9 March 2020

Natalie Akoorie NZMF

Via email: natalie.akoorie@nzme.co.nz



100 Heads Road, Private Bag 3003 Whanganui 4540, New Zealand

Dear Ms Akoorie

## Official Information Act Request - OIA mental health

On 7 February, under section 12 of the Official Information Act, you requested the following information from Whanganui District Health Board (WDHB):

I am writing to request information under the Official Information Act related to mental health patients who have left district health board facilities.

Please state how many patients detained under the Mental Health Act have:

- 1) Left a DHB-operated open or secure facility/ward in the past seven years, 2013 to present, when they were not supposed to or were supposed to return through;
- a) escorted leave;
- b) unescorted leave;
- c) escape;
- 4) transfer:
- 5) weekend or day leave;
- 6) any other way.

Please break down by year and type of facility.

- 2) Please state how many of those patients who left while under DHB mental health care died by suicide or suspected suicide. Please break down by year, ethnicity and gender.
- 3) Please state how many of those patients disappeared and were never found again.
- 4) Please state how many of those patients suffered an adverse event/trauma through the unapproved departure; ie raped, robbed, assaulted, accidental death or homicide etc.
- 5) Please state for the same time frame the number of patients who died INSIDE the DHB-run mental health facility and type of death, eq suicide, suspected suicide, accidental death, illness etc.

If this request is not applicable to your DHB, for example the DHB does not have mental health facilities, please respond acknowledging that.

## Whanganui District Health Boards response:

Please state how many patients detained under the Mental Health Act have:

- 1) Left a DHB-operated open or secure facility/ward in the past seven years, 2013 to present, when they were not supposed to or were supposed to return through;
- a) escorted leave;
- b) unescorted leave;
- c) escape;
- 4) transfer;
- 5) weekend or day leave;
- 6) any other way.

## Please break down by year and type of facility.

Service users who are under the auspices of the Mental Health Act are known as 'formal' patients. When formal patients breach the conditions of care, intentionally or otherwise- those breaches are registered by the clinician caring for them on an internal database, known as the Incident Register.

The following table shows the number of incidents tagged as absent without leave (AWOL), relating to formal patients who were admitted inpatients at the time of the incident. The flag 'AWOL' covers all of the categories you have listed, but does not distinguish between them.

Incidents flagged MHA Act, AWOL	Year								
	2013	2014	2015	2016	2017	2018	2019	2020	Grand Total
Total	30	22	13	40	80	83	26	6	300

In the period from January 2013 to date, there have been on average about 40 incidents per year, totalling 300 in all. These incidents range between the very minor; perhaps a patient momentarily leaving an open unit, to more significant incidents over a protracted timeframe.

Many of the incidents can be related to a single individual, so the table represents the incidence rate, rather than the number of 'people', although we can say that it was evenly separated between male and female (F-132, M-167).

2) Please state how many of those patients who left while under DHB mental health care died by suicide or suspected suicide. Please break down by year, ethnicity and gender.

Cause of death is a matter for the Coronial Service and is not information held within Whanganui DHB.

3) Please state how many of those patients disappeared and were never found again.

None

4) Please state how many of those patients suffered an adverse event/trauma through the unapproved departure; ie raped, robbed, assaulted, accidental death or homicide etc.

This is not information which exists in such a way as can be compiled.

5) Please state for the same time frame the number of patients who died INSIDE the DHBrun mental health facility and type of death, eg suicide, suspected suicide, accidental death, illness etc.

One patient passed away while an inpatient within our mental health service, in 2016, due to complications arising from a pre-existing physical health condition.

Should you have any further queries about the above information, please contact our OIA co-ordinator Anne Phoenix at anne.phoenix@wdhb.org.nz

Yours sincerely

Russell Simpson
Chief Executive

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