



ADHB Media Release

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Coroner's Report Into the Death of Maria Eve Richardson

Auckland District Health Board (ADHB) accepts the findings of the Coroner's inquest into the death of patient Maria Eve Richardson and has already made significant progress on addressing many of its recommendations.

Director of Mental Health Services Clive Bensemman said ADHB had improved its systems and procedures to ensure better care for patients in the Te Whetu Tawera acute inpatient mental health unit.

"This is a sad situation and we regret that Maria did not receive better care in our system," Dr Bensemman said.

"We recognise there were failings within the service and Maria's death has prompted improvements to many of our procedures.

"In the three years since Maria's death, we have made significant progress in implementing systemic changes to the way we care for our mental health inpatients."

An external review and other internal review processes have seen:

- A strengthened leadership structure within the adult acute inpatient unit, with the inclusion of a nurse advisor;
- The implementation of an inpatient model that embraces the recovery philosophy, while being underpinned by individual risk management strategies;
- Enhanced observation policy and procedures within the inpatient service; including for physical health problems
- Establishment of a GP clinic

- Appointment of a Nurse Specialist in physical health to assist in upskilling nursing staff and improving processes to deliver nursing care for general medical problems
- Establishment of a nurse educator position to support staff development.

Dr Bensemman said the recently appointed Clinical Director of the Te Whetu Tawera unit continues to drive the improvement program.

“We have made good progress on improving our mental health service since Maria’s death,” he said.

“We have taken, and continue to take, all reasonable steps to provide the best service possible to our patients.”

ENDS

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