Waitematā
District Health Board

Best Care for Everyone

Specialist Mental Health and Addiction Services
Level 3, 44 Taharoto Road
Private Bag 93-503, Takapuna
Auckland 0622
Telephone: (09) 487-1500
Freephone: 0800 80 9342
Facsimile: (09) 487-1333
Visit: www.waitematadhb.govt.nz

27 June 2019

[redacted]

Dear [redacted]

Re: Official Information Act request – Operation of He Puna Waiora

Thank you for your Official Information Act (OIA) request received by Waitematā District Health Board (DHB) on 31 May 2019, seeking a range of information about the operation of He Puna Waiora mental health inpatient unit.

This is our second response to you on the matter of this OIA. Waitematā DHB has already answered some of your questions as you requested information under urgency. Waitematā DHB also notes your comment that *"In seeking this information, I am wanting to establish whether there have been any recent issues in the operation or safety of this unit or the quality of care offered at this unit. So I am seeking any material that directly speaks to this query from approximately the last 12 months".*

We have endeavoured to answer all of your questions below.

1a. What are the staff-to-patient ratios in the unit?

Information already provided in OIA response sent under urgency.

1b. Please also provide details of experience and staff mix in terms of those ratios and the risk levels of the patients. What are the recommended ratios?

The recommended ratios of staffing are part of our model-of-care. The nursing and health care assistant ratios were provided in the OIA response sent under urgency. The staffing of the inpatient unit is also made up of shift workers, including nursing and health care assistant and non-shift workers including medical staff, registered social workers and occupational therapists, a clinical psychologist, a cultural advisor, a clinical nurse specialist, a pharmacist, visiting consumer and whānau advisors and administration staff. We aim to have a range of experience in our staff on the unit at any one time to enable more-experienced staff to support newer staff with decision-making about clinical care. New graduate staff, ie staff who have graduated from their clinical training the previous year, are also supported by our New Entry to Specialist Practice (NESP) programme and will generally be assigned to work with people who are presenting with less-complex presentations and who are at lower risk of harming themselves or others.

2. In the past 12 months, how many times has the unit been understaffed or under optimum staffing levels? Please provide details. These details should include but not be limited to any reports, memos or emails relating to these matters.

The unit has consistently operated at or above optimum staffing levels for the past 12 months. There have been rare instances where any shift not filled on the nursing and health care assistant roster has been filled by inpatient allied health staff, community mental health nurses, or nurse leaders working on the floor.

3. What is the average length of a shift at He Puna Waiora?

Information already provided in OIA response sent under urgency.

4. How many times in the past 12 months have patients in He Puna Waiora had access to items they should not have had; for example patients in suicide prevention gowns still having access to towels or sheets or patients on observation and at-risk, who still have access to prohibited items? Please provide details, including but not limited to any reports, memos or emails relating to these matters. Please provide details of action taken following any such events.

Waitematā DHB can advise of one reported incident at He Puna Waiora in 2018 where a patient was found to have accessed an item inappropriately. A patient lit a fire in the seclusion room, having concealed a lighter in an intimate area in order to bring it into the unit. Smoke was seen by a nurse during therapeutic engagement observations and the smoke alarms were activated. The service-user was moved to an adjoining interview room and there was a response from Fire Services, Security and the Duty Manager.

As this was a single, isolated event, providing additional detail carries a significant risk of the patient becoming identifiable. For this reason, we refuse to provide reports or other correspondence about this event under Section 9(2)(a) of the Official Information Act in order to protect the privacy of natural persons.

If you are dissatisfied with this decision, you have the right to make a complaint to the Office of the Ombudsman, whose details are available via www.ombudsman.parliament.nz.

5. In terms of patient checks, please provide details of any instances where patient checks have not been carried out at the appropriate time or to an acceptable level. In particular, please provide specific details relating to night time checks. How often are checks audited?

Based on our weekly audits, Waitematā DHB is not aware of any instances where inpatient observations have not been carried out to an acceptable level. When observations are not recorded as having been completed, this is usually because staff were involved in de-escalating a situation with an aggressive service-user or protecting other service-users from a person who is acting out. Even in these situations, staff continue to observe service-users but this may not always be formally recorded as the immediate priority was maintaining safety and managing the situation.

Therapeutic obsevations are continuous and to provide an analysis of all occasions would require substantial collation and research as we would have to review more than 2200 observation records over the last year. We have considered whether extending the timeframe for responding or charging for the staff time required to undertake this work would assist with managing this part of your request. We note that this work would need to be undertaken by a person or people with detailed experience of our reporting systems. We have concluded that neither option would assist

because there is a national shortage of skilled and experienced mental health staff. Therefore, we are refusing to provide this level of detail under s18(f) of the Official Information Act as the information cannot be made available without significant collation or research. If you are dissatisfied with this decision, you are entitled to make a complaint to the Office of the Ombudsman, whose details are available via www.ombudsman.parliament.nz.

6. What patients get one-to-one observation and what is HPW's policy around this?

Information already provided in OIA response sent under urgency.

7. What is the wait time for people discharged from inpatient care at He Puna Waiora to access a clinical psychologist via the community mental health team? Please provide details of wait times over the past 12 months.

Information already provided in OIA response sent under urgency.

8. How many complaints has He Puna Waiora received in the last 12 months and what are the nature of those complaints?

Information already provided in OIA response sent under urgency.

9. In the case of the two recent deaths, what specific steps did you take to ensure patient safety after the first death? This should include but not be limited to details of increased staffing and patient checks.

Information already provided in OIA response sent under urgency.

10. Did you inform family of all other patients of the death and if so over what time frame?

Information already provided in OIA response sent under urgency.

11. In the case of the two recent deaths, what frequency of checks were the patients on and what type of checks. In a recent interview, Dr Cleary said they were on a monitoring regime rather than continuous observation. Were these checks done to the required level? What is that level? And if not, why not?

Information already provided in OIA response sent under urgency.

12. At the time of the patient deaths, was the unit fully staffed, with staff of an appropriate experience level?

Information already provided in OIA response sent under urgency.

13. How many staff vacancies are there currently at HPW?

Information already provided in OIA response sent under urgency.

14. Please provide details of any briefings, memos instructions to staff after the first death and any material/warnings sent to patient representatives after the first death and the second death.

As previously advised, after both the first and second death the patients' families were contacted by phone by staff to advise them their loved ones had died.

Copies of internal instructions to staff after the first death can be found in Appendix One. Please note that the names and contact details of staff have been redacted under Section 9(2)(a) of the Official Information Act to protect the privacy of natural persons. If you are dissatisfied with this decision, you have the right to make a complaint to the Office of the Ombudsman, whose details are available via www.ombudsman.parliament.nz.

Also please note that after the first death, staff coordinated an inpatient community meeting to advise all service-users that a fellow inpatient had died in the unit. The request by our Adult Operations Manager in an email sent at 4.07am on 13 May to staff to not advise service-users of the death was because this meeting was being organised separately. The purpose of the community meeting was to ensure the news was delivered in a sensitive and supportive way where all inpatients were told at the same time.

Please also note that in an email at 3.57am on 13 May, our Adult Operations Manager advised colleagues that the Coroner had attended the unit. This should have instead read that the undertaker had attended the unit.

15. Please provide copies of any reviews or incident reports completed after the deaths.

Waitematā DHB has decided to provide the information requested in summary form on the ground that releasing the full incident reports would compromise the privacy of the two patients. In our view, the public interest in the full incident reports being made available does not outweigh the need to protect the privacy of the two patients. The public interest is sufficiently served by providing summaries of the key details in the incident reports. The full reports are withheld under s9(2)(a) of the Official Information Act to protect the privacy of natural persons. If you are dissatisfied with this decision, you have the right to make a complaint to the Office of the Ombudsman, whose details are available via www.ombudsman.parliament.nz.

Patient 1 was found at 10.40pm on 12 May 2019, in his room at He Puna Waiora inpatient unit. Resuscitation efforts were continued for 36 minutes by staff from the unit and the hospital's resuscitation team. When the patient was unable to be resuscitated, he was declared deceased and family and police were notified. The Coroner was notified and police attended the unit.

Patient 2 was found at 9.40pm on 16 May 2019, in his room at He Puna Waiora inpatient unit. Resuscitation efforts were continued for 25 minutes by staff from the unit and the hospital's resuscitation team. When the patient was unable to be resuscitated, he was declared deceased and family and police were notified. The Coroner was notified and police attended the unit.

16. Please provide details of daily activities, talk therapy and occupational therapy that are available to patients, including the number of hours budgeted for each patient for these activities or similar for each day.

Information already provided in OIA response sent under urgency.

17. What are the daily nursing objectives and practices of staff?

The daily objectives for the Registered Nurses on the inpatient unit are to provide quality nursing care that contributes to quality patient outcomes. This includes tasks such as:

- Spending time with each person whose care they have been allocated to provide a thorough assessment and discuss treatment and care and recovery plans.
- Completing ocumentation.
- Escalating any concerns to the medical staff or Clinical Charge Nurse.
- Liiaising with family/whānau.
- Administering medications and monitoring their effects.
- Providing a full handover to incoming staff.
- Providing direction and delegation to Health Care Assistants.
- Supporting service-users to debrief after any incidents.
- Having an overview of Mental Health Act activites.
- Supporting discharge planning.
- Liaising with other services and agencies.

18. What patient information is required to be transferred to staff at shift changes or handover and who is required to be present? How is the information transferred?

Information already provided in OIA response sent under urgency.

19. What is HPW protocol for informing parents or guardians if their loved one has apparently committed suicide? Is it acceptable to relay this information to a parent by phone rather than in person?

Information already provided in OIA response sent under urgency.

I trust this information will satisfy your request. Waitemata DHB, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare.

This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider this.

Yours sincerely

Dr Susanna Galea-Singer
Director
Specialist Mental Health & Addictions Services

APPENDIX ONE

Communications to staff and patient representatives

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Monday, 13 May 2019 3:57 a.m.
To: Kevin Cleary (WDHB); Pam Lightbown (WDHB); Greg Finucane (WDHB)
Cc: Evelyn Mcphillips (WDHB); Susanna Galea-Singer (WDHB); Debra Kynnersley (WDHB); Alex Craig (WDHB); Michelle Dawson (Adult Mental Health) (WDHB)
Subject: Adverse Event [redacted] 12 May 2019.docx

Hi all,

here is a triage form. It will need further information added in the next day or so.

OVERNIGHT ACTIONS (from 1200-0300hrs):

- Debi led informal debrief with staff
- Police took staff statements (Debi present)
- Megan met with family [redacted] on the ward
- Clinical file & death certificate requested and photocopy given to Police
- Coroner attended & took [redacted] body to Auckland mortuary
- Triage Form initiated
- Bedroom closed off

PLANNED ACTIONS FOR TOMORROW:

- CCN (Paul) to inform RC (Mimoza)
- Arrange for the room to be blessed & then cleaned
- Ward community meeting to inform service users of [redacted] passing / offer support
- Arrange further debrief EAP for staff & follow up with staff who are most affected
- Will follow up further with family over the week, contact details given

NOTE: - The family have specifically asked us not to contact [redacted] as they intent to visit him tomorrow to tell him. They have a close relationship with him and wish to provide support in person, preferring they hear the news from the family.

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Monday, 13 May 2019 4:12 a.m.
To: Debra Kynnersley (WDHB); Michelle Dawson (Adult Mental Health) (WDHB); Paul Colebrook (WDHB)
Cc: Greg Finucane (WDHB)
Subject: Death of an inpatient

FYI – we have covered pretty much everything but still need to information GP's (Can happen tomorrow via clinical team).

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Wednesday, 15 May 2019 8:08 a.m.
To: Debra Kynnersley (WDHB); Mimoza Trenceva (WDHB)
Cc: Greg Finucane (WDHB); Paul Colebrook (WDHB)
Subject: funeral arrangements

Hi Debi and Mimoza,

I heard back from [redacted] late yesterday to say that staff were welcome to attend the funeral for his [redacted] (where appropriate).

This will be held on [redacted] at [redacted] at the:

[redacted]
Auckland

Can you please pass this on those staff who had been involved with [redacted] and let me know who is likely to attend?

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Monday, 13 May 2019 4:07 a.m.
To: Paul Colebrook (WDHB)
Cc: Michelle Dawson (Adult Mental Health) (WDHB); Silvana Smith (WDHB)
Subject: FW: Adverse Event [redacted] 12 May 2019.docx

Hi Paul,

we know that you will hear about [redacted] passing first thing this morning, but here is an overview in the triage form. Please can you ensure staff do not pass on any details of his death to service users, just to make sure that we minimise distress.

Debi and I will be at home getting some sleep but can you please pick up on the following?

1. let Mimoza know as soon as possible when she arrives on the ward
2. Talk with Hinerau and arrange for the room to be blessed & then cleaned
3. Ward community meeting to inform service users of [redacted] passing / offer support (could be arranged for the afternoon when staffing would allow)

Debi will touch base with staff involved/affected in the afternoon, and review EAP needs / support needs (3 key people were [redacted] - MHCA, [redacted] – RN, [redacted] – RN)

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Monday, 13 May 2019 3:57 a.m.
To: Kevin Cleary (WDHB); Pam Lightbown (WDHB); Greg Finucane (WDHB)
Cc: Evelyn Mcphillips (WDHB); Susanna Galea-Singer (WDHB); Debra Kynnersley (WDHB); Alex Craig (WDHB); Michelle Dawson (Adult Mental Health) (WDHB)
Subject: Adverse Event [redacted] 12 May 2019.docx

Hi all,

here is a triage form. It will need further information added in the next day or so.

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- Debi led informal debrief with staff
- Police took staff statements (Debi present)
- Megan met with family [redacted] on the ward
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- Coroner attended & took [redacted] body to Auckland mortuary

- Triage Form initiated
- Bedroom closed off

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- Will follow up further with family over the week, contact details given

NOTE: - The family have specifically asked us not to contact [redacted] as they intent to visit him tomorrow to tell him. They have a close relationship with him and wish to provide support in person, preferring they hear the news from the family.

Kind regards Megan

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44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Monday, 13 May 2019 11:12 a.m.
To: Paul Colebrook (WDHB)
Subject: RE: Adverse Event [redacted] 12 May 2019.docx

thanks Paul – will touch base later in day

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Paul Colebrook (WDHB)
Sent: Monday, 13 May 2019 6:31 a.m.
To: Megan Jones (Adult Mental Health) (WDHB)
Subject: RE: Adverse Event [redacted] 12 May 2019.docx

Thanks Megan,
I hope you and all involved are alright? And that both you and Deb get much needed rest. As requested I shall follow up all that you have detailed in your e.mail.

Thanks and kind regards,

Paul Colebrook I Clinical Charge Nurse
He Puna Waiora Acute Inpatient Unit I Waitemata DHB
M: 021874724 EXTN: 43448
Paul.Colebrook@waitematadhb.govt.nz

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Monday, 13 May 2019 4:06 a.m.
To: Paul Colebrook (WDHB)
Cc: Michelle Dawson (Adult Mental Health) (WDHB); Silvana Smith (WDHB)
Subject: FW: Adverse Event [redacted] 12 May 2019.docx

Hi Paul,

we know that you will hear about [redacted] passing first thing this morning, but here is an overview in the triage form. Please can you ensure staff do not pass on any details of his death to service users, just to make sure that we minimise distress.

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To: Kevin Cleary (WDHB); Pam Lightbown (WDHB); Greg Finucane (WDHB)
Cc: Evelyn Mcphillips (WDHB); Susanna Galea-Singer (WDHB); Debra Kynnersley (WDHB); Alex Craig (WDHB); Michelle Dawson (Adult Mental Health) (WDHB)
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Kind regards Megan

Megan Jones | Adult Operations Manager
Specialist Mental Health & Addiction Services | Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 | m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Monday, 13 May 2019 2:38 p.m.
To: Kevin Cleary (WDHB); Pam Lightbown (WDHB); Greg Finucane (WDHB)
Cc: Evelyn Mcphillips (WDHB); Susanna Galea-Singer (WDHB); Alex Craig (WDHB); Michelle Dawson (Adult Mental Health) (WDHB); Debra Kynnersley (WDHB)
Subject: RE: Adverse Event [redacted] 12 May 2019.docx

Hi all,

please be aware of the following updates;

- All staff involved in the incident have been called for support (RN [redacted], RN [redacted], MHCA [redacted])
- RN [redacted] has requested to take the next 2 days off as sick then she is on leave, she has been offered EAP for support and is aware that we will be contacting EAP to provide a group session
- The room has been blessed by the Komatua with Cultural Worker (Hinerau)
- There will be a community meeting at 1530 pm, with service users
- Dr Trenceva has phoned supported the family today, they have my contact number and I will call them in 2 - 3 days time

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
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Email: megan.jones@waitematadhb.govt.nz
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Cc: Evelyn Mcphillips (WDHB); Susanna Galea-Singer (WDHB); Debra Kynnersley (WDHB); Alex Craig (WDHB); Michelle Dawson (Adult Mental Health) (WDHB)
Subject: Adverse Event [redacted] 12 May 2019.docx

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p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Tuesday, 14 May 2019 6:33 p.m.
To: Pam Lightbown (WDHB)
Subject: RE: Adverse Event Triage [redacted] May 2019.docx

Hi Pam,

I couldn't see anything that needed changing in the triage form and no doubt any gaps will be picked up in the full review. But if there is further information that is requested, then do let me know,

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Pam Lightbown (WDHB)
Sent: Tuesday, 14 May 2019 3:54 p.m.
To: Megan Jones (Adult Mental Health) (WDHB)
Subject: FW: Adverse Event Triage [redacted] May 2019.docx
Importance: High

Hi Megan – attached is what I sent to Dale & Andrew y'day if you wanted to update/add anything please let me know & I will send an update.
Pam

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Wednesday, 15 May 2019 3:04 p.m.
To: Pam Lightbown (WDHB)
Cc: Greg Finucane (WDHB); Michelle Park (WDHB); Evelyn Mcphillips (WDHB); Susanna Galea-Singer (WDHB); Kevin Cleary (WDHB); Alex Craig (WDHB); Andrew Howie (WDHB); Dean Manley (WDHB)
Subject: RE: AE panel investigation - [redacted]

- Hi Pam – I am the contact person for the family and have arranged with CCN (Paul) to inform RC (Mimoza)
- Arrange for the room to be blessed & then cleaned
- Ward community meeting to inform service users of [redacted] passing / offer support
- Arrange further debrief EAP for staff & follow up with staff who are most affected
- Will follow up further with family over the week, contact details given

NOTE: - The family have specifically asked us not to contact [redacted] as they intent to visit him tomorrow to tell him. They have a close relationship with him and wish to provide support in person, preferring they hear the news from the family.
(Spokesperson) to touch base with him early next week (after the funeral) to talk through the next steps.

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
44 Taharoto Rd, Takapuna, Private Bag 93 503
p: 487 1406 or ext 47457 I m: 021 283 0072
Email: megan.jones@waitematadhb.govt.nz
www.waitematadhb.govt.nz

From: Pam Lightbown (WDHB)
Sent: Wednesday, 15 May 2019 2:34 p.m.
To: Evelyn Mcphillips (WDHB); Susanna Galea-Singer (WDHB); Kevin Cleary (WDHB); Alex Craig (WDHB); Andrew Howie (WDHB); Megan Jones (Adult Mental Health) (WDHB); Dean Manley (WDHB)
Cc: Greg Finucane (WDHB); Michelle Park (WDHB)
Subject: RE: AE panel investigation - [redacted]

Thanks Evelyn – this sounds sensible. Have the family been advised yet?
Pam

From: Evelyn Mcphillips (WDHB)
Sent: Wednesday, 15 May 2019 2:33 p.m.
To: Susanna Galea-Singer (WDHB); Kevin Cleary (WDHB); Alex Craig (WDHB); Pam Lightbown (WDHB); Andrew Howie (WDHB); Megan Jones (Adult Mental Health) (WDHB); Dean Manley (WDHB)
Cc: Greg Finucane (WDHB); Michelle Park (WDHB)
Subject: AE panel investigation [redacted]

Kia ora
I have just been having a conversation with Greg about progressing the adverse event investigation for [redacted].

Mark Fisher from CMDHB has agreed to lead the panel. He is on leave until 5 June 2019.

Greg suggests leaving the start of the investigation until Mark is available, as in the meantime the whānau have asked for some time (and are happy to have staff at funeral)

Is everyone happy with that approach?

Ngā mihi
Evelyn

Evelyn McPhillips I Quality & Improvement Lead
Specialist Mental Health and Addiction Services I Waitemata DHB
Level 3, 44 Taharoto Rd, Takapuna I p: 021 529 323

From: Megan Jones (Adult Mental Health) (WDHB)
Sent: Wednesday, 15 May 2019 4:08 p.m.
To: Andrew Howie (WDHB); Evelyn Mcphillips (WDHB)
Cc: Susanna Galea-Singer (WDHB); Kevin Cleary (WDHB); Alex Craig (WDHB); Pam Lightbown (WDHB); Dean Manley (WDHB); Greg Finucane (WDHB); Michelle Park (WDHB)
Subject: RE: AE panel investigation [redacted]

Sound sensible

Kind regards Megan

Megan Jones I Adult Operations Manager
Specialist Mental Health & Addiction Services I Waitemata DHB
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From: Andrew Howie (WDHB)
Sent: Wednesday, 15 May 2019 3:22 p.m.
To: Evelyn Mcphillips (WDHB)
Cc: Susanna Galea-Singer (WDHB); Kevin Cleary (WDHB); Alex Craig (WDHB); Pam Lightbown (WDHB); Megan Jones (Adult Mental Health) (WDHB); Dean Manley (WDHB); Greg Finucane (WDHB); Michelle Park (WDHB)
Subject: Re: AE panel investigation - [redacted]

Yes -if others are happy.

Sent from my iPad

On 15/05/2019, at 12:11 PM, Evelyn Mcphillips (WDHB) <Evelyn.Mcphillips@waitematadhb.govt.nz> wrote:

Kia ora
I have just been having a conversation with Greg about progressing the adverse event investigation for [redacted].

Mark Fisher from CMDHB has agreed to lead the panel. He is on leave until 5 June 2019.

Greg suggests leaving the start of the investigation until Mark is available, as in the meantime the whānau have asked for some time (and are happy to have staff at funeral) and urgent work is

happening on ligature points in a couple of rooms at least at He Puna Waiora while other work can be organised. And we continue working on the ligature policy.

Is everyone happy with that approach?

Ngā mihi
Evelyn

Evelyn McPhillips I Quality & Improvement Lead
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