30 September 2025

[redacted]

Tēnā koe [redacted]

## Your request for official information, reference: HNZ00094528

Thank you for your email on 27 July 2025, asking Health New Zealand | Te Whatu Ora for the requesting information under the Official Information Act 1982 (the OIA) Your request is attached as Appendix One.

## Response

Please refer to **Appendix Two,** which sets out our decision on the release of the documents within scope of numbers 1, 2, 3, 6, 7, 9, 12, 16, 17, 18, 25 and 27. The documents able to be released are attached as **Appendix Two.**

Some information is withheld under the following sections of the OIA:

- 9(2)(ba)(i) as it is subject to an obligation of confidence, and if released, would likely prejudice the supply of similar information in the future. It is in the public interest that this information should continue to be supplied.

- 9(2)(a) of the OIA in order to protect the privacy of natural persons.

For clarity, I will address further questions in turn.

2. *Any documentation outlining decision-making frameworks or processes – formal or informal – used to guide the assessment, referral, admission, and discharge of patients presenting to EDs at the Hospitals with acute or severe health issues. This includes:*

c. *The roles and responsibilities of duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties, including involvement in any decision making.*

If a person is discharged from ED to a MHAIDS inpatient unit or a Crisis Respite unit, this is coordinated through a MHAIDS Crisis Resolution Service (CRS) clinician who contacts the MHAIDS Duty Manager to access an acute resource. It is the responsibility of the MHAIDS Duty Manager to ensure appropriate allocation of the acute resource utilising MHAIDS bed access policy where a MHAIDS inpatient bed is required.

3. *Any protocols, procedures, or shared clinical pathways that define or guide communication, coordination, or role expectations between ED and other clinical staff, including on call specialists, wards/departments, and external or integrated entities or services, and duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties, including but not limited to timing, thresholds, and documentation requirements.*

Further to question **3**, Health NZ can advise when a person has been admitted to ED the responsibility for directing and coordinating care remains with ED. In cases where ED determines that input or assessment from mental health services is required ED will make a referral to the MHAIDS Crisis Resolution Service. MHAIDS CRS staff are guided by Section 3.14 of the 1.100837 Crisis Resolution Service Operations & procedures manual which directs CRS staff to undertake an assessment of a person referred to CRS by ED within two hours of receiving such referral and directs how CRS staff interact and consult with ED staff.

Section 5 of the manual directs the documentation requirements for recording interactions with CRS.

8. *Any documentation outlining decision-making frameworks or processes – formal or informal – used to guide the assessment, referral, admission, and discharge of patients presenting to EDs at the Hospitals with acute or severe mental health issues or suicide risk. This includes:*
    a. *The roles and responsibilities of ED staff and MHAIDS clinicians (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services), and other clinical staff, including on-call specialists, and wards/departments during suicide risk assessment and follow-up.*

Further to question **8a**, Health NZ can advise the point of entry to the hospitals for a person presenting with acute or severe mental health issues or suicide risk is the Emergency Department. MHAIDS CRS staff attend ED when they receive a referral from ED staff. MHAIDS CRS staff roles and responsibilities are outlined in the CRS Operations and Procedures manual provided in response to request 3.

11. *Criteria or decision frameworks for when MHAIDS clinicians (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services) are contacted, and who is responsible for accepting, declining, or initiating referrals for inpatient admission and other psychiatric services.*

Further to question **11**, criteria or decision frameworks for contacting MHAIDS are set by the hospital department initiating the contact.

26. *Any documentation reflecting the coordination, referral, or communication pathways between hospital-based services (including but not limited to EDs, inpatient units, specialist disciplines, and MHAIDS) and general practitioners (GPs), particularly regarding medication management, follow-up care, or clinical escalation involving patients with mental health needs.*

Further to question **26**, Health NZ can advise the MHAIDS Te Ara Oranga policy describes at which points in the care pathway MHAIDS sends communications to a person's GP.

28. *Any incident reports, adverse event reviews, internal investigations, or similar documents arising from the death by suicide of any service user(s) between 20 April and 30 May 2025, who had received care from, or been assessed by, EDs at the Hospitals and MHAIDS services (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services), or Wise Group Pathways respite care in the weeks prior to their death.*

We note that the Coroner determines whether a person has died by suicide, and that no documents exist relating to a service user whose death has been ruled as a suicide between 20 April and 30 May 2025.

We also note that, to the extent any information exists with respect to any deaths by suspected suicide, we consider that, due to the specific time period involved, any information provided could lead to the identification of the service user(s). We note that the appropriate

process for requesting information about a specific individual is in accordance with the Privacy Act 2020/Health Information Privacy Code. With respect to a person who is deceased, the person's representative (i.e. the executor or administrator of the will) has legal status to make a request. If the person does not have a will, and there is therefore no executor or administrator, we will then consider the request under the Official Information Act 1982. In considering a request under the Official Information Act 1982 in such circumstances, it is helpful for us to understand the relationship between the requester and the person, and the reason for the request, so that we can apply the balancing test under the Official Information Act 1982 – that is, whether, in the circumstances of the particular case, the withholding of the information on the grounds of privacy, is outweighed by other considerations which render it desirable, in the public interest, to make that information available.

## Remaining information

As you are aware, we contacted you on several occasions between 4 and 12 August 2025 in an attempt to refine your request; however, these efforts were unsuccessful.

Given the interlinked nature of the information you have requested, we believe the material already released to you addresses the majority of your request. The remaining aspects of your request are very broad and would require substantial manual research and collation to identify and compile all documents within scope.

Therefore, I am refusing the remaining parts of your request under section 18(f) of the Official Information Act 1982, as the information cannot be made available without substantial research and collation.

I have considered whether fixing a charge for the supply of the information or extending the timeframe for response would enable Health NZ to respond. I do not consider that either option would remove the impact that supplying the information would have on our other operations.

We welcome a more specific request for information made with due particularity, as outlined in section 12(2) of the Act, and we are happy to work with you to refine your request to enable a response.

## How to get in touch

If you have any questions, you can contact us at HNZOIA@tewhatuora.govt.nz.

If you are not happy with this response, you have the right to make a complaint to the Ombudsman. Information about how to do this is available at www.ombudsman.parliament.nz or by phoning 0800 802 602.

As this information may be of interest to other members of the public, Health NZ may proactively release a copy of this response on our website. All requester data, including your name and contact details, will be removed prior to release.

Nāku iti noa, nā

pp. Gareth H

**Danielle Coe**
**Manager (OIAs) – Government Services**
**Health New Zealand | Te Whatu Ora**

## Appendix One

*Emergency Department Care and Escalation Protocols*

1. *Protocols or clinical pathways used to manage patients presenting with acute or severe health issues at the Hospitals, including:*

    a. *Policies outlining the escalation of clinical risk from Emergency Department (ED) staff at the Hospitals to consultants or specialists, including registrars, other wards/departments/external or integrated entities or services, duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties.*
    b. *Policies outlining the escalation of clinical risk, as per sub-clause a, in complex cases where responsibility may need to be shared between more than one specialist discipline. This includes situations where there is diagnostic uncertainty, overlapping clinical responsibility, or ambiguity in escalation pathways.*

2. *Any documentation outlining decision-making frameworks or processes – formal or informal – used to guide the assessment, referral, admission, and discharge of patients presenting to EDs at the Hospitals with acute or severe health issues. This includes:*

    a. *The roles and responsibilities of ED, other clinical staff, including on-call specialists, wards/departments, and external or integrated entities or services.*
    b. *The delineation of decision-making authority between ED, other clinical staff, including on-call specialists, wards/departments, and external or integrated entities or services, and who holds final responsibility for decisions.*
    c. *The roles and responsibilities of duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties, including involvement in any decision making.*
3. *Any protocols, procedures, or shared clinical pathways that define or guide communication, coordination, or role expectations between ED and other clinical staff, including on call specialists, wards/departments, and external or integrated entities or services, and duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties, including but not limited to timing, thresholds, and documentation requirements.*

4. *Any documentation outlining standard protocols, care models, or procedures governing interdisciplinary coordination between clinical specialties within the Hospitals. This includes expectations for shared care planning, joint consultation, referral pathways, or co-management of individuals with complex medical needs.*

5. *The basis for these arrangements, including but not limited to, Te Whatu Ora policies, standards, guidelines, procedures, or other similar documentation, at the local, regional, district and national levels, including any legacy DHB documentation.*

6. *Any oversight, review, escalation, consultation, or dispute-resolution processes used when there is clinical, operational or administrative disagreement between ED and other wards/departments, and external or integrated entities or services, or when escalation criteria or risk thresholds are unclear or contested.*

*Emergency Department Care and Escalation Protocols (Mental Health)*

7. *Protocols or clinical pathways used to manage patients presenting with acute or severe mental health issues or suicide risk at the Hospitals, including:*

    a. *Policies outlining the escalation of clinical risk from ED staff at the Hospitals to consultants or specialists, including registrars, psychiatric services, the Mental Health, Addiction and Intellectual Disability Service (MHAIDS) – a specialist service directorate within Te Whatu Ora – and its services (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services), duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties.*
    b. *Policies outlining the escalation of clinical risk, as per sub-clause a, in complex cases where responsibility may need to be shared between more than one specialist discipline in regard to patients presenting with severe acute mental health distress or suicidal ideation but where an underlying or related medical condition contributes to the distress (e.g. psychiatry and neurology). This includes situations where there is diagnostic uncertainty, overlapping clinical responsibility, or ambiguity in escalation pathways.*

8. *Any documentation outlining decision-making frameworks or processes – formal or informal – used to guide the assessment, referral, admission, and discharge of patients presenting to EDs at the Hospitals with acute or severe mental health issues or suicide risk. This includes:*
    a. *The roles and responsibilities of ED staff and MHAIDS clinicians (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services), and other clinical staff, including on-call specialists, and wards/departments during suicide risk assessment and follow-up.*
    b. *The delineation of decision-making authority between ED and MHAIDS (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services), and other clinical staff, including on-call specialists, wards/departments, and who holds final responsibility for decisions.*
    c. *The roles and responsibilities of duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties, including involvement in any decision making.*

9. *Any protocols, procedures, or shared clinical pathways that define or guide communication, coordination, or role expectations between ED and MHAIDS (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services), other clinical staff, including on call specialists, wards/departments, and external or integrated entities or services, and duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties, including but not limited to timing, thresholds, and documentation requirements.*

10. *Any documentation outlining standard protocols, care models, or procedures specifically governing coordination between psychiatric and neurological services within the Hospitals. This includes consultation procedures, shared clinical pathways, escalation protocols in*

    *complex diagnostic presentations, and any barriers or limitations identified in delivering integrated care between these specialties.*

11. *Criteria or decision frameworks for when MHAIDS clinicians (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services) are contacted, and who is responsible for accepting, declining, or initiating referrals for inpatient admission and other psychiatric services.*

12. *Documentation outlining referral or clinical pathways between EDs at the Hospitals and MHAIDS including Crisis, Community, Addiction, Opioid Treatment Service, and*

*inpatient services, including expectations for when MHAIDS should be contacted and who is responsible for making the referral*

13. *The basis for these arrangements, including but not limited to, Te Whatu Ora policies, standards, guidelines, procedures, or other similar documentation, at the local, regional, district and national levels, including any legacy DHB documentation.*

14. *Any oversight, review, escalation, consultation, or dispute-resolution processes used when there is clinical, operational or administrative disagreement between ED, Crisis Resolution Service, other MHAIDS services, psychiatric inpatient services, and other psychiatric services, or when escalation criteria or risk thresholds are unclear or contested.*

15. *Any documentation detailing the standard staffing arrangements and on-call clinical coverage provided by MHAIDS and any relevant medical specialties – particularly psychiatry and neurology – to each of the Hospitals between 20 April and 30 May 2025. This includes:*

    a. *Rosters, service schedules, or protocols outlining routine or urgent availability of psychiatric and neurological consultation*
    b. *Any arrangements or policies relating to interdisciplinary coordination between psychiatry and neurology*
    c. *Identification of services available on-site, off-site, or via remote consultation during this period*

16. *Documentation clarifying the structural and governance relationship between MHAIDS, inpatient psychiatric units, and EDs at each of and between the Hospitals. This includes but is not limited to: any reporting lines to duty managers, hospital management, Te Whatu Ora leadership, and any other relevant parties; and any shared care protocols, escalation pathways, or other operational mechanisms defining coordination between these services.*

17. *Documentation describing, including but not limited to, communication and reporting relationships between MHAIDS and Te Whatu Ora, and the nature of MHAIDS's relationships, coordination or interface with district-level and hospital-based (at both of the Hospitals), operational and clinical leadership, such as operational responsibilities, decision-making frameworks, joint planning processes, and any policies or structural arrangements defining MHAIDS's placement within Te Whatu Ora governance.*

18. *Information relating to the Crisis Resolution Service (CRS), including any CRS-related decisions, communications, or service delivery carried out within hospital facilities or involving hospital-based staff. This includes:*

    a. *Clarification of the interface and coordination between CRS, each of the Hospitals, and between the Hospitals*
    b. *Any documentation describing the operational and clinical relationship between*

    *psychiatrists and CRS, including their integration within the service, referral and access arrangements, reporting structures, and any delineation of responsibility for care delivery.*

19. *Care planning, and inter-specialty coordination and integration of care, for individuals with complex combined psychiatric and medical needs, including situations where*

*other, non-psychiatric medical specialties are, or should be, involved in assessment or treatment (including, but not limited to, neurology or pain medicine)*

20. *Any documentation reflecting the coordination, communication, governance, or operational integration between Wellington Regional Hospital and Hutt Valley Hospital, particularly in relation to emergency mental health care, shared protocols, escalation frameworks, or service alignment across sites. This includes any materials addressing differences or duplication in procedures, staffing, or service responsibility across the two hospital sites.*

21. *Any other documentation reflecting the relationships between the Hospitals, MHAIDS, and other mental health service providers, and between each of the Hospitals themselves, where not otherwise covered above.*

*Consult Liaison Psychiatry Service*

22. *Documentation describing how individuals are referred to the Consult Liaison Psychiatry Service (CLPS), including which clinical services may initiate referrals, any formal criteria or pathways governing this process, and the role of coordination between the Hospitals, CLPS, and MHAIDS. This includes any documentation outlining oversight responsibilities, shared clinical authority, or communication, governance, and escalation protocols among these services.*

23. *Documentation outlining the eligibility criteria, structural limitations, or decision-making protocols that determine access to CLPS for individuals experiencing psychiatric distress secondary to a medical condition, particularly in cases where the individual is not admitted as an inpatient. This includes whether high-risk individuals can be seen by CLPS despite capacity or structural barriers, and any relevant guidance addressing such scenarios.*

24. *Documentation describing how decisions are made regarding admission for individuals presenting with medical conditions accompanied by psychiatric distress, including criteria for whether such individuals are admitted to a medical ward or psychiatric ward. This includes the extent to which psychiatric distress influences the decision to admit, the role of hospital capacity constraints, and the responsibilities of CLPS in such cases.*

*Emergency Services and GP Liaison*

25. *Any documentation outlining the procedures and accountability mechanisms for ensuring coordinated and timely response to high-risk acute mental health emergencies involving multiple service touchpoints (including but not limited to: MHAIDS crisis services, 111 emergency services, ambulance services, hospital EDs, Whakarongorau, and taxi service providers). This includes protocols and expectations for confirming follow-up by any of the involved services, regardless of which service was initially contacted by an individual, and the conditions under which responsibility may be transferred or delegated back to the individual.*

26. *Any documentation reflecting the coordination, referral, or communication pathways between hospital-based services (including but not limited to EDs, inpatient units, specialist disciplines, and MHAIDS) and general practitioners (GPs), particularly regarding medication management, follow-up care, or clinical escalation involving patients with mental health needs.*

*Adverse Events*

27. *Any documentation outlining the processes, protocols, or frameworks for initiating, conducting, and reviewing adverse event reviews, internal investigations, or similar inquiries within MHAIDS or the Hospitals. This includes:*

    a. *Criteria for when such reviews are triggered*
    b. *Who is responsible for overseeing or participating in the review process*
    c. *Circumstances under which external parties (e.g. Te Whatu Ora leadership, Health and Disability Commissioner, Coronial Services, independent reviewers, or regulatory agencies) are involved, consulted, or notified.*

28. *Any incident reports, adverse event reviews, internal investigations, or similar documents arising from the death by suicide of any service user(s) between 20 April and 30 May 2025, who had received care from, or been assessed by, EDs at the Hospitals and MHAIDS services (including Crisis, Community, Addiction, Opioid Treatment Service, and inpatient services), or Wise Group Pathways respite care in the weeks prior to their death.*

## Appendix Two

| # | Question 1 | Title | Decision on release |
|---|---|---|---|
| 1. | April 2021 | Triage in the Emergency Department Guideline.pdf | Released in full. |
| 2. | May 2023 | Hutt Valley Paediatric Vital Signs Chart: 0-11 Months | Refused under section 18(d) of the OIA. Information is publicly available: 13803-GENERIC-Paediatric-Vital-Signs-Chart-0-11-MONTHS-WEB.pdf |
| 3. | May 2023 | Hutt Valley Paediatric Vital Signs Chart: 5-11 Years | Refused under section 18(d) of the OIA. Information is publicly available: NEW-GENERIC-Paediatric-Vital-Signs-Chart-5-11-YEARS-WEB.pdf |
| 4. | May 2023 | Hutt Valley Paediatric Vital Signs Chart: 12+ Years | Refused under section 18(d) of the OIA. Information is publicly available: 13803-GENERIC-Paediatric-Vital-Signs-Chart-12-YEARS-WEB.pdf |
| 5. | April 2025 | Hutt Emergency Department PAEDIATRIC Asthma/VIW Protocol | Released in full. |
| 6. | - | Early Warning Score National Chart | Released in full. |
| 7. | - | MEWS Chart with Local HVDHB Escalation Pathway.pdf | Released in full. |
| | **Question 2** | | |
| 8. | Jan 2022 | Monitoring and Observations in the Emergency Department | Released in full. |
| 9. | Nov 2023 | MHAIDS Operations Centre Duty Manager Procedure Manual | Some information withheld under the following sections of the OIA:<br>• s9(2)(a)<br>• s9(2)(ba)(i) |
| 10. | Dec 2024 | MHAIDS Accessing Beds in the Adult Acute Inpatients Unit | Released in full. |
| 11. | Aug 2025 | Trauma Management Policy | Released in full. |
| | **Question 3** | | |
| 12. | Nov 2023 | Hutt Hospital ED – Ward Handover Checklist | Released in full. |
| 13. | Feb 2025 | MHAIDS CRS Operations Manual | Released in full. |

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| 14. | May 2025 | Emergency Department Information System | Released in full. |
| 15. | - | CRS ED Process | Some information withheld under the following sections of the OIA:<br>• s9(2)(a) |
| 16. | - | Inpatient Team Orientation to Te Pae Tiaki \| Wellington ED | Some information withheld under the following sections of the OIA:<br>• s9(2)(a) |
| | **Question 6** | | |
| 17. | Mar 2020 | CC ED Escalation Flipchart Guideline – 2020 | Released in full. |
| 18. | Apr 2021 | HV Triage in the Emergency Department – 2021 | Released in full. |
| 19. | Jun 2021 | CC Clinical emergencies including resuscitation - 2021 | Released in full. |
| 20. | May 2022 | 2DHB Partners in care Observation and Engagement Policy – 2022 | Released in full. |
| 21. | Aug 2022 | Rohe Karaka Orange Zone & Wahi Matakitaki Emergency Department Observation Unit - 2022 | Released in full. |
| 22. | Dec 2022 | CC Mental Health Nursing Assessment Tool & Referral Process, Te Pae Tiaki – ED - 2022 | Some information withheld under the following sections of the OIA:<br>• s9(2)(a) |
| 23. | Jun 2023 | District Wide Clinical Handover Policy - 2023 | Released in full. |
| 24. | Feb 2024 | CC Triage in the Emergency Department – 2024 | Released in full. |
| 25. | Feb 2025 | Responsibility for patient Care – Te Pae Tiaki \| Emergency Department | Released in full. |
| 26. | Apr 2025 | CCHV Transfer of Care and Test Results Responsibility - 2025 | Released in full. |
| 27. | May 2025 | CC Intra-hospital transfer of the Emergency Department patient ED - 2025 | Released in full. |

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| 28. | Jun 2025 | CCHV Self-Discharge Guideline Emergency Department – 2025 | Released in full. |
| 29. | Jul 2025 | CCHV Adult & paediatric vital sign measurement, early warning score and escalation - 2025 | Released in full. |
| | **Question 7** | | |
| 30. | July 2020 | Emergency Assessment of Suicide Ideation | Released in full. |
| 31. | Feb 2023 | Mental Health Assessment Guideline 000000105805 | Released in full. |
| 32. | June 2023 | Management of inpatients in Matairangi for medical management following a MET call 000000105066 | Released in full. |
| 33. | Feb 2025 | MHAIDS CRS Operations Manual | Released in full. (Document 13) |
| 34. | - | Preferred ED Process | Released in full. (Document 15) |
| | **Question 9** | | |
| 35. | July 2022 | Te Ara Oranga MHAIDS | Released in full. |
| | **Question 12** | | |
| 36. | - | Preferred ED Process | Released in full. (Document 15) |
| | **Question 16** | | |
| 37. | April 2025 | ED MH Interface Meeting TOR | Released in full. |
| | **Question 17** | | |
| 38. | Apr 2020 | MHAIDS Internal Transfer of Care - 2020 | Released in full. |
| 39. | Apr 2020 | TKW 777 emergency responses on the Kenepuru and Ratonga Rua o Porirua campuses for MHAIDS - 2020 | Released in full. |
| 40. | Dec 2020 | Management of Persons Admitted to Hutt Valley General Hospital primarily for Mental Health & Addiction Treatment - 2020 | Released in full. |
| 41. | Aug 2021 | Existing clients GP Liaison GPL/ Primary Care Liaison PCL Nurse services for existing clients of Community Mental Health Teams - 2021 | Released in full. |

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| 42. | Mar 2023 | Whole Service Response Plan Procedure MHAIDS - 2023 | Released in full. |
| 43. | Nov 2023 | MHAIDS Operations Centre Duty Manager Procedure Manual - 2023 | Released in full. (Document 9) |
| 44. | Apr 2024 | MHAIDS Mental Health & Addictions Prioritisation Triage Scale - 2024 | Released in full. |
| 45. | Mar 2024 | MHAIDS Internal request for service - 2024 | Released in full. |
| 46. | May 2024 | MHAIDS Intake and Assessment Procedure - 2025 | Released in full. |
| 47. | Dec 2024 | MHAIDS Accessing Beds in the Adult Acute Inpatient Units policy - 2024 | Released in full. (Document 10) |
| 48. | Jan 2025 | MHAIDS Observation and Engagement Procedure - 2025 | Released in full. |
| 49. | May 2025 | MHAIDS Intake and Assessment Policy - 2025 | Released in full. |
| | **Question 18** | | |
| 50. | Feb 2025 | Crisis Resolution Service Operations & procedures Manual - 2025 | Released in full. (Document 13) |
| 51. | Dec 2021 | Crisis Resolution Service CRS Desktop Manual - 2021 | Some information withheld under the following sections of the OIA:<br>• s9(2)(ba)(i)<br>• s9(2)(a) |
| | **Question 25** | | |
| 52. | Oct 2018 | Missing persons – Emergency Department & Emergency Department Observation Unit | Some information withheld under the following sections of the OIA:<br>• s9(2)(ba)(i)<br>• s9(2)(a) |
| 53. | Mar 2020 | Wellington Co-response Team CRT Memorandum of Understanding - 2020 | Released in full. |
| 54. | Jan 2022 | MHAIDS Phone access for general practices to Specialist Mental Health & Addictions advice - 2022 | Released in full. |

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| 55. | Apr 2022 | Memorandum of Understanding between NZ Police (Wellington District) and MHAIDS - 2022 | Released in full. |
| 56. | Jun 2025 | CCHV Self-Discharge Guiding Emergency Department | Released in full. (Document 28) |
| | **Question 27** | | |
| 57. | June 2017 | HQSC National Adverse Events Policy | Released in full. |
| 58. | March 2019 | Adverse Event and Incident Management | Released in full. |
| 59. | Mar 2019 | CC Adverse Event and Incident Management - 2019 | Released in full. |
| 60. | Mar 2021 | CC Consumer Complaints, Advocacy and Code of Rights - 2021 | Released in full. |
| 61. | Sep 2022 | CCHV Serious Event Review Policy - 2022 | Released in full. |
| 62. | Sep 2022 | CCHV Serious Event Review process map for patient and Whanau - 2022 | Released in full. |
| 63. | Sep 2022 | CCHV 8 Step Process SAC 1&2 Serious Event Review - 2022 | Released in full. |
| 64. | July 2023 | District Wide HDC Complaints Process - 2023 | Released in full. |
| 65. | Aug 2023 | Event/Incident Reporting | Released in full. |
| 66. | - | Always report and review list | Released in full. |