

## Multiple failings in care provided to woman in relation to an assault in the ED

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### Executive summary

1. On 27 April 2022, Miss A attended Hutt Hospital Emergency Department (ED; Health New Zealand | Te Whatu Ora Capital, Coast and Hutt Valley (Health NZ)) with a friend who was experiencing a mental health crisis. She was asked to remain with her friend but felt unsafe, and he subsequently assaulted her. Miss A complained to the Health and Disability Commissioner (HDC). This investigation focuses on whether Hutt Hospital staff appropriately considered and managed Miss A's safety before the assault and undertook appropriate follow-up and reporting measures after the assault.
2. I find Health NZ in breach of Right 4(1) the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide services to Miss A with reasonable care and skill. I also find Health NZ in breach of Right 4(2) for failing to act in accordance with its Intimate Partner Violence Intervention Policy (2021).

### Recommendations

3. Health NZ implemented the following changes in late 2023 as a result of a separate review of an unrelated event in 2020.
  - Access control (swipe card access) has been installed for the whānau room.
  - A new door has been installed between the whānau room and the waiting area.
  - Screens and a quick-release security door have been installed in the administrative area.
  - Security coverage in the ED has been reviewed and significantly strengthened. There is now a 24/7 roaming security presence, with checks conducted every 15 minutes.
  - Additional security assist alarms have been installed in the ED.
  - Security camera systems around the department have been upgraded.
  - National Crisis Prevention Institute Training for ED clinical staff, which focusses on de-escalation techniques, managing challenging behaviours, and preventing violence, has commenced.

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- Two full-time violence prevention trainers have been appointed, one of those in Hutt Hospital. These trainers focus on supporting and training clinical and security staff in de-escalation and violence prevention techniques.
4. I acknowledge and support the changes already made by Health NZ. In addition, I recommend that Health NZ:
- provides a written apology to Miss A for the failings identified in this report, which is to be sent to HDC for forwarding within three weeks of the date of this report;
  - updates relevant policies to guide staff in managing a witnessed assault in the ED (including emphasis on when police should be notified, safety planning, and discharge planning) and uses an anonymised version of this report to provide training to staff on the updated policies. Evidence of this should be provided to HDC within six months of the date of this report.

### **Background**

5. At the time of this incident, Mr B was boarding with Miss A and her two children.<sup>1</sup> Health NZ clinical records indicate that, two weeks before this incident, Miss A had attended Hutt Hospital ED after Mr B had physically assaulted her. However, in response to the provisional report, Miss A said this was not the reason for her visit to the ED. Miss A told HDC that she was concerned about Mr B's deteriorating mental health and that Mr B went to Hutt Hospital ED early on the morning of 27 April 2022 but was later discharged home. Miss A became increasingly concerned about Mr B's behaviour and so accompanied him to the ED again at 10pm that same day.
6. Health NZ told HDC that, on arrival, Miss A consented to being Mr B's support person while he awaited review, but this is not documented. Miss A and Mr B were placed in the whānau room, which Health NZ said is a private room adjacent to the reception desk where the triage nurse, receptionist, and a security guard sit. Miss A said they were left alone in the room and that she began to feel unsafe. In response to the provisional report, Miss A said that there was no security guard outside the room. She said that she reported to two different nurses that she felt unsafe but was asked to stay to support Mr B.
7. Miss A said that she then wrote a note expressing that she felt unsafe and gave it to the overnight ED registrar when he entered the room. She said she was advised that the note would be read later and that she was encouraged to stay and support Mr B. There is no documentation in the records of these conversations or of the note being given or its contents. Health NZ did not provide statements from the nurses involved in the events beyond what was included in the clinical records. In response to the provisional report, Miss A provided HDC with a photograph of the note that she handed to the ED registrar. In summary, the note lists Mr B's current behaviours of concern, states that, when he becomes unwell, he tries to hurt and 'kill' Miss A and includes a

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<sup>1</sup> Both children were under the age of 18 at the time of the events. Mr B was the father of Miss A's younger child.

request that Mr B not be released. Miss A also provided videos that she had taken while they were waiting in the room to demonstrate Mr B's behaviour at that time.

8. At 12.21am on 28 April 2022, the ED registrar documented that he had reviewed Mr B with Miss A present, who had advised that Mr B had been agitated at home and that she 'feels unsafe with him around due to previous violence at home when [he] is in this state.' The registrar told HDC that Miss A expressed discomfort about Mr B and what he may do but that he considered the ED to be an implicitly safe place where any violent behaviour 'could be addressed before it escalated.' The ED registrar said that he regrets not giving greater consideration to Mr B's risk to others and ensuring he was more closely monitored.
9. Miss A said that Mr B's behaviour continued to escalate until he physically assaulted her. During the assault, she sustained injuries to her arms, hands, and head. In response to the provisional report, Miss A said that she lost consciousness. Clinical notes indicate that, on hearing the altercation, staff entered the room, activated the duress alarm, and removed Miss A to a bed in the ED. A Security Staff Incident Report Form detailed the incident, which is noted to have occurred at 1.15am, but police were not notified of the assault at this stage. Miss A told HDC that it was her daughter who notified police of the assault.
10. At 1.57am, Miss A was physically reviewed by the ED registrar. The clinical notes state that she experienced no loss of consciousness but had a mild headache and pain in both hands. The clinical notes record 'likely hand contusions and concussion, no concerns regarding needing CT head.' In response to the provisional report, Miss A said that she did not report having a headache but that she repeatedly told staff that she felt like her head was caved in and that her head was sore and that she was dizzy. Miss A underwent an X-ray of both hands; the results were normal, and the plan was documented as pain medication and discharge home with 'a safety plan.' There is no subsequent documentation of a safety plan being formulated before Miss A was discharged, nor of further investigation or safety netting advice being provided regarding a possible concussion.
11. The ED registrar told HDC that, although Miss A did not have any outward signs of concussion, he should have put greater emphasis on the provision of information on recognising and treating concussion. He said that this information had been provided to Miss A two weeks previously when she had presented to the ED. The registrar said that he was balancing providing this information against the benefit of getting Miss A back home to her children, which was her expressed wish.
12. The Security Staff Incident Report Form states that Mr B absconded from the ED at 1.35am. At 2.16am, the registrar documented that Miss A had been informed and police notified (this was the first time that ED staff contacted police about the incident). The registrar told HDC that he regrets not calling police immediately when Mr B left the ED.

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13. The ED registrar prepared a discharge summary for Miss A at 2.31am. The discharge summary advised Miss A to take regular pain medication and to see a physiotherapist for her hand injury if necessary. It also stated, '[I]f you feel unsafe especially if [Mr B] returns please call 111 for help. The police will be in touch regarding what happened ... this evening.' Miss A was discharged home sometime after 2.30am. She said she was asked whether she would like police to take her home, but she was disoriented from the assault so she walked home by herself (approximately 10 minutes from the hospital). In response to the provisional report, Miss A said that she should have been in the hospital being taken care of.
14. According to the Security Staff Incident Report Form, police located Mr B and returned him to the ED sometime between 2.30am and 2.55am, following which he was voluntarily admitted to Te Whare Ahuru inpatient unit (a 24-hour mental health assessment and treatment service). Internal email correspondence reflects that Te Whare Ahuru staff were advised not to grant leave to Mr B or discharge him from the service without first liaising with police and Miss A. On 3 May 2022, Mr B was discharged from Te Whare Ahuru and taken into police custody.
15. In the days after the incident, Miss A's mother made several phone calls to Hutt Hospital to follow-up on what had occurred on 27 April 2022. On 2 May 2022, staff from Hutt Hospital met with Miss A and her parents. Meeting notes reflect that Miss A felt that no one had listened to her concerns while in the ED, and she questioned why police were not called immediately after the assault. Health NZ accepted that police should have been called, and a Clinical Nurse Specialist (CNS) was assigned at that point to assist Miss A in liaising with the police, the Family Support Team, and Women's Refuge.
16. No Severity Assessment Code review<sup>2</sup> or internal investigation was undertaken as a result of this event; however, Health NZ's Violence Intervention Programme Leaders (VIPLs) subsequently conducted a review of Miss A's case and made the following findings:
  - Miss A should have been believed and a safety response actioned when she advised staff that she felt unsafe while supporting Mr B in the ED.
  - ED staff should have notified police immediately after the assault occurred.
  - ED staff should have completed an Intimate Partner Violence Risk Assessment and Intervention Form. This form guides health professionals in assessing risks and safety planning for people experiencing violence from a partner.
  - A Report of Concern was completed on 29 April 2022 but should have been completed at the time for Miss A's two children (both aged under 18 years) living in the household with Mr B.

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<sup>2</sup> A structured review used to analyse serious adverse events.

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### Finding: Health NZ – breach

17. For clarity on HDC’s jurisdiction on this matter, I accept that Miss A was not a consumer of the service when she attended the ED as a support person. However, I note that the staff had access to the notes from her visit as a patient after a possible assault only two weeks prior<sup>3</sup> and had a duty of care to her in the management of her concerns as they were relayed during this visit before the assault on 27 April 2022. Further, I am of the view that, after the assault, Miss A became the consumer as a direct consequence of the actions of Mr B and the inactions of the staff. On that basis, the events in the ED leading up to her becoming a patient are relevant in the context of this investigation.
18. Miss A said that she expressed to staff several times that she felt unsafe supporting Mr B in the ED but that she was not listened to and was asked to remain with Mr B for support. Although no statements from nursing staff are available, the registrar’s clinical notes do refer to Mr B’s previous assault on Miss A and that she had taken him to the ED because she felt unsafe at home because of his escalating behaviour and tendency to become violent while in distress. Further, the ED registrar told HDC that Miss A had expressed discomfort but that he considered the ED to be an implicitly safe place where violent behaviour could be addressed before it escalated. With the information before me, I accept that Miss A had significant and warranted concerns about her safety around Mr B in the ED and that staff did not adequately address these concerns.
19. The VIPL review found that staff should have believed Miss A’s concerns and actioned a safety response. Having independently reviewed the information, I agree, and I am critical that this did not occur and that Miss A was left alone with Mr B.
20. Health NZ’s Intimate Partner Violence Intervention Policy (2021) contains a flowchart that provides detailed guidance on the process to be followed should a person disclose abuse. The flowchart states that if a person discloses abuse, then staff should discuss a safety plan and referral resources, such as legal options and Women’s Refuge, and preferably make contact with a referral service and make a plan for follow-up. The ‘Safety Planning’ section of the policy states that safety planning should be done in consultation with the person who has experienced violence and that the healthcare provider has an important role in assisting victims to understand their degree of risk, help them work through their options, and actively connect them with additional resources.
21. There is no evidence that a safety plan was developed after Miss A’s assault on 28 April 2022 or that any escalation occurred as required under the policy. I acknowledge the registrar’s comments that he wished to get Miss A home to her children; however, in my view, it was entirely inadequate and contrary to Health NZ’s policy for staff to allow Miss A to leave the ED without staff having undertaken the above actions. I note that the VIPL review also concluded that an Intimate Partner Violence Risk Assessment

<sup>3</sup> As noted at paragraph 5, although Miss A said in her response to the provisional report that her attendance at the ED two weeks earlier was not due to an assault, the clinical records from the visit on 27 April state that Miss A had presented two weeks prior as a result of inter-partner violence, making it likely that staff were of the understanding at that stage that Miss A had been a victim of an assault by Mr B two weeks prior.

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should have been completed to assist in assessing risk and safety planning. I am very critical that this did not occur.

22. Health NZ's Intimate Partner Violence Intervention Policy 'Guideline for notification to police for family violence' states that, if a victim of violence expresses fear of the perpetrator, it is appropriate for Health NZ staff to contact police. In light of the witnessed assault and that Miss A expressed fear for her safety on several occasions, I am very concerned that staff did not immediately notify police of the assault. Health NZ's VIPL review also identified that police should have been notified of the assault immediately.
23. Miss A was discharged from the ED while Mr B's whereabouts were unknown. Miss A said she was asked whether she would like the police to drop her home but that she was confused from the assault so chose to walk home by herself. Given the circumstances, and the high risk of further harm to Miss A, I am critical that Health NZ did not do more to ensure Miss A got home safely.
24. Miss A reported having sustained trauma to her head during the assault, and the ED registrar's notes state 'likely ... concussion,' but there is no evidence that any further evaluation of this injury took place, and the registrar accepted that education and safety netting for a possible concussion was not provided. Although I acknowledge the registrar's comments that this information had been provided to Miss A during a previous admission (two weeks prior) and that he was trying to get Miss A home to her children, I am critical that staff did not appropriately assess her for a possible head injury and provide safety netting advice in case she developed symptoms later.
25. I am also critical that no incident report was completed after the assault. Although I acknowledge that security staff completed a Security Staff Incident Report Form and that Health NZ's VIPL subsequently conducted a review of Miss A's case, it is my view that, given the seriousness of a physical assault occurring in the ED, incident reporting should have occurred and would have provided an opportunity for shared learnings.
26. I find Health NZ in breach of Right 4(1) of the Code, which states that every consumer has the right to have services provided with reasonable care and skill. In my view, by failing to respond appropriately to Miss A's expressions of feeling unsafe; allowing her to walk home alone after the assault, when Mr B's whereabouts were unknown; failing to appropriately assess her for a possible head injury; failing to provide concussion safety netting advice; and for not completing an incident report after the assault, Health NZ failed to provide care to Miss A with reasonable care and skill.
27. I also find Health NZ in breach of Right 4(2) of the Code, which states that every consumer has the right to have services provided that comply with ethical and professional standards. In my view, by failing to notify police of the assault when it occurred and to formulate a safety plan or take appropriate escalation steps in line with the policy, Health NZ failed to act in accordance with its Intimate Partner Violence Intervention Policy (2021).

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**Conclusion**

28. For the reasons outlined above, I find Health NZ in breach of Rights 4(1) and 4(2) of the Code.

**Distribution**

29. A copy of this report with details identifying the parties removed, except Health New Zealand | Te Whatu Ora Capital, Coast and Hutt Valley and Hutt Hospital, will be placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.

Dr Vanessa Caldwell

**Deputy Health and Disability Commissioner**

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