Review of Escalation Pathway:

Waikato Hospital Event

9 March 2025

Te Kāwanatanga o Aotearoa
New Zealand Government

Health New Zealand
Te Whatu Ora

Summary

- Health New Zealand's (Health NZ) Mental Health (including Intellectual Disability) and Addiction Services escalation pathway was being reviewed to meet current circumstances. A custom and practice process was in place.
- This process was not followed through to completion which resulted in the Chief Clinical Officer (CCO), Chief Executive Officer (CEO) and the offices of the relevant ministers not being notified.
- The level of detail included at each escalation point within Health NZ varied and did not meet the standard required.
- Oversights were due to human error and the relevant people have acknowledged their error and apologised.
- The new escalation policy is being developed. This will include a standardised checklist of the information that is required to be escalated to the CCO, CEO and ministerial offices.

Purpose

1. The purpose of this escalation pathway review ("the review") is to determine the steps taken by (Health NZ and the Ministry of Health (MoH) to escalate the Serious Adverse Event (SAE) which occurred in Waikato Hospital on 9 March 2025.
2. The escalation pathway review is a companion document to the Rapid Incident Review, which investigates this SAE.

Scope

3. The review considers the period from when the event was first escalated from the district to the MoH and some members of the national Health NZ team on 10 March 2025, to the time when media enquiries were received by Health NZ on 21 March 2025.

Methodology

4. Senior Health NZ and MoH employees involved in the escalation pathway were interviewed to inform this review. A list of interviewees is found in Appendix 1. Documentation detailing the escalation pathway was also sourced.

Exclusions

5. Internal escalations within the district are excluded from this review.

Background

6. At the time of this event, Health NZ had a 'Specialist Mental Health (including Intellectual Disability) and Addiction Services serious adverse events escalation pathway' ("current escalation pathway") in place (Appendix 2). This escalation pathway was established in January 2024 to reflect the structure of Health NZ at the time and the recent appointment of a Minister for Mental Health. This escalation pathway was known to the Health NZ and MoH employees involved in this event at the national and district level.

7. At the time of this event, the current escalation pathway did not reflect Health NZ's structure which had changed due to restructuring. In particular, the current escalation pathway included the disestablished role of National Director Hospital and Specialist Services and did not include the recently established role of National Chief Mental Health and Addiction.

8. The current escalation pathway in place at the time of this event stated:
   a. **Group Director of Operations (GDO)** (or their nominated representative) notifies the **Regional Director HSS** of the event.
   b. **The Regional Director HSS** notifies the **National Director HSS** of the event.
   c. **The National Director HSS** will then ensure that the following are advised, depending on the seriousness of the event:
      I. CEO – noting the CEO may choose to advise the Chair of the Board
      II. National Media team
      III. Minister's office

9. At the time of implementation of the current escalation pathway (January 2024), a custom and practice was put in place between the Director Specialist Mental Health and Addiction and the then National Director Hospital and Specialist Service (HSS), whereby:
   a. The National Director HSS would escalate to the CEO; and
   b. The Director Specialist Mental Health and Addiction would escalate to the Minister of Mental Health's Office.

10. Since subsequent changes to national and regional HSS structures, the custom and practice in place is that the Establishment Deputy Chief Executive (DCE) notifies the CEO, in place of the previous National Director HSS. The Director Specialist Mental Health and Addiction retained the role of escalation to the Minister of Mental Health's Office.

11. A new escalation pathway was in draft at the time of the event and was scheduled to be presented to Health NZ Executive Leadership Team for review and endorsement on 2 April 2025. This new pathway would then replace the current escalation pathway and custom and practice pathway, once approved.

Findings

Triggering of Escalation

12. The nature of the event appropriately reached the threshold for notification under the current escalation pathway within Health NZ, and the requirements for reporting mental health events to the Office of the Director of MH&A at the MoH.

Escalation Timeline

13. The event was first escalated by the Director of Area Mental Health Services to the Director Mental Health and Addiction, MoH on 10 March 2025 by phone call at 8.33am, followed by an email at 9.07am. This email included an attachment of the reportable event notification form (Appendix 3).
14. The MoH Director of Mental Health and Addiction escalated the event to the acting Deputy Director General, Clinical Community and Mental Health verbally at approximately 5.00pm on 10 March 2025. The acting Deputy Director General, Clinical Community and Mental Health did not escalate this event to the acting Director General of Health because it was assumed escalation was occurring within Health NZ.
15. The event was escalated from the GDO to the DCE, Midland Region (Te Manawa Taki) at 10.52am on 10 March 2025 via text. The DCE did not escalate the event further as the information provided did not reach the threshold to trigger an escalation. The DCE anticipated further detail to be provided. No further detail was received. This was an unintentional oversight by the Waikato GDO who was managing competing high pressure demands.
16. The event was escalated from the Acting Director, MH&A Waikato to the National Chief MH&A and the Director Specialist MH&A at 1.03pm on 10 March 2025 by email. The Director Specialist MH&A did not escalate the matter further (to the Minister of Mental Health's Office). This was an unintentional oversight by the Director Specialist MH&A who had returned from leave that day and was managing other large programmes of work requiring significant attention.
17. The National Chief MH&A would usually highlight any serious adverse events to the Chief Clinical Officer (CCO) through discussion during their scheduled meetings. This did not occur due to subsequent significant clinical events which were prioritised in the next scheduled meeting.
18. The Director Specialist MH&A and the National Chief MH&A were assured that the district was treating the event with appropriate seriousness and that the district leadership was reviewing the event.
19. There was no further senior escalation within Health NZ until 21 March 2025.

20. Health NZ received notification from Police of a media enquiry about the event at 9.59am on 21 March 2025. The Communications Team at Health NZ sent the message to the DCE and GDO at 11.24am as an FYI and asked if Health NZ records could be checked for anything relating to such an incident. Health NZ and the Offices of the Ministers of Health and Mental Health also received media enquiries on 21 March 2025. The media enquiry sent to Health NZ was received at 4.52pm.
21. The Chief Communications Officer at Health NZ contacted the DCE via text message at 5.38pm noting that the Minister's office and Health NZ had received media enquiries and asking if the interim CEO was aware. The Minister of Health contacted the CEO at 5.51pm. The CEO notified the Commissioner at 6.17pm.

Escalation Content

22. The level of detail included at each escalation point within Health NZ varied and was not in line with the current escalation pathway requirements, which are (Appendix 2):
    a. Nature of the event;
    b. Brief relevant background;
    c. Current state analysis;
    d. Immediate actions taken:
    e. Further actions planned: and
    f. Confirmation of whether local Comms lead has been involved.
23. The notification to the MoH was completed as required and included the 'Reported Event Notification Form' (Appendix 3) as required.

Summary of Findings

24. The custom and practice escalation pathway which was in place at a national level had separate escalation pathways to the CEO and to the Minister of Mental Health's Office, neither of which were followed to their end points (contacting the CEO of Health NZ or the Minister of Mental Health's Office).
25. The Health NZ custom and practice escalation pathway was followed to the extent that the relevant regional and national individuals were made aware of the event, however the detail included at each escalation point was not in line with requirements.
26. Escalation to the CEO in line with the custom and practice escalation pathway was not followed by the DCE because the escalation threshold was not met by the information provided. Fuller information sharing may have addressed this.
27. Escalation to the Minister of Mental Health's Office by the Director Specialist MH&A in line with the custom and practice escalation pathway was not followed due to an unintentional oversight and competing priorities.

28. The individual responsible for the notifying the Minister of Mental Health's office has reflected on what has occurred and has apologised to the Minister of Mental Health. The lack of notification to the Minister of Mental Health's Office was an unintentional human error.
29. Notification did occur in line with Ministry of Health process to the Director MH&A (MoH), who in turn escalated to the acting Deputy Director General, Clinical Community and Mental Health (MoH). The acting Deputy Director General, Clinical Community and Mental Health did not escalate to the Director General of Health because it was assumed escalation was occurring within Health NZ.
30. The escalations which did occur within Health NZ did not include all the required information as outlined in the current escalation pathway guidance.
31. Escalation to the Chief Clinical Officer did not occur from the National Chief MH&A - as would have been expected - due to subsequent significant clinical events which were prioritised for discussion. The CCO is responsible for overall clinical safety and quality within Health NZ and for ensuring appropriate oversight of adverse events.

Recommendations

The following short-term actions are recommended:

32. The revised escalation pathway for MH&A Serious Adverse Events should be agreed and implemented as soon as possible to ensure clarity for all involved parties, in line with current Health NZ structures, and ensure a single escalation pathway to the CCO, CEO, Commissioner and relevant ministerial offices.
33. A standardised check list should be developed of all information required in the escalation pathway. A completed checklist should be included with any information that is escalated to any senior officers, including the CCO, CEO, Commissioner and ministerial offices.
34. The revised escalation pathway should also include a flowchart for ease of comprehension.
35. All individuals involved in the escalation pathway should be fully informed of the new escalation pathway to ensure a common understanding. An annual training session should be held with all members of the pathway. The pathway should be updated following significant structural changes within Health NZ.
36. The Director, MH&A (MoH) should be consulted on the revised escalation pathway to ensure appropriate communication points with the regulator are included.
37. A clinical escalation pathway for all Severity Assessment Code (SAC) 1 events should be implemented at Health NZ, reporting through to the CCO. SAC code descriptors are included in Appendix 4.

38. An initial Human Resources investigation should be undertaken, to determine whether any further employment action is recommended in relation to the escalation of this event.

The following longer-term actions are recommended:

39. Health NZ should explore digital solutions that can assist to automate these pathways.

Appendices

1. List of Interviewees
2. Current Escalation Pathway
3. MoH Reportable Event Notification Form
4. SAC Code Descriptors

Appendix 1: List of Interviewees

- Acting Director MH&A Waikato, Health New Zealand
- Operations Director MH&A, Health New Zealand Waikato
- Director of Area Mental Health Services, Health New Zealand Waikato
- Group Director of Operations, Health New Zealand Waikato
- Establishment Deputy CEO, Te Manawa Taki, Health New Zealand
- National Chief Mental Health and Addiction, Office of the Chief Clinical Officer, Health New Zealand
- Director Specialist Mental Health and Addiction, Planning Funding and Outcomes, Health New Zealand
- Director Mental Health and Addiction, Ministry of Health
- Acting Deputy Director-General, Clinical, Community and Mental Health, Ministry of Health

Appendix 2: Current Escalation Pathway

Health New Zealand | Te Whatu Ora Specialist Mental Health (including Intellectual Disability) and Addiction Services – Serious Adverse Events Escalation Pathway

This escalation pathway document recognises that from time to time there will be serious adverse events within Specialist Te Whatu Ora Mental Health and Addiction Services involving tangata whai ora, whānau, visitors, and/or staff members. It reflects that serious adverse events involving mental health services have significant potential for public and political concern.

This document is intended to replace and clarify interim guidance distributed in December 2022.

This guidance does not change other reporting requirements such as those related to HQSC SAC 1 and SAC 2 events; Coronial Act requirements; and other DAMHS/Addiction Directors regular reporting to the Director of Mental Health/Addictions.

The purpose of this document is to:

1. **Clearly** identify which serious adverse events occurring within specialist mental health, addiction, and intellectual disability services must be escalated within Te Whatu Ora.
2. **Provide** clinical leaders and senior managers with a clear escalation pathway to use following a serious adverse event involving tangata whai ora, whānau and / or staff members.
3. **Clarify** Manatū Hauora reporting requirements to the Director of Mental Health.

Escalation is to ensure that necessary information is available to senior leaders to assist with appropriate responses to media, the ELT and Board, and to Ministers.

This pathway is not intended to replace:

1. Immediate local district level responses which may be required to support tangata whai ora, whānau, visitors, and staff members following adverse events.
2. Liaison with other agencies or partners such as the police, unions and District Inspectors.

Whilst these requirements may vary depending on the specifics of the serious event, **escalation within Te Whatu Ora is required** when any of the following occur:

- Suspected suicide or serious self-harm by any person receiving care, treatment and services in a continuous care setting or within 72 hours of discharge. This includes approved and unapproved leave status, and respite services.

- Suspected homicide by a person currently engaged with (or 'open to') specialist mental health, intellectual disability or addiction services or within 28 days of discharge from the service.
- Assault by a person currently engaged with (or 'open to') these specialist services causing serious harm to another person.
- Other serious offences allegedly perpetrated by someone engaged with these services.
- Alleged assault or other abuse by a staff member of a person engaged with these specialist services.
- Serious harm to a staff member arising in the context of their employment.
- Delayed recognition of a consumer's deterioration resulting in permanent severe disability or death (e.g. cardiomyopathy, myocarditis or toxic megacolon while taking clozapine).
- Medication or treatment plan error resulting in death.
- Serious harm to a visitor to a HHS mental health, addictions or intellectual disability facility.
- Facility damage or impairment resulting in compromised function of the setting or service.
- Anticipated media attention.

Additional Notification Requirement in Some Circumstances:

Although the above events are **not** required to be routinely notified to the Manatū Hauora Director of Mental Health/Director of Addiction Services, the following events must be (in addition to the escalation within Te Whatu Ora) notified to that office:

- Death of a person subject to the provisions of the Mental Health (Compulsory Assessment and Treatment) Act must be notified to the **Director of Mental Health** under the provisions of section 132 of that Act.
- Although no parallel provision applies in the Substance Addiction (Compulsory Assessment and Treatment Act), the Director of Addiction Services requires Area Directors of Addiction Services to notify serious events such as unauthorised absences from compulsory care settings.
- Special patients – to assist with considering implications for matters such as approvals for leave, the Director of Mental Health must be notified of unplanned interruptions or deviations in the care of special patients.

Escalation Pathway

When a serious adverse event occurs, the following notification process must be followed:

1. **The local senior clinical leader of the Mental Health and Addiction Service** (in conjunction with their relevant operational leadership partners) advise the Group Director of Operations about the event (***verbally and in writing*** – see further below). This verbal notification must occur ***as soon as possible after the event,*** with a

summary as set out ("Information required") emailed as soon as possible. This email must be **copied to the Director Specialist Mental Health Services within the Te Whatu Ora HSS senior leadership team. ([redacted]*@health.govt.nz).***

Consideration must also be given by the local senior clinical leader and operational manager at this stage to notification of the local communications lead. The Director Specialist Mental Health and Addictions will consider notification of the Mentally Well (Te Whatu Ora) or Oranga Hinengaro (Te Aka Whai Ora) commissioning leads.

2. **Group Director of Operations** (or their nominated representative) notifies the **Regional Director HSS** of the event.

3. **The Regional Director HSS** services notifies the **National Director HSS** of the event.

4. **The National Director HSS** will then ensure that the following are advised, depending on seriousness of the event:
   a. CEO – noting the CEO may choose to advise the Chair of the Board
   b. National Media team
   c. Minister's office

Information required:

- Nature of the event.
- Brief relevant background.
- Current state analysis.
- Immediate actions taken.
- Further actions planned.
- Confirmation of whether local Comms lead has been involved

For those items requiring notification to the Director of Mental Health/Director of Addiction Services a concurrent process will occur between the **Director of Mental Health Services (DAMHS)** or the **Area Director of Addiction Services** to the national **Director of Mental Health/ Addiction Services,** where necessary using the s132 reporting template issued by the Director.

Issued by: National Director, Hospital and Specialist Services

Guidance dated: January 2024

Appendix 3: Reportable Event Notification Form

Appendix 3

MINISTRY OF HEALTH
MANATŪ HAUORA

DIRECTOR OF MENTAL HEALTH

Reportable Event Notification Form

Reason for reporting this event*: ☐ s.132 Death ☐ Special Patient Event ☒ Media Attention

Event category: ☐ Death ☐ Suicide ☐ Homicide ☐ Attempted Suicide ☐ Assault ☐ AWOL ☐ Breach of Leave Conditions ☒ Other

DHB responsible for care:	Waikato DHB	Legal status- Act/Statute: Eg. MH(CAT) Act	MH(CAT) Act 1992
Overseeing DAMHS:	[redacted]	Legal status- Section: Eg. s.30	Informal
Date event occurred:	[redacted]	Legal status- Leave: Eg. s.52	Informal
Narrative description of event*:	Misidentified Patient - A person was found by Police and bought to ED under S109 MHA. Was initially identified as a missing patient under S29 MHA. [redacted]		
First name:	[redacted]	NHI number:	[redacted]
Middle name(s):	[redacted]	Date of birth:	[redacted]
Last name:	[redacted]	Gender:	Female
Also known as (AKA):		Ethnicity:	[redacted]
Diagnoses at time of event:	[redacted]		
Provisional cause of death*:		Inpatient/Outpatient:	Inpatient
Provisional mode of death*:		Date of last contact with mental health services*:	[redacted]
Location where event occurred:	Hospital	Mental health service responsible for care:	[redacted]
Other comments or notes:	[redacted]		

* Further discussion of this item is on the next page.

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MINISTRY OF HEALTH
MANATŪ HAUORA

DIRECTOR OF MENTAL HEALTH

Reportable Event Notification Form

This form is the first step of the event process overseen by the Director of Mental Health. It must be completed and sent to the Director within **14 days** of an event occurring, for all events that meet the Director's reporting criteria. Depending on the nature of the event, the Director may also require the following documents:

- Notification and details of any media coverage and your response.
- Internal Sentinel Event Review Process (SERP) Report.
- External Sentinel Event Review Process (SERP) Report.
- Coroner's report confirming cause of death.
- Inquiry/Investigation documents. (eg s.75, s.95, HDC, Coroner, etc)
- Audit documents detailing the implementation of recommendations from the above reports.

Reason for reporting this event
On 1 July 2009 the Director changed the requirements for reporting mental health events to the Office of the Director. From this date onwards, only 3 types of events need to be reported to the Director. These events are:

1) Notifications of patient deaths in accordance with **s.132** MH(CAT) Act 1992. Patients are further defined as either; a person required to undergo assessment under s.11 or s.13; a person subject to a compulsory treatment order; or a special patient.
2) Adverse events involving **special patients**. This includes attempted suicide, AWOL, assault, and breach of leave conditions (eg alcohol use).
3) Adverse events likely to draw **media attention**.

Please note that other reportable event systems (such as the QIC system based on SAC ratings) are not connected to the Office of the Director and run in complete separation.

Narrative description of the event
This is a brief description only, outlining what has happened and including any significant points that may not be captured elsewhere in the form.

Date of last contact with mental health services
This contact may be face to face or by telephone.

Cause and Mode of Death
The provisional cause and mode of death provided with this form must always be followed up with a definitive cause of death provided by a Coroner's finding or medical certificate.

Appendix 4: SAC Code Descriptors

SAC descriptors for the rating of harm

SAC 1: severe	SAC 2: major	SAC 3: moderate	SAC 4: minor
Death or harm causing severe loss of function and/or requiring life-saving intervention • Not related to natural course of illness or treatment • Differs from immediate expected outcome of care • Can be physical, psychological, cultural or spiritual	Harm causing major loss of function and/or requiring significant intervention • Not related to natural course of illness or treatment • Differs from immediate expected outcome of care • Can be physical, psychological, cultural or spiritual	Harm causing short-term loss of function and/or requiring moderate additional intervention • Not related to natural course of illness or treatment • Differs from immediate expected outcome of care • Can be physical, psychological, cultural or spiritual	Harm causing no loss of function and requiring little or no intervention • Not related to natural course of illness or treatment • Extra investigation or observation • Review by another clinician • Minor treatment • Can be physical, psychological, cultural or spiritual Includes near misses

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