DHB FAILS FAMILY, BUT CLAIM CARE FOR NICKY STEVENS "*WAS OF A GOOD STANDARD*"
[Report attached]

The family of Nicky Stevens, the 21-year-old man who died in March 2015 while under the legal care of the DHB, have expressed outrage at the DHB's official 'report' claiming Nicky's care "*whilst in Henry Rongomau Bennett Centre was of a good standard"*.

Almost two years after Nicky's death, the DHB has produced what the family regards as a backside-covering report, clearly designed to justify the DHB staff and management actions, and inaction, that led to Nicky's death.

The family (mother Jane Stevens, brother Tony Stevens and father Dave Macpherson) have agreed to meet with DHB Chair Bob Simcock, CEO Nigel Murray and an HRBC Manager at 12.00 noon on Friday 17th February, in Hamilton, to "*discuss the findings*" and hear the DHB *"offer an apology on behalf of the Waikato DHB for shortcomings in our processes".*

We do not accept for one minute that allowing a patient, who had clearly demonstrated a high risk of suicide, to take unescorted leave on numerous occasions, against the wishes and pleas of his family and friends, suggests anything "*good*" about the standard of care provided to Nicky. No reasonable New Zealander would think that Nicky was well cared for by Waikato DHB.

The family firmly believes that, had their verbal and written requests for Nicky not to be given unescorted leave been followed, and had DHB management promises (to ensure just that) been actioned, Nicky would likely be alive today.

<u>Despite the ridiculous claim that Nicky received a good standard of care from the DHB, their self-chosen review group have reported a long list of failings in Nicky's care in the areas of</u>:

- Inadequate and confusing patient risk assessment (the DHB Policy having expired over 2 years before Nicky's death)
- A leave process and leave approvals that were contradictory and confusing to staff, management and family
- Inadequate and only partially followed procedures for handling the AWOL situation in Nicky's case
- A lack of formal family involvement in Nicky's care, despite his request that they be involved
- A lack of medication management and follow-up, plus evidence that he may have been on incorrect medication

How these failings can add up to a "*good standard*" of care is beyond the family's comprehension, and suggests the DHB spin doctors have invented a Trump-like set of 'alternative facts'.

<u>To this list, the family adds</u>:

- The failure for two years for the DHB to say "sorry' to Nicky's family for their part in his death
- A total lack of bereavement support provided to the family
- The arrogance and disdain shown towards the family by a number of senior DHB clinicians

- The lack of independence of any investigation into Nicky's death
- The full state funding of legal representation for the DHB and its staff, and for the Police, at the coming Coroner's hearing, while the family has to meet 100% of its legal costs, after the DHB refused to assist
- The disappearance of some key medical records from Nicky's file
- Dangerously low staffing levels, including in Nicky's Ward on the day he disappeared
- The failure of staff to record and pass on vital factual information relating to Nicky's care
- The effect of the DHB's blanket 'no-smoking' policy on HRBC patients, forcing them literally onto the street, regardless of the risk to them or the public
- Shoddy and non-existent security and safety procedures at the HRBC, including the ward Nicky was placed in
- Ineffective management and leadership in the DHB's mental health sector (some of whom have since, tellingly, been removed)

The family is concerned that the Coroner's Hearing relies on this inadequate 'Serious Incident Report' to form the backbone of its own investigation; and have already faced a worrying request from the senior lawyer representing the Coroner to have no hearing at all, something the family has rejected in no uncertain terms.

WHAT DOES THE FAMILY WANT

1 The family want a full and unequivocal apology from the DHB for their part in Nicky's death - he was legally placed under their 'inpatient' care by one of their own clinicians, authorised under the Mental Health Act.

2 They want the DHB to fund their involvement at the Coroner's Hearing to the same level as they are funding themselves and their staff.

3 They want a public acknowledgement from the DHB that there are serious problems with the DHB's mental health service, which leads to a community-led action plan to fix it, in the Waikato and elsewhere.

4 They want their son and brother to be remembered for the light his death has shone on some of the shortcomings in the mental health system, and the steps taken to fix them.

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