MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 11-649, Wellington • New Zealand
13th Floor, Mid City Tower • 139-143 Willis Street, Wellington
Telephone (04) 381 6816 • Fax (04) 802 4831
E-mail mpdt@mpdt.org.nz
Website www.mpdt.org.nz

DECISION NO: 308/04/123D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings designated under the Health & Disability Commissioner Act 1994 pursuant to Section 102 of the Act against **JOHN ANGUS MARKS** medical practitioner of Gisborne but formerly of Wellington.

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Dr I D S Civil, Dr M Honeyman, Dr A D Stewart, Mrs H White (Members)

Ms K L Davies (Hearing Officer)

Ms H Hoffman (Stenographer)

Hearing held at Wellington on Monday 6 through to and including Thursday 9 December 2004

APPEARANCES: Ms K P McDonald QC and Mr J Tamm for the Director of Proceedings

Mr C J Hodson QC and Ms R Scott for Dr J A Marks

Introduction

1. Dr John Angus Marks is a registered medical practitioner practising in Gisborne as a Consultant Psychiatrist. At the time of the events in question, he was practising at Wellington.

The Charge

2. Dr Marks has been charged with professional misconduct pursuant to ssl02 and 109 of the Medical Practitioners Act 1995 by the Director of Proceedings regarding his management of the late AB between 11 August 1999 and 16 October 1999.

3. The charge sets out the particulars in which it is alleged that, if proved, either separately or cumulatively, Dr Marks' conduct amounted to professional misconduct as follows:

    1. On or about 11 August 1999, or any time thereafter, he failed to:

        1.1 Undertake or document an adequate clinical assessment of AB; and/or

        1.2 Undertake or document an adequate risk assessment; and/or

        1.3 Develop or document an adequate treatment plan;

    And/or

2. On or about 10 September 1999, or any time thereafter, he failed to

2.1 Undertake or document a thorough and systematic review of AB's mental status; and/or

2.2 Adequately formulate or document a diagnosis;

And/or

3. On or about 17 September 1999, or any time thereafter, he failed to undertake an adequate review and/or adjustment of AB's medication plan in light of his presentation;

And/or

4. On or about 8 October 1999 he failed to adequately communicate with AB, and/or his partner, Ms E, and or AB's parents regarding the advantages and/or disadvantages of admission to hospital.

Name Suppression Orders

4. On 1 September 2004 the Tribunal made an order pursuant to section 106(2)(d) of the Act prohibiting publication of the name, occupation and other identifying details of the late AB and his parents CB and DB and any information that might lead to their identification.

5. At the commencement of the hearing on 6 December 2004 Ms E (referred to as "Ms E"), the partner of the late AB, made an application that her name be included in the above order. The Tribunal made an order accordingly.

6. These orders are referred to at the end of this decision under the heading of "Conclusion and Orders".

Witnesses for the Director of Proceedings

7. The Director of Proceedings called five witnesses:

(a) The complainant CB, the mother of AB.

(b) The complainant DB, the father of AB.

(c) Dr Bridget Margaret Taumoepeau, Consultant Psychiatrist of Wellington.

(d) Deborah Leigh Antcliff, Consultant Psychiatrist of Auckland, who was called as an expert.

(e) Dr Russell Howard Wyness, Consultant Psychiatrist of Auckland, who was called as an expert.

Witnesses for Dr Marks

8. Dr Marks gave evidence on his own behalf.

Expert Witnesses

9. The Tribunal was appreciative of the expert testimony provided by Dr Antcliff and Dr Wyness.

10. When Dr Wyness was called to give evidence, Mr Hodson objected to its admissibility, essentially on two grounds. First, that Dr Wyness did not have the requisite or relevant expertise in the particular areas under consideration, and secondly, that he could not have complied with the Practice Note (No. 3) issued by the Tribunal on 5 February 2004 regarding the giving of expert evidence as he had not seen it prior to being called.

11. Mr Hodson argued that it was not a matter of what weight, if any, should be attributed to Dr Wyness' evidence but that it should not be admitted at all.

12. Dr Wyness was given a copy of the Practice Note to read. He undertook to comply with it when giving oral evidence and that insofar as it related to the content of his written brief of evidence (which had already been exchanged between counsel and which the members of the Tribunal had read) he believed it complied with the Practice Note.

13. Ms McDonald elicited further evidence from Dr Wyness (in addition to his curriculum vitae which was produced) regarding his experience and proposed expertise.

14. The Tribunal then ruled that it would receive and hear Dr Wyness' evidence.

15. Having heard fully Dr Wyness' evidence including his cross-examination, the Tribunal has no hesitation in finding that Dr Wyness does have the relevant knowledge and experience to admit him as an expert.

16. The Tribunal also observes that much of the opinion evidence which Dr Wyness gave was in accord with the expert evidence of Dr Antcliff.

Legal principles

Evidence and Submissions

17. While the Tribunal, in reaching its decision, has given full and careful consideration to all of the evidence presented together with the documents produced and the very helpful submissions of Counsel, for the sake of brevity it has not necessarily made reference to every aspect of them in this decision.

Onus of Proof

18. The onus of proof is on the Director of Proceedings whose Counsel accepted at the outset that it was for her to produce the evidence which proves the facts upon which the charge is based and to establish that Dr Marks is guilty of the charge, that is, professional misconduct.

Standard of Proof

19. As to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies according to the gravity of the allegations and the level of the charge. If the charge against the practitioner is grave then the elements of the charge must be proved to a standard commensurate with the gravity of what is alleged.

Professional Misconduct

20. The starting point for defining professional misconduct is to be found in the judgement of Jefferies J in *Ongley v Medical Council of New Zealand* (above) when he posed the test in the following way:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

21. In *B v The Medical Council* (unreported HC Auckland, HC11/96, 8 July 1996) Elias J said in relation to a charge of "conduct unbecoming" that:

> *"… it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards".*

Her Honour then proceeded to state:

> *"That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation."*

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> *"The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice, but patient interest and community expectations, including the*

expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."

22. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J delivered his judgement in *Ongley*. In the Tribunal's opinion the following are the two crucial considerations when determining whether or not conduct constitutes professional misconduct:

(a) There needs to be an objective evaluation of the evidence and answer to the following question:

> Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?

(b) If the established conduct falls below the standard expected of a doctor, is the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards, and/or punishing the doctor?

23. The words *"representatives of the community"* in the first limb of the test are essential because today those who sit in judgement on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his decision in *Ongley* in 1984. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the community's expectations may require the Tribunal to be critical of the usual standards of the profession: *B v Medical Practitioners Disciplinary Tribunal* (above). In *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) the learned Judge stated: *"If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. <u>But</u> a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in*

B goes beyond usual practice to take into account patient interests and community expectations."

24. This second limb to the test recognises the observations in *Pillai v Messiter* [No. 2] (1989) 16 NSWLR 197, *B v Medical Council, Staite v Psychologists Board* (1998) 18 FRNZ 18 and *Tan v ARIC* (1999) NZAR 369 that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

25. In the recent High Court case of *McKenzie v MPDT and Director of Proceedings* (unreported High Court Auckland, CIV 2002-404-153-02, 12 June 2003), Venning J endorsed the two question approach taken by this Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. He stated at para 71 of his judgement:

> *"[71] In summary, the test for whether a disciplinary finding is merited is a two-stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the Disciplinary Tribunal or the Court to become engaged in a consideration of or to take into account subjective consideration of the personal circumstances or knowledge of the particular practitioner. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner."*

Conduct Unbecoming

26. The Medical Practitioners Act 1995 provides three offences, namely, "disgraceful conduct in a professional respect", "professional misconduct" and "conduct unbecoming".

27. In *B v Medical Council* (above) Elias J observed at p.14:

> *"The scheme of the Medical Practitioners Act 1968 establishes a hierarchical conduct for disciplinary purposes. In ascending order of gravity the categories*

> *are unbecoming conduct (a category introduced by the amendment to the Act in 1979) professional misconduct and disgraceful conduct. …There is little authority on what comprises 'conduct unbecoming'. The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale must be conduct which departs from acceptable professional standards. … The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional misconduct or conduct unbecoming".*

28. In *McKenzie v Medical Practitioners Disciplinary Tribunal and The Director of Proceedings* (28 May 2003) Venning J referred to "a trilogy of disciplinary offences in an ascending order of gravity and penalty" and observed that the penalties imposed by the 1995 Act for "conduct unbecoming" and "professional misconduct" are exactly the same.

He further observed:

> *"The term 'professional' within 'professional misconduct' is not to be interpreted as within a simple rising scale in which it necessarily starts above 'conduct unbecoming a practitioner' in gravity. In law the professional misconduct offence could be of equal or even lesser gravity".*

Background events

29. AB was born in 1968, the eldest of four children. He had a normal childhood, had been a successful student both academically and socially, was well-liked and excelled at sport. He was highly creative and had a particular talent as a writer of poetry, fiction and drama. During his time at university and subsequently from 1987 through to January 1990 A's illness began to manifest itself with a gradual but marked decline in his academic and work achievements and a slow deterioration in his level of functioning, and depression.

30. In February 1990 he was admitted to Timaru Hospital's psychiatric ward having suffered his first psychotic episode with paranoid delusions and hallucinations. While an inpatient there, he was diagnosed as having schizophreniform psychosis. He was prescribed an anti-psychotic medication which resulted in a degree of recovery and an anti-depressant medication, imipramine. Following his discharge from hospital almost a month later he returned to Wellington to resume living with his parents. However, his mental health began to deteriorate again.

31. In April 1990 A was admitted to Ward 27, the psychiatric unit at Wellington Hospital. He had discontinued his anti-depressant medication of imipramine, had become suicidal and had attempted to hang himself.

32. From the time of his presentation, there was uncertainty about A's diagnosis as he presented with both schizophrenic and affective symptoms.

33. This was the first of a number of suicide attempts which A would make.

34. While an inpatient at Ward 27, A was diagnosed with schizophrenia with a differential diagnosis of bipolar disorder – depressed phase. He was treated with chlorpromozine which was discontinued prior to his discharge in May 1990. However, treatment with imipramine was continued and he was prescribed lithium, an anti-psychotic drug.

35. In early March 1991 A was again admitted to Ward 27 of Wellington Hospital. He had made a further attempt at suicide, this time by an overdose of his medication. At that time, he was very depressed. He was discharged after one week. He was continued on anti-psychotic medication but treatment with lithium was ceased due to unpleasant side effects.

36. In early July 1991 A was admitted to Ward 27 of Wellington Hospital for a third time where he remained for just over two months until his discharge on 6 August.

37. He was admitted on this occasion due to increasingly bizarre behaviour. He was initially treated with pimozide, an anti-psychotic drug, and clonazepam. After 10 days following his admission, A was also treated with carbamazepine, a mood stabiliser. This was because of his elevated mood state and because of the mood swings he had undergone in the past.

38. Due to ongoing problems with acceptance of medication, A was commenced on haloperidol, an anti-psychotic drug, by injection. The dose at that time was 150mg four-weekly.

39. During this period, the diagnosis was changed from schizophrenia to schizoaffective disorder due to the further period of mood disturbance associated with psychotic features.

40. For approximately the next two years between August 1991 and May 1993, A's condition stabilised. He continued to live at home with his parents, working part time and was seen regularly as an outpatient.

41. On 31 May 1993 A was admitted for a fourth time to Ward 27 at Wellington Hospital.

42. At this time, he was having grandiose religious delusions and hallucinations. The sudden onset of psychotic symptoms followed the discontinuation of carbamazepine and a reduction in his dose of haloperidol earlier in 1993. He was discharged on 8 June 1993.

43. Following his discharge, A became severely depressed and, on 15 June 1993, he made a further serious attempt at suicide, on this occasion by electrocution when alone at home.

44. On 16 June 1993 A was admitted for a fifth time to Wellington Hospital. He was started on imipramine 150mg daily and continued on haloperidol (100mg 4 weekly).

45. A was a voluntary patient and was given home leave.

46. On 26 June 1993 he returned to the hospital in a psychotic state and, four days later, on 30 June he left the ward without permission. On this occasion, A made two further serious attempts at suicide on the same day. The first attempt was by jumping from a moving car in which he was a passenger and the second was getting into a truck with the keys still in the ignition (while the driver was absent) and crashing the vehicle into a building which housed a pre-school centre. Fortunately, no-one was hurt in that incident.

47. As a result, A was re-admitted to hospital in the forensic psychiatric unit as a compulsory inpatient under the Mental Health Act due to his impulsivity and high risk behaviour.

48. A was continued on haloperidol 100mg once every four weeks. He was given it in the form of the depot long acting injections which are used as regular medication for those who are considered to have ongoing psychotic illness which requires maintenance therapy. He was also given carbamazepine daily in order to stabilise his mood swings.

49. On 22 October 1993 the care of A was transferred to the Community Psychiatrist.

50. In 1996 the B family underwent a personal tragedy when A's brother and the brother's partner committed suicide.

51. Despite this, from the end of 1993 until July 1998 A remained stable with the support of his family, his healthcare providers and a successful medication regime of haloperidol and carbamazepine on which he was maintained. According to his parents, A was a happy and creative young man during this period and was doing well despite the difficulties he faced; and that the medication regime he was on worked very well.

52. In 1998 and 1999 a number of changes took place in A's life. These included entering a new relationship with a woman (Ms E) with whom he had been friends for a number of years; and suffering a break-in to his home during which he was the victim of a violent attack by Ms E's former husband. This latter incident resulted in A having to have contact with both police and the criminal Court which he found most unwelcome.

53. It was at this time that A also questioned the reason for his illness. He formed the view that he was not mentally ill but rather had been the victim of sexual abuse in his early years (by a third party).

54. A also experienced a series of changes in relation to the health professionals involved in his care, including being changed to a new psychiatrist, Dr Marks.

55. By July 1998 Dr Marks had been assigned to take over the role of A's treating psychiatrist.

56. On 15 March 1999 A had his first consultation with Dr Marks at the Tacy Street Clinic in Kilbirnie, Wellington.

57. There were further consultations with Dr Marks on 9 April, 30 April, 28 May, 11 August, 10 September, 17 September, and 8 October 1999.

58. On 15 October 1999 A attempted suicide by hanging and died the following day as a result of his injuries.

Evidence called by Director of Proceedings

CB

59. Mrs B, A's mother, was the first of the witnesses to be called on behalf of the Director. Mrs B outlined A's background and the history of his illness from when he first began to manifest symptoms of it, a brief history of which is set out above.

60. Mrs B referred to A's period of stability between 1993 and early 1999. She was of the view that the medication regime A was receiving worked very well.

61. She also referred to the changes in A's life in 1998 and 1999 which, in her assessment, caused considerable stress for A and which she referred to as "stress factors".

62. On 15 March 1999, A had his first consultation with Dr Marks when Dr Marks attended at A's home.

63. There was a change from a previous care manager (Ms Boyd) to a new care manager (Ms Clarke). Previously a nurse would attend at A's home to give him his regular intra-muscular haloperidol injections but the new care manager required A to attend at the clinic to have it. Mrs B explained that A found this distressing.

64. At around this time A began to question his medication regime and wanted it reduced. It appears that Ms Clarke disagreed that it should be reduced as a result of which A had a falling out with her. This resulted in a new care manager (Mr Verner) being appointed in June 1999.

65. One of the stress factors in A's life was when he entered into a relationship with Ms E in early 1999. This relationship became complicated when Ms E's ex-husband broke into A's home and attacked him with violence in March 1999. As a result, A had to have dealings with both the Police and the law Courts which he found most disturbing and became fearful that he might be the subject of a further attack.

66. A further issue was A's concern about the impact his medication was having on his life and how it was affecting his relationship with Ms E. Prior to this, Mrs B said that A had come to terms with the side effects of the various medications he required and that he was particularly compliant as he feared the possibility of a relapse. Because of the effect on his relationship with Ms E, from February 1999 onwards he and Ms E began to question whether changes could be made to his medication regime.

67. Another issue was that in early 1999 A began to raise questions in relation to the reason for his illness. He asserted he had been sexually abused in his childhood (by a third party) and that this was the cause of his illness rather than him being schizophrenic. The assertion of sexual abuse had not been raised before.

68. Also associated with this was some issue in A's mind that he may have been in some way responsible for his brother's death.

69. Mrs B referred to a further stress factor which related to a new flatmate who lived in A's home with him which did not work out. A had some fears about being alone in his house at night and as a result, A's parents were faced with the prospect of relocating him.

70. It should be stated at this juncture that Mr and Mrs B were totally devoted parents committed to doing everything within their ability and their means to support A and, did so, from the outset of his illness until his death.

71. Over the years, the impression they had received from A's various care workers and psychiatrists was that A's stress levels should be kept at a minimum.

72. There were some matters of which Mrs B was not aware at the time of A's death but of which she became aware after his death from his medical notes and other documents disclosed and from the Coroner's inquest.

73. Mrs B described A's deterioration, in particular from about July 1999 onwards when he began to suffer from depression, was not eating properly, was sleeping to excess, was very

slow and could not complete simple tasks such as doing the dishes and generally looking after himself. Mrs B was keeping A company when Ms E was not around.

74. She referred to his delusional thinking which was episodic but, in her experience of him, came to the fore when he was very ill. She knew that either severe depression or a manic phase were the typical precursors to the onset of A's psychosis and was very concerned about his wellbeing.

75. It appears that a common theme of those attempts was that they were preceded by a state of depression in the presence of mood disturbance associated with psychotic features.

76. As a result of her concern, Mrs B had a number of dealings with Mr Verner and Dr Marks.

77. Although Dr Marks had eight appointments/consultations with A between 15 March and 8 October 1999, it is the consultations of 11 August, 10 and 17 September, and 8 October 1999 to which the charge more particularly refers.

78. Mrs B requested and, with A, attended a consultation with Dr Marks on 11 August 1999 at the Clinic. She said the consultation was lengthy and that they had not had one like that for some time basically because they had not had the same degree of concern for A until then.

79. Dr Marks wrote in the notes concerning the 11 August 1999 consultation the following:

> *11/8/99 Came (with) Mum.*
> *Seen (by) Mike V.*
> *"Not too good. Not too flash"*
> *'Come into a period where I'm unable to do anything'*
> *-Unmotivated, indecisive, depressed*
> *Not handling finances, anything properly.*
> *On haloperidol 80mg IM @ 6/52.*
> *Off CBZ 6/12. was on 200mg bd*

Low mood began 3/52 ago after assault by

G'friend's ex-partner. Police sentenced him to just 2 mos.

A feels cheated by police who 'did deal' (with) his assailant

Feels his change of mood related to these events.

Mum

Noticed change in mood

OK last Friday

Not eating properly

Not looking after self

Sleeping to XS

Slower – can't even complete dishes

treatment imipramine 50mg tid

1/12

80. During the course of the consultation, Mrs B said she explained in detail the concerns she had regarding A and the changes in him.

81. Mrs B referred to the clinical notes made by Dr Marks concerning the carbamazepine which records *"off cbz 6/12"*. This note indicates that A had not been taking the carbamazepine for the previous six months. However, Mrs B said that Dr Marks did not inform her of this at that consultation.

82. While Dr Marks' clinical notes for this consultation also record that A was prescribed the drug imipramine 50mg, Mrs B said she was not advised of this at the time when she attended this consultation.

83. Mrs B referred to a consultation A had with a GP, Dr Pickett, on 23 August 1999 of which she became aware (after his death) from reading his diary and other documents. The purpose of his visit was in relation to the side effects he was experiencing from the imipramine. Dr Pickett made changes to the medication in a bid to reduce the side effects. He told A to take two pills at night only. It is apparent from A's medical notes that he informed his care manager, Mr Verner, of this on 25 August 1999. However, with regard

to Dr Marks' earlier clinical notes of 11 August 1999, there is no record in them of the dose of imipramine being titrated.

84. In early September 1999 A told his parents that he was dying of lung cancer. They made an appointment and accompanied A to their family GP. Following an examination of A, the GP assured A he did not have that illness and that he was physically very healthy.

85. In the days following, Mrs B was so concerned about her son's mental state that she made contact with A's care manager, Mr Verner, and expressed her concerns to him.

86. Mr Verner paid A a home visit on 3 September. It appears A did not keep a subsequent appointment with Dr Marks on 8 September on which date Mr Verner telephoned A. Mr Verner received a telephone call from Mrs B on 9 September during which she expressed her concerns at A's mental state and behaviour. Together they discussed a plan for the following day. On 10 September Mr Verner paid A a home visit, and it was agreed A would see Dr Marks that afternoon.

87. On 10 September 1999 Mrs B accompanied A to his appointment with Dr Marks at the Tacy Street clinic.

88. Dr Marks wrote in the notes concerning that consultation the following:

> *10/9/99 C/o Tired all the time.*
> *Mood low scared –but sleeping xsively*
> *Has been on imipramine 50mg bid*
> *But has only been taking one tablet because of side effects*
> *therefore Try CBZ 200mg one tablet bd*
> *On Haldol 100mg. I/M @ 6/52*
> *Akathesia and restlessness evident*
> *Declined anticholinergics.*
> *to see Mike V*

89. Mrs B said she was surprised to learn at this consultation that A had not been taking his carbamazepine which, on her observations, had helped him so much in the past. A was

re-instated on carbamazepine. At A's request, Mrs B undertook to ensure that A took his medication as she would administer it to him.

90. On 15 September 1999 Mr Verner paid A a home visit.

91. Mrs B accompanied A to his next consultation with Dr Marks on 17 September 1999.

92. Dr Marks wrote in the notes concerning that consultation the following:

> *17/9/99 Irritable, angry, sleeping ++*
> *Too tired to do anything.*
> *On CBZ 200mg one tablet bd. Haldol 100mg @ 6/52*
> *for Haldol 50mg I/M @ 1/12 + amitryptiline 50-100-150mg nocte*
> *for Community psychiatric nurse.*
> *1/12*

93. Dr Marks' clinical notes record that he reduced A's haloperidol medication to 50mg once every four weeks; and started A on the drug amitryptiline in place of imipramine due to the latter's side effects. Mrs B told the Tribunal of her concerns that Dr Marks neither consulted nor advised her about those changes to A's medication. Her understanding was that A was still having the same dose of haloperidol as he had had previously (prior to 30 April 1999), that is, 100mg once every five weeks.

94. She said that the label on the packaging for the amitryptiline simply advised that A was to take three tablets at night. She said there was no mention either on the packet or from what she could ascertain A had been told of the dose needing to be titrated.

95. She said during this consultation the care manager had criticised A for not taking his anti-depressants and, in response to this, A had asked his mother in Dr Marks' presence to assist him with allocating his medication on a daily basis.

96. Mrs B recalled that at some time in September 1999, she spoke to A's care manager expressing concerns she had about Dr Marks. A's parents were considering whether they

should be looking at having someone else care for A as they had both become increasingly unhappy at A's failure to improve. However, Mrs B told the Tribunal that neither she nor her husband were aware of changes which had been made to A's medication.

97. On 22 September 1999 Mr Verner paid A a home visit.

98. On 24 September 1999 Ms E's ex-husband was sentenced regarding his assault on A. Also, Ms E applied for a restraining order against her ex-husband, which impacted on A's mood and caused him further distress.

99. At this time, A was tending to stay more often at his parents' home rather than his own. His parents were ensuring that he was taking his medication and eating and drinking properly although he was still very low and getting worse.

100. On 27 September 1999 Mrs B telephoned A's care manager as she was particularly concerned about A's condition that day, and told him that despite A taking his medication, his mood was still very low. She described A's symptoms which included A's thoughts that his body was dying and that he was angry that he could not help himself. Mr Verner attended on A at Mr and Mrs B's home that day where A was staying.

101. Mrs B said that in the days following, A's condition showed no sign of improvement. He was tired and depressed. The care manager visited A again on 30 September 1999 at his parents' home where he was staying. A expressed feelings to him that he was not coping, that he still felt worthless and was unmotivated with no energy.

102. Mr Verner visited A on 5 October 1999 at A's home where he administered an injection of 50mg haloperidol.

103. Mrs B said that throughout October A's condition deteriorated further. He was afraid to be living alone and although he had returned to his own home he was spending his days with her at her home. They went for long walks and did things together.

104. On 6 October 1999 Mrs B made an appointment to see Dr Marks on 8 October following a discussion with A and Ms E about A's medication.

105. That same day, Dr Marks received a phone call from Ms E who said A was not improving and questioned the treatment he was receiving. He invited her to attend the clinical review (set for 8 October) with A and his parents.

106. On 8 October 1999 A, his parents and Ms E attended the consultation with Dr Marks. It appears that this consultation was a very lengthy one taking up to anything from 2 to 2½ hours with Ms E walking out of the meeting about half way through.

107. Dr Marks wrote in the notes concerning that consultation the following:

Came (with) g'friend and parents
"Unable" to move last 5/52
c/o pin pricks in my body
Intellect gone to bits – no thoughts – too tired
thoughts they're cyclic all the time – "stuck record syndrome"
and they're not good – not worth talking about
"- it's my fault – I have no reference point – I am a ghost"
Mum – firm on taking his drugs
Dad – talks about – re effects on his physical being
girlfriend – side-effects so heavy it's depressing
Mum – he's started reading paper A but I read it 20 times.

Long discussion (with) parents and g'friend
Re: 1) effect of psychotropic drugs
2) uncertainty of diagnosis
3) prognosis & management
Agreed:
1) A would continue on I/M haloperidol
2) " " " amitryptiline 150mg nocte
3) A and g'friend felt CBZ making him worse
Want to discontinue it. Agreed.
Close F/U by community psychiatric nurse Mike Verner
Psychiatric outpatient department 1/12

108. Mrs B said the purpose of the meeting was to enable all of them to discuss A's medication, the reasons why he was on it and how low he was at that time.

109. At this consultation, Mrs B said there was a long discussion about A's medication.

110. She expressed her concern that he had not improved on the antidepressant (amitryptiline) he had been taking and wanted it changed because of the side effects it appeared to have been having on A.

111. While Ms E was opposed to the haloperidol, Mrs B wanted it explained to Ms E why it was important for A to stay on it as she and her husband believed that their son should stay on it as it had been so successful in treating his condition in the past. (She said she had asked Dr Marks some months earlier to have a similar conversation with Ms E.)

112. Ms E had stated that haloperidol, imipramine and amitryptiline were not a good mix and that haloperidol should be reduced or stopped altogether.

113. During the discussion, Mrs B said Ms E asked Dr Marks why he had stopped prescribing carbamazepine for A to which Dr Marks responded that he believed it "does nothing". When Ms E questioned Dr Marks further as to why he had given carbamazepine to A recently, Mrs B said Dr Marks replied that the only reason he did so was because A had asked for some but that he could see no reason for prescribing it, particularly while A was depressed as it could stabilize him in a state of depression. Mrs B told the Tribunal she could still see the look of disbelief on A's face when Dr Marks said this.

114. She herself was very surprised by Dr Marks' comments about the carbamazepine as it had been her understanding that it had been a key part of A's treatment during the six years A had been stable. Dr Marks said Mr Verner would visit every second day.

115. She said in the end Dr Marks agreed that A should stop taking carbamazepine but stated he should stay on amitryptiline and that this would be effective if A took the current dose and gave it time to work; and he reduced the dose of haloperidol.

116. Mrs B said that apart from the reduction of the haloperidol which was discussed at this meeting, she and her husband did not know that A's haloperidol had been reduced on any earlier occasion until after A's death when she was reading through his medical notes.

117. Mrs B was adamant that at no time during this consultation was the issue of admitting A to hospital discussed and neither did Dr Marks mention the issue or possibility of hospitalising A to her at any other time.

118. Mrs B added that while A was never happy about having to go into hospital, her experience with him was that it was never difficult to get him to go into hospital if he needed to go. She was quite sure that if Dr Marks had mentioned hospitalisation to her at that consultation, she and her husband would probably have agreed with that plan.

119. Mr Verner gave A 50mg of haloperidol that day and visited A at his home on 12 October.

DB

120. A's father, Mr B, also gave evidence and confirmed his wife's evidence to the extent possible as it related to their dealings with Dr Marks, and reflected his recollection of events.

121. He confirmed that his wife took the lead role in A's care but that they shared the load, often working together to ensure that A's needs were met. When Mrs B was not available, Mr B stepped into her role.

122. He described his son as very good-natured and generally very compliant when it came to taking his medication although he had been expressing concerns about the side effects he was experiencing on his anti-depressant medication, imipramine.

123. Mr B referred to the consultation which he also attended with his wife on 8 October 1999 with Dr Marks. He confirmed that his wife's recollection of events accorded with his own.

124. With regard to the haloperidol, he said the 8 October consultation was also the first occasion on which he learned that Dr Marks had reduced the dose.

125. He confirmed also that it was agreed that Mr Verner would visit A every second day in order to keep a close check on him.

126. Mr B was equally adamant that at no stage during that consultation was the issue of possible hospital admission raised or discussed. He said hospital was never mentioned. He confirmed Mrs B's evidence that it was his experience that if A needed to be admitted, while A would protest about it, in the end he would agree to it. Mr B also confirmed that had Dr Marks mentioned hospitalisation at that consultation he and his wife would have persuaded A to agree to go, as they had done in the past.

127. During the early afternoon of 15 October 1999 Mr B drove A to the Tacy Street Clinic for an appointment which Mrs B had made earlier that day. A's parents were so concerned about him that they believed he needed to be seen. A had been talking about hospital himself the previous evening with his mother which indicated he felt worse.

128. Mr and Mrs B had discussed whether they should put A straight into hospital but in the end decided to have A seen on 15 October. Mr B waited in the car while A saw his care manager as he felt A might feel freer in his conversation if he were not present.

129. Later that afternoon A attempted suicide by hanging and was taken to the Emergency Department and then to the Intensive Care Unit at Wellington Hospital where he was put on a ventilator.

130. Mr B said that while he was standing beside A's bed in the Intensive Care Unit Dr Marks entered and told him how sorry he was. He said Dr Marks commented that he wished he had not reduced the haloperidol. Mr B was adamant this was what Dr Marks had said. He said this comment stuck in his mind because it was so at odds with what Dr Marks had said about haloperidol previously and particularly at their family meeting of 8 October.

Bridget Taumoepeau

131. Dr Taumoepeau is a consultant psychiatrist who is, and was at the relevant time, working at Capital and Coast Health. She obtained her medical degree in 1970 from the United

Kingdom and has been a Fellow, since 1987, of the Royal Australian and New Zealand College of Psychiatrists.

132. As Dr Marks had commenced working with Capital & Coast Health in 1998 having practised in the UK he was, in the usual way, given temporary registration by the New Zealand Medical Council as a condition of which he was required to be under clinical supervision.

133. However, additional terms and conditions were imposed which were quite separate from the usual supervision described above.

134. Dr Taumoepeau was one of Dr Marks' clinical supervisors. She explained that supervision is essentially a discussion process driven largely by the supervisee who can choose the cases for discussion because of their complexity or some other difficulty, with the supervisor offering advice or ideas using a problem solving methodology.

135. In a letter dated 7 July 1999 to Dr Marks from Dr Peter McGeorge, Clinical Leader, Mental Health Services, Capital & Coast Health, Dr Marks was specifically directed to meet with Dr Taumoepeau at least once every two weeks to discuss cases where there was a difference of opinion. He was directed to put into practice any advice which Dr Taumoepeau gave him. Dr McGeorge also directed that those meetings were to be used to discuss any other clinical or communication issues. As far as Dr Taumoepeau recollects, from the time of Dr McGeorge's letter she met with Dr Marks for about a one hour session each fortnight at the Tacy Street Clinic.

136. Dr Taumoepeau explained the role of the supervisor and what supervision entails.

137. She commented that there was a difference between supervision and obtaining a second opinion about a patient from another psychiatrist. She said that whether the advice was given as part of the supervision process or as a formal second opinion, decisions about treatment remained the responsibility of the treating consultant psychiatrist (in this case, Dr Marks).

138. While she recalled Dr Marks discussing his patient, AB, with her at their regular supervision meetings, she did not keep records of any of the meetings as it was not usual practice for the supervisor to do so. However, if specific cases were discussed at any of the supervision meetings then any input she might give could well be recorded by the treating psychiatrist in the notes of the particular patient discussed. She said she considered it wise for the treating psychiatrist to record any specific and important discussions with colleagues about treatment of specific cases and to record whether or not the treatment was to change as a result of those discussions. Further, if the advice, or the second opinion, differed from the treating psychiatrist's own view, then the latter should record why he/she had decided not to follow that advice or opinion.

139. When such discussions regarding a particular patient are involved, Dr Taumoepeau said her general approach (which she believed she would have explained to Dr Marks at the relevant time regarding A's situation), involved the following:

(a) Assessing the patient's risk/safety; and
(b) Querying what could be safely put in place in the community between family, friends, support systems and mental health services (including close follow up); and
(c) Querying whether there was sufficient risk to merit admission; and if there was sufficient risk, to consider whether the patient would agree to a voluntary admission and, if not, then to consider whether the risk was sufficient to merit using the Mental Health Act for a compulsory admission.

140. Dr Taumoepeau described how the treating psychiatrist might manage the issue of admission where the patient and, to some extent, his family might have some resistance.

141. This involved an assessment of risk. She said in A's case the major risk was suicidality due to depression.

142. She explained that it was relatively common for a psychiatrist to find themselves in a situation where in the end they had to bring to bear their own professional decision about the matter, despite the wishes of the patient or family.

143. Dr Taumoepeau said she understood Dr Marks had claimed that A was descending into psychotic depression and that he made her aware of it. She said it was not her recollection; that it was certainly not clear from the notes that Dr Marks considered this and that there was not any evidence he had discussed it with her. Her recollection was that there was considerable discussion about the precise diagnosis (the differences between schizophrenia, schizoaffective disorder; bipolar disorder). She said her view was that the most important thing was to treat the symptoms with both antidepressants and anti-psychotics and that the diagnostic issues would become clearer with further review of the history and the way the illness was unfolding.

144. In summary, Dr Taumoepeau recalled advising Dr Marks, with regard to A's treatment, that she did not believe that the haloperidol would be causing A's persistent depression; that A's treatment should include both anti-depressant and anti-psychotic medication if depression were a significant part of the clinical presentation; and that her view was that the anti-psychotic effect of the haloperidol was still very much required in conjunction with anti-depressants.

145. Dr Taumoepeau said that having reviewed A's medical records when preparing to give evidence before the Tribunal, she noted that Dr Marks did not appear to have recorded any specific discussions he had had with her about A's treatment and her advice concerning it.

Deborah Antcliff

146. Dr Antcliff was called by the Director as an expert. She is a consultant psychiatrist having been a Member since 1983 and a Fellow since 1987 of the Royal Australian and New Zealand College of Psychiatrists. She is employed by the Auckland District Health Board as its Director of Area Mental Health Services and as Clinical Director for its Community Mental Health Services and the Buchanan Rehabilitation Centre.

Clinical Assessment

147. With regard to clinical assessment, Dr Antcliff stated that an adequate clinical assessment of A would have included exploration of his pattern of sleep, any diurnal variation in mood,

his appetite, loss of pleasure and sexual interest, guilty ruminations, content of his thinking, especially with respect to ideas of death or disease, hopelessness, experience of hallucinations, and suicidality.

148. Dr Antcliff said this was necessary because it would have fully elucidated the depth and severity of his depression and psychotic phenomena and the psychosocial issues precipitating and perpetuating the depression. This then enables a comprehensive treatment plan to be developed.

149. In her opinion, in none of the appointments with Dr Marks in August, September or October 1999 was there evidence of such a clinical assessment being documented.

Risk Assessment

150. Dr Antcliff stated that with regard to risk assessment "risk" refers to risk to health and safety of the person and/or others, and includes the risk of self neglect and exploitation from others.

151. She stated that an adequate risk assessment of A would have included exploration about ideas of death and his wish to live, and what plans he had for his future, thoughts or plans of suicide, thoughts about harming anyone else, his ability to take care of himself and what support he was requiring to manage his basic needs.

152. Dr Antcliff stated there was no evidence from Dr Marks' notes that he discussed the possibility of suicide with A or developed any opinion about his suicide potential. She said his notes were entirely silent on the matter. An assessment of suicide risk should have been noted following the contacts on 10 September, 17 September and 8 October 1999 (when it would have included the family's perspective), because of the severity of the depressive symptomatology displayed at each of those reviews and the lack of response to the treatment which would have increased A's sense of hopelessness. She added that regardless of whether any other member of the mental health team was assessing risk and filling out the risk assessment forms that did not obviate the need for the treating psychiatrist to assess the risk in the way she had indicated. Dr Antcliff said that the

psychiatrist was the most expert member of the clinical team in evaluating the mental state and eliciting phenomenology and making the diagnostic formulation. It was one of the primary responsibilities and roles of the psychiatrist to ensure this was done to the requisite standard.

153. Dr Antcliff referred to Dr Marks' report and verbal evidence to the Coroner (which was before the Tribunal). She noted that Dr Marks had said he was extremely concerned about A's potential for suicide and had said he had made comments to Mr Verner along the lines of *"he (meaning A) will kill himself if we do not get him off the Haldol"*.

154. She referred to Dr Marks' evidence before the Coroner when he said he was reassured by a discussion he had had with A who had told him he would not take his own life, and that Dr Marks had said he was also reassured by A's close supportive family and partner, with whom he claimed he had discussed the potential for suicide and that they understood the risk. Dr Antcliff referred to the family's evidence that suicide was not explicitly discussed with them. She also observed that there was no written evidence that it had been.

155. It was Dr Antcliff's opinion that, in the face of the serious depressive symptoms displayed during the family meeting on 8 October 1999, the management of suicidality should have been addressed with A and his support network at that meeting.

156. Dr Antcliff stated that as A had a history of serious suicide attempts, any such discussions which occurred should have been documented to ensure continuity of care between the various staff members. If the care manager had seen documentation that the psychiatrist had assessed A as a serious suicide risk it would have influenced his perspective. She said, however, the care manager was documenting his own assessments which did not elicit suicidal thinking which, in turn, could have been influencing the psychiatrist.

157. Dr Antcliff said it was essential for a thorough risk assessment that suicidal ideas and plans were explicitly sought in every patient who was depressed and, most particularly, with those who have psychotic symptoms, as they are the ones who are greatly at risk.

158. She said that such a risk assessment potentially decreased the risk of suicide by enabling appropriate interventions to be put in place.

159. Dr Antcliff referred to the fact that Mr Verner was assessing suicide risk and recording his evaluations and that on the day of A's death he had recorded *"no obvious signs of suicidality observed"*.

160. Dr Antcliff observed that Mr Verner was seeing A much more regularly than Dr Marks was and clearly did not believe that he was an extremely high suicide risk. It was her view that if Mr Verner had assessed A as a suicide risk on 15 October he would have insisted on him seeing Dr Marks for the appointment that Dr Marks had made available that day.

161. When Mr Verner updated the risk management plan on 1 October 1999 Dr Antcliff noted there was no mention of the recent onset of depression with emerging psychotic symptoms or a suicide assessment. She said this rendered the routine re-assessment of risk meaningless as it did not lead on to a comprehensive review of A's treatment plan which would have been extremely relevant for A at that particular juncture. She emphasised that this was the point of regularly reviewing risk issues.

162. She referred to the treatment review document which had a risk analysis but which was not completed. She said Mr Verner updated the risk management plan in a mechanistic way which did not take into account that the situation had changed. She added that Dr Marks had not recorded that he had assessed A as psychotically depressed and he had not demonstrated, through his documentation, that he was concerned about A's suicide potential. She said this could have unduly reassured Mr Verner.

163. From the documentation and from the evidence given to the Coroner, she concluded that Dr Marks and Mr Verner did not consider A a particularly high suicide risk, despite his past history. Dr Antcliff stated that with the benefit of hindsight this was clearly an incorrect assessment and that if the proper processes had been adhered to then these might have produced a different outcome.

164. She said that in particular the elicited symptoms should have been acknowledged and expanded upon and the diagnosis of depression with mood congruent psychotic features recorded.

165. Dr Antcliff explained to the Tribunal that major depression with psychotic features has a higher rate of successful suicide. The expressed concerns of A, his family and Ms E that he was not improving should have alerted Dr Marks to be more concerned and should have prompted full discussion of all the options. A review of his presentation when last psychotic and suicidal might have revealed similarities in his presentation giving warning signs.

Management/Treatment Plans

166. With regard to an adequate treatment plan, Dr Antcliff stated that an ideal one would have included a determined effort to ensure A received therapeutic doses of imipramine and carbamazepine, in the first instance. It would have included a full explanation to A, Ms E and his parents of the depressive symptoms he was experiencing to ensure everyone knew why he needed the treatment. Such an explanation would have included a description of possible psychotic and psychomotor features which could emerge. The plan would include the frequency of reviews and who to contact if any of them were worried. She said there should be some indication of the expected timeframes within which events would be expected to occur. It would include what clinical staff would take responsibility for which aspects of treatment, in order to ensure that interventions did occur as planned. She said A should have been asked to identify what steps he could take if he felt suicidal or got impulses to harm himself and this would be communicated to his family with his consent. Dr Antcliff stated the circumstances where the Mental Health Act might be considered and indications for inpatient treatment and ECT would be covered as it became evident that the first line treatments were not taking effect.

167. She said this was necessary because it would provide a framework within which everyone could participate and know if that which is happening is what is expected to happen, thereby lessening the ignorance and uncertainty that most patients and their families experience at times of illness. She said it would provide the range of choices and allow more informed participation in the process.

168. In Dr Antcliff's opinion there was no evidence in the notes that Dr Marks discussed or developed a comprehensive plan of treatment, although obviously some options were explored at the family meeting of 8 October. It appeared to her that the interventions were reactive and predicated on the diagnosis that the main contributing agent to the depression was the haloperidol.

Failure to document

169. As previously outlined, Dr Antcliff stated there was no evidence in the documentation of a full clinical assessment, risk assessment or treatment plan.

170. She stated that the reason such assessments and plans should be recorded in the notes is because this is the communication channel for all clinicians involved in the treatment process. It indicates what the clinicians have elicited at a point in time which can be compared and contrasted at each contact with the patient and with feedback from the family. She said it also identifies what has been planned with and communicated to the patient and the family and what each clinician is expected to do to fulfil their professional duties.

11 August 1999 consultation

171. Dr Antcliff was critical of the care provided by Dr Marks to A from 11 August 1999 onwards.

172. With regard to the 11 August consultation, she stated there was a marked change in A's presentation. He was exhibiting significant signs of a depressive relapse. It was her opinion that Dr Marks should have documented that he had explored the full range of depressive symptoms, paranoid ideation, suicidal ideation and any plan; that he should have recorded a diagnosis accounting for the change in presentation; and that he should have recorded a more comprehensive plan of treatment.

10 September 1999 consultation

173. By the time of the 10 September consultation, Dr Antcliff stated that it was evident A's depression was worsening with the emergence of psychomotor agitation (Dr Marks had recorded "Akathesia and restlessness evident").

174. She said that again the full range of depressive symptoms, including psychotic and suicidal ideas, should have been explored and recorded.

175. She said this was documented by using a standard mental state format addressing the standard domains of appearance and behaviour; speech form and content; affect and mood; thought form and delusions; perceptions; cognitive ability; insight and judgement; including risk to self and others.

176. She said that if this were undertaken, one would expect to see in the notes a summary of the findings in each domain.

177. She added that similarly, there was no evidence of the formulation of a diagnosis which should have been done because it was the role of the psychiatrist to integrate the history, presenting complaints, mental state examination findings into a cohesive whole in the form of a diagnostic formulation. She added that if there was uncertainty about the diagnosis, then it was even more important to document what the possible diagnoses were. In her opinion, the diagnosis should have been documented because it is the consistent platform for informing the patient, their family and the team about the contributing factors and the problem requiring treatment, and why the treatment has been chosen.

17 September 1999 consultation

178. With regard to the 17 September consultation, Dr Antcliff said it was evident that A was presenting with a further deterioration in his mood and with very severe lethargy, which was the result of his deepening depression.

179. She said there was no exploration of suicidality, thoughts of death or psychotic phenomena yet the decision was made to go ahead and lower his haloperidol and change his antidepressant to amitryptiline which is very sedating.

180. Dr Antcliff said there appeared to be no exploration about A's compliance with the treatment which by now was of critical importance as his previous non-compliance with treatment was known. She said if A were not taking his medication that would account for why he was not responding and might also contribute to any consideration of using the Mental Health Act. She added there was a strong sense throughout this relapse that A was being encouraged by his partner, Ms E, to challenge the medication which she maintained were causing these effects and which Dr Marks was also having to manage without alienating himself from A or Ms E

181. Dr Antcliff thought this probably strengthened Dr Marks' belief that the haloperidol was causing A's depression and was most likely to have influenced his decisions about the treatment options available.

182. She said Dr Marks may have been trying to accommodate A and Ms E's attitudes to medication to enhance his therapeutic alliance. A was a voluntary patient and therefore all treatment plans had to be developed collaboratively with his cooperation which can be difficult if patients are resistive to accepting treatment.

183. In Dr Antcliff's opinion, Dr Marks did not appear to have adequately factored in the non-compliance with carbamazepine, which was likely to have a profoundly destabilising effect on A's mood.

184. It was not evident from Dr Marks' notes that he did a full mental state examination to ensure he had identified the full extent of A's depressive symptomatology.

185. Dr Antcliff observed that for six years A had been stable on haloperidol. By 17 September, Dr Marks should have had regard to the severity of the functional impairment A was describing. He would have been greatly assisted if he had done a full mental state examination specifically exploring for psychotic signs and recorded his findings. If he had

elicited psychotic symptoms this would have alerted him to the risk of reducing the haloperidol. It would have given him stronger grounds to firmly insist on adequate doses of mood stabiliser and antidepressant and would have reinforced A's need for sufficient antipsychotic medication at that stage of his relapse.

8 October 1999 consultation

186. The consultation of 8 October was set up on 6 October at the request of Mrs B. That same day, Dr Marks received a phone call from Ms E, where she identified that A was not improving and that she questioned the treatments he was receiving. Dr Marks invited Ms E to the clinical review, with A and his parents which Dr Antcliff said was very appropriate and which reflected Dr Marks' attempt to include everyone in the consultation and planning, and to hear the variety of perspectives.

187. Dr Antcliff told the Tribunal that meetings where the participants have quite discrepant perspectives are difficult to manage successfully as each perspective must be articulated and considered and there is often no singular *"correct"* consensus outcome possible. Usually each perspective has some merit and all options may be considered without any particular one standing out as clearly "*the best*".

188. However, with regard to the scenario with which Dr Marks was presented at the 8 October meeting, Dr Antcliff explained it was quite common for psychiatrists to try and manage this sort of range of differing views, and to have multiple roles in a family meeting of this kind.

189. By the time of the 8 October family meeting, Dr Antcliff said it was evident from the notes that A was severely depressed with mood congruent psychotic features. She said he had severe psychomotor retardation (*unable to move*), somatic hallucinations (*pinpricks in my body)*, depressive ruminations (*stuck record syndrome*), but the content is unknown (*they are not good – not worth talking about).* He had nihilistic delusions (*I am a ghost).* This was nearly two months after the first presentation with depression and there had been a steady deterioration in his mental state, despite treatment.

190. In Dr Antcliff's opinion, f Dr Marks had done a more formal suicide assessment and explored for psychotic symptoms when he saw A at this consultation he might well have developed a more accurate understanding of the severity of the situation. While he documented several statements A made which revealed how depressed A was he did not take the opportunity to do a full mental state examination because it was a family meeting and it can be difficult to address the various imperatives of all the attendees.

191. While admission was not automatically indicated at the point of the family meeting, Dr Antcliff said Dr Marks should have discussed the option of hospitalisation and the circumstances that would indicate it. These would include the possibility that the family might feel they could no longer provide sufficient support and might ask for admission to relieve them of the responsibility for his safety.

192. Given the nature of A's symptoms observed at that meeting, Dr Antcliff said Dr Marks should definitely have discussed with those present the possible need for a hospital admission.

193. The benefits of hospital admission, if required, would be that staff could observe him, mental state examinations could be done repeatedly during the day and if the risk of suicide was, or became very high, he could be admitted to a Mental Health Intensive Care Unit. Admission also provides an opportunity to make and monitor adjustments to a medication regime. If A had been admitted it might have been possible to ensure he received the proper dose of medications, which there was no guarantee was happening at that time while he was in the community.

194. Dr Antcliff explained that sometimes for a patient who is acutely depressed, it is a "relief" to be admitted to hospital, because then the awful daily struggle to "manage" is not expected and there is due recognition of the overwhelming nature of the depressive process. Clinical staff members are available to provide safety from the impulses to "end it all" which are very intense, particularly for a person who is psychotically depressed and can see absolutely no end to the torment.

195. In Dr Antcliff's view, if Dr Marks were concerned about A's mental state and suicidality, he should have made an appointment to review him urgently, soon after the family meeting, with a view to admission, bearing in mind Dr Marks had said on an earlier occasion that he had spoken to Mr Verner about the possible need for admission.

196. Dr Antcliff added that even if A and Ms E were opposed to hospital admission, it needed to be discussed. The outcome may or may not have been that A was admitted, but all parties would have been properly involved in making the decision.

197. The outcome of any discussion about the circumstances for admission or use of the Mental Health Act should be recorded according to Dr Antcliff. They are a guide to any other clinician about the seriousness of the situation and what has already been discussed and the opinion of the lead clinicians of what should occur if they are not available.

Russell Wyness

198. Dr Wyness was also called by the Director as an expert. He is a consultant psychiatrist practising in Auckland. He presently works 6/10ths at the Mason Clinic (Auckland Regional Forensic Psychiatric Services) and 4/10ths in private practice dealing with adult general psychiatry. During the period 1995 to 2000 he worked at the Continuing Care Team in West Auckland which team managed patients with persisting or recurrent psychotic or mood disorders who were living in the community either in their own accommodation or in supported accommodation. Since 1995 he has been a Fellow of the Royal Australian and New Zealand College of Psychiatrists. As already stated above (para. 17) the Tribunal accepts that Dr Wyness has the relevant qualifications, knowledge and experience to qualify him as an expert.

Clinical Assessment

199. The Tribunal also heard from Dr Wyness on what constituted an adequate clinical assessment, risk assessment, and adequate treatment plan.

200. In Dr Wyness' opinion, given the concerns which were raised at the consultation of 11 August 1999 about A's deteriorating mental state, Dr Marks should have carried out a full

clinical assessment of A, the purpose of which would have been to ascertain the extent/severity of A's depression and the possible reasons for it. This would then have enabled Dr Marks to develop an appropriate management/treatment plan.

201. Dr Wyness explained that an adequate clinical assessment of A on this occasion should have involved Dr Marks questioning A about such matters as his sleep patterns, appetite, mood, thought patterns, feelings of hopelessness, hallucinations, ideas about life and death, and his suicidality. It should also have involved at least a partial mental status examination covering the particular phenomena of concern such as thought form and content, abnormal perceptions, mood and affect. Dr Wyness observed that no such examination was recorded.

202. Dr Wyness said that in addition, the clinical assessment should have involved a formulation of A's case. He noted there was an absence of any formulation of this being documented on this occasion (or at any other time); that is, there was no attempt to explain A's current mental state in terms of his history and current situation. Such formulation would normally include an assessment of current risks.

203. He stated there was no evidence in Dr Marks' notes that a full clinical assessment was carried out and if it had been then Dr Marks should have documented it for future reference, not only for himself, but for all other mental health workers involved in A's care.

204. In Dr Wyness's opinion, there was no evidence of a full clinical assessment being recorded at any of the subsequent consultations on 10 September, 17 September and 8 October 1999.

Risk Assessment

205. Dr Wyness stated that in A's case, an adequate (although basic) risk assessment (which should have been undertaken by the treating psychiatrist) on 11 August 1999 (or at any time thereafter), would have involved a review of recent and current issues in the light of his history of psychiatric illness marked by psychotic symptoms (delusions and hallucinations)

and mood changes, and a clinical knowledge of psychiatric illnesses and treatments. Dr Wyness stated a risk assessment on 11 August 1999 should have included;

(a) An acknowledgement of A's previous serious suicide attempts and their contexts (depressed mood and suicidal ideation) and an exploration of his suicide potential; and
(b) An acknowledgement that A's previous relapses occurred when medications were stopped or decreased. Dr Wyness stated there was no evidence that at this consultation Dr Marks considered the possibility of previous reductions of the dose of haloperidol or carbamazepine as possibly having had an impact on A's deteriorated mental state over the previous month. This was despite the time which had elapsed since the first decrease Dr Marks had made to six week frequency of haloperidol injections (on 30 April 1999), being just over three months. He said this was a typical period for the reduction of depot haloperidol to be showing clinical effect. The only possible cause noted for A's lowered mood was his own view about the assault on him by Ms E's ex-husband).
(c) A consideration of A's symptoms at the time of those relapses (including subjective loss of emotional reactivity, loss of concentration, loss of motivation and low energy with a loss of appetite and a tendency to oversleep) and associated behaviours which had previously included suicide attempts; and
(d) A recognition that the assault was an additional stressor/risk factor.

206. In Dr Wyness' opinion, there was nothing documented which he would consider as showing that an adequate risk assessment had been carried out at any of the consultations (which are the subject of the charge).

207. Dr Wyness referred in particular to the last two consultations (17 September and 8 October 1999), when it should have been obvious that A's mental state (severe depression) was deteriorating despite the changes that had been made to the medication regime, and given the previous suicide attempts and the fact that concerns were expressed that A was not improving, Dr Marks should have been prompted to carry out a full risk assessment. An essential part of such an assessment at that time should have involved a discussion with A with a view to exploring his suicidality. Dr Wyness said there was no

record of Dr Marks having done so. Had such a discussion occurred, depending on its outcome, appropriate safeguards against suicide may have been incorporated into the management/treatment plan.

Treatment Plan

208. Dr Wyness told the Tribunal the only evidence of a treatment plan being developed or documented on 11 August 1999 was the prescribing of the antidepressant, imipramine. There was no indication in the notes that Dr Marks discussed with A, or with his mother, safety issues, acute crisis contacts available or arrangements for crisis services to visit him at home if necessary. He explained there was a difference between knowing how to contact the services on the one hand and knowing when to and for what, on the other. He added that there was no clear indication of a plan for a follow-up appointment with either Dr Marks or the care manager.

209. Despite Dr Marks' notes of this consultation including reports from A and his mother about his condition, there was no explanation recorded for A discontinuing the carbamazepine. In Dr Wyness' opinion such an explanation should have been recorded. He said when others are dealing with a patient in an acute situation they may not always have time to get a good grasp of the entire file including notes dating back six months.

210. In Dr Wyness' opinion the records indicated that Dr Marks failed to develop or document an adequate treatment plan on 11 August 1999. The 'treatment plan' recorded did not include plans for the management of risk, including the possibility of suicide, or communication of concerns to others. Explanations or rationales for medication changes were not made/given or, then they were not recorded.

211. With regard to the subsequent consultations A had with Dr Marks, Dr Wyness said there was nothing documented which in his opinion would constitute an adequate treatment plan.

212. In Dr Wyness' opinion, because carrying out clinical and risk assessments and developing appropriate treatment plans are some of the key functions of a psychiatrist in managing

patients, the failures on Dr Marks' part (which he outlined) amounted to significant deviations from accepted practice.

213. Dr Wyness then addressed the allegation that on or about 10 September 1999 or at any time thereafter, Dr Marks failed to undertake or document a thorough and systematic review of A's mental status and/or adequately formulate or document a diagnosis.

214. By 10 September 1999, when Dr Marks saw A, his depression had not improved and perhaps had worsened. Mr Verner, Mrs B and A himself had recently expressed concerns about A's mental state. Against that background, in Dr Wyness' view, it would have been wise for Dr Marks to have carried out and recorded a thorough mental status assessment and to have formulated A's current situation in the light of his history. He should also have recorded his diagnostic interpretation

Review of Mental Status

215. Dr Wyness stated that with regard to Dr Marks' note of the consultation on 10 September 1999, other than a line in the note recording that akathesia and restlessness were evident in A, there was no recorded evidence of Dr Marks having carried out an assessment or review of A's mental state at this consultation. By way of example, there was no recording of A's thought form or content, any abnormal perceptions, mood state or affect and neither was there a recorded assessment or formulation of A's presenting situation and clinical state at that time as viewed in the context of his past history (including his risk to himself and others). Dr Wyness stated that the full range of symptoms A was presenting with did not appear to have been explored, or if it were, then it was not recorded. He added that while arguably Dr Marks' note recorded the main mood issues, there appeared to have been no exploration of what A was scared about or any indication of the presence or absence of psychotic symptoms. In all the circumstances, particularly in the light of the worsening depression, there should have been.

216. Dr Wyness stated that if the note Dr Marks had made of the 10 September consultation accurately recorded what was discussed then it was his opinion that Dr Marks failed to carry out or document a thorough and systematic review of A's mental status at that time.

In his view this failure amounted to a significant deviation from acceptable practice, particularly as the consultation on 10 September 1999 was arranged as a matter of some urgency because of the concerns which had been expressed around that time about A's deteriorating mental state.

217. According to Dr Wyness, there was no record of Dr Marks having carried out a thorough and systematic review of A's mental state in any of the subsequent consultations either.

218. Dr Wyness did not believe that a thorough and systematic review of A's mental status would necessarily require an updated summary of A's case to be prepared as at 10 September 1999, as this is often very difficult to do in the context of a busy outpatient schedule. However, he stated it would be reasonable to expect that as at 10 September 1999 or, if not then, then at some stage shortly thereafter, Dr Marks would review previous summaries on A's past admissions and past decompensations and make a note of similarities and differences in his current state compared to past deteriorations. Dr Wyness said he had not read any material which showed that Dr Marks did this at any stage.

Diagnosis

219. With regard to diagnosis, Dr Wyness said that the contemporaneous notes which he had reviewed did not indicate any diagnostic formulation having been made or documented at the consultation on 10 September 1999, or at any of the subsequent consultations.

220. He referred to the fact that earlier in A's treatment by the Wellington Mental Health Services, his diagnosis had been a matter of some debate but nevertheless there was strong support over the years for the diagnosis of schizophrenia or schizo-affective disorder.

221. Dr Wyness observed that in Dr Marks' report of July 2001, and in the report by Dr Mark Davis dated 2 July 2001 prepared for the Coroner's hearing, it was recorded that Dr Marks felt that A's disorder was primarily a Cycloid Psychosis or bipolar affective disorder. If that were the case then Dr Marks did not record any such diagnosis at any time.

222. While Dr Wyness was of the view that the lack of the recording of a diagnosis was not of overriding importance in this situation, he thought that a significant omission on the part of Dr Marks was the absence of any diagnostic formulation of A's presentation on 10 September 1999, or at the following consultations. Dr Wyness referred to the context of A's past history, the absence of a discussion of possible differential diagnoses and the absence of a rationale for the treatment plan being followed at that time.

223. While it was important in the longer term to determine the diagnostic picture, Dr Wyness said that in the period under discussion, the key aspects were to deal with the acute symptoms that were present, including A's deteriorating mood state with the depressive features as well as some psychotic symptoms which were emerging. The specific diagnosis was not so important as managing the acute period. He said that much of the treatment in psychiatry is aimed at dealing with symptoms.

Medication

224. Dr Wyness then referred to the allegation that on or about 17 September 1999 or at any time thereafter, Dr Marks failed to undertake a review and/or adjustment of A's medication plan in the light of his presentation.

225. In his opinion reviewing A's history at any time in 1999 would have indicated the following factors:

(a) A had remained reasonably well controlled symptomatically and had not needed hospitalisation for approximately six years (from 1993-1999). Throughout this time he had been on 100mg haloperidol decanoate every five weeks or more and had been taking carbamazepine for most of this period; and

(b) A's decompensation occurred in the period between three and six months following the initial decrease in haloperidol dose made on 30 April 1999, and again on 3 June 1999. The decrease in available haloperidol in the patient's body would have become significant within a few months (two to three) and would have settled to the new reduced steady state around October 1999 (following the 3 June 1999 reduction). This appears to have coincided with A's deteriorating mental state; and

(c) A's deteriorating mental state consisted of depressive symptoms with hopelessness and guilty feelings which, in the past, had led to suicide attempts and admissions to hospital.

226. He referred to the consultation of 17 September 1999 where A presented with no improvement in his mental state and when he and Ms E were insisting that his medications were the cause of his low mood and lethargy.

227. At this consultation, Dr Marks changed A's medication regime by reducing the haloperidol decanoate to 50mg monthly and initiating treatment with amitryptiline, which was to increase in steps from 50 to 100 and then 150mg at night. The time between the increasing steps of amitryptiline was not specified.

228. Dr Wyness said he would support the re-starting of an anti-depressant (amitryptiline) at that time given A's depressed mood. However, there was no indication in the notes of there being a plan developed to cope with suicidality while this anti-depressant began to work over the next few weeks. It was Dr Wyness' opinion that if a plan were not developed then Dr Marks' failure to develop one was unacceptable.

229. He did not believe decreasing the haloperidol further was appropriate in light of A's past history. It should not have been made without him having taken into account the fact that for a considerable period of time (some six years) A had remained stable while on haloperidol. Further, there was no record in the notes available of the serum haloperidol level having ever been done on A. Had it been, this may have aided the recognition of a recurrence of an illness when serum levels presumably dropped below a therapeutic level. (Mr Hodson referred to documents produced that on two occasions A had refused blood tests. However, the Tribunal noted there were other documents produced which showed A had undergone blood tests after that time.)

230. Dr Wyness thought that Dr Marks's decision to decrease the haloperidol suggested that he had not undertaken a review of A's medication changes since March 1999 and his associated clinical condition or had not drawn the conclusion which it suggested, that is,

that decreasing the haloperidol and stopping the carbamazepine may have caused the worsening of his mental state.

231. He referred to the Coroner's inquest where Dr Marks had indicated to Dr Davis, that his view was that A was suffering from a cycloid mood disorder and that the haloperidol was further depressing (or aggravating) his mood and needed to be discontinued. He added that if this were the case then Dr Marks' line of reasoning was not recorded in the notes for the consultation on 17 September 1999; and nor was it recorded in any previous or subsequent notes. Dr Wyness believed that it would be difficult to attribute a deterioration in mood state to haloperidol, particularly when that was occurring following a decrease in its dose after six years of higher dosage treatment.

232. Dr Wyness added that Dr Marks had made no reference in the notes to the fact that A's previous non compliance with his carbamazepine may have had some impact on his mood. If he believed A had a Cycloid Psychosis, then carbamazepine would be an important component of treatment. He said Dr Marks should not have agreed to stopping it on 8 October without replacing it with a mood stabilising medication.

233. In summary, he believed that the note Dr Marks made of the consultation on 17 September 1999, and the decisions he made at that time, suggested that when altering A's medication on that date he did not first review the medication history or adjust the treatment in the light of A's past history and current presentation.

234. Dr Wyness stated that Dr Marks' medication changes at this time were not accompanied by any recorded rationale to explain the changes, and should have been. He referred to Dr Marks' report of 10 November 1999, where he indicated that A was complaining bitterly of side effects of the haloperidol and imipramine. Dr Marks had stated he felt that the haloperidol should be further reduced or stopped which was in line with his belief that haloperidol was causing depression and the side effects complained of by A. Dr Wyness stated that Dr Marks' retrospective explanation in his report was not consistent with A's previous response to treatment over the previous decade.

235. Dr Wyness said that despite A's current medication regime being questioned by his partner, Ms E, during a telephone call on 6 October 1999, the contemporaneous notes did not record a review of the medication plan at the consultation on 8 October 1999. Dr Marks' report of 10 November 1999 described A as having explained some of the actions of the various medications he was taking. By way of example Dr Marks had explained haloperidol as being used *"to prevent him [A] going suddenly and dangerously psychotic"*. Dr Wyness said there appeared to be no recognition that the reduction of haloperidol which had occurred since Dr Marks took over A's care, had led to a process of gradual deterioration into psychosis by A at a time interval consistent with the formulation of haloperidol being used. Dr Wyness believed that if a review of A's past responses to medications, particularly anti-psychotics, had not been carried out at the consultation on 17 September 1999 then it should have been carried out on 8 October 1999. If review was not carried out on either of those occasions then in his view, Dr Marks' failure to do so was unacceptable.

Hospital Admission

236. Dr Wyness then addressed the allegation that Dr Marks failed to adequately communicate about the advantages and disadvantages of admission to hospital at the 8 October 1999 consultation.

237. Dr Marks' contemporaneous notes for the consultation on 8 October 1999 did not indicate any discussion having occurred about the advantages or disadvantages of admission to hospital.

238. Dr Wyness said when Dr Marks saw A (and his family) on 8 October 1999, he should have initiated a discussion about a plan for treatment which should have included a discussion of treatment options and methods of maintaining safety while those treatments were implemented. This would or should have included a discussion about whether A should be managed in hospital and what the family could do to try and maintain safety. A discussion about the possible need for hospitalisation should have been initiated despite A's and Ms E's opposition to hospital admission in the past. Dr Wyness said such a discussion would have involved Dr Marks explaining the advantages and disadvantages

(which Dr Wyness identified in his evidence) of hospital admission, and why, with A and his family.

239. In Dr Wyness' opinion, if Dr Marks did not discuss with A and his family, treatment options, including hospitalisation, on 8 October then Dr Marks' failure to do so was unwise and constituted a deviation from the accepted standards of practice of a consultant psychiatrist in Dr Marks' position, as those standards were in 1999.

240. Overall, Dr Wyness said the standards of practice to which he had referred were the reasonable standards.

Dr Marks' Evidence

241. Dr Marks is a consultant psychiatrist having graduated from the University of Edinburgh in 1972. He was made a member of the Royal College of Psychiatrists in 1978 and in 1998 was elected to a fellowship of that College as well as the Royal Australian and New Zealand College of Psychiatrists. He came to New Zealand in 1998 as an employee of Capital Coast Health Limited (CCHL). The intention was that he would be employed full time at the Wellington Addiction Clinic. However, due to a shortage of psychiatrists in CCHL, his time was allocated by spending a day of each week commencing Monday and finishing Friday over five different clinics respectively, that is, Porirua Hospital, Addiction Clinic, South Clinic Tacy Street Kilbirnie Wellington, regional visits around certain centres such as Napier and Nelson, and Central Clinic Tory Street Wellington.

242. He subsequently left the employ of CCHL and took up a position with Gisborne Hospital in 2002 as the Clinical Director of Psychiatry.

243. Dr Marks' qualifications and experience were set out in his written brief of evidence and in a curriculum vitae produced to the hearing. Insofar as the present charge is concerned, Dr Marks was, at all material times, A's treating psychiatrist.

Consultation 11 August 1999

244. Dr Marks stated that he believed that he initially undertook and documented an adequate clinical assessment of A when he first saw him on 15 March 1999. He stated that by the end of June that year A had fallen out with his then case manager and that Mr Verner had been appointed in her place which was successful. He said that both he and Mr Verner were able to establish a good relationship with A which endured over the ensuing months.

245. When he saw A on 11 August 1999 Dr Marks said his presentation had altered. He believed that on that occasion he undertook an adequate clinical assessment of A's mental state and, in that regard, referred the Tribunal to the note of his consultation which he said set out the significant features supporting his diagnosis.

246. Dr Marks said his view was that A was entering depression demonstrating that his underlying illness was *"cycloid psychosis"*.

247. Dr Marks described A having been maintained for the previous six years in *a reasonably exhilarated state, modified by the haloperidol, but was now entering into depression*.

248. Dr Marks said he believed that his note for this consultation documented, for any psychiatrist, that A was suffering from depression and included his management which was essentially to embark on a course of imipramine.

249. With regard to the phrase *"cycloid psychosis"*, Dr Marks said that he found this was unfamiliar in New Zealand.

250. Dr Marks explained that the first and most significant aspect of A's presentation (to Dr Marks on 15 March 1999) was his full ambulant personality despite his anger (and that of Ms E) at the mental health services. When he visited A at his home on that occasion he said there was a group of friends present and that A clearly had a full range of emotions, was articulate, and did not display disorder of thought form and was mildly elevated and certainly angry and irritable.

251. Dr Marks said he was impressed from the outset that A responded to treatment usually used for cyclothymia and manic depression. He described psychothemia as a mild, almost sub-clinical sometimes, form of manic depression. He said that manic depression was the most common form of cycloid psychosis and was commonly referred to in American terminology and in New Zealand as *"bipolar affective disorder"*.

252. Dr Marks told the Tribunal that cycloid psychosis – manic depression bipolar affective disorder was a proper sub-group of cycloid psychosis where the poles are straightforward elation, elevation of mood and depression of mood.

253. He stated that in cycloid psychoses, the remainder of the cycloid psychoses that are not simply manic depression are relatively rare. He described the poles of three kinds, that is, anxiety happiness, motility and stupor, and excited, disorganised confusion versus muteness. He said that they were not common.

254. He said that the particular category of cycloid psychosis which A displayed was the anxiety elation psychosis which was clear at the beginning and appropriately treated by Professor Mellsop in the 1990's with lithium salts and imipramine and amitryptiline.

255. Dr Marks said that when A was elated or happy then the haloperidol would be appropriate; and when he was low the anti-depressants would be appropriate; but that in between times the only drug indicated was a prophylactic one which would be a mood stabiliser. More recently, that was carbamazepine.

256. Dr Marks stated that when the patient is well, he/she can be managed just on the mood stabiliser and that the haloperidol is only necessary when *"they go high"* and the anti-depressant necessary *"when they go low"*.

257. Dr Marks stated that over a period of time when one forms a relationship with one's patient and the patient is well-schooled in his condition then the patient ends up knowing as much as the physician about his disease and becomes able to manage it relatively independently.

258. Dr Marks proffered the opinion although A had been stable for the previous six years on a combination of medication which included haloperidol, it was his view that for much of the time A would not have needed to be on the haloperidol but only on the mood stabiliser.

259. When asked by his own Counsel to comment on the evidence of Drs Antcliff and Wyness that Dr Marks could not know if A were *"exhilarated"* or on an upswing during the previous six years because the haloperidol was controlling this Dr Marks replied that he agreed, as it *would dampen a person down whether they were euthymic* [normal mood] *or elevated.*

260. With regard to the allegation that he did not undertake or document an adequate risk assessment, Dr Marks stated that the risks for a young male entering a period of depression are well known which he did not feel required documentation.

261. He added that if this allegation was meant to relate to completion of the CCHL Risk Assessment forms, then it was important to be aware that at CCHL at that time this task quite explicitly devolved on the case manager. He said that while a psychiatrist might have an involvement, he certainly did not have prime responsibility.

262. Dr Marks stated that the climate at the Tacy Street Clinic at that time and the doctrine of CCHL involved a significant amount of authority going to what they called the case manager, who was usually the community psychiatric nurse. He referred to tension between him and the former case manager (Ms Clark) and of her objection to what Dr Marks was planning to do. He said that was followed by the direction that he must follow the treatment essentially put forward by the case manager concerning haloperidol that this could not be altered without the agreement of the case manager.

263. He said the clinical authority in his view was subverted, which created a problem.

264. He added that Drs Antcliff and Wyness were quite able to see from his notes that A was entering into a phase of depressive psychosis and that the risks of such a condition were familiar to every psychiatrist.

265. He said he did not feel that for colleagues or himself that these would need to be spelled out in addition to a form that was being completed.

266. With regard to the allegation that, at the time of this consultation, he did not develop or document an adequate treatment plan, Dr Marks stated that the treatment plan was clearly noted which was to introduce imipramine.

267. He added that he was faced, as he was faced throughout, with a patient who he actually liked. He could see a future with the appropriate treatment. However, A's partner was hostile to psychiatrists and their treatments, perhaps for good reason as A had a long history of being weighted down with haloperidol and it was very difficult to persuade him to co-operate with treatments.

268. Dr Marks said he thought that the haloperidol had affected A's musical, sexual and other functions at a time when he was wanting to restart them and he noted as a matter of fact that A had only taken 80mg and not 100mg per his prescription.

269. He said that at this consultation he similarly noted that A had stopped taking his carbamazepine for the previous six months.

270. Dr Marks added that while he could have noted *any number of things*, what he did note were the significant things.

271. He stated that he noted that A should start on imipramine because A and Ms E were hostile to anything else.

Consultation on 10 September 1999

272. With regard to the allegation that he failed to undertake or document a thorough and systematic review of A's mental status, Dr Marks said he had available to him the extensive notes made by Mr Verner. He said his own impression was that the condition he had observed on 11 August had not significantly changed and that his notes indicated largely a repetition of what had gone before.

273. In those circumstances, Dr Marks said he did not see a necessity for documenting a "thorough and systematic review". He said that there had simply not been a change sufficient to require this.

274. Dr Marks said he thought that what he had done had complied with Dr Wyness's own view as to what one does having taken on a patient new to the service which was a full history, a mental status examination, formulation and management / and formulating and managing a development/treatment plan.

275. With regard to the allegation that at this consultation he failed to adequately formulate or document a diagnosis, Dr Marks stated that his diagnosis throughout was cycloid psychosis.

276. He acknowledged that this was not documented and he accepted that it would have been preferable for him to have clearly stated this in writing. He stated that it was discussed, however, by him with Mr Verner and others involved in A's care.

277. Dr Marks added that he had had previous experience of finding that clinical staff found the concept difficult and that he did find it necessary to explain *cycloid psychosis* in words more familiar to them. He said that Mr Verner understood and accepted and agreed with his assessment of the condition. He said he also explained this to A's family at the last consultation on 8 October 1999. With regard to that occasion, he said that he particularly remembered Mr B's very understandable dismay that the diagnosis remained in question and/or *here was yet another doctor changing it* but he said he did state it and tried to explain it.

Consultation on 17 September 1999

278. The next consultation when he saw A was on 17 September 1999.

279. With regard to the allegation that at this time or any time thereafter he failed to undertake an adequate review and/or adjustment of A's medication plan in light of his presentation, Dr Marks stated that the notes of this consultation indicated the extent to which matters had changed.

280. He said that the depression was deepening and that he adjusted the medication plan in the light of the presentation and also in the light of A's expressed wishes in which he was supported, not to say influenced, by his partner Ms E.

281. He said that he could not over stress the fact that at all times A was a voluntary patient and that he was resistant to medication. He added that for some reason his partner was the most resistant to his carbamazepine and his secretly ceasing to take this medication which was very important and which substantially influenced his (Dr Marks') thinking. He said he was deeply sceptical of the value of the haloperidol but he did not feel he had any option but to continue it.

282. When asked by his counsel to summarise for the Tribunal his view about the use of haloperidol in 1999, its effect and the desirability of its continuation, Dr Marks stated that haloperidol was perfectly appropriate in the upswing of a bipolar illness but that it is the opposite of what is required in a down swing when mood stabilisation and lifting of the mood was what was required.

283. He referred to haloperidol as a major tranquillizer and that its prime use was to bring down mood from elevation which was exactly what one did not want when a patient was sinking in mood.

284. He said that what he observed on 15 March 1999 when he saw A was a mild elevation and for precisely that reason he counselled that he should not reduce his haloperidol. He said he did not know at that time that A had discontinued his carbamazepine and that he strongly advised A at that earlier consultation that he continue with it while he seemed in a high phase of his illness.

285. Dr Marks said that as soon as A was descending to euthymia and was more reasonable throughout June/July 1999 and certainly by August 1999 in Dr Mark's view he should have been off the haloperidol completely.

286. When asked by his counsel whether he would substitute anything else for it, Dr Marks said he would certainly give A an anti-depressant but he would insist that he took the mood stabiliser.

Consultation on 8 October 1999

287. The next and last time Dr Marks saw A was on 8 October 1999.

288. In relation to that consultation, it was alleged that Dr Marks failed to adequately communicate with A, and/or his partner Ms E, and/or A's parents regarding the advantages and/or disadvantages of admission to hospital.

289. Dr Marks said he accepted that A's parents had a different recollection of what occurred at that consultation which he described as a long one; and that a lot of time was spent discussing the effect of the drugs.

290. He said it was his invariable practice to warn that motor impulses would return before the mood lifted and it was necessary to be alert to increased risks, and that he had specifically noted that they discussed prognosis and management and that it was inconceivable that this could have been discussed without the mention of the possibility of admission to hospital.

291. He said it had to be remembered that all present at the meeting had lengthy experience with mental health illness and that A had already experienced many admissions in the past, and that everyone was well aware that sometimes it was unavoidable.

292. Dr Marks said that both A and his girlfriend were opposed to any question of admission and felt it would, in effect, finish A off. He said Ms E was clear she would be in a position to keep A company at all times and that his parents realised that as this would not in fact be wholly practicable, they undertook to be available whenever required. He said the parents offered to fill in that gap because he had made the point about the drug being prophylactic and that they were very good and helpful and co-operative about the medication.

293. Dr Marks said it was difficult to convey the impact that A's statement had had on him (as it had had on his parents) that he would not betray his brother's memory (by committing suicide).

294. Dr Marks stated he did not believe that anyone present at the 8 October meeting was unaware of the advantages and/or disadvantages of admission to hospital.

295. He said the outcome of the meeting was that agreement was reached on what A would take by way of medication and that there would be close follow-up by Mr Verner which included the care to be afforded by Ms E and A's parents.

296. Dr Marks accepted that in retrospect the notes that he made could have been more fully set out and in particular the diagnosis could well have been properly recorded but that he had great difficulty with the concept that he failed A by not giving him due consideration and care which he said was the underlying theme of the charge.

Meeting with Dr Taumoepeau post 8 October

297. Dr Marks said he had a meeting with Dr Taumoepeau following this consultation.

298. Dr Marks said that his recollection of his discussion with Dr Taumoepeau was in line with hers. He said his basic argument was that A was very near compulsory admission but that he opposed it and that A had nominated Ms E as his next of kin over his parents.

299. He said that he did not agree with Dr Taumoepeau's recollection of that discussion that she and Dr Marks were at *loggerheads*.

300. Dr Marks said that at the end of the discussion he had with Dr Taumoepeau that there was no permit to change the prescription of haloperidol.

Meeting with father in Intensive Care Unit

301. Dr Marks said that when he learned that A had attempted suicide and was in the Intensive Care Unit he went there immediately and spoke to Mr B who, he said, thanked him for

going. He said that he remembered choosing his words very carefully because it was an unhappy time and that he said the words *"the haloperidol should have been discontinued"*. He said that it was clear to him from what Mr B had said to him in evidence before the Tribunal that he could not have heard the *"dis"* which was understandable in that situation.

302. With regard to this particular piece of evidence the Tribunal prefers and believes Mr B's version of events. While the occasion would have been for Mr B an intensely emotional one, the Tribunal found him to be a reliable and credible witness and accepts that such a remark at that time would have *"stuck"* in his mind, as he put it.

Decision

303. Dr Marks' case was amply presented by his counsel, Mr Hodson QC, who urged the Tribunal to avoid the bias of hindsight. The Tribunal was careful at all times when considering the evidence and the submissions of counsel and in its deliberations not only to avoid the bias of hindsight but to ensure that it remained objective at all times and did not allow itself to be influenced by what was, for all interested parties a tragic outcome, that is, the death of A.

304. Having carefully listened to and read all the evidence including all the documentation and having considered the submissions of counsel, the Tribunal was unanimous on the findings it made and the decision it reached regarding each particular of the charge.

305. However, before the Tribunal deals with the particulars of the charge, there were a number of matters raised during the hearing by either or both counsel for the respective parties.

<u>Employment situation</u>

306. Under cross examination, Dr Marks agreed that he had told the Coroner at the inquest that on more than one occasion he had said of A from about August 1999 onwards that *"this man is going to commit suicide unless we get him off the haloperidol"*.

307. When asked to whom he had said those words, he said he had done so to Mr Verner and, when asked if anybody else, he replied *not in those words*, but he had said to Dr Taumoepeau that continuing A on haloperidol was preventing his recovery and that he (Dr Marks) felt it put A at much greater risk of suicide. He said Dr Taumoepeau disagreed with that.

308. There was then an exchange of questions and answers between counsel for the Director and Dr Marks as to whether he had raised this with his employer and, if not, why not.

309. In essence, Dr Marks blamed his employer for imposing on him conditions which did not allow him to treat A in the way that he wanted to. When pressed whether he had raised his concerns with his employer either orally or in writing, he said he had specifically raised his concerns about A to his employer in writing but had not named A for privacy reasons. When pressed further whether there was correspondence available to confirm this, Mr Hodson offered to provide the relevant documentation.

310. However, when the document was produced, it was an email dated 7 July 1999 from Dr Marks to Mr Henry Stubbs, Secretary of the Association of Salaried Medical Specialists.

311. A perusal of the email indicates that it raised employment conditions about which Dr Marks was not happy. However, there was nothing in that document which referred to A's particular case. In the light of that document, once produced, the Tribunal found that Dr Marks' earlier answers to Ms McDonald were clearly misleading.

312. In his closing submissions, Mr Hodson stated that the case was unique in his experience, and that he was not aware of any case in which a consultant had been compelled by his employer to follow a course of clinical management with which he disagreed and at the same time be held responsible for the clinical outcome. He referred to the letter from Dr McGeorge and also to the written evidence of Dr Taumoepeau and, in particular, a series of answers she had given him arising out of cross examination which he referred to as *extraordinary*.

313. Mr Hodson referred to *the impossible dilemma* in which Dr Marks was placed. He submitted Dr Marks was directed in Dr McGeorge's letter to follow Dr Taumoepeau's advice and was not given any alternative of going beyond her.

314. Mr Hodson submitted that the conditions under which Dr Marks was compelled to practise and their application to this particular patient were dysfunctional and to the discredit of his employer with an inevitable effect on the standard of care in this case. He added that it was manifest that Dr Marks was being held as solely accountable for management by a team of varying composition in this environment.

315. In the Tribunal's view, while particular conditions were imposed on Dr Marks' practice by Dr McGeorge's letter, there was nothing at all to prevent Dr Marks from bringing his concerns to the attention of his employer in clearly written terms, or to the specific attention of his supervisor either orally or in writing or indeed to any other responsible person or persons (including A's parents) his alleged concerns that A was at high risk of suicide.

316. It is readily apparent to the Tribunal from all the evidence, including all of Dr Taumoepeau's evidence (and not just an isolated extract of it), that had Dr Marks asked Dr Taumoepeau to see A she would have done so and it was also open to him to seek another psychiatrist to see A. He did not do so.

317. The Tribunal does not accept either Dr Marks' assertion or the submission made on his behalf that he was prevented from making known to either his employer, his supervisor, A's parents or any other responsible agent the claim that he was being prevented from treating A in the way he thought appropriate which was putting A at high risk of suicide.

318. In this regard, the Tribunal finds Dr Marks' evidence neither reliable nor credible.

<u>haloperidol/Haldol</u>

319. The terms haloperidol and Haldol were used interchangeably throughout the hearing and in the medical notes. The Tribunal understands that haloperidol is the generic term and Haldol is a brand name for the same drug.

320. Counsel for the Director in her closing submission submitted that there were a number of aspects to Dr Marks' conduct in relation to the medication prescribed for A which were of concern. She stated that the most obvious was Dr Marks' view that if he had had his way he would have discontinued the haloperidol altogether.

321. She submitted that this view was contrary to the expert evidence of Drs Wyness and Antcliff and of others who were involved at the time, namely, his supervisor Dr Taumoepeau, the Clinical Director Dr McGeorge, and the former Care Manager for A, Ms Clark.

322. Ms McDonald referred to the evidence of Drs Antcliff and Wyness that the standard treatment for a psychotic depression was dual treatment by the use of an anti-psychotic such as haloperidol in conjunction with an appropriate antidepressant. She submitted that the opinions of those doctors had not been undermined in relation to either their qualifications or experience.

323. She referred to an earlier report written in 1993 by Dr A.D. MacDonald a consultant psychiatrist concerning A following his seventh admission to hospital for treatment of a psychotic mental disorder. Ms McDonald submitted that while it may have been written some 11 years ago, it provided a careful, comprehensive and insightful analysis of A's situation. (This was a report produced to the hearing among a variety of documents and, when read, all members of the Tribunal independently reached the same view of that report as Ms McDonald's view.)

324. Ms McDonald submitted that even at that early stage of A's treatment it was clear that he would require dual, if not triple, treatment in relation to his illness.

325. She submitted that other than providing a few references from texts which were either outdated or irrelevant in the context of this case, Dr Marks had not been able to cite any significant or recognised research to substantiate his claims regarding the need to discontinue haloperidol; and nor had he called any expert opinion to justify his position. She added that Dr Marks claimed to have been taken by surprise by saying he had not

expected this issue to arise at the hearing but that it was always clear that his views in relation to the use of haloperidol would be a central feature of this case.

326. It also arose during Dr Marks' cross examination that he had made errors in his documentation in recording the actual doses of haloperidol which A was having. In particular, the Tribunal's attention was drawn to Dr Marks' clinical notes for his first consultation with A on 15 March 1999 where Dr Marks had recorded that A was receiving haloperidol both by injection and orally which, if correct, was 20 times the appropriate dose. Dr Marks was not able to explain his error other than to refer to it as being ridiculous. However, when he reported by letter to A's general practitioner the following day, he repeated the error.

327. Further, with regard to the consultation of 11 August 1999, Dr Marks had recorded that A was receiving 80mg of haloperidol by injection every six weeks whereas Dr Marks had stated in evidence that there had been no change to A's prescribed amount of 100mg every five weeks. As Ms McDonald has pointed out in her submissions, the entry that Dr Marks made at this consultation was misleading and had the potential to cause confusion for any other clinician who might have had to deal with A's case.

328. Mr Hodson submitted that although much evidence had been devoted to the merits and demerits of haloperidol in the management of A, he noted that Dr Marks had not been charged with failing to hand over A to another doctor, nor with wrongly prescribing haloperidol, nor with erroneous notation in relation to the haloperidol. He added that despite the time taken on those issues by the prosecution, Dr Marks was not charged with wrong diagnosis, nor with treating the patient inappropriately.

329. While Mr Hodson is correct to the extent that the use of haloperidol does not form part of the particulars of the charge, its use is relevant to the basic facts as it is a central plank of Dr Marks' defence that but for the administration of haloperidol A might have been spared and that it was Dr Marks' view that it should have been reduced or stopped altogether.

330. In those circumstances, it is not surprising that the prosecution would call evidence regarding the use of it as an appropriate form of treatment in A's case. The Tribunal

accepts the evidence of Drs Antcliff and Wyness that the standard treatment for a psychotic depression (which the facts establish A had) was a dual treatment by the use of an anti-psychotic such as haloperidol in conjunction with an appropriate anti-depressant.

331. Dr Marks was not able to present before the Tribunal any persuasive or credible evidence to the contrary.

332. Where there is conflict on this particular issue, the Tribunal prefers the evidence of Drs Antcliff, Wyness and Taumoepeau.

333. The Tribunal also notes the errors which Dr Marks made in his records for the consultations of 15 March and 11 August 1999 regarding the doses of haloperidol, for which he was not able to provide any adequate explanation.

Particular 1.1

On or about 11 August 1999, or at any time thereafter, Dr Marks failed to undertake or document an adequate clinical assessment of A.

334. On behalf of Dr Marks, Mr Hodson made submissions of a general nature regarding particulars one, two and three.

335. He submitted that they were subtly different in respect of each of the three consultations (11 August, 10 and 17 September 1999) and that analysis of the particulars was not an easy task. By way of example he referred to the four allegations of failing to undertake various tasks which required an examination of what was in Dr Marks' mind. Mr Hodson submitted this was attempted by Ms McDonald resulting in answers from Dr Marks which demonstrated that he had in fact undertaken all those tasks.

336. Mr Hodson stated that whether or not Drs Antcliff and/or Wyness and/or anyone else now agreed with those assessments or reviews was beside the point; a difference of professional opinion could not in circumstances such as this amount to professional misconduct.

337. He stated there were clear differences of professional opinion and that unusually they extended to differing schools of international medical thought. He submitted that the Director had not suggested that views other than those held by New Zealand psychiatrists were unacceptable but that the differences had simply been acknowledged. He stated that it was not professional misconduct to disagree with New Zealand doctors as the test was whether the views held were unacceptable to the doctors' peers. In this case he stated that the New Zealand experts had said they would hold different views and acknowledged without condemnation of Dr Marks' training and experience and the resulting approach he brought to the management of A.

338. Mr Hodson pointed to the reports produced which noted that Professor Mellsop (who had treated A in the 1990s) had entertained bipolar disorder (which Mr Hodson said was a cycloid psychosis) and had favoured that diagnosis and treated A with lithium salts and imipramine which was specific treatment for a downswing in cycloid psychoses, but not haloperidol.

339. On the issue of undertakings, Mr Hodson stated that what the prosecution's expert witnesses were saying was that they did not know whether or not the undertakings had been done by Dr Marks but they did not think that they had been adequate for the reason that the results had not been documented to their standards and/or satisfaction.

340. Mr Hodson stated that clearly, the allegations that Dr Marks did not do what he should have done, as opposed to writing it down, had not been proved and could not be proved by subsequent review.

341. With regard to the context of making notes, Mr Hodson submitted that the medical records as a whole constitute the clinical records in relation to every patient which includes correspondence and other documentation such as the prescribing record as well as the clinical notes of a consultation, and it was for that reason that any disciplinary view must and always does take into account all the written material. (The Tribunal has done this.)

342. Mr Hodson submitted there was a philosophical divide between prosecution and defence evidence. He stated it was apparent that according to the prosecution nothing less than

notes, which to a very substantial extent wrote down, in one place at each consultation, information that was apparent elsewhere on the file and would have been known to everyone in the case, including the parents, and would be apparent to anyone looking at the file, would be acceptable.

343. Mr Hodson referred to Dr Marks' training in Edinburgh which he submitted was thorough and that every tabulation must be set out on every occasion and dutifully, even tediously, completed. He referred to Dr Marks' expressed view that what was necessary was recorded. He added that it may be that the ideal lies somewhere in between. He stated it was not ideal, or even desirable, that notes should go to the lengths propounded by the prosecution otherwise there would be neither paper nor time for anyone to undertake this task and there was understandably nothing produced in evidence to demonstrate that such is the practice in any New Zealand hospital.

344. He gave by way of example, of what he called the over-emphasis of the prosecution witnesses on written material, the contention that it should be recorded that the patient was advised that he should contact the team when he felt he needed assistance. He stated that A and all his connections were well aware and experienced over several years in doing just that, as would be patently obvious to anyone looking at his file.

345. With regard to the Risk Assessment Form, Mr Hodson submitted that whatever view one took of its value all, including Dr Marks, were agreed that it was necessary for him to assess the degree of risk applicable to the patient. He said Dr Marks was adamant he did so. He submitted that Dr Marks' assessment agreed at all times with that of the case manager, Mr Verner. He stated that the only occasion on which Dr Marks was said to have failed in that regard was in particular 1.2 on 11 August 1999 when no-one was (or is) of the view that a significant risk of suicide was then presented.

346. Mr Hodson said again the real issue was not whether Dr Marks did this; he could not be gainsaid by a later review but the implications of it not having been written down by the doctor in the format apparently expected by the prosecution.

347. Mr Hodson submitted that the evidence was that Mr Verner and Dr Marks were in agreement and if Dr Marks were at any time of a different view then he could have and would have noted accordingly but this did not occur. He stated there was no suggestion at the time the entries were made the assessments were wrong. He stated that all the notes constitute the record and that there was considerable discussion about the diagnosis. He added that it was clear that over nearly 10 years A presented to several doctors each of whom formed an individual view about diagnosis. Different views were expressed at different times and in the light of different presentation. He submitted that all the doctors, until the assignment of Dr Marks, were familiar with and accustomed to using New Zealand terms of diagnosis and New Zealand methods of management.

348. Mr Hodson submitted it was manifestly clear that what may be to a New Zealand psychiatrist an acceptable and accurate diagnosis (for example schizoaffective disorder) may be anathema to a psychiatrist brought up in a different school.

349. He submitted it would be grossly unjust to find Dr Marks guilty of professional misconduct on any matter relating to diagnosis or management. He stated his approach to the diagnosis and management of A were in accordance with what he had been taught and with what he had been accustomed to doing in practice for many years and in accordance with the ethos of a respectable body of psychiatric opinion, even if a different view was taken in New Zealand.

350. With regard to the 11 August 1999 consultation, Mr Hodson submitted that A had told Dr Marks for the first time that he had been non-compliant with respect to carbamazepine for six months. Present at this consultation was his mother but not his partner, Ms E. Mr Hodson referred to Dr Marks' evidence that he had made considerable but unsuccessful effort to persuade A to restart the medication which A refused but accepted imipramine. Mr Hodson referred to the notes of the consultation which he stated recorded the significant history and symptoms and Mrs B's report to Dr Marks at that consultation of significant signs. He stated there was a clear depressive swing but the haloperidol was required to be continued; and that appropriate follow-up arrangements were put in place was demonstrated by the recorded follow-up.

351. With regard to particular 1.1, Ms McDonald submitted that given the scant records Dr Marks had made, the inadequacy of his notes and, importantly, the nature of the content of the notes, the only reasonable inference was that Dr Marks failed to undertake adequate clinical assessments from 11 August 1999 or at any of the subsequent consultations.

352. She submitted there was no record that Dr Marks explored in any adequate way the depth and severity of A's depression and psychotic phenomena emerging from 11 August 1999 or the issues precipitating the depression. At that time A showed marked changes in presentation and was exhibiting significant signs of depression. His mother was expressing concern to his care workers and he had apparently discontinued his carbamazepine.

353. In reliance on the evidence of Dr Antcliff, Ms McDonald submitted it was clear that Dr Marks not only failed to record any adequate clinical assessment but failed to carry out one. Had he done so, she submitted it was inconceivable he would not have recorded it. She stated the notations to his care were inconsistent with any adequate exploration or analysis or understanding of the significance of what was happening with A.

354. Ms McDonald submitted that had an adequate clinical assessment been undertaken it is expected the entries would show an attempt at a mental state examination, exploration of any suicidality and interpretation of symptoms and signs rather than simply making entries which tended to record some of what Dr Marks was told by A. She referred to a clear example of this in relation to the entry for the consultation of 10 September 1999.

355. Ms McDonald submitted that throughout his evidence, Dr Marks had maintained that his notes recorded an adequate assessment of A. She pointed out that neither Dr Antcliff nor Dr Wyness held the same view.

356. With regard to this issue, Ms McDonald referred to cross examination of Dr Marks when he accepted the criticisms made by Dr Davis at the Coroner's hearing concerning the inadequacies of his documentation in relation to the consultation of 8 October 1999. (However, the Tribunal notes that in accepting the criticism, Dr Marks remarked that while it could have been better he did not accept that it amounted to misconduct.)

357. Ms McDonald submitted that given the scant records Dr Marks made, the inadequacy of his notes and, importantly, the nature of the content of the notes, the only reasonable inference was that Dr Marks failed to undertake adequate clinical assessments from 11 August onwards.

358. Ms McDonald pointed to what she referred to as the clearest example of this which related to Dr Marks' notes of the consultation on 17 September 1999. She referred to the notes of that consultation consisting of a mere five lines yet Dr Marks' evidence in relation to it was that it was at that point or earlier he considered A's condition entered a marked decline.

359. The Tribunal agrees with the submissions of Ms McDonald and her characterisation of the evidence.

360. The Tribunal does not accept the submission of Mr Hodson that the allegation that Dr Marks did not do what he should have done, as opposed to writing it down, has not been proved and cannot be proved by subsequent review.

361. It is open to the Tribunal to draw reasonable inferences from proved facts and there was compelling evidence here which would permit it to do so.

362. Having carefully observed Dr Marks give his evidence, his answers under cross examination, perusing the medical notes which he made of the consultations, and the evidence of the prosecution witnesses, all members of the Tribunal were of the view that Dr Marks failed not only to document an adequate clinical assessment of A but failed as well to undertake an adequate clinical assessment of A at the consultation of 11 August 1999 or at the subsequent consultations.

363. The Tribunal finds both aspects of this particular proved to the requisite standard.

Particular 1.2

On or about 11 August 1999, or at any time thereafter, Dr Marks failed to undertake or document an adequate risk assessment.

364. Ms McDonald submitted there was no suggestion that Dr Marks was required to complete a risk assessment form. The allegation centred not on a failure to complete a risk assessment form but on a failure to assess risk as part of his clinical assessment and/or record or make an appropriate record of any risk assessment.

365. She further submitted that regardless of the responsibilities of the care manager or of the policies in place in 1999 at CCHL, Drs Antcliff and Wyness both expressed the view that the person best equipped to assess risk within a multi-disciplinary team is the consultant psychiatrist.

366. Ms McDonald added that risk assessment is a fundamental requirement and a basic skill of a consultant psychiatrist which it is critical to undertake; and that any failure in this respect, particularly where suicidal threats have been made by a patient, must be considered a very significant departure from the expected standard of care. She stated that a consultant psychiatrist in Dr Marks' position could reasonably be expected to undertake such assessments.

367. The Tribunal accepts the evidence of Drs Antcliff and Wyness regarding the purpose and importance of risk assessments and the responsibility for them; and agrees with the submissions of Ms McDonald in this regard.

368. With regard to the specific allegation in particular 1.2 Ms McDonald submitted that despite what Dr Marks said about A presenting a very high risk of suicide, his conduct was inconsistent with that understanding. She submitted that he failed to communicate A's high risk to others and that this was borne out in the "Risk Assessment Form" completed by Mr Verner on 1 October 1999. She stated that had Dr Marks conveyed to Mr Verner the degree of risk which he claimed to have observed, and referred to in the course of his evidence, the Risk Assessment Form should have looked very different.

369. The Tribunal agrees with this submission.

370. Ms McDonald stated it was clear from the evidence of both Mr and Mrs B that Dr Marks failed to adequately communicate the levels of A's risk to his parents and referred to the particular passages of their evidence concerning this.

371. The Tribunal finds not only that Dr Marks failed to *adequately* communicate the levels of A's risks to his parents but that he did not at any time tell them A was a suicide risk.

372. Where there is any conflict regarding this aspect of the evidence between Dr Marks on the one hand and Mr and Mrs B on the other, the Tribunal prefers and accepts the evidence of Mr and Mrs B.

373. Ms McDonald submitted that as at 11 August 1999 A's treatment and assessment of his risk needed to be assessed against the background of his multiple suicide attempts, and the statements recorded in the poems he sent to the Tacy Street Clinic and the nature and history of his illness. At the very least those factors should have alerted Dr Marks to explore A's thinking but this did not occur. Further, she submitted his notes were entirely silent on the issue of suicidation.

374. The Tribunal agrees with this submission.

375. Ms McDonald further submitted the evidence was clear that there was no adequate record of any risk assessment having been undertaken; and that notwithstanding Dr Marks' statements that he understood A to be a very high risk, he failed to ever adequately explore A's thinking about death/suicide and assess A's risk.

376. Having considered all the evidence both oral and documentary and having carefully observed Dr Marks when he answered the questions put to him, the Tribunal had no hesitation in agreeing with this submission and the characterisation of the evidence.

377. The Tribunal finds that Dr Marks neither undertook nor documented an adequate risk assessment.

378. It finds both aspects of this particular proved to the requisite standard.

Particular 1.3

On or about 11 August 1999, or any time thereafter, Dr Marks failed to develop or document an adequate treatment plan.

379. Counsel for the Director submitted that there was no evidence that Dr Marks discussed or developed a comprehensive plan of treatment for A. She stated that there was nothing in the notes other than some bare references to what Dr Marks had prescribed or that A was to be seen by the care manager that could ever be thought to resemble a "*treatment plan"*.

380. The Tribunal agrees with this submission.

381. The Tribunal refers to the evidence of Dr Antcliff and Dr Wyness (above) as to what an adequate treatment plan should have included. It accepts and agrees with their evidence which it prefers.

382. The Tribunal finds on a careful consideration of all the evidence that Dr Marks neither developed nor documented an adequate treatment plan either on or about 11 August 1999 or at any time thereafter.

383. It finds both aspects of this particular proved to the requisite standard.

Particular 2.1

On or about 10 September 1999 or at any time thereafter Dr Marks failed to undertake or document a thorough and systematic review of A's mental status.

384. Mr Hodson submitted that Dr Marks' notes for the 10 September 1999 consultation recorded that A was tired, low, scared, and sleeping to excess which he submitted were all consistent with persisting depression. He added that the information from the case manager indicated that A was not suicidal which was a view agreed by Dr Marks. He submitted that this note complied with the kind of follow-up note which he said was advocated by Dr Wyness.

385. Ms McDonald submitted on behalf of the Director that at no stage did Dr Marks document a thorough and systematic review of A's mental state. She stated that at best there were a few selected quotes from A. She referred to Dr Marks' evidence that A's condition would have been obvious to any other clinician perusing the records; and that his position seemed to be that A's mental state could have been *"worked out"* by looking at the various entries in the notes and patching together an assessment of A based on the scant notes that were recorded. She submitted that such a piecemeal approach, as advocated by Dr Marks, fell well short of what was accepted practice from a consultant psychiatrist.

386. Ms McDonald submitted that by 10 September 1999 A was tired and scared, his depression was worsening with emerging psychomotor agitation; and he had lowered mood and was sleeping excessively. A had acknowledged that he had only been taking a reduced dose of imipramine (50mg) because of side effects. A, his mother and his care manager had all expressed concern about A's mental state.

387. Ms McDonald submitted there was no record that Dr Marks carried out a mental state examination at any time. Had one been done, she stated it would surely have been noted and, in this regard, she was referring to the expert evidence of Dr Antcliff.

388. Ms McDonald submitted that Dr Marks' note of the consultation on 10 September was brief and that he should have carried out and recorded a thorough mental state assessment and formulated A's current situation in the light of his history.

389. She added that other than a line in the notes recording that akathesia and restlessness were evident, there was no record of Dr Marks having carried out an assessment or review of A's mental state at this consultation.

390. For example, there was no recording of A's thought form or content, any abnormal perceptions, mood state or affect; and nor was there a recorded assessment or formulation of A's presenting situation and clinical state at that time as viewed in the context of his past history (including his risk to himself and others).

391. The full range of symptoms A was presenting with was not explored or, if it was, it was not recorded.

392. Ms McDonald submitted that while arguably Dr Marks' notes recorded the main mood issues, there appeared to have been no explanation of what A was *scared* about or any indication of the presence or absence of psychotic symptoms. She submitted that in all the circumstances, particularly in the light of worsening depression, there should have been.

393. Mr Hodson suggested to Dr Wyness it might refer to A being scared of the husband breaking in. Dr Wyness explained it would be important to explore what the feeling of fear was about as it may not have referred to that but rather be an emerging symptom.

394. Dr Marks suggested that the reference to *"scared"* meant scared of admission to hospital. However, he made no record of that meaning at the time and when challenged in cross-examination it could have meant or referred to any number of things, Dr Marks denied this and did not agree it was appropriate to have recorded its meaning.

395. The Tribunal found Dr Marks' answer opportunistic. The Tribunal thought the more probable meaning, in the circumstances at that time, was that A was scared of Ms E's ex-husband. However, the fact that Dr Marks did not record any explanation for it, left the issue open to speculation. While it may appear a small point, it amply illustrates the prosecution's submission.

396. The Tribunal agrees with Ms McDonald's submission regarding this particular and refers to the evidence of Dr Antcliff and of Dr Wyness in this regard which it accepts and prefers.

397. The Tribunal finds that Dr Marks neither undertook nor documented a thorough and systematic review of A's mental status.

398. It finds both aspects of this particular proved to the requisite standard.

Particular 2.2

On or about 10 September 1999, or any time thereafter, Dr Marks failed to adequately formulate or document a diagnosis.

399. Ms McDonald submitted that despite Dr Marks' claim that he had made the diagnosis of cycloid psychosis there was no record in the notes when or how he came to that conclusion; and that there was no record of such a diagnosis or of a diagnosis of psychotic depression.

400. She referred to the evidence of Drs Antcliff and Wyness who stated that having reached the diagnosis, Dr Marks was required to make a note of it for the benefit of other clinicians. She said this was particularly significant as Dr Marks set about altering A's medication based on his theory of A's illness.

401. Ms McDonald referred to Dr Marks' response that he was prevented from making any such recording as a result of Dr McGeorge's letter of 7 July 1999 and stated that given the degree of concern that Dr Marks suggested he held for A, it was incumbent on him to record a diagnosis and the rationale for his treatment in the interests of his patient's welfare.

402. The Tribunal has already made findings regarding Dr Marks' employment situation. The Tribunal agrees with Ms McDonald's submission and finds that Dr Marks was not prevented from making a record of his diagnosis as a result of his employment situation.

403. Ms McDonald submitted that the most significant aspect to Dr Marks' failure to record a diagnosis was that at no time in A's records had he recorded the onset of psychotic depression. She submitted that Dr Marks had been clear on this point stating both before the Coroner's inquest and this Tribunal that he was aware of the emergence of psychotic features in a depressive phase yet he failed to make a record of that at any stage.

404. She referred to Dr Antcliff's evidence that it was of critical importance that it was appreciated that A had emerging psychotic symptoms.

405. She also referred to the evidence of both Dr Antcliff and Dr Wyness that there was no evidence to suggest that Dr Marks ever appreciated the significance of the emerging psychosis despite the fact that he now says that A was suffering a psychotic depression.

406. The Tribunal agrees with this submission and characterisation of the evidence; and in this regard, prefers and accepts the evidence of Drs Antcliff and Wyness.

407. The Tribunal finds that on or about 10 September 1999, or any time thereafter, Dr Marks failed to adequately formulate or document a diagnosis.

408. The Tribunal finds both aspects of this particular proved to the requisite standard.

Particular 3

On or about 17 September 1999, or at any time thereafter, Dr Marks failed to undertake an adequate review and/or adjustment of A's medication plan in the light of his presentation.

409. Mr Hodson has submitted that by this stage A was being seen only a week after the previous consultation; that the reduction in haloperidol, albeit small, was prescribed in the context of Dr Marks inability to stop it; that this was because of, and not despite, there being no improvement; and that Dr Marks was well acquainted with the natural history of cycloid psychosis and aware from his previous reading of A's file that starting the patient on haloperidol in June 1993 had been closely followed by double attempts at suicide.

410. Ms McDonald referred to the evidence of Drs Antcliff and Wyness in whose opinion it was clear that by 17 September 1999 A's depression was worsening and that A presented at that consultation with no improvement in his mental state.

411. It was at this consultation Dr Marks changed A's medication regimen by reducing the haloperidol to 50mg monthly and starting treatment with amitryptiline. She added that the time between the increasing steps of amitryptiline was not specified.

412. With regard to the titration of amitryptiline, the Tribunal prefers the evidence of Mrs B and finds that Dr Marks did not give any instruction regarding the titration of the amitryptiline, which he should have done.

413. Counsel for the Director submitted that A's discontinuation of carbamazepine earlier was likely to be having a significant effect on him. He was experiencing an emergence of psychotic features. Despite all this, she submitted Dr Marks failed to reverse his decision to lower the haloperidol and failed to carry out or record a full mental state examination specifically exploring for psychotic signs.

414. Ms McDonald stated that if Dr Marks had detected psychotic symptoms this would have alerted him to the risk of reducing the haloperidol. Decreasing it was not appropriate in the light of A's history and his condition at this time. She stated that Dr Marks appeared to have failed to take into account the fact that A had remained stable for six years while on haloperidol. She referred to the note Dr Marks made at this consultation and the decisions he made at that time which she said suggested that when altering A's medication he did not first review the medication history or adjust the treatment in light of A's past history and presentation at that time.

415. She stated that Dr Marks had made no reference in the notes to the fact that A's previous non compliance with his carbamazepine may have had some impact on his mood. If he believed A had a cycloid psychosis then carbamazepine would be an important component of treatment. She added he should not have agreed to stopping it on 8 October 1999 without instituting a replacement mood stabilising medication.

416. Ms McDonald stated that Dr Marks' medication changes at this time were not accompanied by any recorded rationale to explain the changes.

417. She referred to his report of 10 November 1999 (following A's death), in which he indicated that A was complaining bitterly of side effects of the haloperidol and imipramine and that he felt that the haloperidol should be further reduced or stopped. This was in line with his belief that haloperidol was causing depression and the side effects complained of by A. However, she stated that Dr Marks' position about this issue was not consistent

with A's previous response to treatment over the previous decade and it strongly suggested that Dr Marks either ignored the earlier period of stability or failed to appreciate its significance.

418. Counsel for the Director stated that despite A's current medical regimen being questioned by his partner during a telephone call on 6 October 1999, the contemporaneous notes did not record a review of the medication plan at the consultation on 8 October 1999 except to agree to stop the carbamazepine.

419. She referred to Dr Marks' report of 10 November 1999 which described him having explained some of the actions of the various medications A was taking. For example, Dr Marks explained haloperidol as being used *"to prevent him going suddenly and dangerously psychotic"*.

420. Ms McDonald submitted there appeared to be no recognition that the reduction of haloperidol which had occurred since Dr Marks took over his case had led to a process of gradual deterioration into psychosis by A at a time interval consistent with the formulation of haloperidol being used. She stated it was clear that Dr Marks failed to carry out any adequate review of A's past responses to medications, particularly anti-psychotics, at the consultation on 17 September 1999 or later. She stated that such a review was necessary and, if it had not been done on 17 September 1999, then it should have been carried out at the consultation of 8 October 1999. She submitted that Dr Marks' failure to do so was unacceptable.

421. In this regard she referred to and relied on the evidence of Dr Wyness.

422. The Tribunal prefers and accepts the evidence of Dr Wyness in this regard and agrees with the submissions made by Ms McDonald.

423. The Tribunal also notes Dr Marks' evidence (under cross-examination) that although he had recorded in his notes that he *"agreed"* that the carbamazepine be discontinued, he stated it was not an agreement at all but rather he acquiesced, it was a compromise and he

was unhappy about it. However, he did not record any of this and was not able to provide a credible explanation why he did not.

424. The Tribunal finds that on or about 17 September 1999, or at any time thereafter, Dr Marks failed to undertake an adequate review and/or adjustment of A's medication in the light of his presentation.

425. The Tribunal finds this particular has been proved to the requisite standard.

Particular 4

On or about 8 October 1999 Dr Marks failed to adequately communicate with A, and/or his partner Ms E, and/or his parents regarding the advantages and/or disadvantages of admission to hospital.

426. Mr Hodson submitted that the adequacy of the notes was well illustrated by the opening submission of counsel for the Director which he stated relied on them in demonstrating a *"clearly worsening depression and indicators of the onset of psychosis"*.

427. He referred to the written brief of Dr Antcliff whom he stated was able to use Dr Marks' notes in order to express the view that admission was indicated, but not automatically; and submitted that the consultation complied in its content with Dr Antcliff's expectations.

428. However, that was not how the Tribunal understood Dr Antcliff's evidence when considered in its entirety on this issue.

429. Mr Hodson submitted that it was implicit in the wording of this particular that the Director accepted that there was some communication on this topic. He stated that the particular did not allege failure to communicate at all; and that she must prove what was said at the 8 October consultation about admission to hospital.

430. He referred to the written briefs of evidence of both Mr and Mrs B who said that the issue of possible admission was neither raised nor discussed nor even mentioned.

431. Mr Hodson stated that Dr Marks was equally certain that it was talked about; and that the issue taken by the Director in the charge was the emphasis placed on it.

432. He stated that the only independent corroboration one way or the other came from the statement of Ms E to a meeting a week after A's death. He stated her remark made no sense at all unless admission had in fact been discussed. He stated that Ms E wanted to make it clear that she was speaking for both herself and A when she had expressed her opposition to admission.

433. The Tribunal does not consider this amounted to independent corroboration, as contended by Mr Hodson.

434. Mr Hodson submitted that the Director had not discharged the onus required to satisfy the Tribunal on this particular; and had not proved what was communicated; and that the Tribunal was therefore unable to assess the evidence in terms of being satisfied that there was any demonstrated failure of communication sufficient to support such a charge.

435. Mr Hodson added that, once again, the charge was not that the patient should have been admitted but related to the discussion which the Director had not proved.

436. Counsel for the Director submitted that in the light of the evidence provided by Mr and Mrs B it was clear that Dr Marks did not adequately communicate to A, Ms E or A's parents the advantages and/or disadvantages of admission to hospital. She stated that their evidence was supported by the fact that there was no note that this issue was discussed.

437. Dr Marks had told the Coroner that at this consultation he considered that A's hospitalisation was *"definitely desirable"*. Ms McDonald stated it was apparent from Mr and Mrs B's evidence that Dr Marks did not clearly convey this view to them. The Tribunal agrees.

438. She stated that Mr and Mrs B would have been very receptive to the idea of admission and that while A may not have wanted to go to hospital, it was clear that his parents were

confident they could have convinced him to do so. They had done so previously. The Tribunal agrees.

439. Ms McDonald submitted to the Tribunal that having heard Dr Marks give his evidence it would be well placed to assess the clarity with which he was able to communicate and added that his evidence about this matter was unsatisfactory.

440. She stated that Dr Marks' position in relation to hospitalisation has been inconsistent in that on the one hand before the Coroner he stated there was a *"high index"* in relation to the need for admission and that it was *"definitely desirable"*. However, she stated it was significant that in his evidence before the Tribunal Dr Marks accepted that his views with regard to hospital were *"not pushed"* when questioned by her.

441. Dr Marks also stated in his evidence before the Coroner that A's parents were not averse to the concept of hospital admission which needed to be contrasted with what Dr Marks said in his report of 10 November 1999 where he asserted that Mr and Mrs B were opposed to admission. Under cross examination before the Tribunal Dr Marks accepted that this was *"not as accurate as it could be"*.

442. On 13 February 2003 Dr Marks' counsel wrote to the Health & Disability Commissioner. The letter recorded (among other things) that at the consultation of 8 October 1999 the concept of hospitalisation was discussed; that the *"family then opposed admission"* and that in the previous months A *"had become comparatively estranged from his family"*. Dr Marks accepted before the Tribunal that the letter was written on his instructions. He further accepted that Mr and Mrs B were not opposed to admission (as he had asserted) and nor had A been estranged from his parents.

443. Ms McDonald submitted that either Dr Marks' recollection was poor or he was prepared to say whatever suited him at any particular time and that his evidence on this issue could not be accepted.

444. Ms McDonald further submitted that at the very least if the Tribunal were to accept that there was some discussion of hospitalisation it was inadequate.

445. She submitted that Dr Marks could not rely on his assertion that Ms E was so opposed to hospitalisation that this prevented adequate discussion with A's parents. She referred to the fact that Ms E had left the meeting halfway through which created an ideal opportunity for Dr Marks to raise his views about hospitalisation with Mr and Mrs B. However, despite having a more conducive environment in which to have that conversation in the absence of Ms E, Dr Marks had accepted (in his evidence before the Coroner) that he still did not discuss those issues with A's parents.

446. With regard to Ms McDonald's suggestion that the subject could have been re-opened after Ms E left the consultation, Mr Hodson submitted that this indicated not only the view that the doctor should behave in a devious manner but also that the patient should have been pressured when his support had departed. He stated that 2½ hours had been spent discussing, among other things, *"prognosis and management"*.

447. The Tribunal does not agree with Mr Hodson's interpretation of Ms McDonald's suggestion that it could give rise to a form of *"devious"* conduct in those circumstances.

448. Ms McDonald submitted it was arguable that, as at the 8 October 1999 consultation, A was not in a position to make rational decisions in relation to his care and therefore his attitude should not have been considered an overriding factor in Dr Marks' decision whether to discuss the issue of hospitalisation.

449. The Tribunal agrees with Ms McDonald's submission and finds that A's parents were heavily involved in his care from the outset; and that it was equally clear that A relied on them and that they were able to influence compliance both in general terms and more particularly as it related to the issue of hospitalisation. The Tribunal further finds, in all the evidence before it, that this was known to Dr Marks.

450. The Tribunal further agrees with Ms McDonald's submission that regardless of whether A said at various stages he wanted Ms E to take a part in his care, he had not excluded his parents from that role. In this regard she referred to questions and statements made by Mr Hodson during the hearing when he cited the evidence of A's previous care manager (Ms Clark) from the record of the Coroner's inquest. Ms McDonald stated that it should be

borne in mind that Ms Clark's involvement with A ceased prior to the significant decline in his condition and should be viewed in that context. She submitted that in any event the extracts from the evidence of a witness at the Coroner's inquest have limited value where that witness has not been called in relation to the present matter. She submitted that it was for the Tribunal to ascribe what weight it thought fit given those circumstances.

451. Ms McDonald submitted that Dr Marks had an obligation to discuss the issue of hospitalisation in a way which the family could understand.

452. Ms McDonald submitted and the Tribunal finds that Mr and Mrs B were certainly not left with the impression that Dr Marks considered A should be in hospital or that he was a high suicide risk or that he might kill himself if he kept taking the haloperidol.

453. Having carefully considered all of the oral and written evidence including all of the documentation and having carefully observed the witnesses as they appeared at the hearing, the Tribunal finds not only that Dr Marks failed to *adequately* communicate with A, his partner and his parents regarding the advantages and/or disadvantages of admission to hospital but that he did not communicate with them at all about admission to hospital.

454. In this regard, the Tribunal accepts and prefers the evidence of Mr and Mrs B.

455. It was readily apparent to the Tribunal having observed the witnesses and considered all the evidence that Mr and Mrs B were deeply concerned about the deterioration in their son's mental illness and hence the presence of them both at that last consultation, which consultation the Tribunal finds was brought about as a result of Mrs B's initiative and concern. A was reliant on his parents to a significant extent and, in his last weeks, was spending more and more time at his parents' home and in his mother's company. Both she and Mr B had been able to influence A's compliance. Even at the consultations of 10 and 17 September 1999, A asked his mother, in the presence of Dr Marks, to give him his medication to ensure that he complied.

456. There can be little doubt that Mr and Mrs B were deeply concerned for the welfare of their son at all times and, at this last consultation, had Dr Marks raised the issue of hospital

admission and had he put forward its advantages and had he made it clear to them that A was a high suicide risk (as he made clear to both the Coroner and before this Tribunal) it is beyond question that Mr and Mrs B would have done all that they could to persuade A to enter hospital where he could have been appropriately observed and monitored.

457. The Tribunal finds that Dr Marks was aware of the relationship between A and his parents.

458. The Tribunal does not accept Dr Marks' evidence regarding this particular. It found his evidence to be inconsistent, opportunistic, and lacking in credibility.

459. The Tribunal finds this particular proved to the requisite standard.

Professional Misconduct or Conduct Unbecoming?

460. The Tribunal, having found all the particulars proved, then went on to consider whether the charge, which was laid as professional misconduct, should be altered to conduct unbecoming.

461. Having carefully considered the relevant legal principles applying to both professional misconduct and conduct unbecoming, and applying those principles to the proved facts, the Tribunal reached the view that the charge of professional misconduct was properly laid and that the charge should not be altered to conduct unbecoming.

Conclusion and orders

<u>Professional Misconduct</u>

462. The Tribunal finds that the charge laid against Dr Marks in all its particulars is established and that Dr Marks is guilty of professional misconduct.

463. The Tribunal further finds that the conduct alleged in paragraphs 1 to 4 (including the sub-particulars) either separately or cumulatively amount to professional misconduct.

Penalty

464. Counsel for the Director of Proceedings is to lodge submissions as to penalty no later than 14 working days after receipt of this decision.

465. Submissions as to penalty on behalf of Dr Marks are to be lodged no later than 14 working days thereafter.

Name Suppression

466. There will be permanent orders pursuant to section 106(2)(d) of the Medical Practitioners Act 1995 prohibiting publication of the names, occupations and other identifying details of the late AB, and his parents Mrs CB and Mr DB, and his former partner Ms E, and any information that might lead to their identification.

DATED at Wellington this 20th day of April 2005

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Sandra Moran

Senior Deputy Chair

Medical Practitioners Disciplinary Tribunal