27/7/15

Dear Dr Crawshaw – Regarding the Inspection into the safety of Waikato DHB's services in the mental health area as ordered by the Minister of Health, we wish to request the following issues be covered by your team:

1 **Questionable psychiatrists employed recently by the DHB**

- Mr 'X', charged in July 2015 with fraudulently using the name and qualifications of a USA psychiatrist, after working in triage, crisis and community mental health teams
- Paul Fox, employed from late 2012–2014 as a psychiatrist at the Henry Bennett Centre – was the lead psychiatrist for our son & brother Nicky Stevens in 2013 – surrendered practising licenses in USA states of Connecticut and New York in 2012&13 after not challenging accusations of sexual relationships with patients, and was former pyschiatrist of 2012 Sandy Hook (Connecticut) massacre perpetrator Adam Lanza; removed in February 2012 from NZ Medical Register after failing to disclose reasons for loss of USA licenses
- Manilall Maharajh – a psychiatrist employed by Waikato and Bay of Plenty DHBs, who was found guilty of professional misconduct by the Health Practitioners Disciplinary Tribunal in September 2013, after having sexual relations with a patient and paying her not to inform authorities about this (http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11161434)
- Jason Luty – a psychiatrist employed by Waikato DHB in 2012 after leaving Essex in the UK under a public cloud following publication of offensive pictures of his own children holding shotguns (including one with a muzzle in the child's mouth) (http://www.raow.org.uk/18_19.html).
- *[Non-psychiatrist staff member]* the employment in 2009 of the sister of the Service's Clinical Director as a staff member at Henry Bennett Centre, despite her previous 'record' involving the brutal killing of a family member.

2 **Security failures at the Henry Bennett Centre**

- The allowing of unsupervised 'smoke breaks' for at-risk patients in Henry Bennett Centre, including failure to follow up on AWOL patients, as happened to our son/brother Nicky when he disappeared and drowned in the Waikato River in March 2015 – and the requiring of these to be taken on the

streets and park areas outside the Waikato Hospital precinct

- The 'open entry' practice at Henry Bennett Centre until March 2015, enabling visitors to enter and leave the centre unchallenged and without record
- The failure to record absences, departure and return times of patients in HBC wards – until March 2015
- The 'escape' of patients from a "secure" ward at HBC in April 2015
- The failure of the HBC to provide secure 'smoking' areas for at-risk patients

3 **Managerial failures in the Waikato DHB Mental Health and Addiction Services**

- The disappearance of Nicky Stevens' medical records from the DHB for the 3 days immediately before his disappearance
- The failure of Service managers to follow or monitor their agreement with our family to prevent unsupervised leave for Nicky Stevens, after they were informed – in writing and in person – of his suicidal intentions and attempts
- The failure to ensure that universally clear and timely notes of treatment of, and events relating to, patients of the Service are made, kept and managed adequately
- The failure to establish a risk management protocol or policy enabling the identification of at-risk patients, and the level of care required to keep them, and the public, safe – during and after in-patient treatment.

Our family requests that you consider management roles in all of these matters as part of your Inspection.

We believe management failures to set, enforce, resource, train staff for, and monitor implementation of policies and practices in these areas has led to the series of disastrous events outlined above, causing a clear and public loss of confidence in the DHB's provision of mental health services in the region.

We await your response.
Yours sincerely

Jane Stevens, Dave Macpherson & Tony Macpherson-Stevens
(family of Nicky Stevens)