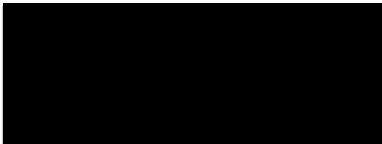




22 August 2019



Dear 

Re: Official Information Act request – He Puna Waiora mental health unit

Thank you for your Official Information Act request received by Waitematā District Health Board (DHB) on 25 July 2019, with clarifications received on 26 July 2019, seeking terms of reference regarding the review of operations at He Puna Waiora Mental Health Unit.

We acknowledge that public discussion about self-harm and suicide can be useful. However, we respectfully ask that all information made available in any responses regarding suicide or suspected suicide is treated with sensitivity to the impact that public discussion about suicide can have, particularly any impact on individuals contemplating suicide.

Guidelines for responsible media management of suicide reporting are published on the Mental Health Foundation website and can be found here: https://www.mentalhealth.org.nz/home/our-work/category/39/suicide-media-response-service?gclid=EAlaIqobChMIk_TIs4OP1wIVQiRoCh3D6g-2EAAYASAAEgIII_D_BwE.

Before responding to your specific questions, it may be useful to provide some context about our services to assist your understanding. Waitematā DHB serves a population of more than 630,000 people. Our Specialist Mental Health and Addiction Services (SMH&AS) are the largest of this kind in the country, by volume of service-users seen. The speciality comprises Adult Mental Health Services, Child Youth and Family Mental Health Services, Takanga a Fohe (Pacific mental health and addictions), Whitiki Maurea (Kāupapa Māori mental health and addictions), the Regional Forensic Psychiatry Service (covering Northland and greater Auckland regions) and Community Alcohol and Drug Services (CADS). All of our addictions services cover the Auckland region. Mental Health Services for Older Adults sits within Waitematā DHB's Speciality Medicine and Health of Older People Division.

On 25 July you asked:

I understand the independent review into the two suspected suicides earlier this year is now underway and that terms of reference have been agreed. Please provide an update on the review. Please provide the terms of reference for the review.

As a result of subsequent communication with you on 26 July, we understand that your request relates to the overarching independent review of the He Puna Waiora inpatient unit, announced on 17 May. In response, the panel's work is now underway. Please see Appendix 1 for the Terms of Reference. You will notice that the initials of the deceased persons have been redacted to protect

their families' privacy. The panel is working independently, and have not yet determined the timeframe to report findings.

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 Greg Finucane
Acting Director
Specialist Mental Health & Addictions Services

He Puna Wāiora Review

Background

He Puna Wāiora is an Adult 35-bedded Inpatient Unit located in Takapuna, Auckland, adjacent to North Shore Hospital. It opened 4 years ago and has been in continual use since then. Until last week, there had never been an inpatient suicide in the unit since opening.

On Sunday 12th May 2019, in the late evening, an inpatient, ■, was found deceased.

On Thursday 16th May 2019, in the evening, an inpatient, ■, was found deceased.

As a result of these two most-serious inpatient patient safety events, it has been decided to have an overarching external review of the functioning of He Puna Wāiora, chaired by a nominee of the Director of Mental Health.

As part of the review, all questions asked by whānau /family members will be documented and transparently responded to. A kaumātua can be available for staff or whānau on request.

Terms of Reference

To review:

- The physical safety of the ward environment, including ligature points and to advise about any remediation required.
- The clinical governance processes on the ward, to identify any deficits and possible solutions.
- The functioning of the clinical teams on the unit, including a review of the clinical culture on the ward, quality-of-care being provided and areas for improvement.
- Any other areas for improvement in the oversight of the quality-of-care provided by the mental health leadership team.
- The policies concerning communication with families and the practice on the ward of responding to urgent concerns raised and escalated by whānau and family members to staff.