



**AUCKLAND DISTRICT HEALTH BOARD**

Communications

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## **ADHB Media Release**

**December 17, 2010**

### **Kirsten Biggs Coronial Report**

Auckland District Health Board (ADHB) acknowledges the findings of a Coroner's Report released today into the suicide of mental health inpatient Kirsten Biggs in June, 2008.

Dr Gregory Finucane, Clinical Director of Te Whetu Tawera mental health inpatient service, extended ADHB's sympathies to Ms Biggs' family and said her death had led to changes in how patients with complex diagnostic issues were managed by ADHB.

"This is a sad situation and our thoughts are very much with Kirsten's family," Dr Finucane said.

"Kirsten had complex mental health issues which required staff to balance opposing treatment philosophies and ADHB accepts the Coroner's view that we should have done better at managing this.

"We have put a Complex Case Review Policy in place since Kirsten's death that ensures a second opinion is sought in the management of complicated cases like hers.

"Improvements have also been made to our observation policy.

"We accept that delayed entry of notes was a key issue in Kirsten's care and we have taken steps to strengthen the management of documentation and planning as well as risk assessment and staff handover processes.

“There has also been an increase in the number of Intensive Care beds available since Kirsten’s death.

“Whilst it is impossible to say that any of these individual improvements would have prevented Kirsten taking her own life, we are confident that the systems and processes we now use cater better for patients with complex needs.”

**ENDS**

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