



**REPORT OF INVESTIGATION
INTO THE COMPLAINT OF
MRS N AGAINST HOSPITAL Y**

JULY 2011

INVESTIGATION INTO THE COMPLAINT OF MRS N AGAINST HOSPITAL Y

1. The Complaint

- 1.1. On 16 January 2009, I received a complaint from Mrs N about the treatment she received in the Emergency Department (ED) at Hospital Y in late 2008 after she was taken there by Police for psychiatric assessment. Hospital Y is one of the State's public hospitals administered by the Department of Health and Human Services (DHHS).
- 1.2. She complained primarily that she was detained against her will, subjected to restraint with the use of excessive force by security staff and injected with medication without her consent.
- 1.3. She alleged that she was lifted from a chair in which she was sitting in the seclusion room in ED and pushed face down onto the bed. Her arm was pulled up behind her back and a knee was pushed into her lower back to hold her down. Her pants were pulled down in front of the male orderlies and she was given two injections. She was then transferred to a ward by wheelchair. She found this treatment unjustified and demeaning, describing it as 'a vicious assault.'

2. Background

- 2.1. Mrs N came to the attention of Federal Police when she became disorientated whilst trying to leave the airport car park in her car.
- 2.2. She explained to the police that she had been driving to the Magistrates Court to lodge an application for a restraint order against a man who had assaulted her nine years before and who was again threatening her. On the way there she said that she had been threatened and traumatised by a man in a vehicle wielding a knife through his vehicle window. She described then being unable to drive to the court because she was 'blocked in' by other vehicles cutting across her, which 'forced her' out of the city and over the bridge. As she believed she was being followed, she continued to the airport and the perceived safety of security cameras.
- 2.3. Because of her driving behaviour and her explanation for it, and the fact that she was in a distressed and confused state, she was taken by the police to ED for psychiatric assessment.
- 2.4. After assessment in ED, Mrs N was placed on an Initial Order under the *Mental Health Act 1996* (MHA) with a preliminary diagnosis of bipolar disorder (manic phase). This was based on her symptoms of

accelerated thought and speech, irritability, poor sleep, and delusional thinking, as well as her previous history of bipolar disorder. The complainant rejected this diagnosis, saying that she suffered from post-traumatic stress disorder as a result of the assault nine years before, but it was supported by her treating psychiatrist who was subsequently contacted about the case.

- 2.5. She remained at the hospital, still refusing treatment, until her discharge when the Mental Health Tribunal (MHT) revoked a continuing care order. The MHT accepted that the complainant suffered from an exacerbation of long standing bipolar disorder but did not accept that she was a risk to herself or others.

3. The Investigation methodology

- 3.1. Information was sought from the hospital, which provided a written response to the complaint on 7 May 2009. The patient's relevant medical records were provided on 4 June 2009. The hospital 'Code Black' policy, its restraint and seclusion policies and documentation relating to the recording of the incident in question, were provided on 18 November 2009.
- 3.2. Information was sought from hospital staff involved in the incident. Interviews were held on 23 February 2010 with the four orderlies who carried out the restraint of Mrs N. The two nurses involved in her care in ED were interviewed on 17 March 2010. The registrar in charge at the time, who ordered the restraint and medication, was interviewed on 6 May 2010.
- 3.3. After reviewing all the evidence, I formed preliminary conclusions about the issues raised in the complaint. I sent a copy of a preliminary report to the hospital to allow a reasonable opportunity to respond. I also sent a copy for comment to Professor Mark Oakley Browne, Statewide Clinical Director of Statewide & Mental Health Services, and Chair of its Serious Incident Review Committee (SIRC).
- 3.4. Both Professor Oakley Browne and the hospital replied to the invitation to comment, and their responses have been taken into account in concluding this report. Professor Oakley Browne indicated that the members of the SIRC approved the preliminary report and recommendations, and stated that the new MHA currently in preparation would deal with chemical restraint. The hospital took issue with various aspects of the report.

4. Issues

- 4.1. Although Mrs N raised some other issues in her complaint, the focus of this investigation has been confined to whether or not it was

appropriate for hospital staff to inject Mrs N with medications without her consent.

5. Investigation

The Facts

- 5.1. In its initial written response to the complaint, the hospital advised that “due to her uncooperative nature, Mrs N was given a standard Code Black (Personal threat) intramuscular medication to enable a safe transfer to the ward).” She was described as uncooperative because she:
 - refused an ECG
 - refused to take medication, and
 - refused to sit in a wheelchair.
- 5.2. It is common ground that the complainant did not consent to either the oral medication offered to her in ED, or to the injections of medication complained of. The hospital records show that the injections consisted of 10mg of Haloperidol, an anti psychotic medication, and 3mg of Midazolam, a sedative. The patient notes depict a patient who cooperated with an assessment for an initial order under the MHA and show that she consented to blood and urine tests. They do not reveal any aggressive or threatening behaviour, although they report increasing irritability, with complaints about being held against her will and requests to see a lawyer or advocate. She voluntarily remained in the seclusion room with the door open for almost nine hours before the restraint process took place.
- 5.3. Nurse A, a nurse with psychiatric training, had care of Mrs N for almost seven hours in ED following her admission. When interviewed, she described Mrs N as irritable, argumentative and difficult to please, not least because she was waiting in the seclusion room for a very long time. She was, however not at all aggressive or threatening in her manner. Nurse A said the patient was cooperative with her and believed that this was because of her psychiatric training, which provided the skills to take the time necessary to talk to her.
- 5.4. Nurse B, who took over on the change of shift, was not psychiatrically trained. Nevertheless, she also stated that in her opinion there was no question of risk to personal safety to or from Mrs N. Although Mrs N was described as somewhat time-demanding and confused, she did not appear to Nurse B to be that unwell. The nurse also described Mrs N as being cooperative until mention was made about transferring her to the ward. Mrs N then argued against this course of action, raising her voice and demanding an explanation as to why she was being kept in hospital when she had been cooperative. Nurse B did not assert that Mrs N had refused to accompany her to the ward,

but rather that Mrs N repeatedly questioned the reason for it, refused to get into a wheelchair and requested legal assistance.

- 5.5. Nurse B said that even if Mrs N had agreed to walk to the ward, or even if she had got into the wheelchair, she would not have transferred her alone. She would have called for what she described as a 'Code Black transfer' – although this terminology is not used anywhere in the written policies supplied by the hospital. In fact what then occurred was that Dr R, the psychiatrically trained senior registrar on duty who had been called earlier by Nurse A, arrived at ED. He ordered what he described as a Code Black Medication. 'Code Black Medication' is defined in the emergency procedures policy as 'situations where behaviour management requires medication administration as the main component of the clinical management plan and part team response is required.' Nurse B said that by this time Mrs N had been in effective seclusion for nine hours and had become increasingly vocal about her legal rights.
- 5.6. There is no documentation in the patient notes or information from interviews with staff to suggest that Mrs N underwent any risk assessment for the transfer to the ward at all prior to her being restrained. Both nurses believed that she might abscond from the hospital during a transfer to the ward but did not comment on, or address in the patient notes, the question of what risk, if any, she would present to herself or others during the transfer. Further, no assessment was made or recorded as to what other options were available to address any risk she might present, and in particular, nothing in the notes explains if or why restraint and sedation was determined to be the least restrictive option available.
- 5.7. Dr R had the most psychiatric training of the medical staff on duty that night. He said that he did not assess the patient because that had already been done by Dr L, the intern on duty, prior to his arrival at ED and he agreed with her decision on management. He was involved "only in ordering the Code Black and ordering the medication." There is nothing in the patient notes to that effect. Dr R did not record any patient notes at all and the last clinical notes by Dr L, an inexperienced intern, were made several hours before. These notes do not include an assessment of risk or disclose any decision about how Mrs N should be managed or cared for.
- 5.8. Whilst the two nurses comprehensively documented their interactions with and observations of Mrs N over the period she was in ED, there was no documentation at all about the decision to use restraint or the nature of restraint required, save for a record on the drug chart of the medication administered. Dr L made no notes about her mental health subsequent to her initial assessment at 1547hrs, noting at 1830hrs that Mrs N was 'awaiting psychiatric assessment.' Dr A assessed her at 2100hrs when he made the order for her admission and detention as an involuntary patient. He recorded that he was unable to assess risk 'due to guardedness and lack of rapport.' He

made no note referable to the restraint process save the comment that 'if unmanageable, secondary agitation/psychosis > another ward is an option.'

Nothing in his notes suggests that Mrs N was 'unmanageable' when he saw her. According to the records, there was no further intervention by a psychiatrist prior to the 'take down' (forcible restraint without consent at approximately 2400hrs) save for Dr R's brief discussion with her, and no note that she became unmanageable at any stage.

5.9. Dr R said that, although he spoke to her only briefly, he was of the opinion that Mrs N was verbally aggressive and was a danger to herself and others because she wanted to leave the hospital. He believed that the only way to prevent that was to inject her with medication and take her to a secure ward although he did not explain why he thought there were no other options available. His recollection was that the reason for calling the Code Black was her refusal to go to the ward rather than simply a refusal to get into a wheelchair. In the absence of any contemporaneous records, Dr R was relying only on his memory of an incident which had occurred 18 months before, in circumstances where he acknowledged that he was involved in 'Code Blacks' several times a week. His recollection of the reason for the use of restraint on this occasion is at variance from that of Nurse B, and the medical notes, neither of which indicated a direct refusal to go to the ward.

5.10. At 2410hrs Nurse A's notes state:

'Attempted to move patient to the ward. Refused to sit in wheelchair – asking for advocate or lawyer again. Explained the process in seeking these people again. Pt refused ECG. Pt refused to take oral medications. Code black escort called. Pt refused to get in wheelchair. Dr R saw patient. Code Black medication commenced (error) ordered. Medications given APC. Moved to cubicle 8. For another ward admission now. Await code black escort. Nurse manager and psych Drs. Pt asked nursing staff to document 'we are adding to her trauma.'

5.11. All the staff interviewed agreed that patients may, if well enough, walk from ED to the ward as there is no policy requiring transfer by wheelchair. However, according to the nurses, the decision to transfer the complainant to another ward was specifically because she would not voluntarily get into a wheelchair and would thus need to be sedated for that to occur. Because of the risks involved in sedation, sedated patients need to be monitored in another ward before being conveyed to the ward and transfer by wheelchair to another ward is then mandatory.

5.12. There is no indication in the notes of any perceived risk to the patient during a transfer to the ward in the absence of restraint and

medication and there is no mention of any need for medication by way of emergency treatment. Although anxious, paranoid and distrustful she expressed no suicidal thoughts and was orientated to time, place and person when last assessed by Dr L.

- 5.13. The patient notes make no reference to any, and if so, what risk Mrs N may have presented to others and set out no rationale for the use of restraint and medication as is required by the Hospital Y Restraint Policy.
- 5.14. Information was obtained from the four orderlies who took part in the restraint of Mrs N. None recalled it. They all said that 'Code Blacks' are commonplace. One said he attended about twenty per month. He advised, however, that in his experience patients were never medicated for the purpose of transfer within the hospital and that forcible transfers were very rare. Whilst there was not a policy of transfer to the ward by wheelchair, it was said by the orderlies to be easier for staff to have a person in a chair. Patients who did not resist could walk to the ward. If there was resistance to transfer, the usual process was described by one of the orderlies thus: staff, including orderlies, would try as gently as possible to get the patient into a wheelchair. If they still resisted, the team would try to lift them gently into the wheelchair. If there was strong resistance, the team would walk the patient.
- 5.15. In obtaining information from the nurses it was obvious that there was confusion about the Code Black and Restraint Policies and neither was clear on the difference between a Code Black and a Code Black transfer and the documentary requirements that accompany them. Nurse B had tried to look up the Code Black Policy but had been unable to find it. As Code Black Response Team Leader on the night, she was unsure as to who was responsible for documenting required information, where it was to be recorded and what it should contain.
- 5.16. Dr R advised that documenting Code Blacks was the responsibility of the nurse in charge. He said that a Code Black transfer like this one was 'purely precautionary' but involved the same protocols as for a Code Black. He commented that in some cases a show of force was enough to avoid an injection and that injecting a patient was distressing and very much a last resort.
- 5.17. Dr R advised that the medication given to Mrs N by injection was for the purpose of restraint only and was not intended to be for treatment even though the Haloperidol could have constituted the first injection in a course of therapeutic treatment had this eventuated.
- 5.18. The four male orderlies, Nurse B and Dr R were present during the restraint and medication process. The description of it by Nurse B did not differ from that of Mrs N. She described it thus: 'It was an undignified process. The team chatted to her and we shut the area

off. She continued to protest that she did not know why this was happening. She was then held face down on the bed by the orderlies with one arm behind her back whilst she was injected. She was then rolled over onto her back. I don't think there was too much force but there could be no attempt to inject her without holding her down.'

- 5.19. The patient notes show an entry where Mrs N 'presented to the nursing station showing a bruise the size of a ten cent piece on her upper left arm claiming that she was excessively manhandled by the security staff.'

The Law governing the use of restraint on an involuntary patient.

- 5.20. The application of any form of physical restraint to any person without consent constitutes an assault (*Criminal Code Act 1924* ss 182,183 and 184 and *Police Offences Act 1935* s 35). It also constitutes a civil wrong, and may give rise to an entitlement to damages. A decision to apply restraint of any kind to a person thus carries with it significant legal responsibility.
- 5.21. Relevant law is to be found in international law, State law and the Common Law.

International Law

- 5.22. Australia ratified the *Convention on the Rights of People with Disabilities* on 17 July 2008. The Convention obliges Australia, amongst other things, to adopt legislative, administrative and other measures for the implementation of the rights recognised in the Convention – Article 4(1)(a). These rights include the right of every person with disabilities, on an equal basis with others, to liberty and security of the person (Article 14) and to respect for their physical and mental integrity (Article 17).
- 5.23. Whilst these international obligations might logically lead to a national approach to the use of restraint practices in relation to persons with disabilities, there is in fact significant variation amongst State jurisdictions in the definition and regulation of restraint. Only Victoria has attempted to address this area of disability law.

State Law

- 5.24. Under Tasmanian legislation, the principles governing the management of involuntary patients such as the complainant are set out in s 7 of the MHA, which states relevantly that:
- restrictions on the liberty of the patient and interference with that patient's rights, dignity and self respect must be kept to the minimum consistent with the needs to protect that patient and other persons

- effect must, if practicable, be given to that patient's wishes so far as that is consistent with:
 - that patient's best interests, and
 - the need to protect that person and other persons.
- 5.25. The restraint of involuntary patients is governed by s 34 of the MHA, which provides that "a person may be placed under bodily restraint only if the restraint" is "necessary" -
- for medical treatment of the patient
 - to prevent injury to the patient or to others or
 - to prevent the patient from persistently destroying property.

The MHA does not differentiate between treatment and control of patients in its sections on restraint and seclusion. The word 'treatment' is not defined. However, 'bodily restraint' is defined in s 3 of the Act as meaning 'a form of physical or mechanical restraint that prevents the free movement of the limbs'. There is no reference to chemical restraint in the MHA, and indeed currently only one reference to 'chemical restraint' in Tasmanian legislation – in r 7 of the *Corrections Regulations 2008* (where the expression is not defined).

- 5.26. A useful definition of 'chemical restraint' is set out in s 3 of the *Disability Act 2006* (Vic). This definition includes:

'the use, for the primary purpose of behavioural control of a person with a disability, of a chemical substance to control or subdue the person but does not include the use of a drug prescribed by a registered medical practitioner for the treatment, or to enable the treatment, of a mental illness or a physical illness or a physical condition.'

- 5.27. The injection of Mrs N with medication undoubtedly falls within the Victorian definition. However, this did not constitute "bodily restraint" within the MHA definition, since it is not "physical or mechanical restraint", and so is not covered by s 34 of the MHA. One might add that Mrs N was not medicated for the purposes of treatment, but for behavioural control, that there was no need to medicate her for the purpose of preventing injury to herself or others, and that there was question of the persistent destruction of property. More than that, the chemical restraint was not necessary to achieve the object of the personnel involved – the transfer of Mrs N to the ward.
- 5.28. Nor was the restraint authorised by s 40 of the *Guardianship and Administration Act 1995*, which permits the carrying out of urgent medical or dental *treatment* without consent on a person with a disability who is incapable of giving consent to the carrying out of that treatment, if the medical practitioner or dentist carrying out or

supervising the treatment considers that it is necessary as a matter of urgency for one of three purposes –

- to save the person's life
- to prevent serious damage to the person's health, or
- except in certain circumstances, to prevent the person from suffering or continuing to suffer significant pain or distress.

This was not a case of medical treatment.

5.29. I am not aware of any other statutory provision in Tasmania under which the chemical restraint of Mrs N might arguably have been lawful.

The Common Law

5.30. The relevant common law principle is what is commonly referred to as the doctrine of necessity. This is relevantly summarised in para 415-365 of *Halsbury's Laws of Australia* in these terms –

“A defendant may justify a battery or an assault on the ground that the act was reasonably necessary for the preservation of or protection of life and that the plaintiff was at the time unable to consent to the act.”

The footnotes to this statement add that the “act must be one which a reasonable person would undertake in the face of real and imminent peril”, and that the “mere fact that the act was, in the circumstances, suitable or convenient, is not sufficient”.

5.31. Clearly, the restraint and injection of Mrs N was not justifiable under these principles.

Hospital policies on the use of restraint

5.32. The hospital's Restraint Policy (SPE15) 2008 governs ‘the use of physical or chemical restraint in exceptional circumstances, for any patient of the hospital whilst medical reasons/causes are being investigated’. It defines restraint as ‘the use of any device, agent or practice and/or action, word or deed which deprives an individual of freedom of movement.’ The policy states that ‘restraint must only be used in exceptional circumstances when all other methods to control a patient have failed and only for the purpose of securing the safety of a patient who is at risk of personal harm or where the patient poses a risk of harm to others.’

5.33. This expansive approach deals with all patients, not just mental health patients, in a way which is not consistent with the detail of the legal provisions, and the common law doctrine of necessity, to which I have referred.

- 5.34. The Restraint Policy sets out the required procedure for the implementation of restraint and the documentation which must accompany it. In the absence of a violent or potentially violent situation, (which is subject to the Aggressive Behaviour Policy), it does not envisage the calling of a Code Black or the intervention of the Code Black Response Team.
- 5.35. The Code Black definition of 'aggression' is 'verbal, non verbal or physical behaviour exhibited or perceived to be threatening by any person to another person or object.'

6. Responses to the Preliminary Report

6.1. As earlier indicated, Professor Mark Oakley Browne, Statewide Clinical Director of Statewide & Mental Health Services, and Chair of its Serious Incident Committee, provided comments on the preliminary report. These were to the effect that the Committee approved the report and had no comments to add regarding the report and its recommendations. He went on to explain that chemical restraint is being addressed in the new *Mental Health Act* under preparation, and outlined the controls that have presently been included in the Bill. A consultation draft of the Bill has recently been released.

6.2 Professor Oakley Browne's letter contains the following information –

“ ... the new Mental Health Act will regulate chemical restraint, where this is defined as medication to control the conduct of the person to whom it is given.

The new legislation will limit the use of chemical restraint such that a person may only be placed under chemical restraint if:

- the person is an involuntary patient in an approved hospital or assessment centre*
- the restraint is authorised as being necessary for one of the following reasons by the Chief Civil Psychiatrist [CCP]:*
 - to facilitate the person's treatment*
 - to ensure the patient's health or safety*
 - to ensure the safety of other persons; or*
 - to effect the patient's transfer to another facility, whether in this State or elsewhere*
- the CCP is satisfied that the use of chemical restraint is a reasonable intervention in the circumstances*
- the restraint lasts for no longer than is authorised.*

Persons placed under chemical restraint must be regularly observed. The restraint must be discontinued if its continuation is

to the obvious detriment of the patient's mental or physical health. The provision also makes it clear that nothing in the Act is to be taken as conferring any kind of authority for a patient to be placed under restraint as a means of punishment or for reasons of administrative or staff convenience.

The new legislation will establish the independent statutory office of Chief Civil Psychiatrist. The Chief Civil Psychiatrist will have the power to issue standing orders and clinical guidelines and will be required to issue a standing order with respect to chemical restraint. The Chief Civil Psychiatrist will also have a special power of intervention with respect to matters including restraint.

The new legislation will provide the Mental Health Tribunal with the power to review instances of restraint and will oblige the Tribunal to conduct a review if asked to do so by a person with standing.”

6.3 The hospital responded to the preliminary report by a letter under the hand of its Chief Executive Officer. In summary, the CEO made the following points –

- that the conclusion in the preliminary report that the use of chemical restraint at the hospital is a common occurrence had been based on anecdotal evidence, and that the investigation had not included “a review of the hospital incidents and data provided on Code Black management” [sic]. However, in making this observation, the hospital proffered no data to indicate how frequently chemical restraint is in fact used.
- that it is necessary for the safety of patients, staff and others that the hospital's Restraint Policy and associated Code Black policies be drafted to authorise the use of medication to restrain psychiatric patients.
- that the hospital believes that the policies comply in this respect with s 34 of the MHA.
- that the preliminary report disclosed some deficiencies in clinical documentation in this case, and some misunderstanding by staff who had been involved in the Code Black.
- that Hospital Y undertakes regular educational training for all staff who are involved in Code Black calls throughout the hospital.
- that a review was recently undertaken into the provision of Code Black Services across the hospital campus, which led to a number of recommendations for new educational requirements, which will be implemented.
- that the restraint that was implemented in this case was authorised under s 34 of the MHA, in that the evidence indicated that the medical and nurse practitioners involved formed the honest and

reasonable belief that Mrs N was a flight risk, and that it was necessary to sedate her for the safety of herself and others.

- that the restraint was authorised by s 40 of the *Guardianship and Administration Act* on the basis that Dr R had the honest and reasonable belief that the restraint was necessary to save Mrs N from significant distress or serious damage to her health.

7. Conclusions

Based on the analysis in section 5 of this report, I have come to the following conclusions:

- 7.1. On the evidence of the hospital staff members who were spoken to during this investigation, it appears that the use of chemical restraint is not an unusual occurrence at the hospital (5.9, 5.14).
- 7.2. The use of chemical restraint is only authorised by law in Tasmania under very limited circumstances – where there is consent or appropriate substitute consent; where s 34 of the *Mental Health Act* applies; where the restraint is an incident of urgent medical or dental treatment authorised by s 40 of the *Guardianship and Administration Act*; or where the circumstances attract the application of the common law doctrine of necessity (5.24 to 5.30).
- 7.3. In this case there is no evidence in the patient record of any assessment to determine whether there was any and if so what risk to Mrs N or others during transfer from ED to the ward. However, the two nurses involved do say that they were concerned that she might abscond if taken to the ward by a nurse alone (5.6). Restraint was not, in her case, used as a last resort (5.7, 5.12, 5.13, 5.24).
- 7.4. The evidence does not support the conclusion that Mrs N was abusive, aggressive or violent at any stage during the time she was in ED (5.2, 5.3, 5.4).
- 7.5. Mrs N refused to get into a wheelchair for the transfer, but there is no persuasive evidence that she refused to go to the ward on foot, even though she argued against going to the ward in principle (5.9). She says that she offered to walk, and her willingness to walk was never put to the test.
- 7.6. There was no consideration of the minimum level of intervention required for the transfer of Mrs N from ED to the ward, short of chemical restraint. No attempt was made to adopt the conservative, and apparently usual, strategies for patients resisting transfer described by the medical orderly in paragraph 5.14. If Mrs N would not get into a wheelchair, was reluctant to walk or if there was concern about her leaving the hospital, she could have been ‘walked’ by staff as described, even if she had resisted transfer. There was clearly no shortage of staff to assist in this if needed, as six staff

members were made available for the 'take down.' In this case the management strategy escalated from an oral request to get into a wheelchair for the purpose of transfer, to a physical 'take down' and medication involving six staff, apparently without consideration of any intermediate strategy. The force used may have been necessary to safely administer injections, but it was excessive in these circumstances because the use of medication was not justified. The inevitable effect on Mrs N was to cause her to feel humiliated, violated and traumatized and this was unnecessary and inappropriate.

- 7.7. The reasons given for the use of restraint in the hospital's written response to the complaint are set out in paragraph 5.1. The response does not shed light on why it was thought that the administration of drugs was required to restrain Mrs N. The reasons offered do not justify the action taken. Firstly, there is no policy requiring a patient to transfer from ED to the ward by wheelchair. Refusal to cooperate with staff by getting into a wheelchair should not, of itself, have been used as a justification for restraint of any kind. Secondly, a refusal to take medication or to submit to an ECG can never be a ground for restraint. Restraint must be justified on one of the legal bases mentioned in paragraph 2, and none of those bases applies in this case.
- 7.8. As this last sentence implies, I do not accept the submission by the hospital that the restraint of Mrs N by chemical means was lawful. It was not justified under s 34 of the MHA for at least the following reasons –
- it was not "bodily restraint", for reasons already explained (5.27);
 - it was not necessary for any of the purposes stated in s 34(a); and
 - it violated the principle stated in s 7(a) of the MHA (5.24).
- 7.9. Nor was it justified under s 40 of the *Guardianship and Administration Act*. This was not a case of medical treatment, as Dr R admitted (5.17) and, even if it was, it was not treatment that on an objective basis was reasonably necessary to prevent serious damage to Mrs N's health or to prevent her from suffering or continuing to suffer significant pain or distress.
- 7.10. I conclude that the actions of forcibly restraining and injecting Mrs N against her will were unlawful and unjustified, and that her complaint is therefore substantiated.
- 7.11. This investigation indicates shortcomings in:
- Hospital Y's restraint policy insofar as it purports to authorise the use of medication to restrain psychiatric patients without due attention to the strict requirements of the MHA, the *Guardianship and Administration Act*, and the common law

- staff understanding of patients' rights and the legislation which protects those rights as a starting point for a decision to restrain a patient in any way
- staff familiarity and compliance with hospital restraint policies and procedures generally
- assessment of patient risk
- proper documentation of restraint procedures.

8. Concluding remarks and recommendations

- 8.1. This case demonstrates that clear controls are needed within Tasmania over the use of chemical restraint.
- 8.2. I am pleased to see that the lack of such controls for patients with a mental illness has been addressed in the consultation draft of the proposed *Mental Health Bill 2011*. I am also pleased to see that the Bill deals with chemical restraint as if it is a type of intervention which needs careful control, less it be used inappropriately.
- 8.3. The draft controls are such that what happened to Mrs N would most likely not have happened if they had been in place at the time. Under the proposals in the Bill –
- Chemical restraint will require specific authorisation by the Chief Civil Psychiatrist (CCP) or the CCP's delegate (ss 78(1)(b)(ii) and s 24).
 - Delegated power to give such authorisation can only be given to a medical practitioner: ss 24(2) and (3)(b).
 - Chemical restraint may only be applied for a "prescribed reason": s 78(1)(b). Transfer within the same facility is not such a reason, unless one can argue that this is necessary to facilitate the patient's treatment, to ensure the patient's health or safety, or to ensure the safety of others.
 - The person authorising such restraint must be satisfied that it is a reasonable intervention in the circumstances: s 78(1)(c).
 - Such restraint must not be applied for reasons of administrative or staff convenience: s 78(3).
 - Special standing orders must be in place in relation to chemical restraint (s 78(5)), and any chemical restraint must be managed in accordance with them (s 78(1)(f)).
 - Certain overriding principles – termed the "mental health service delivery principles" – must be observed in the exercise of responsibilities under the Act: s 16 and Schedule 1. These include respecting, observing and promoting the dignity of persons with mental illness, and interfering with or restricting the rights of persons with mental illness in the least restrictive way and to the

least extent compatible with protecting them and the public:
Schedule 1, items (1)(a) and (b).

One would hope that the special mention made of chemical treatment in the Bill, and the special controls that are applied to it, will mean that, if these controls become law, such restraint will be used with circumspection.

- 8.4. I recommend that, pending the enactment of such provisions, a clear interim policy in relation to chemical restraint be developed within DHHS, which explains the very limited circumstances under which it is currently lawful for such restraint to be used. This policy ought prudently to be checked by the Solicitor-General before its promulgation. The development of the policy should include the development of standard documentation for use when such restraint is applied.
- 8.5. I ask the Secretary of DHHS to let me know within 3 months of the date of this report, what action has been taken to implement this recommendation.

Simon Allston
Health Complaints Commissioner

July 2011