IN THE COURT OF APPEAL NEW ZEALAND **CA 524/2013**

BETWEEN **B**

Applicant

AND **THE WAITEMATA DISTRICT HEALTH BOARD**

Respondent

AFFIDAVIT OF DAVID GRANT MACPHERSON

Dated this day of April 2015

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I, David Grant MacPherson, swear,

1. I reside at 2733 River Road Ngaruawahia,

2. I am the father of Nicholas Taiaroa Macpherson Stevens (Nicky Stevens).

3. Nicky Stevens was a patient at the Henry Rongomau Bennett Centre (HBC) in Hamilton from 19 February 2105 until an unspecified time and date between 9 – 12 March 2015. The HBC is run by the Waikato District Health Board.

4. Nicky had been admitted to the HBC after attempting suicide by cutting his wrists severely, which involved seven hours of urgent corrective surgery.

5. Nicky had periods of "unescorted leave" for the purpose of smoking cigarettes off the HBC premises and on the sidewalk of Selwyn Street. The unescorted cigarette breaks were written into Nicky's treatment plan by the clinicians at the HBC. However, along with other family members, I objected to the way that the breaks were unescorted and allowed my son to walk out onto Selwyn Street where he could not be seen from the unit.

6. On two occasions between 19 – 28 February 2015, Nicky informed my partner and my other son that he had attempted to drown himself in the nearby Waikato River while on unescorted leave for a cigarette break.

7. I alerted the management at the HBC of these reports in an email dated 2 March 2015, and followed the message up with face to face discussions with HBC staff later the same day.

8. On 9 March 2015, Nicky disappeared from the vicinity of the HBC while outside on Selwyn Street unescorted on a cigarette break.

9. On 12 March 2015, Nicky's body was found in the Waikato River downstream from Waikato Hospital.

10. I had previously observed Nicky outside the HBC on Selwyn Street, unescorted, smoking cigarettes on several occasions.

11. I formally lodged a complaint on 21 February 2015 with the Waikato Hospital about the problem with Nicky exposed to potential dangers while on cigarette breaks. I suggested that Nicky's cigarette breaks should be moved from Selwyn Street to the immediate frontage of the HBC. I also proposed that I would supervise him or another hospital official should.

12. I was present, and involved in, a discussion with senior management of the HBC on 2 March 2015, in which I objected to the smoke-free policy not allowing patients to smoke in the secure external courtyards attached to each of the wards of the HBC.

13. I believe that the HBC's policy of giving unescorted leave outside the premises for cigarette breaks is foolhardy, irrational and dangerous. I expressed my concerns to the Waikato Hospital management both before and after Nicky's death.

14. I am also aware that this is not the first time that the smoke-free policy at the HBC has resulted in loss of life and serious injury. On 19 January 2010, a psychiatric patient (Christine Morris) was instructed by medical professionals at the HBC to go outside and have a cigarette to calm down. During the cigarette break, Christine Morris took the opportunity to leave the premises and killed her neighbour. These facts are set out in a statement by Dr Rees Tapsell, clinical director of the HBC. (Annexed and marked with the letter "A" is a copy of the statement).

15. I believe the smoke-free policy at the HBC has directly led to my son's death.

SWORN at Hamilton by the said)
DAVID GRANT MACPHERSON)
this day of April 2015)
before me:)

.....

A Barrister and Solicitor of the High Court New Zealand

A Justice of the Peace

Independent Police Conduct Authority report released

Dr Rees Tapsell

An independent Police Conduct Authority report has today been released into the police response to events preceding the murder of Diane White in Frankton on Tuesday 19 January 2010. (http://www.ipca.govt.nz/)

Christine Judith Morris, a voluntary inpatient in Henry Rongomau Bennett Centre at the time, was later found guilty of the murder.

The authority investigated the police response after Mental Health and Addictions staff notified them by both fax and telephone that Ms Morris had "escaped" from Henry Rongomau Bennett Centre and had threatened to kill her next door neighbour, Diane White.

Our statement from Dr Rees Tapsell* today follows:

"We acknowledge the release of the Independent Police Conduct Authority report, the impact the report will have on Diane White's family and we offer our sincere condolences to them.

"There are clearly things that Henry Rongomau Bennett Staff could have done differently in retrospect knowing now what we know about the defendant's state of mind. We have spoken to the staff involved about some of those things but no one acted negligently or unprofessionally and no one person could reasonably be held responsible.

"We would like to clarify a couple of points in the report:

- The community support worker (as opposed to social worker as described by the police) was not employed by Waikato DHB but by a non Government organisation (NGO).
- Staff made a reasonable judgement to allow Ms Morris to have a cigarette in the courtyard to cool down. While in the courtyard, she scaled the fence and staff were unable to stop her. They then contacted the police as described in the authority's report.

Read the police media release or watch the video.

Below is our release made on 2 March 2012 following Christine Morris' sentencing and a link to an earlier release.

* Dr Rees Tapsell is the Executive Clinical Director of PUAWAI: The Midland Regional Forensic Psychiatry Services and Director of Clinical Services, Waikato DHB Mental Health and Addictions.

Waikato DHB statement following murder sentencing

The defendant Christine Morris was a voluntary inpatient receiving respite care in the Henry Rongomau Bennett Centre in Hamilton, up until she went absent without leave two hours before killing Diane White in January 2010.

She has pleaded guilty to a charge of murder and was sentenced today.

Waikato DHB Mental Health and Addictions director of clinical services Dr Rees Tapsell expressed both his and the service's condolences to the family and friends of Mrs White for their tragic loss.

The defendant was a long standing client of Mental Health and Addictions and was deemed to be a complex client, with high needs.

Waikato DHB undertook a Serious and Sentinel Events review of the circumstances that led to her leaving the ward. This review was conducted by a panel of very senior clinicians from outside Waikato DHB.

"I am not at liberty to discuss the details of this review as it was conducted as part of a protected quality assurance activity," Dr Tapsell said.

He acknowledged that some people might find this unsatisfactory but asked that they understand that such protection is necessary so that staff are able to freely review important issues related to such incidents.

"This will assist to avoid such a tragedy in future and improve the quality of services provided to the people Waikato DHB cares for."

Dr Tapsell acknowledged that the public would have a number of questions for Waikato DHB related to this tragedy and questions have been raised by the media.

Our responses are:

1. *Could this tragedy have been predicted, and therefore avoided?*

   No one could reasonably have predicted this tragedy. The review did, however, identify a number of areas for service improvement. These included:

   - Improved training in risk assessment and management
   - Increased awareness of the policy on the observations of patients at risk
   - Reviewing the open ward environment.

   Each of these recommendations has been acted on.

2. *Is any one person to blame for this and, will anyone lose their jobs?*

   No. Staff acted with the best of intentions. There are clearly things that the staff would have done differently in retrospect knowing now what we know about the defendant's state of mind. We have spoken to the staff involved about some of those things but no one acted

negligently or unprofessionally and no one person could reasonably be held responsible.

3. *Having realised that the service user had absconded from the ward did staff act promptly to inform the appropriate authorities? Did Waikato DHB staff contact the police? And when contacted by members of the public, is it correct that staff advised them to ring the police?*

   - Waikato DHB staff faxed a missing persons form to the police a few minutes after the defendant scaled the fence and left Henry Rongomau Bennett Centre
   - Staff then rang the watch tower number at Hamilton Police Station provided by the police as part of Henry Rongomau Bennett Centre's "missing from the ward procedure"
   - There was no answer so staff rang an alternative number provided by the police. It was answered and police confirmed they had received the fax
   - Staff asked to speak to a police officer about the threats, the call was transferred to another extension but there was no answer
   - Staff rang 111 and said there was a patient absent without leave from the Henry Rongomau Bennett Centre and that the patient had threatened to kill a woman and gave the police the woman's address.
   - Staff made two more calls to the police with updated information
   - Staff advised members of the public who rang into Henry Rongomau Bennett Centre to contact the police.

4. *Could this ever happen again?*

   It is impossible to say with certainty that an incident like this would never happen again. Dr Tapsell is confident, however, that the combination of the implementation of the recommendations from the review and other service driven quality improvements will minimise the future likelihood of such a tragedy.

Dr Rees Tapsell is the Executive Clinical Director of PUAWAI: The Midland Regional Forensic Psychiatry Services and Director of Clinical Services, Waikato DHB Mental Health and Addictions.

ENDS

Date: 2 March 2012

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