

***OMBUDSMAN FOR
THE NORTHERN TERRITORY***

INVESTIGATION INTO

***THE UNJUSTIFIED USE OF
RESTRAINT AND DETENTION***

AT

**ROYAL DARWIN HOSPITAL
(INTERIM REPORT)**



**The Hon Kon Vatskalis
Minister for Health
Parliament House
Darwin NT 0800**

Dear Minister

I present to you for tabling in the Legislative Assembly an Ombudsman Own Motion investigation report regarding the use of restraint and detention at Royal Darwin Hospital.

This report is the result of an investigation conducted under section 26(1) of the *Ombudsman (Northern Territory) Act*, is furnished pursuant to Section 28(2) of the *Ombudsman (Northern Territory) Act* and is delivered to you as the Minister responsible for the Department of Health & Families. The Act requires this report to be tabled in the Legislative Assembly within 3 sitting days.

Yours sincerely



**Carolyn Richards
Ombudsman**

29th April 2009

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VOLUME 2 - ANNEXURES

Glossary:

LHMU – Liquor, Hospitality, Miscellaneous Workers Union
PCA – Patient Care Assistant
NRC – Nursing Resource Co-ordinator

Introduction

On 10 December 1948 the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights.

Article 9 states *“No-one shall be subjected to arbitrary arrest, detention or exile”*.

Article 13.1 states *“Everyone has a right to freedom of movement and residence within the borders of each state”*.

Magna Carta and the Bill of Rights 1688, which are received law in Australia, guarantee that a citizen’s fundamental freedom of movement shall not be restricted except in accordance with a law of the Parliament, or common law.

In the Northern Territory the Code of Health and Community Rights and Responsibilities (the Code), a Parliamentary instrument, provides relevantly:

“Principle 3: Decision making

1. *Subject to any legal duties imposed on providers, users have a right to:*

(a)

(b)

(c) refuse care and treatment, against the advice of the provider;

(d) withdraw their consent to care and treatment, which includes the right to discontinue treatment at any time, against the advice of a provider;”

Royal Darwin Hospital – Charter of Patient Rights states relevantly:

“Your Rights.....

You may withdraw consent [to treatment] at any time. You may also leave the hospital at any time, but if you do so without hospital approval you will be asked to sign a risk form.”

There are some circumstances in which interfering with a person’s liberty is justified under the law. There are some circumstances in which medical treatment can be given to a person without their consent and even against their wishes.

- A person who lacks the capacity to give consent to medical treatment due to a mental illness can be detained and treated under the *Mental Health and Related Services Act* upon certification by a psychiatrist that the person has a mental illness and is in need of treatment and not capable of making rational informed decisions because of that illness.
- A person who suffers from an intellectual disability can be treated against that person’s wishes if a substituted decision maker is appointed by a Local Court under the *Adult Guardianship Act*. The Court can authorise detention of a person and restriction of that person’s liberty for the purpose of treatment being given.
- In the case of need for treatment in an emergency, as defined in the *Emergency Medical Operations Act* a blood transfusion can be given and a medical practitioner may carry out an operation if “*the patient is in danger of dying or suffering a serious permanent disability*”. The legislation covers only “*operations and blood transfusions*”.

The law also allows excuses for the crimes of assaulting a person or depriving them of liberty in some circumstances. Those circumstances fall within the doctrine of necessity. The distinction between the law ‘justifying’ otherwise unlawful action and the law ‘excusing’ unlawful actions has been

explained as follows by the Supreme Court of Canada whose words have been approved by Australian Courts.

Otherwise criminal conduct that we choose not to treat as criminal is 'justifiable' if the reason for treating it as non criminal is that it is conduct that we applaud: conduct is 'excusable' if we deplore it but for some extrinsic reason conclude that it is not politic to punish it.

In the context of this report I use the word 'unjustifiable' as it is understood in the common law relating to the doctrine of necessity. That doctrine and whether a person's otherwise criminal action is excusable under the law has very strict limits. Those limits are imposed because:

*"...the defence of necessity exists to meet cases where circumstances overwhelmingly impel disobedience to the law...[and] **the law cannot leave people free to choose for themselves which laws they will obey, or to construct and apply their own set of values inconsistent with those implicit in the law**"*

If health service providers detain or use force to keep a person in hospital they break the law unless they can justify doing so under legislation or have an excuse of necessity.

THE DOCTRINE OF NECESSITY AT COMMON LAW AS A DEFENCE TO CHARGES OF CRIMINAL ASSAULT OR DEPRIVATION OF A PERSON'S FREEDOM

For the defence of necessity to be available certain elements must exist:

1. There must be an urgent situation of clear and imminent peril to life or irreparable serious harm. As the courts have stated "*at a minimum the*

situation must be so emergent and the peril must be so pressing that normal human instincts cry out for action and make a counsel of patience unreasonable”.

2. The person committing the criminal act must have had no “*reasonable alternative to disobeying the law*”.
3. The harm inflicted must be less than the harm sought to be avoided.
4. The defence must be strictly controlled and scrupulously limited.
5. Necessity may only be invoked as an excuse for criminal conduct and not a justification for it.

A summary of the law is found in the decision of the Supreme Court of South Australia (Full Court) *Bayley v Police* (2007) SASC 411 @ p7.

Detaining a person in hospital when that person wishes to leave, impeding their movement, locking them in a room or a ward would normally be a crime if no defence existed. Physically restraining a person, tying someone to a bed, injecting them with chemicals to sedate them, taking hold of them to stop them leaving would be assaults in the absence of a defence recognised by the law.

Such is the value of liberty and such is the value of personal inviolability and autonomy in our society that without lawful authority or effective consent no person in the Northern Territory can have their human rights violated by being given medical treatment or detained in a hospital or elsewhere to have treatment except in the circumstances described above. (There are some different legal considerations for persons under 18 years of age, for children suspected of maltreatment under the *Care and Protection of Children Act*, or patients with a notifiable disease which are not relevant to this report but which I mention for completeness.)

This report is about Corporate Executives at Royal Darwin Hospital (RDH) between about June 2008 and at least March 2009 establishing an administrative process for detaining and treating people contrary to

international standards and in breach of human rights of patients. This report is about how RDH Corporate Management ignored the objections of its own security officers, misunderstood its own legal advice and instituted policy and procedures which by administrative process purported to authorise actions prohibited by law and international standards.

These administrative actions were taken by RDH corporate management with the best of intentions, from caring and compassionate motives and implemented by several administrative actions that required security officers to restrain and detain patients, and after struggling for many years to manage and reduce the self-destructive, resource wasting, and heart-breaking behaviour of a number of patients. Nonetheless the actions taken were wrong, contrary to law and ill conceived.

The General Manager of RDH and the Chief Executive of the Department of Health and Families informed me that after 9 February 2009 RDH had permanently ceased detaining patients by relying on the provisions of Section 16 of the *Medical Services Act*. On 24 March 2009 officers of the Office of the Ombudsman found, in the notes of a patient's medical records, that the breaches occurred again at least on 16 February 2009 and on 19 February 2009. A patient (F) with acknowledged cognitive deficits had been attempting to abscond and go home since 3 January 2009. He had been brought back against his will on the authority of a certificate issued under Section 16 of the *Medical Services Act* by "the person in charge of the hospital". There was no external review of that decision, no right of appeal and in my opinion no legal authority to keep patient F in hospital.

The United Nations Declaration on the Rights of the Mentally Retarded states very clearly:

'7. Whenever mentally retarded persons are unable, because of the severity of their handicap, to exercise all their rights in a meaningful

way or it should become necessary to restrict or deny some or all of these rights, the procedure used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic review and to the right of appeal to higher authorities.'

The United Nations Declaration on the Rights of Persons with a Disability adopts the same wording. Patient F was first admitted to RDH in November 2008, his medical notes indicate that he had been trying to leave RDH for several months since January 2009. The legal safeguards established by law in the *Adult Guardianship Act* had been delayed by RDH management; there is no documented imminent risk to his life to crystallise the common law defence of necessity: he did not need a blood transfusion or operation and he did not have any emergency. Emergencies in my view do not continue for four months.

The Chief Executive Officer of DHF in response to my comments regarding patient F's stated *"All actions taken in relation to patient F were taken in consultation with his parents. As is set out above an Adult Guardianship application was commenced in November 2008."* Additionally Dr Ashbridge requested that the words 'there was no imminent risk' be deleted, he stated *"As set out above the risk to patient F at any particular time during his extensive admission was a clinical decision made by medical staff at the time, and outside the Ombudsman's jurisdiction"*.

I made enquiries of the Chief Magistrate about how long it usually takes for the Local Court to list for hearing an application for an order appointing a guardian to give consent to medical treatment for a person with an intellectual disability. I was informed that between filing the application and the first hearing it is usually about a week. I was also informed that if it was urgent the Court can and has given a hearing time on the same day or next day after

the application was filed. I was also informed by the Registrar of the Court that no application had been filed at Court as at 6th April 2009, for patient F.

I originally received no explanation from the RDH or DHF as to why no application had been made to the Court for the patient (F). That patient was still being contained against his will at RDH on 20 March 2009. This was despite the Chief Executive of DHF and the General Manager of RDH both assuring me in writing on 23 March 2009 that the RDH had permanently ceased relying on Section 16 of the *Medical Services Act* to restrain people at RDH since 9 February. Technically that information may be correct but that did not explain why patient (F) had not been allowed to leave RDH as he requested when no legal authorisation existed to keep him there.

When commenting on the draft of this report on 21st April 2009 the Chief Executive of DHF advised that an application under the *Adult Guardianship Act* had been made. It was filed at Court on 20th April 2009, ten days after a draft of this report was sent to the Chief Executive criticising the failure to make such an application. Later in this report I have commented on that delay.

The overall management of this issue by senior executives for administrative management at RDH in my opinion has been inept and incompetent. Managerial ineffectiveness and a misunderstanding of clinicians by management have led to apparent breaches of the law, to glaring errors in the use of coercive powers and confusion for staff. The circumstances examined in this investigation show the weaknesses in leadership and corporate governance at RDH.

The clinicians at the Emergency Department were unsupported; they resorted to using stratagems under the *Mental Health & Related Services Act* that they knew were a fiction, inefficient, time wasting and an abuse of powers. In order to ensure that people were treated who needed it, as a matter of necessity, they tolerated that situation until, on 30 October 2008, the Director

of the Department of Emergency Medicine wrote to the General Manager, Deputy General Manager and Medical Superintendent of RDH:

“This stupidity has gone on long enough patients are now being put at risk. I have informed ED medical staff we will use the principle of necessity when a section is not appropriate and we will not use sections inappropriately.”

(The full text of this message appears at p50-51.)

When putting forward its defence to this statement, in the draft of this report, the Chief Executive Officer of DHF said that *“The email statement quoted (above) is a statement of the doctor’s frustration at the attitude of the security staff, not hospital management. To base such broad sweeping conclusions upon a single email is unsafe”*. I stand by the accuracy of the conclusion.

Thereafter a policy was promulgated, forms put in use to keep people against their wishes, to impose mechanical restraints, such as locking in a room, or tying to a bed or “escorting” them for long periods of time without lawful justification. The policy did not contain any directions for limiting the time that a person could be detained nor did it explain the grounds or criteria necessary to lawfully detain a person with force if necessary.

The only instance in the 10 cases where the investigator read the patients’ files that consideration was given to applying to the Local Court for an order under the *Adult Guardianship Act* was patient E (described later). It should have been apparent by 2 February 2009 that patient E could not consent to surgery, that he had no ability to understand his situation and that to keep him in hospital against his will some legal justification was needed. It is hard to imagine that his surgery was an “*emergency*” as he was admitted on 1 February 2009 and, as at 9 February 2009, he had not had surgery. In the meanwhile he had attempted to leave the hospital several times in taxis and had “*jumped over the fence*” into the private hospital grounds. There was no

entry found in his notes that he was at “*imminent risk of death or immediate harm*” to justify containing him and sedating him under the common law doctrine of necessity. He is not recorded as having a notifiable disease, nor did he, according to his medical records, have a mental illness or mental disturbance. He was brought back to the hospital by security guards on the administrative decision and act of the person in charge of the hospital, the General Manager, issuing a form under Section 16 of the *Medical Services Act*.

In his response to this draft report the Chief Executive of DHF informed me that the patient recovered to the extent that he was able to make reasonable decisions and there was no need to make an application to the Court. No details were volunteered of when he recovered his capacity to make decisions. Nothing was in the patient’s notes to verify the recovery of mental capacity when the investigating officer inspected patient ‘E’s file on 9 March 2009.

SECTION 16(2) & (3) OF THE MEDICAL SERVICES ACT RELEVANT TO THIS INVESTIGATION

16. Person in charge of hospital

(2) The person in charge of a hospital or nursing home may issue such instructions applicable to staff and patients of, and visitors to, the hospital or nursing home as may be necessary to secure the maintenance of good order and conduct in the hospital or nursing home and its grounds.

(3) All persons in a hospital or nursing home or its grounds are subject to the control of the person in charge of the hospital or nursing home.

The clear and natural meaning of the words in this legislation is:

- there is no power to control anybody once a person is outside the grounds of the hospital
- there is no power in this legislation to give treatment to a person as part of control
- there is no power to use force to achieve control
- there is no power to prevent a person leaving the hospital

(hereafter called 'the purported powers').

The Corporate Executives of RDH issued administrative instructions, made administrative decisions and implemented them within the hospital to detain, restrain and treat patients against their expressed wishes by informing staff

that the words of Section 16(3) of the *Medical Services Act* gave the purported powers to the “person in charge of RDH”, the General Manager, to authorise the issue of a certificate or form under Section 16(2) and/or (3) of the *Medical Services Act* (MSA) and that if such a certificate was given or made all staff must comply with it as it was legally effective to authorise use of the purported powers of restraint, detention and use of force.

I consider that those administrative acts and decisions were wrong, and contrary to law.

In 1908 the High Court of Australia O’Connor J stated the law which prevails today (*Jumbunna Coal Mines v Victoria Coal Mines* (1908) 6 CLR 309@363):

Every Statute is to be so interpreted and applied as far as its language admits as to be not inconsistent with the comity of nations or with the established rules of international law.

Chief Justice Gleeson re-iterated the same principle in 2003 in the case of *Plaintiff S157 v the Commonwealth* (2003) 211 CLR 476:

Where legislation has been enacted pursuant to... the assumption of international obligations, in case of ambiguity a court should favour a construction that accords with Australia’s obligations.

The interpretation of Section 16 of the MSA made by the Executive Team at RDH clearly does not accord with Australia’s obligations under the United Nations Declaration of Universal Rights and Rights of those with Mental Disability. The interpretation adopted by RDH management also offends the long established principle of statutory interpretation that Courts “*do not impute to Parliament an intention to abrogate or curtail fundamental freedoms or rights unless such intention is clearly manifested by unmistakable and unambiguous language*”. That too was stated by O’Connor J in the High Court as long ago as 1908 when he stated:

It is in the last degree improbable that the legislature would overthrow fundamental principles, infringe rights or depart from the general system of law without expressing its intention with irresistible clearness.

The High Court in 1991 approved that statement in the case *Bropho v Western Australia* (1991) 171 CLR 1 @ 20.

In the Northern Territory there are two pieces of legislation with detailed requirements and processes controlling the grounds on which a person can be detained or treated when their informed consent is not given or a person is unable to give consent by reason of mental illness, mental disturbance or mental disability. That legislation is the *Mental Health & Related Services Act* and the *Adult Guardianship Act*.

Establishing a third process giving the purported powers to the person in charge of RDH by administrative action under Section 16 of the *Medical Services Act* was tantamount to abrogating fundamental human rights and freedom contrary to the international obligations that Australia has under United Nations instruments which Australia has adopted; inconsistent with the intent and codes set out in the *Mental Health & Related Services Act* and the *Adult Guardianship Act*, and was tantamount to usurping the role of the Legislative Assembly which itself could only have taken away the fundamental rights of freedom of movement and freedom from personal violation by expressing its intention to do so “*with irresistible clearness*”. The process was a travesty of compliance with the law and international standards.

This report is not about the care or standard of treatment provided by clinicians or nurses or allied health staff at RDH. I intend to make no criticism of them. My criticism is of the Corporate Governance at RDH and of the executive staff whose function it is to manage the administration of RDH and to establish and maintain support to enable treatment and care to be provided

by clinical, nursing and allied health professionals, to improve systems and to be responsible for the management of finance, personnel, resources, equipments, supplies, policies and procedures and management of the hospital to ensure an optimum environment in which patients and those who actually deliver treatment and care services can function.

In my opinion the leaders of Executive Management at RDH by establishing the administrative process of issuing certificates or forms under Section 16 of the *Medical Services Act* undermined, or at the very least let down, the health and care providers by exposing them to the risk of performing unjustified and unlawful acts.

Executive Summary

In December 2008 and January 2009, information was given confidentially to the Ombudsman as a result of which an 'Own Motion' investigation was commenced by the Office of the NT Ombudsman into systemic concerns surrounding the legality of powers being exercised to restrain and/or detain patients at Royal Darwin Hospital (RDH).

The investigation has been of the administrative actions and decisions of Corporate Executives managing the administration of RDH in directing and initiating a process of authorising restraint and detention of patients relying on the provisions of the *Medical Services Act* Section 16.

That Act does not authorise for the restraint and/or treatment without consent, nor arrest of a person trying to leave the hospital.

Implementation of the policy endorsed by the RDH General Manager Mr Len Notaras in December 2008, titled '*Policy for the Management of Patients pursuant to Sections 16(2) and (3) of the Medical Services Act*' (to address the use of the *Medical Services Act* by RDH) was unjustified under the law of the Northern Territory, and breached the fundamental human rights and freedom of patients.

My investigation in summary has revealed that:

1. The Executive Management team at RDH has misinterpreted Section 16 of the *Medical Services Act* and established a procedure of detention, physical and chemical restraint and arrest of patients.
2. The procedures to implement that policy are contrary to the United Nations Declaration of Human Rights and the Declaration on the Rights of Persons with a Mental Disability.

3. The Executive Management team at RDH provided incorrect information to employees regarding the provisions of the *Medical Services Act*; and led them to believe and to act as though the provisions of the *Medical Services Act* gave them the power to detain/restrain and treat patients against their wishes.
4. RDH employees acting on administrative decisions and actions of the RDH Executive team, relied on Section 16 of the *Medical Services Act*, to detain and/or restrain persons within RDH without obtaining or documenting any other lawful grounds for those actions.
5. The *Mental Health and Related Services Act* (called after this the *Mental Health Act*), and the powers under that Act, and the circumstances when the doctrine of necessity at Common Law could be used were not explained by the Corporate Executive team to staff. Policies on the use of the legal powers available to assist staff were not formulated and adequate training was not given to all staff. Those failures together with wrong directions about the effect of the *Medical Services Act*, caused uncertainty and confusion for staff at RDH. (See email at page 51 from Acting CNM). The powers of detention and treatment under the *Mental Health Act*, were used for a purpose not authorised by that Act, and hence an abuse of power occurred, albeit in good faith, by staff. (See email Dr P 30/10/08 page 52-53.)
6. The facts and circumstances surrounding the adoption of an administrative policy for restraining and detaining patients in 2008 demonstrates very clearly the urgency for the hospital and the DHF to implement the recommendations of the report by the Australian Council on Health Care Standards delivered to the Hon Kon Vatskalis, MLA, Minister for Health, on 23 February 2009. On page

14 of that report the authors set out a model for good governance to be applied to RDH. What has occurred with respect to detaining and restraining patients in 2008, when measured against that model, highlights the extent of the lack of effective corporate governance (as opposed to clinical or nursing governance) at RDH of which this is but an example. The Acute Care Executive, in September 2008, endorsed guidelines that no patient could be forcibly returned to hospital even though at risk of injury unless there was an order of Guardianship by the Court or a certification under the *Mental Health Act* or the *Notifiable Disease Act*. At the same time RDH Governance Group was developing a policy, management had introduced a process and people were being detained at RDH and returned when they left under Section 16 of the *Medical Services Act* quite contrary to the Acute Care Executive Guidelines. This is a clear case of the left hand not knowing what the right hand is doing.

This report has been released as the matters raised are of significant public interest. The administrative actions of the corporate executives at RDH, the procedures implemented to restrain, arrest, detain and treat people have amounted to breaches of various United Nations declarations on human rights and I consider that the Minister, the Legislative Assembly and the Public should be aware of these administrative actions, pending a full investigation to disclose how this occurred. The situation will be remedied by DHF and steps have been promised to be taken to do that. To ensure nothing similar happens again does, however, needs an examination of how it came to occur on this occasion.

This investigation has not finished but, because of the seriousness of this matter, I am releasing this interim report now under Section 28(2) of the *Ombudsman (Northern Territory) Act*, and recommending that DHF have the opportunity to conduct its own investigation.

Recommendations

1. That RDH immediately:
 - (a) facilitate the discharge and transport of all persons who wish to leave but who are contained, restrained or detained at Royal Darwin Hospital (including Cowdy Ward) and who have not been either certified as having a mental illness or mental disturbance within the meaning of the *Mental Health Act* or who have an intellectual disability and who do not have an adult guardian and an order of the Local Court authorising their detention and/or restraint;
 - (b) make application to the Local Court for an order appointing an adult guardian and for approval to detain or restrain a person to give that person medical treatment for all persons that have an intellectual disability and are in need of an adult guardian and there is no means less restrictive on the freedom of decision and of action that could be adopted;
 - (c) that RDH immediately take all reasonable steps to inform all its staff that the policy endorsed by the RDH General Manager entitled "*Policy for the Management of Patients, pursuant to Section 16(2) and (3) of the Medical Services Act*" has been revoked and that all patients for whom there exists a certification or "*sectioning*" under that policy are to be discharged if the patient chooses unless they can be detained under the *Mental Health Act* or by authority under the *Adult Guardianship Act*, or under the common law of necessity with a clear instruction that the doctrine of necessity does not authorise long term detention but is confined to only so long as there is imminent risk of death or of substantial irreparable harm.

DHF response to recommendation 1 – I do not agree that either 1(a) or (b) is necessary or could be implemented by DHF. Subparagraph (c) has already been implemented via the recent network-wide policy (attached). I am advised that there are currently no patients detained (upon any basis) at RDH. A memo has been distributed to all medical and nursing staff making clarifying the position with respect to treatment of patients without their consent.

- 2.1 DHF undertake a thorough investigation to identify all occasions and patients since January 2008, when the *Medical Services Act* has been relied on to contain, restrain, or detain patients wanting to leave the RDH.
- 2.2 DHF undertake an investigation of all occasions since January 2008 when any patient at RDH has been kept at RDH for treatment

against the patient's wish in reliance on the common law doctrine of necessity.

- 2.3 On completion of these investigations, or within one month, whichever is sooner all details of persons identified and their medical history and of the circumstances under which they were detained or restrained be provided to the Health and Community Services Complaints Commissioner, and to the Ombudsman.**

DHF response to recommendation 2 – Recommendations 2.1 – 2.3 will result in an unnecessary waste of resources. It is noted that further review is unlikely to be of any assistance to the patients concerned and will not assist in the DHF handling of these difficult situations given that the policy has already been reviewed and improved.

Ombudsman Comment: The new policy is, in my view, inadequate.

- 3. DHF undertake an immediate review of all NT hospitals to ensure that any document referring to restraint and/or detention powers under Section 16 of the *Medical Services Act* is revoked, and any person being kept in the hospital against their wishes either be released or an order to detain such patient be applied for to the Local Court under the *Adult Guardianship Act*, or the process under the *Mental Health Act* be followed.**

DHF response to recommendation 3 – Recommendation 3 is unnecessary as there is no such document. I am advised that there are no persons detained in reliance upon s.16 MSA in any Territory hospital.

Ombudsman Comment: The assurance is accepted but does not say if persons are being detained except under other legislation.

- 4. DHF issue an apology to its own staff who had been challenging RDH's misinformed directive to use restraint and/or detention techniques against persons pursuant to Section 16 of the *Medical Services Act*.**

DHF response to recommendation 4 – RDH clinicians have acted with the highest integrity based upon legal advice provided at the time. The law has not been tested in any court and therefore alternative interpretations can emerge. We are happy to apologise to security staff for any distress that the perceived ambiguity relating to patient detention, particularly over the last three months, has caused.

Ombudsman Comment: The use of the words "perceived ambiguity" is inconsistent with the assertion by DHF that the Section 16 process was unjustified.

- 5 That the Quality Unit of DHF conducts a comprehensive analysis of existing hospital protocols/policies/procedures to ensure that these documents accurately reflect detention and/or restraint powers.**

DHF response to recommendation 5 – Recommendations 5.2 and 5.3 (draft has been amended in this report to read rec 5) have been complied with in this letter. The new policy applies to all DHF hospitals and has been endorsed by the Acute Care Executive. Further review of existing policies is currently being undertaken.

- 6.1 DHF provide and deliver adequate education and training to staff to enable them to understand and act appropriately, in the event that a patient who is competent to make a decision concerning their medical treatment, decides not to accept that treatment.**
- 6.2 DHF provide and deliver adequate education and training to all staff in all hospitals in the Northern Territory on the circumstances when a person who lacks the ability to give informed consent may be treated against their wishes.**
- 6.3 That DHF consider designing that training program in partnership with CDU Law Faculty, or other tertiary institution or registered training organisation.**

DHF response to recommendation 6 – Appropriate training will be provided to relevant staff in DHF hospitals on the policy relating to providing medical treatment to adult patients without their consent. DHF will consider appropriate suppliers of educational advice; of which the CDU may be one.

- 7.1 RDH security department keeps comprehensive records relating to situations where person/s (including patients) are restrained and/or detained or whose movements are hindered or arrested within the hospital grounds.**
- 7.2 RDH security department immediately change their practice and incident forms so that a person who leaves or attempts to leave RDH is not labelled, referred to, or described as an “offender”.**

DHF response to recommendation 7 – With the implementation of the new policy a form will be developed which will be completed by the attending medical practitioner outlining the reasons for treating the patient without their consent. A copy of this will be sent to Medical Administration for central filing and to Security Services to confirm status of patients. The original will be maintained on the patient’s file.

- 8. RDH management establish a register that identifies each person who is subject to restraint and/or detention and upon whom any mechanical restraint is used and who leaves the hospital or a**

ward in the hospital without permission and/or against advice. In respect of each such person the following information is to be entered in the register and not just on a patient's medical records:

- (i) the date, time and period of any restraint, detention or mechanical restraint;
- (ii) the legal authority to restrain, detain that person citing the relevant section of any legislation or "at common law";
- (iii) if a person is detained or restrained under the authority of the common law, details of the medical practitioner(s) holding the opinion that there was a risk of death or severe incapacity that was imminent for the patient and the grounds of that belief;
- (iv) whether or not the person restrained or detained had a "mental illness", "mental disturbance" or "intellectual disability" as those terms are defined respectively in the *Mental Health Act* and the *Adult Guardianship Act*;
- (v) that the powers of the Community Visitor under the *Mental Health Act* be extended to monitor all persons detained or restrained in any hospital in the Northern Territory whether under the doctrine of necessity at common law or otherwise;
- (vi) that all hospitals within 24 hours of detaining a person give notice to the Community Visitor of all matters to be entered on the register described above.

DHF response to recommendation 8 – See response to recommendation 7.

Ombudsman Comment: I note the denial of the need for external accountability and review as required by United Nations instruments.

9. That DHF and, so far as necessary, the Minister for Health, implement as soon as possible the recommendations of all the Independent Review of Governance arrangements at RDH by the Australian Council for Health Care Standards dated 23 February 2009 with particular attention to recommendations 2, 4, 7, 8, and 9.

DHF response to recommendation 9 – The recommendation is outside the scope of the inquiry and is not relevant to the matters dealt with in the interim report.

Ombudsman Comment: The matters dealt with in this report show that the problem was caused "at the top". The solution needs to start at the top. There have been developments since the draft of this report was prepared, namely the appointment of a Director of Hospitals, and I accept that this recommendation is best considered by the Minister who has the discretion to decide on the solution.

Background

In December 2008 and early January 2009, the Office of the Ombudsman was approached by several RDH staff concerned about instructions given by management at RDH, relating to the forceful detention and/or restraint of persons pursuant to section 16(3) of the *Medical Services Act*. In essence the complainants advised that they had voiced their concerns to management over the potential illegalities of these instructions, and despite attempting to resolve the matter internally were unable to do so and were threatened with disciplinary action.

The Ombudsman determined to conduct an '*own motion*' investigation, as the information provided suggested that persons at RDH who were not detainable or liable to be restrained and/or detained under the *Mental Health Act*, and not subject to any order of the *Adult Guardianship Act* had been by force (either directly or indirectly applied) detained and/or restrained on the premises of RDH. This raised the possibility of a breach of human rights and a breach of criminal law.

Australian Standard 4485.2 – Security for Health Care Facilities Part 2: Procedures Guide section 5.37.2 'Restraining' states:

Health care security officers have no legal right to restrain patients unless there is a direct threat of violence or harm to the officer, themselves or others, as per State, Territory or Federal law. Security officers may be requested to assist medical staff in physically restraining a patient. Under these circumstances written security procedures and policy should specifically cover the circumstances, authority and procedures as agreed with the Director of Medical Services.

This investigation found not only incidents where persons had been restrained and/or detained in circumstances relying on the provisions of section 16 of the *Medical Services Act*, but instances where the *Mental Health Act* appeared to have been used to detain for treatment persons who did not exhibit symptoms of mental illness other than a failure to consent to recommended treatment.

The decisions of RDH Executive Management relating to Section 16(3) of the *Medical Services Act*; the instructions issued to staff; and the policies compiled and implemented, purportedly authorised by Section 16(3) of the *Medical Services Act*, were found during this investigation to be contrary to both international and Australian law. DHF, by letter to the Ombudsman dated 19 February, admitted that persons could not be detained or restrained solely on the authority of Section 16 of the *Medical Services Act*.

This investigation has so far revealed that at least one patient with legal capacity and the right to decide on whether or not to have treatment was having those wishes overridden by RDH staff. In other cases patients have been deprived of their liberty and/or assaulted, despite the good intentions of RDH staff when there was no evidence or grounds recorded that this was done because of the necessity to prevent imminent death or imminent permanent injury/illness. If the patients were at such imminent risk to justify overriding the normal law of deprivation of liberty and assault, records have not been kept justifying that decision under Common Law, but an administrative form has been completed instead under Section 16 of the MSA.

Upon being approached by the Ombudsman the Acting Director of Acute Care Services of DHF claimed that patients were being detained and treated against their wishes not in reliance on Section 16 of the *Medical Services Act* but under the doctrine of necessity. That attempt at justification was plainly contrary to:

- the express words of the RDH policy document

- the express words of oral and written instructions given to RDH staff especially security officers
- the use of template forms that all staff were instructed to use and which referred only to Section 16 of the *Medical Services Act*
- the medical records of the patients which were inspected by the Ombudsman's investigator and which were peppered with notes that the patients were "sectioned" under Section 16 of the *Medical Services Act*. There was not one reference to the doctrine of necessity.
- the information presented in the RDH auditorium on 19 December 2008 to an audience of registrars, medical officers, nursing and allied health practitioners by the Director of Psychiatry and a Barrister Kelvin Currie. That medical-legal session was advertised as being about "Section 16 Medical Services Act sectioning".
- an email dated 22 January 2009 from the Deputy General Manager of RDH sent to all senior executives, senior clinicians and managers at RDH stating that the policy [on restraint and detention] under Section 16(3) of the *Medical Services Act* was now final and had been endorsed by "Governance, Legal Services and Mental Health".

In short, the response from the Acting Director of Acute Care Services dated 19 February 2009¹ (Annexure 1) made statements that had only scant connection with the facts contained in the RDH's own records. The Chief Executive, DHF, was asked in a letter from the Ombudsman dated 20 January 2009:

'9. Is there a Department of Health and Families and/or RDH policy or documented process that provides for the detention and/or restraint of persons pursuant to the provisions of the Medical Services Act?'

¹ Letter of Mr Beirne 19 February 2009

The Acting Director of Acute Care Services replied on 19 February 2009 on behalf of the Chief Executive:

'A policy had been prepared and issued in draft form. The policy was not formally adopted by RDH or Acute Care. However in view of the Solicitor-General's advice a new policy and procedure will be developed.....'

A copy of the policy was included. The copy was watermarked "draft". I have no doubt that as at 19 February 2009 the policy had already been issued to staff at RDH with no reference to it being a draft and that it was acted on both before and after 22nd January 2009. The investigation has shown that the policy was:

- endorsed by the General Manager in December 2008
- directed to be posted on the RDH website for all RDH employees on about 22 January 2009 with no mention that it was a draft, but with a positive statement that it was final and replacing an earlier draft
- the policy and forms to be used to implement the policy and which were part of the policy and copies of the policy itself were not marked as "draft" and are on patient records from at least January 2009
- that a number of patients had already been detained or restrained in reliance on the published policy before the Acting Director's letter of 19 February 2009 claiming that the policy was a "draft" not yet endorsed
- given to the Security Manager as early as 10 November 2008 who was instructed at a meeting with Ms J Evans, the Deputy General Manager, RDH; Human Resources Manager, RDH and Barrister Kelvin Currie that the policy to restrain people under Section 16(3) of the *Medical Services Act* was to be enacted from 10 November 2008 and any security officer who was informed that a "declaration" under Section 16(3) of the *Medical Services Act* had been made and who was requested by a clinician to restrain a person may be subject to

disciplinary action if the security officer failed “*to respond to a lawful instruction of a clinician to restrain a person*”.

I sent a draft of this report to Mr Beirne for him to set out his defence to the above adverse comments. In reply he submitted that he referred to it as a ‘draft’ policy because it did not comply with the policy for making policies. He is correct. It did not comply with the policy for making policy. His response did not mention that my question referred to “any documented process”. The ‘draft’ policy is attached as Annexure (2). It has as a footnote “*Endorsed GM RDH December 2008*”. There can be no doubt that, on his own admission, there was a “*documented process*” in place when I asked the question on 20 January 2009. In fact there appears to have been one in place as early as June 2008. On 23 April 2009 Mr Beirne sent me a copy of relevant entries in the minutes of meeting of the RDH Governance Group of 27 June 2008. The minutes refer to a draft policy being approved for use under Section 16 of the *Medical Services Act* for restraint and detention. I have not seen that document, but I have no doubt it is a “documented process” and the subject of my request in question 9 of my letter of 20 January 2009. I also mention that on 23 January 2009 I wrote to Dr Ashbridge and enclosed a list of all documents that I wanted produced. On that list was:

- ❖ *The minutes of any meeting, report, email, agenda item or correspondence of [RDH] or [DHF] or the Board of Management of RDH or the Security Officers or legal officers regarding the provisions of Section 16 of the Medical Services Act.*

The fact that the minutes sent to me were only provided on 23 April 2009 after my draft report was released to DHF (and others) on 9 April 2009 indicates to me that Mr Beirne was unaware; careless or cavalier in his response to me 19 February 2009. The same minutes I received on 23 April 2009 also refer to other documents relevant to this investigation which I requested on 22 January (Dr Notaras) and 23 January 2009 (Dr Ashbridge). They confirm my view that when replying to my letter of 20 January 2009 on behalf of DHF Mr

Beirne was not aware or not candid or else careless or cavalier about providing all relevant information. Mr Beirne has offered no explanation of how a watermark 'draft' was on the copy of the policy sent to me on 19 February 2009 when every other copy on patient files before that date was not so watermarked.

As I have said this is an interim report. I have recommended that DHF review within one month all cases where patients have been detained etc using Section 16 of the *Medical Services Act* and provide a report to me.

I hope that if the report is internally reliable and discloses all relevant information without evasiveness I will not need to go further with this investigation. I say this as I consider that such disclosure was not made in response to my enquiries of 20 and 23 January 2009.

I note also that patient (F) previously referred to was, according to his medical records of 15 February 2009, still in RDH, still being detained in reliance on Section 16 of the *Medical Services Act* and "*frustrated*", "*shouting swearing and kicking requiring the assistance of security staff and sedation with oral diazepam*". On 9 February 2009 Dr David Ashbridge, Chief Executive of DHF gave me his written undertaking that, pending a reply to my enquiries, "*no person would be detained or retrained at RDH in reliance on Section 16 of the Medical Services Act*". That reply on behalf of DHF was received on 19 February 2009. The note about the patient dated 15 February 2009 conjures up for me, despite the benign words, a picture of a patient with no understanding of his condition, being forcibly held by at least two security officers and given a sedative as chemical restraint to keep him in RDH. In his defence to this draft report Dr Ashbridge said that patient F had been "sectioned" under the *Medical Services Act* prior to his assurance to me on 9 February, so when the events of 15 February occurred, there was no non compliance with his undertaking. That is mere sophistry.

The law, however, is clear. The declarations of the United Nations are clear. It is not for RDH administration management to decide if he should be so treated and chemically restrained. It is for a Court to decide or, if the excuse of necessity applies, for a medical expert. It is the ultimate responsibility of the Minister of Health who, under the *Adult Guardianship Act*, is the Public Guardian in whom the power to allow such treatment can be vested by the Local Court. The doctrine of “*necessity*” cannot have application when patient X has been trying to leave the hospital repeatedly since January 2009 and an application to the Local Court for an order under the *Adult Guardianship Act*, for authority to detain the patient, can be brought on for hearing within a week.

I was informed by DHF in reply to the draft of this report on 21 April 2009 that action had been taken to obtain an order under the Guardianship Act for patient F. No supporting documents were volunteered. I had been informed on 6 April 2009 by the Court Registrar that an application had not been made. I requested DHF to verify the statement made on 21st April. On 26 April 2009 I received a copy of a document with the Court seal indicating that the application for an order under the Adult Guardianship Act had been filed at Court on 20 April 2009. It was listed for hearing 27 April 2009, ie within a week. I was advised by Dr Ashbridge and Mr Beirne on behalf of DHF that the application had been faxed to the Adult Guardianship Board on 9 January 2009. The application is made by the parents of the patient. They executed it on 17 November 2008. The explanation, given for the delay, since 17 November 2008 is as follows:

The time period taken to gather the material required by the Guardianship Panel to advise and make recommendations to the Court for an adult guardianship application is illustrated by the progression of the adult guardianship application made in relation to patient (F). The interim report's statement that no adult guardianship application had been commenced for patient F is untrue. I am advised that the social work department of RDH

completed an application for adult guardianship for patient F on about 17 November 2008. Requests were made for reports to support the application. On 9 January 2009 the application, together with a carer's report, social work report and occupational therapists' report were faxed to the Executive Office of Adult Guardianship. A Panel was appointed on 28 January 2009. The medical report was faxed to the Executive Officer on 15 February 2009.

I am advised that the social workers' letter accompanying the application received by the Executive Officer asked that the case be treated with priority. However, the Executive Officer noted that there was to be a review by a Neuro psychologist on 23 February 2009 and it was determined to await that report, which was received on 24 February 2009. In accordance with usual practice, the matter was then referred to the community panel member. Her report was received on 1 March 2009. Panel meetings for adult guardianship are convened periodically, not usually for single matters. I am advised that this matter was considered by the Guardianship Panel on 16 April 2009 that a recommendation has been made and the matter will shortly be listed for hearing by the Court.

The application will ask that patient F's parents are appointed as his guardians. I have been told that during the process patient F's parents have been involved in decisions concerning his care. Your report and conclusions fail to refer to or consider this important aspect. Patient F has now been discharged and is living with his parents.

If the procedures of the Executive Office of Adult Guardianship and of the Panel generally take the time outlined by Dr Ashbridge, in my opinion action needs to be taken urgently to expedite those procedures and time frames.

The time frames to get reports from staff employed at the hospital are unacceptable. If this patient was at such imminent life threatening or immediate harm risk that he could be detained and prevented from leaving the hospital under the doctrine of necessity in January 2009, it seems incongruous that reports on his condition could not be documented for the Panel fairly promptly. The Office of Adult Guardianship is a division of the Department of Health & Families. The resources available to that office, the number of staff to manage the workload, the procedures, technology, and ultimately the time frames are within the management of the Chief Executive of DHF. If DHF is aware of the unacceptable timeframes to prepare and file at Court an application not only is it within the power of the Chief Executive of DHF to take action to reduce those timeframes it is his obligation to do so.

This investigation is not one enquiring into the operation of the Adult Guardianship service. However, the Chief Executive of DHF has raised as a defence to my conclusion that an order for patient F should have been applied for that the time frames involved within the hospital, (under his management), and within the Adult Guardianship Office, (also under his management), make it necessary to resort to the administrative malpractice of setting up a process under the *Medical Services Act* Section 16. I do not accept his defence as any excuse. There is no explanation as to why it took from 17th November 2008 until 9th January 2009 for the social worker and occupational therapist at RDH to prepare their reports and one from his mother.

The issue of the power of medical practitioners to restrain/detain a patient for the purpose of providing care and treatment has been an ongoing issue for many years within RDH. In 2003, 2004, 2006, 2008 various legal advices were provided to RDH relating to this issue. RDH chose to ignore the very clear advice from its independent legal advisers over several years. On 20 October 2008 the current Legal Officer of DHF wrote advice addressed to Ms Jan Evans, who is now the Deputy General Manager of RDH *"If a person is of sound mind and legal capacity (ie not a minor or under guardianship) they*

cannot be forced to stay in the hospital if they don't consent. In my opinion Section 16 of the Medical Services Act does not permit anyone to authorise police to go and pick up an absconding patient if the patient knows what they are doing and refuses treatment".

The main issue examined in this interim report is if a person **does not know** what they are doing refuses treatment what does Section 16 of the *Medical Services Act* authorise. The answer is the *Medical Services Act* is irrelevant. The Corporate Management team at RDH made an administrative decision however to rely on it.

Investigation

Jurisdiction of the Ombudsman

Pursuant to section 14(1)(a) of the *Ombudsman (Northern Territory) Act* the Ombudsman is empowered to “investigate any administrative action taken by, in or on behalf of any department or authority to which this Act applies”. The Department of Health & Families is a department or authority within the meaning of the Act.

An administrative action includes a decision, or a recommendation to make a decision. The administrative action involved in this investigation are the acts and decisions of members of the Corporate Executives for RDH administration as employees of DHF which is an agency within the *Ombudsman (Northern Territory) Act* definitions.

Investigative process

Before commencing an investigation pursuant to the *Ombudsman (Northern Territory) Act*, it is a requirement of Section 19(1)(a) that the Ombudsman shall in writing inform the:

- (a) *Principal officer of that department or authority and the responsible Minister.*

On the 20th January 2009 correspondence relevant to this investigation were sent to Dr David Ashbridge (CEO DHF) and the then Minister for Health Dr Chris Burns MLA.

A copy of this correspondence was also sent on this date to the Quality Improvement & Complaints Co-ordination Manager (DHF), the Director of

Medical Services and Education (RDH) and to Dr Len Notaras the General Manager of RDH.

On the 22nd January 2009² (Annexure 9) further correspondence was sent to Dr Len Notaras seeking information and documents that would assist the Ombudsman in determining the matter. A copy of that letter was sent to Dr Ashbridge Chief Executive of DHF on 23 January 2009. Each had an opportunity to give full disclosure of all relevant information and any defence to the issues outlined in the letters to them. Each had an opportunity, and indeed, an obligation, from that date to inspect all records, inform themselves of the facts and reply candidly and comprehensively.

The response prepared by the Department of Health & Families (19 February 2009) was authored by Mr Peter Beirne the Acting Executive Director Acute Care Division of DHF, and stated that he was replying on behalf of DHF. His response to the questions asked by the Ombudsman appears in full later in this report (page 84).

Further information was sought by the Ombudsman. On the 26th February 2009 correspondence was sent to the Acting Executive Director Acute Care Division requesting that legal advice provided to RDH in 2004; guidelines prepared in 2004 and the minutes of the 'working party' that considered the *Adult Guardianship Act* were sought and provided.

On the 9th March 2009 two of my senior officers delegated with my authority and on Notice attended RDH to inspect the medical records of persons identified by the DHF as having been restrained and/or detained under the *Medical Services Act*.

On the 20th March 2009 the final medical records were inspected by my staff as they were not available for viewing on the 9th March 2009.

² Correspondence from Ombudsman to RDH.

Evidence considered

- ❖ *Medical Services Act*
- ❖ *Mental Health & Related Services Act*
- ❖ *Adult Guardianship Act*
- ❖ *Solicitor-General's advice*
- ❖ *Other Counsel/s legal advice*
- ❖ *Response of DHF*
- ❖ *Emails between DHF and RDH employees*
- ❖ *Security Incident Reports*
- ❖ *DHF Policy*
- ❖ *Evidence gathered during RDH site visits (via Notice to Produce)*
- ❖ *Patient medical records*
- ❖ *Responses in correspondence from the A/Director of Acute Care Services, DHF, Chief Executive of DHF, General Manager of RDH*
- ❖ *Discussions with RDH General Manager Dr Len Notaras*

It is to be noted that all information (except legislation) received, all documents examined and analysed, were provided by either DHF or RDH. The request to provide documents and information is annexed. It is hard to imagine that Dr Ashbridge, Dr Notaras and Jan Evans could have been in any doubt about the issues and evidence relevant to this investigation. They each claimed to have been denied natural justice by the time allowed to present their defence to any adverse comments. I do not agree.

Draft of this report

A summons was issued for production of patients' medical records so as not to put RDH in the position of breaching patients' confidentiality without lawful authority.

Section 26(7) of the *Ombudsman (Northern Territory) Act*, states that:

The Ombudsman shall not in any report under this Act make any comment adverse to any person unless he has taken steps which are, in his opinion, sufficient to ensure that the person has been given a reasonable opportunity of being heard in the matter and the person's defence (if any) is fairly set out in the report.

On the 9th April 2009, the draft of this report was sent to the following persons who are adversely commented on within this report:

- Chief Executive, DHF, Dr David Ashbridge (defence Annexure 4)
- The General Manager of RDH – Dr Len Notaras (defence Annexure 6)
- The Deputy General Manager of RDH – Ms Jan Evans (defence Annexure 7)
- The Acting Director of Acute Services, DHF – Mr Peter Beirne (defence Annexure 5)
- Mr Kelvin Currie – Barrister (defence Annexure 3)

Mr Currie is not subject to any investigation by the Ombudsman. The DHF has admitted early in this investigation that the administrative process of purporting to rely on Section 16 of the *Medical Services Act* was wrong. The DHF's defence was that it relied on legal advice in good faith. Mr Currie gave that advice, so I thought it fair to give him an opportunity to comment on the adverse implication about him by DHF and because I also believe that the advice he gave was incorrect at law. Mr Currie provided a response to the draft. I have included it in full as DHF Annexure 3.

The comments I make on Mr Currie's defence are that DHF have admitted that Mr Currie's advice was incorrect and reassured me that they will not follow it. The Solicitor General's advice is not compatible with Mr Currie's advice. The cases relied on by Mr Currie do not take into account Australian

judicial pronouncements on statutory interpretation or the doctrine of necessity or the various declarations of the United Nations.

Mr Currie has also made comment on my draft report which he appears to me to have misunderstood. Those comments are gratuitous and ill informed and I do not propose to respond to each of them.

The defences put forward to the draft report by DHF is included as Annexure 3³.

Numerous documents were supplied by DHF/RDH or inspected at RDH during this investigation. The following information has been extracted from that documentation.

³ Annexure – DHF responses to the DRAFT report.

“Absconding Patients – the dilemma for RDH”

On the 22nd July 2008 at 10:30am an email from a Nursing Resource Coordinator (NRC) was sent to the following persons: Dr Len Notaras – General Manager RDH; the Deputy General Manager RDH; the Operations Manager RDH and the Security Manager RDH. The NRC wrote:

Just in regard to this gentleman – we have a double edged sword when it comes to some of the patients who have taken leave without permission. They present with significant health issues and leave without receiving the correct care and so the Doctors in ED and on the wards want them brought back, but as these patients often have very destructive lifestyles and leave of their own accord because the hospital does not fit in with the way they live their lives there is little we can do. We are covering ourselves by reporting them but if the police go round and they refuse to return then that is that until they become so unwell they represent. Unless someone has significant mental impairment we are running the risk of detaining them against their will if the doctors section them. (Ombudsman emphasis).

All the staff are very aware of the requirement to make people aware of the risk they run if they chose to leave the hospital against medical advice and unfortunately many of the doctors feel they are not providing duty of care if they do not list them as missing if their illness warrants this. There is very little security/(operations) can do in many of these cases and we can only do what is required and hope for the best outcome.

Thanks for your understanding.

On the 5th August 2008 an adult patient went missing (‘absconded’) from RDH. The NRC sent an information email at 12:28pm titled ‘(patient name withheld) – 2B’ to the following staff - Dr Len Notaras (RDH General Manager); RDH Operations Manager; and others:

(Patient name withheld)

Sepsis due to chest infection.

Sectioned.

Last seen 05/08/2008 @ 0950

NRC notified @ 1100

Police notified @ 1105

.....

This (patient) also absconded yesterday and was bought back by police

'Sectioning' a patient is a term in general used for patients who are admitted (involuntarily) to a hospital under the provisions of the *Mental Health Act*. Having said this, this investigation has revealed that employees of RDH have referred to 'Sectioning' as a term used when a person is detained and/or restrained within RDH relying on the *Medical Services Act*.

(The *Medical Services Act* has no provision for detaining and/or restraining a person to provide medical treatment, unless otherwise stated within this report, any reference to 'sectioning' is to be read as a person being certified by the person in charge of RDH relying on the *Medical Services Act* and specifically Section 16(2) or (3).)

On the 5th August 2008 at 12:30pm Dr Notaras responded to all persons noted in the NRC's email at 12:28pm (shown above). Dr Notaras wrote:

Dear All....I am concerned that with section this person has left twice in as many days.

At 12:43pm on the 5th August 2008 the NRC responded to Dr Notaras' email copying in several staff:

Concerns noted.

The (patient) was allocated a PCA (Patient Care Assistant) special last night after (patient) was returned and for the present shift as well. Speaking with the PCA allocated to this patient today she was not informed of the sectioned patient, stating she was only told about the other patient in the room. This will be looked into, but as I was not the NRC staffing for the am duty I cannot make comment on what the previous NRC had told this PCA. However I will press the issue to the PCA coming on for the next shift about the importance of sectioned patients...

On the 15th September 2008 a NRC wrote an email titled 'Absconded patient 5B'. She sent this email to the RDH Operations Manager; the RDH General Manager; the Director of Surgical Nursing; the RDH Security Manager and several others:

(8 year old Patient details withheld).

I was notified by 5B staff at 1900 hours that this patient had been missing from the ward since 1400 hours. The team leader discussed it with the Paeds Reg who stated that she wanted the Police to bring the child back. I spoke to the Registrar and stated that if the child were to be actively looked for by the Police then it would need to be sectioned and to discuss this with the Med Superintendent on call.....

I was then contacted by the Paediatric Consultant (name withheld) who stated that there was no need to section the child as they were covered by the Children's and Family Services Act -or similar Act- which allowed a child to be returned to hospital within 40 hours of it missing from hospital. I discussed this with (Names withheld) and the Police, all of whom were unaware of this procedure. Furthermore, the police stated that if they were to look for the child they would require a section to be in place. I again discussed this with the Paediatric Consultant, who stated that she was not prepared to section the child, and she would follow up in the morning. Fortunately, the mother and child returned to the ward at approx 2100hours.

It would appear from this email that the 8 year old child was not reported as missing to the NRC until five hours after the child went missing and that there was much confusion about whether or not a 'child' patient required sectioning.

Concerning to me was a 5 year old 'abscondee' from paediatric ward 5B who appeared (according to several RDH emails) to have gone missing on the 13th September 2008.

In emails between RDH staff on the 15th September 2008 a dialogue took place regarding a missing adult patient (who was apparently reported missing to Police on the 14.09.2008) and a missing 5 year old patient (apparently missing from the 13.09.2008).

At 05:56am on the 14th September 2008 a NRC wrote an email titled 'Absconded patient Ward 2A' to RDH General Manager Len Notaras; RDH Deputy General Manager; RDH Operations Manager; and many others:

*Patient Name (withheld)
Promis number: (withheld)*

Sectioned after discussion with surg registrar.

I was notified at 0200 hrs that the patient had not been seen on the ward since approximately 1000hrs on Saturday morning. This had not been handed over to the night staff. The patient is known to go downstairs for extended periods of time but would always return.

The concerns are:

- 1. High risk of sepsis due to extensive open leg wound.*
- 2. Patient is now wheelchair bound and if fell, would not be able to get back into chair.*

Situation discussed with Surgical Registrar and it was decided that patient required sectioning based on above concerns.

RMO contacted (Doctor) who authorised section and requested (Operations Manager) be informed. DON also informed. Security performed search of grounds. Police notified of patients change in section status and high risk factors...

At 07:06am on the 15th September 2008 RDH General Manager Len Notaras on-forwarded this email titled 'Absconded patient Ward 2A' to several staff:

Thank you...

I am aware that the patient has now returned, however discussion with Professor (name withheld), revealed that he too became aware of this case at or about 03:00 hrs ... which is yet again a concern ... The length of time is astonishing ... can I once again ask all to be alert to "absences", supervision and reporting.

At 08:26am on the 15th September 2008 RDH Operations Manager on-forwarded an email titled 'Absconded Patient Ward 2A – update', to Dr Len Notaras RDH General Manager; the RDH Deputy General Manager; the RDH Security Manager and many others:

Good morning – as usual, the devil is often in the detail.

After receiving a call during the night, there was nothing more to be done other than security keeping up a search. I spoke with NRC just before 0700 and (patient) had not returned. Spoke to Comms Sgt at 0730 and they provided sketchy details of what was on their system of this (patient). Police were busy..... but I insisted that a GD's unit attend and take statements from 2A staff and that the duty NRC scour the patient file to provide as much detail to police (they simply knew that (patient) had been stabbed in Katherine but nothing new and no address for the mother – she had been visiting (patient) at RDH but no one knew where she was staying).

On examination of the notes, (NRC) found that (patient) had returned early Sat evening and had left with (patients) mother at approx 1940 hours with ward staff's knowledge.

(Patient) did need IV antibiotics rather than oral hence requirement to return.

With this new information, the matter was in a bit more perspective eg. That (patient) wasn't necessarily missing/in the bush etc. I asked that the Section remain in place and asked police to continue to liaise with (Patient) was subsequently located mid morning and returned to RDH...

At 08:43am on the 15th September 2008 a CNC on-forwarded this email and titled it 'Absconded patient Ward 2A – update Not at RDH!' to the Director of Operations; the RDH Deputy General Manager; RDH General Manager and many others:

Yes the detail – unfortunately this man is not here. His return to ED does not show on CareSys (the hospital information system used in all NT hospitals) or in his notes. I have just checked with Casuarina police supervisor; The police have closed the job as they returned him to ED at approx 1400 yesterday, following checking with the ward re where to admit him. It seems he did not wait. So if he is still considered a high risk and still sectioned it will require a new reporting to police. (Also, understandably, the police are a bit disappointed that, after all their efforts, some sort of 'watch' was not put on this man when returned if he was sick enough to warrant sectioning/searching). FYI

At 10:40am on the 15.09.2008 the Director of Nursing at RDH on-forward the email titled '*Absconded Patient Ward 2A – update not at RDH!*' to the RDH Deputy General Manager; RDH General Manager; RDH Security Manager; RDH Police Officer and many others:

*Dear All
We have re-alerted the police and (NRC) and I are looking into the ED Issues. Many thanks....*

The Police confirm that this patient was a constant absconder from RDH and that they were requested to look for him on a number of occasions.

An extract from another email dated the 15.09.2009 at 11:46am from an NRC to the RDH Operations Manager; the RDH Deputy General Manager; RDH General Manager; Director of Nursing and many others titled '*Absconded Patient Ward 2A – Update Not at RDH!*' states:

(Name withheld adult patient) was located by Police in Gray yesterday morning. (Patient) was returned by Police to the ED Dept waiting room at 12.40 hrs – where the Police requested Security to attend in order for the Police to be relieved. Security did attend, unfortunately there were 2 abscondee's returned by the Police in the same vehicle. The other abscondee was a 5 yr old child. Security gave the Triage Nurse (Adult patients) details....

Security escorted the child back to 5B and did not return to (adult patient) as they were not asked to do by the Triage Nurse. I have spoke with (CNM ED) regarding the above, as I spoke with both the Triage Nurse and the ED TL yesterday alerting them to the fact that (adult patient) was a high risk patient, absconded for over 12 hrs – Police out searching all night and now bringing through to ED for re-admission, sectioned etc etc. I cannot determine exactly what happened because I cannot speak with the Triage Nurse who spoke with the Police. We need to urgently get some protocols in place in order for this not to happen again. High risk patients who have TOL (taken own leave) and are located and returned to RDH by the Police must be brought into the ED Dept (not left in the waiting room) as soon as they present to ED (this must be done immediately whether ED is busy or not). Security should be involved with these patients and must escort the patient (when patient sectioned) until relieved by PC or other. I have apologised to the Police on behalf of RDH....

At 11:55am on the 15th September 2008, the Deputy General Manager of RDH responded to this email titled '*Absconded Patient Ward2A – update not at RDH!*' to the NRC:

Thanks (name withheld) – we didn't know about the 5 year old either? I can't understand what it is we have to do to get the staff on the wards to take any notice of these incidents.

Are we getting to the point of disciplining staff who do not report and then do not take appropriate action to prevent recurrences?

I shall seek some advice from HR.

Any other suggestions – we look like fools.

On the 20th March 2009 two of my officers attended RDH to review the 5 year old patient's file. There were two '*Absconding Patient Details*' forms attached.

On the 13th September 2008 at 5:30pm the 5 year old child is recorded on the absconding form as being last seen on Ward 5B at 05:30pm. The date and time the Police were notified is listed as the 14th September at 09:45am (16 hours after the child was found to be missing) with the following description listed within the form: *Height - ?; Build - slim; Hair - short brown; Distinguishing Features/marks/wounds – Plaster on left arm ? IVC rt hand; Clothes – blue hospital shorts.*

The medical notes written on the 13th September 2008 at midnight state: '*patient and Aunty remain off ward have not been seen since commencement of shift. NRC informed ...Dr (B) phoned and not concerned to bring patient back to RDH. Paed Reg informed as was on ward. Wanted to bring child back but spoke to NRC on phone and now we have to section patient if Police are to bring back. Team leader informed...*'

At 09:45am on the 14.09.2008 the follow entry is recorded: '*Nursing: absconding form completed police notified, fax of form sent to NRC.*' At

11:30am the notes state: *'Nursing: Contact from Police re child found at Palmerston. Will return to Ward'*. An entry written at 12:00pm states *"I was on duty from 1400-2200 13/09/2008, at no stage was I contacted about this child being absent from the ward. All paediatric staff must be aware that we do not wait 4 hrs before we notify authorities regarding paediatric patients. Informed by team leader (name withheld) that patient had been located and is now returning to hospital. RN (registered nurse) spoke with completed an incident report regarding this. I will review and add my comments when completed (signed by NRC)"*.

The second absconding form contains a similar description and notes the child was last seen on the ward at 5:30pm on the 19th September 2008 and the Police were notified at 08:30am on the 20th September 2008 (15 hours). Medical notes written on the 19.09.2008 at 10:30pm state *'Nursing: NRC notified of patient AWOL at 2200. NRC advised me to call contact numbers in chart. Contacted Aunty as per custodial care form, Aunty believes they are at 1 mile dam. Aunty also stated no contact number for (mother) and she doesn't know who else would be out there to contact. NRC (name withheld) spoke with (Operations Manager) and he is happy to wait for morning to find patient due to current situation in hospital (no power) and that patient is low risk and in his mothers care. Patient has also done this before. Ortho reg on call Dr (V) happy with this plan'*.

The medical notes written at 09:00am on the 20th September 2008 state: *'0900 nursing: absconding form completed – and police notified. NRC notified. 0930 call from police – will attend to our notification but if mother refuses to come back – they will not be able to force her as child not sectioned. Dr (V) notified. He still wants child back in hospital due to risk of wound infection ? may need to report incident to FACS if child remains AWOL. 1800 hours nursing: call from Police to ascertain whether child had returned to ward. Child not returned to ward.'* The medical notes written on the 21.09.2008 indicate that the patient *left hospital on the 19.09.2008 at 22:30 hours against medical advice...staying with relatives in Darwin –*

wanted to visit family. The plan listed for the child included the comment 'If he leaves hospital again will need to be listed as absconded and police informed'. On the 22nd September 2008 at 11:40am there is an entry that reads '...We are not happy with discharging him at this moment (unreadable) contact NRC/Police, bring patient back, (unreadable)'.

The NRC responded to the RDH Deputy General Manager by email on the 15.09.2008 at 12:12pm:

... The 5 yr old from 5B was last seen at 1730 hrs on 13/9. NRC notified in am as was Police (09:45hrs)! I asked for an incident report to be completed once notified yesterday and will follow up with the CNM 5B today.

The NRC's email supports that a 5 year old child went missing from Paediatrics Ward 5B at 5:30pm on the 13th September 2008 and the NRC was not notified by the ward until the next morning. Additionally it appears the Police were not notified until 9:45am on the 14th September 2008, and as a result of the notification located and returned a missing adult and the child. The situation of the child going missing occurred again on the 19th September 2008.

All of this information was provided to the Ombudsman to consider in response to the Ombudsman's request for all information about absconding patients who were detained at RDH under Section 16 of the *Medical Services Act*. It was not apparent whether Section 16 was used in these cases but DHF considered them relevant.

In relation to 'absconding' I refer to the DHF Policy "*Take Own Leave Guidelines*" revised and re-endorsed in September 2008 which states that "*In the event that a search fails to locate the patient and where the patient is a minor...., the Medical Administrator/Executive on-call, next of kin/legal guardian and/or the police must be notified immediately*".

On the 16th September 2008 at 09:09am a NRC wrote an email titled “*Absconded patient 5B – some thoughts*”. This email was sent to the RDH Operations Manager; Dr Len Notaras RDH General Manager and other RDH staff:

Dear All,

Just some thoughts because of my role in the follow-up 24 hrs on:

The ...situation seems to be to possibly be an example of a need for an official meeting with police management & RDH or DHF to discuss and establish agreed priorities between the Hospital and local police for TOL (take own leave) patients deemed to be ‘at risk’.

The ‘at risk’ categories required by us to be reported to police in our current (updated/reviewed version due out soon) ‘Patients who leave hosp without official discharge’ Policy & Guidelines – NT Network Manual, are not just people kept sectioned under various Acts, but also those deemed ‘at risk of .. serious injury...’ and ‘Minors’ – it doesn’t mention sectioning these two. Maybe there also need to be some clarification about just what are RDH’s responsibilities covering the return of ‘minors’ under the Community Welfare Act, - quoted as one of the references in the current Policy document – or the Care and Protection of Children Act.

However I am pretty sure police feel that if they search for a patient who is not sectioned, locate them and then the pt refuses to return/police cant forcibly return, then they have wasted effort & resources. Hence of recent times it seems police tend to only want to search for sectioned patients (though this is not always the case – seems it just depends who in police communications gets the report from RDH)...

The legal principles raised within RDH

On the 20th October 2008 (05:06pm) an email from the A/Director of DHF legal services was sent to RDH’s Deputy General Manager. Titled ‘*RE: Form and policy for Retrieving patients under the power of the medical superintendent*’, this email is quite clear about the provisions of section 16(3) of the *Medical Services Act*. An extract states:

If a person is of sound mind and legal capacity (ie not a minor or under guardianship) they cannot be forced to stay in hospital if they don't consent. In my opinion s.16 of the Medical Services Act does not permit anyone to authorise police to go and pick up an absconding patient if the patient knows what they are doing and refuses treatment.

If it is the case that a person is at risk (including because they have a medical condition) and are "missing" then the police should treat them as a missing person. I think this would also be the situation with children or those under adult guardianship orders. I would have thought Police would act pretty quickly in the latter group of cases.

Section 16 of the Medical Services Act, is really about maintaining order in the hospital. It basically reflects the common law position and would include authorising the person in charge of the hospital (who may act through others) to use reasonable force to restrain a person who is disorderly/confused etc. and therefore a danger to themselves or others whilst in the hospital. It is, however, of no use in recovering an absconding patient once they have actually left the hospital campus because they are then no longer in a hospital and are outside the control envisaged by the MSA. As stated above, the MSA can't be used to prevent a person leaving the hospital if they have the capacity to make decisions for themselves, even if they are very sick and would be better off staying. I think the law is pretty clear on that point....

Another option is to detain a person who has been admitted as a voluntary patient for up to 6 hours as an involuntary patient under s.30 [of the Mental Health Act]. But this section is unlikely to be useful in recapturing the person once they have absconded. The terms of s.30 seem to be predicated upon actually having the person in the facility already. Where s.30 is useful is where the staff get notice that a person is intending to leave as it may then be used to keep the patient in the facility against their will.....

At 11:31pm on the 26th October 2008 an NRC sent an email titled 'Section 16 3' to Dr Notaras RDH General Manager; the RDH Deputy General Manager; the RDH Operations Manager; and one other:

Just to inform you of developments during the night. I was contacted by the nurse in charge of ED who informed me that they had a conversation with security who had informed them that they were not going to detain or restrain any of the patients under the

medical super section. They have apparently had advice that this does not exist or they are not covered. I asked (name withheld) to document in the notes this information just to cover us in case they abscond overnight. The affected parties will need to sort out their position asap so we know what is going on and what we can advise our staff accordingly. I have informed (names withheld) tonight.....

On the 27th October 2008 (04:32pm) the DHF Acting Director of Legal Services sent an email to Dr Len Notaras (blind copies to the Solicitor for the NT officers Ms Sally Sievers and Greg MacDonald):

Hi Len

I tried to give you a call but you were busy. I have spoken to Kelvin and read the advice that he sent this morning and don't disagree with it. It is one thing to reasonably control a patient who is within the hospital (I would include the grounds and other buildings in that) where that is required either in the interests of the patient or the good order of the hospital. It is quite another to forcibly stop a person leaving who has capacity to make the decision and refuses to stay.

However, I also understand that there is a 'grey area' around people who are not formally without capacity (ie under formal order etc) but who aren't capable at that time of understanding the implications of their decision. There is a tension here between the duty of care to provide appropriate medical treatment and the autonomy of the patient to determine what happens to them. There isn't any easy answer to this. It needs a practical approach.

If a person is confused (not understanding what is going on, on the day) then I would agree they should be prevented from leaving and other steps should be taken to determine why they want to leave including the extent of their capacity, whether they understand the issues etc.. I can see no reason why security officers who are employees of the hospital can't be directed to carry this out. I am more than happy to come and speak with the security officers if that would help. In fact Kelvin has suggested that we both attend and I am happy with that approach.

On the 27th October 2008 an email titled "Problems with Medical Services Act 16" from the Acting Clinical Nurse Manager – Emergency Department was sent to numerous persons including RDH General Manager Dr Len Notaras and the RDH Operations Manager. This email states:

.....

We have had some problems over the weekend and today (Monday) in regard to the Medical Services Act – Sect 16.

“Person in charge of hospital”. We have some problems with the actual implementation. Security state that they are unable to stop the person from leaving, and are not able to be utilised in detaining this kind of patient.

Today one PCA was sent for two patients, and when she followed them both outside, for a smoke, they wandered away from her, and she was unable to convince them to stay. Security would not detain this person unless the section became a section 34 or 32 [Mental Health Act]. Doctors and Nurses were concerned on what legal grounds they have to detain this patient. The Team Leader notified the NRC, and when the police were notified, we found out there was a court order out.

Often we cannot get a PCA, due to shortages, and the ED staff, do not have the time to watch the patients. That is why they then abscond.

We need to have a clear pathway for staff to follow, and what steps to take, if the patient wants to leave.

The NRC’s also have the same confusion. The Act needs to be backed up with a clear policy that staff can follow.

At 4:34pm on the 30th October 2008 the RDH Operations Manager on-forwarded the email titled ‘*Problems with Medical Services Act 16*’ to many persons including Dr Notaras; and the RDH Security Manager:

.... There has been extreme confusion regarding the issues of patient restraint and detention for a long time. Many months ago, the auditorium was full to the brim with security officers, nurses, allied health and doctors wanting clear and unambiguous policy and guidelines on the legal aspects of this matter.

Following the meeting, Kelvin was to provide a comprehensive policy and guidelines but I’m not sure that status. This would cover the limitations of Medical Services Act 16.3 and the Mental Health Act and the applicability of each. There are many concerned and confused medical and nursing staff throughout RDH and I would

suggest the other Territory hospitals as they too would face their own situations.

RDH security staff, via their union, sought independent legal opinion. I understand, they were informed this was fraught with problems as there was a lack of clear policy and guidelines as to its applicability. Some police officers have stated that this legislation does not have the necessary provisions and if they were personally detained, they would undertake their own legal action against the officer concerned.

There is a desperate need for this matter to be resolved and in my opinion, it needs a legal officer to draft.

At 05:09pm on the 30th October 2008 the email titled 'Problems with Medical Services Act 16' was on-forwarded from Dr (P) in the Emergency Department to Dr Len Notaras General Manager RDH; Ms Jan Evans the Deputy General Manager RDH, and one other (name withheld).

Dr P's email stated:

Exec

This needs to be sorted out please.

We keep having the following bizarre incidents in the ED – examples –

- 1. Confused patient with grade 1 subarach put on section 34 (mental health) to keep him in the ED and ensure a security guard can be present. The patient then needs psychiatry "clearance" when we know his problem is a bleeding aneurism but had to use the device to get a security guard.*
- 2. Confused drunk who could be head injured requiring a similar section to keep him here for a CT head – need a psych section which then has to be "cleared" by approved psych practitioner (often with considerable delay).*
- 3. Most recently patients returned by police under section 16.3 and security refused to keep as they have had "independent legal advice" they cannot restrain these people.*

This stupidity has gone on long enough.

There are the ED policies on these issues.

Patients are now being put at risk.

I have informed ED medical staff that forthwith we will use the principle of necessity when a section is not appropriate, and we will not use sections inappropriately.

If the security staff feel in their judgement that they are the competent authority over the medical officer then the medical officer is to document in the notes that s/he has informed the security officer that s/he requested the security officer to restrain the patient (as there is a concern for life) but the security officer refused.

We have had legal advice from Kelvin which is sensible and conforms to every other hospital in which I have worked (I have an interest in consent). There is apparently some "independent" legal opinion from security at odds. Not everything needs a specific section – the small thinkers (who are part of devising the section instruments) have ignored the common law which is applicable.

We know what is required – we just need security to do it – and to feel "safe" and "supported" following orders.

This may require education/policy/guideline.

As one point Kelvin offered to come and address the security people – maybe that is required.

I do not think this needs more work – I think it needs management of the security people hence I am referring to the exec for your action.

On the 30th October 2008 (07:21pm) the RDH Deputy General Manager responded to Dr P's email of 30 October 2008 titled 'Problems with Medical Services Act 16':

Thanks (P) – I agree. I have asked (Security Manager) to show me the advice that he has and is relying on – but there has been no response.

....., can you please see whether you are able to come out to speak with relevant security/ED and other staff as soon as possible.

We need this fixed as (P) says.

On the 10th November 2008 a meeting was held at RDH to discuss Section 16(3) of the *Medical Services Act*. Present at this meeting was the RDH Security Manager; Ms Jan Evans RDH Deputy General Manager; RDH Human Resource Manager and Barrister Kelvin Currie. No instructing Solicitor was recorded as being present.

There are no minutes of this meeting, so reliance as to what occurred is placed on the email of the same date from the RDH Security Manager to security staff titled "Section 16.3". Copied into this email were the RDH Deputy General Manager (present at the meeting), Legal Services and the Manager of HR (present at the meeting).

The Security Manager's email requested that all security staff read and sign the information contained within his email. An extract from the Security Manager's email states:

.... As stated above, Section 16(3) provides for the 'person in charge of the hospital' to make declarations on people located within the hospital.

From time to time, the person in charge of the hospital will be contacted by clinicians and for clinical reasons may make a declaration that a patient can be restrained and detained.

This has already occurred on a number of occasions.

Policy to be enacted from today 10 November 2008.

At the meeting this morning, an instruction has been made that where a declaration under the Medical Services Act Section 16(3) has been duly agreed by the person in charge of the hospital, a clinician will advise security that this has occurred and security officers will apply the same response as required under a Mental Health section until advised differently.

I have been assured by the above group that the application of reasonable force to restrain a person is lawful. Furthermore, it remains lawful that a security officer can be instructed by a clinician to detain a person against their will and that this will have been covered by the clinician with the consent of the person in charge of the hospital.

In your incident report (IR) ensure that you provide the name of the clinician issuing the instruction and note the time. Other details to be recorded include the amount of resistance offered by the person and the amount of force needing to be applied to reasonably restrain and then detain the person and any other relevant matters including injuries suffered to yourself or the person. Where a person has been injured as a result of the instructed restrain, ensure that the clinician has been informed so that an examination can be conducted. Ensure this is recorded in your IR (Incident Report).

I have been instructed to advise that should security officers fail to respond to a lawful instruction by a clinician to restrain a person, this may be subject to disciplinary action...

Staff queries about the legality of instruction to detain under Section 16 of the Medical Services Act

On the 11th November 2008 (01:56am) a Security Officer responded to the Security Manager's email titled "Section 16.3". The security officer wrote:

(Security Manager) This causes me grave concerns, however they will be addressed in a different forum. In the meantime there are some very obvious questions to be asked:

As far as this sentence is concerned:

"I have been instructed to advise that should Security Officers fail to respond to a lawful instruction by a clinician to restrain a person, this may be subject to disciplinary action".

I assume you are referring to discipline under Section 49c of PSEMA (c) disregards or disobeys a lawful order or direction given by a person having authority to give such an order or direction;

In which case, can it be established who is a person having the authority to give a lawful order? Notwithstanding any order under 16.3 to use force upon someone has not as yet been shown to be lawful, and therefore no person is obliged to perform an illegal act, just who can give such an order? Registrar, Consultant, Student?

Under the NT Criminal Code, an act is only lawful if it is authorised, justified or excused. Where is the authorisation in law to use force in relation to the Medical Services Act? An action does not become

lawful because a committee says so, that's why we have laws, passed by Parliament. May I also point out that this 'group' will have no influence over Police Prosecutions or the DPP.

Who has deemed that: At the meeting this morning, an instruction has been made that where a declaration under the Medical Services Act Section 16(3) has been duly agreed by the person in charge of the hospital, a clinician will advise Security that this has occurred and Security Officers will apply the same response as required under a Mental Health section until advised differently.

The Mental Health Act specifically quotes the use of force, that is why it is used. Where is the use of force equivalent to that of the MHA in the Medical Services Act? Is there a reference to the Mental Health Act in the Medical Services Act, or has someone just arbitrarily decided to use the powers of one Act for another? Why not just quote section 28 of the Criminal Code which gives you the authority to cause death or grievous harm? Get my point?

Does the person unlawfully detained under 16.3, with the same response as the Mental Health Act have to be reviewed by a psychiatric registrar? Have they the right to phone a Magistrate or to make an application to the Mental Health Tribunal, or have they no rights at all? Indeed, have they the right to request that they be examined by a psychiatric registrar for want of being deemed mentally competent? If they are mentally competent, why are they being detained?

Does the RDH Patient's Charter not apply to these people?

"Your rights. By coming to hospital you have given general agreement for treatment to begin. Some procedures require specific consent and for these you will be asked to sign a consent form. The procedure must be explained to you first. You may withdraw this consent at any time. You may also leave the hospital at any time, but if you do so without hospital approval, you will be asked to sign a risk form".

If a person is not capable of making their own decisions about treatment, who is? Is every patient who is placed under a 16.3 going to be referred to Adult Guardianship?

If for some reason the patient is not deemed capable of making decisions about their own treatment, can a relative not make such decisions, or have their rights been removed as well?.....

On the 12th November 2008 (10:28pm) a RDH Security Officer wrote an email that was sent to the Deputy General Manager of RDH titled “RE: Section 16.3”:

(Security Manager)

As the union delegate for security, it is my duty to look after the LHMU members whom I represent. On their behalf, I have constantly sought legal advice on this matter, and I continue to be told from different legal sources that the hospitals legal advice is wrong and would leave officers open to criminal charges.

My colleagues and I have been treated in a demeaning and condescending manner throughout this debacle and feel as though they are being bullied and threatened. The current union advice is that we should not exercise any force under 16.3.

I have also been advised that people who give ‘orders’ should consider section 12(2) of the Criminal Code.....

On the 12th November 2008 (11:14am) the Security Manager on-forwarded this email to RDH Deputy General Manager; RDH HR Manager and DHF legal services advising that he did not feel in a position to answer this email which was addressed to him (but sent to the RDH Deputy General Manager).

At 11:25am on the 12th November 2008 the Deputy General Manager responded to the Security Manager’s email titled “16.3”, copied into this email was the HR Manager; DHF legal services and Barrister Kelvin Currie. The Deputy General Manager wrote:

Thanks (Security Manager). You drafted the email to your staff about the disciplinary action. If you don’t understand your email that is a problem? Perhaps (security guard) would like to seek the clarification of his issues, once again from his legal advisor. Has he been given a copy of our Legal Advice? I will speak with Kelvin and perhaps he can do another session with security.

On the 13th November 2008 (09:36am) the RDH Deputy General Manager on-forwarded the security officer’s email titled “16.3” (12.11.2008 10:28pm) to the security office; Barrister Kelvin Currie; DHF Acting Director of Legal Services;

RDH HR Manager; the security guard who sent the above email; the LHMU and Dr Len Notaras:

.....It is clear that Security are still refusing to accept the Department's legal advice in this matter.

Can I please have your advice as to how we progress his issue that has serious consequences for patient and staff safety.....

On the 15th November 2008 (12:29pm) two security guards emailed the Security Manager. The email is headed "RE: section 16.3" an extract is below:

.....I have just returned following rostered days off and while bringing myself up to date I read with concern a memo from (Operations Manager) dated 13/11 which begins and I quote "It is clear that Security are still refusing to accept the Department's legal advice..."

This implies that the entire Security department is refusing to act on any patient placed under a Section 16.3 by medical staff – totally incorrect.

You issued a memo dated 10/11 following the meeting between you and 3 other parties.

This directive by you is being strictly adhered to and until further advised will remain.....

On the 19th November 2008 the Security Manager on-forwarded the above email to two persons including the RDH Deputy General Manager. This email states:

...this is the email I mentioned yesterday that I received on the weekend. It appears to be in response to an email I was not included in but all makes sense now. As discussed in our meeting security are responding and have been responding to 16.3 sectioning since the 10/11/08. Until advised otherwise they will respond in the same manner as with a section 34a.....

At 03:22pm on the 9th December 2008 a DHF employee on behalf of RDH Dr (B) sent an email titled 'Medico-legal presentation Detention/Restraint' to the following persons - Dr Len Notaras RDH General Manager; the RDH Deputy

General Manager; RDH Executive Officer; DHF Director of Medical Services & Education; Dr (C); an officer from Medical Administration and others:

Good afternoon.

We have arranged for this presentation on the next LAD, Friday 19th Dec, 1:15-2:45pm to be held in the RDH Auditorium as previously requested to organise by (RDH Deputy General Manager). We have confirmed both Kelvin and (Director of Psychiatry) availability for this session date and time.

We have prepared the attached flyer to circulate, advising all medical officers to attend, please advise if you wish us to assist to circulate. We have included the invitation to all medical officers, nurses and allied health. As this is not one of our set sessions for junior medical officer training and education, can the departments be advised that attendance will be required on this LAD.

We have arranged medico-legal sessions to cover broad topics during both the Intern orientation and RMO/Registrar orientation sessions and we plan to have some follow up sessions throughout the year at the weekly Tuesday sessions.....

On the 9th December 2008 (03:58pm) the Deputy General Manager of Royal Darwin Hospital on-forwarded this email titled "*Medico-legal presentation Detention/Restraint*".

..., Kelvin may want to hand out his legal advice and also our draft policy and forms related to detaining someone pursuant to section 16 of the MSA. Can you check with him and arrange copies? Can you get ... to send out the email to Div Heads asking them to ensure attendance?

At 4:40pm on the 18th December 2008 RDH Deputy General Manager sent an email to '*THS ROYAL DARWIN HOSPITAL TIWI*' titled '*Information Session for Staff – Restraint and Detention in a hospital setting*'. This email had attached a flyer advertising an information session being presented on the 19th December 2008 from 13:15pm – 14:45pm, presented by Barrister Kelvin Currie; and the Director of Psychiatry.

On the 18th December 2008 (4:42pm) the Deputy General Manager of RDH on-forwarded the email to staff titled "*Information Session for Staff – Restrain and Detention in a hospital setting*":

Dear all, can I please encourage you to attend this session tomorrow and also ask that you encourage your medical officers to attend so that a good discussion can be had around s.16 Medical Services Act sectioning.

In December 2008 Dr (P) sent an email to Barrister Kelvin Currie:

Hi Kelvin

As discussed

Case Précis:

- *42 male brought in by police after alleged assault*
- *Seen by ED Registrar*
- *Intoxicated, possibly head injured, also with low oxygen saturations, wanting to leave.*
- *Clearly documented that he does not appear to comprehend risks documented (registrar) that patient "not competent" at present*
- *Discussed with the duty ED consultant: thought possible head injury / possible intoxication / need to recheck oxygen sats as this may be a miss-reading – should be detained under the principle of necessity whilst we make the assessment*
- *The Security Officers refused to keep the patient – ED Registrar documents that the security officers thought they were not "covered" to physically restrain the patient – despite a consultant being involved and wanting to keep the patient by physical restraint if necessary*
- *The patient walked / stumbled out*

Hasn't come back and the coroner's officers haven't come visiting.

Questions:

- 1. I, and my fellow consultants, do not see the need to use any instrument except common law for this – we jointly have about 80 yrs of medical experience and have always (in many places in AU and in other countries) when faced with this (expected to be temporary) situation acted under common law. Are we wrong?*
- 2. Who is responsible under law if this patient is now dead from a subdural?*

3. *Who is responsible if the patient subsequently seeks legal redress for assault if restrained in this circumstance?*

*Regards
Dr P*

On the 19th December 2008 at 9:12am Barrister Kelvin Currie sent an email titled 'Brief Advice on A Case' to Dr (P):

Hi (name withheld)

I will be out at the hospital in the early afternoon in pursuit of some mutual understanding on these sorts of things.... But the crux of the problem in this and others has been that it is not so much a legal problem as one of practice and the result of years of misunderstanding.

As to the questions. You are not wrong. If you look at the Criminal Code Act it has these provisions:

In relation to the definition of assault it is NOT an assault:

“(c) when rescuing or resuscitating a person or when giving any medical treatment or first aid reasonably needed by the person to whom it is given or when restraining a person who needs to be restrained for his own protection or benefit or when attempting to do any such act.”

In addition section 149 places a positive duty on people having the “charge” of those suffering some form of disability or condition such that they are unable to care for themselves (I have left out the parts about children under 16 for ease of reference but it includes the same duty to those children).

It is the duty of every person having charge Of any person who is unable to withdraw himself from such charge by reason of age, sickness, unsoundness of mind, detention or other cause and who is unable to provide himself with the necessaries of life –

(a) to provide the necessaries of life for that ... person; and

(b) to use reasonable care and take reasonable precautions to avoid or prevent danger to the life, safety or health of the ... person and to take all reasonable action to rescue such ... person from such danger.

In effect you have the duty to care for the patient and the breach of that duty is a criminal breach. It is not an assault to restrain him...

so the problem is simply that everyone is not on the same page (and it seems from my discussions to date are not wanting to be ... we might need to have more education about these situations).

In relation to who is responsible... in effect the NT is responsible civilly (the net effect of vicarious liability and S22A Law Reform (Miscellaneous Provisions) Act.

As you can see from the above it is not an assault to restrain such a patient so if charged there is an absolute defence.

On the 19th December 2008 at 10:10am Dr (P) sent an email titled '*Principle of Necessity in Common Law*' to 5 of his colleagues (names withheld):

Colleagues

Please see below – in red is the clinical case that we (name withheld) dealt with according to our (Darwin Emergency Physician Group) consensus view AND according to our written guideline (which as been signed off by me and has been subject to external legal review).

I have obtained another legal opinion specifically on this case and it vindicates my / our opinion – which is not surprising but it is in writing.

We are trying to educate security and I will raise this with the RDH executive to establish if disciplinary action is warranted as this is a significant risk not only to our patients but to the organisation.

On the 19th December 2008 at 10:24am, Dr (P) on-forwarded the email titled '*Principle of Necessity in Common Law*' to the RDH Deputy General Manager and Dr Len Notaras:

Exec

Please find below a case and a legal opinion and a major risk to patient care and a major risk to this organisation.

I think that it is coming to the point where the security people need to be told what to do and if they do not follow that advice then it becomes a disciplinary matter – there is a limit to the value education in this group.

We will continue our practice of using the principle of necessity. I am publishing the below discourse to all ED staff.

On the 19th December 2008 an information session for staff regarding the 'Restraint and Detention in a Hospital Setting' was presented by Barrister Kelvin Currie and others.

At 05:36pm on the 19th December 2008 Dr (P) sent an email titled 'Restraint in RDH – solutions' to the Deputy General Manager of RDH; Dr Len Notaras General Manager RDH and Barrister Kelvin Currie.

Find attached the ED policies and the Acute Care policies relating to this. The acute care policies were written from the ED policies and mental health input. Unfortunately – you will notice when comparing – the Principle of Necessity / common law was left out of this. This common law element is where most of our issues arise.

It appears that some medical folk think that this can all be covered by a "section" of the MHA – which is not true. This misunderstanding, in my view, has been passed onto security and resulted in "demands" to sign a signed mental health section on every patient (and only mental health sections appear to be valid in security's eye –which is notable).

The Acute Care Policies are due for review in March 2008 – the Mental Health aspects already appear excellent and can perhaps be reviewed by email – security (whoever is the opinion leader) can be directly (face to face) involved in the policy review process with DHCS legal representation (preferably Kelvin) and a clinician or two – so that way the policy becomes "Security's" policy and also reflects safe practice".....

Ombudsman Comment: At this point of time it is both inexplicable and inexcusable that the General Manager and the Deputy General Manager took no action to revise the policy and instructions relating to the detention of patients to include the information and guidelines on the doctrine of necessity that was clearly explained in the Emergency Department Guidelines and the messages of Dr P.

The RDH Security Manager's email (of the 10th November 2008) was subsequently on-forwarded on the 31st December 2008 at 02:14pm to RDH security personnel (cc to name withheld) stating:

In response to recent questions regarding security's role with Section 16.3 patients, I reiterate the instructions of my email dated 10/11/2008 and request that all officers adhere to the following policy until I advise otherwise.

On the 31st December 2008 at 03:12am a security officer (name withheld) sent an email to the Security Manager. The subject heading is "16.3". The officer wrote:

Received a phone call from Team Leader (name withheld) ED at 0055hrs 31/12/2008 regarding 1 x male (patient). (Patient) had been knocked out earlier in the night and was very intoxicated with huge bump on head. Doctor placing (patient) under Section 16.3. (Second security officer) advising (author) that he had told the Doctor that Security could only watch (patient) and not stop him from leaving the hospital. (Author) asked security officer 2 why he had told the Doctor this. Security officer 2 informing author that (Security officer 3) had tried to give him a letter but he referred him to the NRC. Author contacted the NRC who was unaware of this. NRC came down to ED to speak with Security officer 2. Author also spoke with both of them stating that Security Officers had been directed by you (security manager) that we were covered under this section act. I believe the letter that (security officer 3) tried to show (security officer 2) is the same on the white board from Halfpennys Lawyers. Security officer 2 also informed author that the other night security officer 3 had refused to stand-by a patient. (Security Manager) as you are aware we restrain patients when required in resus some with head trauma some as a result of MVAs also drug overdoses not yet sectioned. I can't see how we can be charged with assault when a person has been placed under a section 16.3 as there is a concern for their health. I don't understand why (security officer 3) keeps pushing this. I await your reply...

On the 22nd January 2009 (02:03pm) the RDH Deputy General Manager sent an email to numerous persons headed "Detaining of patients pursuant to Section 16 of the Medical Services Act":

Dear all

Further to our previous discussions about the use of section 16 of the Medical Services Act and the draft documents that were circulated prior to Xmas I now attach the final documents as endorsed by Governance, Legal Services and Mental Health...(Ombudsman emphasis).

What is required now is:

- 1. ensure that the documents are circulated throughout the hospital and that appropriate advice is provided to Medical, Nursing, Security and other relevant staff. I assume that Medical and Nursing Education will take responsibility for the medical and nursing staff and that security, NRCs and ALOs will be responsible for their areas.*
- 2., can you please arrange for the policy and forms to be uploaded onto our RDH Hospital Manual on the internet and advise us all once this has been done so that staff are aware where to find them.*
- 3. Co-Directors can you please arrange for some of the forms to be printed (along with the policy) and located on the wards with preliminary advice to staff.*
- 4., I assume you will look after informing the ED staff. Please let me know if you have any concerns.*

For your information today we have been advised by the Ombudsman that she intends to undertake an investigation into allegations related to the forceful detention and/or restraint of patients in RDH. This may be related to our use of Section 16 of the Medical Services Act and no doubt you will all be consulted and/or involved in this investigation.

Attached to the RDH Deputy General Manager's email were three documents:

- *a 16(2,3) form A;*
- *a 16(2,3) form B; and*
- *Patient Management Handout 16(2) and 16(3).*

These instructions were issued by the RDH Deputy General Manager Jan Evans despite numerous legal advices and opinions received by DHF since the year 2000 that did not support their legal basis; despite the very reasonable queries raised by the security officers; despite the messages and information provided by Dr P; despite being aware that I was investigating the matter and despite having received correspondence dated 16 December

2008 from solicitors for the LHMU warning RDH that, in their opinion, the process being implemented was unlawful. Ms Jan Evans was invited to set out her defence to this adverse comment about this apparent high handed action when a draft of this report was sent to her. Her defence is that she acted on legal advice from Mr Currie and in good faith, believing that the process documented in the policy was lawful. Her full response⁴ is included as Annexure (7). It is noted that the emails in relation to Ms Evans email of 22 January 2009 supplied on summons from this Office were incomplete, no reason has been provided as to why the complete information had not been provided. The additional emails regarding this issue are attached in volume 2.

Despite what Ms Evans states, I do not resile from my opinion that her action was high handed. The first draft of the policy in question was in June 2008. The use of Section 16 of the *Medical Services Act* is documented in patients' notes as early as April 2008. It is incorrect that the policy was not implemented. The forms circulated on 22 January 2009 appear on several patients' files. The policy and forms, I have since been informed, were not posted on the intranet.

Dr Ashbridge in his defence to the draft report confirms that patients were detained under Section 16 of the *Medical Services Act* on 1st November 2008, 17 November 2008, 24 November 2008, 1 December 2008, 27 December 2008, 12 and 13 January 2009, and 1 February 2009.

I do not accept that it was a coincidence that Ms Evans sent out the direction to implement the policy on 22 January 2009, stating that it was a final policy endorsed by "Governance, Legal Services and Mental Health" the same day that my letter of 20 January 2009 was received. The policy was not approved by the Governance Group according to:

(a) the footnote on it;

⁴ Ms Jan Evans response to Ombudsman Draft report.

(b) information provided by Mr Beirne.

Ms Evans also stated in her defence that she was not the Assistant General Manager at RDH in March 2004. That is correct. However, the advice from the NT Solicitor of March 2004 was addressed to her by name. Ms Evans also defended her belief by stating that earlier legal advice had not addressed Section 16 of the *Medical Services Act*. That in one sense is correct. Section 16 of the *Medical Services Act* had not been mentioned in earlier legal advices. What had been advised on was **all** the powers of RDH to detain patients to prevent them leaving the hospital. Section 16 of the *Medical Services Act* was not mentioned because clearly it gave no such power and was irrelevant.

Legal advice to DHF and RDH

On 18 March 2004 the Solicitor for the Northern Territory addressed his advice to DHF marked for the attention of “*Jan Evans*”. That advice comprehensively listed the legislation and common law doctrines that could be used by RDH to restrain patients and treat them against their will. No reference was made to the *Medical Services Act*. This is because it contained no such power.

On 4 August 2004 Mr M Grant (as he then was, now M Grant QC, Solicitor General) provided written advice for DHF. His summary stated “.....*in the absence of some legislative authority or substitute consent the hospital may only restrain a person incapable of providing informed consent for the purpose of administering care and treatment in cases of emergency or where treatment is necessary to avert **IMMINENT** (my emphasis) harm to the patient*”.

He also advised on draft Health Care Guidelines to be issued to all DHF staff on the question of restraining or detaining patients. He stated “,,,,, *the guidelines do not presently incorporate any notion of imminence and are*

arguably misleading as to the circumstances in which treatment can be performed without consent". The Guidelines were corrected as he advised. The Emergency Department's understanding of the common law authorising detention and treatment as a matter of necessity when there was imminent danger of serious physical harm was reduced into RDH Department of Emergency Medicine Clinical Guidelines. After setting out an explanation of the doctrine of necessity the Emergency Medical Clinical Guidelines stated:

- *In the ED there may be circumstances where you may encounter a situation where none of the other statutory provisions apply and yet it is plainly necessary that the person be kept in ED against their will. In such a case the common law doctrine of necessity may be relied upon.*
- *There is an ill-defined limit of time under which you can treat under common law but in any event it is only so long as it remains "necessary". For example, patients with long term problems and who lack capacity to consent to care and treatment, the hospital should seek to have an adult guardian appointed to consent to health care that is in the best interests of the person, in order that this decision (and any decision to restrain the person) is not left to the hospital itself.*

These two guidelines operate in the Emergency Department and are an accurate statement of the law. Dr P made that clear to the Administration Executives. In 2008, however, RDH corporate managers ignored that part of the guideline which stated that a person could only be treated against their will for an *"ill defined limit of time"* and that if a person has a long term problem and lack capacity to consent, an application must be made to appoint a guardian. The Emergency Department Guidelines were reviewed in September 2006 by Kelvin Currie, then legal officer employed by DHF. The *Medical Services Act* was a law of the Territory in 2004 and if it had authorised a person's detention in hospital a barrister of Mr M Grant's calibre would have advised that it gave power to the person in charge of RDH to detain someone. He did not so advise. The only person to offer the opinion to RDH or DHF that Section 16 of the *Medical Services Act* authorised the

detention of patients against their wishes appears to be Mr Kelvin Currie, in about November and December 2008. His comment on the draft of this report was that he did not advise that the *Medical Services Act* authorised treatment. His instructions to advise have not been produced. I find it illogical, however, that patients were to be detained but not treated. There would be no point to that. I will be investigating further how it came about that, as early as April 2008, Section 16 of the *Medical Services Act* was being used to detain patients.

On 20 October 2008 the DHF legal officer, in an email directed to Ms Jan Evans, provided advice that the *Medical Services Act* did not give authority to detain people for the purpose of giving them treatment. The legal officer gave advice consistent with previous advice from the NT Solicitor, Cridlands Solicitors and Mr M Grant dating back to the year 2000.

At 2:22pm on the 22nd January 2009 a DHF employee responded to the RDH Deputy General Manager's email '*Detaining of Patients pursuant to Section 16 of the Medical Services Act*':

Hi ...

Thanks for the forms etc. May I comment on this paragraph:

"Whilst being managed under Sections 16(2) and (3), the patient should be reviewed weekly by the treating medical practitioner in conjunction with the supervising consultant at least every 72 hours. Following the weekly review, Form B should be completed by the treating medical practitioner or their delegate and kept in the patient's clinical notes". Should read "treating consultant and by a treating medical practitioner at least every 72 hours".

The first sentence is as clear as mud: does it mean the treating doctor reviews weekly AND the supervising consultant every 72 hours, or both review every week and every 72 hours, or weekly or every 72 hours. I am confused.

Also, do you think it worthwhile including a little bit more detail in this section –

Implementation

Where it is considered that a patient attending the Emergency Department and/or admitted to RDH cannot give informed consent to their continued hospitalisation and treatment and where other NT legislation is not appropriate, determination for their management should be made by the patient's treating medical officer in consultation with the relevant supervising consultant and with the approval of the "The person in charge" of the hospital.

It might be useful to refer to the Mental Health Act or Guardianship Act as "other NT legislation". ...

At 2:26pm on the 22nd January 2009 a DHF employee responded to the RDH General Manager's email 'Detaining of patients pursuant to Section 16 of the Medical Services Act':

Dear...

The words for the second last paragraph in the management are a bit muddled.

"Whilst being managed under Sections 16(2) and (3), the patient should be reviewed weekly by the treating medical practitioner in conjunction with the supervising consultant at least every 72 hours. Following the weekly review, Form B should be completed by the treating medical practitioner or their delegate and kept in the patient's clinical notes". Should read "treating consultant and by a treating medical practitioner at least every 72 hours".

Sorry about the late notice on this...

At 03:16pm on the 22nd January 2009 Dr P responded to the RDH Deputy General Managers email. Copied into his response was Mr Kelvin Currie – Barrister and a DHF employee (name withheld):

Dear...

I have two concerns.

1. The patient who is briefly incompetent and under assessment prior to definitive diagnosis – which is usually a period of a few minutes to a couple of hours. Eg the classical intoxicated vs head injured patient. I – and my fellow consultants – have used the

principle of necessity over many years on many hundred and probably thousands of cases, in many jurisdictions in Australia (including this one) – the process set out in the email below is excellent for the longer term but there is a phase of process before the institution of Section 16 MedSA. Kelvin and I have previously discussed this at length and he has in fact endorsed our guidelines (including the use of the principle of necessity).

2. I am also a tad vexed that the ED was not involved in the decision making process leading to this edict – as a specialist group we see more cases requiring such assessment and management than any other – by far.

Kind regards....

At 11:31am on the 23rd January 2009 a DHF employee (name withheld) responded to the RDH Deputy General Manager's email:

*....
Re Patient Management under 16(2) and 16(3) there is no mention of actual physical/use of reasonable force. This is a concern for security who feel it should be included...*

**BARRISTER ADVISING THE DEPARTMENT OF
HEALTH & FAMILIES – MR KELVIN CURRIE**

On or about the 27th October 2008 Barrister Kelvin Currie compiled a document titled *'Restraint and Detention in a Hospital Setting'*⁵. It is not apparent from any documents produced by DHF or RDH who was his instructing solicitor, nor what his instructions were. There is also reference in an email dated 27 October 2008 from the DHF Legal Officer to Len Notaras (Page 48) of Kelvin Currie's written advice sent that day. This has not been produced despite two requests to DHF to produce all legal advice.

Under a subheading titled "sections" Mr Currie provides the following information regarding the *Medical Services Act*.

Another "section" that has been utilised is the powers of the Person in Charge of the hospital (General Manager) pursuant to the Medical Services Act.

Section 16(1) sets out the General Manager's responsibilities and 16(2) and (3) are the specific powers by which those responsibilities might be carried out.

Subsection (2) speaks of the issue of instructions for the maintenance of the good order and conduct of the hospital and subsection (3) uses the phrase "all persons in a hospital are subject to the control of the person in charge..."

The phrase "the maintenance of good order and conduct" is one generally found in the powers of directors of detention centres and the "control" mentioned has no qualifier. Accordingly, the interpretation would be the general meaning of the word and for that the dictionary would be called upon. The Macquarie Dictionary provides its meaning as "to exercise restraint or direction over;"

The Shorter Oxford English Dictionary provides its meaning similarly as "to exercise restraint or direction upon the free action of;"

Combined with the responsibility to provide safe medical care for all patients the General Manager may control the movement, ingress and egress of patients as well as visitors and staff.

In many cases the exercise of that power may not be specifically required as the general law might be invoked in any event. However in situations where there might be doubt or uncertainty the use of an instruction or direction from the General Manager provides the specific mechanism for the control.

There is no specific requirement for that instruction or direction to be in writing however it should be documented and a form referring to the powers and signed by the General Manager would constitute good practice.

Under the subheading of “Differences of Interpretation” the following extracts are taken:

There has been suggestion by some that section 16 of the Medical Services Act does not allow for restraint but only for the normal incidences of an occupier of property. This interpretation is plainly inadequate and I will deal with the law as to Trespass below.

....

The person in charge of the hospital is a competent authority that any person within the hospital is bound to obey by reason of Section 16(3) of the Medical Services Act. Additionally, staff are bound to obey directions of the General Manager by reason of the Public Sector Employment and Management Act.

To restrain or detain by reason of a direction or instruction of the General Manager cannot be manifestly unlawful because:

- 1. The plain wording of the section provides for the power; and*
- 2. It is likely to be in accordance with the general duty of care of the hospital and its staff to keep safe the patients.*

Accordingly, it is the obligation of staff (and others) to follow and implement the instructions and directions of the General Manager and in so doing they cannot be criminally liable due to s.26 of the Criminal Code Act (or civilly liable due to the s22A of the Law Reform (Miscellaneous Provisions) Act).

SOLICITOR-GENERAL'S OPINION

After my investigation commenced the DHF sought advice from Mr M Grant, QC, Solicitor-General. In his advice dated 12 February 2009 he stated:

"It is a fundamental common law doctrine and right that a person or his or her duly authorised representative has control over what may be done to the person's body. As discussed above, that doctrine is subject to the defences of medical emergency and imminent harm in circumstances where the patient is not capable of giving informed consent, and no substitute consent has been proffered.

Legislation is presumed not to alter common law doctrines or invade common law rights unless that intention is expressed with "irresistible clearness". It has been said that to give such effect to general words simply because they have that meaning in the widest, or usual, or natural sense, would be to give them the meaning in which they were not really used: see Potter v Minahan (1908) 7 CLR 277 at 304. This principle continues to be applied – more zealously if anything – in the contemporary context.

Section 16 of the Medical Services Act vests the person in charge of a hospital with no more than: (a) responsibility for the general supervision of medical services, the maintenance of good order and conduct by staff, patients and visitors, and the security of staff, patients and property; (b) power to issue instructions to secure the maintenance of good order and conduct in the hospital; and (c) general control over persons in the hospital. The proposition that these general powers of management and control authorise the person in charge of a hospital to restrain, detain and/or treat a patient without consent, in circumstances other than those recognized by the common law, is untenable."

He went on to advise that Section 16 did give authority to the person in charge of a hospital to establish or formulate policies and procedures but that advice did not subtract from the above clear advice that no powers to detain, restrain or treat a person without consent were given by Section 16.

SOLICITOR FOR THE NORTHERN TERRITORY

On the 28th January 2009 Barrister Sally Seivers provided advice from the office of the Solicitor for the Northern Territory⁶ to DHF CEO Dr David Ashbridge titled '*Patients leaving Royal Darwin Hospital (RDH) and the power to restrain and detain them*'. No documents or records have been provided to explain how this came about or why or what her instructions were despite a request for DHF to produce that information or records.

Relevant extracts from this document are shown below:

1. Summary Advice

Section 16 of the Medical Service Act enables the person in charge of the hospital to instruct RDH staff to restrain and detain patients and visitors who are disruptive, aggressive, a danger to themselves or others, and who are disrupting the good order of the hospital (including its grounds).

On the other hand, there is nothing in the Medical Service Act which enables the person in charge of the hospital to instruct RDH staff to restrain and detain patients who do not consent to being returned to the hospital for the purpose of ongoing medical treatment.

However, in limited circumstances, restraint or detention of patients may be exercised under the common law when, for example, a patient lacks the competence to consent to medical care, or refuses medical care, if leaving the hospital places them in imminent danger.

A clear, transparent protocol for restraining/detaining incompetent patients needs to be developed for all medical and security staff until such time as desperately needed law reform is implemented. The protocol needs to lay down criteria, procedures, time limits and a process for review.

..... The issue of what powers medical staff, nursing staff, security officers and other employees at RDH and other Territory hospitals possess to compel patients to stay at the hospital, with the objective of continuing their medical treatment, has been ongoing for at least the last ten years (Ombudsman emphasis).

Guidelines were prepared by Chris Rowe after consultation with Michael Grant in 2004, and also by the writer for (RDH Operations Manager).

The very clear advice in 2004 was that there was a need for legislative reform because of the lack of protection and certainty in the common law with regard to detention, restraint and treatment of patients lacking competency who were not under guardianship, and who do not fall within the provisions of the Mental Health & Related Services Act.....

The issue again received considerable attention in 2008, and numerous interested groups at RDH have raised the matter.

On 27 October 2008, Mr Kelvin Currie provided an advice titled 'Restraint and Detention in a Hospital Setting'.

Ongoing meetings were held with RDH staff throughout October and November 2008.

Competent adults cannot be detained/restrained or treated without their consent, however dire the consequence of the refusal may be. Competent adult patients are entitled to refuse treatment even in an emergency or life-threatening situation.

The review of NT law conducted by numerous lawyers in 2004, and the extensive consideration and analysis of the treatment and/or restraint of Rita Anderson (which was closely examined during the inquest into her death) did not include employing s.16 of the Medical Services Act as a mechanism to restrain or detain.

*The opinions previously provided did not identify any statutory power in the NT (**and certainly not under the Medical Services Act**) to treat, or restrain for treatment, patients who lack competency to consent to the same (apart from the Acts already mentioned earlier in this advice).*

Further, there is a real danger in the current practice of referring to the use of s.16 as 'sectioning people'. Whilst it is a phrase that security guards and police are familiar with, it is outdated and inaccurate.....

It is apparent from the clear advice of the Solicitor-General of 12 February 2009 that the opinion offered by Mr Currie was untenable. Ms Sievers of the Office of the NT Solicitor is clearly of the same opinion.

DHF and specifically Jan Evans by name had received the same advice from M Grant, QC and Ms S Sievers as early as 2004. Ms Evans was not Deputy General Manager of RDH at that time.

Halfpenny's, who were instructed in December 2008 to act for the LHMW Union representing the security officers, informed RDH management that the policy issued in November 2008 required the security officers to act illegally. The clinicians in the Department of Emergency Medicine in December 2008 expressed their views that the doctrine of necessity, not certification, under legislation was what the clinicians relied on and emphasised the short time frame for which that could be relied on.

Despite all of this the policy and instructions were implemented on 10 November 2008, formally issued on 22 January 2009, not revoked until 22 March 2009 and were still being used to keep patient F at RDH on 20 March 2009.

There were patients detained prior to 10 November 2008 but information about the use of Section 16 of the *Medical Services Act* has not been fully disclosed by RDH or DHF and has not yet been investigated.

DHF POLICY

The DHF Policy “*Detaining Patients against their Will*” (Annexure 8) which was reviewed/approved by Acute Care Executive March 2007 and was due for review in March 2008, was provided to this investigation.

This document states that the legislative framework to detain a patient ‘*against their will*’ includes the statute - “*NT Medical Services Act (Section 16) 2006*”. The body of this policy does not provide information relating to this Act and I accept its inclusion as relating only to the policy development. The *Medical Services Act* was not however enacted in 2006. It was enacted in 1982 and has only had minor consequential amendments since then. It came into operation on 4 February 1983.

In December 2008 Dr Len Notaras endorsed a DHF policy titled “*Policy for the management of patients pursuant to sections 16(2) and (3) of the Medical Services Act⁷*”. The review date is listed for December 2009. The copy of that policy that was provided by DHF to me on 19 February 2009 is watermarked with ‘DRAFT’. In conflict with this ‘draft’ is the email from the Deputy General Manager of RDH who sent out notification on 22 January 2009 to staff that the policy was endorsed and provided for use, and was final replacing a draft distributed in 2008. The RDH documents relating to the *Medical Services Act* Sections 16(2) & (3) are titled Form A and Form B (attached). The relevant extract from Form A states “*Reasonable force may be used to ensure that the patient is not permitted to leave*”.

The DHF policy “*Competence: Ethics and the Law Guidance*” reviewed/approved by the Acute Care Executive March 2007 and due for review in March 2008, is quite clear on what is allowed by law, but provides untested information under the heading of ‘*Legal Obligations*’, and fails to inform the reader that a patient who is deemed incompetent can not be

⁷ Full policy attached annexure.

treated unless the treatment is necessary because of an imminent risk of death or to prevent imminent serious permanent injury to a person's health:

Competent patients have the right to refuse treatment. To treat them against their wishes violates their autonomy and constitutes battery or malpractice. However, complying with an incompetent patient's refusal of treatment risks harm to the patient and breaches a clinician's duty of care.

Competence

Competence is the ability to perform a task and as such is task specific (ie. A patient can be competent to consent/refuse for one thing, but not another). In cases of doubt or conflict, courts are the final arbiters. The principles for determining competence have been tested in the courts and accordingly medical staff should be familiar with the principles that a court may use to determine competence.

Legal Obligations

All adults are presumed competent until the contrary is proven. The burden of proof lies with the person questioning competence ie the medical staff. Thus a doctor faced with a patient who refuses medical treatment should be able to prove, on the balance of probabilities, that the patient is incompetent before the patient's refusal can be overridden.

The DHF guidelines "Take Own Leave" endorsed by the Acute Care Executive in June 2006 and revised and re-endorsed in Sep 2008 in part refers to "patients whose clinical conditions requires medical intervention for their own safety". The policy purpose is "To reduce the risk of harm to the patient, the community and the hospital that may result following a patient taking their own leave from hospital without official discharge". The important information within these guidelines is the statement **"Unless a patient has been detained under the relevant sections of the Mental Health and Related Services Act or is non-compliant under the Notifiable Diseases Act, or is the subject of a Guardianship order, the patient may not be forcibly returned to hospital even though they may be at risk of injury. Police do not have the power to forcibly return patients except in the above circumstances"**.

I have no information to explain how, in September 2008, the Acute Care Executive endorsed these guidelines when at the same time the Governance Group of RDH had been developing an inconsistent policy to use Section 16 of the *Medical Services Act*, and had actually used Section 16 of that Act to detain and restrain a patient in April 2008. In response to this draft DHF have stated that governance arrangements at RDH are irrelevant to this investigation. This example of the “left hand not knowing what the right hand is doing” proves otherwise.

RDH Incident Reports

This investigation was supplied with a list of patients who appear to have been restrained/detained within RDH utilising the provisions of Section 16 of the *Medical Services Act*. Of interest is that the patients are referred to within these incident reports as 'offender' and the author is required to fill in the 'offender's name'. Whilst information regarding the use of section 16 from 2006 to 2009 was sought, only the following incident reports appear to have been produced regarding section 16 of the *Medical Services Act*. I note however that in the emails between RDH staff that earlier in 2008 a number of patient's were 'sectioned' however incident reports were not supplied regarding these persons. I conclude from this that these patients who absconded either were not notified to security, or it was not the practice of the Security Department to complete incident reports prior to the instructions on 10 November 2008. The below information has been de-identified:

<i>Date</i>	<i>Cause</i>	<i>Description</i>
14/11/2008	Escort patient	5:15pm. Security asked to return section 16.3 patient back to ward. After speaking with patient he agreed and returned to ward by wheelchair. Completed without incident.
16/11/2008	Assistance (Standby)	2:30am. Security notified by ED staff that patient was on a section 16.3. Security attended and stood-by. Doctor speaking to medical superintendent at 2:15am placing patient on a section 16.3.
24/11/2008	Confused/agitated patient (standby)	11:50pm. Security attended emergency. Officers spoke with sectioned patient who was on a section 16.2 because of his medical condition. Patient was being verbally abusive towards staff and had also made physical threats however he became compliant but still abrasive when cautioned by security. Officers stood by until relieved by PCA. After leaving the scene of the incident security were immediately requested to return as an altercation between the PCA and the patient was imminent. Officer cautioned the patient once more and remained in the vicinity until the patients aggressive symptoms subsided and the treating doctor permitted the patient to have a cigarette break.
07/12/2008	Confused/agitated patient	11:55am Security called to the front of the kiosk to assist with patient. Patient needed to return to the ward for medication and lunch. Officers attended and were able to talk the patient back to the ward. Once back on the ward security confirmed that the patient had earlier been recommended for a section 42 but this time had been rejected by psych and placed on a section 16.3 Officers then assisted whilst medication was administered IM.
27/12/2008	Standby	9:00pm Security called to ED to standby (sec 16.3). Patient self admit with stab wound to the throat. Patient escorted to RAPU where officers handed over patient to nurse and PCA special.
29/12/2008	MHS Patient (Standby)	1:00pm Security officers were stopped when walking through ED by nursing staff. Advised that there was a section patient who has a MHS history. Was under section 19.2 until relieved by PCA then stood down.
11/01/2009	Drug-Alcohol (Standby)	11:30pm. Security officers attended ED for post assault victim who was brought in by Police. Patient sustained a head injury in an altercation in town. Dr notified

		officers that patient was trying to leave ED and refused treatment. Dr said that she would not let him leave the ED area as it was her duty of care that he not leave the ED area as he was under observation for the head trauma he sustained. The patient became agitated and frustrated so it was suggested he be placed under a Section 16.3 at 12:30am by Dr. Officers stood by until he was medically cleared at 06:45am and allowed to leave.
13/01/2009	Confused/agitated patient	10:00am. Security was approached by a PCA and asked if they would give him a hand to take a patient X back to his ward. Spoke with patient and he walked back to his ward with his PCA. Some time later noticed patient being escorted back through the foyer with a nurse and a different PCA. At 10:00am saw patient X walking again through foyer with his PCA, security officer followed them on the outside camera to keep an eye on them. Patient was getting more aggressive with the PCA as he wished to have his own space. Security then noticed patient being escorted back to the ward with a nurse. Security advised a 1:00pm that patient had been returned back to his ward and was now under a section 16.3. At 10:30am we saw patient walking again through the foyer with his PCA and nurse hot in pursuit of their patient. Security also followed. Spoke with nurse and again asked if patient was sectioned was told they did not know. Noticed hospital Police officer stopped patient and spoke with him but patient still refused to go back to his ward. Security was advised by control that patient was not under any section. Security also attempted to speak with patient still refused to go back to the ward. Patient walked off down Florey Road still followed by his PCA. Security returned to the office and picked up the security vehicle, then picked up the PCA and Nurse along Rocklands Drive. Staff returned to RDH. Security stood down. Security advised at 1:00pm that patient had been returned to his ward and was now under a section 16.3.
13/01/2009	Section 16.3 patient. (Assist patient) with	4:15pm. Security called by ward advising that their sectioned patient M was leaving the ward and was heading down stairs. Officers search the foyer and front of the hospital then called the ward who advised security that patient had returned to the ward. Security then attended the ward and assisted staff by escorting patient back to bed on ward. As patient had threatened self harm a Doctor had prescribed an injection to calm her down. Security assisted staff while they gave patient the injection. Once staff were happy that patient had settled security was stood down.
30/01/2009	Medical Section 16.3 (Absconding patient)	10:30am Security contacted by PCA stating that her patient X was refusing to return to the ward. As the PCA did not know whether the patient was under a section, or in fact what a section order was, she was advised to contact the ward. Again she contacted security, this time she presented herself but when questioned was unable to confirm any details of the patient. Officers then attended outside bus the PCA was down near the bus stop and the patient was up near the children's playground. When approached the patient was quite happy to return with Security to ward as requested. Upon return to the ward staff were unable to confirm or deny whether the section 16.3 which was created 13/01/2009 was still current as the patient's notes were still in (withheld) from this morning.
30/01/2009	Medical Section 16.3 (Absconding patient)	3:40pm Security escorted patient X who was confused and agitated back to his ward. Security stood by as the staff gave him medication and spoke with him in order to diffuse his agitation.
01/02/2009	Medical Section 16.3 (Absconding patient)	9:10pm Asked by CRO to go to front entrance of the MWB as sectioned patient Z was outside and refusing to return to the ward. After some persuasion security persuaded him to return to the ward. Once back on the ward Dr tried to explain to him that he had to stay in hospital. Security remained with patient till he calmed down and remained in his room.
01/02/2009	Medical Section 16.3 (Absconding patient)	7:50pm. Called to 2A by nursing staff as confused patient was trying to leave. When we got there we were informed by RMO that they were waiting for registrar to come and fill out the notes and place patient on a section 16.3. Dr arrived on the ward and spoke to patient and informed patient that because of patients condition patient should remain in hospital. Patient was offered some medication which patient took to calm patient down. After Dr finished speaking to patient,

		patient, partner and a PCA went downstairs for a smoke. Officer accompanied them while officer waited and witnessed Dr completed in the notes that the Medical Superintendent had been contacted and patient was placed on a section 16.3. After patient had smoke returned to the ward and security was stood down.
03/02/2009	Medical Section 16.3 (Standby)	6:00am Security officer's observed 16.3 section patient Z attempting to catch a taxi home. Security officers talked patient out of taxi and back up to ward. On ward patient requested nursing staff to phone his partner to pick him up and take him home, his partner refused...Patient stated he was going to walk home. At this stage two security officers were assisted by two more officers and the patient was escorted back to ward where he was going to wait to see his doctor.
03/02/2009	Confused/agitated patient.	7:50am Officers were advised by PCA that a sectioned (16.3) patient Z was trying to leave. Security spoke to the patient and returned him to ward. 8:05am Patient observed striding out of the main ward with PCA following. Security followed and stopped him from getting into a taxi. After a short discussion patient returned to ward with PCA.
03/02/2009	Medical Section 16.3 (Escort patient)	8:40am Security officers attended outside main entry to assist PCA to get patient Z out of a taxi and escort him back to his ward and bed. Escort was completed with no problems. Security then stood down.

Ombudsman's comment: Despite the clear legal advice provided on the 28th January 2009 to RDH by Ms Seivers, it can be seen from the above table that five days later at least one patient was stopped from getting into a taxi and leaving the hospital. He was prevented from leaving on three occasions. On one of those occasions four security officers were called to "*escort him*".

Response of DHF to questions asked by the Ombudsman and the Ombudsman's comments.

On 20th and 22nd January 2009 the Ombudsman sent correspondence to Dr Ashbridge and Dr Len Notaras seeking responses and documents relating to the following numbered questions. Where annexed to this report the DHF annexures are prefaced with the letters 'DHF':

1. Have security staff working at RDH been instructed by any person employed by the DHF or RDH (specifying which) to detain and/or restrain person/s solely relying on the provisions of Section 16 of the *Medical Services Act*?

The definition of "solely relying on the provisions of Section 16 of the *Medical Services Act* for all of these questions was:

"The expression "solely relying on the provisions of Section 16 of the *Medical Services Act*" means that a person detained or restrained was not at the time of detention or restraint

- (i) committing or about to commit a criminal offence;
- (ii) not the subject of any certification order or action under the *Mental Health and Related Services Act*;
- (iii) not the subject of any notice under the *Trespass Act*;
- (iv) not the subject of any substituted decision making order under the *Adult Guardianship Act* under which a guardian had given consent to restraint or detention;
- (v) not in the custody of police or the Department of Correctional Services or the Department of Immigration and Citizenship while on the premises of RDH."

DHF response: *Attached (RDH A1) is an email from (Security Manager), dated 10 November 2008 and resent 31 December 2008. Although the main reference is to s.16 of the Medical Services Act (MSA) it is the view of the Department that the practical intent was only to restrain/detain those persons to whom the common law principle of medical emergency would also apply, however it is acknowledged that the limits of that common law doctrine and the role of the MSA were poorly understood amongst some staff at this time. The Department does not believe that s.16 MSA provides a sole basis for the restraint of any person. The role of that section is to enable the making of policies and procedures within a hospital. A new policy is being developed with input from medical staff and LHMU.*

Ombudsman's comment: It is clear that there was abundant confusion about the provisions of Section 16 of the *Medical Services Act* within RDH [see pages 46-62]. It was the obligation of the management team at RDH to provide leadership to remove this confusion. In my opinion it failed to do so. The reasons it failed to do so are at least partly due to the unsatisfactory governance arrangements at RDH fully discussed in the report of the Australian Council for Health Standards Review of Governance at RDH delivered to the Minister for Health on about 23 February 2009.

This investigation revealed that directions given to RDH staff resulted in certain patients, being detained and/or restrained the belief by staff that Section 16 of the *Medical Services Act* gave RDH staff the power to do so. It also resulted in persons who lacked the capacity to consent to treatment being detained and, on another occasion, shackled to a bed without justification.

I also dispute that the LHMU was having input into the development of a new Policy.

On the 19th March 2009 the LHMU contacted my Office to voice their concern that some security officers at RDH were still of the view that the instruction

relating to section 16(3) of the *Medical Services Act* to restrain and/or detain a patient was unlawful. The LHMU and the Security Officers stated they had received no communications from RDH management not to use Section 16 of the *Medical Services Act*, were not informed of any action taken by RDH or DHF to prevent the use of Section 16 of the *Medical Services Act* when Dr Ashbridge assured me such use would cease. The statement about the LHMU having input into the development of the new policy is but another example of the carelessness of DHF in supplying information to the Ombudsman.

In Ms Evan's defence to the draft report, Ms Evans stated I was not correct in saying that she took no account of correspondence from the Solicitors for LHMU. She said "...no response was received from LHMU to the policies and procedures I sent out on 22 January 2009". The list of persons to whom the email was sent did not include the LHMU representative at RDH, nor the LHMU itself or its Solicitors. On the 28th April 2009 this information was double checked with the LHMU, they advised that there was no contact between RDH and the LHMU from 16th December 2008 to 13th February 2009. I can draw no other conclusion that the statement made by Mr Beirne on 19 February 2009 that a 'policy was being developed with input from the LHMU' was made without grounds.

Having received an assurance in writing from Dr Ashbridge on the 9th February 2009 that no person would be detained or restrained relying solely on the *Medical Services Act* my staff sought a response from RDH. On the 20th March 2009 two of my staff attended RDH. The Assistant Ombudsman Ms Julie Carlsen spoke with Dr Len Notaras about the matter raised by the LHMU. Ms Carlsen asked Dr Notaras what direction/instruction/bulletin had been provided to staff after the hospital received the Solicitor Generals legal opinion of the 12th February 2009. Dr Notaras advised that his belief was that either the Deputy General Manager of RDH, who is in charge of security, or one of the other executive team members sent out notice or the LHMU after meeting with the RDH executive imparted the knowledge that 16(3) was not to

be used. Dr Notaras was asked if he had any document that would support his belief that an instruction was sent to staff, and further he was asked if he wanted to provide any other document or information pertinent to this investigation for my consideration. Dr Notaras provided an email dated the 19th March 2009 (02:21pm) from him to the Director of Medical Services and Education and one other:

"Dear Mac, if it is no problem can we replace the earlier message to Security Officers with this one ... you might say that this is an "updated" and "clearer version" ... I have also included Peter (Beirne) for his info. 'To avoid any confusion, security officers are advised that s16 of the Medical Services Act is not to be employed for the purpose of restrain or detention in the case of patients seeking to leave the Hospital. In circumstances where a person cannot given informed consent or is not competent to make a decision and immediate care and treatment is required to avert serious imminent harm to the patient the common law defences of necessity and or medical emergency, enables a medical officer to authorise short term restrain of the patient. All such decision will be clearly documented".

I do not know what the earlier message to security was, and Dr Notaras advised Ms Carlsen that he was disappointed that the only message posted on the security officer's notice board was his email shown above after his discussion with the LHMU on the 19th March 2009.

2. Were Security Officers instructed, either orally or in writing that failure to adhere to an instruction/order to detain and/or restrain a person pursuant to Section 16 of the *Medical Services Act* would result in disciplinary action? If such instructions were given, provide details of when, to whom and the substance of the instructions and identify any documents containing or recording the instructions.

DHF Response: *The relevant document is Annexure A1 referred to above. The instruction was actually in the following terms “....should Security officers fail to respond to a lawful instruction by a clinician to restrain a person, this may be subject to disciplinary action”. Although the reference to s.16 MSA is acknowledged, this instruction should also be understood in the context that at this time there was concern about the level of security assistance at RDH generally and the feeling of clinicians that security staff had a poor understanding of relevant common law principles. A copy of an email from Dr (P), from the Emergency Department, is attached (RDH A2) explains this further. Recent discussions with LHMU indicate that this issue is likely to be resolved to the satisfaction of all parties in the near future.*

Ombudsman’s Comment: The impetus for this investigation was several RDH staff believing that should they disobey or challenge the legalities of an instruction to detain/restrain persons pursuant to Section 16 of the *Medical Services Act* it would result in disciplinary action. It would be easy to draw this conclusion based on the email direction sent by the RDH Security Manager on the 10th November 2008 and subsequently reinforced on the 31st December 2008. The subsequent compiling of section 16(2) and (3) instruments under the *Medical Services Act* and endorsed by the RDH General Manager, then emailed, and printed for use on the ward reinforces that view. In my opinion no other reasonable interpretation of that direction would be open. It may well transpire that with some patients there was justification under the doctrine of necessity for detaining them or returning them to the hospital but that is not what happened.

The administrative acts of the Corporate Executive team of putting in place a process that stated it was based on Section 16 of the *Medical Services Act* and recording of that section as the grounds for detaining people nullified any reasonable belief required for the doctrine of necessity to be a defence except for the clinician who may have subjectively believed that he/she was acting under necessity when breaking the law. Such a defence could not be

available to a security officer. The only exception to that was in the Emergency Department after 30 October 2008.

3. Since 1 January 2006 how many people have been restrained or detained at the RDH premises solely relying on the provisions of Section 16 of the *Medical Services Act*?

DHF response: *Unknown. Decisions made about restraint of incompetent patients have been made in the context of providing good and safe medical care. They have been viewed as clinical decisions. Therefore, in most cases documentation as to decisions taken was to be kept only as part of the clinical record of the patient and no additional documentation is available. It is not practical to conduct a search of every patient record made since 1 January 2006.*

Ombudsman's comment: This answer exposes the inadequacy of RDH records as well as the lack of any accountability for intrusive and potentially unlawful acts. It is unacceptable that RDH does not have a system that enables it to identify when force is used on patients. The security department is required to complete and retain incident reports. Incident reports are completed during or at the conclusion of an incident to retain a record of what action was taken. The patient table above demonstrates that several people were detained and/or restrained pursuant to the *Medical Services Act* between November 2008 and February 2009. It is apparent from reading some patient medical records that patients had been detained and returned to the hospital against their wishes prior to November 2008. I cannot find out how many, who, and in what circumstances, nor can the RDH. I consider that to be 'inept' management.

4. What are the names or Hospital Record Number of each such person?

DHF Response: *The most relevant documents which we have been able to find, outside general patient records, are security incident forms that refer to s.16. These forms have been filled out only since about November 2008. The names, HRN and dates of birth are provided here along with the security logs of assistance provided. (See patient table page 81)*

Please note that the patient medical records have not been attached at this time as it appeared that in these cases the security incident forms (which are attached in full) contained sufficient details to answer the question.

We have email correspondence regarding 3 other matters in which patients may have been detained, at least in part in reliance upon s.16 MSA. Although the documentation refers to these patients as being 'sectioned' it is unclear what their competency status was and, in 2 cases, whether in fact they were detained or merely requested and then consented to return to the hospital. Persons concerned are:

31.12.2008 (Patient initials withheld). Head injury and intoxication, patient presented in ED. Reference to doctor placing patient under 16.3. No further details.

14.09.2008. (Patient initials withheld). Returned to hospital by police, at risk due to sepsis in open wound. Wheelchair bound patient. Referred to in email as having been 'sectioned' but no further details. Appears that patient immediately left hospital after being returned by police and was not further detained.

05.08.2008. (Patient initials withheld). Sepsis due to chest infection. Returned to hospital by police. Refers to patient being 'sectioned' but no other information.

Emails from staff regarding these matters are attached as part of Annexure A5. Patient records have not been searched for these persons due to privacy concerns.

Ombudsman's Comment: It is laudable that DHF respects a patient's right to confidentiality. This highlights, however, the lack of similar regard for other important rights of liberty of movement and choice about treatment or regard for accountability and transparency. That RDH administration are unable to identify the records of patients who have been detained, restrained or treated without consent is unacceptable practice.

5. How many of such persons were Aboriginal or identified themselves as Aboriginal?

DHF Response: *Of the patients referred to in the Security Incident Forms, 2 identified themselves as Aboriginal.*

Ombudsman's Comment: This answer demonstrates either the inadequacy of records or evasiveness. The question was not confined to patients referred to in the Security Incident Forms, but the answer has been so confined and therefore not answered candidly in my opinion.

6. On each occasion when a person was detained or restrained solely relying on Section 16 of the *Medical Services Act*. (This question in its entirety has been split into 5 parts – see below 6.1 to 6.4).

DHF Response: *It is considered that common law principles sanctioned most of not all of these cases. Acknowledging, however, that that section has been stated as a purported basis for actions taken, the following answers are provided:*

Ombudsman's comment: I interpret this answer to mean that although RDH used forms stating that a person was detained under Section 16 of the

Medical Services Act; informed all of its staff that patients were being detained under Section 16 of the *Medical Services Act*; instructed security staff that the authority they would use was Section 16 of the *Medical Services Act*, and entered in patient records that a patient had been “sectioned” under Section 16; these actions were a fiction and RDH really meant something else. One only has to state that proposition to see how untenable it is. Common law principles of necessity do not appear so far to apply to some of these identified patient circumstances. That principle requires that the risk of substantial harm must be “imminent”. If that risk continues it is imperative that an application for authority to keep containing a patient is made to the local Court under the *Adult Guardianship Act* unless a person can be detained under the *Mental Health Act*.

In defence to this conclusion, DHF submitted that the patients’ notes are insufficient to decide if the doctrine of necessity authorised detention. If that is true, and if as I have been informed by DHF there are no other records, there is no accountability or check or mechanism to monitor the use of coercive powers. That is a failure of management practice and a disregard for patients’ rights. In my opinion to have a process that authorises by an administrative action of the General Manager of RDH the detention and restraint of patients and when the grounds are not recorded anywhere because the patient notes do not contain “sufficient” information is itself a violation of rights even if no-one has been detained or restrained through that process.

6.1 Who authorised the detention or restraint?

DHF Response: *Decisions have been made firstly through consultation with the clinical team responsible for the patient’s care. Responsibility for these decisions rests with the Director of Medical Services and Education who reviewed the recommendations with the treating clinical team*

Ombudsman’s Comment: If RDH were purporting to rely on Section 16 of the *Medical Services Act* that provision states that the detention or restraint

must be authorised by the person “*in charge of*” the hospital. That is not the Director of Medical Services and Education. The person in charge of the hospital is the General Manager. Dr Notaras on 20 March 2009 informed my investigating officer that he did in fact authorise clinicians to detain patients under Section 16 of the *Medical Services Act* in all cases where that occurred.

6.2 Who implemented the decision to detain or restrain?

DHF Response: *The senior consulting clinician led the implementation of the decision. Clinical staff engage in consultation with the patient and where necessary sought the assistance of the security staff to assist with reasonable endeavours to ensure that the patient does not leave the hospital. In referring to the attached Security Incident Report Forms it is noted that on no occasion does there appear to have been an application of anything other than minimal force reported there. In several cases it appears that the patient is likely to have consented to return to the ward once spoken to by security.*

Ombudsman’s comment: This answer is inconsistent with Dr Notaras’ statement that in cases where Section 16 of the Medical Services Act was used to detain a patient he authorised it. Without his authorisation, the policy could not be implemented.

Whilst it is not disputed that the medical treatment provided was with good faith and probably in the best interests of the patients’ health. This does not limit the issue that the *Medical Services Act* was misapplied and persons were detained and/or restrained against their will. All of these patients cannot be identified and DHF in its defence has submitted that contrary to their own records, they were detained on other legal grounds but those grounds are not recorded in the patients’ notes or anywhere else. In one particular case the patient was so aggrieved by the decision to continue treatment against his will, the patient called the Police asking for assistance to have him released from the hospital.

6.3 What records were created?

DHF Response: *Consultations are noted in the patient's medical record and, in the matters set out in the answer to question 4 above and at Annexure A3, in the Security Incident Report Forms.*

Ombudsman's comment: Section 57 of the *Mental Health & Related Services Act* sets out what records of medical treatment need to be maintained if a person is detained or treated under that Act. That legislation contains detailed provisions about review of a person's detention, strict time limits and conditions on the use of mechanical restraints such as shackling a person to a bed and an independent review by the Mental Health Review Tribunal. The *Medical Services Act* has no such provisions. The *Medical Services Act* was never a statute that provided powers to impose compulsory treatment or detention of persons and contains no provisions similar to the *Mental Health & Related Services Act* to protect patients, ensure they are reviewed, have rights to appeal, and to hold clinicians transparently accountable for the intrusive and exceptional action of detaining and treating persons without their consent. The security incident forms were only used after 10 November 2008 and only when Security was involved. I am not satisfied that there were no other patients locked in their rooms or tied to their beds or chemically restrained without the involvement of security. Records supplied to this Office in relation to another matter appear to indicate that the *Medical Services Act* was also being relied upon by security officers in 2007.

6.4 Where are the records now located?

DHF Response: *Medical Records are stored at Royal Darwin Hospital. The original Security Incident Report Forms are stored in the Security section.*

Ombudsman's comment: Medical records of some patients identified by RDH were perused by my delegates and are referred to later in this report.

Further intensive investigation is required of each case to know if they were detainable under legislation or at common law. There is no doubt as admitted by DHF that they were wrongly detained for the reason and under the administrative process used by RDH, namely section 16 of the *Medical Services Act*.

7. Have you seen, requested or obtained advice from a legal practitioner on the legality of restraining and/or detaining person under the *Medical Services Act* or on your power, or that of your employees, servants or agents, to detain or restrain persons and, if so, identify the document by date, author and addressee if it was in writing. If the said advice was oral and partly written, what was the substance of the advice? If oral advice was reduced to writing in any email, correspondence, report, minute of any meeting or other document please identify the document(s) concerned including any document or writing requesting advice.

DHF Response: *Three formal legal advices have been received over the past 6 months:*

Mr K Currie (Barrister), undated but received in final form on or about 24 November 2008;

Ms S Sievers (Dept of Justice) 28 January 2009;

Mr M Grant QC, Solicitor-General, 12 February 2009.

Copies of these advices are attached at Annexure A4. (Not attached to this report).

Ombudsman's comment: I considered that this response was evasive and an attempt to cover up the fact that previous legal advice existed that was contrary to that provided by the DHF's ex-solicitor. The above advices are not the only legal advice that had been received by RDH. The question did not limit the response to the past 6 months; nor was it limited to "formal" advices.

It very clearly asked about “oral advice”. This investigation found that there were advices, some oral, some written, dated as follows:

Date of Advice	From	To	Written/Oral
Undated	Kelvin Currie	Not specified	Written
11 September 2000	Cridlands	Robyn Cooke	Oral
16 October 2000	Cridlands	CEO Territory Health Services	Written
19 January 2001	Cridlands	CEO Territory Health Services	Written
28 March 2002	Cridlands	Manager, Legal Support Services, DACS	Written
9 April 2003	Cridlands	Operations Manager, RDH	Oral
1 May 2003	Cridlands	Operations Manager, RDH	Written
4 June 2003	Cridlands	Operations Manager, RDH	Written
20 June 2003	Cridlands	Operations Manager, RDH	Written
18 March 2004	Solicitor for NT	Jan Evans DHCS	Written
4 August 2004	Michael Grant	Cridlands for DHF	Written
20 October 2008	M. Day, DHF Legal Officer	Jan Evans, Deputy General Manager, RDH	Written
10 November 2008	Kelvin Currie	RDH Security Manager, Deputy General Manager and HR Manager	Oral
16 December 2008	Halfpenny's	DHF – RDH Attention L. Notaras	Written

19 December 2008	Kelvin Currie	Audience at session at RDH	Partly written, partly oral
19 December 2008	Kelvin Currie	(Dr P), ED, RDH	Written

Mr Beirne in defence to this adverse comment stated that he was unaware of previous legal advice. I accept his statement. It is unsatisfactory and poor management however when being specifically asked by the Ombudsman not to make enquiries. The existence of the earlier legal advice was recited in the advice of Sally Seivers of the NT Solicitors Office dated 29 January 2009 which Mr Beirne provided to me. He either did not read Ms Seivers advice or he was careless about his response to the question.

8. Describe how persons are detained and/or restrained at RDH and under what circumstances?

DHF Response: *Reference is made to Annexure C, RDH Department of Emergency Medicine policies concerning Chemical Restraint, Detaining Patients Against their Will; Physical Restraint in the ED; and Restraining Patients. These policies give a general answer to this question. These policies give the range of restraints used and the circumstances as they apply in the ED.*

Refer also Annexure A3 as to specific examples. There have been situations (Not disclosed Annexure A3) where patients have been placed in a locked room for a short period for their own and/or staff protection. Most of these cases have involved patients detained under the Mental Health and Related Services Act detained in the "Oleander Room" or patients who are violent or potentially violent. There are no records (other than patient files) where this information is kept.

Ombudsman's comment: I have great concern about RDH, or any person or organisation exercising powers of detention, restraint and containment with

force, not having accessible records to record and justify those actions. The RDH was, at its discretion, exercising powers equivalent to those of the power of arrest by police. By adopting the procedure described under Section 16 of the *Medical Services Act* not only did they avoid the provisions of the *Mental Health Act*, no procedures were established for recording and being in a position to account for and justify each occasion when these coercive powers were used. At the very least management should have simply directed that when any person is detained or treated under Section 16 of the *Medical Services Act* the same procedures are to be followed and the same records kept that are required under the *Mental Health Act*. From November 2008 the security department kept incident reports but it is clear that even before November 2008 RDH was exercising coercive powers. There also have been occasions when security was not involved and no central record is kept. RDH ought to have a procedure that when any person is pressured, detained, restrained, locked in, or contained, a written report is provided to the General Manager and that record is retained in addition to any notes on the patient's file. Whenever an officer of NT Police uses force of any kind a written report is made forthwith of the force, the reason for its use and the extent of it. The particular information is reviewed by the officer-in-charge of a station and, in due course, all such reports are reviewed by senior management. This is the type of procedure that RDH should have even now if detaining people under the doctrine of necessity. The failure by the Corporate Executive team to establish any similar accountability process when establishing the process to detain people under Section 16 of the *Medical Services Act* has led me to describe the Corporate Management team as 'inept'. I have received strong objections to that conclusion from the General Manager Dr Len Notaras and the Assistant General Manager Ms Jan Evans in response to the draft of this report. I do not resile from the use of that description when considering their administrative acts and decisions related to the process of using Section 16 of the *Medical Services Act* to detain and/or restrain and/or treat patients on occasion with force. Those administrative acts were not only contrary to law but contrary to the Acute Care Executive policy endorsed in September 2008.

9. Is there a Department of Health and Families and/or RDH policy or documented process that provides for the detention and/or restraint of persons pursuant to the provisions of the *Medical Services Act*? If so, please describe the policy or process. If in writing, please identify the documents containing the policy or process.

DHF Response: *A policy had been prepared and issued in draft form. The policy was not formally adopted by RDH or Acute Care. However, in view of the Solicitor-General's advice, a new policy and procedure will be developed which cover restraint and detention at common law. Refer to accompanying letter.*

Ombudsman's comment: I do not accept that this was a draft policy. The Acting Director of Acute Care Services, Peter Beirne, was given a draft of this report for explanation. He provided the explanation that there are networking policies and RDH policies and policies on how to make each of those policies. He did not consider that the policy sent out on 22 January 2009 complied with the policies of DHF or RDH on how policies are to be made, so he called it a 'draft' when replying to the Ombudsman. He later, on 23 April 2009 provided a copy of the RDH policy on how to make an RDH policy. The procedure required the Governance Group to approve the Policy before it could be placed on the RDH intra-net and become part of the RDH Policy Manual. A copy of the minutes of the Governance Group approving the policy had to be provided and a written request signed by the Chair of the Governance Group given to the Quality Risk Management Unit. No record of compliance with any of this policy on how to make a policy has been produced to this investigation despite a request for all relevant minutes of any meetings or documents relevant to the use of Section 16 of the *Medical Services Act*. I conclude there are none.

I note the statement by Ms Evans on 22 January that the documents had been endorsed by 'Governance'. When commenting on the draft of this report. Ms Evans did not mention any grounds for that statement which in my

view was incorrect. An excerpt of Ms Evans email of 22 January 2009 is shown below:

Further to our previous discussions about the use of section 16 of the Medical Services Act and the draft documents that were circulated prior to Xmas I now attach the final documents as endorsed by Governance, Legal Services and Mental Health...(my emphasis).

What is required now is:

- 1. ensure that the documents are circulated throughout the hospital and that appropriate advice is provided to Medical, Nursing, Security and other relevant staff. I assume that Medical and Nursing Education will take responsibility for the medical and nursing staff and that security, NRCs and ALOs will be responsible for their areas.*
- 2., can you please arrange for the policy and forms to be uploaded onto our RDH Hospital Manual on the internet and advise us all once this has been done so that staff are aware where to find them.*
- 3. Co-Directors can you please arrange for some of the forms to be printed (along with the policy) and located on the wards with preliminary advice to staff.*
- 4., I assume you will look after informing the ED staff. Please let me know if you have any concerns.*

It can be seen from the RDH Deputy General Managers email of 22 January 2009 email that the '*final documents as endorsed by Governance, Legal Services and Mental Health*' were attached for circulation throughout the hospital, that the forms and policy were to be uploaded onto the RDH Hospital Manual (intranet) and forms were to be printed and positioned on the wards. I do not believe that the RDH Deputy General Manager sent out these forms watermarked with '*draft*' to be circulated for use, to be placed on the intranet and printed for staff to use whilst in '*draft*'. On the 20th March 2009 two of my staff attended RDH to continue perusing patient files. On one of these files the above mentioned policy was located as were the applicable forms A & B. This policy and these forms were not watermarked as drafts.

In responding to the draft of this report both DHF and Ms Evans stated that despite the direction by Ms Evans the forms were not uploaded to the RDH intranet. I accept this is so. The forms however were used and the DHF does not deny that. Nor has it or Ms Evans denied that the actions in paragraphs 1, 3 and 4 of the email were carried out.

10. The names of all Royal Darwin Hospital Security Officers who have detained and/or restrained a person utilising Section 16 of the *Medical Services Act* including the names of those assisting or accompanying.

DHF Response: *The security staff involved in the incidents upon which we have reports are identified in Annexure A3. No other documents are available.*

11. A copy of any incident report referring to or about utilising Section 16 of the *Medical Services Act* at Royal Darwin Hospital to restrain or detain a person.

DHF Response: *Attached at Annexure A3.*

12. A copy of all log/ledger/diary entries, including those held by the Royal Darwin Hospital Security Office referring to utilising the provisions of Section 16 of the *Medical Services Act*.

RDH Response: *The only records we are aware of are the ones attached at Annexure A3.*

Ombudsman's Comment: As I have stated, the failure to keep records that could be accessed to account for all occasions where a person's liberty was interfered with or restraint used, is a failing of administrative management and for that reason I have recommended that not only does RDH establish a central registry for all uses of restraint, detention and coercion but that an

independent entity be advised and have the opportunity to inspect those records. Without that there will be no accountability and RDH will put Australia and the Northern Territory in breach of its international obligations under United Nations instruments.

13. A copy of minutes of any meeting held with security staff at Royal Darwin Hospital pertaining to the use of force or the power or detention or restraint utilising Section 16 of the *Medical Services Act*.

RDH Response: *Our enquiries (of Security Manager) indicate that meetings with security staff were informal and not minuted.*

Ombudsman's comment: Considering the numerous recommendations made by me as a result of complaints over the last two years, both as the Ombudsman and Commissioner for Health and Community Services Complaints to improve record keeping within RDH, I express my approbation that important meetings continue not to be documented. The failure to keep a record of the vital meeting on 10 November 2008 with the Security Manager; Jan Evans RDH Deputy General Manager; the HR Manager; and Barrister Kelvin Currie is deplorable.

14. A copy of all records containing dates and names of person restrained and/or detained at RDH under the provisions of Section 16 of the *Medical Services Act* and details of that action.

DHF Response: *Refer Annexure A3. If specific patient details are available then medical records could be searched for additional details.*

Ombudsman's Comment: Once again this answer highlights the improbability of anyone at RDH being accountable for coercive actions because there is no way of knowing when they occurred or on what grounds or to whom, unless Security was involved. Security records relating to the

Medical Services Act supplied to this investigation only date from November 2008.

15. A copy of **all emails** sent from or to the RDH Security Department **or any other staff** relating to Section 16 of the *Medical Services Act* and restraint or detention under that section.

DHF Response: *Emails from the security department and RDH management concerning this issue attached at Annexure A5.*

Ombudsman Comment: Once again the information supplied is only a portion of what was requested and the response is careless.

16. A copy of any written instruction and or order or advice to any Department of Health and Families staff referring to the provisions of Section 16 of the *Medical Services Act* and its application in connection with restraint or detention.

DHF Response: *Refer attachment A1. A policy was circulated in late January but was never formally adopted by RDH or Acute Care Division. That policy is now being redrawn to conform to the advice from the Solicitor-General.*

Ombudsman's comment: In my opinion, this response is either evasive or careless. Either way it does not answer the question nor show any appreciation of obligations to be accountable. The Acting Director, Acute Care Services had an opportunity to comment on my opinion on receiving the draft of this report. His defence (full copy attached Annexure 5⁸) has been previously set out together with my comments. This question asked about "instructions, orders or advice" and the response refers only to a policy.

⁸ Mr Beirne's response to draft.

17. Any documents, including emails, created by Department of Health and Families legal officers or legal advisors in private practice to any RDH staff member, unit or section referring to the provision of Section 16(3) of the *Medical Services Act*.

DHF Response: *Legal advices sought and relied upon by the Department are attached (Annexure A4) at question 7 above. Two emails containing legal advice created by (name withheld) A/Director Legal Services concerning this issue are attached as Annexure A6.*

18. The minutes of any meeting, report, memo, email, agenda item or correspondence of RDH or the Department of Health and Families, or RDH Management Board, or the Security Officers at RDH, or the legal officers regarding the provisions of Section 16 of the *Medical Services Act*.

DHF Response: *Our enquiries indicate that there are no such minutes.*

Ombudsman's Comment: This answer is contemptuous. It also proved to be wrong. In response to this request DHF ought to have disclosed:

- requests to Mr Currie for his advice. Legal advice is not given unless it is requested. Legal advice cannot be properly evaluated unless a reader knows what the legal adviser was told (called instructions and about what he/she was asked to give advice;
- any letter, memo, report to the RDH Management Board;
- the minutes of the RDH Medical Advisory Council, the Governance Group, the Executive and any memo or email;
- any other document record relating to the use of the *Medical Services Act*.

The reply "Our enquiries indicate there are no minutes" ignored the request for everything except the minutes. There is clear evidence that Section 16 of

the *Medical Services Act* was used in April and October 2008. There is now clear evidence that a draft policy on the use of Section 16 of the *Medical Services Act* was in existence in June 2008. This material has been withheld and if this question had not been treated so peremptorily by the DHF when responding I have no doubt that a great deal more information would have been known. On the 23rd April 2009 minutes of meetings of the Governance Group from May to November 2008 were given to me. They contain entries indicating that the use of Section 16 of the *Medical Services Act* was considered at least at four meetings. The documents considered have not been provided. No explanation has been provided to explain the inconsistency between the answer and the existence of minutes provided to me at the last minutes before its finalisation.

19. A copy of any complaint/s made to the Department of Health and Families or Royal Darwin Hospital regarding the use of detention and/or restraint by Royal Darwin Hospital staff.

DHF Response: *Our enquiries have been unable to identify any complaints.*

Ombudsman's comment: I cannot explain or account for this response. Within the records available to this investigation a patient was identified who was aggrieved by the decision to detain him pursuant to Section 16 of the *Medical Services Act*, and this patient rang the Police seeking assistance to leave the hospital. Patient identified as A, according to his notes, was tied to his bed because he was complaining that he was being kept against his wishes. Patient F has complained persistently since January 2009 and up to March 2009 about being kept in hospital.

20. A copy of any document pertaining to injuries sustained by Royal Darwin Hospital staff who were utilising restraint and/or detention powers relying on the provisions of section 16(3) of the *Medical Services Act*.

DHF Response: *To the best of our knowledge (enquiries made with HR Services Acute Care and DBE Workplace Injury Solutions) no injuries have been sustained by RDH staff utilising restrain/detention powers solely in reliance upon s.16 MSA. Although there have been workers' compensation claims arising from injuries sustained by staff at the hands of patients, inquiries with DBE WIS have not identified any which are obviously 's.16' situations. The workers compensation documentation is held by DBE.*

Ombudsman's comment: If proper records of the use of force were kept by RDH, as suggested in my comment on an earlier response, RDH would have this information readily available. The fact that it does not shows a further failing of administrative management and governance at RDH.

21. A copy of any Department of Health and Families or RDH policy and/or procedure that refers to Section 16(3) of the *Medical Services Act*.

DHF Response: *Refer Annexure B. Note that the references to s.16 MSA in these network policies is to the role of that section in enabling making policies and setting procedures, and is not intended to be interpreted as reliance upon that section as part of the underlying basis for restraining a person.*

Refer also Annexure A7 which is a draft policy concerning s.16 MSA. This draft policy has not and will not now be formally approved by RDH or Acute Care Division (as a network policy) in view of the Solicitor-General's advice of 12 February 2009. A new policy is under development.

Ombudsman's comment: Once again the answer is only about a portion of the question. The failure to refer to an RDH policy and to elaborate on what was the status of the RDH policy is in my opinion misleading. The document referred to has a footnote "endorsed by the General Manager December 2008". An explanation should have been forthcoming.

22. All documents, records, reports, memos, guidelines, instructions containing any record of the restraint, detention, confinement in a room without free and unrestricted access of any person at RDH (which includes the grounds) relying solely on Section 16 of the *Medical Services Act* since 1 January 2006.

DHF Response: *Refer answers above. Except as stated above, the only records would be contained in patient medical records which cannot be effectively searched without patient names and, preferably, dates.*

Ombudsman Comment: This answer clearly shows that RDH does not know and cannot find out how many patients have been detained, restrained or treated against their wishes relying on an administrative stratagem; RDH cannot identify the patients, nor account for or justify what was done to them, whether it was done legally; whether patients with a mental disability were treated and managed in accordance with United Nations standards. It is the role of the General Manager and the administrative executives to manage and lead document management, records and RDH accountability. The answer to this question, in my view, demonstrates a total lack of management competence and a disregard for a lack of appreciation of the seriousness of depriving a person of liberty, with force on occasion, and the need to maintain records sufficient and accessible to be accountable and transparent.

23. All documents identified as having been created or existing in response to the requests set out in paragraphs 1-10 of this letter.

DHF Response: To the best of our knowledge, the relevant documents are attached throughout.

Department of Health & Families view

DHF provided a covering letter to their initial response. It is important to include an extract from this correspondence from the Acting Director Acute Care Division dated 19th February 2009. The Acting Director Acute Care Division indicates that he has the reporting responsibility for all of the Northern Territory's five hospitals. A copy of the complete correspondence is attached⁹. He wrote:

...first and foremost I am able to reassure you that:

- 1. This Department hold a commitment to the human rights as a central tenant of its mission;*
- 2. We do not believe that any action taken by RDH, nor its staff, on whatever purported basis, has in fact resulted in any breach of the criminal or civil law when all of the circumstances are examined;*
- 3. Inquiries reveal that, to the best of our knowledge, we have never received a complaint from a patient or a patient's family in regard to a patient being requested to return, returned to or detained at RDH to enable them to receive medical care; and*
- 4. This Department does not believe that s.16 of the Medical Services Act (MSA) of itself authorises the restraint or detention of any patient. The relevance of s.16 is that it enables the person in charge of a hospital to put in place policies and procedures which regulate how staff and patients should approach the taking of action based on common law principles.*

⁹ DHF letter of 19 FEB09 from Acting Director Acute Care Division

***Ombudsman Overall Comment on Preliminary
Investigation***

Notably the DHF letter of the 19th February 2009 contains contradictory information when compared to the actions taken by RDH administrators. For example, response three (3) in the DHF letter of 19 February 2009 suggests that DHF inquiries have not revealed any person who has complained about being detained. I refer to records of the patients above who not only complained constantly but one of whom rang the Police to seek assistance in leaving the hospital and all of whom appear to have complained about being kept in hospital.

Under the DHF response heading of ‘background’ it is stated that “*We are well aware that it is never appropriate to restrain a competent person, behaving lawfully, who has decided not to remain in hospital. Nor is it appropriate to attempt to administer treatment to such a person...*” The numerous emails between RDH staff (including emails involving DHF legal services), security incident reports, policy for the management of patient’s pursuant to sections 16(2) and (3) of the *Medical Services Act* with templates Form A and B and the patient records reviewed for this investigation in the majority conflict with the Acting Executive Director Acute Care Divisions view on this issue. Undoubtedly, according to the records, some of the patients are recorded as not understanding their situation; and inferentially being unable to give informed consent. However, even those patients cannot be detained without the authority of the *Mental Health Act* or of the Local Court once the risk of imminent harm to them has faded.

The Acting Executive Director also stated:

“Unfortunately it is often the case that staff in our hospitals are required to provide services to patients who are difficult to manage. It is not unusual for medical and nursing staff to be spat at, abused

or even physically assaulted in the course of their work. In one recent incident a nurse at RDH had her nose broken by a patient she was attempting to assist. It is a fact of life that even with the best of training and management procedures, such incidents will occur from time to time. The Department aims to minimise adverse incidents by:

- a) Clear policies and procedures on OH&S issues for staff;*
- b) Clear policies and procedures for managing difficult patients; and*
- c) Training and education of staff on an ongoing basis”.*

I do not and have not suggested that medical staff do not have a very difficult job or that these staff may be subjected to aggression or assault. I agree completely that hospital staff have a very difficult and stressful job. It is imperative that their difficulties are managed according to law, that they know who can do what, how far they can go and for how long. The manner in which the policy or the use of Section 16 of the *Medical Services Act* was communicated failed to give that support. This is a failing of those in charge of the management of the hospital who have failed to support clinical nursing and allied health staff to know what is lawful and to act with confidence.

The administrative actions taken deflected staff from the real issues. The administrative actions created a fiction which resulted in clinicians and nursing staff recording in notes that they were acting under Section 16 of the *Medical Services Act*, when they were not. Certainly the ED clinicians were not. The urging of the ED clinicians to management to get it right, to have policies similar to ED were not acted on.

I have however in recent times, (November 2008) as the Commissioner for the HCSCC, identified that training and education of staff at RDH is sporadic and inadequate. The HCSCC RDH paediatric security investigation also revealed that there was a lack of knowledge by frontline staff about policies

and procedures within RDH (see HCSCC investigation into security at RDH – tabled November 2008). The subsequent policy drafted in December 2008 and documented as endorsed by ‘Governance’ in January 2009 was not clear. It was not “endorsed by Governance” Group. Several staff offered opinions for improvement and questioned the ambiguity of the policy.

Within his letter, under the heading of “Security Guards” the Acting Executive Director states:

Security Guards at RDH perform a vital part in maintaining the safety and security of the hospital. The Department and the Hospital are appreciative of their efforts, sometimes in difficult circumstances. The role of the security guards was considered in the 2007 Lingard Report, the recommendations of which are in the process of being implemented. As a normal part of their duties, security staff are sometimes called upon to restrain persons in the hospital. The situations in which this can occur include where security act upon instructions of medical staff to detain a person who is subject to control under the Mental Health and Related Services Act and the Notifiable Diseases Act. The Adult Guardianship Act provides a mechanism for substituted consent in where it applies. These legislative bases are clear.....

Conclusion

The Acting Executive Directors letter of 19/02/2009 concludes:

I conclude by thanking you for raising this issue with the Department. I acknowledge that the extent and application of s.16 MSA has been misunderstood by some staff at RDH in the past. I would ask you to take the following matters into account in deciding what steps you now take:

- *Previous purported reliance upon s.16 MSA was in good faith and based both upon genuine concern for patients and legal advice obtained at the time;*
- *The Department has recently sought advice from the Solicitor-General of the Northern Territory as to how to proceed, and has accepted that advice which will form the basis of all future action and policy;*
- *The Department acknowledges that it is inappropriate to rely solely upon s.16 MSA as an independent basis for restraint of persons;*
- *In most, if not all, of the known cases the actions taken, although purported to have been taken under s.16 MSA, were objectively justifiable upon common law grounds;*
- *There is no evidence that any patient has been injured. There is no evidence that any staff member has been injured directly as a result of an action based solely upon s.16 MSA;*
- *The Department is currently working with the stakeholders, including the LHMU, security staff and medical staff to put in place policies and procedures which will best enable management of these difficult situations in the current legal environment; and*
- *The Department is actively considering appropriate legislative change to ensure that both patients and staff are properly protected in situations where incompetent patients must receive medical assistance.*

The Department would welcome your continued involvement and input into this issue.....

The statement that *'most, if not all, the known cases were objectively justifiable upon common law grounds'* is not justified by my investigation so far. Nor is there evidence that it is unjustified. That is the criticism I make of the administration management. Not all persons who were *'persuaded'* into

returning to their wards were, according to the medical records, under threat of imminent danger/death and in the majority had not at that time been identified as being persons who were incapable of making informed decisions. I accept that there may be many clinical issues not investigated. These patients have not been interviewed for this investigation. I have relied so far on the patient records and on information provided by DHF and I am sceptical about how accurate and comprehensive these are. I am issuing this report now as it will take many months to discover the truth, mainly due to the poor record keeping. This investigation may or may not continue. That will depend on action taken by DHF, RDH or the Minister for Health in response to this report, and its recommendations.

The statement that there is *'no evidence that a patient had been injured by security using the provisions of s.16 to restrain/detain a person'* is not justified. The DHF and RDH simply do not know and have no system to find out. That is what I mean when I refer to the management of this issue as *'inept'* on the part of those responsible for administration, not on the part of those providing treatment and care. A more apt statement would be that the records of patients detained/restrained pursuant to s.16 of the MSA from 2006 to 2009 (the requested search period) have not been accessed and therefore no comment can be made as to whether a person suffered any injury from the actions of being restrained/detained under s.16. DHF/RDH have not interviewed any patient/staff to ascertain if a patient being *'treated'* under section 16.3 was injured as a result of any interaction, I can not comment on this issue and I have made recommendation for an investigation.

The statement that this is the *'current legal environment'* is misleading, in that United Nations declaration case law and legislation relating to restraint/detention of patients has been in place for many years. To suggest that this is a novel or previously unexplored issue is patently wrong.

There are several key matters that this preliminary investigation has established:

1. The Executive Management team at RDH has misinterpreted and established a procedure of detention, physical and chemical restraint and arrest of patients.
2. The procedures to implement that policy are contrary to the United Nations Declaration of Human Rights and the Declaration on the Rights of Persons with a Mental Disability.
3. The Executive Management team at RDH provided incorrect information to employees regarding the provisions of the *Medical Services Act*; and led them to believe and to act as though the provisions of the *Medical Services Act* gave them the power to detain/restrain and treat patients against their wishes.
4. RDH employees acting on administrative decisions and actions of the RDH Executive team, relied on Section 16 of the *Medical Services Act*, to detain and/or restrain persons within RDH without obtaining or documenting any other lawful grounds for those actions.
5. The *Mental Health and Related Services Act* (called after this the *Mental Health Act*), and the powers under that Act, and the circumstances when the doctrine of necessity at Common Law could be used were not explained by the Corporate Executive team to staff. Policies on the use of the legal powers available to assist staff were not formulated and adequate training was not given to all staff. Those failures together with wrong directions about the effect of the *Medical Services Act*, caused uncertainty and confusion for staff at RDH. The use of powers of detention and treatment under the *Mental Health Act*, for a purpose not authorised by that Act, was hence an abuse of power, albeit in good faith by staff.

6. The facts and circumstances surrounding the restraining and detaining of patients throughout 2008 demonstrates very clearly the urgency of the hospital and the DHF implementing the recommendations of the report by the Australian Council on Health Care Standards delivered to the Hon Kon Vatskalis, MLA, Minister for Health, on 23 February 2009. On page 14 of that report the authors set out a model for good governance to be applied to RDH. What has occurred with respect to detaining and restraining patients in 2008, when measured against that model, highlights the extent of the lack of effective corporate governance at RDH of which this is but an example.

FURTHER QUESTIONS AND ATTENDANCE AT RDH

On the 26th February 2009 I sent a '*Notice to Produce*' and correspondence to the CEO of DHF, cc to Dr Len Notaras and the Acting Executive Director of Acute Care Services.

On Monday the 9th March 2009 and the 20th March 2009 two officers delegated with my authority to inspect medical records attended at Royal Darwin Hospital. I express my thanks for the assistance provided to my officers by Dr Notaras and his staff.

Relevant extracts were taken from patient notes and have been copied below in a manner not to identify the patient. Bracketed words/ sentences are not exact records to minimise identification of patient. When the Chief Executive Office of DHF commented on the draft of this report he criticized me for including this information and as a breach of patient confidentiality. I have given serious consideration to that. In my opinion there is no other adequate means of providing the evidence on which some of my conclusions in this report are based. The forms used to detain a person using Section 16 of the *Medical Services Act* stated that the grounds for detaining a person were to be entered in the patients' notes. No other record exists apart from the Security Incident forms after about November 2008. The time frames over which patients were kept and their condition can best be gauged from the medical notes. Most importantly the absence of any record or entry that a person was being detained under the common law doctrine of necessity can only be demonstrated by what is not in the records.

I also hope that the readers of this report will see the challenging behaviour of the patients, the exasperation and challenge that faces those professionals who treat them. This will put in context why it is so important that those "at

the coal face” must have competent, effective administrative management to support them.

Ombudsman comment on the first patient’s case

The first patient A is a classic case in which an application for a guardian should have been made. Attempts were made to use the *Mental Health & Related Services Act* when there was clear evidence from the most senior Consultant and Registrars on four occasions stating the patient did not have a mental illness. My analysis of the dealings with this patient is:

4/4/08 8.30pm patient brought back to medical ward by security after leaving.

5/4/08 4.00am patient “sectioned”. It is not recorded whether he was made the subject of a declaration under Section 16 of the *Medical Services Act* or under a section of the *Mental Health Act*. I conclude it was not in accordance with the *Mental Health Act* as there is no record on his file that complies with the requirements of that Act.

Between 4.00am and 8.00am (most likely) he was reviewed by a doctor and the doctor’s opinion was that there was no evidence of a mental illness.

8.00am – patient left ward.

Between 8.30am and 10.00am the Security Department and Police were asked to retrieve patient. Patient telephoned ward and told nurse he would not come back. Police informed ward they would not bring patient back unless the provisions of the *Mental Health Act* were followed. This could not be done as a doctor had, upon examining the patient a few hours earlier, given

the opinion that he did not have a mental illness or mental disturbance.

The note made was as follows:

“No psychotic bright reactive affect features in particular no FTP hallucinations or delusions, no evidence of depression/manic syndrome, no suicidal no previous history of mental illness, no family history of mental illness reported, knows consequences of treatment/no treatment.”

Despite that certification, at 11.00am on 5 April, Patient A was kept in hospital until he “*absconded*” [as opposed to exercised his right to leave] on 7 April 2008, apparently at about midday. After he left he was seen in a lift at the hospital on 8 April. The Police were requested to bring him back. They did not. After he left, a note was made by a doctor which is undated and the signature is indecipherable in the following term:

“From my experience and previous review by psychiatrist he is not mentally unwell..... I have discussed with Dr [name withheld - Specialist] and Professor [name withheld – Specialist] – he is quite capable of making decisions.”

25/9/08 2.45pm. The patient presented voluntarily at RDH again. He was irritable and aggressive and attempted to assault staff.

10.30pm. Under Section 34 of the *Mental Health Act* a medical registrar signed a recommendation for a psychiatric examination. This gave lawful authority to detain the patient for up to 24 hours or until he had been assessed by an authorised psychiatric practitioner. He was then “*tied to his bed*”.

11.40pm. The patient was examined by a psychiatric practitioner. He was screaming to be released. The psychiatric practitioner authorised him to be tranquilised and under Section 42 of the *Mental Health Act* and admitted him as an involuntary patient on the ground that he had a mental disturbance. This meant that he could be lawfully detained for up to 72 hours. The *Mental Health Act*, Section 63, provided that non-psychiatric treatment could not be given with the patient's consent or the consent of the Mental Health Review Tribunal unless it:

"was immediately necessary -:

- (a) to save the life of the person or to prevent irreparable harm to the person;*
- (b) to remove a threat of permanent disability to the person;*
or
- (c) to remove a life threatening risk to, or to relieve acute pain of the person."*

10.30pm 25/9/08 – 27/9/08 10.00am. Patient kept tied to his bed. The entries in records and procedures required under Section 61 of the *Mental Health Act* to use a mechanical restraint may or may not have been complied with. Sections 61 and 63 were not complied with as at 30 September 2008. It is not recorded whether while tied to his bed for about 36 hours he was kept under constant observation and examined every four hours by a doctor. The absence of entries in the patient's notes suggests that the *Mental Health Act* was not complied with.

1 October 2008. The patient was to be reviewed by the Mental Health Review Tribunal.

30/9/08 Patient was reviewed by a consultant psychiatrist who decided that the patient had no evidence of thought disorder, no evidence

of a major mental illness and did not fulfil the requirements for being detained under Section 42 of the *Mental Health Act*. The note of that psychiatrist stated “*so needs to be detained please use Sec 16 of the Medical Services Act*”.

Because of this opinion the order under section 42 of the *Mental Health Act* was revoked there was no requirement to proceed with the review by the Mental Health Tribunal. The patient was discharged on Wednesday 1 October. The records do not show if that was a self discharge against medical advice or not. He returned to the hospital on 2 October 2008. Despite the fact that on 5 April 2008, on about 9 April 2008, and on 30 September 2008 three psychiatric practitioners had given opinions that he did not meet the requirements for involuntary admission under the *Mental Health Act*, on 3 October 2008 at 1.00am he was made subject to a Section 34 *Mental Health Act* involuntarily admission for assessment of whether or not he had a mental illness or mental disturbance.

On 3 October at around midnight he was asking to go home.

3/10/08 10.30am. The patient was assessed by a psychiatric practitioner who stated

“No reason to place on a Section 42 [Mental Health Act] (mental disturbance) at this time.”

“Suggest that he be detained in hospital under the Medical Services Act 16.3 as he does not fulfil the criteria of the Mental Health Act at this time”.

My opinion of this course of events is that it amounted to an abuse of the processes laid down in the *Mental Health Act* and an

evasion of all the protections, checks, balances and review mechanisms set out in that Act and designed to protect vulnerable people.

6/10/08 A note was made by a medical intern:

“Nurses asked me to section patient under Medical Superintendents Act. I don’t think this is required or suitable for this patient.

Shackling and sedating patient is not required. I discussed situation with Medical Registrar who said patient is not for sectioning.”

9/10/08 Entry in notes *“If he leaves with cvc insitu please call police to have him brought back”*. No entries about his mental state, capacity to make his own decisions or the lawful power to bring him back was made.

31/10/08 At 10.00am. A second year medical either made an entry *“..... should be sectioned and sent to Cowdy Ward (Psychiatric). “Attempted to contact Dr Notaras to clarify what type of section to place patient under”*.

11.00am. *“Spoke to Prof (name withheld) Prof happy to section under Section until 1300 today”*.

11.00am. Psychiatric registrar reviewed the patient. Placed on Section 42 involuntary admission to enable transfer to Cowdy Ward for assessment by psychiatric consultant.

1/11/08 6.00PM. Patient was reviewed by psychiatric registrar who stated that he needed to continue under Section 42. He did not note why

but noted “*Having [known] [patient] in past it is unlikely he suffers from depression*”.

2/11/08 1.10pm. Patient reviewed by psychiatric registrar who continued the Section 42 order.

3/11/08 2.40PM. Consultant psychiatrist reviewed patient and discharged the Section 42 order. That assessment ruled out mental illness, diagnosed the patient as having an adjustment disorder with antisocial traits and conduct disturbance. [Note from Ombudsman: none of these conditions is a mental illness]. He specifically noted “*no thought disorder, no apparent delusions*”. He concluded: “*If needing continuing admission and not consenting – consider Section 16 (2) & (3) powers*”.

I interpret this assessment to conclude that he was capable of making his own decisions.

21/11/08 1.40pm. Patient’s notes record that a discussion occurred with the psychiatric registrar who advised that the patient could not be “sectioned” under the *Mental Health Act* as he did not fit the criteria.

The Medical Superintendent was contacted and the patient was “sectioned” under *Medical Services Act* Section 16.2 – 16.3.

25/11/08 “Section” lifted and patient discharged.

RDH PATIENT RECORDS

PATIENT A

- ❖ **04.04.2008** (08:30pm) Plan: Need to bring patient back- inform security. May end up sectioning patient.
- ❖ Time unknown – Spoke to Medical Superintendent over the phone. Said if (Doctor) knows and agrees that the patient should be detained (Doctor) can proceed with the detention. (Doctor) spoke to (Doctor) who agreed with the detention – patient harmful to (patient)..... To be detained in the ward until tomorrow.....Special PCA to monitor patient....
- ❖ **05.04.2008** (04:00am) Patient sectioned due to events from yesterday evening.....
- ❖ Time unknown – (reviewed by Doctor).... Patient still not complying with any requests. No evidence of psych illness....
- ❖ (08:30am) Nursing: Patient left ward @ 0800 for a cigarette. Dr called security to retrieve patient. PCA informed nurse that security unsuccessful in retrieval. NRC & Doctor informed. Absconding patient report filed copy police. (09:10am) Nursing: patient rang ward stating he was feeling 'sick'... Nurse encouraged (patient) to return to hospital. Patient angry and declined to return.....Police will only return patient if patient sectioned. Relayed info to Doctor....(10:30am) Patient returned to ward @ 1000....Patient verbally and physically aggressive. Code black called. Security returned patient.... Psych review organised by RMO....

- ❖ *Time unknown: ... patient very aggressive attempted to assault (Doctor) then ran from the ward....Plan 1. Section MHA – security in attendance.*
- ❖ *11:00am: (Doctor) attended to review (patient). No psychotic, no evidence of depression/manic syndrome, no suicidal /no previous history of mental illness, no family history of mental illness reported,... knows consequences of treatment/no treatment....*
- ❖ **07.04.2008** (06:20am)Patient returned to the ward by security. Patient verbally abusive after security left the ward, walked out to the nurses desk and laid on the floor then vomited large amounts on the floor as patient would not return to the bed, security called and patient returned to the bed. Patient has been very difficult to look after due to (patients) behaviour on top of (patients) illness. NRC informed of situation and requested an extra staff member. NRC informed me that I should ring (names withheld).....
- ❖ *08:00am – (Doctor)... contacted @ 0730 this am re severe behavioural problems overnight. Patient has been telling nursing staff that (patient) intends to 'get' me. Patient non-compliant with all medical therapy.... Patient not currently on ward... Issues:.. constantly off the ward....3) Awaiting Dr Notaras input; 4) section under MHA until psychiatric review to allow behavioural medical treatment plan.....6) Psychiatric register to review.....*
- ❖ *(08:55am) Instrument Recommendation for Psychiatric Examination pursuant to Section 34 of the Mental Health & Related Services Act. OMBUDSMAN NOTE: This instrument was incomplete. The section that states 'I make a recommendation for psychiatric examination and authorise (name of person/s authorised) to take reasonable measures to control and take the above named person to an approved treatment facility' and the area where the*

medical practitioner endorses and dates the instrument is blank.

- ❖ (10:45am) Nurse: Pt left ward....nowhere to be found...Staff informed patient currently NOT sectioned under MHA, signed order apparently not valid. Team waiting for medical superintendent.... OMBUDSMAN Note: as stated above this instrument was not signed. (11:45am)...(patient) not found – ... to contact Medical Superintendent. No luck. I contacted (Doctor) and (unreadable) Medical Superintendent. Section under (unreadable) by Dr Len Notaras at 11:50am....
- ❖ 12:08pm – Nurse: Absconding patient details reported to police. Police notified patient currently sectioned by Dr Len Notaras. Police asking for paperwork (unreadable) section – otherwise they cannot bring patient back involuntarily. Currently trying to get in contact with nursing director....RMO & med reg notified – was told by them that Dr Notaras will have to sign form....Nurse: Awaiting signed letter from Len Notaras – will be back @ 1315 – to be faxed to police – re involuntary detention of patient. ... Med reg signed form 41A on behalf as discussed with Len Notaras and asked (unreadable) to fax asap to Police – done - ...
- ❖ (time unknown) (Doctor) Plan on readmission – notify RMO 3. PCA special – patient not permitted to leave ward if he does, security to be informed immediately and PCA to follow patient at safe distance and record events. 4. As soon as blood sugar level under 20 ... discharge from hospital.
- ❖ **08.04.2008** (05:20am) (Doctor) Patient has not been returned to ward by police as I was informed was happening yesterday afternoon. Contacted Casuarina Police Station.... Informed police of importance of return of

patient – notified ED of patient and all events – asked to contact me if patient presents to dept. Discharge from hospital for bed.....Patient seen in lift by Medical team. Patient declined further treatment despite ward nurses urging him to stay. Patient stuck up middle finger @ medical team. (Patient) was mobilising independently.

- ❖ *(09:45am) (Psychiatric Doctor). Thanks for asking me to see (Patient) who is currently off the ward. (Patient) was seen on Saturday by (Doctor) who found no evidence mental illness..... I do not feel (patient) is determinable under the MHA but would be happy to review (patient) if (patient) returns to the ward....*
- ❖ **10.04.2008** *.....(Patient) chose to leave the hospital. With consultation with psychiatry patient was not considered a candidate for medical superintendent's powers. (Patient) refused to return to hospital. (Patients) disappearance was reported to police who did not locate (patient).....*
- ❖ **25.09.2008** *(2:45pm) (Patient) came back onto ward, verbally aggressive to staff, threatening behaviour....security called in an attempt to placate (patient). I tried to get (Patient) to calm down, ... very agitated and aggressive. Plan: (Patient) has gone downstairs for a cigarette...(patient) is allowed back on the ward if (patient) can guarantee that (patient) will not be aggressive towards nursing staff....If not able to behave in a calm and cooperative manner, please call security to escort him from the premises – to return only in the case of life-threatening illness.*
- ❖ *(5:40pm) Nursing: Patient returned from downstairs after Continued to swear and abuse staff. Refused to go to (patients) room but sat in the corridor then continued to abuse staff then came to nurses station and threw (patients) vomit bag at one of staff. Rang RMO who came*

and discharge patient. Patient was escorted out of ward by security.

- ❖ *(10:30pm) As discussed with (practitioner) this patient is a danger to (patient) and others. (Patient) is a danger to (patient) and is currently likely to be delirious due to his (medical)... has also taken 'speed'. (patient) is a danger to others in that (patient) has repeatedly attempted to assault staff. (Patient) is therefore detained under Section 34 of the Act and must be treated against his (unreadable) for the next 12 hours....(signed Medical Registrar).*
- ❖ *(10:00pm) Instrument 'Recommendation for Psychiatric Examination' pursuant to Section 34 of the Mental Health & Related Services Act.*
- ❖ *(11:40pm) (Psychiatric practitioner): Requested to review patient...needing immediate treatment. History of... non compliance...(medication).... Admitted on 20/9 for (medical) and discharged against medical advice this am. Brought back by Police Currently tied to bed on a section 34 to ensure treatment. Screaming to be released...Agree to (unreadable)... follow (unreadable) tranquilization protocol .. – section 42.*
- ❖ **26.09.2008 (00:02am)** *Section 42 approved.*
- ❖ *Instrument "Examination at an approved Treatment Facility" pursuant to section 42 of the Mental Health & Related Services Act for up to 72 hours.*
- ❖ *(time unknown) (patient) sleeping restless and agitated at times. Remains on Sec42 under MHA. Will need psychiatric reg review daily while on sec 42. Can be transferred to sec 16(3) under Health Act -med superintendent powers to hold him for med treatment. Probably better on sec42 at present due to altered (medical) needs regular psychiatric review....*

- ❖ (1:00pm)..... Patient has woken several times this morning demanding to be released....Note: patient sectioned for 72 hrs since 2230 last night. Psych review tomorrow..... Plan:.... 4) Psych team to be called over w/end for behavioural management issues, not RMO/intern on call. Do not take restraints off unless psych team instruct to do so....Addit – keep physically restrained for patient and staff security....(6:00pm) Requested to release (patients) arms. Was not aggressive....(8:30pm) Patient was sleeping most of the time, woke up 5-6 times in between and screaming to take off the hand restraints. Patient was verbally abusive...tried to get out of bed.....
- ❖ 11:30pm – Patient woke uprequesting restraints to come off and to speak to the Doctor. Became aggressive and threatening....Explained to patient that (patient) would be reviewed in the morning
- ❖ **27.09.2008** (time unknown)...verbal aggression towards nursing staff. Currently shackled, angry desperate to have shackles removed....
- ❖ 09:05am -Patient refusing any medication. Patient aggressive and verbally abusive to staff. Security called. Psych reg consulted over whether section will cover for us to administer (medication) involuntarily – Psych reg informs that we can administer involuntarily....
- ❖ 10:00am – Psych reg: .. antisocial... recurrent admissions ... under s42 for Emergency treatment given this morning due to (medical). Patient initially reluctant to take (medication) but eventually agreed. ..Patient presents as argumentative and demanding....Reports want to have shackles off, go outside for a smoke. Wants to come back to hospital to get better. ... Plan: continue section 42. Trial shackles off, go outside for smoke... If leaves hospital to be brought back (under s42). Risk to self.... If threatening

or non compliant essential medical treatment nursing may use shackles security/ special/sedation to enforce this...

- ❖ *Time unknown: Psychiatric reg note: Advice from security – under 16 2/3 they are unable to use force to keep patient in hospital. Discussed with psychiatrist on call (Doctor) as his medical condition is likely to be causing his altered mental state – reasonable to treat the medical condition to help mental state under Mental Health Act.*
- ❖ *11:00am...continues under section 42 and advice from psychiatrists is that he may be given medical treatment against his will if required....*
- ❖ *12:30pm...Is still under section 42 until Sunday 2400. Psych continuing to review....*
- ❖ **28.09.2008** (8:00pm) *Instrument “Notification to Legal Representative of Involuntary Admission” pursuant to section 42 of the Mental Health & Related Services Act. Due for review by Mental Health Review Tribunal on the 1st October 2008.*
- ❖ **30.09.2008** (time unknown) *Please get the med team to fill in the MHA forms in the front pocket of the folder ie physical restraint and need for non-psychiatric treatment. Failure to do so is a \$5000 penalty for each thing!!!*
- ❖ (time unknown) *Dr (name withheld) consultant Psychiatrist.Does not fulfil requirements for s.42 – no evidence of thought disorder. History has been reviewed, no evidence of major mental illness. So needs to be detained, please use Section 16 of Medical Services Act (see copy in front pocket).*
- ❖ *12:00pm taken downstairs for cigarette at 11:50....*
- ❖ **01.10.2008** (time unknown) *Nursing....Refuses meds charted beside (medication) which patient administers... Going down in wheelchair and escorted for smoking at 07:45.*

- ❖ **03.10.2008** (time unknown)Patient was deemed to be a danger to (patient) and others and was therefore detained under section 34 (and later section 42) by psychiatry team. (Patient) required sedating agents to control (patients) aggressive behaviour.....
- ❖ (01:00am) Instrument - patient recommended for psychiatric examination Section 34 Mental Health & Related Services Act.
- ❖ 08:30am ...Can't PCA special. Not to go downstairs unescorted...
- ❖ 10:30am Well known patient and recently reviewed. Went to see (Patient) to review (patient) as (patient) has a s.34 on him....Patient's presentation consistent with (patients) usual angry demeanour. No reason to place a s.42 mental disturbance section on (patient) at this point of time. (Patient) remains high risk for harm to self, if (patient) leaves the hospital given his history suggest that (patient) be detained in hospital under the Medical Services Act 16.3 as (patient) does not fulfil the criteria of the Mental Health Act at this point of time.
- ❖ 1:30pmI will contact the team ? plan. Informed nursing staff (patient) must be brought back to check (medical)....
- ❖ **09.10.2008**.....Plan.... – if (patient) leaves with the (medical) please call the Police to have (patient) brought back.
- ❖ **14.10.2008** (09:30pm) patient abusive and aggressive, threatened violence if met outside when (patient) was discharged.
- ❖ **31.10.2008** (time unknown) Instrument - Examination at an approved treatment facility pursuant to section 42 Mental Health & Related Services Act. Detain for up to 72 hours.
- ❖ 10:00am Nursing staff have informed that discussion between Len Notaras & NRC stating patient should be

sectioned and sent to Cowdy Ward as patients actions seem as a suicide attempt.

- ❖ *Time unknown – Attempted to contact Dr Notaras to clarify what type of section to place patient under. Dr Notaras in meeting. I have left message at receptionist and asked to be paged. (Doctor) has suggested review by (psychiatric unit).*
- ❖ *Time unknown – Spoke to (psychiatrist) on call who will review patient... psychiatric reg thinks patient may not be appropriate for psychiatric section. Has recommended for medical section for time being. Psychiatrist reg please address. 1) Whether needs to be placed under psychiatric section; 2) ? need to transfer to Cowdy.*
- ❖ *Time unknown – AM to section to prevent discharge. If walks out of hospital and unable to be stopped please give (medication).*
- ❖ *11:00am Spoke to (name withheld) re: sectioning patient to stop self-discharge. (name withheld) happy to section under section 16 until 1300hours today. (Name withheld) recommending patient be reviewed by psychiatric reg and sectioned under Mental Health Section ie. Viewed attempted suicide..... (Patient) lying calmly in bed playing with his phone. Alert, reactive, Actually had reasonable discussion with (patient). Very angry re this admission.... I do not feel he is currently delirious or psychotic....Have discussed with (acting c/t consultant) re need for a diagnostic admission. She is agreeable to this. Patient would have to be a s42 – mental disturbance – due to risk of absconding, refusingJRU – secure environment. However, currently JRU is full and no bed is available at present (and unlikely to clear for at least 1-2 days) and it is a very volatile environment due to current client mix. We shall place on s.42 for now which will last 72 hours max. If*

for assessment in JRU needs to be expediated, suggest consultant to consult given complexity of issues.

- ❖ *04:00pm Information – Notified there were no beds JRU for patient this evening.... To be managed under section by nurse special on ward. Contacted NRC, unable to provide nurse special, will provide with PCA in interim.*
- ❖ ***01.11.2008** (5:00pm) Nursing: I called psych registrar on call around 1400 hours. Doctor agreed to come and review patient around 1500-1600 hours. But not yet reviewed at the time of reporting....*
- ❖ *6:00pm (Doctor meets with patient)....needs to continue under section 42 with PCA special....*
- ❖ ***02.11.2008** 04:55am Patient remains sectioned.*
- ❖ *01:10pm (Doctor called to review patient). Have been called to review (Patient) as (patient) was under Section 42.... (patient) was lying in bed, very angry and unstable... Plan: continue section.....*
- ❖ ***03.11.2008** (2:40pm).....Discharge of Section 42... - if needing continuing admission and not consenting – consider section 16(2) & (3) powers.....*
- ❖ ***03.11.2008** Notification of discharge from involuntary status from an Approved Treatment facility Section 40(3) & 44 Mental Health & Related Services Act.*
- ❖ ***06.11.2008** (time unknown) ... Nurses asked me to section patient under Medical Superintendents Act. I don't think this is required or is suitable for this patient. Shackling and sedating patient is not required for this patient. I discussed situation with med reg who said patient is not for sectioning. Can be PCA specialised if nurses think would help. Please get patient to sign against medical advice form if leaving ward. If you have concerns or are asking for sectioning re behavioural issues then please contact my registrar. I realise this is a difficult situation and once*

patient is stable and (medical) (patient) will be discharged...

- ❖ **21.11.2008** 10:40am..... found patient outside smoking....
- ❖ 12:00pm (Patient) will likely need sectioning
- ❖ 12:30pm Called NRC on duty to request PCA special for (patient). NRC informed me there are no PCA's available for the next shift.
- ❖ 1:30pm Patient asking to go outside for cigarette, explained to patient the importance of staying on the ward due to having (withheld). Patient stating he will be ok and walked out. Security rang and x 2 nurses went outside c patient. 1 nurse remained whilst patient had a cigarette.....
- ❖ 1:40pm (On call Psychiatric Doctor reviewed patient). Patient not able to be sectioned under Mental Health Act – doesn't fit criteria apparently. To notify med team patient is under, to see if they want patient sectioned under Medical Health Act section 16.2. Team .. keen for patient to be sectioned and PCA specialised. Discussion with (name withheld) Medical Super. Patient to be sectioned under Medical Health Act Section 16.2-16.3. To have PCA special to follow patient outside when going for cigarette etc in order to notify nursing/medical staff if patient collapses or has (withheld).
- ❖ **24.11.2008** Absconded X 2 today from ED and RAPU...,uncontrolled, non-compliant...well known to ED. On arrival confused....verbally aggressive, security in place.....
- ❖ **25.11.2008** Well known, frequent admission, personality disorder, self discharge without (medication), given threat to OD.
- ❖ (time unknown) Currently under Medical Section.
- ❖ (time unknown) For discharge this am. Usual (medication). Note Section 16.2 via ED. Needs to leave with Security

while (patient) has the (medication). (Patient) can then be taken off the section in ED and then discharged...(Patient) is refusing (medication) here. From my experience and previous (psychiatric assessment/s) (patient) is not mentally unwell. (Patient) is answering questions when asked, conversing normally, however gives irrational answers consistent with (patients) usual personality – getting attention by refusing treatment. I have conversed with (names withheld) (patient) is an adult capable of making decisions and (patient) manages (Patient) has refused advice, but is well now... (Patient) can be discharged without taking (medication) ... (Patient) is taken off the Section 16.2 by (name withheld)

PATIENT B

- ❖ **04.12.2008**.....was admitted yesterday for investigation of deterioration in mental state. (Patient) has diagnosis of frontotemporal dementia.... Deterioration at home with hallucinations, agitation and (partner) experiencing difficulties dealing with (patient) behaviour....still undergoing medical tests for organic factors possibly contributing to delirium....(medication) this am but remains agitated, wanting to leave, believes that people are talking to (patient) and 'someone is coming'. Difficult to engage in interview.....has no thoughts of self harm or harm to others. Is insistent on leaving hospital, not wanting to remain here for issues to be sorted out concentration limited, poor insight into (patient) current presentation and impaired judgement.

Assessment: Dementia with acute exacerbation of behaviour and psychotic symptoms ? resulting from

delirium. Discussion with (Doctor) re appropriateness of Section 42 – (doctor) has instructed that (patient) should not be held under Mental Health Act but should remain in hospital under Medical Superintendents powers Sec 16(2)(3) health act.....

PATIENT C

- ❖ **27.12.2008** Section 16.3 (Patient) has sustained a potentially life threatening stab wound to the neck which requires admission to hospital and observation and exploration in theatre. (Patient) is currently intoxicated and in my assessment is unable to make a rational decision regarding (patients) medical treatment. (Patient) has expressed the wish to leave – and I wish to keep him in hospital under a duty of care. I am concerned (patient) will deteriorate if allowed to take (patients) own leave from ED.
- ❖ 8pm – patient requesting to self discharge, explained that he can leave but he is intoxicated. ? is (patient) responsible for (self) to discharge (self). Dr and Surgeon aware will attend to talk to patient.
- ❖ 8:05pm patient taken outside with security for cigarette.
- ❖ 9:00pm Patient requesting discharge, explained over and over again that (patient) can not go home. Also explained that (patient) is under a section. Surg Reg also explained to patient that patient is not happy to let him discharge until the am. They want to watch (patients) airway overnight. Security attending patient while under a section....
- ❖ 9:36pm Patient called Police on his mobile phone complaining that (patient) had been held against (patients) will by hospital staff and explained to Police why (patient) was held against (patients) will. The Police explained the

same to the patient and asked (patient) not to phone police again....

PATIENT D

- ❖ **16.11.2008** (00:04am) ...Patient fell over hitting back of head. Patient intoxicated. ... Patient doesn't remember incident...Laceration back head bleeding controlled... no dizziness. No blur vision...No nausea...
- ❖ 00:45am Patient in nil pain – neuro obs intact. Patient orientated in time and place. Head bandage intact and clean. Waiting to be reviewed.
- ❖ 01:50am Neuro obs, attended. Nil pain.
- ❖ 02:30am Section 16, security present.
- ❖ 03:50am patient unaccompanied by security at the time – spoke with security who states the MO is happy that patient is cooperative and (partner) present and so security presence is not required... above confirmed NRC made aware. If patient does start to leave – security are to be contacted.
- ❖ 08:00am Checked with ED (doctor) is allowed to eat and drink. Allowed to go outside but with PCA special.
- ❖ 08:02am Explained to (patient) reason (patient) has PCA special due to (patients) desires to up and leave ED. Due to the fact (patient) has had a ? head injury (patient) cannot leave hospital. Patients states he understands this.
- ❖ 08:23am Been outside and came back. PCA special with patient.

PATIENT E

- ❖ **01.02.2009** time unknown Patient extremely agitated, wanting around ward, telling staff (patient) is leaving. Very difficult to

reason with, wont event listen to (partner). Taken downstairs by (partner) and PCA special for a smoke. Still agitated. As discussed with Dr (name withheld) medically section patient, Dr (name withheld) to do. Security to be notified if need....be very careful of head wound, still bone missing! Patient must not be allowed to leave.

- ❖ *08:20pm Instrument 'Form "A" In Respect to the Management of Patients Pursuant to Sections 16(2) and (3) of the Medical Services Act, completed by Consultant. Medical notes: Medical section 16.3 – Dr (name withheld) has discussed with medical superintendent need to medically section (patient). Patient can be held against his will due to need to keep patient in hospital for his safety regarding head injury and craniotomy. Needs to be reviewed every 72 hours. Gen Surg continued: patient sectioned. Security to be called if needed, aware of patient.*
- ❖ *08:30pm Nursing: patient becoming increasingly agitated over the afternoon. Administered (medication) with very minimal effect. By 7:15pm patient threatening to leave ward. Very difficult to reason with, highly irrational. Not responding to (partner). RMO notified who reviewed patient as per above (sectioning). 2.5mg haloperidol ordered stat – patient took with no issue however with advice from RMO, told patient it was also for his headache. Patient still demanding to leave, security called to ward. Patient requested to go outside for smoke – permission granted. Patient returned after 10 minutes and is beginning to settle. Remains PCA special. Patient now medically sectioned – security aware. Patient has been complaining of headache – regular and PRN analgesics administered.*
- ❖ *Time unknown – Very difficult situation as (patient) alert and awake .. that its hard to distract (patient) etc. I'm really not keen on (patient) being held down etc, and thrashing around with (patient) uncovered cranium etc. (Patient) got no drip and I*

think would be (unreadable) attempts to insert one – would probably escalate the situation. I'm (unreadable) for (patient) to have 20mg of oral (medication) but (patient) need to be (unreadable) overnight with (unreadable) the whole time.

- ❖ *9:30pm Nursing: Patient continuing to be very agitated. Spoke to RMO and further 1mg haloperidol given. No effect. Spoke to RMO and Reg and 20mg diazepam given at 9:15, awaiting effect. Patient still demanding to leave. Reg spoke to patient with security present. Patient finally sat in wheelchair and is going back to bed.*
- ❖ **02.02.2009** *05:30am: Nursing night shift. Patient remained agitated this shift. Further 1mg haloperidol administered, with little effect. Requesting to go downstairs for cigarette – PCA took patient (unreadable) settled (patient) for approx ½ hour. Requesting to speak to (partner) at midnight but encouraged not to and returned to room. Nil aggression noted, but patient often confused and disorientated. Does know (patient) is in hospital, but conversation with (patient) offend does not make any sense. Always wears helmet when mobilising – appears to understand that (patient) must comply with this. Did not sleep at all overnight, constantly in and out of bed, fixated on moving the med out of (patients) room, saying (patient) has to go and do 'a thing'. (Partner) will be in before 11am in the hope of keeping patient calm and compliant....*
- ❖ *Instrument signed by Consultant at 08:15am on the 02/02/2009 - 'Form "B" in Respect to the Management of Patients Pursuant to Sections 16(2) and (3) of the Medical Services Act. The management plan was commenced on 01.02.2009.*
- ❖ *08:15am medical notes: Events yesterday noted – currently sectioned. (unreadable), obs stable. Plan- for cranioplasty (Friday), continue (unreadable), around suture lines to prevent infection – continue with medical section.*

- ❖ *02:30pm Trauma Nurse Review – Issues with agitation last night noted, which then required medical section. Discussed with (partner) PTA and issues with agitation. (Patient) has been more settled this morning (had sedation overnight). Has been downstairs for only one cigarette. Nutrition is a problem....*
- ❖ *02:50pm Nursing: (patient) has been quite settled this shift. (patient) walked down the corridor and took (patient) to the toilet independently at the start of shift. (patient) has been downstairs with partner once for cigarette at 11:00hours. Some mild agitation evident then, asking why (patient) couldn't go home.*
- ❖ *08:00pm Nursing: patient remains PCA special. Much more settled this evening. (medication) administered and no further sedatives required. Refusing oral intake. ... pupils appear equal. Patient verbalising that he wants to leave but is not attempting to leave. Sleeping at times....*
- ❖ **03.02.2009** *04:00am Nursing Night Shift: patient quite settled on commencement of shift – responds well to male PCA, some agitation notice with female PCA. Neuro obs attended to 4/24 left pupil sluggish and slightly larger than right pupil (has been reviewed by RMO – see above notes). (Medication) applied to cranial suture lines as charted. Became agitated at around 3:30am – insistent on going downstairs for cigarette, wanting to phone wife/get wife to pick him up. Attempting to get into taxis to go home but PCA intervened and convinced patient to come back to ward. Remains confused, unable to verbalise where (patient) is and disorientated to time. Conversation with patient nonsensical unsure of why (patient) is in hospital, unable to construct proper sentences. Safely mobilising with close supervision. Nil other issues, if remains agitated plan to give haloperidol...*
- ❖ *06:00am Nursing Night Shift: Patient remained increasingly agitated this shift. Insistent on going outside so taken by PCA.*

Security guard came up to ward @ 04:30am informing nursing staff that patient had been wandering around carpark looking for someone to drive (patient) home, and was asking everyone who drove up to the emergency dept for a lift home as well. PCA unable to reason with patient, so n/s went downstairs in attempt to coax (patient) back to ward. Spoke to patient about importance of staying in hospital and that (patient) could not get the care (patient) needed at home as it would be too hard on (patients partner). Patient difficult to reason with, kept stating (patient) lived 5 minutes away and (patient) would get the operation sorted out by (patients) doctor at home. Eventually able to coax patient back up to ward – gave (patient) some meds for headache as charted – where (patient) remained for approx 20 minutes but insisted on going outside again. Taken by PCA where (patient) currently remains. Phone call to security – they are keeping an eye on patient and will report to ward if they require nursing intervention.

- ❖ *07:10am Nursing night shift: visit from security guard – patient was downstairs attempting to leave hospital threatening to walk home. Cannot understand need to remain in hospital, agitation increasing. Patients (partner) phoned and spoke to patient though this seemed to increase his agitation more. (RMO) paged who ordered (unreadable) haloperidol, attempted to given same to patient who refused. Security guards had lengthy talk with patient informing (patient) they would have to physically restrain (patient) if (patient) attempted to leave. Eventually able to shepherd patient back to ward and wait for Doctors. Patient accepted haloperidol – awaiting effect. Patient currently downstairs again in company with PCA – becoming increasingly difficult to nurse.*
- ❖ *8:25pm Nursing: patient agitated most of shift. Security called and remained in attendance for almost all shift. Haloperidol and diazepam given with little effect. Patient insisting to go home or*

downstairs. When taken downstairs patient tried to leave hospital and had to be escorted back to ward by security. Patient just settling into bed...

- ❖ **04.02.2009** 02:00am Nursing night shift: patient remained agitated this shift. Downstairs x 2 for cigarettes. Cigarettes were being stored in drug trolley for RM's 5-8 (night staff unaware of same) and patient unlocked trolley (self) to get them out. Told not to go near drug trolley and to ask for cigarettes – risk for (patient) now taking medications out as (patient) knows how to open trolleys. Cigarettes moved to patients med notes pigeon hole – (patient) is unaware of same. PCA unable to encourage patient back to ward from downstairs, required security guard involvement – reports attempting to leave hospital grounds in taxi's. On return 2nd time, patient reports that television told him to go downstairs and sort the thing out, unable to reason with patient and taken downstairs in company with PCA and security guards a 3rd time. Returned a short time later in company with security guards. Haloperidol administered, await effect.
- ❖ Time unknown Trauma Nurse Review: I cam to see (patient) earlier but (patient) was downstairs. Caught up with (patient) on ward just as (patient) was leaving for another cigarette. (Patient still does not understand the extent of (patients) injuries or have a great deal of insight. I have discussed with NRC PCA special requested a male PCA when available.
- ❖ Instrument signed by Consultant at 01:50pm on the 04/02/2009 - 'Form "B" in Respect to the Management of Patients Pursuant to Sections 16(2) and (3) of the Medical Services Act. The management plan was commenced on 01.02.2009.
- ❖ 08:00pm Nursing: Patient has been restless this shift. Security have attended patient x 2 this shift. Patient when downstairs in company with PCA this evening and jumped over fence to DPH and tried to run to home. Security seen patient jump fence on

video camera and gave chase and stopped patient. Patient returned to ward under security escort. NRC has stated patient to be kept on ward overnight until team review in AM. Medication given as per e-scribe

- ❖ *05:20am Nursing Night Shift: much more settled night this pm. PCA special very effective in supervising and providing distraction for patient when (patient) woke up during the night. Up several times to toilet and wandering around room – agitation down greatly as compared to previous 3 evenings. Compliant (unreadable) interventions; accepting meds, cream for cranial suture-line and allowing for observations to be attended to. GCS 14/15 pupils unchanged. Remains very confused – attempting to...*
- ❖ **05.02.2009** *Form titled 'PCA Pathways for Specialising Patients' (trial form) dated 05/02/2009. Patient's Preferred Name (withheld). Is suffering from – Section (16) Act.*
- ❖ *03:00pm. Nursing: Have contacted Social Worker to arrange Adult Guardianship for (patient). I have requested social worker to contact co-director re the process of officiating Adult Guardianship for the patient. I have advised home team ... to fill Mr (name withheld) about events which happened to the patient and referrals to (unreadable) consultants (rehab and psy)...*
- ❖ *4:30pm Social Work:.....Discussion with legal services – recommended given situation that application for temp guardianship is made. Spoke with CNM & RMO to complete carers and medical report for Guardianship asap – at front of file. Social Worker will collect once completed. Have spoke again to partner who is aware of guardianship application and will proceed with joint guardianship. Social worker to follow up tomorrow.*
- ❖ *9:00pm Nursing: General condition stable. Patient is confused obs stable. Afebrile, neuro obs done every 4 hrs, medications*

done as per charted. Patient was settled throughout the shift, PCA special.

- ❖ *08/09/08 (sic 08.02.2009) 2:10pm Nursing. Pt ADL's attended. Patient PCA special continues. Patient wearing helmet when out of bed. Meds and obs as charted. ... Nil concerns or complaints voiced this shift.*
- ❖ *09.02.2009 10:30 ... Patient resting in bed. Calm. Discussed events so far and plan for cranioplasty ? later this week. Explained need to remain in hospital, patient understands.... Plan: 1. Continue PCA special & medical superintendent section; application for emergency guardianship pending ? social worker input.*

PATIENT F

- ❖ *Behaviour Pattern Chart reason for assessment – Medically Sectioned due to Ongoing Issues related to A.B.I.*
- ❖ *15.02.2009Memory, judgement and decision making impaired which can cause (patient) to become anxious and aggressive although his temperament has been more congenial since admission to ward; however there have been regular outbursts and these have been managed as per Action Plan as well as recorded in a Behaviour Record. (Patient) is currently PCA specialled as has absconded in the past and he is presently medically sectioned (16)..... Has very limited cognitive insight to his condition and, does not believe he needs to be in rehabilitation, and just wants to go home. Finds it confusing being in a different ward which has a very different layout and routine. (patient) is still settling in and does get frustrated which has escalated into shouting, swearing and kicking requiring the assistance of security staff and sedation with oral diazepam.... No insight into his condition does not believe he should be in rehabilitation. ... Has an action plan in place if tries to abscond*

and a PCA special 24 hrs a day. Is currently medically sectioned 16...

- ❖ **16.02.2009** *time unknown. Patient attempted to leave ward and difficult to bring back.*
- ❖ **19.02.2009** *8:50am patient rushed from ward saying he had to go to NRN (Northern Rehabilitation Network)...PCA special followed him to lift.*
- ❖ *Time unknown: ...Memory, judgement and decision making impaired which can cause (patient) to become anxious and aggressive although his temperament has been more congenial since admission to ward; however there have been regular outbursts and these have been managed as per Action Plan as well as recorded in a Behaviour Record. (Patient) is currently PCA specialised as has absconded in the past and he is presently medically sectioned (16)last episode of absconding 19/02 nil major issues..... Has an action plan in place if tries to abscond and a PCA special 24 hrs a day. Is currently medically sectioned 16...*
- ❖ *Time unknown: ...physically stable, although grumpy on waking...*
- ❖ **20.02.2009:** *... PCA specialised...*
- ❖ *Entry by Rehab RMO 'Discussed with the Medical Superintendent about continuing to hold the patient under our care. He advised that medical section 16 only lasts a few days. As the patient still has no insight into his problems and is at risk of absconding, we have reverted to keeping him under the common law duty of care. If he absconded or wandered off, he would not be safe'.*
- ❖ *2:00pm Attended NRN – PCA special, now under common law duty of care instead of Section 16.*
- ❖ **02.03.2009** - *...Understands and speaks English coherently. Memory judgement and decision-making impaired, which can cause patient to become anxious and aggressive although his*

temperament has been more congenial since admission to ward; however there have been regular outbursts and these have been managed as per Action Plan as well as recorded in a Behaviour Record. (patient) is currently PCA specialled as has absconded. Last episode of absconding 19/02. Goal: to minimise episodes of aggression, frustration and prevent (patient) from absconding..... (patient) is settling into the ward better now, still becomes frustrated and overwhelmed at times but security has not been required.....(Patient) is no longer medically sectioned but is kept under the common law duty of care as he would be at risk should he abscond or wander off due to his lack of insight into his problems. He is PCA specialled during the day and an action plan is in place if (patient) tries to abscond....

- ❖ **03.03.2009**..... *Mobile with supervision due to tendency to get lost, continue with PCA special...*
- ❖ **08.03.2009** *(patient) currently PCA specialled as has absconded. Last episode of absconding 19/02...*
- ❖ **11.03.2009** 8:30pm *Condition unchanged. Remains PCA special...*
- ❖ **15.03.2009** ...(patient) *currently PCA specialled as has absconded. Last episode of absconding 19/02. (patient) is currently showing improvement in his short term memory recall, written information processing and problem solving tasks this slow but gradual improvement also appears to reduce his level of frustration and angry outbursts.....(patient) is no longer medically sectioned but is kept under the common law duty of care as he would be at risk should he abscond or wander off due to his lack of insight into his problems. He is PCa specialled during the day and an action plan is in place if (patient) tries to abscond....*

MENTAL HEALTH & RELATED SERVICES ACT (MHRSA)

There are provisions within the *Mental Health & Related Services Act* to cover the legal authority to detain, restrain and provide treatment to certain persons in certain circumstances. These are included so that anyone reading this report will understand the extensive protection and checks and balances built into that legislation in order to comply with the International Standards laid down in various United Nations Declarations. The effect of the avoidance of those protections and the abuse of the power of detention and restraint without those protections by RDH resorting to Section 16 of the *Medical Services Act* must be understood in that context:

Section 4 states that ‘mentally disturbed’ means behaviour of a person that is so irrational as to justify the person being temporarily detained under this Act; and section 6 states in relation to a mental illness that (1) In this Act, mental illness means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised (a) by the presence of at least one of the following symptoms: delusions; hallucinations; serious disorders of the stream of thought; serious disorders of thought form; serious disturbances of mood; or by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a). Subsection 3 states that a person is not to be considered to have a mental illness merely because he or she (e) is intellectually disabled; (f) uses alcohol or other drugs; (g) has a personality disorder or a habit or impulse disorder; (n) has been treated for mental illness or has been detained in a hospital that provides treatment of mental illness; (p) has been admitted as

an involuntary patient on the grounds of mental disturbance; or (q) has acquired brain damage.

Sections 14 and 15 provide the criteria for the involuntary admission of a person on the grounds of mental illness or mental disturbance:

14. The criteria for the involuntary admission of a person on the grounds of mental illness are that: (a) the person has a mental illness; (b) as a result of mental illness; (i) the person requires treatment that is available at an approved treatment facility; (ii) the person: (A) is likely to cause imminent harm to himself or herself, a particular person or any other person; or (B) is likely to suffer serious mental or physical deterioration, unless he or she received the treatment; and (iii) the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment; and (c) there is no less restrictive means of ensuring that the person receives the treatment.

- ❖ *15. The criteria for the involuntary admission of a person on the grounds of mental disturbance are that: (a) the person does not fulfil the criteria for involuntary admission on the grounds of mental illness; (b) the person's behaviour is, or within the immediately preceding 48 hours has been, so irrational as to lead to the conclusion that: (i) the person is experiencing or exhibiting a severe impairment of or deviation from his or her customary or everyday ability to reason and function in a socially acceptable and culturally appropriate manner; and (ii) the person is behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that justify a determination that the person requires psychiatric assessment, treatment or therapeutic care that is available at an approved treatment facility; (c) unless the person receives treatment or care at an approved treatment facility, he or she: (i) is likely to cause imminent harm to himself or herself, to a particular person*

or to any other person; (ii) will represent a substantial danger to the general community; or (iii) is likely to suffer serious mental or physical deterioration; (d) the person is not capable of giving informed consent to the treatment or care of has unreasonably refused to consent to the treatment or care; and (e) there is no less restrictive means of ensuring that the person receives the treatment or care.

Section 61 of the *Mental Health and Related Services Act* sets out the requirements for using mechanical restraints on a person with a mental illness. It states:

61 Mechanical restraint

*(1) In this section, **mechanical restraint** means the application of a device (including a belt, harness, manacle, sheet and strap) on a person's body to restrict the person's movement but does not include the use of furniture (including a bed with cot sides and a chair with a table fitted on its arms) that restricts the person's capacity to get off the furniture.*

(2) A person must not apply mechanical restraint to a person other than:

(a) to a person who is being assessed, or receiving treatment, under this Act; and

(b) in accordance with this section.

Maximum penalty: \$5 000.

(3) Mechanical restraint of a person in an approved treatment facility may only be applied where no other less restrictive method of control is applicable or appropriate and it is necessary for one or more of the following:

(a) for the purpose of medical treatment of the person;

(b) to prevent the person from causing injury to himself or herself or any other person;

(c) to prevent the person from persistently destroying property;

(d) to prevent the person from absconding from the facility.

(4) Mechanical restraint of a person must not be applied unless it is approved:

(a) by an authorised psychiatric practitioner; or

(b) in the case of an emergency, by the senior registered nurse on duty.

(5) The senior registered nurse on duty must notify the person-in-charge of the approved treatment facility and an authorised psychiatric practitioner as soon as practicable after approving the mechanical restraint of a person.

(6) The form of mechanical restraint and its duration must be:

(a) determined by the authorised psychiatric practitioner or senior registered nurse who approves it; and

(b) if the mechanical restraint has been approved by the senior registered nurse on duty – reviewed and, if necessary, re-determined by an authorised psychiatric practitioner as soon as practicable after it has been approved.

(7) Mechanical restraint may be applied to a person without the person's consent.

(8) A person to whom mechanical restraint is applied:

(a) must be kept under continuous observation by a registered nurse or medical practitioner;

(b) must be reviewed, as clinically appropriate to his or her condition, by a registered nurse at intervals not longer than 15 minutes;

(c) must be examined by a medical practitioner at intervals not longer than 4 hours;

(e) must be supplied with bedding and clothing that is appropriate in the circumstances;

(f) must be provided with food and drink at appropriate times;

(g) must have access to adequate toilet facilities; and

(h) must be provided with any other psychological and physical care appropriate to the person's needs.

(10) Mechanical restraint must not be applied to a person who is admitted as a voluntary patient for longer than a continuous period of 6 hours.

(11) If a medical practitioner, senior registered nurse on duty or an authorised psychiatric practitioner is satisfied, having regard to the criteria specified in subsection (3), that the continued application of mechanical restraint to a

person is not necessary, he or she must, without delay, release the person from the restraint.

(12) The person-in-charge of an approved treatment facility must ensure that a record is kept of:

- (a) the form of mechanical restraint applied; and*
- (b) the reasons why mechanical restraint was applied; and*
- (c) the name of the person who approved the mechanical restraint being applied; and*
- (d) the name of the person who applied the mechanical restraint; and*
- (e) the period of time the mechanical restraint was applied.*

(13) The person-in-charge of an approved treatment facility must ensure that a copy of the record kept under subsection (12) is placed on the person's medical records.

(14) The principal community visitor must ensure that the record kept under subsection (12) is inspected by a community visitor at intervals not longer than 6 months.

(15) The person-in-charge of the approved treatment facility must ensure that the adult guardian of a person to whom mechanical restraint has been applied is notified of the following as soon as practicable after the application of the restraint:

- (a) that mechanical restraint was applied to the person;*
- (b) the form of mechanical restraint applied;*
- (c) the reasons why mechanical restraint was applied;*
- (d) the period of time the mechanical restraint was applied.*