Waikato District Health Board

Report to the Chief Executive and Waikato District Health Board of the Serious Event Review into Nicholas Taiaroa Macpherson Stevens (Nicky)

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Glossary

ACT	Acute Community Team
AWOL	Absent Without Official Leave
BEUL	brief unescorted leave
CATT	Community Assessment and Treatment Team
CEO	Chief Executive Officer
CTO	Community Treatment Order (Mental Health Act 1992)
CWS	Clinical Workstation
Dave	Father of Nicky
ED	Emergency Department
Hauora	Hauora Waikato – is an NGO who support the early intervention service within mental health
HDC	Health and Disability Commission
HRBC	Henry Rongomau Bennet Centre, which is the mental health facility of the Waikato DHB
IPCA	Independent Police Conduct Authority
Jane	Mother of Nicky
LAI	Long acting injection
MDT	Multidisciplinary team often made up of doctors, nurses and allied health professionals
MH&A Services	Mental Health and Addiction services
MHA	Mental Health Act
NGO	Non Governmental Organisation
NRT	Nicotine Replacement Therapy
OT	Occupational Therapist
PA	Psychiatric Assistant
RMO	Registered Medical Officer
RN	Registered Nurse
SAC	Severity Assessment Criteria and supports the nationally agreed system for investigation of serious events
SMO	Senior Medical Officer
SW	Social Worker
Te Aka Toro	Early intervention service for Hauora Waikato
WAVE training	A grief education programme that aims to support adults bereaved by suicide in their understanding and management of grief and development of resilience.

1. EXECUTIVE SUMMARY

21 year old, Nicholas Taioroa MacPherson Stevens (Nicky) presented to the Emergency Department on the evening of 17 February 2015, with self-inflicted lacerations to both forearms. Although medically stable, he required surgery to repair tendon and nerve damage. Following surgery and discharge from the plastics ward, he was admitted on 19 February 2015 into Henry Rongomau Bennett Centre (HRBC) under Section 29(3)(a) of the MHA.

On 9 March 2015, Nicky did not return from an unescorted leave and an AWOL procedure was activated. On 12 March 2015, Nicky's body was discovered in the Waikato River.

The initial SAC 1 review was commenced on the 23 March 2015, with a family meeting held on 14 April 2015. The investigation was put on hold on 24 April 2015 due to the instigation of a criminal investigation by the police with a possible charge of clinical negligence. The review was restarted in August 2016 after the Police confirmed that no criminal prosecution would be made.

Summary of findings and recommendations

Overall, the care offered to Nicky whilst in HRBC was of a good standard. The opinion of the review team is that the individuals involved in the care and treatment of Nicky between February 2015 and March 2015 did not intentionally take action or omit to take actions to the detriment of Nicky's welfare. There were a number of areas of good practice including well written policies and procedures based on best evidence and staff who were committed to supporting Nicky in his recovery.

However, the review team have identified omissions in some processes and therefore opportunities where improvements could be made. Key issues identified are set out fully within this report and include

- Risk assessment
- Leave process
- AWOL
- Family involvement
- Medication management

The review team have made a number of recommendations, including:

- Strengthening of the leave procedure and practice in a number of areas but particularly in relation to evaluating escorted leave with family, whanau and friends and incorporating the information from these evaluations in leave and treatment planning.
- The AWOL procedure to include a clear search process and regular simulation exercises for staff.
- The notification to Police in relation to a patient who is AWOL to include a telephone notification and handover using the SBAAR framework and documentation being securely and reliably transmitted to police by scanned document sent by email.
- The process for family consultations must ensure that there is an agreed summary of the outcomes of the meeting that is documented in the medical record. This should include listing points of difference and how these can be resolved or worked on towards deeper understanding and resolution.

- During orientation and ongoing training, promote the principles outlined in the 'DHB family / whanau participation policy', particularly around collaborative partnership.

The death of Nicky Stevens is a terrible tragedy, most poignantly for his family but also for staff that knew him and were caring for him. He was clearly unwell with a relapsing mental illness associated with periods of acute psychosis. As with many who suffer from such conditions he appears to have found it difficult to accept that he was unwell and needed the help of medication to recover and remain well.

It is frequently the case that a person in the early stages of recovering from an acute psychosis is susceptible to very significant changes in their mental state which are not predictable despite the most thorough risk evaluation.

There were a number of events in the months and days leading up to his death that if altered, may have changed the outcome for Nicky and his family. The review team concluded that these events did not constitute serious failings by the individuals involved, and that even if different actions had been taken, it cannot be known whether the final outcome would have been altered.

The review team hopes that the recommendations outlined will reduce the likelihood of a similar event occurring in the future.

2. TERMS OF REFERENCE

The serious event review process is a quality improvement process and is used to identify care or service delivery problems.

- Is there evidence of a care / service delivery problem to provide proper care?

Areas should include but not be limited to – risk assessment process, decision making process regarding the granting of leave, authorised / unauthorised leave process, family involvement/ communication issues. See attached views from family with regard to issues to be included, discussed at an initial family meeting 14 April 2015 (see appendix 1)

- If such evidence exists where, when, how and why did the care / service delivery problem occur?

- What recommendations should be made to avoid similar problems in the future?

- Identify what (if any) actions have been put in place since this tragic event to avoid a similar occurrence

3. THE REVIEW PROCESS

- London Protocol approach was taken with a fishbone diagram used to identify contributory factors

3.1 Review Team

- Team leader – Mo Neville, (RGONnz) Director Quality and Patient Safety, Waikato DHB
- Consultant Psychiatrist (External) - Nick O'Connor, Clinical Director North Shore Ryde Mental Health Service, Northern Sydney Local Health District and Senior Clinical Lecturer, Department of Psychiatry, University of Sydney, NSW, Australia.
- Clinical Nurse, Mental Health (External) – unable to recruit to this role, following the restart
- Lay member (External) - Cathie Morton (RNnz), a senior health manager experienced in DHB primary care and non-profit mental health management

NZ. Post grad Diploma Public Health. Coordinated mental health for primary care practice. Managed 12 bed forensic unit and adolescent unit in London. Director of MIND in UK. Manager Schizophrenia Fellowship for 7 years.

3.2 Level of investigation

An initial triage process was undertaken by the mental health service in March 2015, which identified that a Severity Assessment Classification (SAC) 1 review be undertaken.

The initial SAC 1 review was commenced on 23 March 2015, with a family meeting held on 14 April 2015. The investigation was put on hold on 24 April 2015 due to the instigation of a criminal investigation by the police with a possible charge of clinical negligence. An interim report for the Chief Executive Officer (CEO) was written at this stage.

In early August 2016, the Police confirmed that no criminal prosecution would be made and the CEO requested the review be restarted. Unfortunately when the review was re instigated, neither of the clinical experts originally retained were able to participate due to workload / change in circumstances. A new team was formed and the first staff interviews took place on 15 August 2016.

3.3 Scope of review

The review covered from admission to the emergency department, Waikato DHB on 17 February 2015 to the discovery of Nicky's death, on 12 March 2015.

3.4 Documentation and information reviewed

- Incident form 317310 identifying initial AWOL
- Full clinical record (both electronic and paper records)
- Blood results from 19 February 2015 – specifically haemoglobin levels
- Missing person's report (p2-5)
- CCTV footage for the 8 and 9 March 2015
- Door security log (FOB) access for 9 March (Identification badge access through security doors to wards / departments)
- Phone logs from 9 March 2015
- Fax log from 9 and 10 March 2015
- Policy, guideline and procedure documents
    - Missing from the ward
    - Leave management
    - Levels of observation
    - Risk assessment
    - AWOL (Absent Without Official Leave)
    - Absences Causing Concern (July 2016)
    - Family/Whānau Participation
- Compulsory treatment orders
- Hauora Waikato Whanau consent form (Oct 2009)
- Initial triage report MH&A services Waikato DHB, recommending a SAC1 review (March 2015)
- Initial triage report Hauora Waikato, covering period leading up to emergency department attendance (March 2015)
- Hauora Waikato Independent review of care (April 2016)
- Independent Police Conduct Authority report (May 2016)

3.5 Site visits

A visit of the facility including location of the CCTV cameras was undertaken by the review team to understand the layout of the HRBC. They also sighted the entrance of the gully to see where it was positioned in respect to the HRBC building.

A review of the walk to the river from the HRBC was undertaken by the review team leader. The 'gully' has a small stream along part of the path. The gully path comes out at the archery ground on Cobham drive. There appears to be no practical access to the river within 15 minutes' walk of the HRBC.

3.6 Witnesses who were interviewed

Interviews took place from 15 August 2016 through to 25 October 2016, seventeen months after the death of Nicky. Most staff interviewed had written statements in advance of the interviews (mostly shortly after the event) or supplied the statements prepared during the police investigation.

The panel had formulated questions in advance of these interviews, based on the clinical record, timeline document, concerns raised by the family and a review of the statements.

Interviews were held with:

- Consultant in charge of Nicky at the time of AWOL
- Consultant Liaison psychiatry service, on call 17 February 2015
- Charge Nurse Manager, ward 35
- Registered nurse assigned to Nicky on 8 and 9 March 2015
- Psychiatric assistants on shift 9 March 2015
- DHB Security manager / CCTV manager
- Clinical Director of the acute adult service
- Assistant Group Manager (now Director) Mental Health and Addictions service
- Director of Nursing Mental Health and Addictions service (note not in place in March 2015)
- Nicky's mother and father

3.7 Involvement and support of family

An initial two hour family meeting was held on 14 April 2015 with the review team chair and the original external consultant psychiatrist, which enabled a better understanding of Nicky as a person, the concerns that the family had and the areas they wanted to have investigated as part of this review.

A further family meeting with the new full review team was held on 16 August 2016 where the family's expectations for the review were discussed.

An update meeting was held with Nicky's parents and the review team on 30 September 2015 (team leader and lay member) and a structured interview held with both parents and the full review team on 25 October 2015.

3.8 Involvement and support provided for staff involved

All staff involved in the initial incident were supported by the MH&A Services senior management team

All staff interviewed were offered the opportunity to bring a support person and all gave their time willingly, including coming in from leave.

4. INVESTIGATIONS UNDERTAKEN BY OTHER BODIES

4.1 Hauora Waikato, Te Aka Toro, early intervention service – triage report (March 2015)

Nicky had been under the care of Te Aka Toro since 2012. An initial service incident review report was presented at the Mental Health and Addiction Services, Serious and Sentinel Event Committee on 26 March 2015.

In this report there is a brief background outlining the clinical context and summary of events from October 2014 when the whanau raised concerns regarding Nicky not presenting for his fortnightly depot LAI treatment, olanzapine Relprevv 210mg and showing early signs of psychosis. He was under the Mental Health Act at this time.

The report confirms that there had been an 8 day delay with the LAI in October 2014 due to difficulty contacting Nicky, with an emerging pattern of small delays in administration (2-3 days) over the previous 6 weeks.

In November 2014, there was a further 7 day delay between injections (no reason noted). No delays were identified in December 2014 (pending documentation review).

In January 2015, Nicky was due his LAI on 6 January however he could not be located. The LAI was administered on 3 February 2015, six weeks late.

Weekly contact with the treating team was planned with Nicky and with next injection and contact due on 17 February 2015. The review team noted that this had not occurred.

The report stated that the Hauora community team visited the address on 18 February 2015 and were informed that Nicky was in a ward in Waikato hospital.

4.2 Hauora Waikato Independent Review of Care (April 2016)

Hauora Waikato commissioned an independent review 17 April 2015 regarding the care provided by Hauora Waikato to Nicky between the date he was referred to Te Aka Toro on 23 November 2012 and March 2015.

In particular

- Review and report on whether the care provided by Hauora Waikato to Nicholas was consistent with the standards of care you would expect to be provided by an early intervention service;
- Make recommendations on any areas where you consider Hauora Waikato could improve its service delivery

The author acknowledged that Nicky's parents had rejected the second draft of the report and Hauora Waikato had expressed that the clinical record provided clear evidence that there was frequent and meaningful contact between Hauora Waikato and the parents.

The author stated *' It is my opinion that the care provided by Hauora Waikato to Nicky, although communication with his parents could have been improved, was not inconsistent with the standards of care I would expect to be provided by an early intervention service under the existing resourcing constraints.'*

The report noted '*Nicky's insight into his psychotic illness (intermittently complicated by substance abuse) appears to have been very limited, and his treating team appears to have consciously struggled with the tension of a more permissive approach (hoping for better engagement and rapport) as opposed to a more paternalistic approach, which changed in relation to increasing Nicky's age and developmental stage'*

The author believed it would have been helpful to all parties if such dilemmas were to have been more thoroughly discussed (and noted that documentation of some discussions having occurred) between Hauora Waikato and the parents, including the risks and the benefits of each approach, and the practicalities thereof.

Outcome:

Communication with the family is a specific area where it is considered Hauora Waikato could improve its service delivery. A meeting between Hauora Waikato and Nicky's parents, facilitated by an independent party acceptable to all should occur.

4.3 Internal review following publication of Coroners report into Client W (April 2016)

The Coroner's report for Client W, who died in November 2011 when an inpatient at HRBC, was published at the end of December 2015. In the previous 12 months there had been a number of events in the mental health service that had increased external attention and raised questions on whether the service had learnt lessons from previous events and implemented the actions identified for improvement. The CEO commissioned a review of the previous reports recommendations and corrective actions to assure the DHB Board that improvements had been made.

Outcome:
The report stated that action following the serious event, coroner's findings and Health and Disability Commission actions *'shows the service has a good overview of progress against recommendations through its leadership group and their governance process'.*

The report also noted that '*the service is to be congratulated for the development of the integrated audit tool (mental health recovery care – inpatient audit tool) which if implemented well and monitored regularly through the governance group, will enable ongoing assurance to the Board on compliance with policies and guidelines within the service'.*

The report stated that further work was required to ensure a planned clinical audit programme that includes high risk policies and procedures was put in place, and where non- compliance was shown, that a re-audit was undertaken in a timely manner.

4.4 Section 99 Inspection of Waikato District Health Board Mental Health and Addiction Services (April 2016)

In early 2015 there were a number of serious events at the Waikato DHB mental health and addiction services. Following these events, Dr John Crawshaw, Director of Mental Health, decided to use his statutory powers under section 99 of the Mental Health (Compulsory Assessment and Treatment Act) 1992 to inspect the services to ensure they were providing a good quality of care to people in the Waikato region. The inspection process was complex. In addition to those in leadership and management positions, the team met with over 200 front line staff. The consumer leader on the team directly heard from over 150 people using the services and their whanau

Outcome:
The report published in April 2016, noted that the MHAS and its leadership team had made significant improvements to the service since 2009. The direction of travel of the change was appropriate, and showed good strategic thought as to contemporary models of practice. The shift in models of care through this time had been significant, and it needed to be acknowledged that the transformational change was yet to be completed.

The report states that *'overall, the MH& A services are well managed and led. They provide a good standard of care. Staff, despite the problems of morale and increased pressure, are dedicated to doing their best for people accessing the services. People accessing the services and their families/whānau can be assured that they can expect to receive good care'*

A number of recommendations were made which are currently being worked on and the DHB Board is monitoring progress.

4.5 Independent Police Conduct Authority (IPCA) – Police response to missing report regarding Nicholas Stevens (May 2016)

The Authority conducted an independent investigation into the family's complaint in May 2015, regarding delays in the search process. The report sets out the results of that investigation and the IPCA's findings and recommendations.

The IPCA examined issues relating to the Police Northern Communication Centre's handling of the missing person report, the oversight of the incident by the Waikato District Command Centre, the Police's search for Nicky, Police media releases, and whether Police liaised appropriately with Nicky's family while he was missing.

The report confirms that the police had received notification from Henry Rongomau Bennet Centre (HRBC) staff of Nicky having gone missing at 2:38pm on Monday 9 March 2015 and that he was at risk of suicide. A search and rescue operation was instigated on the afternoon of the 11 March 2015, forty eight hours after the initial notification.

The review team noted that there was no recommendation in relation to the method of AWOL alert from HRBC.

5. BACKGROUND AND CONTEXT – Current Review

After developing his first episode of psychosis, Nicky was seen by the assessment service (Ngaa Ringa Awhina) at Hauora Waikato in October 2009. He had two admissions to HRBC in December 2012 and May 2013. He was then placed on a Community Treatment Order (CTO) in May 2013 and commenced on olanzapine 210mg long acting injection (LAI) every two weeks.

According to the initial triage report from Hauora Waikato in March 2015, for the two to three months prior to admission, the outpatient clinicians at Hauora had found it difficult to follow-up Nicky and as a consequence, compliance with his LAI had been erratic. Nicky's parents advised the review team that they felt that earlier intervention by Hauora Waikato had been indicated and this may have prevented Nicky's admission to the emergency department.

The full descriptive chronology of the events leading up to the death of Nicky can be found at appendix 2. It is a broad level summary of Nicky's contact with health care professionals and service providers in the defined period. It was developed from the clinical record, supported by the additional documents reviewed and by interviews with individuals involved.

5.1 Nicky

According to his parents, when Nicky was well, he was cheeky, always singing and insightful. He enjoyed his music and his cat. He had been engaged in a music program at Wintec where he was the key organiser of the class band and a motivator for the group. He made friends easily and had formed some deep and close relationships. He was sharp and curious. He liked asking questions and debating but was a gentle, caring person.

When Nicky was unwell he was 'zoned out, with little ability to communicate'. His body language was closed down and his responses delayed. In January, Jane felt that Nicky was the sickest she had ever seen him. He was making no sense, singing to himself and had periods of 'screaming abuse' and talking to himself.

5.2 Mental Health Act

Nicky was changed to inpatient status under section 29 (3)(a) on 19 February 2015 for a period of 14 days, until 5 March 2015.

On 5 March 2015, whilst still an inpatient in Ward 35, this was changed to reassessment under section 29 (3)(b) for a further period of 14 days which was due to finish 19 March 2015.

As part of this reassessment, the clinical report to the Director of Area Mental Health Services on 5 March, noted that Nicky *'appeared somewhat dishevelled in his appearance, denied current suicidal thoughts…and just wanted to get on with his life'. Nicky noted that he was worried about being kidnapped by aliens when he cut his wrists'.* The clinician noted *'a lack of acknowledgment of the seriousness of his actions from Nicky and that this signalled an intention to disengage with services without close follow up and legal requirement to do so'.* The clinician also noted *'that Nicky had reported to his family that he had suicidal thoughts with a plan to drown himself in the river'.*

Section 29 (1) to (3) of the Mental Health (Compulsory Assessment and Treatment) Act 1992 states

(1) A community treatment order shall require the patient to attend at the patient's place of residence, or at some other place specified in the order, for treatment by employees of the specified service, and to accept that treatment.

(2) Every employee of the service specified in the order who is duly authorised to treat the patient may, at all reasonable times, enter the patient's place of residence or other place so specified for the purpose of treating the patient.

(3) If, at any time during the currency of the community treatment order, the responsible clinician considers that the patient cannot continue to be treated adequately as an outpatient, the responsible clinician may direct that the patient -

(a) be treated as an inpatient for a period of up to 14 days; or

(b) be re-assessed in accordance with sections 13 and 14.

5.3 Consultation with family / whanau re the Mental Health Act

Section 7A(4), of the Mental Health Act, is clear that a responsible clinician must consult with the patient before consulting with the patient's family and whānau. The patient may not want their family or whānau to be consulted but the responsible clinician can still consult with the family or whānau if they believe this would be in the patients best interests.

5.4 The Henry Rongomau Bennett Centre

HRBC provides inpatient care for people suffering a mental illness. The centre is located close to Waikato Hospital on the Selwyn Street side of the Waiora Waikato Hospital Campus. It is adjacent to a gully that leads through to Cobham Drive, Hamilton. There is a local dairy situated on the corner of Pembroke and Selwyn Street which is frequently used by HRBC clients for escorted and unescorted leave. At the time of this incident, both ward 35 and ward 36 were 'open' wards, with clients admitted based on where they lived (geographical admissions), although both these areas could be locked if there were high risk patients, and overnight to prevent people entering (for security of patients and staff)

5.5 CCTV cameras

CCTV cameras are in place for site security and not for monitoring of client movements. They are situated at HRBC Level 1 and Level 3 entrances, opposite the Puna Whiti building and looking out to the gully beside Hockin house.

The staff in the HRBC do not have access to the CCTV screens for monitoring or review. The CCTV footage can be viewed in the main security department near the emergency department (on the opposite side of the campus).

5.6 Ward acuity

Ward 35 had capacity for 21 service users on 9 March 2015. There were 17 service users as of 08:00 hours on 9 March.

For 9 March the activity on the morning shift included:

- One admission
- Two discharges
- Two service users going on agreed leave (escorted and unescorted)
- Three service users transferred in from Ward 36
- One service user off ward for MRI investigations and required supervision
- Two AWOL incidents

5.7 Staffing matrix

Discipline	HRBC agreed staffing level for 21 clients	Actual staffing level on 9 March 2015 for 17 clients
Registered Nurse (RN)	5	2 *+ 1 new graduate RN
Psychiatric Assistant (PA)	2	2 + 1 PA orientating to ward
Charge Nurse Manager (CNM)	1	1
Clinical Nurse Specialist (CNS)	1	Off
Other	-	1 RN to cover 11:00 – 15:00
Total staff numbers	9	4 +1 part shift +2 new staff +CNM = 8

**note 1 RN sick and 1RN on annual leave*

There are no nationally agreed or mandated staffing levels / mix in mental health (NZ).

Early shift is 07:00 – 15:30 or 16:00. Breaks for lunch are agreed at the start of the shift however these can often change depending on the dynamics of the ward.

Both psychiatric assistants were very experienced – with 3 and 8 years' experience.

The registered nurse assigned to Nicky on 8 and 9 March, had transferred to a full time contract on Ward 35 on 1 March 2015 having previously been bureau (bank / casual) staff from March 2014 moving around all HRBC wards and was experienced in this setting.

The CNM had worked on ward 35 since 2004 and was a very experienced mental health nurse.

5.7 Policy awareness

All staff interviewed for this incident were aware of the AWOL process that existed when they started – it had formed part of their orientation process.

6. KEY ISSUES

The review team have identified omissions of optimal care and therefore opportunities where improvements could be made. These relate to a number of key issues

- Risk assessment
- Leave process
- AWOL procedure
- Family involvement
- Medication management

6.1 Risk assessment

Waikato DHB policy 5241 'The assessment and management of consumers / tangata whaiora at risk of harm to self or others' expired in November 2012 (the Policy).

In April 2015, the Clinical Director advised the review team leader that the service was aware that the Policy was out of date. The Policy was considered to be of critical importance to the service. The service had made a conscious decision to continue to work to this expired Policy. A new Policy had not been introduced because a regional approach to establishing a consistent risk assessment, management and documentation process was being developed and implemented. A proposed 'roll over' of the expired policy was made whilst service finalised minor changes prior to reissue and implementation. This has since been completed.

The purpose of the Policy was:

- to denote the philosophy and principles of risk assessment and management; and
- to provide guidance for the assessment and management of risk to self and others within the mental health service; and
- to describe the risk assessment and management process.

Core principles included:

- Partnership between mental health staff, service users and their family / whanau
- Identifying and building on the individual service users strengths
- Based on knowledge of research evidence, knowledge of individual service users and their family / whanau, cultural context and clinical judgement

The Policy identified static and dynamic risk factors with an 'acceptance that a service user's level of risk has the capacity to change over time and that each service user requires a consistent and individualised approach to their assessment and management planning'. The Policy also noted that in plan development, evidence of collaboration with the service user, the multidisciplinary team, their family / whanau and wider agencies was required.

Static risks are those that cannot be changed, and contribute to a person having life-long elevated risk of suicide (compared to someone without those risks). According to the consultant in charge of Nicky, his static risk factors included gender (men complete suicide more often that women), his age (suicide attempts increased in young adults and older adults), and the fact that he had attempted suicide in the past (leads to an increased risk of future attempts).

Dynamic risk factors are those that are changeable over time and are often the targets of psychiatrists (and team) interventions during someone's hospitalisation. For Nicky, these included: substance abuse (more likely to attempt suicide while intoxicated due to lack of inhibition), psychosis (paranoia may lead a person to pre-emptively kill themselves or auditory hallucinations of voices may tell someone to kill themselves), and access to means (limiting a person's access to weapons, items

used in hanging etc.).Other factors include more obvious factors like depressed mood and suicidal thoughts.

Strengths and protective factors are considered to help mitigate some of the risk posed by the static and dynamic factors. The consultant in charge of Nicky, considered that during his admission to HRBC, Nicky was taking regular antipsychotic medication (by injection), that he had family support and support from friends, that he had accommodation and that he was an intelligent person who had some degree of community functioning when he was mentally well.

According to the clinical record, Nicky's acute risk of suicide was deemed low by the treating team. Nicky consistently and adamantly denied self harm.

The clinical record frequently noted Nicky's behaviours and delusional ideation with visual hallucinations and talking about a spirit world. There were entries pertaining to his *'talking to aliens and spirits'*. There were also repeated entries that Nicky denied any suicidal ideation. He was deemed to be at moderate risk of AWOL on 24 February but by 27 February this was seen as low. On 2 March, RN3 noted '*there is a risk of AWOL based on how Nicky was presenting'* and *'was continuing to display poor insight at this time'*. On 5 March, SMO4 noted '*Nicky denied suicidal thoughts, intent or plan'.* There was a note from the family meeting on 6 March that Nicky *'felt that to commit suicide was a noble one'.*

According to the clinical record, the family believed that Nicky was at risk of self harm and had raised on a number of occasions that he had thought of drowning and had been down to the river. Specifically, Jane informed the evening nursing staff on 27 February that Nicky told her that he been to the river three days before, taken off his dressings and had intended to drown himself. There is a clinical note on 24 February that '*Nicky had removed his bandages and thrown them in the bushes'.*

A review of the walk to the river from the HRBC showed that there appeared to be no practical access to the river within 15 minutes' walk of the HRBC. The clinical record did not note that Nicky had been late back from unescorted leave in the period 20-24 February. However, Nicky had breached his leave on 25 *February 'as he had been drinking while saying good bye to a friend'*. The record does not identify how late Nicky was coming back from this leave.

All staff interviewed stated that they had no reason to believe that Nicky was at risk of harm. One noted that 'he was spending more time out of his room, he had a sense of humour, and he was behaving less bizarrely'. Another noted that 'he was improving, his psychosis had reduced significantly'. There had been a meeting on the morning of 9 March 2015 where it had been agreed that a key worker should be arranged and that discharge should be planned for 13 March 2015.

When interviewed by the review team, both Dave and Jane said that they had remained concerned for Nicky's safety, particularly after the reported incident at the river. They had been told by staff that Nicky's leave would be stopped on 26 February because he had returned late from leave and had been drinking, but within a day, Nicky had been granted four episodes of unescorted leave. To Dave and Jane, this showed a disregard of their concerns. They felt that their comments and concerns around Nicky's 'bizarre' behaviour and conversations were 'dumbed down' and so the message became diluted in the clinical record. Their perception was that Nicky was at higher risk than that noted by the health care professionals.

The review team noted the discrepancies in Nicky's behaviour as noted in the clinical record and staff accounts, with some changeability around Nicky's behaviour and thoughts throughout his admission; repeated denial of suicidal intent or self harm but also a lack of regret about his wrist cutting and curiosity about passing to the spiritual world.

Findings:

- The risk assessment undertaken by SMO4 was comprehensive and informed.
- The clinical team - doctors and nurses all agreed with Nicky's risk level as low.
- The Policy 5241 was out of date (but content remained valid).
- The family / whānau did not feel they were listened to regarding the risk and their concerns for Nicky's safety.

Review outcome: ***lessons can be learned***

Areas for improvement

- Families/whanau need to feel included in decision-making even if they do not agree with the outcome. The family should be respected for their expertise and experience in both caring for their family member and observing signals of impending deterioration. The review team suggests a change of procedure be considered whereby evaluation of escorted leave with family / whanau / friends is included in the leave policy so that valuable collateral information about the patients progress and risk status can be updated
- The assessment and management of consumers/tangata whaiora at risk of harm to self or others policy must be kept up to date

6.2 Leave Process

Procedure 2184 'Leave status and its application' was effective on March 2015 (the Procedure)

The Procedure outlined the process to be followed when identifying the leave status to be applied for service users / tangata whaiora in mental health inpatient wards and that all inpatients were to have a leave status applied throughout their admission.

The Procedure defined leave as a period of time away from the unit whilst remaining an inpatient under the MHA. The Procedure also noted that leave may be escorted or unescorted. Leave could only be granted for service users on a low risk level of observation and the leave may occur for a range of time periods from 15 minutes, but not to exceed 3 days.

The Procedure stated 'Leave from an inpatient unit is a planned intervention that recognises the therapeutic value for the service user of maintaining connections and links with the family/ whanau and community as part of the recovery process'

The Procedure provided that a service user's leave status be discussed and assigned by the admitting clinicians (inclusive of SMO/RMO) with consideration given to the mental status; risk of AWOL, and risk of harm to self / others. Leave status was to be clearly communicated to the service user and the whanau as applicable, with rationale for decision taken and a plan for review provided. The Procedure outlined that responsible clinicians decide on appropriate leave for the service user based on clinical risk and a continuous assessment process for level of risk associated with leave provision is completed.

The Procedure outlined that the process included

- Having a conversation with the service user covering the purpose of the leave, where they are intending to go and
- Stating the length of leave (and ensuring the service user has a means of identifying time)

The Procedure also stated that 'incidents of increased acuity of mental state, incidents of aggression, irritability, and harm to self or others should result in a discussion about suspending or changing leave entitlement.'

According to SMO4, the leave process enables the clinical team to observe how the clients manage themselves, their ability to show some organisation skills, to shop and interact. The leave process is seen as an important part of the rehabilitation process and a necessary step towards recovery and discharge.

According to the consultant psychiatrist on the review team it would be inconceivable in Australia and New Zealand that some form of inpatient leave was not available to assist in evaluating the service user's recovery progress and readiness for discharge.

According to RN3 and M1, the leave management plan was agreed by the Consultant and enacted by the rest of the team. A registered nurse could decide whether leave was taken at the point in time it was requested by the patient or they could cancel the leave if they felt there was a risk or any breaches in the plan. The registered nurse could not increase the amount of leave.

The leave process was usually undertaken by the psychiatric assistants at the direction of the registered nurse. It was the responsibility of the registered nurse to manage the service users leave during the shift and to check if the client had returned at the arranged time.

According to the psychiatric assistants interviewed, it was normal for unescorted leave to occur at 08:00 and 12:30 each day, after medication rounds. This made it easier to monitor activity. The psychiatric assistants were responsible for informing the registered nurse if they had any issues or concerns following leave, including concerns of non return.

The leave plan was communicated to staff in various ways including via:

- an entry in the multidisciplinary (MDT) ward note
- clinical progress notes
- morning MDT meetings
- discussions at family meetings.

There was also a 'patient status at a glance' board in the nurse's station, listing each patient's details and details pertaining to their leave status from the ward.(e.g. BUEL)

Staff interviewed, stated that as part of the ongoing risk assessment process, there was constant communication during the shifts between the psychiatric assistants, the registered nurses and the service users, following escorted leave and unescorted leave to highlight any issues, or changes.

According to the psychiatric assistants interviewed, escorted leave and unescorted leave were seen as 'smoke breaks' despite this not being the therapeutic purpose.

When interviewed by the review team, Nicky's parents also felt that the leave was seen as a smoking opportunity and did not feel that the real purpose of Nicky's leave had been fully outlined to them.

On the evening of 19 February 2015, Nicky's first day admission to HRBC, the registered nurse approved escorted leave with his mother to smoke. There was no record that this had been agreed by the admitting consultant.

During the weekend 21 and 22 February, Nicky went on escorted leave with both friends and family. The length of these leaves was not recorded in the plan apart from noting 'escorted short leave'.

On 25 February 2015 Nicky returned late from his leave '*as he had been drinking while saying good bye to a friend'*. Leave was removed for one day by the clinical nurse but 4 unescorted leaves were instigated the day after by SMO2.

On the weekend 28 February and 1 March, there were two leave plans in place. One from SMO2 allowing four unescorted leave and one from RMO3, who noted that the weekend plan was for escorted leave only. It is unclear why there was this discrepancy in planning or how staff knew which was the correct plan to follow. It appears the leave plan of SMO2, was followed by the staff with the parents believing the plan developed by the RMO3 was the current plan.

SMO4, who took over Nicky's care on 3 March, believed that there were benefits for Nicky to go on leave. *'He liked to go out for walks. He was an intellectual person, and didn't feel others on the ward were his intellectual equals so he felt quite isolated. He got joy and pleasure from being off the ward on his own and to have longer periods with his family'*. The consultant stated at interview that the information that Nicky's parents had provided about Nicky's symptoms and treatment had been considered and that Nicky's mental state was a key consideration in addition to Nicky's static and dynamic risk factors.

In consideration of all these factors and input from various sources, including the consultant's clinical assessment of Nicky's mental state and the team discussion about Nicky's mental state and risk factors, the consultant granted leave as documented. SMO4 chose to reduce Nicky's leave from the four brief unescorted leave given by his previous consultant, to two brief unescorted leave, to be more conservative and to ensure Nicky complied with the leave rules and expectations (with leave suspended if he did not). This was documented on 3 March 2015. There was one minor change to the plan, that leave should be spread across the day.

According to SMO4, the active leave plan for Nicky was based around the management / care plan that was agreed on 5 March. SMO4 stated at interview, there had been no change to this plan between 5 March and 9 March and felt the plans were clear due to a previous episode where the leave had been breached and alcohol was involved, that if there was any breach, leave was to be revoked. RN3 noted *'that there was a weekend plan written on 6 March that only referred to 2xBUEL 15 mins per day and leave with family not about revoking leave'*.

According to SMO4, on 8 and 9 March 2015, the plan was for two short unescorted leaves, one per shift (morning and afternoon shifts). Escorted leave could also be used. If there were any breaches in the plan, leave was to be revoked.

On 8 March 2015 Nicky returned 30 minutes late from his unescorted leave. He was assessed on return from leave by his assigned nurse but did not have his leave suspended. SMO4 was unaware that Nicky had breached his leave conditions. According to SMO4, if the breach had been reported, it would at the very least triggered a review on the 9 March 2015.

On 9 March 2015, at the MDT meeting, the clinical team did not review the clinical notes where the breach of leave had been noted by RN3. Nicky's assigned nurse was not at the MDT, due to workload, to mention that Nicky had breached his leave by 30 minutes the previous day.

On 9 March, Nicky had one of his unescorted leaves and two escorted leaves with PA1 before 10:00am. Nicky returned from escorted leave at 10:40 and then asked for a further unescorted leave but was denied it by his assigned nurse.

Despite having the leave denied, Nicky went out at 11:00 for 8 minutes (confirmed by CCTV) without approval. At interview no staff member seemed to know how Nicky left the ward and the door security log is unhelpful.

There is a discrepancy between PA2 and RN3 with regard to approval of the unescorted leave that Nicky had at 12:30 the same day.

It was noted by the review team that there was no process of sign in / sign out by service users who were going or returning from leave. The service users did not routinely carry mobile phones. There was no client pass that might electronically trigger an alert when a service user was late back from leave. The system did not have a 'fail safe' design.

The parents noted when the review team met them in August and September 2016 that they both felt that Nicky was at risk when on leave. They also mentioned that they felt they were informed of the leave plans, rather than being part of the decision making discussions.

When the review team interviewed Dave and Jane on 25 October 2016, Jane said she 'felt that the leave was not helping Nicky and that if anything it was making Nicky worse'. Whilst both parents agreed that there had been a discussion about leave at the family meeting on 6 March 2015, and they understood the need for leave as a process to get Nicky back home, there appeared to be a misunderstanding with regard to what was agreed at the meeting and what had been documented. Dave felt that if discharge was the goal then increasing leave gradually would be part of planning towards that. Both parents disagreed with the way this had been interpreted as 'father wanting to increase leave and mother not wanting leave'.

The whanau had been reassured on a number of occasions that Nicky would have his leave stopped if he breached any conditions, or that leave had been stopped as was the case on the weekend of 28 February when they were informed that Nicky had escorted leave only as per weekend plan.

Findings:

- Procedure 2184 'Leave status and its application' was up to date and clear about documenting the rationale and purpose for leave.
- Changes to Nicky's leave status were made when the family raised their concerns
- The rationale for the decision and the plan for review of Nicky's leave was not documented in accordance with the Procedure, however the review team acknowledges that this may have occurred verbally
- There was limited documentation of a discussion with Nicky regarding the purpose of the leave, where he was intending to go, how he proposed using it, however the review team acknowledges that this may have occurred verbally
- There was a lack of clarity in the plans regarding what brief / short escorted meant and the escorted leave with staff with regard length and number
- Some staff considered leave as a smoke break and this has resulted in inconsistency in understanding and application of the procedure
- Whilst there was the leave plan, the white board, and hourly checks, it was not clear how these supported the team to monitor service users returning from leave.
- Nursing staff did not appear to receive a report from Nicky's friends or family about how each episode of escorted leave went and whether they had any concerns from their time with him *(noting that were this to be policy, it would raise the issue of potential conflict for family and friends damaging the trust between them and the patient).*
- The 'weekend plan' written by an RMO on the evening of 27 February, was different to the one agreed that same morning by the consultant in charge with no reason noted for the change
    - Morning plan = 4 brief unescorted leaves, hourly observations

    - Later afternoon plan = only escorted short leave and 10 minute observations
- Nicky had breached his leave plan on 3 previous occasions during this episode of care
    - 25 February, late and had been drinking. Leave suspended the following day
    - 8 March, returned 30 minutes late. Leave not suspended
    - 9 March, unapproved leave for 10 minutes. No action taken
- Staff did not enact the leave plan or follow the leave procedure in the following instances:
    - On the day of admission, 19 February, escorted leave for a cigarette was granted by an RN, without an identified plan by the consultant in charge.
    - On Sunday 8 March, Nicky returned 30 minutes late from his unescorted leave and leave was not suspended. It was noted in his clinical record. It was not noted at the MDT the following day and SMO unaware
    - On 9 March, Nicky went on unescorted leave at 11:00 and returned at 11:08, although no documentation of who agreed and who let him leave
    - On 9 March, the second unescorted leave was used in the same shift
- There is a discrepancy in views by some staff over what the actual leave plan for Nicky was on 8 March 2015.
- There appears to be a fundamental disagreement between health care professionals and family about Nicky having unescorted leave.

Outcome of review: System of care issue

- Not all staff followed the individual management plan or the Leave Procedure
- The Leave Procedure is unclear in some areas

<u>Areas for improvement</u>

- The Leave Procedure should be revised to clarify:
    - where the leave plan should be recorded to ensure the most up to date leave plan is known by all and followed
    - what constitutes 'brief' leave,
    - the need for evaluation of escorted leave by discussing the leave with those who escort clients (staff, whanau, friends) as appropriate
    - having a safe and private mechanism for family and friends to feedback both concerns and encouraging facts
- Staff need to document the purpose of any leave given and be clear that it is for therapeutic purposes and not as an opportunity to smoke
- A more robust process for noting leave start and end times and a clear trigger when clients are late returning.

6.3 Absent without Official Leave (AWOL) process

The term AWOL applies when a service user under compulsory processes absents themselves without authorisation from the ward or from a specified community placement. This includes when the service user leaves an escort or does not return from a period of specified leave.

In March 2015, there was a 'Missing from the Ward' procedure 3555 on the DHB policy / guideline intranet site (the Procedure). It was approved in November 2010 and expired on November 2013.

There was also a ward guideline in place titled 'missing from the ward'. Both the procedure and guideline were the same. The ward guideline document was not held on the DHB guideline intranet site and was undated.

The guideline outlined the steps to be taken by HRBC ward 34/35/36 staff when a service user was missing from the ward and /or under escort. The document outlined that the registered nurse caring for the service user was to initiate a thorough search of the ward and HRBC surroundings, to confirm AWOL and to inform the Charge Nurse Manager of the level of observation and level of risk and noted that this must be done in a timely manner.

On 9 March 2015, Nicky was perceived (and documented in the clinical record) to be low risk. The Procedure stated 'should a client AWOL who is perceived as a low risk and is under the Mental Health Act (MHA) the AWOL procedure is completed within one hour of the service user/tangata whaiora absence from the ward'.

The AWOL procedure was:-

- A NZ Police Missing Person's Report completed and faxed to Hamilton Central Police Station Watch House and CATT service. Follow up with a phone call to the Police and CATT to ensure they have received the documentation
- Inform relatives/support people
- Email clinical services director, operations manager, Clinical Director, Charge Nurse Manager and Clinical Nurse Specialist
- Contact key worker and follow up with email
- Incident notification form to be completed
- All actions must be clearly documented on the clinical results viewer (CRV)
- Risk assessment form updated
- Each shift needs to follow up on the AWOL process until the service user is located

RN3 noted at interview that as Nicky was assessed as low risk, there was an hour to complete the AWOL process and was aware of the actions needed. RN3 was aware that the action taken depended on the level of risk identified in the clinical record by the Consultant and reviewing team, as well as the staff on the shift when the absence was noted as there would be dynamic risks present.

Nicky was due back at 12:45, having commenced a known unescorted leave at 12:30. The 13:00 check had not been undertaken. There was no reason identified, although the ward was very busy, staffing levels were slightly below the agreed staffing level due to sickness and leave and one PA was off the ward with a service user having an investigation.

Nicky was noticed to be missing about 13:20 when staff noticed he was not on the ward and when the observation check was completed by PA1 who noted Nicky was not present.

There was, therefore, a delay of 35 minutes before the staff noted that Nicky was not on the ward and had not returned from his unescorted leave. He was classified AWOL and a search of surrounding areas was commenced.

The health care professionals undertook a search of Nicky's room, all other service users' rooms, bathrooms / toilets, courtyards and the perimeter of the HRBC. This included the wall where most service users go to smoke and the road (Selwyn street) leading to the dairy. The gully to the creek is outside the DHB boundary and as such was not checked as part of this perimeter check.

The clinical record identified that by 13:30, there had been a search started and M1 had been informed that Nicky had not returned from his unescorted leave.

Once this initial search had been completed the formal AWOL process was commenced i.e. informing the Police and other relevant staff.

SMO4 and RMO1 when informed of AWOL at 13:30, had 'no immediate concerns for his safety'

At 14:35 (2.35pm) RN3 had filled out a missing person's form and thought it had been faxed to the police.

RN3 phoned the Police, confirmed that a fax had been sent and relayed the information from the missing persons form. The missing person's report was incomplete although RN3 stated at interview that the relevant details were relayed to the Police and this was confirmed by the Police investigation.

The phone transcript by RN3 to the Police stated there was a suicide risk and that Nicky had mentioned the river. The conversation was disjointed and did not appear to be very structured although all relevant detail was conveyed. The content of the phone call was driven by the Police not by HRBC staff

The agreed DHB communication tool, SBARR was not used in the phone call (***S****ituation: What is happening? (Reason for call)* ***B****ackground: What is the relevant history?* ***A****ssessment: What are the issues?* ***R****ecommendation: What is the plan?* ***R****esponse: What is needed, by whom, by when?)*

Nicky was noted as low risk by all the staff interviewed. There was another patient also AWOL at the same time, who frequently went AWOL. The review team considers this may have distracted the team.

At the time of Nicky's AWOL, the DHB security staff had no involvement in the adult inpatient areas in HRBC so Waikato DHB security team were not informed of Nicky's failure to return from leave until 4:00pm when M1 contacted them to ask for a search of the gully to be undertaken at the request of SMO4 (noting the parents reports about the river).

The CCTV footage was not viewed to see which direction Nicky may have headed when he left HRBC. According to the footage viewed by the review team, Nicky remained on site until 13:04 (it was noted by the review team, that the CCTV footage times are not accurate and do not align with the door security logs)

According to staff interviewed, their role was to check the immediate surroundings for the service user, whilst continuing to look after the remaining service users. The usual search process was to look for the service user only, not to search rooms for belongings or check CCTV footage etc.

When the review team met Dave and Jane, they both felt there was a long delay to act on Nicky not returning to the ward. On the afternoon 11 March, two days after Nicky's AWOL, Nicky's brother Tony, went to the HRBC to search Nicky's belongings. Nicky's wallet and eftpos card were found in a property bag.

Staff did not appear to have documented in the clinical record or reported to anyone that they had packed a wallet / eftpos card of Nicky's when they packed / cleared his room.

Findings:

- An immediate search of 'surrounding areas' was undertaken once Nicky was noticed to be missing

- The AWOL process was commenced within the 'one hour' time frame although not quite completed within the one hour identified in the missing person's guideline.
- The Police were notified by phone at 2:35pm. This timeline was reasonable in light of Nicky's documented 'low risk'.
- In response to the interim review report (April 2015), the MH&A service responded that an updated AWOL procedure document had been approved by the Mental Health Clinical Governance Forum in January 2015 and was pending upload to the controlled document centre.
- Nicky had gone on unapproved leave earlier in the shift at 11:00 but had returned 8 minutes later. This would no longer be possible as the ward is now a 'closed ward' and has a double 'air lock' type locking system in place.
- Nicky was noticed missing at 13:20, 35 minutes after he should have returned from leave.
- If the 13:00 observation / check round had been completed, Nicky's absence may have been picked up 20 minutes earlier.
- The missing person's report was incomplete in detail and the fax 'clipped' some information off
- It is unclear if the fax did or did not get sent at 2:30pm as thought by the registered nurse. It was successfully sent at 01:08, twelve hours later by a nurse on the night shift. Fax seems an outdated form of communication and it is noted by the review team that Police notification process has since been changed to a designated email address.
- There is a lack of clarity in the Procedure regarding time to contact Police - 'notify in a timely manner' has various interpretations
- There appears to be no agreed process in response to an AWOL with regard to searching and coordination of effort
    - Search checklist including an identified grid search
    - Checks of CCTV footage to see 'where last seen and in what direction travelling' were not undertaken
    - Checks of clients belongings to check for wallet, shoes, phone etc. not undertaken
    - A central coordinator of the AWOL process

Review outcome: ***lessons can be learned***

The AWOL process in place at March 2015 was not clear and missed important search elements, although the review team noted that there had been a number of improvements to the Procedure over the last 17 months

<u>Areas for improvement</u>

- Involvement of Waikato DHB security team when a patient is AWOL from HRBC so they can initiate a facility and perimeter grid search
- The AWOL Procedure should be reviewed to ensure gaps are addressed:
    - clearly defining time frames to call Police
    - when CCTV should be viewed
    - when client property should be checked,
    - instigating a structured search grid,
    - identifying whether clients have mobile phones with them and if so that staff have the number etc.
- The use of SBARR should be used in all communications with Police and staff during an AWOL
- Consider the use of simulation exercises of the AWOL process

6.4 Communication and family involvement

6.4.1 Informing family of admission to emergency department

Nicky was under the MHA and his CTO was changed to inpatient 29(3)(a) on transfer from the plastic surgery service to the mental health service.

Section 7a(4), of the Mental Health MHA, is clear that a responsible clinician must consult with the service user before consulting with the service user's family and whānau. The service user may not want their family or whānau to be consulted but the responsible clinician can still consult with the family or whānau if they believe this would be in the service user's best interests.

Nicky's parents told the review team that they were under the impression that with Nicky being under the MHA they would be told about all of his treatment. They also told the review team that Nicky had signed an agreement in 2009 with Hauora Waikato stating that the parents could overturn decisions when Nicky was unwell and that this agreement was in place when Nicky was admitted to the emergency department.

The whanau consent form dated 23 October 2009 outlined that Nicky authorised himself and his whānau to receive clinical oversight and care from Ngaa Ringa Awhina and understood that they (Hauora) could obtain relevant information from friends, whānau, counsellors, medical practitioners etc. This information enabled Hauora to appropriately assess, co-ordinate or provide care and support on Nicky's behalf.

The consent allowed for release of any formal reports to other medical agencies and that the consent to obtain or release information could be withdrawn by Nicky. The consent form did not mention that it allowed for whanau to overturn decisions made by Nicky.

When Nicky presented at the emergency department on 17 February 2015 with cut wrists and resulting tendon damage, he requested for his parents not to be informed. The fact that he was under a CTO under the MHA was solely in relation to the assessment and treatment of his mental illness and did not presume he was necessarily incompetent to make decisions in other areas of his life. Nicky provided consent to the treatment of his injury and there were no legal grounds for the clinicians to go against Nicky's express wish not to inform his parents during his time in ED.

SMO1 who reviewed him on the morning of the 18 February, twelve hours after he presented at the emergency department was also his Consultant Psychiatrist at Hauora Waikato so knew Nicky well. SMO1 noted that Nicky was very reluctant for contact to be made with his parents. After exploring this with him, he agreed to contact them himself. SMO1 emphasised with him, that if he did not contact his parents in 24 hours, SMO1 would. This negotiation occurred in the context of a supervised hospital environment, including high risk observations with a special watch, containing any immediate risk of harm to Nicky.

As Nicky was under a CTO, there was a legal obligation to contact the family if the responsible clinician decided that it was necessary to reassess him under sections 13 and 14 of MHA, or treat him as an inpatient. (sections 29(3) and 29(6) of the MHA) . This was done by the SMO1 once the decision to admit Nicky to HRBC was made.

6.4.2. Family involvement in decision making

New Zealand and international guidelines for involving and working with families in mental health care strongly encourage integrating family support, education and

meaningful involvement into the ongoing care of people with mental illness[1]. Families invariably wish to maintain a sense of connection with their family member and they can offer insight into decision-making that long experience, observation and knowledge has developed. In the MOH guidelines this is explained as "whanaugatanga, the interconnectedness and interdependence of all members of the whanau".

The Policy 0896 'Family/Whānau Participation', stated that 'family whanau rights, interest and wellbeing is supported by MH & A Service while their loved ones are receiving treatment in MH & A Service that they will engage in active collaborative partnership with family/whanau at all levels to facilitate and promote a readiness within MH&AS to engage with family/whanau as part of routine practice.'

The Policy stated that the 'service values and acknowledges the experiences and knowledge of families/whanau who live with or support loved ones with a mental health and addiction illness. The service endeavours to embrace specific cultural, emotional, physical, social, spiritual experiences and needs of each family/whānau and to develop and maintain a positive, respectful and professional relationship based on open and honest communication.'

During meetings that the review team had with Nicky's whanau, both parents felt that they had not always had their cultural needs recognised or respected. For example, Nicky's ethnicity had been recorded on the patient management system as NZ European when Nicky identified as Māori. This was supported by his request for a Māori cultural advisor. The service ensured Kaitakawaenga support was provided.

The family told the review team that they did not feel that their concerns about Nicky's leave or risk were heard. An example of this perceived dilution is the message about Nicky's bizarre behaviour when on a walk with his mother at the lake. The clinical record noted that 'behaviour 'fighting motions' as if fighting demons, minimally verbal communication' but Jane did not feel this adequately reflected her level of concern. SMO4 had noted that Jane had raised this behaviour during a phone conversation on 5 March 2015.

A further example in the clinical note stated *'Escorted leave with family for his father's birthday. On return, Nicky said: it went really well, am beginning to be organised*', which is at odds with the parents who informed the review team at the end of October 2016, that Nicky ate very little dinner that night and tried to give his food away to other restaurant patrons. Nicky had told Jane that he needed to purify himself and that he had a number of super powers and that people believed he was God.

The clinical record frequently noted the parents' concerns and the service / health care professionals felt there were regular occasions when they engaged with the family. SMO4 had made regular contact after taking over the care on 3 March 2015.

The whanau felt that while they had meetings and discussions with staff members, including the psychiatrists, they did most of the initiating of discussions and did not feel they were listened to. They told the review team at an update meeting in September that they "could not keep their son safe".

The family meeting held on 6 March, was felt to be one of the saddest that the SMO4 had attended. SMO4 stated at interview that Nicky was dismissive of his family and friends – he exhibited little insight or empathy. Every one at the meeting tried to convey how concerned they were for him, and tried to make him understand but he didn't seem to care. His parents stated that the healthcare professionals just *'got up and left the meeting'*.

[1] Involving Families Guidance Notes, 2000, Ministry Of Health, NZ

The review team noted it is often a difficult balance between what might be best practice in terms of including family and other supports, and what the service user is willing to share or agree to communicate. Interwoven in this is the real need for the whanau to maintain a relationship with Nicky.

In voicing concerns and making recommendations they were acting as both their own and their son's advocate, all the while knowing that they could be alienating Nicky by "interfering in his life". This was a very painful and upsetting position to be in. It was accentuated by having time with Nicky being dominated by his need to smoke.

Findings:

- The Policy 0896 'Family/Whānau Participation' was up to date and based on best evidence
- Initially, Nicky did not want his family involved and the clinical team upheld his decision, feeling he was capable of making that decision. If the clinician decides that consulting with the family is not in the best interests of the family/ whānau member, the reasons for the decision need to be documented clearly. This was done.
- The Hauora whanau consent form does not appear to allow for whānau (Jane or Dave) to overturn decisions made by Nicky.
- There appears to be evidence of poor communication of the parents' concerns through the clinical staff on the ward to the treating team.
- The documented outcomes from family meetings did not appear to accurately reflect the discussions and agreements (and disagreements) with the family.
- There appears to be a difference of opinion between the parents and the health care professionals about Nicky's leave - there did not appear to be agreement about Nicky's level of risk or that the recommendations of staff for leave were logical and understandable to both parents.

Review outcome: ***lessons can be learned***

Areas for improvement

- Consideration should be given to developing guidance for how to deal with differences of opinion (and resolve if possible), for these discussions / actions and the agreed outcomes to be clearly documented in the clinical record.
- Promote the principles outlined in the 'DHB family / whanau participation policy', particularly around collaborative partnership during orientation and ongoing training

6.5 Medication management

Long-acting injectable (LAI) forms of antipsychotics such as Olanzapine, allow for rapid identification of non-adherence, obviate the need for the patient to take the medication on a daily basis and increase adherence to some significant degree.

When injected into the muscle, the salt slowly dissolves and dissociates into separate molecules of olanzapine and pamoic acid at the site of injection; both these components enter into systemic circulation. The rate of dissolution of the crystalline salt is slow and regular; resulting in the absorption of olanzapine over a period of 4 weeks. Olanzapine concentrations are observed immediately upon injection. The half-life of olanzapine pamoate is 30 days (vs oral olanzapine 33 hours). As each injection builds on the drug still being released from previous injections, concentrations increase gradually until a steady state is reached after ~3 months.

Nicky was on olanzapine long-acting injections every 2 weeks. He had become non compliant with this regime in the months leading up to his admission to the HRBC ranging from delays of between 2 and 41 days. His last LAI prior to admission had been 3 February 2015 (and was next due 17 February 2015)

Following admission to HRBC, Nicky had received his LAI on 20 February 2015 and 6 March 2015. He was also charted Olanzapine orally / by injection to a maximum dose of 15mg in 24 hours for agitation.

There is some evidence that high levels of smoking can impact on the therapeutic levels of olanzapine. **http://www.medscape.com/viewarticle/562754_4.**

Olanzapine, a widely used atypical antipsychotic, is extensively metabolized by direct *N*-glucuronidation, with CYP1A2 and CYP2D6 being minor metabolic pathways. Smokers have been found to have an approximate fivefold lower dose-corrected steady-state plasma olanzapine concentration compared with non-smokers.

Another study found the dose-corrected plasma concentrations of olanzapine to be 12% lower in patients who smoke. Olanzapine's clearance is increased by 98% in smokers.

There had been some discussion and thought given to changing Nicky's medication regime. Initially when he had presented in ED due to his non-compliance in the months previous and again when he changed consultants.

His new consultant considered making a change from olanzapine to clozapine and discussed this with Nicky's mother. Jane felt that he was unlikely to comply with the blood tests that are mandatory for any person taking clozapine and that his best chance for successful treatment was to stay on the long-acting injection. Based on that feedback, SMO4 did not make a change to Nicky's medication.

Both parents commented on Nicky's increased smoking. It was noted in the clinical record that Nicky said he smoked because there was nothing else to do.

Findings:

- Nicky received his LAI as prescribed when he was in HRBC.
- The HRBC staff had encouraged Nicky to use Nicotine Replacement Therapy (NRT).
- Nicky had increased his level of smoking since admission into HRBC, despite the use of NRT.
- Nicky had been non compliant with his LAI in the months leading up to his admission.

Outcome of review: System of care issue

- Non-compliance with LAI regime with delays ranging from 2-41 days in the months leading up to Nicky's admission to HRBC

7. CHANGES IMPLEMENTED IN THE LAST SEVENTEEN MONTHS

7.1 HRBC Improvement Plan (March 2015)

A plan was developed in March 2015, by the senior team in the Mental Health and Addictions Service that brought together work already underway, in addition to improvements identified as result of the following key events and issues:

- Recommendations from significant Coronial and Health and Disability Commission findings in relation to environmental and practice changes.
- Environmental constraints related to the existing facilities with HRBC to manage service users requiring inpatient acute care and rehabilitation.

- An internal review of the care of a service user who on 9 March 2015 did not return from short term leave and was subsequently found deceased.

The plan has been approved by the Mental Health Governance Forum and progress is monitored through this forum. There are two areas of relevance to this review :

Service user leave:
After Nicky's death, a review of the leave process was undertaken. This covered who could approve leave, documentation of individual management of leave processes, discussion of all decisions to grant leave at multidisciplinary team meetings (MDT) and sign off by the Consultant in charge (with Clinical Director overview / signature)

Model of ward placement:
A decision was made to move from an inpatient model based on sectorisation to one based on risk, acuity, intensity of care and security. While the model based on geography and sector integration is an ideal model of care, there are inherent tensions and risks managing a heterogeneous population in ward environments that were both open. An approach based on stepped care was developed and implemented:

- Ward 35 – locked ward (air locked and has a fenced courtyard)
- Ward 34 – open ward

7.2 AWOL process

A revised AWOL procedure has been put in place (dated May 2015) which identifies the category of risk the patient presents with and the subsequent action to be taken. Further changes have been made during 2016 to instigate a 'code red' approach. It has been agreed with the DHB security team and the Police service and contains a missing person checklist. As of September 2016, this is being implemented across the service. Other changes include:

- Ward / unit staff are responsible for knowing the whereabouts of service users / tangata whaiora they are responsible for at all times.
- Informing Police of AWOL - Most up to date procedure which clearly states that in addition to a phone call Police notification and handover, the documentation is reliably and securely sent by scanning and emailing.
- Service wide procedure for AWOL response; inclusion of response based on risk category for Mental Health and Addictions Service and Police.
- Update to checklist and requirement to upload to clinical workstation (CWS).
- Inclusion of information that security is only involved for on hospital campus incidents.
- 'Code red' activates the central security team and Police are made aware of the areas that security staff have checked - a structured grid search approach is being developed internally and externally for HRBC and should be in place before the end of 2016.

The review team notes that the prevalence of unauthorised leave has reduced markedly in the last 15 months.

AWOL incidents are reported through the electronic risk management system and reported at the Mental Health Governance Forum. There is now a staff debrief following any AWOL incident so that ongoing improvement in the process can be identified and implemented.

7.3 Environment

A number of changes to the environment have been put in place.

- Access to ward 35 is via an air lock. This minimises the risk of patients leaving the facility behind another person without their knowledge.
- New fenced courtyard in ward 35
- Adult wards reclassified
- Increased security presence with security staff at main entrance to HRBC from 07:00 to 19:00. This role is for signing in / out visitors such as attendants, nutrition and laundry staff and client visitors (family and friends) to reduce unnoticed movement into the wards.

7.4 Police notification process

Faxing has ceased. All missing person reports are now securely scanned and emailed to the Police

7.5 Audit process

There are increased audit cycles with regard to compliance with high risk policies such as leave, levels of observation. The results are reviewed and discussed at the mental health clinical governance forum.

For AWOL, the initial results in late October 2015, showed 57% compliance with 'the whereabouts of service users is easily identifiable on the patient at a glance board' and neither of the 2 patients who had gone AWOL in the audit sample had evidence of a debrief within an hour of return in the clinical work station and the service user management plan had not been updated.

A re-audit of the AWOL procedure was undertaken in mid April 2016. Risk assessment and debrief following AWOL needed to be improved with only 2 of 6 patients having had this completed. Documentation rather than a failure in practice is apparent in some findings e.g. whilst 5 patients did not have their risk identified in the clinical work station, it was identified in the email to the operations manager.

The AWOL and Absences Causing Concern Procedure has been recently updated and the most recent audits since the update of the procedure have demonstrated full compliance with the procedure.

7.6 Bereavement support

New funding has been made available for counselling for families of those bereaved by suicide. This is in addition to funding already in place in primary care through general practice. An information leaflet outlining how this fund can be accessed has been developed and distributed to general practitioners and funeral directors.

There have been two WAVES training events facilitated by Waikato DHB suicide pre and postvention advisory group to assist in the development of community based self-help groups. The advisory group has also commissioned a project looking at existing self-help groups and support available for grieving families and friends, as well as investigating the development of a consumer reference group to assist the DHB with the prevention of suicide. This project is due to be completed by the end of October 2016.

8. RECOMMENDATIONS

- Strengthening of the leave procedure and practice in a number of areas but particularly in relation to evaluating escorted leave with family, whanau and friends and incorporating the information from these evaluations in leave and treatment planning.
- The AWOL procedure to include a clear search process and regular simulation exercises for staff.

- The notification to Police in relation to a patient who is AWOL to include a telephone notification and handover using the SBAAR framework and documentation being securely and reliably transmitted to police by scanned document sent by email.
- The process for family consultations must ensure that there is an agreed summary of the outcomes of the meeting that is documented in the medical record. This should include listing points of difference and how these can be resolved or worked on towards deeper understanding and resolution.
- During orientation and ongoing training, promote the principles outlined in the 'DHB family / whanau participation policy', particularly around collaborative partnership.

9. FOR CONSIDERATION

- Encourage service users to develop Advance Care Plans – to ensure agreed approach to family involvement when well, so when a crisis occurs, everyone is clear about desired treatment and involvement. Ensure this is in an electronic record to be shared among all providers.
- Request the governing group for suicide pre and postvention keep the mental health governance forum up to date on improvements with bereavement support post suicide for the Waikato DHB area.
- Waikato DHB should strengthen their collaboration and quality and patient safety monitoring of their contracted providers and primary care.

10. CONCLUSION

The death of Nicky Stevens is a terrible tragedy, most poignantly for his family but also for staff that knew him and were caring for him. He was clearly unwell with a relapsing mental illness associated with periods of acute psychosis. As with many who suffer from such conditions he appears to have found it difficult to accept that he was unwell and needed the help of medication to recover and remain well. This type of illness is often associated with feelings of stigma and failure, a desire to try to assert one's right to autonomy and self-determination.

It seems possible that Nicky's insistence that he was not suicidal and was not experiencing his psychotic symptoms may have been due to a genuine wish to be out of hospital and living his own life again. It also seems possible that his increased smoking in his final days could have been both a symptom of deterioration in his mental state and a factor contributing to that deterioration. It is frequently the case that a person in the early stages of recovering from an acute psychosis is susceptible to very significant changes in their mental state which are not predictable despite the most thorough risk evaluation.

The opinion of the review team is that the individuals involved in the care and treatment of Nicky between February 2015 and March 2015 did not intentionally take action or omit to take actions which would be to the detriment of Nicky's welfare. There were a number of areas of good practice including well written policies and procedures based on best evidence and staff who were committed to supporting Nicky in his recovery

There were a number of events in the months and days leading up to his death that if altered, may have changed the outcome for Nicky and his family. The review team concluded that these events did not constitute serious failings by the individuals

involved, and that even if different actions had been taken, it cannot be known whether the final outcome would have been altered.

The review team hopes that the recommendations outlined will reduce the likelihood of a similar event occurring in the future.

The investigations undertaken by both Hauora Waikato and the Independent Police Conduct Authority and resulting outcomes and recommendations should be read alongside this review to allow a fuller system view.

APPENDICES

1. Views from Nicky Stevens family – *extract from a document used as a basis for conversation at the family meeting 14 April 2015*

2. Full chronology of events

Views from Nicky Stevens family – *extract from a document used as a basis for conversation at the family meeting 14 April 2015*

5. In terms of the issues to be considered by the review team, the family wants included:

5.1 The actions, or lack thereof, of Hauora Waikato in the treatment and care of Nicky

5.1.1 Including specifically the actual medication programme followed (as opposed to the one planned)
5.1.2 Decisions by Hauora Waikato on the removal / replacement of staff responsible for Nicky
5.1.3 The 2015 claim by Hauora Waikato staff that the family was not to be involved in Nicky's treatment, and any proof of this, including the 2009 document approving Nicky's treatment by Hauora Waikato

5.2 The decision by Waikato emergency department, and by the Henry Bennet Centre not to inform the family of Nicky's admission to the hospital on the 17 February 2015 after a suicide attempt

5.3 Decisions by 'psychiatrists' to include 'unescorted leave' for Nicky from the HBC as part of his 'treatment plan'

5.3.1 Including any consultation they claim to have had with family on this aspect of the plan
5.3.2 Including the purpose of the 'unescorted leave'
5.3.3 Including any instructions or policy on how this leave was to be administered, such as timing, length, authority to grant

5.4 Specific details on the chain of delegated authority within Waikato DHB for the granting of the 'unescorted leave'

5.7 Formal and informal policies of the HBC relating to

5.7.1 Family involvement in the care and treatment of patients
5.7.2 Leave for patients
5.7.3 Monitoring of the use and effectiveness of these policies

5.8 Policies, protocols and instructions relating to

5.8.1 the disappearance of patients
5.8.2 the reporting as Missing Persons to Police of disappeared patients
5.8.3 the searching for patients who have disappeared from the HBC facility

Full chronology of events

Appendix 2

Developed from the clinical record, and other supporting information and documents outlined within the main report

Tuesday 17 February 2015

Nicky was due contact and olanzapine 210mg LAI today from the Hauora Waikato community treating team but he did not receive this.

Nicky presented to the emergency department (ED) at 21:45 and was triaged 3 (national definition - due to potential adverse outcomes from delay greater than 30 minutes). He was pale but alert; walking up and down and smoking outside the department (Haemoglobin 145, BP 110/61, pulse 65 – all within normal limits). He had multiple cuts to his forearms - left slightly worse than his right. There was no significant blood loss. He denied suicide, did not want to die, wanted to harm himself and feel pain. It was noted that he seemed in control of faculties and own health decisions.

Wednesday 18 February 2015

Nicky required surgery to repair tendon and nerve damage and was referred to the plastic surgery team about 03:00. He was put on watch assessment for intentional harm and referred to the consultant liaison psychiatry service.

He refused to talk about any of the circumstances surrounding his admission, except to say that he cut himself to feel other people's pain. He said that in understanding the pain of others, he would understand people better. Nicky denied suicide intent or ongoing self harm but there were features of worsening psychotic symptoms such as delusions of spiritual nature, visual and auditory hallucinations.

When asked, Nicky stated he did not want his family to know about his admission to hospital. He was found competent to make decisions (about contact with family) by both ED and psychiatric staff. SMO 1 was also Nicky's consultant at Hauora Waikato and had been since March 2014. Limits of confidentiality were explained to Nicky. In discussion with the SMO1, he agreed to inform his parents himself. The assessing clinician "*did not think it was in his best interest for us to inform his parents without his consent today with the risk of losing his engagement with us and in the absence of any immediate risks".* SMO1 gave Nicky 24 hours to inform his parents and noted if he did not contact them, SMO1 would.

Nicky was admitted to the plastics team and underwent a 2 hour surgery for bilateral wrist/ forearm laceration and exploration and repair. He was transferred to ward M7 (plastics) where a comprehensive mental health assessment was completed.

Thursday 19 February 2015

The community treatment order was changed to inpatient and Nicky was admitted to the HRBC under Section 29(3)(a) due to his ambivalence about receiving inpatient care. His care was transferred to SMO2. The impression was that Nicky had had a relapse of psychosis, probable diagnosis schizophrenia, with an increased risk to self but immediate risk low.

Nicky denied any outside influence on his choice to harm himself. He stated that he did not want to cut himself again as he did not like the pain it caused and worried about the function of his hands – especially the effects it could have on him playing his guitar. He denied any suicidal intent or plans. He wanted to live until he was old and die naturally. It was noted that there was lack of clarity about the factors that

contributed to his recent self-harm attempt and consequently the need to monitor risks of Nicky at the time of admission.

Some time after 10:00am, the SMO1 attempted to contact both his parents by phone without success. SMO1 left messages for them both and requested ward staff to please contact the parents. SMO1 also relayed the management plan to RN1 at Hauora Waikato.

Around 2:30pm, Nicky's mother, Jane contacted SMO1. Jane noted that she was concerned about her son's mental state recently as he had talked about hanging out with a friend "Ethan", which might have been a hallucination. He had also been planning to relocate to Auckland to live with his brother over the weekend. Jane was concerned about him leaving hospital against medical advice but felt reassured that Nicky had been admitted as a formal patient.

Following admission to the ward, Nicky was placed on 10 minute observations; emphasis was placed on building and maintaining a therapeutic relationship.

RN2, on the evening shift noted that Nicky was outside in a courtyard and smoking with a friend in the bushes (the friend was asked to leave). Nicky's mother later visited, brought him some snacks and cigarettes. She wanted to know when he would be reviewed by a consultant psychiatrist. She also asked if she could take Nicky out for a cigarette. The RN2 allowed Nicky one escorted leave (with his mother). He returned uneventfully.

<u>Friday 20 February 2015</u>
At clinical ward round with SMO2, Nicky stated that he wanted to live and grow old. He denied being directed by voices and claimed that, after cutting his forearms, he spoke to a friend and asked for medications as he didn't want to come to hospital. He denied feeling depressed and denied auditory hallucinations. He was reluctant to discuss the self-harm incident but said no regrets about the attempt. He described not wanting to self-harm again as he had "already done it".

Nicky was not keen for family to be involved, but happy for friends to be involved. Kaitakawaenga support arranged at Nicky's request and family facilitator service requested.

Decisions were made to increase his olanzapine, for a family meeting to be arranged for the following Wednesday and for Nicky to have short escorted leaves and to remain on 10 minute observations.

Mid-afternoon, staff record that Nicky appeared to be experiencing some delusional/perceptual content regarding spirituality – he reports spending time talking to spirits, dead people, aliens and that the aliens could see through his eyes. He received subliminal messages from TV programs but "did not want to tell doctors as they may think I'm crazy. He denied any suicidal ideation. He was making his needs known when approached by staff but had minimal interaction with other patients.

Nicky had been using escorted leave without concern and was seen in the courtyard throughout the afternoon. Ten minute observations were stopped at 14:00 and extended to hourly observations as per RMO1, noting 'stable behaviour shown'.

During the evening, his LAI olanzapine was given (3 days late, and same dose as pre admission. The reason for delay was not documented). It was reported that he was jovial and dancing and skipping around the ward, listening to music. His mood was

euthymic and displayed a reactive affect. He had escorted walks with his mother to smoke.

Saturday 21 February and Sunday 22 February 2015
It was noted that that Nicky maintained a medium profile on the ward. He was visited by parents and friends and utilised escorted leave and returned to ward with no concerns. His thought process were noted to be disorganised. He was seen laughing and giggling to himself. At times was seen running around and being over-excited.

A nurse noted that Nicky described his self-cutting was to experience the spiritual world as he feels "queasy with the aliens"'. He reported feeling the presence of these aliens but denied being troubled by them saying that they "come and go". He denied any self-harm thoughts.

Monday 23 February 2015
It was recorded that Nicky was polite and pleasant in interactions. He was not observed dancing around the ward or displaying any bizarre behaviour. His mood was settled although affect was blunted. He was described as being pleasant, voicing delusional ideations and visual hallucinations and talks about the spiritual world, aliens and spirits. He denied any thoughts to harm self. He utilised brief leaves with his friends escorting him – no issues noted.

RMO2 was called to see Nicky during the evening as he was not responding normally and had pulled his bandages off (Jane reported to staff on the 27 February, that Nicky had stated he had gone to the river and taken his dressings off with intent of drowning). The clinical record for that day, notes the dressings being removed when Nicky was off the ward with friends. There is no note of feedback from friends or family with regard to any issues whilst out on leave with them.

RMO2 wrote a note following the review of Nicky. *He was very spiritual – believing in a form of God and spirits who had been communicating with him since his awakening a few years ago. Some spirits were good and bad – most being bad. He was "spiritually married to one – but she was a bad one". Some of the spirits came from the Big Bang. They could put thoughts into his mind about which he struggled to articulate. They could control his body and make him do bad things – he stated they were controlling his body when he cut himself prior to admission – he found this very scary. The spirits "talk to him directly and tell him to do things" and also talk to him in the third person. He receives messages from them when he is in a dream state. He had persecutory delusions – believing the American Secret Police were after him. He did not believe that he had a mental illness and felt that he should not be in hospital. He wanted to be released to continue his spiritual journey. He was accepting of medication and felt that it helped him calm down.*

He was maintained on hourly observations, a family meeting was organised for the 24th at 9:30am and he was allowed to continue to have brief escorted leave.

A whānau hui organised by Hauora Waikato today. DHB received formal complaint from father regarding ED presentation and lack of communication – a meeting was arranged for 2 March to discuss the complaint.

Tuesday 24 February 2015
Nicky was reviewed by SMO2 and team. Nicky presented with multiple ongoing psychotic phenomena, believing that everyone in the world has the ability to have telepathy and experience someone else's spirits and described living with the spirit

world. *Continues to have conversations with spirits if he chooses and believed that he didn't need medication and expressed a wish not to be used as a guinea pig. He believed that he didn't have a mental illness.* The impression gained by the team was that he was floridly psychotic with a relapse of Paranoid Schizophrenia. The risks were described as "moderate" to himself but a low risk to others and that he was vulnerable whilst psychotic. He was deemed to be a moderate risk of AWOL.

The plan included brief escorted leaves only, hourly observations, and to liaise with Hauora regarding medication options.

There is a clinical note that '*Nicky had removed his bandages and thrown them in the bushes'.*

A family meeting was held with SMO2, family coordinator, registrar and trainee. The family did not feel listened to by SMO2 and had had care transferred to another psychiatrist during a previous admission. They also felt that the community team didn't listen to them and in part was why Nicky had been admitted now. They were not aware that LAIs had been missed.

Notes extracted from initial triage report for 24 February 2015

A meeting with his parents was held 10:05. Father expressed concerns about Nicholas being admitted to Ward 36, "drugged to the eyeballs" and all his clothes being taken off and lost. He was pleased with Nicholas being admitted but was concerned about the lack of communication. They expressed their concern about the way he was admitted and everything being pretty horrific. They believe they know a lot about Nicholas' mental illness, seeing him often rather than every few weeks – months. They felt the community team didn't listen and this contributed to part of why Nicholas was admitted. The parents agreed with depot treatment but felt the dose was too low and Nicholas had been "able to call the shots on the dosing". The possibility of transferring his care to Waikato DHB CMHS as opposed to Hauora was raised – Nicholas' parents expressed interest therein.

Mother expressed the concern that they didn't want to alienate Nicholas because this was the first time he said he didn't want his parents to know about his situation. "Mother expressed concerns that Nicholas didn't see them to be against him or on the doctor's side in case he stopped opening up to them and telling them things." The concept of an advanced directive was raised – parents were under the impression that with Nicholas being under the Mental Health Act they would be told about all of his treatment. Nicholas' parents were aware that he smoked cannabis and probably did other drugs but most likely didn't use synthetic cannabis or drink alcohol in excess.
Parents felt that he had started deteriorating in January with him laughing inappropriately, talking to spirits, screaming on their deck. A past history of self-harm was noted with him cutting along neck/chest (Nicholas claimed this was an attempt to tattoo himself) and trying to hang himself when about 16 years old.
Nicholas, who joined the meeting later, expressed a wish to be off the Mental Health Act and have cigarettes whenever he liked. He articulated no regret about harming himself but noted that he would not do it again. He felt safe in hospital but wanted to have unescorted leave for cigarettes.

Wednesday 25 February 2015

Nicky had a moderate profile on the ward. He displayed signs of paranoia, believing that there were cameras in the ward. He went on two escorted leaves with friends. On one of these leaves, he came back late. When questioned, Nicky reported that he had three bottles of beer when he was out with his friend – the friend was leaving

Hamilton and had brought some beers over to say goodbye. This was communicated to the treating team.

Thursday 26 February 2015

RMO1 review - Nicky described the last few days being fun with all his friends coming in and making it more bearable. He felt that hospital was making him apathetic – he was encouraged to join OT activities. He denied talking to spirits for the last few days and that he "had calmed his mind". He felt that he shouldn't be in hospital. He discussed having three beers while on leave.

The plan was to continue hourly observations, no leave due to his breach of leave conditions yesterday and an expected discharge in one week.

The clinical record states Nicky was voicing delusional ideation with visual hallucinations and talked about the spiritual world, aliens and spirits. He denied any thoughts to harm himself or others. Jane raised her concerns that Nicky was talking about aliens and that the coming weekend will be the last weekend on earth. She was concerned that he might try and harm himself and that she was wondering what medications could help him.

A nurse discussed these concerns with Nicky. He did not confirm any of the delusions; he was not happy with his leave being stopped.

Friday 27 February 2015

11:30 - Nicky was reviewed by SMO2 and team. Nicky continued to occasionally experience telepathy but "it's not harmful or anything, it's fun". He elaborated about when he cut his arms. He noted 'grim reaper' voices that told him to kill himself by cutting his wrists and throat but he "could control them". He could "stare the voices down to stop them". At times he experienced positive voices when he needed support from people in the past life. He felt there was "nothing wrong with him" and that it was "the stupidest mistake I've ever made cutting myself because it hurts me and my friends". He described cutting his arms because he didn't want to live at the time but now thinks that life is worth living. He stated that he shouldn't have done it but it happened so he has chosen to move on. He described not wanting to be on medications because they hinder him and his special talents (existence in the spiritual world). He described when he was not on olanzapine that the "talent hit him all at once" and he couldn't cope with it. He wants to stop bad voices and to keep existing in the spiritual world. He described "holding back" because he was afraid clinicians would think he was crazy and lock him up even more. He denied going to the river.

The clinical impression was that he continued to suffer with Paranoid Schizophrenia with minimal improvement but with risks (including the potential risk of self-harm) being low.

The plan was for him to

- remain on hourly observations
- trial of unescorted leave for 4 times each day of 15 – 20 minutes
- Not to go on leave when his friends are around
- And for the family to be aware of any changes.

Nursing notes reflect that Nicky spoke at length with SMO2 about his voices and talents and how he didn't want any medications to help them go away. Nicky stated

he would not hurt or harm himself while he was in hospital and he would talk to staff if the grim reaper came back and was not able to control the voice.

Nicky had four brief unescorted leaves with no concerns.
Notes written at 16:18 (after the ward round by SMO2) – the Weekend Plan was written by RMO3 for Nicky to have escorted short leaves and 10 minute observations Jane discussed with the evening nursing staff her concerns about the plans of unescorted leave and that Nicky had told her that he went to the river three days ago, took off his dressings and had intended to drown himself. She felt that this coming weekend would be high risk as he had voiced that this weekend would be the time he needed to go to the spiritual world to "get out from the aliens" and that he might commit suicide. The staff nurse advised Jane that the staff would do risk assessment prior to allowed leave.

Jane highlighted that she did not want to divulge her concerns to her son and that both Jane and Dave were willing to visit during the weekend to escort Nicky for brief periods of leave.

After Jane left, Nicky was interviewed by the staff nurse regarding the risk of him going on unescorted leaves and the previous incidents. He was described as becoming defensive, challenging, irritable and saying that the writer was deluded as the writer made assumptions and linked the past with the present. He reported that he previously cut himself to experiment and he wouldn't do it again. He denied going to the river with the intent of drowning himself. He denied telling anyone about self-harm attempts and the things he tells his family are "personal business".

<u>Saturday 28 February 2015 and Sunday 1 March 2015</u>
Nicky had used 3 of his 4 brief unescorted leaves (as agreed by SMO2 the previous morning) by 3:00pm on the Saturday. He requested a number of additional leaves which were denied. He was allowed a 'smoke break' at the start of the evening shift. Nicky continued to have escorted leave with his family.

In the evening he presented with an elevated presentation, disorganised behaviours, was laughing loudly, shouting and swearing in the courtyard and became irritable with the staff. He requested an appointment with the police to have an alarm which he could press if he was in danger.

On Sunday, Nicky had used all his 4 unescorted leaves by the end of the morning shift. Nicky's parents note their concerns about his leave off the ward as they had been told on Friday that he was to have escorted leaves only (this was compatible with the weekend plan documented by RMO3).

The history about Nicky telling his parents and brother that he had been swimming in the river and had attempted to drown himself was again documented. It was agreed with parents that all unescorted leave would be terminated (HRBC coordinator) and significant risk observations recommenced at 7:30pm.

<u>Monday 2 March 2015</u>
A family meeting was held to discuss the complaint received on 23 February from father regarding ED and unescorted leave decision. It was agreed that no leave was to occur until it was discussed and approved with the team and that the parents needed to be involved in any changes to treatment plan.

SMO3 visited ward and discussed with team leader and responsible nurse about the concerns expressed by father regarding the unescorted leave. Nicky's observations

were kept at 10 minute observations with no leave and the plan was for consultant review tomorrow for possible escorted leave thereafter. RN3 notes that there is a risk of AWOL based on how Nicky was presenting. He continued to display poor insight and an ongoing wish not to have medication; he does not want his family involved.

Tuesday 3 March 2015
Care was transferred to SMO4 who met with Nicky for 45-60 minutes to establish rapport and undertake an initial assessment (with registrar). SMO4 details in depth a summary of the assessment. There was a clear description of the events leading up to his self-harming which was compatible with past descriptions.

Nicky described having conscious dreams of aliens, believing that aliens were possessing people and controlling them and to fight this he "closed his eyes and hangs on". He believed that aliens were affecting his friends and this was his fault. He wanted his family involved but wanted to be present when clinicians discussed issues with them. He described consuming 3 bottles of beer when on leave with his friends but denied jumping into the river/lake. The clinical note states 'we had a frank discussion about behavioural expectations around brief leaves from the ward. I told him they were not for smoking, as we had NRT to offer. I explained that our expectation is that he will not drink alcohol, consume drugs, self harm…'

The multidisciplinary team agreed the plan -

- two unescorted leaves of 15 minutes – no more
- escorted leave for longer with parents – (not with friends)
- if behaviour deviates from expectations, failure to return in allotted time; leave to be revoked
- significant observations discontinued

SMO4 attempted to contact Dave, regarding the unescorted leave; a message was left on his phone. SMO4 discussed the assessment; observations and plan with Jane, for approximately 30 minutes later that afternoon including an update on the meeting, the change in leave status – unescorted and escorted leave with family. SMO4 provided positive feedback for family's support of Nicky and explored a list of discharge options in terms of community follow up. A family meeting was scheduled for 6th March.

Nicky utilised his two unescorted leaves with no concerns

Wednesday 4 March 2015
Nicky had unescorted leaves off the ward both before lunch and returned with no concerns. He was engaging well in conversation about his favourite music, spent time watching TV in the lounge and was working well with staff.

Thursday 5 March 2015
29(3)(b) inpatient treatment order status reassessed in accordance with sections 13 and 14, next due 19 March 2015.

Clinical note from SMO4, denied suicidal thoughts, intent or plan. Primarily focused on discharge. Nicky believed that aliens were "out there" but that they hadn't got to him yet and that he wasn't going to worry about them. Judgement fair and using leave without problem last couple of days.

Plan was to maintain brief unescorted leave x 2 per day (one per shift) and to be revoked if misused.

SMO4 spoke with Jane that afternoon to update her and Jane described that Nicky was making odd gestures with his hands and feet suggestive of 'fighting motions' as if fighting off demons, when they went for a walk around the lake.

Friday 6 March 2015
A family meeting was held at 2pm including SMO4, registrar, family coordinator, several other clinicians and Jane, Dave and flatmate Joel.

Nicky mentioned that he shouldn't be here and feels that life was being taken away from him due to the stresses of others. He felt that to commit suicide was a noble one (there was no additional expansion of this in the notes). The current leave situation was discussed including 2 x 15 minutes (unescorted) and leave with family over the weekend.

His parents wanted to have a holistic approach to his follow up in the community and want to engage with a keyworker prior to discharge. They attempted to explain to Nicky that they feel he needs medication and that he needs to engage with the support being put in place.

A plaster cast was applied to his arm.

Nicky had 2 unescorted walks without incident and 2 escorted leaves with staff.

The fortnightly LAI olanzapine was given as prescribed and it was noted that his mental state and behaviour appear to be improving; some staff thought he looked a little bit sad. Risk of impulsive behaviours noted.

Saturday 7 March and Sunday 8 March 2015
On Saturday, Nicky had unescorted leave without incident. Noted to be unkempt and mood appears low, affect flat.

Escorted leave with family for his father's birthday. On return, he said: "it went really well, am beginning to be organised'. One escorted leave with staff.

According to the clinical notes, Jane complained to a PA that Nicky was smoking too much and he never used to do so prior to his admission. She was also concerned that he did not talk to them when they took him out nor did he eat well. "If Nicky calls, all he wants is for them to visit so he can go on escorted leave to smoke and his father now does not feel like coming up".

When asked by staff, Nicky agreed that he usually only eats a small amount and it's because he does not want to gain weight. He stated that; 'he does not talk to them because all they talk about is the Henry Bennett Centre and his smoking'. He said he was smoking as he has nothing else to do

On Sunday, Nicky was 30 minutes late returning from his unescorted leave first thing in the morning (08:30 – 09:15). According to RN3, when Nicky had not returned within the time, he was located immediately outside the HRBC on the road smoking. Nicky's appearance and his explanation all fitted with him not having a watch, and having lost track of time explaining why he had not returned. Nicky explained that situation and apologised for not returning, and returned to the ward willingly
RN3 told him that he may lose leave as he had breached conditions. CCTV shows Nicky leaving through front door 08:29, returning through front door at 08:40, leaving again through level 3 and back through front door at 09:02.

Nicky was later adherent to requirements imposed upon him by RN3, around tidying his room, before being granted a further period of unescorted leave. Nicky also had leave with his parents and an escorted leave with staff later that day. RN3 referred to the leave condition breach in his handover to the new shift that evening.

Monday 9 March 2015
As of the morning MDT meeting, it had not been communicated to the consultant in charge of Nicky that he had breached his leave conditions on 8 March 2015.
MDT meeting held at 09:00 - It was noted that Nicky needed a high level of care in community; referrals were to be made to Acute Community Team, occupational therapist and the social worker. Nicky was to remain on 2 brief unescorted leaves. There is no mention of the breach of leave the previous day.

In the summary of the morning shift by RN3, Nicky denied racing thoughts, persecutory delusions, thoughts of self harm or suicide. He was constantly asking to go off the ward (this was normal according to staff). He was noted pre-occupied at times. The nursing note included: *Currently low risk to self harm / suicide ideations*

Timeline of the leaves taken before 12:30

- CCTV 08:44- 08:53 **Unescorted leave 1.** (given by PA1) door security log shows PA2 and PA1 exiting ward around these times. PA1 allowed Nicky an unescorted leave break. He returned after 10 minutes. PA1 spoke with Nicky and *found him hard to engage, however this was not unusual for him.*

- 09:15 RN3 spoke to PA1 re escorted leave. It was agreed PA1 would take Nicky out with a co-client. PA1 noted Nicky was engaged, talking with co-clients, no concerns noted. The nursing note included: *Denied racing thoughts, persecutory delusions, hallucinations, thoughts of self-harm or suicide. Speech normal, mood appeared euthymic, affect reactive, congruent and appropriate*

- CCTV 09:18 – 09:27 Escorted leave (PA1) door security log confirms. PA1 escorted Nicky and a co-client outside. According to PA1, Nicky initially expressed his frustration at having to wait for staff and told that as a nurse PA1 “should do something about this”. PA1 informed Nicky, that she was a Psychiatric Assistant and stated after realising this Nicky ‘became less frosty’, he then started talking about music and shared that he had a brother. Conversation was appropriate, nothing to raise concern. Nicky then asked if they could go down to the dairy. PA1 states she said no, that they would need to go back to the ward and check this out with his nurse which he accepted.

- Both RN3 and PA1 state they discussed that leave had gone well without incident, and agreed that PA1 would take Nicky to the dairy at 1030 hours. PA1 commented there were no concerns about Nicky, his conversation was ‘normal’ and he was not dancing around and talking about the spiritual world. If PA1 had any concerns PA1 states would not have taken him. RN3 agreed with the plan given that previous leave had been without concern and based on the conversation earlier with Nicky.

- CCTV 10:19 – 10:40 Escorted leave (PA1) door security log shows PA1 leaving but no correlating time of return. Visited dairy. No concerns noted

- 11:00 Nicky wanted leave. RN3 states this request was denied, but agreed 'we would see after lunch to which Nick agreed'. PA1 also stated that Nicky was constantly asking to go out (not unusual) but requests denied as per nurses instructions

- CCTV 11:00-11:08 **Unescorted leave 2**. (unsure who agreed / let out) door security log shows PA2 exit 11:05 but no return

- RN3 notes Nicky seen about 12:20 eating his meal.

- CCTV 12:29-12:44 **Unescorted leave 3.** (PA2) allowed leave as part of group. PA2 stated RN3 nodded confirming ok to go out. RN3 denies being asked to give leave. PA1 also stated that Nicky was granted his second unescorted smoke break (along with the other smokers)

  Door security log confirms:
  PA2 exit 12:29;
  RN3 exits at 12:39 and granted entry 12:59 (this is during the period when PA2 states he informed RN3 that Nicky had not returned);
  PA1 exits 12:41 (was taking a patient to MRI)

- CCTV 12:44 security footage shows Nicky returning via front entrance

Note *CCTV times and door security log exit times do not align. Door security log times seem to be 5-10 minutes later, according to a review of the records.*

The timeline below shows leaves and activity after 12:45 (When Nicky should have returned)

The CCTV footage shows Nicky coming and going from the HRBC – his demeanour is similar to that of the morning and of the previous day. The security officer who looked through all the video footage of previous days, notes there was little change in Nicky's movement (walk, carriage etc.) across the days observed.

Video footage shows Nick

- **CCTV 12:45** Nicky leaves **unescorted** HRBC by front entrance
- **CCTV 12:52** returns HRBC front entrance
- **CCTV 12:53** leaves **unescorted** HRBC front entrance
- **CCTV 12:56** returns HRBC front entrance – squats down in entrance
- **CCTV 12:57** leaves **unescorted** HRBC level 3 entrance
- **CCTV 13:03** Appears on Puna Whiti camera
- **CCTV 13:04** seen on gully camera outside Hockin and disappears from view

- 13:00 RN3 states went for a meal break for about 30 minutes.

- 13:20 RN3 was approached by PA2 (time confirmed by both PA2 and RN3) and informed that Nicky had gone out and not returned. According to RN3, asked PA2 who had let Nicky go on leave. RN3 did not give permission according to statement.

- About 13:20-13:30 PA1 returned to the ward after taking a client for an MRI. The ward was really busy; two people had transferred in from ward 36. PA1 picked up

the paperwork to do the check (for those out on leave) and noticed that a group of patients had not come back from leave including Nicky and mentions this to colleagues.

- PA2 told RN3 that RN4 had gone out to look for Nicky.

- RN3 went off the ward (downstairs) to help RN4. RN3 went to the dairy, searched the courtyard, toilet and shower and others searched bedrooms.

- RN3 then started the absent without leave process (AWOL). RN3 knew what the process was as had done it before and was aware of the folder on the ward that details the process. RN3 knew there was an hour to complete the process

- 13:21 – note written by SMO4
    - As discussed in MDT this morning, team will complete a referral to ACT team with suggestion for psychologist referral as well. Remains on x2 brief, unescorted leaves per day at this point in time.
    - Received a phone call from Nicholas mother, updated her on discussion from this morning. She informed that she will be going to Dunedin from Wednesday this week to Tuesday next week. She is concerned that Nicholas is smoking excessively and seems to only care about smoking during their visits with him.
    - Have asked OT to complete functional assessment for Nicholas to help inform discussion about discharge planning options and supports.

- 1330-1350: M1 states she was approached by RN4 and informed that Nicky had gone AWOL. M1 asked RN4 if RN3 knew and to inform if not. Some of Nicky's friends had come in to see him. RN4 states there were 3 friends who left once they were informed Nicky was not on the ward (Confirmed on security footage that friends had come in at 1344 and left at 1350).

- 13:30 SMO4 and registrar informed Nicky is AWOL – they had no immediate concerns for his safety

- 14:00 PA1 completes check –Nicky has not returned or been seen and it is also noticed that another patient appears to have not returned from leave.

- 14:00 RN3 called Nicky's mother to enquire about locations he could be or any other helpful information that could be passed to the police. She told RN3 that Nicky could be down by the river.

- RN3 then completed the missing person's report and faxed this to the Police from the ward 35 office fax as per the guidelines.

- 14:15 M1 spoke with RN3 to make sure that the AWOL process had been started. RN3 informed M1 that a search had been completed but Nicky had not been found.

- 14:35 RN3 called the police and told them the report had been faxed. RN3 did not check that they had received the report as assumed the fax has been successfully transmitted

  RN3 had a 10-15 minute conversation giving the police a physical description of Nicky including that he had bandages on his arms (but did not note that a plaster

had been applied on 6 March), what Nicky was wearing, that he was on unescorted leave, reason for admission to HRBC, current risk considered low, previous thoughts of self-harm while in hospital but no recent suicidal ideation. Father notes in his statement that the police recording of the conversation by RN3, there is mention of a risk of suicide.

RN3 also gave the police Nicky's parents address and phone number. Police event no PO20479384 – written in notes. RN3 did not write in notes about conversation with the police or with mother.

- The police transcript confirms the time of the call at 2:38pm and also the details given regarding 'currently low risk but potential to self harm and stuff like that', ' 'he came to the hospital because he cut his wrist, attempted suicide', and possibility of the river being a destination ' or 'down by the river as per family'

- RN3 completed the incident report – 317303 – documented this on the clinical work station.

- 14:30 M1 was contacted by Jane. M1 stated Jane was very upset and asking why Nicky had been allowed out on leave and why it had taken so long for the AWOL to be noticed. M1 invited her to come in and discuss her concerns but was told the priority was finding Nicky. M1 informed Jane that the AWOL process had been started, that police had been informed and they were aware of recent concerns about significant harm prior to admission, previous reported history of being by the river and voicing suicidal ideas.

- 14:45 Conversation between RN3 and M1 to check what had been completed in regards to the AWOL procedure and what information had been given to the Police. RN3 was aware that Jane had phoned M1 as a result of the call to her. M1 stated RN3 showed her the missing person's report. M1 stated RN3 said all the detail had not been put in the report but that RN3 had spoken with the police as well and given them detailed info such as reported above.

- 15:30-16:30 M1 met with SMO4 and RMO1 in the ward office and checked they were aware of AWOL which they were. They had a discussion about Nicky's risk. SMO4 states they agreed risk was low which was why he was approved leave.

  M1 states SMO4 and RMO1 had no immediate concerns for his safety and asked SMO4 to write a plan for when Nicky returned from AWOL (see note 17:01 later). SMO4 asked M1 to ask security to check the gully in front of the hospital, as parents had raised concerns about Nicky going to the river.

- RN3 completed clinical notes for the day and handed over to afternoon shift about the AWOL and need to contact the police for updates.

- Clinical note from RN3 (electronic record shows 15:39)
  - *Nicholas had a settled night. At commencement of morning shift, he was awake.*
  - *Nicholas engaged in a pleasant and polite manner with staff and patients.*
  - *Upon asking RN3 he denied any racing thoughts, persecutory delusions, hallucinations, thoughts of self-harm or suicide. His insight and judgement were noted as impaired. His risks were assessed as "Currently low risks to self-harm or suicidal ideations. However, potential to self-neglect, self-harm and verbal aggression."*

- *He requested to go out for smoke at about 1230 hours after having meal as he has two approved unescorted leave per day.*
  - *AWOL process done, family and crisis team has been notified.*
  - *Police event no P020479384. Incident no 317303*

- RN3 then sent an email to SMO3, (copy to M1) informing him of the AWOL.

- 16:00 M1 asked security to check Hockin house and the gully toward the river.

- 16:00 – 16:30 M1 called Jane to give the police number. Jane told M1 she had already spoken with the police. They agreed a time that M1 would call her the next day 10/03/15 for an update.

- 16:00 Nicky's friend Storm called to see how Nicky was. Informed him that he was not on the ward.

- 17:00 Security guard came onto the ward and spoke with staff. Informed that two of Nicky's friends had come to HRBC stating that Nicky had texted them asking them to visit him. The security guard asked to check his room and he also checked the courtyard.

- 17:01 – note written by SMO4
  - *Informed of Nicholas going AWOL around 1330 this afternoon.*
  - *Has not to my knowledge, at this writing, been located.*
  - *AWOL procedures have been completed.*
  - *Asked M1 to ask security to check area behind Hockin House and down toward the river (as Nicky reported to his parents in the past that he went down that way).*
  - *Plan:*
    1. *Nicky to have no leave from the ward upon return to the ward. Ensure adequate NRT available.*
    2. *See earlier note - plan to refer to ACT team, for psychology and OT functional assessment.*

- At 17:18, a fax was resent to 078349400 – it remains unclear if this was the missing persons form for Nicky or something else.

- 18:00 M1 was approached by RN5 about two friends of Nicky that had come to the ward (security footage confirms) and said they had received a text from Nicky. M1 asked that if they returned or contacted the ward again to ask them for the number they received the text from, or ask them to call Nicky on their phone – M1 thought Nicky more likely to answer a call from them.

At 21:30 RN5 received a phone call from Jane asking for an update. Informed her about the two friends who visited. Jane noted that Nicky "does not have a mobile phone". Shortly afterwards Dave also phoned and spoke with RN5.

RN5 contacted the police and shared the information about the two friends visiting and discussed the suspicion that he could have gone to a co-clients home who was on leave. RN5 states that while phoning the police a colleague phoned the home of the co-client but they stated Nicky was not there. RN5 then contacted the police again with this information.

2200 (approx.): After-Hours Co-ordinator received a phone call from Dave. According to her statement he introduced himself and said that there was a rumour going around that 2 friends of Nicky's had come to the HRBC and been told by security that he was not there. The friends said that they had received a text from Nicky to say that he was at the HRBC. Dave asked for clarification about this. After-Hours Co-ordinator told Dave that she would go to the ward and gather information, and ring him back. He gave his numbers (landline and cell phone) and thanked her. After-Hours Co-ordinator then went to the ward and spoke with the staff. RN5 informed her that 2 friends had visited at dinner time (17.00ish) and said that they had had a text from Nicky to say that he was in the HRBC. Also clarified that the ward had been searched and that Nicky was definitely not in the ward or surrounds. Unfortunately the security officer did not get the names of the visitors, nor did they see any text.
Note: on the 10 March the friend (Jack) stated that they only said Nicky had texted them as a way of getting on the ward.

2230: After-Hours Co-ordinator rang Dave back and relayed the information received from RN5.

Tuesday 10/03/15
At 01:08; a nurse noticed a fax sitting on the fax machine that had been sent earlier but with an error message -- which probably meant it was not received. This was the missing person's report for Nicky. A new cover sheet was added and successfully sent it to the police.

RN3 arrived at work and asked if could be allocated Nicky again to follow up. RN3 called the police for any update but no news. RN3 contacted Nicky's cell phone but there was no service on this. According to Jane, Nicky did not have a cell phone.

RN3 contacted the family to see if they had any other info about where Nicky could be. RN3 spoke with Dave who was very angry with the call. RN3 informed M1 about this call and was advised not to call the family again and leave all contact with them to M1.

During the morning, SMO4 discussed with SMO3 applying for a warrant to apprehend, signed by a court judge. This was completed by SMO4 and sent to the police. SMO4 also informed the Clinical Director / Director of Area Mental Health Services, of Nicky's AWOL status.

M1 phoned the police for an update and spoke with Paul, Sergeant in charge at Hamilton police station – he confirmed the following information

- They are aware of Nicky's history of harm to self, his diagnosis, his MHA status, his possible whereabouts (including the river) and physical description
- Aware there is 'a lot of concern regarding his safety'
- He (Paul) has sent an URGENT request to the bank to check banking transactions in last 24 hours
- Police officers currently out walking through town and along the riverside carrying a photo of Nicky

Wednesday 11/03/15
M1 contacted the police for an update – there was no new information. Police asked for a copy of the warrant. M1 contacted the police again to suggest that Nicky may have gone to Whitianga and confirmed that a photo of Nicky had been uploaded onto his electronic police file that all police can access.

11:15 (approx.) M1 and SMO4 phoned Jane and noted:

- Police had warrant info
- Police had information about Wilderlands property in Whitianga.
- Jane informed them she had spoken with the Police that morning and the police informed her there had been no activity on bank account since Monday morning.
- That a timeline of day was being done, which included a review of security camera footage and conversations with staff, documentation.
- Jane to email photo to M1 to give to security at Waikato DHB.
- Mother confirmed that calling at approximately 11-11:30 is a good time to check in with her.

M1 made a further phone call to police (spoke with Edith) after security video footage reviewed. Informed the police that Nicky had been seen crossing the road and going into bushes across the street at 1304 hours and suggested police search the area by Hockin House and surrounding area.

M1 informed Edith that police can get footage by contacting Waikato DHB security.

12:30 (approx.) further phone call to Jane with the following information:

- M1 and SMO4 had viewed security video footage
- Provided a brief timeline of Nicky's appearance on the video
- Informed her that family can liaise with the police to view footage
- That information about Nicky's movements had been given to the police including the suggestion to search Hockin House and surroundings

At about 2:30pm, Tony (Nicky's brother), arrived at HRBC and wanted to search Nicky's room to see if it would help with locating him. PA2 on Ward 35 phoned M1 for advice as this was not usual practice.

SMO3/M2 meet Tony and explain that this was not normal practice without client consent but allowed him access. Wallet and eftpos card found in property bag as room had already been packed up

Thursday 12/03/15
At approx. 08:00 police phoned – there was a possible sighting of Nicky and it was being investigated. M1 asked if a river search was being undertaken and encouraged them to do.

M2 informed M1 that the family has requested no contact from HRBC staff.

At approx. 12:00, the HRBC staff received confirmation that Nicky had been located, deceased.

Friday 13/03/15
A service was held on the ward for patients and staff by Kaitakawaenga and Māori chaplain and a blessing of Nicky's room conducted