed.

I am also satisfied that the Findings have been carefully written and that they address the terms of reference.

I have decided to accept the Findings of the report (with some qualifications, as set out below) and have in large part accepted the recommendations. I will now set out my opinion and reasoning.

Findings

Term of Reference 1

Under the first term of reference the Inquiry examined matters relating to five patients.

The findings in regard to Patient A are clear and lead naturally to the associated recommendations under the heading "Differences between Inpatient and Community Teams" on page 16.

Patient B findings reflect issues in clinical practice and documentation. As with patient A there were issues relating to the interaction between the inpatient and clinical teams. The recommendations on page 16 will assist in addressing the concerns.

It is evident from the Findings that Patient C's management was challenging. I concur with the findings with respect to the care of this patient. I note that there were issues in the relationship between Mental Health and Community Intellectual Disability Services. I agree with the recommendation on page 16 that addresses this.

The findings in respect to Patient D are troubling. A serious incident occurred and no notifications occurred either internally to appropriate governance authorities or to my office until some months after the event. There is evidence that some of the treating clinicians appeared to have limited knowledge of the event. In my opinion this is completely unacceptable and represents a considerable risk to the Mental Health Service (the Service) and its patients. There were issues in terms of this patient's overall clinical management. Of concern is the finding that a factor contributing to this patient's compromised treatment was significant staff shortages. I return to this issue in my opinion around operational and clinical governance matters on page 13.

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While the findings in relation to the care of Patient E are that the overall standard of clinical care was reasonable. The Inquiry has drawn my attention to two areas of concern.

- The care provided by and the actions of Dr A (see page 18 for my conclusions on this issue).
- The inappropriate actions of Human Resources and the DHB towards a staff member who was mentally unwell.

I note there are no specific recommendations with respect to this area. The DHB did tender evidence that there had been subsequent changes in practice. In my opinion, there is a particular responsibility for a DHB to ensure that staff members who identify that they have mental health issues are able to access appropriate and confidential care. There should be clear advice to staff (especially to those in management roles) on how to handle the issues that arise in these circumstances. I will therefore be seeking formal advice from the DHB on changes that have occurred and the current processes and advice to staff.

I note that in respect of this patient that the coroner has released the report of his findings.

Term of Reference 2

The Inquiry found that the allegations made under this heading were proven.

- The functioning of the office [the Statutory role of the Director of Area Mental Health Services at Hutt Valley DHB] was disorganised
- There was poor communication between the District Inspectors and the DAMHS including requests from the District Inspectors for information about the incidents and events not being complied with.
- The Administrative requirements of the Mental Health (Compulsory Assessment & Treatment) Act 1992 were not always complied with raising issues of patients' rights under the Act being breached or denied. One such incident involved the recent lapse in recertification of the Duly Authorised Officers.
- Te Whare Ahuru was operating as a Locked Unit potentially raising an issue of unlawful detention for informal patients.
- Sentinel Event Reports were not provided to the Director of Mental Health in a timely and regular fashion and in accordance with statutory reporting obligations.

These findings are of great concern to me as they mean that the fundamental checks and protections of the rights of patients and proposed patients as set out in the Act were being undermined.

It is clear in the Findings under Term of Reference 2 and Term of Reference 3 that the DAMHS for most of the period in question, Dr S, was under significant workload pressure. He was not only the DAMHS but also the Clinical Head of Department. He had been given the joint task (with the Service Manager) of driving significant organisational change in the Service. He was also working as a consultant on the acute unit. This workload pressure was

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aggravated by a shortage of consultant psychiatrists from October 2009 to February 2010. In the Inquiry Findings Dr S reports how difficult he found these circumstances.

In addition to the above it is also clear that the DAMHS relationship with a number of key staff (not just the DAMHS) had become strained and aggravated the issues above. Further, the administrator of the DAMHS office had made it clear that she was struggling to cope. In part she stated it was for lack of supervision. In addition, she clearly had workload pressures and it is stated that there were issues with the administrative systems outside the DAMHS office.

Overall the impression is gained of a system with multiple points of failure that lead ultimately to the DAMHS office being disorganised and failing in its statutory duties. While as the Statutory appointee Dr S must bear significant responsibility for this, it is clear that the service system around him and the service changes contributed to this (see the Findings under Term of Reference 3 below).

Term of Reference 3

I have accepted the Findings of the Inquiry on this Term of Reference with some qualifications. In particular I noted that there were findings in respect of nursing related to the ward management but relatively little consideration of how this related to the wider nursing of the DHB. I have commented on this where appropriate.

I have also formed the view that I need to emphasise several aspects of the Findings under this Term of Reference, as it is necessary for me to reach a judgement on the issues raised.

In essence the Inquiry considered the following matters:

- Internal event reporting
- The role played by the HVDHB Five Year Strategic Plan ('Whakamahingia' – Make it Happen)
- The closure of the Māori Mental Health Service (To Oranga Hinegaro)
- Staff shortages on the inpatient ward
- The role of the Chief Medical Adviser
- The dual role of Clinical Head of Department and DAMHS
- The PRN Medication Notice
- DHB conflict with registrars
- Dr A's practice

The Findings in this section are very concerning and in part explain some of the issues in the preceding section.

Internal event reporting

The Inquiry found that it could not establish precisely or comprehensively what serious incident or sentinel events had occurred. Nor could the Inquiry corroborate whether

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serious incidents that had occurred were reviewed for the period mid-2008 to late-2009. This is a significant issue as the monitoring and reporting on serious incidents is one of the mechanisms of monitoring the overall quality and safety of the service. It is one of the elements of good clinical governance and the finding indicates concerns in terms of the overall clinical governance of the service.

The role played by the HVDHB Five Year Strategic Plan and the Dual role of Clinical Head of Department and DAMHS

The Inquiry investigated the contribution played by the implementation of the 5-year Strategic Plan. The rationale and need for the change was clearly articulated by senior management. The view of senior management was that change was necessary due to the Service being "isolated, dysfunctional and marked by poor relationships within the service and poor access rates by the target population". The Inquiry documents the reason for this view being formed, including concerns about patient care and outcomes.

The Inquiry does not appear to have challenged the rationale for making the change. At issue in the Inquiry appears to have been the timing and speed of change – particularly when there were a number of other significant pressures on the Service. As the Inquiry comments:

> *"…the MHS was already facing a series of events including the locking of the exterior door to TWA, the opening of the door to ICU, ongoing staff shortages, and a high level of staff dissatisfaction with restructuring: differences between management and registrars, ongoing difficulties with the administration of the Mental Health Act and a falling out between the change agents … Taken together, those were strong reasons to apply the brakes."*

The Inquiry noted that the DHB strongly disputed that the changes were driven too quickly. However, the Inquiry concluded that the "implementation itself began in the final quarter of 2009 at a time when the Mental Health Service was in trouble on a number of fronts. It agreed with the assessment of the current CEO:

> *"Although recognising that there needed to be some relatively significant change to Mental Health Services, he went on to say*
>
> > *The way that was done led to some results that were less than optimal as far as change management goes and … I don't think the organisation has done itself too many favours in the way that some of those processes were gone through."*

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The Inquiry concluded:

- The speed and direction with which the Whakamahingia Plan was implemented partly caused the destabilisation of the Mental Health Service, which was already in difficulty with staff shortages, leave issues and internal dissension.
- The DHB's Chief Operating Officer ("COO")] had a clear view that the Mental Health Service was isolated, dysfunctional and marked by poor relationships within the service and poor access rates by the target population.
- As a result was determined to drive the restructuring proposal and chose the DAMHS, Dr S and the Service Manager within their leadership positions as agents of change.
- Dr S had too many roles as DAMHS, Clinical Head of Department, Acute Ward Clinician, as well as change agent for the restructuring.
- As a result his ability to operate effectively was compromised. This also contributed to the destabilisation of the Mental Health Services.

Staff shortages on the inpatient ward

The Inquiry found that by December 2010 the Service was in significant difficulties with staff shortages, poorly coordinated leave for medical staff aggravating medical staff shortages and what the Inquiry team describe as "internal dissension." This finding raises concerns around the effectiveness of the operational governance of the service and its impact on the clinical governance of the service.

The inquiry concluded that staff shortages had a number of impacts that in the in the opinion of the Inquiry lead in part to the de-stabilisation of the Service and that patient care suffered as a result. In particular the Inquiry found the following:

- Staff shortages contributed to the de-stabilisation of the Service, and patient care suffered as a result.
- There was a continuing shortage of medical and nursing staff from August 2009 to March 2010.
- The Service lacked an effective strategy for dealing with staff shortages.
- There was a lack of nursing leadership and the Inpatient Ward after the restructuring.
- The Clinical Nurse Manager had heavy responsibilities outside the ward and was largely absent from it.
- Day to day leadership was left to the Associate Clinical Nurse Manager which was not appropriate.
- The Associate Clinical Nurse Manager frequently had to take a partial or full case load which was inappropriate to their role of overseeing patient management.
- Nursing staff shortages compromised levels of patient observation, which was unacceptable to adequate patient care.

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- Contrary to Ministry of Health Policy enrolled nurses were working on the ward. There is no evidence that they were working without proper supervision.

While the Inquiry commented on the role of the Chief Medical Advisor (see below), I noted no comment in regard to the wider nursing leadership in the DHB. This is somewhat surprising given that it was clear from the Findings above and throughout the document that nursing and nursing leadership in the service was under considerable pressure and strain. In addition to the Findings above, the following impacts of staff shortages were evident:

- Patterns of leave and related unwellness of clients not seemingly observed and acted on.
- Inappropriate reliance on relatives for client support.
- "Special nursing" policy suspended because of contextual rather than clinical judgement.
- Mental Health Act paperwork unattended to.
- Locked doors in an open unit.
- Unlocked Intensive Care Unit in an environment where safety was not able to be provided.

While I have noted the comment about the use of enrolled nurses this does not appear from the Findings to have played a significant part. What does seem evident is that the skill mix and rostering of nursing staff was problematic.

I was also disturbed to read in the report that at one point the Clinical Nurse Manager, the two Associate Clinical Nurse Managers and the Clinical Head of Department were all away at the same time. This would have represented a significant risk to the overall clinical leadership to the ward and the potential to compromise patient care.

The role of the Chief Medical Advisor

The Inquiry examined the involvement of the Chief Medical Advisor and concluded:

- The Chief Medial Advisor was not appropriately advised in a timely way of significant issues in which he could have played a useful or central role in resolving.
- The Chief Medical Advisor's central place in the DHB clinical governance structure should have ensured he played a more central role in the resolution of those issues. His potential contribution was not fully used.

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The role of Dr S

I have previously commented on the multiple roles assumed by Dr S. The Inquiry reached specific conclusions on this point:

- The appointment of Dr S to the multiple roles of DAMHS and CHOD and his role in implementing the restructuring programme, in addition to his clinical duties, was inappropriate.
- The appointment was one of the causes of the disorganisation of the DAMHS office and the breakdown in the administration of the Mental Health Act.

The PRN Medication Notice

The Inquiry concluded that the notice issued by the Clinical Head of Department, which was placed in the Inpatient Ward in March 2009, prescribing PRN medication (particularly by intramuscular injection) was inappropriate as it was too prescriptive.

DHB conflict with registrars

The Inquiry also investigated issues raised by the registrars and found that in general that the process used to deal with differences between DHB Management and registrars was unsatisfactory. It also found that issues in dispute should have been handled from the outset by senior management. Instead Human Resources played a major role in engaging with registrars. Specific issues around the registrar night on call and their relationship with the Clinical Head of Department were examined. In regard to the latter it was concluded that the DHB's failure to refer the dispute at the outset to the Chief Medical Advisor limited the likelihood of its successful resolution.

The Inquiry also concluded:

> *"At times during the period under review, there was no medical cover for the CATT Team. Registrars beginning on-call duties were expected to see and assess patients referred by the CATT Team during the working day. This was inappropriate because of the general high workload consequent on this and because of reduced support after hours for registrars lacking qualifications and experience."*

I also noted that Medical Officers Special Scale (i.e. non-consultants) were supervisors registrars on-call. This is not acceptable.

The closure of the Māori Mental Health Service (Te Oranga Hinegaro)

Finally the Inquiry concluded the Māori Mental Health Service was closed because data collected indicated it had not operated efficiently, had low patient numbers and difficulties with record keeping.

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Dr A's practice

I have carefully reviewed the Finding's made in terms of Dr A's practice. I note that the Inquiry found:

- He did not make adequate clinical records on some of the patient files.
- He failed to document risk issues on those files and to consider these sufficiently in prescribing or dispensing decisions.

While the Inquiry has recommended that I seek an independent audit of his practice in my view that is not the best course of action. I have sought advice on this point and have concluded that as this raises issues of professional practice and a potential failure to reach the requisite standard expected of a consultant psychiatrist it is more appropriate for this matter to be referred to the Medical Council of New Zealand. I therefore plan to do this.

Director of Mental Health Conclusions

The reason I have highlighted the findings and made the comments above is because, taken collectively, they present a very challenging and concerning view of the Service. Collectively the Findings suggest a breakdown in the operational and clinical governance of and surrounding the Service at multiple levels. I am left with the clear impression that this not only had the potential to compromise patient care but that in some instances it probably did. Taken together with Term of Reference 2, it is evident that this breakdown also was a significant factor in the failures in the performance of the various statutory duties.

It is clear that the change management process stressed an already fragile operational and clinical governance process in a service under significant stress. In my view this should have lead to alterations of the change management process and/or additional supports from outside being put in place while this process was underway. Change management in mental health is a challenging process and often requires significant external support if it is to be effective.

While there are recommendations that address the various elements that contributed to this breakdown in operational clinical governance I have concluded that these need to be strengthened (see Recommendations on page 13).

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The Current Position

The Inquiry report has provided me with a summary of the current position concerning the mental health services at Hutt Valley Health. The team commented favourably on the changes reported by the District Health Board. I have extracted the commentary below:

"The Inquiry Panel is encouraged by the evidence of the new Chief Executive Graeme Dyer (appointed July 2010) who in his statement to the Inquiry gave

> *"a personal commitment that I will continue to work with the Mental Health & Addiction Service to ensure it continues to improve and that any emergent strategic and operational issues are addressed and that the Inquiry's recommendations are implemented expediently."*

Mr Dyer will be assisted by new staffing at Hutt Valley Health . At corporate level, in addition to his own appointment, there is a new Chief Operating Officer, a new Chief Medical Advisor and a new Director of Nursing.

The Mental Health Service has a new senior management team: Clinical Director; Director of Area Mental Health Services; Director of Operations (formerly Service Manager); Inpatient Clinical Nurse Manager; and Community Team Manager.

With a major injection of new managerial and clinical talent, the Mental Health Service is well placed to go forward with confidence.

We have received a statement from the Director of Operations (formerly Service Manager) Toni Atkinson, making reference to changes which have taken place within the MHS since the period under review. Ms Atkinson reports that (i) the relationship between management and staff has improved and (ii) the service as a whole is much more settled and staff feel valued and supported.

Changes, as reported Ms Atkinson, include:

Relations with Wairarapa District Health Board (WDHB)

The Inquiry notes with approval the significant steps taken to strengthen ties with WDHB. These include:

(i) A weekly multi-disciplinary team meeting which includes discussion on each Wairarapa patient in the Inpatient Unit;
(ii) Regular quarterly regional meetings including Service Managers and the Clinical Director;
(iii) Assisting with consultant cover WDHB when requested;
(iv) The provision by HVDHB of video teleconference facilities;
(v) Priority given to the provision of a discharge summary for patients on the day of discharge.

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Mental Health Act Administration

Support for the new Mental Health Act Administrator has been strengthened in the following ways:

(i) The Administrator now reports to the Quality Manager. She works within the Quality Team.
(ii) This physical move places her close to the hospital offices of both the Clinical Director and the Director of Area Mental Health Services.
(iii) The legal tracking facility from the hospital database is now fully operational. The Director of Operations states that patients no longer fall off the Mental Health Act due to administrative or other error.

District Inspector Relationship

The Inquiry report notes with approval the actions taken by the new Mental Health Service Management Team to improve the relationship with the District Inspectors with the aim of ensuring the Service meets the requirements of the Mental Health Act.

Staffing Issues

The Inquiry further notes with approval the statement of the Director of Operations that as at 29 November 2011:

(i) The Inpatient Unit was fully staffed across all disciplines.
(ii) All but one consultant position in the Service was filled.
(iii) Consultant and staff leave policies have been clarified.

Registrars

The director of Operations now managers the registrar roster and is available to registrars regarding roster issues. She advises:

(i) The latest registrar run is staffed with a full complement of eight registrars.
(ii) Registrars have raised no new concerns about that coming six month run.

Incident Reporting

There is now a clear process for incident reporting both internally and to the District Inspectors together with a robust process for reporting and reviewing serious and sentinel events within the Service and reporting them to the Ministry of Health. In June 2010 following the failure to report the self harm by Patient D on 31 January 2010, a Mental Health Event Reporting Flow Chart was developed and distributed to assist staff to understand the Event Reporting Processes and their responsibilities.

Clinical Governance

Ms Atkinson advises that on 1 November 2011, HVDHB changed it service structure to strengthen clinical leadership across the hospital services. There are now three new

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directorates i.e. “Medical and Community Health”, “Surgical, women and Children”, and “Mental Health and Addictions”.

The management structure within each directorate, including the Mental Health and Addiction Service, has been changed to a ‘diamond’ structure of Director of Operations, Clinical Director, Nursing Director and Allied Health Director.

She advises that clinical leadership has been further strengthened through these directors reporting to their own clinical lead, e.g. Executive Director of Nursing, Executive Director of Allied Health and Chief Medical Advisor.

Recommendations

The Inquiry has made a number of recommendations most of which I plan to adopt. I have set them out below and where I plan to do something else have proved a commentary in red italics below the relevant recommendation. I also plan to undertake other actions as I set out in the relevant preceding sections.

1. The Role of DAMHS

1.1. A newly appointed Director of Area Mental Health Services (“DAMHS”) should receive full instruction in the formalities of the role, preferably from another experienced DAMHS nominated by the Director of Mental Health.

1.2. A DAMHS on appointment must ensure that all Responsible Clinicians understand their duties under the Mental Health Act. Newly appointed Responsible Clinicians should be given such instruction on appointment.

1.3. To avoid confusion reporting lines and job specifications should make it clear that responsibility for the work of the DAMHS Administrator of the MHA lies with the DAMHS.

1.4. The DAMHS should ensure that the Administrator of the MHS has proper training, supervision and support to undertake the role.

1.5. The DAMHS should ensure there are robust mechanisms in place to monitor the requirements of Section 59 of the Mental health Act.

The Office of the Director of Mental Health is in the process of updating the Director General’s Guidelines for DAMHS. These recommendations will be reviewed to ensure that the Guidelines are consistent with these recommendations.

2. Training of Duly Authorised Officers

2.1. The Director of Mental Health should issue guidelines to Directors of Area Mental Health Services to ensure a clear process is in place for Duly Authorised Officers (DAOs) to undergo appropriate training and testing by the DAMHS to ensure their competence in dealing with mentally disabled persons.

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2.2. The Hutt Valley DAMHS should explore the possibility of combining DAO training and update arrangements with the Capital & Coast DHB.

In relation to recommendation 2.1 the Office of the Director of Mental Health is in the process of updating the Director General's Guidelines for DAMHS and Duly Authorised Officers. This recommendation will be reviewed to ensure that the Guidelines are consistent with this recommendation.

3. Nursing/Staffing

3.1. Inadequate staffing numbers and skill mix on a sustained basis needs to be alerted regionally and flagged with the Ministry, professional organisations and unions by the Nurse Leader.

3.2. Escalation pathways need to be clear for staff raising safe staffing issues. (Who to report to and what to do if no action is taken).

3.3. When Registered Nurses (RNs) are proving difficult to recruit, opportunities for regional cooperation should be explored to ensure the availability of sufficient RNs with necessary specialist knowledge and skills required in an acute inpatient environment.

3.4. Registered Nurses employed on the inpatient mental health ward will either have a New Zealand Nursing Council condition on their practice "May practice only in mental health nursing" or have completed a Mental Health Entry to Speciality Practice Programme. The key point is that RNs employed with mental health settings have appropriate mental health knowledge and skills. A mental health/psychiatric nurse is defined by the World Health Organisation as "A graduate from a recognised, university level nursing school with specialisation in mental health nursing". The recommendation contained in 3.4 is consistent with that definition.

3.5. Enrolled nurses will not be rostered on the acute inpatient ward.

3.6. When non-registered staff are utilised on the acute inpatient ward, their role will be clearly defined and understood. They will be directed by the registered nurse who will retain responsibility for patient care.

Recommendations 3.4 to 3.6 are essentially about the skill level, skill mix and adequate staffing level for an acute psychiatric ward. I have therefore sought advice as to how these could be generalised to other DHBs:

- *Each ward should have a clear statement of its 'ideal' skill mix (i.e. what is the mix on each shift of senior nurses, junior nurses, enrolled nurses, unregulated staff as well as what medical staff are available).*
- *There should be a clear process and strategy that ensures nurses working in mental health setting have the appropriate mental health knowledge and skills.*

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- *Where Enrolled Nurses are employed in acute mental health units they are part of an appropriate level of skill mix and that they are afforded the direction and delegation support they require related to this scope.*

- *Where un-registered staff are employed in acute mental health units their role and function should be clearly specified and set out in the ideal skill mix of the unit.*

- *The Office of the Director of Mental Health and the Chief Nurse will work with the Mental Health Nursing leaders in the DHBs to develop policy to guide DHBs in this area.*

4. Nursing – Leadership

4.1. The nursing structure within the acute inpatient unit should be strengthened in the following ways:

4.1.1. The ward should have a dedicated Clinical Nurse Manager.

4.1.2. The role and responsibilities of the Associate Clinical Nurse Managers should be clearly defined and understood to ensure they have 'time to lead', do not take a patient load and have their responsibilities clearly delegated by the Clinical Nurse Manager.

4.1.3. The acute inpatient ward should have a dedicated role to focus on the development of mental health nursing practice, and to support mental health nurses in their practice.

4.1.4. The holder of this role should have input into all nursing appraisals, providing feedback on all nursing practice and supporting ongoing professional development.

4.1.5. Performance reviews should reflect NZ College of Mental Health Nurses standards of practice.

4.2. The development of policies / procedures and guidelines should be informed by Ministry of Health guidelines and NZ legislation.

4.3. Nursing staff should have input into all policy and procedure development.

4.4. When DHB or Mental Health Service policies and procedures are unable to be followed due to resource constraints this should be the subject of an incident report and escalated through the clinical and service management structures.

4.5. Nursing leadership should employ ways to ensure inpatient nursing staff are aware of relevant policies.

4.6. The use of second nursing opinions is to be encouraged when people present with behaviours that challenge nursing practice.

While I accept the importance of a clear nursing leadership structure set out in 4.1 I do not think it appropriate for my Office to specify the titles of the holders of the various positions. Rather it is important that there is dedicated nursing leader for each acute

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mental health unit and those secondary nurse leaders who are appointed in these units are given the time and authority to provide the appropriate nursing leadership.

It is also important that nursing leadership within a unit has a clear line of professional accountability to the Executive Director of Nursing (or equivalent) within a DHB. This should be evident in the clinical governance of the DHB.

5. Patient needs – appropriate services

Intellectual Disability services (including the Intellectually Handicapped Children organisation) and Mental Health Services need to find ways of ensuring patient needs are met by the most appropriate services rather than excluding people who sit on the borderline between services.

This recommendation should be extended to ensuring all patients under the Act receive appropriate services (including psychological therapies).

6. Difference between Inpatient and Community Teams

6.1. Discharge in the absence of agreement between inpatient and community teams is often problematic. It is important that there be robust mechanisms in place to resolve such differences.

6.2. The following recommendation arises from evidence of differences between Wairarapa Community and Hutt Valley Inpatient Teams:

6.3. A Memorandum of Understanding should be drawn up between Wairarapa District health Board ("WDHB") Community Mental Health Service and Te Whare Ahuru ("TWA") acute inpatient unit covering the following matters:

6.3.1. Communication between Wairarapa and Hutt Valley DHBs: Where a patient normally attending WDHB Community Service is placed as an inpatient in TWA, WDHB Mental Health staff shall have full information about the mental state or leave/discharge arrangements for that patient.

6.3.2. To facilitate discussions between TWA and WDHB clinical teams, video-conferencing facilities should be readily available as an alternative to personal attendance/

6.3.3. Admission and discharge: Where a patient from WDHB Community Mental Health Service is admitted to TWA, WDHB Mental Health Service staff shall have:

6.3.3.1. The ability to complete a verbal handover to the TWA clinician before a client is admitted

6.3.3.2. Receipt of a verbal handover from inpatient staff before a patient is discharged back to his Wairarapa address.

6.3.3.3. Involvement in all clinical discussions with the TWA clinical team over plans and arrangements for leave and discharge.

6.3.3.4. Timely receipt by WDHB clinicians of a full written discharge summary where a patient is discharged from the inpatient unit.

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6.3.4. In case of disagreement between WDHB and TWA staff over any of the above maters, or over patient treatment, the matter may be escalated in the first instance to the DAMHS of each DHB for discussion and resolution.

6.3.5. The HVDHB Clinical Pathway Procedures and Documentation Manual, which addresses medical handover and discharge summaries, was reviewed and updated in February 2011. HVDHB should ensure it adequately addresses these points.

7. Management / Governance

7.1. The DHB should review the clinical governance functioning to ensure the Chief Medical Advisor (CMA) role is centrally placed within the governance process, in order to ensure that the CMA is engaged in medical staffing issues, coronial issues and medical treatment of staff.

7.2. There should be a clear demarcation between the roles of management and Human Resources in Mental Health Services, with Human Resources playing an advisory role.

7.3. A nurse leader should be appointed to a role in governance of the Mental health Service working together with the manager and Clinical Head of Department as occurs in other services.

I have concluded some further actions are required in this area:

7.4. The HVDHB is to outline the operational and clinical governance structure for the Service and how this fits within the overall governance structure of the DHB. It is to provide details of how that operational and clinical governance structure works in practice.

7.5. The HVBDH is to report on the steps it has taken to ensure staff members who identify that they have mental health issues are able to access appropriate and confidential care. This is to include the current policies and process of the HVDHB and advice that this given to staff.

In addition I shall be writing to each DHB Chief Executive, seeking information as to the operational and clinical governance arrangements with respect to their Mental Health Services and how they articulate with the overall operational and clinical governance arrangements within their DHB.

8. DHB Registrar Rosters

Rostering of registrars, currently undertaken by an HVDHB employee, should be integrated more closely with CCDHB registrar rosters. The on call rostering of registrars may usefully be done by an officer covering both DHBs

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9. HVDHB Emergency Department Mental Health Service Facilities

The Mental Health Service Manager and CHOD to ensure that the new Emergency Department of HCDHB has enough facilities to ensure that the needs of the Mental Health & Addiction Service are met.

10. Dr A's practice

It is recommended that the Director of Mental Health seeks an independent audit of Dr A's practice.

As noted, I have sought advice on this recommendation and will refer the matter to the Medical Council of New Zealand.

11. Implementation of Recommendations

The Chief Executive Officer has agreed to audit/monitor the implementation of recommendations in this report. He is to advise the Director of Mental Health in three months from report date of progress.

Publication

I have carefully considered whether this report should in some way be published.

The Findings will be made available to the DHB to ensure the recommendations are acted upon. In addition the patients and in the case of the deceased patients their families should receive copies of the parts relevant to them.

The Inquiry has been a significant one and involves the overall functioning of a MHS. It is therefore my opinion that there is a balance in favour of the report being made available to the wider public. However, this should be weighed against the protection of the privacy of individuals (particularly the patients involved).

I have therefore decided that with respect to Term of Reference 1 that only the summary findings will be available publically and that all identifying details of individuals will be redacted. However the full section that is applicable to the individual patient (with other names redacted) will be made available to the patient or patient's family in the case of deceased patients. This is necessary to ensure that privacy of individual patients is protected and that current patients and future patients can have confidence in giving personal details vital to their treatment without fear that it would enter into the public arena. It is in the public interest that patients and their families continue to disclose what is often deeply personal material to clinicians to ensure high quality services to patients. This is consistent with the provisions of sections 9(2)(a), 9(2)(ba), and 9(2)(c) of the Official Information Act.

With respect to Terms of Reference 2 & 3, the statement around the current position and the recommendations in my opinion these sections should be publically available given that

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it is about publically provided services. While the report is critical of aspects of the services this is not a reason not to publish. It is important for the public to see that should problems arise within services, those problems can be reviewed and steps taken to rectify problems. It is also important that the public has faith in the legal protections put in place to protect the rights of patients and that where these fail that Director of Mental Health can intervene and ensure that a proper inquiry is undertaken that results in recommendations to remedy any failings.

However, I think there is a need to protect individual privacy in these sections and hence names of individuals will be redacted from the publically available document.

In case of Dr A there is a further reason to withhold his name, namely that I intend refer his conduct to the Medical Council of New Zealand. It is therefore necessary to withhold details so that any investigation by the Medical Council is not prejudiced in accordance with section 6(c) of the Official Information Act.

I would like to thank the Inquiry team (Barry Wilson, Dr Clive Bensemann and Heather Casey) for their diligence and care in completing this Inquiry. I also thank the various witnesses who took part.

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