

Summary Report:

Mental Health Service Event in Whanganui in June 2024

March 2026



This has been an incredibly tragic event, and our thoughts remain with the family, friends and communities affected. As National Director, Mental Health & Addictions Enhancement for Health New Zealand | Te Whatu Ora, Phil Grady extends Health New Zealand's heartfelt sympathies to everyone impacted.

Events of this nature are rare, but when they occur, we take them extremely seriously. The learnings from this event are already informing improvements across the service, including strengthening clinical leadership, improving information sharing, clarifying clinical protocols such as drug screening, and enhancing whānau engagement and staff training.

Mental health care in the community is complex, and risk can never be removed entirely, especially in the case of serious mental illness like schizophrenia, but these improvements are designed to strengthen safeguards and provide reassurance to the people we care for, their whānau, and the wider community.

Background

This report is the high-level public summary of this incident and the learnings identified from an external review of services provided by Central Forensic Mental Health Services team (CFMHS); an internal review of the services provided by Stanford House by Whanganui Mental Health Services; and a services review by the Forensic Community Mental Health Team (FCMHT), CFMHS and Whanganui Mental Health Services more broadly,¹ with a view to improving the quality and safety of care delivery and the experience of team members.

Case Summary

Person A had a diagnosis of schizophrenia and substance use disorder (mainly cannabis and alcohol). In 2024, he had employment as a truck cleaner and as a carer for his mother.

Person A was a former 'Special Patient', meaning they were detained in a forensic hospital under the specific legislative provisions of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP Act), following a Not Guilty by Reason of Insanity (NGRI) finding in relation to the homicide of a partner in 1997 when acutely unwell. Person A had remained under the care of Regional Forensic and Rehabilitation Services, CFMHS (part of the Mental Health, Addiction and Intellectual Disability

¹ At the time of writing, these reviews are still in the process of being finalised.

Service for Wairarapa, Hutt Valley, Capital and Coast districts of Health New Zealand) since that time. Initially, Person A was treated as an inpatient at the Porirua campus. Over the next few years, his schizophrenia was successfully treated. In 2001 he transferred to Stanford House, an extended secure forensic inpatient unit in Whanganui, which brought him closer to his whānau and his community in Whanganui.

Person A re-entered the community in 2012, as a special patient, to independent living under the care of the FCMHT and after a sustained period of stability, Person A had a change in October 2021 of legal status from 'Special Patient' status under the CPMIP Act, to being managed under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MHA) under a s 29 Community Treatment Order. The s 29 Community Treatment Order requires a patient subject to this order to attend for treatment and accept treatment as prescribed (medication). Since the change in legal status, Person A was no longer subject to the same restrictions as a Special Patient and had declined to continue with urinary drug screening tests, did not want FCMHT to engage with whānau; had declined consent to whānau being provided with a copy of his Wellness Plan and had declined home visits by the FCMHT.

On 23 May 2024 Person A was arrested by Police following an alleged assault on a whānau member who was living in his house. No charges were laid but Person A was served with a Police issued 10 day safety order. The Co-Response team contacted the Mental Health After Hours Team. After a crisis mental health assessment, Patient A was admitted to an inpatient stay at Stanford House under section 29(3)(a) of the MHA for a period of assessment. He remained as an inpatient for seven days before being discharged to resume community care under the FCMHT on 30 May 2024. Follow up was arranged for 4 June 2024 when Person A was administered his usual medication around midday. In the afternoon a family member contacted his FCMHT case manager to raise concerns about Person A's mental health. The case manager provided the family member with the Responsible Clinician's contact cell phone number and updated the Responsible Clinician of the concerns. An appointment with Person A's Responsible Clinician was organised for 48 hours later.

On 5 June 2024 Person A was arrested for the alleged killing of his mother. Following his arrest, he presented with symptoms of his known schizophrenic illness and was admitted from Whanganui court to a secure forensic inpatient ward under section 38(2)(c) of the CP (MIP) Act.

Findings

The findings of the external review² can be summarized as:

Positive Findings of the Review

- (a) FCMHT staff made good efforts to integrate key information across the separated clinical records of CFMHS and Whanganui District.
- (b) FCMHT and Whanganui District Mental Health Services have fostered and maintained a good working relationship over many years.
- (c) FCMHT staff and Whanganui District Mental Health Services acted quickly and collaboratively in facilitating a crisis admission for Person A on 23 May 2024.
- (d) After the death of Person A's mother there was excellent collaboration by all parties (police, crisis mental health services and CFMHS clinicians to ensure Person A was safely transferred to an appropriate acute forensic inpatient setting as quickly as possible.

Findings and Recommendations

Finding 1: Whānau engagement

FCMHT did not uphold MHAIDS Whānau Framework and Whānau Participation Policy.

Recommendations:

- (a) Team Leader to ensure all FCMHT staff have read the MHAIDS Whānau Framework and Whānau Participation Policy within three months of receiving this report. There should be a complete staff list which is signed by each staff member to show evidence of this being actioned.
- (b) Whānau engagement across all CFMHS Forensic Community Teams is to be audited within six months of receiving this report and the findings presented to

² At the time of writing, this report is still in the process of being finalised. However, the recommendations have been acted on in advance of the finalisation of the report.

CFMHS Clinical Governance group for discussion and the outcome of this discussion reported back to SERC/Improvements.

- (c) Using the new CFMHS and ID Services Whānau Engagement Procedure as a base document, CFMHS Clinical Governance will ensure this document includes their community-based teams through either creating a community-based whānau engagement procedure, or incorporating community-team practice into the existing document within 12 months of receiving this report.

Finding 2: Absence of Senior Medical staff and diffuse clinical leadership.

Throughout and prior to the period of investigation there was a lack of a Specialist Psychiatrist within the FCMHT. In the past, the Specialist Psychiatrist/Responsible Clinician in the FCMHT had acted as the leader of the MDT coordinating oversight of compulsory treatment with the delivery of antipsychotic treatment and oversight of care plans. There had not been an incumbent Senior Medical Officer/Responsible Clinician for more than a year with a variety of locum tenens or cross-covering clinicians.

Recommendations:

- (a) CFMHS review and strengthen clinical leadership structures within the organisation and within the resources available. Each team needs a consistent and appropriately qualified clinical leader who is present for case reviews and care planning.
- (b) Every patient of the FCMHT has a three-monthly review by a vocationally registered psychiatrist (as per CFMHS operations manual page 8).
- (c) CFMHS support ensure that maximum efforts have been made to employ a specialist psychiatrist to work with the FCMHT.

Finding 3: Model of Forensic Community Care

The FCMHT section of the CFMHS Procedure Manual is inadequate to describe the goals, methods, purpose, and admission and discharge criteria for Forensic Mental Health community care delivery. There was discrepancy between senior leadership views of the role and purpose of the forensic community team and those of clinicians. There were also differences in understanding and expectations regarding urine drug screens (UDS).

Recommendations:

- (a) All FCMHT staff to read the existing CFMHS Operations Manual in relation to FCMHT. This should be done within three months of receiving this report. There should be a complete staff list which is signed by each staff member to show evidence of this being actioned.
- (b) The CFMHS Operations Manual section on FCMHT is revised by the CFMHS Clinical Governance with consultation from all FCMHT teams to include guidance on the model of care delivery (e.g. modified assertive community team), expectations about role and purpose of Forensic Community Team, working with whānau and minimum standards of care.
- (c) The CFMHS Operations Manual section on FCMHT should clearly outline the expectations and process for UDS for all FCMHT tāngata whaiora.

Finding 4: Service Level Agreement between services

At the time of this incident, there was no agreed Service Level Agreement (SLA) in place that described the relevant roles and responsibilities of Whanganui District and CFMHS in the care of Forensic Community Clients in Whanganui area. Due to well-established and collegial relationships, all parties worked in a coordinated manner through the review period. However, the complexity of the interservice relationships created gaps in service delivery.

Recommendations:

- (a) The Clinical Director and Group Manager for CFMHS will ensure the draft SLA between Whanganui District and CFMHS is finalised within 12 months of receiving this report.
- (b) The SLA mandates that acute inpatient admission of FCMHT clients occur where there are adequate resources (staff and facilities) available for assessment. Where there are not adequate resources an escalation protocol needs to be developed and incorporated into the SLA.
- (c) Clinically effective integration of electronic mental health records between Whanganui District and CFMHS for FCMHT clients in the Whanganui district within 6 months of receiving this report.

Finding 5: Clinical Documentation

Not all FCMHT team members who interacted with Person A documented the interactions in the notes on a regular basis.

Recommendation:

- (a) Team Leader will speak to all staff about the importance of making notes following all interactions with clients or whānau upon receiving of this report. Team Leader needs to show evidence of this being done and provide evidence back to SERC/Improvements to show this has been done within 3 months of receiving this report.
- (b) Team Leader will identify any staff who require documentation training and ensure training is completed within 3 months of receiving this report. Team Leader needs to show evidence of this being done and provide evidence back to SERC/Improvements within 3 months of receiving this report.

Finding 6: Process for Reclassification of Special Patients

The process of review and recommendation for reclassification of special patients for Person A is outside the time and scope of this review.

Finding 7: Recruitment of Senior Medical Staff (SMO)

There are significant and persistent SMO shortages within forensic services, but advertising is not consistently in place. Senior management did not believe there was a systematic recruitment strategy within the organisation.

Recommendation:

- (a) A national strategy to recruit and retain specialist forensic medical staff is required, with participation from all regional forensic services across New Zealand. Recruitment processes for senior medical staff needs to be reviewed.

The findings of the internal review of services provided by Stanford House found:³

Findings and Recommendations

Finding 1: Admission Process and DAMHS Direction

The admission process involved multiple services including Police/mental health crisis co-response team, police, the Mental Health Assessment and Home Treatment (MHAHT) team and on-call psychiatrist, the FCMHT, and the Director of Area Mental Health Services (DAMHS). The admission was safe with the appropriate outcome of a directed period of admission to Stanford House. Some aspects of the procedure were identified as “grey areas” needing clarification for future admissions.

Recommendations:

- (a) Develop clear guidance for the FCMHT staff in Whanganui and Whanganui after hours on-call psychiatrists about which DAMHS to contact for urgent forensic community pathway admissions to Stanford House. Guidance should also include who to contact for DAMHS cover during absences.

³ At the time of writing, this report is still in the process of being finalised. The Improvement Plan incorporates and/or addresses some of these findings and recommendations. Once finalised, the Improvement Plan will again be reviewed and updated to ensure all recommendations have been captured, and are being progressed.

Finding 2: Clarity of admission location and the purpose, plan and reason for the episode of care

There was a lack of clarity of the location and purpose of admission. The Responsible Clinician who is employed by CFMHS, entered notes in the MHAIDS patient information system. The notes were not accessible to the Stanford House nursing staff and they did not see the Responsible Clinician's assessment of Person A or the plan for the admission. This led to a misinterpretation by the staff that Person A was at Stanford House for respite/reset and did not receive the comprehensive mental state assessment that was required to identify any underlying symptomatology of psychosis.

Recommendations:

- (a) Establish a process to ensure intentions of the psychiatrist, DAMHS and Responsible Clinician around admission location to Stanford House and the purpose are clearly communicated to all staff.
- (b) Work with the Mental Health Medical Directors with oversight of MHAIDS and Whanganui clinicians to develop a standardised section of the admission documentation to include a comprehensive plan to cover the first 48hrs of assessment, care and treatment on admission; the content will cover at a minimum the purpose and location of the admission, legal status, this plan will address risk, and provide directives for the nursing staff about frequency of documented assessment of mental state and level of observation. If they are not the admitting clinician, the responsible clinician will follow up with a more comprehensive plan within 48hrs.
- (c) Develop a clear process so people know where to access clinical notes from other districts.
- (d) Reassess the clinical process that identifies who would be the most effective and appropriate clinician responsible for acute patient admitted to Stanford House.

Finding 3: Documentation of mental state assessment and care planning by the Stanford House nursing staff.

Stanford House staff are not recently trained or experienced in providing the more acute forensic care required for patients who, like Person A, are admitted urgently and

unplanned.

Documentation of mental state assessments was inconsistent across shifts. Evaluating underlying aspects of mental state for any clinician viewing consecutive shifts documentation of mental state was not achievable because there was insufficient detail recorded.

The inpatient care plans are not fit for purpose and lacked sufficient details in goals, interventions, and evaluations significantly limiting the effectiveness of assessment and observation and the overall depth of the understanding of “what was going on for Person A”.

Recommendations:

- (a) Upskill the Stanford House nursing staff in thorough, more acute mental state assessment and consistent documentation of the acute forensic patient.
- (b) All staff must ensure that every patient encounter, along with any information that may contribute to a better understanding of the patient’s mental status, is thoroughly documented.
- (c) Continue working on the care plan template Stanford House Clinical Governance group are developing that provides a comprehensive plan for their familiar rehabilitation focus. Consider how well this would function as a care plan for an acute patient who is on the community forensic pathway when they are admitted urgently. Potentially develop changes accordingly as an adjunct template that includes the planned care and assessment goals, interventions, timeframe and evaluations in sufficient detail to support the comprehensive care needs of a more acute type of patient.

Finding 4: Use of alcohol and other drugs

On admission to Stanford House, Person A was directed to provide a UDS sample—the first since December 2022, as testing was no longer required or made a condition once he ceased being a special patient. He had consistently refused to consent when asked previously. The sample taken at Stanford House tested positive for cannabis.

Recommendations:

- (a) Ensure community forensic pathway patients are well supported by AOD clinicians if they have or develop substance use problems.
- (b) Plan to consistently offer counselling to any community forensic pathway patient who has been assessed to have unresolved grief and/or trauma in their past.
- (c) Engage all community clinicians in discussion regarding a successful way of negotiating with patients, at the time of reclassification, that will motivate and move them to provide urine drug screens when there is a high suspicion of AOD use in the community for forensic pathway patients.

Finding 5: Limited face to face whānau involvement in Person A's wellbeing plan

Whānau involvement was limited; family were not present at discharge hui despite having valuable insights into Person A's substance use and daily challenges.

Standards emphasise the expectation of active involvement of patient's whānau in their care where possible.

Recommendations:

- (a) Facilitate whānau participation in acute MDT hui, other hui and court appearances to strengthen patient support, care and contextual understanding.
- (b) Ensure staff receive updated training with regard to encouraging Patient and Whānau centred care as per the national standards, guidelines and service specifications while respecting the patient's individual wishes and confidentiality.

Finding 6: Management of Personal Items

There is no longer a process for recording/logging in all items when a patient is admitted, as long-term patients that staff have experience admitting come from one of the units at the MHAIDS service in Kenepuru, Porirua.

Recommendations:

- Reinstate secure processes for recording and storing patient belongings, as per normal hospital policies and processes.

- Ensure that there is consistent documentation of items being returned to patients, so it is clear what is with the patient and what is being safely stored.

Future Opportunities

The review highlights opportunities to strengthen processes for unplanned forensic admissions in Whanganui:

- **Clarity of the pathway to inpatient and back to the community:** Define how and where acute forensic assessments should occur, and how patients are safely discharged back into the community.
- **Safety and appropriateness:** Ensure community forensic pathway admission, assessment, care, treatment and discharge are tailored to patient, whānau needs and community and staff safety.
- **Patient and whānau centred care:** People do not exist in isolation, nor should we care for them in isolation from their whānau. Stanford House practices need to ensure a focus on strengthening involvement with whānau, especially for acute forensic pathway patients.
- **Clinical rigor:** Reinforce comprehensive mental state assessment especially when symptom masking is known, and improve care planning, and documentation standards.
- **Safe processes within Stanford House:** Secure processes for recording and safekeeping of patient belongings and tracking these items for return on discharge

Recommendations

The following recommendations have been identified as a result of the external review of services provided by CFMHS; the internal review of the services provided by Stanford House by Whanganui Mental Health Services; and a services review by the FCMHT, CFMHS and Whanganui Mental Health Services more broadly, with a view to improving the quality and safety of care delivery and the experience of team members.⁴

The recommendations have been grouped under the following six themes:

1. Whānau Engagement;

⁴ Note – these reviews are in the process of being finalised. The Improvement Plan will be updated and revised to ensure it covers all recommendations, once the reviews have been finalised.

2. Clinical Leadership and Senior Medical Staff;
3. Model of Forensic Community Care;
4. Service Level Guidelines and Interservice Collaboration;
5. Regional Service Alignment (CFMHS and Stanford House, Whanganui); and
6. Clinical Documentation.

The recommendations as against each of these themes is set out below.

Theme	Recommendations
1. Whānau Engagement	1. Ensure all FCMHT staff read the: <ul style="list-style-type: none"> • MHAIDS Whānau Framework • Whānau Participation Policy • CFMHS and ID Service Whānau Engagement Procedure
	2. Review of CFMHS and ID Service Whānau Engagement Procedure
	3. Audit whānau engagement across the FCMHT within six months, present findings to CFMHS Clinical Governance Group, and report outcomes to MHAIDS SERC/Improvements Committee.
2. Clinical Leadership and Senior Medical Staff	1. Review and strengthen clinical leadership structures by confirming each team has a consistent, qualified clinical leader for case reviews and care planning.
	2. Ensure every FCMHT client has a three-monthly review by a psychiatrist.
	3. Maximise efforts to employ a forensic psychiatrist for the FCMHT.
	4. Develop or utilise existing national recruitment and retention strategies for specialist forensic medical staff, ensuring consistent collaboration across regional forensic services.
3. Model of Forensic Community Care	1. Revise the CFMHS Operations Manual section on FCMHT. Include guidance on care delivery models, team roles, whānau engagement, and minimum standards.
	2. All FCMHT staff to read the CFMHS Operations Manual section on FCMHT within three months, with a signed staff list as evidence.
	3. Clearly outline expectations and processes for urine drug screening (UDS) for all FCMHT clients.

<p>4. Service Level Guidelines and Interservice Collaboration</p>	<ol style="list-style-type: none"> 1. Finalise the draft Service Level Guideline (SLG) between Whanganui District and CFMHS within 12 months. 2. Ensure the SLG mandates that acute admissions occur where adequate resources are available. Develop an escalation protocol for resource shortages. 3. Integrate electronic mental health records between Whanganui District and CFMHS for FCMHT clients within six months. 4. Schedule and deliver regular in-person training days and workshops for entire FCMHT. This is with a view to enhancing connection and consistent practice between the Porirua hub and team members located throughout the region. Emphasis to be placed on developing forensic-specific skills (e.g., model of care, risk assessment). 5. MHAIDS to ensure all CFMHS staff have the requisite foundation-level skills and knowledge in forensic care and rehabilitation. 6. MHAIDS to work in partnership with NGO providers (e.g., Emerge Aotearoa, Te Waka Whaiora) to ensure NGO staff have the requisite foundation-level skills and knowledge in forensic care and rehabilitation. 7. Complete a feasibility study for the repositioning of Stanford House under CFMHS, identifying governance impacts, operational dependencies, and transition actions.
<p>5. Regional Service Alignment (CFMHS & Stanford House, Whanganui)</p>	<ol style="list-style-type: none"> 1. Team Leader to ensure all FCMHT staff understand the importance of documenting all client and whānau interactions, with evidence provided to SERC/Improvements Committee within three months. 2. To ensure roles, responsibilities and accountabilities are clear, MHAIDS to review current Clinical Director and DAMHS coverage for Stanford House and FCMHT clients who reside in Whanganui. Whanganui District and Emerge Aotearoa leaders to be involved.
<p>6. Clinical Documentation</p>	<ol style="list-style-type: none"> 1. Identify FCMHT staff needing documentation training and ensure completion within three months, with

	evidence provided to SERC/Improvements Committee.
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Improvement Plan

The Improvement Plan outlines how Health New Zealand has and/or will address the recommendations falling out of the reviews of this serious event, and is available as a separate document. It is noted that this is a living document, and that it will be reviewed and updated at regular intervals to ensure that it covers all of the recommendations falling out of this serious event.

