OMBUDSMAN FOR THE NORTHERN TERRITORY

INVESTIGATION INTO

THE UNJUSTIFIED USE OF RESTRAINT AND DETENTION

AT

ROYAL DARWIN HOSPITAL (INTERIM REPORT) Volume 2

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ANNEXURE 1

Mr Beirne's letter dated 19FEB09

Northern Territory Government

DEPARTMENT OF HEALTH AND FAMILIES www.nt.gov.au

87 Mitchell Street Darwin NT 0801
Postal Address: PO Box 40596
CASUARINA NT 0811
Tel: 08 8999 xxxx
Fax: 08 8999 xxxx
email: peter.beirne@nt.gov.au

Our Ref: DD2009/1014
Your Ref: D090100023

Ms Carolyn Richards
Ombudsman NT
GPO Box 1344
DARWIN NT 0801

Dear Ms Richards

RE: USE OF RESTRAINT AND DETENTION AT RDH

Introduction

I write to you in my capacity as Acting Executive Director Acute Care Division of Health and Families, in response to your letters of 20 January 2009 to Dr David Ashbridge and 22 January 2009 to Dr Len Notaras AM. I have reporting responsibility for all of the Northern Territory's five hospitals and the question of restraint is of relevance to all five sites. I would like to take this opportunity to thank you for the accommodation you provided the Department in relation to this response. The answers to the specific questions in your letter to Dr Notaras are set out in Annexure A to this letter. Those answers should be read together with this letter in order to understand the context in which this Department approaches the issue.

However, first and foremost I am able to reassure you that:

1. This Department holds 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.

Background

The Department of Health and Families has as its core business the support of Territorians, often in situations when they are, through illness or other circumstances, most vulnerable. 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. Long-standing Department-wide policies which reinforce this position are attached at Annexure B. Royal Darwin Hospital and Emergency Department policies to similar effect are attached at Annexure C. Please note that any references to the *Medical Services Act* in the context of these policies is understood by the Department to refer to the role of that Act in the process of setting of policies and procedures, rather than as a sole legal basis for the actions referred to.

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 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.

The focus of efforts to avoid risk is upon measures aimed at preventing and 'de-escalating' potentially dangerous situations. Tools such as behaviour management plans, which may form part of an overall treatment plan for a particular patient, are used in addition to more general approaches referred to above. Both our Departmental Union Consultative Committee and OH&S Steering Committee, which include union representation, have been appraised of departmental training and statistics in regard to violence against staff by patients.

Security Guards

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.

At times, however, security staff must act to avert a difficult or dangerous situation in circumstances where their behaviour is sanctioned by the common law rather than expressly authorised by legislation. It is in the nature of these sorts of cases that it is impossible to write a policy or provide an instruction which provides, in advance, detailed guidance upon how to act in every situation. It is fair to say that some security staff have in the past felt very uncomfortable with what they perceive as uncertainty, associated with taking actions which are based upon the common law.

On 13 February 2009 Dr Notaras met with representatives of the LHMU, along with legal representatives for the Department and the Union, to discuss the role of security guards in relation to these issues. I am advised that the meeting was very constructive and it was agreed that s.16 MSA alone was not itself a suitable vehicle for restraint of patients, but that there are limited circumstances in which restraint is sanctioned at common law. It was resolved that the parties would work together on an appropriate policy and procedures. Such policy is to acknowledge the role of the medical staff in making decisions as to competency and imminent danger, but also the need to properly communicate such decisions to security staff to ensure understanding and appropriate action. In that context, the email of the Security Manger of 10 November 2008 has been superseded by the agreement to prepare the new policy.

Legal advice

Mindful of the need to act lawfully, RDH did seek legal advice associated with the limits of the use of s.16 of the MSA. Initial advice was provided in about October of 2008 by Mr Kelvin Currie of William Forster Chambers. Following concerns raised, further advice was sought, upon my request, from the Department of Justice in January 2009.

Following receipt of your letters, the question was referred to the Solicitor-General who provided his advice on 12 February 2009. The Department accepts and will act upon the Solicitor-General's advice. Copies of all three formal legal advices received are attached at Annexure D for your reference.

The special problem of self-discharge of patients in the Territory and the need for legislative change

You may have seen the article in the *Sunday Territorian* of 2 February 2009 entitled "NT patients in big rush to go home" which outlined in general terms the ongoing problem of patients discharging themselves from hospital in circumstances where, by doing so, they are at risk of death or permanent disablement. You may also be aware of the study by Charles Darwin University dated February 2007 entitled "Self Discharge Against Medical Advice from NT Hospitals".

In the case of patients not competent to make decisions in their own interest (in the Re C sense), discharge against medical advice can involve serious risk. Unfortunately, this is not a hypothetical problem. In May 2002 an Aboriginal lady named Rita Anderson discharged herself from Royal Darwin Hospital. In August that year her remains were found in bushland behind the hospital. The circumstances that led to Ms Anderson's demise are unfortunately not uncommon. Ms Anderson was described, in the inquest findings, as having "reached the stage of organic brain syndrome from alcohol abuse" shortly before her death. She was, it was agreed at the Inquest, unable to manage her own affairs. Although an application for an order appointing a guardian under the *Adult Guardianship Act* had been made, it had not been heard by the Court.

Following the Inquest into the death of Ms Anderson, a review of the *Adult Guardianship Act* was instigated. A report was completed in 2005. The recommendations of the Report have been endorsed by the Minister for Health and Attorney-General. After consultation with other agencies, the Department is close to finalisation of proposals regarding amendments to the legislation. A significant recommendation of the Review is for the introduction of substitute decision making provisions, similar to those which have operated interstate (e.g. NSW, Victoria) for some years. Substitute decision making legislation would enable a next of kin or significant person (as defined) to consent to certain kinds of medical treatment for people who are not competent to make decisions for themselves, without the delay involved in making an application to the Court. This legislation will likely be most help in cases where incompetence is temporary or in a period before an application for guardianship goes before the Court. Interstate statutes in this area also include immunity for hospital staff acting in accordance with the legislation.

Proposed policy and process when it is necessary to restrain a person in reliance upon common law

The following section outlines the elements proposed to be incorporated into a policy dealing with common law based actions. It should be noted that further consultation will occur before a policy is formalised.

- If the senior attending clinician is of the opinion that a patient is in imminent danger of suffering serious harm or death if they do not have treatment, and the patient is not competent to adequately appreciate the risk then a person may be detained at common law in the hospital for the minimum period necessary to ensure that the person does not suffer the harm anticipated.
- The clinical team will contact the Director of Medical Services (DMS) and explains the case, including the grounds for considering that the patient is not competent, and the imminent danger for the patient.
- If the DMS agrees that the danger to the patient has been properly assessed, and the patient is not competent, then agreement may be given to use restraint as part of the management plan for the patient.
- The DMS must first seek assurance that where necessary interpreters have been utilised and the impaired cognition is not just a language or

cultural difficulty. The DMS will also seek assurances that specific legislation (*Mental Health and Related Services Act* and *Notifiable Diseases Act)* do not apply. Where necessary this will lead to a further assessment. Also the position in regard to Adult Guardianship is to be clarified if relevant, including enquiries as to the consent of a Guardian.

- Once the DMS agrees, the appropriate notes are made in the patient chart and the patient is informed that they may not leave the hospital and a PCA or a security person is posted at the ward. Consideration is to be given to how to maintain appropriate records of actions taken.

- The situation with the patient is explained to these staff so that they are aware of what is required. If the patient has left the hospital building then security staff (where patient remains within the grounds) and police will be contacted as the patient is then regarded as a missing person with concerns for their welfare.

- It should be noted that the Department does not encourage physical force and security officers are aware of what is appropriate.

Conclusion

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 a 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;

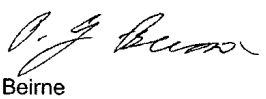
- There is no evidence that any patient has been injured. There is no evidence that any staff member has been injured directly as a result of an action based solely upon s.16 MSA ;

- 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. If you have further queries concerning the above, or any aspect of this response, or wish to meet with me or any other staff member to discuss the issues further, please contact Ms Suzanne Cameron, Sentinel Events and Complaints Coordinator on 89992760 to make arrangements.

Yours sincerely,



Peter Beirne
19 February 2009

ANNEXURE 2
'Draft' Policy Section 16 MSA

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

Royal Darwin Hospital

POLICY FOR THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Policy Purpose
To ensure that any patient who is not competent to give informed consent and who a clinician believes is at risk to themselves should they leave the hospital campus, is prevented from leaving in a safe, efficient, effective and ethical manner.

Policy Statement
- Any patient who is not competent to make their own decisions and who is assessed by a clinician as being at risk should they leave the campus will be prevented from doing so by utilisation of Sections 16(2) and (3) of the Medical Services Act by the "Person in Charge" of the Hospital.

Definitions:

- At risk to themselves – not competent of understanding the risk should they refuse treatment and leave, patients whose clinical condition requires medical intervention for their own safety,

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.
- Under normal circumstances, decisions involving the utilisation of sections 16(2) and (3) of the Medical Services Act must include the treating medical practitioner, supervising consultant, "person in charge" of the hospital, ward nursing staff, Nursing Resource Co-ordinators and the manager or team leader of security.
- The patient's treating medical practitioner must write an entry in the patient's clinical notes outlining the reason for their management under Sections 16 (2) and 16 (3), the discussion with the "person in charge" in respect to their management under Sections 16 (2) and (3) and the management plan for the patient including any restrictions on their movement within and outside of the hospital.
- The treating medical practitioner must complete the required form (Form A), which is to be kept in the patient's clinical notes.
- 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.
- If a patient is mechanically restrained for any reason under the management plan, then they must be reviewed every 24 hours by a medical officer.

Endorsed by RDH General Manager December 2008

Review Date December 2009

Royal Darwin Hospital

POLICY FOR THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

- On initiating the management plan under sections 16 (2) and 16 (3), urgent consideration should be given to initiating further substitute management for the patient under the NT Adult Guardianship Act.

References:

Medical Services Act

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

Royal Darwin Hospital

FORM "A"
IN RESPECT TO THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Patient Name: .....

DOB: .....

HRN: .....

This patient has been reviewed by a Consultant, Dr..... (please use capitals)

And the "person in charge", ... (please use capitals)

As a result of their review, it has been decided that the patient is unable to give informed consent into their current hospital management and that there are no other legislative options available within the Northern Territory to effect their safe management.

As a result, they will be managed under sections 16(2) and (3) of the NT Medical Services Act.

Information on the need for management of the patient under sections 16(2) and (3) is contained in the patient's hospital clinical notes, contemporaneous

Reasonable force may be used to ensure that the patient is not permitted to leave.

Dated: .....

Time: .....

Consultant Name
(Block letters) .....

Consultant
Signature: .....

PLEASE ENSURE THAT THIS FORM IS FILED ON THE PATIENT CLINICAL NOTES

Endorsed GM RDH December 2008 Review date December 2009

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

Royal Darwin Hospital

FORM "B"
IN RESPECT TO THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Patient Name: .....

DOB: .....

HRN: .....

On this date, I reviewed the management plan for this patient.

The patient is currently being managed under Sections 16 (2) and 16 (3) of the NT Medical Services Act.

The management plan was commenced on .....

The continuing management plan for the patient is outlined in the patient's clinical record at a time that is contemporaneous with this form.

Date: .....

Time: .....

Consultant Name
(Block letters) .....

Consultant
Signature: .....

PLEASE ENSURE THAT THIS FORM IS FILED ON THE PATIENT CLINICAL NOTES

Endorsed GM RDH December 2008 Review date December 2009

ANNEXURE 3
MR K. CURRIE

Kelvin Currie

Barrister-at-Law

William Forster Chambers

26 Harry Chan Avenue

Darwin NT 0800

GPO Box 4369

Darwin NT 0801

Telephone: (08) 89 824700

Facsimile: (08) 8941 1541

e-mail: kcurrie@williamforster.com

20 April 2009

The Ombudsman

GPO Box 1344

DARWIN NT 0801

RESPONSE TO INVESTIGATION INTO THE UNLAWFUL USE OF RESTRAINT AND DETENTION

I thank you for the opportunity to comment on the Draft Report.

THE INVESTIGATION

I am somewhat surprised at the conduct of the investigation and the conclusions drawn. It appears that the chosen method of investigation has lead to a situation where the recommendations if implemented would be morally, ethically and legally inappropriate.

In effect you seek that people who are found to be suffering some disability that renders them incompetent to make decisions for their own welfare be permitted to make just such a decision and that the hospital assist those persons in placing

themselves in harm's way. That is despite an apparent acceptance of the various legal advices that people may be appropriately restrained under the common law.

It appears that the investigation has not understood the medical focus of the decisions in such matters. It is legally, and in practice, a matter for the clinicians as to whether a person is competent, needs treatment and if necessary needs to be restrained for that purpose. You will note that in Michael Grant's advice of 12 February 2009 at paragraph 31 he said:

> *As discussed above, where the patient is not of sound mind the matter will turn upon whether the cessation of treatment would give rise to imminent danger. This is ultimately a clinical decision.*

As such, any investigation into these issues might be thought to be extremely deficient if it did not investigate the particular cases and the reasons for the medical decisions in relation to each case. The best evidence of those reasons can only be provided by the clinicians who made the decisions. Those clinicians would be able to explain the grounds for their judgments, clear up any confusion that might abound, indicate what they believe to be the systems in place both at the Royal Darwin Hospital and elsewhere (to provide some comparative perspective) and above all be given the opportunity to provide input before their acts are branded as unlawful. I note that there are no statements by clinicians attached to the Draft Report and no other medical opinion apparently obtained.

That raises the issue that although not named the persons likely to be most aggrieved by the Draft Report have not been consulted at any stage. They have been denied the natural justice of giving their version of why they took the action they did and unless they are permitted to respond to the Draft Report they are denied the opportunity of being heard before adverse comments are made about them (either personally as the persons known in the hospital or generically as doctors of the hospital).

There is instead an attack on the administrators and their legal advisor in what might be described as a "personal manner".

Clearly, one would hope that now I that I have the opportunity, the explanation provided will assist. However, responding to a Draft Report of 130 odd pages within a limited timeframe (I understand that the response is required by the 20th April 2009 which leaves less than 5 business days) when other cases also need attention is far from optimal and in my view (as you will see below) should not have been necessary at all.

I note that the Draft Report indicates that this response will be reproduced in full as an annexure. I trust that will be so. I would also hope that you will consider this response and if it is of assistance amend your Draft Report in response to the issues raised.

MISUNDERSTANDING

The chosen manner of investigation is apt to lead to confusion and a lack of understanding. That is what appears to have happened.

In my opinion there are many misunderstandings but I will only comment on the ones that directly impact on what I regard as the inappropriate comments in relation to my involvement.

There seems to be an incorrect view held by the author of the Draft Report that if a justification for restraining a patient was noted as section 16 *Medical Services Act* then the restraint must necessarily be invalid and unlawful. That is simply not the law. The mechanism or system used does not obviate all other justifications. So for instance, if section 16 was the chosen system or mechanism the actions may still be justified by common law.

Simply forming the view that section 16 does not authorise restraint and then alleging that all instances of exercise of restraint naming that section are unlawful is not appropriate.

SECTION 16 AS A SYSTEM

There seems little dispute about the use of section 16 as the mechanism used (the only dispute is in relation to whether it also independently of the common law can empower the actions of restraining an incompetent patient).

In the advice of 9 February 2009 Michael Grant QC wrote:

> *First, the conclusion I have drawn is that s16 of the Medical Services Act does not empower the person in charge of a hospital to restrain, detain and/ or treat a patient other than in circumstances authorised by the common law. Section 16 does, however, authorise the person in charge of a hospital to set up procedures and protocols, and to give directions, for the purpose of facilitating the management of patients in circumstances that are authorised by the common law. So, for example, where medical practitioners make determinations that a particular patient unable to make an informed decision would face imminent danger unless retained in a ward environment, it would not be unlawful to deploy s16 for the purposes of implementing a procedure by which those clinical judgements were authorised at some higher level in the management hierarchy, and implementing a procedure by which hospital staff could be directed to restrain that particular patient from leaving the ward environment. In those circumstances, the source of the authorisation or justification is the common law and s16 is only being used for procedural purposes.*

Why this advice has been ignored by the Ombudsman's office is difficult to understand. But not only has it been ignored, the whole of the Draft Report is premised on that view being incorrect.

This is of fundamental relevance because I believe that should the evidence have been sought about the reasons for restraint from those who made the clinical decisions it would be found that those actions were justifiable and necessary and accorded the defence of necessity by the common law.

That section 16 was used in such a circumstance provided the mechanism but the authorisation came from the common law. That is not altered even if the person acting was not aware of or did not believe they were utilising the common law at the time.

It is clear from the Draft Report that this aspect has not been understood (especially at pages 18 and 19).

The use of section 16 or a similar system is highly desirable for many reasons including documentation, consistency in decision making and authorisation/review at a higher level.

There is also the difficulty that very few people understand what "the common law" is let alone the extent of its principles as they may impact any particular situation. That leaves the use of "the common law" without some system most difficult. The Draft Report indicates that "the law is clear". On that I respectfully disagree. The law is often not "clear" but in relation to the common law relating to this area it is most unclear.

SECTION 16 AS A SOURCE OF POWER

The second role for the section is where section 16 is believed to actually empower restraint or detention rather than being solely reliant upon the common law. It is on this point that I differ from others that have provided legal advices.

There is a suggestion in the Draft Report that I suggested this could be utilised to treat people. However the only suggestion I have made in relation to its use is in relation to patients judged to be incompetent who would be endangered if they were permitted to leave. In other words the formulation of the power is no different than that for the common law in any event. As such it is a theoretical difference between others and myself only and not one with practical effect.

You will note that the summary on the first page of my advice is similar to the general proposition cited by many as deriving from the common law:

> *Patients that are NOT competent to make decisions as to their best interests may be restrained and detained if they pose a danger to themselves or others or if leaving the facility would put them in danger.*

THE COMMON LAW "CLEAR" or "NOT CLEAR"

It doesn't take a very close reading of Michael Grant's advice of 4 August 2004 (at which date, for the record, I was not employed by the Department) to understand that the law is not easy to interpret. Indeed, paragraph 20 (the last sentence of which reads: "*That is a product of the currently uncertain state of the law in this area*") and all that follows from there is about how to attempt to remedy the uncertainty of the law.

In paragraphs 14 to 18 Mr Grant deals with the common law cases from the House of Lords which provide a number of points of difference (*Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1; *R v Bournewood Community and Mental Health NHS Trust, Ex p L* [1999] 1 AC 458). He concludes at paragraph 18 with these words:

> *It may be that the Australian courts do come to adopt the formulation from the House of Lords. That might properly be seen to be the most just and effective approach.*

Unless it has been recently declared in the Courts the common law is often not at all easy to interpret. In relation to the issues involved with restraint and treatment of the mentally incompetent there have been few cases on point in Australia, and none for decades.

Simply, the law is not known at this point.

Two issues spring from that:

1. The law cannot be declared by a non-judicial body; and
2. It is impossible to determine any action that conforms with one or more possibilities of what the common law may well be to be "unlawful".

I note that you seek to declare the law in the Draft Report and allege certain actions to be unlawful.

To demonstrate the danger of that course I will provide below one of the major examples of what the common may well be (drawn from the cases that Mr Grant thought if adopted might be properly seen to be the most just and effective approach).

REQUIREMENT FOR EMERGENCY

There are cases in the Australian jurisdictions (as in other common law jurisdictions) that most definitely suggest a requirement for "emergency". That is particularly the case with decisions in criminal matters.

However, there is ample common law authority to suggest that emergency may not be a requirement particularly in cases dealing with patients who are not competent to make decisions as to their own welfare.

Lord Goff of Chieveley stated in the House of Lords decision *In Re F (1990) 2 AC* at 74 & 75:

> *We are concerned here with action taken to preserve the life, health or well-being of another who is unable to consent to it. Such action is sometimes said to be justified as arising from an emergency; in Prosser and Keeton on Torts, 5th edition, p. 117, the action is said to be privileged by the emergency. Doubtless, in the case of a person of sound mind, there will ordinarily have to be an emergency before such action taken without consent can be lawful; for otherwise there would be an opportunity to communicate with the assisted person and to seek his consent. But this is not always so; and indeed the historical origins of the principle of necessity do not point to emergency as such as providing the criterion of lawful intervention without consent. The old Roman doctrine of negotiorum gestio presupposed not so much an emergency as a prolonged absence of the dominus from home as justifying intervention by the gestor to administer his affairs. The most ancient group of cases in the common law, concerned with action taken by the master of a ship in distant parts in the interests of the shipowner, likewise found its origin in the difficulty of communication with the owner over a prolonged period of time - a difficulty overcome today by modern means of communication. In those cases, it was said that there had to be an emergency before the master could act as agent of necessity; though the emergency could well be of some duration. But when a person is rendered incapable of communication either permanently or over a considerable period of time (through illness or accident or mental disorder), it would be an unusual use of language to describe the case as one of "permanent emergency" - if indeed such a state of affairs can properly be said to exist. In truth, the relevance of an emergency is that it may give rise to a necessity to act in the interests of the assisted person, without first obtaining his consent. Emergency is however not the criterion or even a pre-requisite; it is simply a frequent origin of the necessity which impels intervention. The principle is one of necessity, not of emergency.*

That case was cited with seeming approval (albeit not directly on the points at issue here) by the High Court in *Marion's Case (Department of Health and Community Services v JWB and SMB [1992]* .175 CLR 218)

You may also note that in *Rogers v Whitaker* (1992) 175 CLR 479 (at 489 paragraph 14) the principle was described as "emergency or necessity" (my emphasis).

THE PAUCITY OF CASES

There are very few cases in the common law that deal with these issues in Australia. Indeed, until recently there have been very few that appear to have arisen anywhere in the common law world.

The first substantial case appears to be the House of Lords case *In Re F (1990) 2 AC 1* quoted from above. There have been other major cases in the United Kingdom since but none in Australia.

The lack of cases was commented upon by their Lordships:

Lord Bridge of Harwich stated at pp 51 & 52:

> *The issues canvassed in argument before your Lordships revealed the paucity of clearly defined principles in the common law which may be applied to determine the lawfulness of medical or surgical treatment given to a patient who for any reason, temporary or permanent, lacks the capacity to give or to communicate consent to that treatment.*

Lord Goff of Chieveley at p72:

> *The argument of counsel revealed the startling fact that there is no English authority on the question whether as a matter of common law (and if so in what circumstances) medical treatment can lawfully be given to a person who is disabled by mental incapacity from consenting to it.*

The foundations for that common law position was affirmed and widened by the House of Lords in 1998 in the case of *In re L (By His Next Friend GE) (1998)*. In that case Lord Goff of Chieveley stated:

> *The second point relates to the function of the common law doctrine of necessity in justifying actions which might otherwise be tortious, and so has the effect of providing a defence to actions in tort. The importance of this was, I believe, first revealed in the judgments in In re F. (Mental Patient: Sterilisation) [1990] 2 A.C. 1. I wish, however, to express my gratitude to counsel for the appellants, Mr. John Grace Q.C. and Mr. Andrew Grubb, for drawing to our attention three earlier cases in which the doctrine was invoked, viz. Rex v. Coate (1772) Lofft 73, especially at p. 75 per Lord*

> *Mansfield; Scott v. Wakem (1862) 3 F. and F. 328, 333, per Bramwell B.; and Symm v. Fraser (1863) 3 F. and F. 859, 883, per Cockburn C.J., all of which provide authority for the proposition that the common law permitted the detention of those who were a danger, or potential danger, to themselves or others, in so far as this was shown to be necessary. I must confess that I was unaware of these authorities though, now that they have been drawn to my attention, I am not surprised that they should exist. The concept of necessity has its role to play in all branches of our law of obligations-- in contract (see the cases on agency of necessity), in tort (see In re F. (Mental Patient: Sterilisation) [1990] 2 A.C. 1), and in restitution (see the sections on necessity in the standard books on the subject)--and in our criminal law. It is therefore a concept of great importance. It is perhaps surprising, however, that the significant role it has to play in the law of torts has come to be recognised at so late a stage in the development of our law.*

That case is also significant because it confirmed that the common law extended to restraint and detention of patients whereas *In re F* that had been a necessary inference.

In Marion's Case McHugh J quoted Lord Devlin in pointing out why there might not be a great deal of law on this issue:

> *"in the centuries when the common law was in the making, medical men were of little account in the community. The apothecary and the leech were not socially esteemed and medicine had still to become a learned profession."*

The leading judgement in the House of Lords was that of Lord Goff of Chieveley. I will not set it out in full (although I suggest that a reading of the case in full is well worth the effort). However the following portion provides an example:

> *The two examples I have given illustrate, in the one case, an emergency, and in the other, a permanent or semi-permanent state of affairs. Another example of the latter kind is that of a mentally disordered person who is disabled from giving consent. I can see no good reason why the principle of necessity should not be applicable in his case as it is in the case of the victim of a stroke. Furthermore, in the case of a mentally disordered person, as in the case of a stroke victim, the permanent state of affairs calls for a wider range of care than may be requisite in an emergency which arises from accidental injury. When the state of affairs is permanent, or semi-permanent, action properly taken to preserve the life, health or well-being of the assisted person may well transcend such measures as surgical operation or substantial medical treatment and may extend to include such humdrum matters as routine medical or dental treatment, even simple care such as dressing and undressing and putting to bed.*

The distinction I have drawn between cases of emergency, and cases where the state of affairs is (more or less) permanent, is relevant in another respect. We are here concerned with medical treatment, and I limit myself to cases of that kind.

Where, for example, a surgeon performs an operation without his consent on a patient temporarily rendered unconscious in an accident, he should do no more than is reasonably required, in the best interests of the patient, before he recovers consciousness. I can see no practical difficulty arising from this requirement, which derives from the fact that the patient is expected before long to regain consciousness and can then be consulted about longer term measures. The point has however arisen in a more acute form where a surgeon, in the course of an operation, discovers some other condition which, in his opinion, requires operative treatment for which he has not received the patient's consent. In what circumstances he should operate forthwith, and in what circumstances he should postpone the further treatment until he has received the patient's consent, is a difficult matter which has troubled the Canadian Courts (see Marshall v. Curry [1933] 3 D.L.R. 260, and Murray v. McMurchy [1949] 2 D.L.R. 442), but which it is not necessary for your Lordships to consider in the present case.

But where the state of affairs is permanent or semi- permanent, as may be so in the case of a mentally disordered person, there is no point in waiting to obtain the patient's consent. The need to care for him is obvious; and the doctor must then act in the best interests of his patient, just as if he had received his patient's consent so to do. Were this not so, much useful treatment and care could, in theory at least, be denied to the unfortunate. It follows that, on this point, I am unable to accept the view expressed by Neill L.J. in the Court of Appeal, that the treatment must be shown to have been necessary. Moreover, in such a case, as my noble and learned friend Lord Brandon of Oakbrook has pointed out, a doctor who has assumed responsibility for the care of a patient may not only be treated as having the patient's consent to act, but may also be under a duty so to act. I find myself to be respectfully in agreement with Lord Donaldson of Lymington M.R., when he said:

"I see nothing incongruous in doctors and others who have a caring responsibility being required, when acting in relation to an adult who is incompetent, to exercise a right of choice in exactly the same way as would the court or reasonable parents in relation to a child, making due allowance, of course, for the fact that the patient is not a child, and I am satisfied that that is what the law does in fact require."

In these circumstances, it is natural to treat the deemed authority and the duty as interrelated. But I feel bound to express my opinion that, in principle, the lawfulness of the doctor's action is, at least in its origin, to be found in the principle of necessity.

Probably the most relevant point from all of this is that all of the legal opinions are simply opinions of what the common law may be. They do not constitute a clear and known dissertation of what the law is.

OTHER PRESSURES ON THE LAW

There are a number of difficulties with the law as currently interpreted in the Northern Territory by lawyers generally:

1. A conflict with the criminal law:

   The *Criminal Code Act* provides a duty in these terms:

   > ***149 Duty of person in charge of child or others***
   >
   > *It is the duty of every person having charge of a child under the age of 16 years or 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 child or other person; and*
   >
   > ***(b) to use reasonable care and take reasonable precautions to avoid or prevent danger to the life, safety or health of the child or other person and to take all reasonable action to rescue such child or other person from such danger.*** *(emphasis added)*

2. Discrimination in medical care against those who are incompetent. One might suggest this to be even more of a concern in the NT than in England.

   In the reason for decision in *In re F (1990) 2 AC* the House of Lords stated per:

   Lord Jauncey of Tullichettle:

   > *My Lords, I should like only to reiterate the importance of not erecting such legal barriers against the provision of medical treatment for incompetents that they are deprived of treatment which competent persons could reasonably expect to receive in similar circumstances. The law must not convert incompetents into second class citizens for the purposes of health care.*

   Lord Griffiths

I agree that those charged with the care of the mentally incompetent are protected from any criminal or tortious action based on lack of consent. Whether one arrives at this conclusion by applying a principle of "necessity" as do Lord Goff of Chieveley and Lord Brandon of Oakbrook or by saying that it is in the public interest as did Neill L.J. in the Court of Appeal, appear to me to be inextricably interrelated conceptual justifications for the humane development of the common law. Why is it necessary that the mentally incompetent should be given treatment to which they lack the capacity to consent? The answer must surely be because it is in the public interest that it should be so.

In a civilised society the mentally incompetent must be provided with medical and nursing care and those who look after them must do their best for them.

3. The law would be in conflict with itself and most unfair if it puts the medical profession (and the hospital) in a position where they would be sued for breach of duty if they didn't treat a person (and possibly charged with an offence) and sued in trespass to the person if they did (excepting only if there was imminent danger/emergency as might be determined by lawyers after the event).

   Lord Bridge of Harwich *In re F (1990) 2 AC*

   It seems to me to be axiomatic that treatment which is necessary to preserve the life, health or well being of the patient may lawfully be given without consent. But if a rigid criterion of necessity were to be applied to determine what is and what is not lawful in the treatment of the unconscious and the incompetent, many of those unfortunate enough to be deprived of the capacity to make or communicate rational decisions by accident, illness or unsoundness of mind might be deprived of treatment which it would be entirely beneficial for them to receive.

   Moreover, it seems to me of first importance that the common law should be readily intelligible to and applicable by all those who undertake the care of persons lacking the capacity to consent to treatment. It would be intolerable for members of the medical, nursing and other professions devoted to the care of the sick that, in caring for those lacking the capacity to consent to treatment they should be put in the dilemma that, if they administer the treatment which they believe to be in the patient's best interests, acting with due skill and care, they run the risk of being held guilty of trespass to the person, but if they withhold that treatment, they may be in breach of a duty of care owed to the patient.

SPECIFIC OBJECTIONS

1. The state of the law is not certain and it is not the function of the Ombudsman to declare the law.
2. It is impossible given the lack of investigation (and also to some extent the uncertainty of the common law) to allege any act to be unlawful or contrary to law.
3. Where a quote is taken as grounds for an opinion it should not be taken out of context such that it is misleading and deceptive (of particular concern is the quote on page 8).
4. The conclusions set out in the Executive Summary are clearly wrong and I suggest more investigation before making such injurious allegations. In relation to the paragraph numbered 2 on page 11 you will note my comments above.
5. In relation to paragraph numbered 3 on page 12 you will note that on any interpretation it is incorrect.
6. The middle paragraph on page 21 misrepresents both the common law and the procedures under the Adult Guardianship Act.
7. The last paragraph on page 21 and 22 seems to misunderstand the words quoted. It is unremarkable in that the advice therein related is no different than every other advice ever provided. No legal officer including myself has ever indicated that s16 operated off the RDH campus or that people of sound mind should be restrained. To suggest that I had stated something different is incorrect.
8. At the foot of page 54 and on page 55 that paragraph is a misinterpretation of the advice given and you will note from a later advice that person was in agreement with my advice.
9. On page 62 I do not agree that the advice of Mr Grant had the effect of making my opinions untenable. Indeed, despite the difficulty in determining what the law is we are in broad agreement and in relation to the use of section 16 he is in agreement with the hospitals use of it as a mechanism for restraint (as opposed to the power to restrain).

Should you wish for more clarification or assistance do not hesitate to contact me.

Kelvin Currie

ANNEXURE 4

DR ASHBRIDGE's RESPONSE TO DRAFT REPORT

HDoc 2009/687

Northern Territory Government

DEPARTMENT OF HEALTH AND FAMILIES www.nt.gov.au

87 Mitchell Street Darwin NT 0801
Postal Address: PO Box 40596
CASUARINA NT 0811
Tel: 08 8999 2766
Fax: 08 8999 2800
email: david.ashbridge@nt.gov.au

Our Ref: DF2009/1615
Your Ref: D090100023

Ms Carolyn Richards
Ombudsman NT
GPO Box 1344
DARWIN NT 0801

Dear Ms Richards

RE: USE OF RESTRAINT AND DETENTION AT RDH

Introduction

I refer to your letter dated 9 April 2009 enclosing your draft interim report entitled "Investigation into unlawful use of restraint and detention at Royal Darwin Hospital (interim report)". Whilst I appreciate the opportunity to comment on the interim report, I must at the outset express my disappointment at the tone of the report, the unsafe conclusions it contains and the unfounded adverse comments made in regard to senior DHF staff, in particular Mr Beirne, Dr Notaras and Ms Evans.

Summary of objections to the report

In broad terms the Department's objections to this report can be summarised as follows:

- There has been insufficient consultation and time to respond, sufficient to amount to a lack of procedural fairness. A fuller investigation would have determined, for example, that an adult guardianship application was in train for patient X and had been for several months;
- The criticism of Peter Beirne is unjustified because the relevant conclusions are not based upon a full appreciation of the facts and are therefore unsound;
- The interim report contains prejudicial but irrelevant material (unrelated to the investigation) which indicates that conclusions drawn overall were likely based upon irrelevant considerations;
- Important conclusions drawn in the report are not supported by the evidence and are therefore unsound and unreasonable (including that competent persons have been detained and purported motives for utilising s.16 of the *Medical Services Act* (MSA));
- The report is unbalanced because there is no fair acknowledgement of the Department's concession in February 2009 as to the proper role of s.16 MSA

and the efforts made by the Department to resolve the issue by obtaining authoritative legal advice and implementing changes upon receipt of that advice; and

- In so far as the interim report purports to inquire into matters which are clinical judgments by medical officers as to the treatment of particular patients and not administrative actions it purports to make findings upon matters which are beyond the jurisdiction of the Ombudsman.

Lack of procedural fairness

The timeframe allowed for response, even acknowledging the 1½ day extension granted as a result of the need for RDH to implement its disaster plan from Thursday 16 April 2009, was insufficient in the circumstances. The draft interim report is a 130 page document containing detailed factual material and serious criticism of the Department and named staff. We have been allowed only 6 working days (including the extended period) to respond. In my view this amounts to a want of procedural fairness. In view of the seriousness of the matters raised in this letter I request that a further opportunity to consider the draft interim report be provided after consideration of this submission and before the report is finalised.

The insufficient response period is compounded by the numerous errors in the report. Whilst some errors appear to be the result of incomplete information, others are conclusions which are not supported by the available evidence. There is significant material which is irrelevant. As a result, many of the conclusions are unsound. This response points out, to the extent possible in the time available, matters which must be corrected. Attached to this letter is an annexure setting out requests for corrections. The detailed basis for some, but not all, of the required corrections are also addressed in this letter. The fact that a correction request appears only in either the letter or the annexure should not be taken as an indication that the correction is considered unimportant. The information contained in this letter is given in good faith on the basis of the best information I can collect in the time available. It contains substantial relevant new material which is not referred to in the draft report.

Interim report release

There is no serious public interest issue which would justify release of this incomplete and seriously flawed report. The RDH was relying upon a power in s.16 of the MSA to detain patients, which reliance has now been abandoned. The Ombudsman was told that this reliance was abandoned. The report does not set out the DHF/RDH position fairly and with balance. There is no credit given in the report for the DHF acknowledgment. The report is inflammatory and misleading because it gives the false impression that people are being detained at RDH against their will without legal authority when it is likely that a full investigation would establish that this is not, and never has been, the case.

Commitment to patient care

I again state that DHF's overriding consideration and commitment is to patient safety and quality of care. The RDH clinicians who provided care and treatment to the patients referred to in the interim report were informed by both their professional skills and ethics and their commitment to quality patient care, patient safety and well being.

I acknowledge that the draft report includes the statement

... These actions were taken by RDH with the best intentions, out of caring and compassionate motives and, after struggling for many years to manage and reduce the self destructive, resource wasting and heart breaking behaviour of a number of patients

Whilst this statement partially acknowledges the position of clinicians it does not fully recognise the immediate and individual aspect of providing patient care. Decisions of clinicians are made on the basis of the care that the particular patient needs at a particular time. These decisions must often be made and implemented immediately, with the life or long-term health of the patient at risk. I am very disappointed that the interim report shows no real appreciation of this fundamental issue.

In making the above comments I am not implying that legal autonomy of patients is less important or relevant and my statements must not be portrayed as such. A fair representation of existing DHF and RDH policies would acknowledge that, overwhelmingly, the patient's right to autonomy is recognised throughout those documents.

Jurisdiction

Whether a patient is competent and is in imminent danger or an emergency situation depends upon their clinical condition at a particular time. Patient's conditions vary, sometimes quickly. What is relevant is whether, at the time when the clinician is required to make the decision, the particular patient was competent to make his/her own decision and whether they were in imminent danger. This situation can and does vary over time. The approach taken to this issue in the interim report is simplistic. It does not suggest a full appreciation of the nature of clinical assessment and judgment.

Further, decisions as to whether a person is competent and whether their medical condition is such that they are in imminent danger are clinical medical decisions. A decision whether a person suffers from a mental illness or mental disturbance is also a clinical decision. Such decisions do not fall within the definition of administrative action because they do not relate to a matter of administration; they relate only to direct provision of medical care to a particular person. Findings and conclusions about clinical decisions concerning individual patients are beyond the jurisdiction of the Ombudsman.

Allegation of misleading statement as to implementation of policy based upon s.16 *Medical Services Act*

The draft report makes the very serious allegation that Peter Beirne has misled you in relation to the status of a policy at RDH concerning the use of a restraint power under s.16 of the *Medical Services Act*. This conclusion is not justified. The allegation is made repeatedly throughout the document at pages 13, 19-20, 82-83, 85, 126 and 130. I request that all of these references be removed.

It appears that you do not have the full facts concerning the status of the policy. The email from Jan Evans of 22 January 2008 was not where the issue ended. What happened was as follows:

- Ms Evans' email of 22 January 2009 was to various people including heads of departments within RDH, legal services and Ms Louise O'Riordan. As Quality and Safety officer at RDH, part of Ms O'Riordan's role is to develop and implement policies, including arranging for publishing of policies onto the intranet website;

- On 23 January 2009 at 9.03am Ms O'Riordan, emailed Ms Evans raising concerns with the policy attached to the 22 January email.
- At 23 January 2009 at 11.44am, after receipt of Ms O'Riordan's email, Ms Evans instructed Ms O'Riordan in the following terms
    - *There have been a couple of other changes recommended, so we'll hold off until I get a chance to make those changes. I'll get back to you all once they are finalised.*
- A copy of this instruction was also forwarded to heads of departments of RDH (although the second group was not completely identical to the original group, key personnel were included);
- A copy of the emails referred to is attached. The reference to the 'other changes' are to comments and requests made by recipients of the email of 22 January which are noted in the interim report at pages 55-57; and
- I am advised that Ms Evans never got back to Ms O'Riordan in relation to the policy and neither she nor Ms O'Riordan took further steps to publish or implement it.

Concerns were raised about the purported policy by Legal Services and Mr Peter Boyce, Senior Director People and Services, DHF on 22 January 2009. On Thursday 29 January 2009 I convened a meeting at which the status of the '22 January policy' was discussed and I directed that the policy was not to go forward and was not to be regarded as a Departmental or RDH policy.

In his letter of 19 February 2009 Mr Beirne advised you, in response to your question, that there was no current RDH or Department-wide policy as to the use of s.16 *MSA*. This was, and remains, true. I accept that you have found that one of the forms from the policy was used on a patient file. That does not prove that Mr Beirne was lying. He clearly would not have known whether a particular staff member had used the form and it would not be reasonable to expect him to know that. I do not dispute that the policy and forms had been in draft since, probably, some time in November 2008 and that Ms Evans said in her email of 22 January 2009 that the policy was finalised. However, as I have stated above, despite Ms Evans' first email the policy was not ultimately finalised and implemented either at the RDH or the Departmental level.

New policy

The Department has an existing network policy on Informed Patient Consent. This policy recognises the right of a patient to refuse treatment as the following extract shows:

> *4. Patients Resisting or Refusing Treatment*
> *Where it is clear that a competent adult patient is resisting or refusing a particular treatment or care, the treatment or care must not be given. This applies even if the patient's condition is expected to deteriorate without the treatment. A contemporaneous note must be made in the patient's medical record as to the refusal, and the explanation of its possible consequences as explained to the patient. The note in the medical record should be in dot point form.*

There was also an existing network policy entitled "Detaining patients against their will" however this policy did not adequately address non-competent patients and therefore the Acute Care Executive agreed that a policy should be developed to specifically cover the Treatment of Non-consenting patients.

The policy on "Providing medical treatment to adult patients without their consent" was first considered by the Acute Care Executive collectively in February 2009 with the intent that it was merged with the "Detaining patients against their will" policy. I can advise that the Acute Care Executive endorsed the policy out of session on 16 April 2009. A copy of the new policy is attached. Consideration is currently being given to consolidating similar policies.

I can confirm that it is the view of the Department that none of the existing or new network policies will utilise s.16 of the *Medical Services Act* as an authority for restraint or detention. A review of existing policies will be undertaken to ensure that this is the case.

Hospital Governance

The draft report makes broad and unfounded allegations concerning RDH management and in particular Dr Notaras and Ms Evans, including at pages 6, 8, 12, 17, 18, 21-22, 52-53, 62, 125 and 129-130 of the report. The comments on these pages are unfair and unfounded and must be removed. Fundamentally, the management of the conflicting advice concerning the power deriving from s.16 of the MSA does not indicate a failure in governance. What it indicates is a genuine attempt to manage a complex issue in the face of conflicting legal advice and the very real concerns of clinicians for the welfare of patients.

I am aware that Dr Notaras and Ms Evans are preparing separate responses. No doubt those responses will deal in detail with the points concerning them. However, it is important to note that since the appointment of Dr Notaras in mid-2007 as General Manager of RDH he has, with Ms Evans' assistance, made significant progress in improving governance of that institution. You refer at page 12, numbered point 6 (repeated at page 129-130) to page 14 of the ACHS report of 23 February 2009. The implication of your paragraph is that page 14 recommends a particular governance structure for RDH. Reading page 14 of the ACHS report it is clear that this is not the case. The section of the ACHS report referred to is a general section about methodology and conceptual models.

The attempt in the draft report to link the current limited issue to the complex matter of governance at RDH is inappropriate. The reference to the ACHS report is misleading. Perusal of that report indicates the complex nature of the issue. The comments at page 23 of the ACHS report give some indication of what is involved and the difficulties faced by RDH executives, amongst others. On that page the authors of the report also said

> We note that RDH is not standing still, and range of people we interviewed recognised the scope of the work needed to improve. There was evidence that the essential structures and personnel were in place or were about to be.

The report went on to note that there is further work to be done. RDH and the Department are working to implement those recommendations of the review which have been accepted by Government. Some issues, notably those which require legislative change, are policy matters for Government and are, therefore, not properly the subject of any administrative review, including by the Ombudsman.

Adult Guardianship

The interim report has been drafted of the basis of and contains repeated statements and conclusions drawn from the information obtained from the Chief Magistrate and quoted at page 7, 11, 14, 21 and 128. Whilst the accuracy of the information is not challenged, it does not reflect the real time frames involved in preparing an adult guardianship application, either a temporary or a full order. Therefore the impression given in the interim report is misleading.

An application for a guardianship order can only be made to the Court after a request has been provided to the Executive Officer of Adult Guardianship, a Guardianship Panel has been established, relevant information (including all relevant expert reports) is gathered and the Guardianship Panel has prepared advice and recommendations for the Court. At present an application can take from three months to substantially longer to process, depending on how soon the Guardianship Panel receive the reports required - eg, medical, carer's, other allied health reports such as Aged Care Assessment Team (ACAT). If it is deemed a psychological assessment is needed, then that can take a few months more, due to the psychologist's workload. Many applications in relation to persons who are Aboriginal and Torres Strait Islander (ATSI) can take longer due to difficulties in tracing relevant family members who live in remote communities.

A temporary order under the Act requires less documentation; however there must still be evidence of intellectual disability and the need for guardianship. This evidence needs to be provided by a current doctor, the person's carer and/or family or social worker to the Executive Officer of Adult Guardianship who then prepares a report for the Court. At present, from the time of the request in urgent at risk situations (including the gathering all the required evidence) the Executive Officer of Adult Guardianship is usually able to have an urgent matter listed within a week.

Further, it is highly questionable whether the use of the adult guardianship provisions will often meet the needs of the type of patients who have been detained under common law or, previously, in reliance upon s.16 of the *Medical Services Act.* In cases where patients have been detained in an emergency or to prevent danger the decision needs to be made immediately to, for example, prevent the patient leaving the Emergency Department (ED). The incident reports and material included in the interim report show that calls were made to the medical superintendent in late evening and early hours of the morning. The fluidity of patient conditions frequently does not allow for applications to be made to the Court. It is relevant to note that in two cases included at the rear of the interim report the patient appears to have been hospitalised for a very short period of time and, in the case of patient D, the admission was to ED only.

It is also relevant to note that under the *Adult Guardianship Act,* major medical treatment can only be authorised by the Court. This requires a full guardianship order to be in place, and cannot be granted on a temporary order. As previously advised recent intensive work has been done by the Department to put options to Government for a review of the adult guardianship laws of the Territory. The matters under consideration include informal substitute decision making legislation and legislation to protect medical professionals who rely upon statutory consents.

Patient X

I firstly note that it would appear that patient X referred to in the Introduction, Executive Summary, is also referred to as Patient F in the investigation component of the interim

report. The use of two identifiers in relation to the same patient is misleading as it gives the impression that there were more patients reviewed than was actually the case.

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 X (who is also patient F). The interim report's statement that no adult guardianship application had been commenced for patient X is untrue. I am advised that the social work department of RDH completed an application for adult guardianship for patient X 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 neuropsychologist 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 11 March 2009. Panel meetings for adult guardianship matters 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 X's parents are appointed as his guardians. I have been told that during the process patient X's parents have been involved in decisions concerning his care. Your report and conclusions fail to refer to or consider this important aspect. Patient X has now been discharged and is living with his parents. This is a small jurisdiction and it is likely that this family will recognise that their son's case is the subject of the report and that his notes are included, despite de-identification. I understand that the family have not been consulted by your office. I am advised that it is the view of the senior medical staff at RDH that hospital treatment for this young man was a key factor in his survival and recovery. On the basis of what I have been told by medical staff, I would be surprised if he or his family felt differently.

I am concerned about the inclusion of the patient notes (even de-identified) in the report. In my view, such patients are entitled to be contacted and at least made aware that the investigator was accessing their records and why. If any patient notes are to be included, or referred to, in the report I request that, at least, the full details of the cases be investigated and accurately recorded. A person without medical training looking at the notes alone is not a sufficient investigation. It is necessary to speak with the patient (if possible), the family and the medical staff involved in providing the care to get the full story.

Request for amendments to do with adult guardianship

In view of the information set out above we request the following changes to the interim report in regard to adult guardianship:

- That the additional information in regard to time frames taking into account the need to receive, process and collate evidence for the Court on an application be added after the last paragraph dealing with this issue on page 7.
- Remove from page 11, numbered paragraph 1 the words "for expediency, and to avoid the process available under the *Adult Guardianship Act.*" This conclusion is absolutely rejected because it is erroneous. It is not available on

the balance of probabilities on the material gathered during the investigation. The Adult Guardianship process as set out above takes time and is frequently not applicable to a clinical situation. In addition, there is no evidence in the report as to the motives of any person, apart from the desire to support patient X in his treatment and recovery. The conclusion, stated in this form, is entirely conjecture and is unfair because it impugns the motivations of hospital staff in the absence of any evidence from which such an inference could properly be drawn.

- Page 21: remove the last sentence of the second paragraph. The statement that 'patient X has been trying to leave the hospital since January 2009' is a misleading generalisation which does not fairly represent the evidence. The evidence shows that on certain occasions the patient requested to leave the hospital. It also suggests that on other occasions he was happy to stay. There is also evidence that the patient's family wished him to stay and that there was an adult guardianship application in train. All reference to there being no adult guardianship application must also be removed or altered;
- Page 128, numbered paragraph 1: remove the words "for expediency and to avoid the process available under the Adult Guardianship Act, as set out above". As stated this is unfounded conjecture, and the investigation has not gathered any information to support it. Further the additional information provided in regard to time frames makes it clear this statement is not accurate.

Irrelevant Material

The interim report contains in the investigation section (from pages 23 to124) a large amount of material not directly relevant to the matter stated, at page 11 paragraph 2, to be the subject of the investigation; namely 'the practice within RDH of restraining and/or detaining persons relying on the purported effect of section 16(3) of the *Medical Services Act*.' In light of the very limited time frame I will only direct your attention to the most obvious material.

The interim report itself, at page 35, states the absconding of a 5 year old patient is not related to the complaints about the use of section 16 however still includes 4 or so pages of information in regard to the issue. The justification, at page 35 paragraph 2, is that this material is that it is 'intertwined' with information in regard to s.16 MSA. The material is not so intertwined that it could not be easily removed. In any event, however, this justification is inappropriate. The material is clearly more prejudicial than probative and has the effect of influencing the reader as to the general competence of the Department and RDH. The inclusion of this material therefore taints the report and leads inexorably to the conclusion that the decisions made (findings and conclusions) have been based upon irrelevant considerations. The reference to unfavourable findings in other reports (pages 34-35) is similarly objectionable.

Further, the inclusion of this material is another example of lack of procedural fairness. Not only has the Department not had an opportunity to be heard on the matter, but conclusions appear to have been drawn without proper investigation. If an investigation is to be conducted into the absence of a child then a proper process should be followed in that regard. I request that all irrelevant material related to the absence of children be removed from the report including at pages 28, 32, 33, 34 and 35.

Secondly, the fact that section 16 MSA was utilised and called 'sectioning', up until about 9 February 2009 has been conceded by DHF in the letter of 19 February 2009. The Department has never attempted to deny this. Therefore, all of the material which establishes the admitted facts, including all email correspondence on the issue and all patient records except those relating to allegations of use of s.16 MSA after 9 February

2009 are also strictly irrelevant and should be removed. These add nothing to the report and give the misleading impression that the facts repeated are contentious, when in fact they are admitted.

Alternatively, at least, the interim report should clearly and fairly acknowledge that the facts have been admitted and that the Department has changed its position about reliance upon s.16 MSA. This would be a fairer representation of the true situation. The report in its current format is highly misleading; it gives the impression that the Department and RDH have failed to make admissions and have continued to rely upon s.16 MSA when that is not the case. This is an example of lack of balance in the presentation of the report.

Previous legal advice

I again restate that clinical staff applied section 16 MSA in good faith. The general portrayal in the report of the tensions within RDH around the use of s16 MSA to deal with an ongoing complex and often daily issue is unfair, and does not reflect the genuine endeavours by clinical staff, RDH management, and legal advisers to arrive at both a practical and legally correct solution.

In particular, not including Mr Kelvin Currie's advice dated 24 November 2008 in the sequence of advices and exchanges from page 36 to 58, creates a misleading impression that RDH were acting without legal advice contrary to advice received from Acting Director Legal Services on 20 October 2008. The reality was that there was a tension between advice that the section did not cover the situation and Mr Currie's advice that it did. It is not unreasonable that time was needed to resolve this. In fact, the Department did resolve it by seeking advice first from the Solicitor for the Northern Territory and, ultimately, from the Solicitor-General. The Solicitor-General's advice was immediately accepted.

Whilst the Department had earlier advices dealing with restraint and detention generally, it was not until 2008 that formal advice was requested on the application of s16 MSA to the issue. The advices set out in tables at p.79-80 (dating from 2000 to before 2008) do not include any reference to s.16 MSA because legal advisers had not been asked to consider it as a possible ground for restraining a patient at risk at that time. It is quite misleading to say, as the interim report does at p.54, that had s.16.MSA applied Mr Grant would have advised accordingly in 2004 when the question had not been asked of him, or the others who advised prior to 2008. There is in my view no basis to characterise the Department's response as 'contrary to its own legal advice' on this issue as that implies that there was only one stream of advice and it was deliberately ignored. That is not a fair representation of what happened.

Comments stating that the Department has acted to ignore legal advice must be removed from the report. They appear at pages 6, 52, 54 and 62. At page 53 and 62 I point out that at the time that the advice of 2004 was received Ms Evans was not Deputy General Manager of the Hospital but held another position in the Department, outside RDH. Further, as noted above, previous advices did not consider whether s.16 MSA applied.

Regarding the comments at p.69 of the interim report; Ms Sievers' letter led to a clear conflict between her advice and that of Mr Currie. In accordance with good practice the matter was referred to the Solicitor-General who gave his advice on 12 February 2009. In my opinion it was not unreasonable for RDH management to resolve not to take any action to change the approach based upon Mr Currie's advice pending receipt of advice from the Solicitor-General. It is also relevant to note here that the fact that a

concession has been made concerning reliance upon s.16 MSA does not mean that the same action was not lawful based upon other grounds, namely common law.

Allegations that patient detained in reliance upon s.16 MSA after 9 February 2009.

Since my undertaking and the Solicitor-General's advice that s.16 MSA did not provide legal justification for detaining patients, RDH has ceased reliance upon that section where a patient needs to be detained for their own safety. Of course, the situations which give rise to the need to take such steps have not ceased to occur. Therefore, DHF has implemented a policy in reliance upon common law principles of emergency and necessity. As you know these principles were always referred to in the RDH ED policies.

Before 9 February 2009, for patients who were in imminent danger, and lacked the capacity to appreciate their situation or were disoriented in time, place or person RDH clinicians have sought to detain these patients in RDH where this was necessary to ensure their safety. The process was that a request was made by clinicians attending the patient to the Director of Medical Services who discussed the case with clinicians and determined whether the conditions were met whereby the patients should be detained for observation or treatment until their mental capacity improved or imminent risk of serious harm was reduced. Legal advice to clinical staff from Mr Currie was that s.16 MSA provided the legal authority to support clinicians in providing medical treatment in this situation.

The Ombudsman's staff reviewed the medical records of nine patients seen at RDH between November 2008 and February 2009. Note that at page 9 of the draft report there is a reference to 10 cases however RDH is only aware of 9 and 6 are actually referred to in the report. Based upon a review of the 6 cases referred to, the report states that RDH has continued to utilise Section 16 after February 9th, 2009 when I gave an undertaking it would no longer be used. I believe this conclusion to be wrong.

The Director of Medical Services (DMS) at RDH has reviewed the medical records in the nine patient files. The results are shown in the table below:

HRN	Date detained	Comment
	20-Feb-09	Originally detained under section 16. Adult Guardianship application made. Detained under Common Law on Feb 20 pending guardianship application
	01-Feb-09	Detained under Section 16
	13-Jan-09	Detained under Section 16
	12-Jan-09	ED attendance only. Assaulted, intoxicated, head injury. Detained for six hours.
	27-Dec-08	Detained under Section 16
	01-Dec-08	Detained under Section 16
	24-Nov-08	Detained under Section 16
	17-Nov-08	ED attendance only. Head injury following skull fracture 4 weeks earlier.
	01-Nov-08	Detained under Section 16

In none of these cases was Section 16 reliance initiated after 9 February, 2009. In the case of the patient X/F ( ), detained after 9 February on common law grounds of necessity, an application for adult guardianship was completed as set out above, on 17 November 2008. I am advised that it is clear from the medical notes that on 20 February 2009 when the patient was discussed with the DMS he still lacked

competency. The more recent assessment of the Guardianship Panel (16 April 2009) would appear to support this view.

I note that the entries in patient X/F's notes of 15 and 19 February 2009 refer to him being 'medically sectioned'. However I do not believe that this means that a decision to detain him under s.16 of the MSA was made after 9 February 2009. Without interviewing the person who wrote the notes it is difficult to say exactly why the entries were written in the way they were. However, it seems likely to simply be a reference to the previous decision and I note in that regard that the language used is consistent from note to note until the matter was brought to the attention of the Director Medical Services on 20 February 2009 who made it clear that actions were to be based upon common law grounds.

I do not accept the finding that the undertaking I gave that no person would be detained based upon s.16 MSA has been breached. In particular, Patient X's case does not evidence a breach of the undertaking. I therefore ask that all such references be removed from the report on the ground that there is no evidence upon which the finding could reasonably be made. For example, the comments at pages 6 & 7 of the interim report are inaccurate and the conclusion is inconsistent with the notes for patient X/F at pages 115 -116 which reflect not that he was detained in reliance upon s16 MSA but at common law as RDH and the Department have said was the case.

In addition, the final two sentences of the first paragraph of page 21 must be removed. The view expressed there is purely conjecture and is not supported by the evidence. To the contrary, the reference immediately above to 'oral' diazepam indicates that there was no holding down and injecting, instead the patient took an oral medication, presumably swallowing it himself. The conjecture is therefore misleading.

No complaints received

The criticism of the response to question 19 at page 86 of the draft report unfairly misconstrues what was intended by the Department in Mr Beirne's letter of 19 February 2009. It is clear that, on its plain terms, the question asked about 'complaints' made (only) to DHF or RDH. Any reasonable interpretation of that question would conclude that it referred to formal complaints made (whether orally or in writing) through usual channels, for example the patient advocate at RDH, the Minister's office, DHF Legal Services etc. I am advised that no such complaint has been received. To refer to the protestations of a person presenting as part of their condition as a 'complaint' is to adopt an unreasonable interpretation of the word and the question and therefore conclusions and criticisms drawn on that basis are unfair. The comments at p.86 in this regard should be removed.

Further, the statement at p.86 that Patient F/X has 'complained persistently' is a misleading overstatement. The notes attached to the report are at least as likely to show that this patient complained intermittently. See for example entry 15/2/09 'more congenial since admission to the ward'. There are also further statements that he did not attempt to leave after 19 February 2009. There is therefore, at the very least, insufficient evidence to find on the balance of probabilities that the patient complained 'persistently'. The report gives the misleading impression that the patient was constantly asking to leave and attempting to do so. I do not accept this as a fair statement of the evidence presented.

In relation to patient E I am advised that a discussion was held with the Executive Officer Adult Guardianship about applying for a temporary order under the Act for this patient. I am also advised that the reason that this was not proceeded with is that E's situation later improved to the point where he was able to make decisions for himself and an adult guardianship order was not necessary.

MHRSA - Patient A

Patient A's details are included twice, between pages 88 – 94 and again at 95-106. This doubling-up of material may mislead the reader into forming the view that there were two different patients.

The material included twice covers two admissions one in April 2008 and another much longer admission in late Sept/Oct/Nov 2008. The patient's condition and hospital response was very fluid during the later admission. Due to the limited time frame in which to respond to the interim report only the later admission has been reviewed by an appropriately qualified psychiatrist, who has found that there is no evidence in the medical records that Royal Darwin Hospital staff have misused the powers of the MHRSA. The psychiatrist was only able to review RDH clinical files volumes 3 and 4 because volumes 1 and 2 were in storage and not available. The CCIS electronic record was reviewed. The issue raised regarding the use of mechanical restraint for patient A has not been able to be investigated in the time allowed. A further period is required to investigate and respond to these issues.

Further, in regard to the April admission for patient A the numerous adverse comments made in regard to clinical decisions by treating medical staff by the Ombudsman's investigator are well beyond her qualifications (see for example pages 92 & 93) and the jurisdiction of the Ombudsman to comment on clinical decisions and must be deleted.

MHRSA generally

The finding that RDH staff have misapplied or abused the powers under the MHRSA is repeated throughout the interim report at pages 8, 12, 18 and 129. The report sets out no clear evidence for this except the Ombudsman's investigator's interpretation of patient A's records. As far as I am aware the Ombudsman's investigation has not included a medical practitioner (who should be a psychiatrist) to assist with reviewing the material.

As set out above, the very adverse conclusions drawn, like many others in the interim report, are not available on the evidence. The attempt to rely upon an interpretation of one email from an ED consultant, which seems more likely to simply set out his frustration at the security service, is unsafe. It is not possible to properly understand what was meant by this email without interviewing the doctor concerned. Given the seriousness of the allegation this is a fatal flaw in this aspect of the investigation, and a denial of natural justice.

Recommendations

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. 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.
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.

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.
5. Recommendations 5.2 and 5.3 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. 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. 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. See response to recommendation 7.
9. The recommendation is outside the scope of the inquiry and is not relevant to the matters dealt with in the interim report.

Conclusion

In closing, I feel I must express the grave concern I have for the conduct of this investigation; the massive resources devoted by your office and, necessarily, this Department; the defamatory personal attacks upon named employees attributing bad faith, malice and dishonesty; the large number of conclusions which are not supported by the evidence; and the general 'tone' of the document.

Notwithstanding the length of the draft interim report, and this response, I believe that the issue is really a very simple one, and the essential facts are quite clear:

1. For some years, the authority for medical professionals to detain patients who, in their professional opinion, would be at serious risk of injury or death if allowed to leave the hospital has been unclear.

2. An application to a court for an adult guardianship order provides no answer in circumstances where an immediate decision is required at the hospital.

3. Various legal advices were received, from time to time, in relation to associated or peripheral issues.

4. A legal opinion was at one point (in writing in late 2008 but orally probably at an earlier undetermined time) provided that s16 MSA gave authority to detain patients in appropriate circumstances.

5. That advice was later superseded by an advice of the Solicitor-General, which was accepted by all to be authoritative. It concluded that s16 MSA was insufficient to support the necessary authority, but that the common law provides (and always provided) authority in particular circumstances.

6. For a period between late 2008 and February 2009 there was some understandable confusion at RDH about whether s16 MSA supported their actions or whether the common law provided the authority.

7. Every medical practitioner, at all times, acted in good faith and was motivated solely to protect their patients from risk of serious injury or death.

It seems to me that, essentially, this investigation has established nothing more than a previous period of confusion among medical practitioners at RDH about subtle legal issues, in circumstances where there was conflicting legal advice and where many of the actions taken appear justifiable on common law grounds. It is notable that there has been no formal complaint and no evidence that any person has been objectively harmed. Further, it has been established that, the issue has been resolved and RDH and DHF have taken steps to ensure that staff are aware that they cannot rely upon s.16 MSA to detain patients; a new policy has been approved and implemented in reliance upon accepted legal principles.

I will not further repeat the matters which I stated at the beginning of this long letter. I have set out to demonstrate to you that the interim report should not be released, certainly not in its current form. At the very least, it would seem that the investigation is incomplete and therefore release of a report is premature. There are other problems with the report which are explained in some detail. I urge you to reconsider your approach to this matter and to decide either not to publish or to re-write the report. If the second option is taken it is clear that it will be necessary to conduct further enquiries.

I ask that a copy of any re-written draft report be provided to the Department, and any other named persons, with a proper opportunity to comment, before it is published.

Yours sincerely,

David Ashbridge

21 April 2009

Annexure A

Requested Amendments to the Interim Report

Introduction

Title of the report 'Investigation into the Unlawful Use of Restraint and Detention at Royal Darwin Hospital'

The title is objectionable and inappropriate because it presupposes the conclusion of the investigation.

Note from the information at p.11 that the own motion investigation was commenced in December 2008 but DHF was not notified of the investigation until 20 January 2009.

Page 6

Delete the words '*detaining and treating people contrary to law and in breach of basic human rights of patients*' and replace it with "and examines the system in place to detain for treatment patients not competent to give informed consent".

The current phrase is a broad statement in the introduction to the interim report that prejudges the issues and which is not supported by the evidence. It is misleading in that it implies, contrary to the evidence (including as contained in DHF policies and as a result of recent actions), that RDH and the Department generally has no cognizance of human rights of patients, when there is no evidence of this, and indeed the evidence is to the contrary.

Delete the words '*RDH management ignored the objections of its own security officers and its own legal advice and instituted a policy of taking the law into its own hands contrary to the Rule of Law*'.

This statement is neither a fair nor accurate representation of the true position. RDH management did not ignore the objections of security officers. To the contrary, the objections of security officers were one of the reasons that the formal legal advice was obtained from Mr Currie. RDH management were entitled to rely upon this advice. Reliance upon the advice does not disclose maladministration.

Delete the word '*autocratic*'. Its use is unjustified and pejorative. Synonyms include tyrannical repressive and despotic; all carry overtones of intent to injure and putting interests of 'rulers' before that of individuals. The evidence does not support that the RDH acted with anything other than the best interests of patients involved.

Delete the words '*officers of the Office of the Ombudsman found, in the notes of a patient's record that the breaches occurred again at least on 16 February and 19 February...*'. and review the whole last paragraph on page 6 as it relates to patient X/F.

This comment should be removed in light of the additional material provide in relation to patient X/F. When the full story of this patient's care is known it is by no means clear that there were 'breaches' as alleged in the report. The whole picture is considerably more complicated. As mentioned above Patient X/F was kept in hospital because his parents and medical advisers formed the view that that was in his best interests. An adult guardianship application was in train. The evidence is not that Patient X was consistently demanding to go home; it is equally likely that this behaviour occurred only occasionally according to the notes provided. Further investigation would be required to determine anything in addition, and therefore any conclusions contained in the report based upon the analysis of Patient X's notes alone are unsafe. The investigation is only partially complete.

Page 7

Delete the words 'RDH have not applied for any legal authority to contain patient X although he has been trying to leave for several months since January.'

All actions taken in relation to patient X were taken in consultation with his parents. As is set out above an Adult Guardianship application was commenced in November 2008.

What this case does demonstrate is the need for informal substitute decision making legislation as exists in other jurisdictions. Such legislation is already under active consideration by DHF.

Delete the words Legal safeguards established by law in the Adult Guardianship Act have been evaded by RDH management and clinicians

This statement is objectionable and should be removed for the reasons stated in the body of the letter.

Delete the words *there was no imminent risk*

As set out above the risk to patient X/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.

Page 8

Delete the words 'I have received no explanation from RDH or DHF as to why no application has been made to the Court for the patient (X) and the rest of this paragraph.

Information has been provided in the body of the letter of the November 2008 application for Adult Guardianship for this patient.

Delete the words *The overall management of this issue can only be described as inept and incompetent.*. and the rest of the paragraph.

There is no basis for the amalgam of conclusions in this paragraph. It misrepresents the situation as it unfolded at RDH, and role of RDH management, clinicians and particularly the Emergency Department. The paragraph contains broad sweeping statements which do not reflect the facts.

There is insufficient evidence to draw the very damaging conclusion that the ED clinicians were using mental health sections inappropriately. Such a conclusion should not be drawn lightly give its potentially very serious consequences for the staff involved and given that there has not been a full investigation.

The email statement quoted at page 8 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.

Further, all the material after '*Thereafter a policy was promulgated.*' needs to be amended in light of the extensive additional material provided regarding the email by Jan Evans on 22 January 2009. For example, the statement that a policy was published on the intranet for all RDH staff is simply wrong.

Page 9

Correct the number of patient files read by the investigator, our information is that only 9 files were accessed. Note that the details of only 6 patients have been included in the interim report.

The information in the paragraph on page 9 is inaccurate in light of the additional information provided in regard to the Adult Guardianship application made on behalf of patient X/F.

Delete the material in regard to Patient E. in light of the material set out in the body of the letter.

Executive Summary

Page 11

Delete the words 'The policy endorsed by the RDH...etc as this is not accurate for the reason set out in the body of the letter.

Delete the words ' *for expediency and to avoid the processes under the Adult Guardianship Act'* for the reason set out in the body of the letter.

Delete the words *RDH provided incorrect information.* The information provided at the time was given by RDH management in good faith based upon the advice of Mr Currie.

Page 12

Delete the words RDH did not always inform NT Police that a person was to be returned to the RDH when no lawful authority entitled NT Police to detain a person.

This sentence is also repeated at page 129 and should also be deleted there.

The sentence is poorly written and its meaning is not clear. The imputation is not available on any of the information contained in the investigation. RDH clinical staff as set out above acted on legal advice which supported the use of s 16 MSA until a definitive advice was received from the Solicitor-General. RDH staff would not have been of the view that there was no lawful authority. Further, the broader powers of police to become involved with patients is not within the scope of this investigation.

Delete the words *'Some RDH medical practitioners appear to have misused the MHRSA'*

The only evidence of this is in an email which appears to have been misunderstood by the Ombudsman. In the absence of proper investigation such a damaging comment is both unfair (there has been no natural justice on this issue so far as the practitioner is are concerned) and unsafe.

Governance – point 6

The statements as to governance can only have substance if the basis upon which the central allegations are made are sound. That is not the case here.

Page 13

Delete all of point 7, the adverse comments in regard to Mr P Beirne for the reasons set out in the body of the letter.

Background

Page 18

Delete the words '*but instances where the Mental Health Act appeared to have been misapplied or its powers abused'*

Delete paragraph 3, DHF do not agree that the patients whose medical notes have been reviewed were competent. It appears more likely that they were not competent at the relevant time. Further, as set out in the body of the letter neither the Ombudsman's investigator nor Ombudsman have skills or jurisdiction to assess or question the clinical decision made in regard either to competence or to the imminent risk of danger to a patient made by clinical staff.

Page 19

Delete words ' *was lacking in candour, made statements that had only scant connection with the facts contained in RDH's own records....* For the reasons in the body of the letter, and above.

Delete the material at page 19 and 20 dealing with the policy sent out on 22 January 2009 by Jan Evans for the reasons in the body of the letter.

Page 21

Delete all references and inaccurate conclusions made in relation to patient X in line with the material set out in the body of the letter.

Delete the words '*RDH chose to ignore the very clear advice from its independent advisers over several years'* in line with material provided in the body of the letter.

Investigation

Page 28 - 35

Delete all references to patients who are children and comments and conclusions in regard to these patients for the reasons given in the body of the letter.

Page 52

Delete the final paragraph which sets out an inaccurate conclusion in regard to legal advices etc provided to RDH/DHF.

Page 54

Delete the words ' In *2008, however, RDH ignored the guideline which stated.....'*

As set on in the body of the letter, DHF do not agree that the conclusions stated in the report in regard to Mr Grant's 2004 advice and s 16 MSA is open on a fair interpretation of the evidence.

Mr Grant QC is now Solicitor-General not Solicitor for the Northern territory.

Page 62

Delete the words *"DHF and specifically Jan Evans had received the same advice from Mr Grant QC and Ms Sievers as early as 2004"*

This, as set out in the body of the letter, is inaccurate and misleading, only general advice was received by DHF, none of the opinions until late 2008 stated s16 MSA

could no be used. Ms Evans was not in her current role in 2004 and was not involved with the management of RDH at that time.

Note also that Mr Currie was not employed by DHF in 2004.

Page 63

Delete the final paragraph including all references to Patient X.

Ombudsman's comments in regard to DHF response 19 Feb 2009

Page 71

DHF does not accept the comment in relation to failure of the management team. It is clear management team doing their best to clarify issues, seeking legal advice drafting policies etc. The attempt to draw a link between this and other governance issues relating to other reports is an example of bias.

Page 71 - Delete paragraph 2, the findings and conclusions which it contains are unsustainable on a fair reading of the evidence.

Page 73

Delete the sentence '*The subsequent compiling of section 16(2) and (3) instruments under the Medical Services Act and endorsed by the RDH executive reinforces that view*' .. for the reasons in the body of the letter.

Page 76

Delete words ' *It is laudable that DHF respects a patient's rights to confidentiality. This highlights, however, the lack of regard for other important rights of liberty of movement and choice about treatment*"

The Ombudsman's comments are unacceptable, unprofessional and flippant. The tension, on a daily basis, for dedicated health care professionals as to their duty of care to provide quality treatment ensuring patient safety and patient autonomy is not a matter medical officers or DHF take lightly.

Page 77

At all times the Director Medical Services and Education was acting at the direction (in the employment sense) of the person in charge of the hospital.

Delete the reference to patient having '*mental capacity to decide if they wanted to continue with treatment or leave the hospital'*

This conclusion is not available on the evidence in the report, and in any event is outside the capacity of the Ombudsman's investigator to comment on and in any event presumes to enquire into a clinical decision which is outside the jurisdiction of the Ombudsman.

Page 79

Delete the words, *"I consider the response 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'.*

This conclusion and the information it is based on are unsustainable as set out in the body of the letter.

Ombudsman Overall Comment on Preliminary Investigation

Page 124

Delete the first paragraph which commences '*..the DHF of the letter 19th February 2009 contains contradictory information to that of the actions taken by RDH.*'

This statement must be removed as it is untrue and contrary to the evidence provided. It is based on two issues, whether there have been complaints by patients and the status of the s16 MSA policy of 22 January 2009. Both of these issues on which this statement are founded have been clarified in the body of this letter and are inaccurately presented in this paragraph.

Delete the second paragraph as it is poorly written and difficult to understand. It appears to confuse the issue of competent and incompetent patients. As set out repeatedly in the body of the letter the issue of detaining/restraining patients to treat them only arises for patients who are not competent.

Page 125

Delete paragraph 2 which alleges management's failure to support staff etc. particularly the last two sentences.

Contrary to the statements in this paragraph what the email exchanges and development of policies and ongoing open exchange show are management and clinical staff seeking to find a solution to a complex problem, while continuing to provide quality care and ensure the safety and well being of patients.

The last sentence which continues over to 126 , delete the words ' *endorsed by the executive in January 2009*' and replace with 'forwarded to a limited number of DHF staff on January 2009'. This is in line with the extensive information provided on this issue in the body of the letter.

Page 127

Delete the final two paragraphs and onto 128,

Characterising persuading as detention: it is not appropriate to uniformly characterise the persuading of patients to return to the ward to undertake treatment as necessarily involving restraint. It is expected of staff, that they use all reasonable means available including interpreters, family member their own powers of persuasion. Whether a particular patient was restrained or was in fact persuaded to consent is a factual question which cannot be resolved on the state of this evidence.

The issue of the inappropriateness of the Ombudsman commenting and making findings on whether particular patients were competent/incompetent or in imminent danger has been discussed in the body of the report. These were clinical decisions.

Page 128

The comments in regard to scepticism regarding accuracy and comprehensiveness of RDH medical notes, should be withdrawn as they are a clear example of bias and prejudging of the matter under investigation.

Numbered point 1 at the bottom of the page remove the words "*for expediency and to avoid the process available under the Adult Guardianship Act*", as set out above this is unfounded conjecture, and the investigation has not gathered any information to support it. Further the additional information provided in regard to time frames makes it clear this statement is not accurate.

Page 129

Numbered point 4 delete the last sentence which reads *'RDH did not always inform NT Police that a person was to be returned to the RDH when no lawful authority entitled*

Police to detain a person". The sentence is poorly written and its meaning is not clear. The conclusion is not available on any of the information contained in the investigation. RDH clinical staff, as set out above, acted on legal advice which supported the use of s 16 MSA until a definitive advice was received from the Solicitor-General. RDH staff and management would not have been of the view that there was no lawful authority. Further the broader powers of police to become involved with patients is not within the scope of this investigation

Point 5- remove the phrase *'but in circumstances that amounted to an abuse of power under the Act.'*

Point 6 – remove the whole paragraph, there is no link between the genuine attempts to find a solution to a complex issue and the governance at RDH."

Page 130

Point 7 – this whole paragraph should be removed for the reasons already given.

PROVIDING MEDICAL TREATMENT TO ADULT PATIENTS WITHOUT THEIR CONSENT POLICY

Policy Purpose
To ensure that correct procedures are followed and fulfilled in line with legislation and the common law, when there is necessity to provide medical treatment without the consent of the adult patient.

The legal basis to provide treatment without consent can be found in:
NT *Notifiable Diseases Act* 1999
NT *Mental Health and Related Services Act*
NT *Emergency Medical Operations Act* 2004
NT *Adult Guardianship Act*
NT *Prisons (Correctional Services) Act* 2006
Common Law principles of emergency and necessity where patients cannot provide consent.
Legal opinion – NT Solicitor General April 2009

Policy Statement
It is unlawful to provide medical treatment to a person who refuses that treatment. Patients have the right to refuse treatment. Treating a patient against their will is an exception to the normal state of affairs. In certain situations legislation authorises the provision of medical treatment.

Where a patient cannot give informed consent, and the legislation referred to above does not apply, a hospital (or other health provider) may administer care and treatment (and restrain or detain a person for that purpose) in cases of emergency or where the treatment is necessary to avert imminent harm to the patient.

Implementation
Providing treatment and restraining/detaining a person under the *Notifiable Diseases Act*
Under the *Notifiable Diseases Act* the Chief Health Officer of the NT, or an official delegate, has the power to order the detention of a person against their will for treatment of, or to prevent the spread of a notifiable disease. Refer to Acute Care Division Policy "Notifiable Diseases Act – Detaining Patients" Policy.

Providing treatment and restraining/detaining a person under the *Mental Health and Related Services Act*
Under the *Mental Health and Related Services Act*, patients who are assessed as having either a mental illness or mental disturbance can be admitted for involuntary treatment.

Providing treatment under the *Emergency Medical Operations Act*[1]
If a person is incapable of giving consent and it is not practicable to delay the performance of the operation until the consent can be obtained and is in danger of dying or suffering a serious permanent disability and an operation is desirable in order to prevent either occurrence, a medical practitioner may perform that operation without the consent of the patient. Refer to *Emergency Medical Operations Act*, s.3.

Providing treatment under the *Prisons (Correctional Services) Act*
Adult prisoners are subject to the direction of the Director of Correctional Services who is responsible for their custody. A doctor or other health service provider should not give treatment to any person in custody unless that person or someone authorised on behalf of that person, has consented to the treatment. There is however exceptions to the requirement for consent to treatment of adults in custody. Refer to Acute Care Division "Prisoner Patients" policy.

Providing treatment under common law principles of necessity and/or emergency
If a patient is to be treated in an emergency situation or to avert imminent harm the onus is upon the hospital/treating clinician to show that all of the elements are present:

- The patient is not capable of providing consent;
- The situation is one of emergency or the need to act to avert imminent harm to the patient;
- The belief of the decision maker as to the above was honestly and reasonably held; and
- The actions taken were proportionate to the risk.

Where it is considered that a patient who is attending the Emergency Department and/or admitted to hospital cannot give consent for their continued hospitalisation and treatment, determination for their management should be made by the patient's treating medical practitioner in consultation with the relevant supervising consultant.

The clinical team will contact the supervising consultant and explain the case, including the fact that the patient is not competent and the basis upon which the supervising consultant can be satisfied that the situation is one of emergency or imminent harm to the patient if they do not receive the treatment to which they cannot consent. If the supervising consultant agrees that the harm to the patient have been properly assessed and the patient is not competent then agreement may be given to use restraint as part of the management plan for the patient. The supervising consultant must seek assurance that interpreters have been utilised to ensure that any impaired cognition is not a language or cultural difficulty.

The supervising consultant must be satisfied that specific legislation such as the *Mental Health and Related Services Act, Guardianship Act, Emergency Medical Operations Act* or *Notifiable Diseases Act* does not apply. Further assessments may be required. The supervising consultant must also ask whether the patient is subject to an order under the

[1] Where the patient is a child the medical practitioner and at least one other medical practitioner must form the necessary opinion.

Adult Guardianship Act. If there is a guardian appointed, the guardian must be contacted to enquire as to consent for treatment.

If approval is given by the supervising consultant, the patient's treating medical practitioner must document in the patient's clinical notes the reasons why the treatment has been provided without consent and document a comprehensive management plan for the patient including any restrictions on their movement within and outside of the hospital.

Patient support staff (eg Patient Care Assistant, Orderlies) or security staff may be called upon to assist with the patient's management and common law provisions of emergency and necessity cover their participation. In these instances full explanation of the patient's situation will be given to the patient support staff or security staff so that they are fully aware of what is required.

If the patient has left the hospital building, then security staff (where patient remains within the grounds) and police will be contacted. The patient is regarded as a missing person with concerns held for their welfare.

Management plans that include any form of patient restraint or detention will be documented by the treating medical officer in the patient's medical record. Clear instructions are to be outlined. Management plans for patients being restrained or detained in the hospital will be reviewed and updated by the treating medical practitioner every 24 hours. Initiation of management plan that includes any form of physical restraint or detaining of a patient in the hospital for periods longer than the time it takes to provide immediate emergency or life preserving action necessitates the consideration of substitute consent arrangements for the patient in accordance with the *Adult Guardianship Act.*

Definitions

Emergency – where treatment is necessary in order to save a person's life or to prevent serious permanent injury to a person's health. Does not include potentially necessary or merely convenient treatment.

Imminent harm – must be assessed by the treating medical practitioner, with reference to the facts at hand. Danger is not imminent if the harm is unlikely to be suffered in the immediate future. Potential harm or gradual deterioration in a condition, which is not immediately life threatening may not be sufficient.

Competence - a patient is competent to make decisions about their own medical treatment if they are able to understand the nature, purpose and effects of the proposed treatment and the likely consequence of refusing that treatment. Refer Acute Care Policy "Competence: Ethics and the Law Guidance".

Honest belief on reasonable grounds – Belief must be honestly held. Test is subjective - the decision maker must really believe it to be true at the time the decision is made. The test of reasonableness is objective. A belief is reasonable if it is one that a person similarly placed would be likely to come to the same conclusions.

Proportionality – an action is proportionate if it is effective to achieve the objective and

does not involve excessive force (or detention). The concept of 'reasonable force' is based upon proportionality.

Restraint - Any work or action that interferes with the ability of the patient to make decisions, or restricts their free movement.

Mechanical restraint – Any manual method or mechanical device applied to the body for the primary purpose of preventing, restricting, or subduing movement of any part of the patient's body.

Physical restraint – The use of physical force to control a patient and prevent them from taking any action that is likely to cause injury to self or others.

Chemical restraint – The use of medication or other substances as prescribed by a medical officer for the sole purpose of behaviour management and control. For example, tranquillisers, sedatives and antipsychotic drugs.

References
NT Hospital Network Policy – "Informed Patient Consent"
NT Hospital Network Policy - "Notifiable Diseases Act – Detaining Patients"
NT Hospital Network Policy - "Prisoner Patients" policy.
EQuIP Version 4 Quality Improvement and Risk Management Standard (Criterion 2.1.2), Leadership and Management Standards (Criterion 3.1.5), Safe Practice and Environment (Criterion 3.2.1).

Review due October 2009

ANNEXURE 5

Mr BEIRNE'S RESPONSE TO DRAFT REPORT

Northern Territory Government

DEPARTMENT OF HEALTH AND FAMILIES www.nt.gov.au

Acute Care Division
87 Mitchell Street, Darwin NT 0801
Postal Address: PO Box 40596
Casuarina NT 0811
Tel: (08) 8999 2938
Fax: (08) 8999 2439
eMail: peter.beirne@nt.gov.au

Our Ref: DD2009/2455
Your Ref: DOC090409-004

Ms Carolyn Richards
Ombudsman NT
GPO Box 1344
DARWIN NT 0801

Dear Ms Richards

RE: INTERIM REPORT OF INVESTIGATION INTO THE UNLAWFUL USE OF RESTRAINT AND DETENTION AT RDH

1. Introduction

Thank you for your emailed letter of 9 April 2009 giving me the opportunity to respond to your draft interim report, because I am personally named repeatedly in negative terms in the report.

I have not sought to address your comments, findings, conclusions or recommendations arising from your investigation, save where you have made adverse, and in my view baseless, conclusions about my personal integrity.

If my initial response dated 19 February 2009 to your request of 20 January 2009 provided insufficient information or documentation, I apologise, but it was never my intention to mislead you or to be evasive about the formulation and promulgation of policy.

I have attached further documentation and ask that you re-consider and correct your very serious and damaging statements that I:

(a) provided to the Ombudsman misleading information - (p.13)

(b) was lacking in candour, made statements that had only scant connection with the facts contained in RDH's own records; and in one aspect positively misrepresented the truth about the introduction of a policy to restrain and detain people in reliance on s.16 of the *Medical Services Act* - (p.10)

(c) provided to the Ombudsman misleading information about the status of policy and forms titled 'Policy for the Management of Patients Pursuant to Sections 16(2) and (3) of the *Medical Services Act'*. - (p.130)

2. Allegation re implementation of policy based on s.16 *Medical Services Act*

Your draft report alleges that I misled you in relation to the status of a policy concerning the use of a restraint power under s.16 of the *Medical Services Act*. The allegation is made repeatedly throughout the document at pages 13, 19-20, 82-83, 85, 126 and 130.

My letter of 19 February 2009 was not factually incorrect in its contents nor was it intended to be misleading. It does appear however that you have not been provided with all of the relevant facts in regard to policy development and approval within the Acute Care Network, or the status of the "policy" on use of s.16.

I have attached (Appendix 1) a PDF of the Acute Care Network Policy Manual that was in force at the relevant time and remains current. This document clearly explains the process for development and publishing of Acute Care Network Policies. The s.16 "policy" in question was never developed or published via this method, and has never been endorsed or promulgated as an Acute Care Network Policy. The "draft policy" was never loaded to that intranet location. An issue of this nature is one that has implications across all Northern Territory Hospitals, requiring endorsement from the Acute Care Executive.

The email from Jan Evans of 22 January 2008, 2.03pm stating the s.16 "policy" was approved was not correct and was not where the policy issue ended. The following relevant facts may not have been made available to you:

- The following morning, 23 January 2009 at 9.03am, Ms O'Riordan, Clinical Safety and Quality Manager at Royal Darwin Hospital (RDH), raised concerns with the s.16 "policy" as emailed by Ms Evans. Part of Ms O'Riordan's role is to administer the distribution of policies, including placing RDH specific policies onto the RDH page of the website. I have attached Ms O'Riordan's email to Ms Evans (Appendix 2).
- Later that morning, after receipt of Ms O'Riordan's email, Ms Evans advised Ms O'Riordan, copied to others, that *"There have been a couple of other changes recommended, so we'll hold off until I get a chance to make those changes. I'll get back to you all once they are finalised."* The email is included in Appendix 2 attached.
- I am advised that, as a result of Ms Evans' response, Ms O'Riordan never arranged for the s.16 "policy" to be loaded onto the web or otherwise distributed as a final policy.

In summary, despite the wording of the email of 22 January 2009, the s.16 "policy" was never considered nor endorsed by the Acute Care Network. I also remain of the view that the "policy" was never adopted by RDH in terms of implementation. I am aware that you may not accept this or hold the same view. It is my long held view that it is possible for two people to hold differing opinions without one or both being misleading or misrepresenting the truth.

Irrespective of the status or correctness of the s.16 "policy", RDH was acting under current legal advice in regard to the application of s.16 for the purposes of managing patients who were not capable of giving consent but who required urgent medical treatment.

This issue was acknowledged in my letter of 19 February 2009, when I wrote:

> "I acknowledge that the extent and application of s.16 MSA has been misunderstood by some staff at RDH in the past".

I trust that this explanation, together with the attached documents, persuades you that I did not intend to mislead you in regard to the status of the so-called policy in question.

Perhaps I should add that it is not in my nature to be untruthful nor did I have any motivation to be misleading as it would not change the acknowledged fact that s.16 of the *Medical Services Act* has been misapplied as an administrative mechanism in the past.

3. Allegations regarding the existence of previous legal advice

At page 79 of your draft report you stated that you considered the response of the Department of Health and Families to be evasive and an attempt to cover up the fact that previous legal advice existed that was contrary to Mr Currie's advice received about 24 November 2008.

I misunderstood your question and your investigation to relate to the use, or misuse of s.16 MSA. To the best of my knowledge none of the previous opinions of advice considered s.16. Each of the formal legal opinions of the past 6 months were therefore included, as they related to the use of that section as an authority to restrain patients.

In hindsight, and having read your draft report, I now understand that your investigation related to the broader question of the legality of restraint and detention, and was not limited to the application of s.16 MSA in that regard.

I had no intention of misleading you or evading the issue of the differing legal opinions. As noted in your findings, the advice of Ms Sievers, dated 28 January 2009, which was provided to you, referred to previous opinions given in 2004 that were contrary to Mr Currie's opinion.

4. Your comments regarding the Conclusions to my letter of 19 February 2009

At page 128 of your draft report you have adversely commented about my conclusion, stating:

> "The statement that there is no evidence that a patient has been injured by security using the provisions of s.16 to restrain/detain a person is misleading."
>
> "The statement that this is the 'current legal environment' is misleading..."

I understand that your investigations may lead you to disagree with some of my conclusions, but disagreement does not justify your findings that the statements are misleading. Such comments, taken in context of your other attacks on my integrity are simply not justified by the objective facts nor do they reflect my intentions in my letter of 19 February 2009.

Yours faithfully

Peter Beirne
Acting Executive Director, Acute Care

20 April 2009

APPENDIX 1

Acute Care Division

Network Policy Manual Policy

Policy Purpose

To facilitate a consistent approach to non-clinical policy development and management across the Acute Care Division.

Policy Statement

There will be a common Divisional policy manual containing administrative policies for all Acute Care services. Policy documents will be written to ensure consistency with existing Departmental and whole-of-Government policies, as well as compliance with current legislation.

The Acute Care Executive prior to implementation will endorse all Acute Care Division policies with a network wide application.

Implementation

The Acute Care Administrative Policy Manual will be located on the Acute Care home page on the DHCS intranet.

Each acute service intranet page should have a link to the network policy manual on the Acute Care home page.

The main index of the network policy manual will be aligned with the functions that comprise the Australian Council on Health Care Standards, Evaluation and Quality Improvement Program as follows:

Clinical Function:
- Continuity of Care
- Access
- Appropriateness
- Effectiveness
- Safety
- Consumer Focus

Support Function:
- Quality Improvement and Risk Management
- Human Resources Management
- Information Management
- Population Health
- Research

Corporate Function:
- Leadership and Management
- Safe Practice and Environment

The network policy manual will include a supplementary index with all entries in strict alphabetical order.

Network Policy Manual Policy

All Acute services should maintain a physical (printed) set of network policy manuals according to their needs.

Policy Review and Revision

Acute Care Policy and Service Development will maintain an electronic master index that records the implementation, review and revision dates of each policy document.

Policy document review dates will be staggered throughout the range of documents contained in the network manual, to effectively manage regular, ongoing review of the manual and the maintenance of current polices at all times.

Acute Care Policy and Service Development will regularly identify policies for review and forward to Quality Coordinators and/or delegated officers for distribution to relevant staff and/or committees.

Final policy drafts should be forwarded via Quality Coordinators and/or delegated officers to Acute Care Policy and Service Development for inclusion on the Acute Care Executive agenda for re-endorsement.

Quality Coordinators and/or delegated officers will act as a conduit for acute services policy consultation and review, and should ensure that policy drafts are sent to all key stakeholders, as well as relevant Departmental checkpoints, eg Legal Services; Information, Privacy and Records Management Branch.

New Policy Development

Acute Services staff wishing to initiate a network policy should do so through their Quality Coordinator or Manager. Thorough checks should be made to ensure that such a policy and/or guidance does not already exist (eg within an existing Departmental or whole of Government policy, or within legislation such as the *Public Service Employment and Management* Act).

The responsible officer of a new network policy should consider whether this is the most effective means of advising staff of a particular process/activity. Effective use of staff orientation material should be made to provide hospital specific information to staff, such as storage of bicycles, use of lifts, availability of food outlets, etc.

In consultation with their manager, the Quality Coordinator and/or delegated officer should advise whether the proposed policy has network wide implications or is acute services specific.

Where the decision supports the development of a network wide policy, Acute Care Policy and Service Development should be advised, in order that a recommendation to approve the policy development can be made to the Director, Acute Care Policy & Services Development.

Network Policy Manual Policy

Hospital Specific Protocols

Hospital-specific protocols, which relate to a network policy, may be included in the network policy manual, eg specific visiting hours, staff accommodation or patient property procedures. When these separate documents are included in the network manual they should be clearly identified as relating to the individual hospital. These documents should be reviewed when the "parent" policy document is reviewed.

Alternatively, network policy documents may include a section of "Localisation" for hospital specific instructions where this information is succinct.

Hospital Responsibilities

Managers and/or supervisors are responsible for ensuring that all staff are aware of the network policy manual, and have ready access to it, either in hard copy or via the Web.

Individual hospitals will be responsible for the management of hard copies of the manual.

References

EQuIP Version 4, Leadership and Management Standard (Mandatory Criterion 3.1.5)

Review due March 2010

Dear Jan,

This must all have been endorsed at Governance whilst I was on leave?

References should perhaps include:
Detaining patients against their will policy
Take Own Leave Policy and Guidelines
Restraint Policy and Guidelines
"Other legislation referred to?"

I also suggest a heading "consultation" and then list DHF Legal Services, Mental Health and Governance to reinforce to staff that DHF legal Services were consulted.

The term "mechanically retrain" conflicts with the Network Policy" Detaining patients against their will policy" which states" reasonable force" for section 16 of the Medical Services Act. If the term "mechanically restrain" is used then training may be questionable. Do we provide accredited training in restraint?

However, let me know if my suggestions are too late and I will put up on the intranet this morning.
Thanks and Regards,

Louise

Louise O'Riordan.
Clinical Safety and Quality Manager.
Royal Darwin Hospital.

Tel: 08 89228215.
JanM Evans/THS/NTG

JanM Evans/THS/NTG
22/01/2009 02:03 PM

To

Barbara Bauert/THS/NTG@NTGeMAG, David Chapman/THS/NTG@NTGeMAG, Maureen Brittin/THS/NTG@NTGeMAG, Pauline Mattschoss/THS/NTG@NTGeMAG, Sharon Sykes/THS/NTG@NTGeMAG, Dianne Stephens/THS/NTG@NTGeMAG, kanganada@gmail.com, Charles Kilburn/THS/NTG@NTGeMAG, NRC THS/THS/NTG@NTGeMAG, Peter Satterthwaite/THS/NTG@NTGeMAG, CulturalConsultant THS/THS/NTG@NTGeMAG, Philip Bates/THS/NTG@NTGeMAG, Mac Mather/THS/NTG@NTGeMAG, Didier Palmer/THS/NTG@NTGeMAG, Louise O'Riordan/THS/NTG@NTGeMAG, Margaret St Leone/THS/NTG@NTGeMAG

cc

Robert Parker/THS/NTG@NTGeMAG, Meredith Day/THS/NTG@NTGeMAG, kcurrie@williamforster.com, Sylvia Cecchin/THS/NTG@NTGeMAG, Ken Donald/THS/NTG@NTGeMAG

Subject

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 (Dr. Rob. Parker).
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. Louise, 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. Didier/Marg, 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 restrain 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.

Jan Evans
Deputy General Manager
Royal Darwin Hospital
Department of Health and Families
PO Box 41326
CASUARINA NT 0810
Phone (08) 89226989
Facsimile (08) 89227627


6 (2,3) Form A.doc


6 (2,3) Form B.doc


Patient Management Under 16(2) and 16(3).doc

ANNEXURE 6

DR NOTARAS RESPONSE TO DRAFT REPORT

Territory Government | DEPARTMENT OF HEALTH AND FAMILIES | www.nt.gov.au

87 Mitchell Street Darwin NT 0801
Postal Address: PO Box 40596
CASUARINA NT 0811
Tel: 08 8999 xxxx
Fax: 08 8999 xxxx
email:

Our Ref: DF2009/1615
Your Ref: D090100023

Ms Carolyn Richards
Ombudsman NT
GPO Box 1344
DARWIN NT 0801

Dear Ms Richards

RE: USE OF RESTRAINT AND DETENTION AT RDH

Thank you for the opportunity to provide further information to assist with the investigation process into the use of the Medical Services Act at Royal Darwin Hospital (RDH). I say at the outset that I reject the unfounded and indeed defamatory statements, which are made about me in my capacity as General Manager of RDH in the interim report.

Many of the general issues with the interim report have been addressed in the Departmental response, however, I do wish to comment on some particular aspects which appear to me to be poorly understood, and are consequently misrepresented. It seems that lack of understanding of what is involved, may have contributed to the drawing of inappropriate conclusions.

Governance at RDH
Since I commenced as General Manager of RDH in mid 2007 I have, with the assistance of the Deputy General Manager, worked at reforming and strengthening management at the hospital.

Since July of 2007, period I have overseen the implementation of a new governance structure at RDH. This structure, has involved the establishment of three distinct clinical Divisions: Surgical and Critical Care, Maternal and Child Health, and Medicine. To head up each, I have recruited and appointed Co-directors – one medical and one nursing, and provided business managers, administrative support, and clear delegations. The structure is well designed to enhance and sustain a culture of safety and quality, accountability, standards, and resource management and allocation.

Complementary to the Divisions and their respective "*clinical coalface tasks*", is the Royal Darwin Hospital Governance Group, which is chaired by the Director of Medical Services and Education, and which consists of the Director of Nursing, the Co-directors of the 3 divisions, and representatives from allied health and quality unit. This group meets fortnightly on a Friday morning, and the meetings are minuted. I should point out that the very matter of restraint and detention was extensively discussed over time in this forum.

It is the task of the Governance Group to discuss and debate issues of policy, operation, resource and strategic planning. In turn, the Governance group informs and recommends its outcomes to the RDH Senior Executive. The Executive consists of the General Manager, Deputy General Manager, the Medical and Nursing Directors, and the Director of Finance. The Executive looks after day-to-day management and governance, liaison with Head Office and also matters of overarching importance.

From a governance perspective, there are two other important groups which also serve to debate, analyze and inform - the Medical Advisory Committee (MAC), comprised of senior specialist clinicians and the Nursing and Midwifery Advisory committee. Both of these bodies meet monthly.

Another important reform that must be noted and recognized has been the restructure of the Medial Administration and Education Unit. Since 2007, the Unit has been restructured with an emphasis upon recruitment and retention, safety and quality, credentialing and scope of practice, and liaison with Offices such as that of the Coroner. Since the appointment of a new Director of Medical Service and Education late in 2008 and the appointment of a registrar in Medical Administration, the Unit has seen the development of significant strategies surrounding Medical Officer Education with a significant strengthening of the Office of the Director of Clinical Training, and the appointment of a Medical Education Officer (MEO). The work was commenced by Professor Ken Donald AO, who is also a Medical Commissioner in the Health Complaints Unit of Queensland, and previously acted in the position of Director of Medical Services, and during that time played a significant role in matters surrounding detention and retention policies within the hospital. Currently, Professor Donald has an ongoing role as Director of Pathology at RDH, and has indicated a preparedness to provide your Office with details of involvement and advice in that area.

While the reforms instituted over the last 18 months have not completed the process of reform at RDH, acknowledgement has been given in virtually all of the reports commissioned in recent times, of the significant work and efforts that have occurred, and indeed continue to occur. One such report, undertaken by the Australian Council of Healthcare Standards (ACHS) was commissioned by the previous Minister to further assist with the process of ongoing reform. That report, dated 23 February 2009 and in your possession, recognizes the efforts to date, and makes constructive suggestions which, where practicable, are welcomed by RDH

I acknowledge that the reform process at RDH is still underway and that any organization can make improvements at any time. However, to say, as the interim report does, at page 8, that as a result of the facts of the narrow issue under discussion my management is 'inept and incompetent' and to, at least impliedly, attempt to draw support from the ACHS report for this statement (pages 6 and 129-130) is not only unfair but presents a misleading picture of what is really happening at RDH from a governance perspective. I request that all of the references noted above which impugn me in my professional capacity as General Manager of RDH be removed.

Policy for dealing with patients under s.16 MSA

Much is made in the interim report about the fact that I approved a policy concerning the use of s.16 MSA for detaining patients who were not competent to make their own decisions and who were in grave danger. Whilst the Solicitor-General, whose advice I of course accept and value, has advised that the *Medical Services Act* does not give the person in charge of the hospital such authority, at the time that the policy was discussed I believed that it did. It was not until Ms Sievers' advice was received on 29

January 2009 that the point became particularly contentious. The process of circulation and later withdrawal of the policy of 22 January 2009 has been addressed in the Departmental response.

I was made aware sometime after 29 January 2009 that no policy was to be promulgated in relation to s.16 MSA as it might apply to restraint or detention of any person. Later, after 9 February 2009 I was made aware that no person was to be detained in the hospital in reliance upon that section. I then took steps to ensure that the Director Medical Services & Education and Professor Donald (who acted under my general direction in these matters) were aware that that was the case. I have previously responded to you on this issue and I refer to my email of 20 March 2009. As you are aware, I caused a general notice to be published to the Security Section concerning this issue on the same date. On 27 March 2009 a notice was published in the General Manager's Message, a publication which goes to all hospital staff clarifying that s.16 MSA was not to be relied upon as a basis for restraint of patients. A copy of the message is attached.

I should also state clearly, that I was not aware of advice purported to have been previously provided by either the Solicitor General or others on earlier occasions in previous years,

In the circumstances, it is unfair to characterize my management of this issue in the manner set out in the interim report. It is also inaccurate to refer to a 'chasm of understanding' between management and clinicians. A fair assessment of the matter shows management and clinicians attempting to work together with legal advisers to reach a resolution of a difficult issue. Indeed, I submit that the endeavors to address the issue were, on the contrary, an example of the proper exercise of the management function.

Therefore I request that these comments be removed as above. I am, of course, happy to assist should you consider that further investigation of the facts is required.

Protecting Patients
As set out at some length in the Departmental response, the allegation that an application under the *Adult Guardianship Act* had not been commenced for patient X is false. I am advised that, in fact, the social work department of RDH commenced the process in November 2008. I will not repeat what then happened.

You have previously requested an explanation of why patient X was hospitalized notwithstanding that he, at various times, expressed a desire to leave. I am advised that:

- The patient's initial admission was with Influenza A Encephalitis, a deadly and debilitating condition that often leads to death and severe confusion;
- Family was involved in at least two case management meetings, and at all times indicated their willingness to provide ongoing care after discharge. The notes stated *"mother was intending to give up full time work to care for patient [x] at discharge"*;
- During his stay patient [x] was severely confused;
- The fact that patient [x] was retained in hospital is considered to be a key factor in his very survival and ongoing recovery. The decision was based upon the advice of a nationally respected neurologist Dr Jim Burrow and

Rehabilitation Specialist, Dr Gavin Chin, and supported by other senior clinicians including Professor Ken Donald;

- I believe that had that patient been allowed to walk out of the hospital on the occasions when he said he wanted to do so he would have been in imminent and grave danger due to his medical condition.

This case, and indeed other cases - in particular the case of Mr. who, while confused wandered from a hospital ward late on a Thursday evening in February 2007, to be discovered three days later "*hypothermic*" and close to death in a hospital drain - well highlight the dilemma confronted on a daily basis by hospital staff.

The Departmental response to the interim report refers to the inadequacy of the current mechanisms in the *Adult Guardianship Act* for dealing with substitute decision-making in the acute clinical setting and I endorse what is said there. In short, it is folly to suggest that in cases such as those listed above, a clinician with concern has the "*luxury*" of even 24 hours. I am told that legislation aimed at clarifying the law with respect to substitute decision-making, and circumstances when medical staff can rely upon it in the case of incompetent patients, is under consideration by the Department. I would welcome such legislation.

What remains fact, are the circumstances of the cases listed above, along with the tragic experience of the case, Mr. and others who, subsequent to leaving the hospital died unnecessarily and tragically ... deaths that could have been prevented. The further fact remains that those "detained" have survived. Perhaps it has best been expressed by Professor Donald who recently wrote to me, in part, in these terms:

> However, every day the clinical problems and therefore the decisions rest with the Clinicians. In my experience of working with the clinical teams at this hospital on this difficult issue, patient safety and quality of care have always been the issue. Clinicians have clearly understood the nuances of the issues and the concepts of "imminent danger and necessity". They have been doing this for many years either here or at other hospitals where the issues are addressed in the same way. The e-mail from Didier captured much of the clinician approach to this but has only been quoted in small extract in the legal debate.
>
> Darwin has this problem probably more frequently than other parts of Australia. Inability to give consent (without mental illness) often comes about because of head injury, alcohol (acute and chronic) and a clear failure to understand clinical conditions by under privileged and poorly educated Indigenous patients. These patients are often in "imminent danger" from increased intracranial pressure or uncontrolled infection. Delay of hours (not days or weeks) can mean life or death or loss of limbs etc. Sometimes the danger persists however for days or weeks to be managed.

Other issues

On 31 March 2009 you request via email an explanation of the term LAD. A LAD day is a "low activity day". They occur each month predominantly in areas that operate Monday to Friday. These areas include Operating Theatres, Same Day Procedure Unit and Outpatients Department. They are designed to assist staff that work in those areas to attend training opportunities. Key meetings are often scheduled for these days. We also take the opportunity to use the theatres on these days for visiting surgeons to perform surgery and give training.

Because LAD days are scheduled there is minimal impact on clinical services as workload and staffing are redistributed to other days. Emergency and urgent operating theatres run on LAD days.

Conclusion

I trust that you will take into account that whilst I have had 5 working days to respond to the interim report in fact my attention has been required during much of that period to the disaster response at the hospital ironically surrounding a humanitarian relief response, and indeed other matters, which have meant that I have not had the opportunity to consider the interim report in the detail which I would have liked.

Accordingly this response is limited to the 'broad brush' issues above. Therefore I request that I have a further proper opportunity to respond to any report on this issue which is to be published and indeed table, prior to its finalisation.

Yours sincerely,

Dr Len Notaras AM
21 April 2009

ANNEXURE 7

Ms EVANS RESPONSE TO DRAFT REPORT

HDOC 2009/486

Northern Territory Government

DEPARTMENT OF HEALTH AND FAMILIES www.nt.gov.au

Executive
Royal Darwin Hospital
PO Box 41326
CASUARINA NT 0811

Tel: 08 89228105
Fax: 08 89227627
eMail: janm.evans@nt.gov.au

Our Ref:
Your Ref:

Ms. Carolyn Richards
Ombudsman of the Northern Territory
GPO Box 1344
DARWIN NT 0801

Dear Ms. Richards

1. Thank you for providing me with the opportunity to make comment on the 'Interim Report' of your investigation into the use of restraint and detention at Royal Darwin Hospital.

2. I am disappointed with the time limit set by you for my response, as it has not given me sufficient time to properly look into many of the allegations you have made. I wish to make it clear that I would have preferred a period of at least 21 working days to examine more carefully the serious allegations concerning me. The Interim Report is 130 pages and has taken your office some 4 months to progress to its present form. That I have been allowed 4 or 5 working days to read, consider, investigate and respond - particularly given the traumatic events of this last week whilst RDH has been in full counter disaster mode - is unreasonable. In the short time frame that I have had to respond to the Interim Report I provide my initial responses below to only some of the more serious allegations.

3. I am and was at all material times the Deputy General Manager of the Royal Darwin Hospital. My role is to assist the General Manager in the day-to-day operation of the hospital. My role is purely administrative: I am not a medical practitioner and I do not have a clinical role or any decisions in clinical matters. I was however not Deputy General Manager of Royal Darwin Hospital in 2004 as claimed in your Interim Report on page 53. I was asked by the Chief Executive of the Department of Health and Families to join the new Management Team of Royal Darwin Hospital in August 2007 with an agenda of reform of clinical and corporate governance, safety and quality and resource management and application. Since that time a new Management/Governance Structure has been implemented, senior positions

responsible for the governance of Royal Darwin Hospital have been recruited to and significant reform and change achieved. The current Governance Group of Royal Darwin Hospital is made up of the General Manager, myself, the Director of Medical Services, Director of Nursing, the Medical and Nursing Co-Directors of the three divisions of Medicine, Surgery and Critical Care, Maternal and Child Health. The Quality and Safety Manager and Director of Finance also are part of this Group. This Group meet fortnightly to deal with the corporate and clinical governance issues of the hospital. The Governance Group members are extremely well credentialled for their leadership roles within both the corporate and clinical areas of the hospital, as well as being senior and highly respected in their professional fields. Many of these senior staff have worked at Royal Darwin Hospital for in excess of 10 years. I strongly deny the allegations in your interim report of weaknesses in leadership and corporate governance at Royal Darwin Hospital.

4. I would like to state that at all times the intent of RDH Management including Senior Executives of the Governance Group of RDH has been to support the decisions of clinicians to provide appropriate clinical treatment for patients, to ensure Security Officer views and concerns were heard and acted on and to assure them that they were legally protected in conducting their day to day operations.

5. The General Manager and I reject the allegations that the overall management of this issue by senior executives of RDH was inept and incompetent, that we ignored legal advice, required Security Officers to act illegally, breached the law and used coercive powers etc. We deny that we did not support clinicians in the Emergency Department who then had to resort to using strategies under the *Mental Health Act*. We rely on the substantial efforts we made to gain consensus on the process, to educate and inform staff and seek legal clarification.

6. The extract of the e-mail from the head of Emergency Department, Dr P, referred to at page 8 is taken out of context. His frustration, as can be seen from the full text of the email at page 40 of the Interim Report, concerns some Security Officers refusing to take direction and do their job. The policy developed and disseminated had the full support and input of clinicians. You will see in the full text of Dr P's e-mail that he wrote:-

> "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 – these 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."

7. It is reasonably clear that the Director of the Emergency Department was concerned about the lack of response from security personnel in carrying out their duties. Dr P made it clear that he was quite content to apply the precepts of the common law, including the principle of necessity, to restrain and detain patients. Clinicians clearly understood the common law as the basis for their decisions to restrain and detain certain patients.

8. In this context, it is mischievous and deceptive to reproduce the short extract reproduced at page 8 to suggest that clinicians in the Emergency Department felt unsupported by management, when they actually felt unsupported by a small number of Security Officers.

9. I note on page 21 that you state "RDH chose to ignore very clear advice from its independent legal advisers over several years". I do not believe that we ever ignored legal advice. We acted on the current legal advice of Kelvin Currie. The advice of Meredith Day of 20 October 2008 quoted in the last para on page 21 and continuing on page 22 - was later reviewed by her, as is evidenced by her email to Dr. Notaras, copied to S Sievers and G MacDonald, extracted and quote at pages 37-38.

10. I am deeply concerned in relation to one matter at page 51, commencing bottom of page, and continuing through to the top of page 53. There you refer to the e-mail sent by me to numerous persons on 22 January 2009, the content of which is reproduced at page 52. You refer towards the bottom of page 52 to the attachments to my e-mail, which are not reproduced, but which I now attach (*).

11. At page 53, you refer to my action in sending out the e-mail and attachments as "high-handed action". The expression "high-handed" means showing no regard for the wishes or interests of other people, overbearing, arbitrary (and other similar, negative, connotations).

12. The reasons you give to suggest that my action was high-handed were: -

12.1 the policies and procedures I disseminated were contrary to "numerous legal advices and opinions received from 2000 onwards";

12.2 the policies and procedures I disseminated did not take into account "the very reasonable queries" raised by Security Officers;

12.3 the policies and procedures I disseminated did not take account of correspondence received from solicitors for the LHMU expressing the opinion on that the procedures were unlawful;

12.4 I did not sufficiently take into account the fact that the Ombudsman was investigating the matter (" ... despite being aware that I was investigating the matter ....".)

13. In this context, I provide you with some background to the policy and forms sent out by me on 22 January 2009. As you are aware, doctors (clinicians), nurses and security staff at Royal Darwin Hospital had sought clear guidelines, processes and forms to be completed in relation to the restraint and detention of certain patients at the Royal Darwin Hospital, in order to satisfy patient clinical record-keeping requirements, clarify legal uncertainty and, in the case of security staff, provide evidence to justify their intervention and provide protection from possible prosecution or other action in the event that force might have been required on their part. There was an issue also in relation to NT Police members who might be called to assist in the case of patients who had decamped from the hospital.

14. On 10 November 2008, I sent to members of the Governance Group, additionally to Dr Rob Parker, Head of Psychiatric Services, and to Mr Philip Bates, head of RDH security section, an e-mail to which I attached a draft policy document and forms intended to be used "for the management of patients pursuant to sections 16(2) and (3) of the Medical Services Act". I enclose a copy of my e-mail dated 10 November and attachments (*).

15. Over the course of the ensuing weeks, I received comment and suggestions from many of the recipients of the e-mail.

16. In November and December 2008, Information Sessions for staff entitled Medico-Legal Aspects of Restraint and Detention in a Hospital Setting were conducted at Royal Darwin Hospital by Mr Kelvin Currie, barrister, and Dr Robert Parker, Director of Psychiatry. RDH Campus Medical officers, Nurses, Allied Health and Security staff were invited to the meeting. The Branch Secretary of the LHMU, the Union body representing the Security Staff, was also invited to attend, but did not respond. Security Staff were present at both Sessions and participated actively.

17. A paper prepared by Kelvin Currie, entitled "Restraint and Detention in

a Hospital Setting" was distributed at the meeting. I enclose a copy of that paper (*). I refer you in particular to the paragraph numbered 2 towards the bottom of the first page:-

> "Patients that are NOT competent to make decisions as to their best interests may be restrained and detained if they pose a danger to themselves or others or if leaving the facility would put them in danger."

18. I interpose at this point that Mr Currie's advice was almost identical to the point sought to be made by Halfpennys, the legal representatives of the LHMU and Security Officers, in its letter dated 16 December 2008:-

> " It is our view that if security guards restrain someone who is lawfully attempting to leave the hospital then the security officer could be charged with assault. The only exception to this, in our view, is if the patient has been sectioned or is in danger of hurting themselves or others." [underline emphasis added by me]

19. I am not qualified to determine which of the two advices is correct, or more correct, in terms of statement of the law; I simply wish to point out how similar they were.

20. As a result of responses received from the recipients of my e-mail sent 10 November 2008, including from Philip Bates who put forward matters relevant to the security section, the 'policy document for the management of patients' was substantially amended from that sent under cover of my e-mail dated 10 November to that which was sent under cover of my e-mail dated 22 January 2009. A copy of the substantially amended policy document is attached (*), with amendments underlined by me (referred to in paragraph 10 of my response).

21. There is another matter, which I need to mention at this stage of my response. The *Medical Services Act*, s.16, may well not provide a power to restrain and/or detain hospital patients. However, the common law does give the Royal Darwin Hospital that power, as referred to in your report, subject to limitations the extent of which is subject to legal uncertainty about which I am not qualified to engage. The significant point, however, is that s.16 *Medical Services Act* does authorise the person in charge of a hospital to set up procedures and protocols, and to give directions, for the purpose of facilitating the management of patients in circumstances that are authorised by the common law. That being the case, any policy or guidelines relating to the management of patients who are not competent to give informed consent and who would be at risk of harm to themselves should they leave the hospital could properly be the subject of an instruction under s.16 (2). This

involves the *procedural use* of the section, as distinct from reliance on that section as giving the power to restrain/detain.

22. In this context, the policy document and forms disseminated on 22 January 2009 appeared to be an appropriate response (1) clinically, (2) legally and (3) practically to the difficult issue confronting Royal Darwin Hospital administration.

23. While I understood that the policy document and forms disseminated on 22 January 2009 would be implemented, I should point out that further changes were likely. My e-mail of 22 January 2009 was sent to a wider group of recipients than my e-mail of 10 November 2008, and I continued to receive additional responses after 22 January 2009. On 23 January 2009 in response to an email from the RDH Quality Manager (send to all of the recipients of the 22 January 2009 email) I advised "Thanks Louise – there have been a couple of other changes recommended, so we'll hold off until I get a chance to make those changes. I'll get back to you all once they are finalised". Due to your letter of 20 January 2009 received 22 January 2009, the forms were not finalised and to the best of our knowledge, ever put into practice.

24. I return now to the reasons you gave to suggest that my action in sending out the e-mail of 22 January 2009 was high-handed (see my paragraph 12 above), and set out my response:-

24.1 the policies and procedures I disseminated were contrary to "numerous legal advices and opinions received from 2000 onwards" - this statement is not correct; see my paragraphs 12 and 16 above and relevant enclosures;

24.2 the policies and procedures I disseminated did not take into account "the very reasonable queries" raised by Security Officers - this statement is not correct; see my paragraphs 14 - 20 above and relevant enclosures, and please note that no response was received from Security Officers to the policies and procedures I sent out on 22 January 2009;

24.3 the policies and procedures I disseminated did not take account of correspondence received from solicitors for the LHMU expressing the opinion on that the procedures were unlawful - this statement is not correct; see my paragraphs 14-20 above, and note that no response was received from LHMU to the policies and procedures I sent out on 22 January 2009;

24.4 I did not sufficiently take into account the fact that you were investigating the matter - While I appreciated that you intended to undertake an investigation, I did not know what course the investigation would take, what legal and factual issues would be pursued, what findings and recommendations would be made, and what time frame was involved. Meanwhile, the day-to-day operation of the Hospital had to continue.

25. Further as to paragraph 24.4, patient safety and quality of care should and will always be the primary focus for the Royal Darwin Hospital and its staff. Probably more frequently and in greater numbers than other parts of Australia, we have high numbers of patients attending at the hospital who, although not suffering mental illness, are unable or incompetent to give consent, whether as a result of head injury, the effects of alcohol consumption (acute and chronic), and/or simple inability on the part of underprivileged and poorly educated indigenous patients to understand clinical conditions and medical explanations. Perhaps all these factors are at work. These patients are often in "imminent danger" from increased intra-cranial pressure or uncontrolled infection. Delay of hours (not days or weeks) can mean life or death or loss of limbs etc. Sometimes the danger may persist and must be managed for days, possibly even weeks.

26. Given the above matters, I believe that you (or the author of the Interim Report, if that is not you) are mistaken in your statement that my action was "high-handed". The exigencies of day-to-day hospital operation could not be put to one side awaiting your investigation. There was considerable urgency. Notwithstanding that, the process followed by the Royal Darwin Hospital and by me as Deputy General Manager to develop and progress a policy and process which were acceptable to all, lawful, easy to understand, and simple to implement was an 'inclusive' process in which all relevant parties participated and contributed.

27. Further, the policy and process were put in place to achieve good governance, rigour of process and best practice; to ensure safety for patients and staff; and provide support for clinical decisions.

28. I ask for a further 21 days to consider and reply to other matters or issues raised by you in your Interim Report. I have identified a number of additional matters I need to reply to.

Yours faithfully

JAN EVANS
21 April 2009

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

ATTACHMENTS REFERRED TO IN PARA 10 OF JE RESPONSE

Royal Darwin Hospital

POLICY FOR THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Policy Purpose

To ensure that any patient who is not competent to give informed consent and who a clinician believes is at risk to themselves should they leave the hospital campus, is prevented from leaving in a safe, efficient, effective and ethical manner.

Policy Statement

- Any patient who is not competent to make their own decisions and who is assessed by a clinician as being at risk should they leave the campus will be prevented from doing so by utilisation of Sections 16(2) and (3) of the Medical Services Act by the "Person in Charge" of the Hospital.

Definitions:

- At risk to themselves – not competent of understanding the risk should they refuse treatment and leave, patients whose clinical condition requires medical intervention for their own safety,

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.
- Under normal circumstances, decisions involving the utilisation of sections 16(2) and (3) of the Medical Services Act must include the treating medical practitioner, supervising consultant, "person in charge" of the hospital, ward nursing staff, Nursing Resource Co-ordinators and the manager or team leader of security.
- The patient's treating medical practitioner must write an entry in the patient's clinical notes outlining the reason for their management under Sections 16 (2) and 16 (3), the discussion with the "person in charge" in respect to their management under Sections 16 (2) and (3) and the management plan for the patient including any restrictions on their movement within and outside of the hospital.
- The treating medical practitioner must complete the required form (Form A), which is to be kept in the patient's clinical notes.
- 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.
- If a patient is mechanically restrained for any reason under the management plan, then they must be reviewed every 24 hours by a medical officer.

POLICY FOR THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

- On initiating the management plan under sections 16 (2) and 16 (3), urgent consideration should be given to initiating further substitute management for the patient under the NT Adult Guardianship Act.

References:

Medical Services Act

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

Royal Darwin Hospital

FORM "A"
IN RESPECT TO THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Patient Name: .....

DOB: .....

HRN: .....

This patient has been reviewed by a Consultant, Dr..... (please use capitals)

And the "person in charge", ... (please use capitals)

As a result of their review, it has been decided that the patient is unable to give informed consent into their current hospital management and that there are no other legislative options available within the Northern Territory to effect their safe management.

As a result, they will be managed under sections 16(2) and (3) of the NT Medical Services Act.

Information on the need for management of the patient under sections 16(2) and (3) is contained in the patient's hospital clinical notes, contemporaneous

Reasonable force may be used to ensure that the patient is not permitted to leave.

Dated: .....

Time: .....

Consultant Name
(Block letters) .....

Consultant
Signature: .....

PLEASE ENSURE THAT THIS FORM IS FILED ON THE PATIENT CLINICAL NOTES

Endorsed GM RDH December 2008 Review date December 2009

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

Royal Darwin Hospital

FORM "B"
IN RESPECT TO THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Patient Name: .....

DOB: .....

HRN: .....

On this date, I reviewed the management plan for this patient.

The patient is currently being managed under Sections 16 (2) and 16 (3) of the NT Medical Services Act.

The management plan was commenced on .....

The continuing management plan for the patient is outlined in the patient's clinical record at a time that is contemporaneous with this form.

Date: .....

Time: .....

Consultant Name
(Block letters) .....

Consultant
Signature: .....

PLEASE ENSURE THAT THIS FORM IS FILED ON THE PATIENT CLINICAL NOTES

Endorsed GM RDH December 2008 Review date December 2009

ATTACHMENTS REFERRED TO IN PARA 14 OF JE RESPONSE

JanM Evans/THS/NTG
10/11/2008 05:13 PM

To: Ken Donald/THS/NTG@NTGeMAG, Len Notaras/THS/NTG@NTGeMAG,
cc: dmhoward@physicians-nt.com, kanganada@gmail.com, kcurrie@williamforster.com
bcc:
Subject: Draft Policy on Management of Patients pursuant to Sections 16(2) and (3) of the Medical Services Act

Dear all, due to the recent issues and confusion around the use of sections 16 (2) and (3) of the Medical Services Act, we have decided to adopt the attached draft policy and forms, the wording for which Rob Parker kindly provided.

It is intended that, should you all agree to the wording of the policy and forms that this be implemented asap. Kelvin Currie has agreed to come out to RDH next week to talk with staff about the issues relating to the use of the Medical Services Act and restraint and detention. We could provide copies of the policy and forms at that forum should you all be happy to sign off on it. We ask that you encourage all staff, nursing and medical to attend as it appears from discussions with the NRCs and the Security Staff that many doctors and nurses are unsure about the application of sections 16(2) and (3).

May I please have you comments asap.

Thanks
Jan


Patient Management Under 16(2) and 16(3).doc


16 (2,3) Form B.doc


16 (2,3) Form A.doc

Jan Evans
Deputy General Manager
Royal Darwin Hospital
Department of Health and Families
PO Box 41326
CASUARINA NT 0810
Phone (08) 89226989
Facsimile (08) 89227627

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

Royal Darwin Hospital

POLICY FOR THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Policy Purpose

To ensure that any patient, who a clinician believes is at risk to themselves should they leave the hospital campus, is prevented from leaving in a safe, efficient, effective and ethical manner.

Policy Statement

- Any patient who is assessed by a clinician as being at risk should they leave the campus will be prevented from doing so by utilisation of Sections 16(2) and (3) of the Medical Services Act by the "Person in Charge" of the Hospital.

Implementation

- Determination for management of patients admitted to Royal Darwin Hospital should be made by the patient's consultant in co-ordination with the "The person in charge" of the hospital where it is considered that the patient cannot give informed consent to their continued hospitalisation and treatment and where other NT legislation is not appropriate.
- The patient's consultant must write an entry in the patient's clinical notes outlining the reason for their continuing management under Sections 16 (2) and 16 (3), the discussion with the "person in charge" in respect to their management under Sections 16 (2) and (3) and the management plan for the patient including any restrictions on their movement within and outside of the hospital.
- The consultant must complete the required form (Form A), which is to be kept in the patient's clinical notes.
- Whilst being managed under Sections 16 (2) and (3), the patient should be reviewed weekly by the consultant at least every 72 hours by a medical officer. Following the weekly review by the consultant, Form B should be completed by the consultant or their delegate and kept in the patient's clinical notes.
- If a patient is mechanically restrained for any reason under the management plan, then they must be reviewed every 24 hours by a medical officer.
- On initiating the management plan under sections 16 (2) and 16 (3), the consultant should give urgent consideration to initiating further substitute management for the patient under the NT Adult Guardianship Act.

References:

Medical Services Act

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

Royal Darwin Hospital

FORM "A"
IN RESPECT TO THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Patient Name: .....

DOB: .....

HRN: .....

This patient has been reviewed by a Consultant, Dr..... (please use capitals)

And the "person in charge", ... (please use capitals)

As a result of their review, it has been decided that the patient is unable to give informed consent into their current hospital management and that there are no other legislative options available within the Northern Territory to effect their safe management.

As a result, they will be managed under sections 16(2) and (3) of the NT Medical Services Act.

Information on the need for management of the patient under sections 16(2) and (3) is contained in the patient's hospital clinical notes, contemporaneous

Reasonable force may be used to ensure that the patient is not permitted to leave.

Dated: .....

Time: .....

Consultant Name
(Block letters) .....

Consultant
Signature: .....

PLEASE ENSURE THAT THIS FORM IS FILED ON THE PATIENT CLINICAL NOTES

Northern Territory Government

DEPARTMENT OF
HEALTH AND FAMILIES

Royal Darwin Hospital

FORM "B"
IN RESPECT TO THE MANAGEMENT OF PATIENTS PURSUANT TO SECTIONS 16(2) AND (3) OF THE MEDICAL SERVICES ACT

Patient Name: .....

DOB: .....

HRN: .....

On this date, I reviewed the management plan for this patient.

The patient is currently being managed under Sections 16 (2) and 16 (3) of the NT Medical Services Act.

The management plan was commenced on .....

The continuing management plan for the patient is outlined in the patient's clinical record at a time that is contemporaneous with this form.

Date: .....

Time: .....

Consultant Name
(Block letters) .....

Consultant
Signature: .....

PLEASE ENSURE THAT THIS FORM IS FILED ON THE PATIENT CLINICAL NOTES

ATTACHMENT REFERRED TO IN PARA 17 of JE RESPONSE.

RESTRAINT AND DETENTION

IN A HOSPITAL SETTING

This is often seen as a fairly complex area primarily because of the many discrete legislative provisions that impact on the clientele of a hospital. There are at least three previous advices provided by the Department of Justice, Cridlands solicitors and Michael Grant barrister (as he then was) however due to the length and intricacies of those advices they have been largely inaccessible. This advice will be kept as brief and clear as possible.

The law as it relates to the restraint and detention of prisoners or illegal immigrants will not be included because these have specific legislation and their security is not a matter for the Hospital.

The perceived complexity has often led a misunderstanding of the law generally with the consequence of inaction and potential breach of the Hospital's duty of care to patients.

The first point that should be addressed is the difference between "restraint" and "detention". Even a short restraining might be described as detaining a patient and a lengthy detention might be described as an ongoing restraint. The act of restraining generally has a connotation of more activity, and restraint might often be described as the mechanism by which detention is achieved. However, for current purposes and at law there is no relevant distinction.

An area that has led to concern is the perceived inability to prevent people leaving the facility despite their suffering of dementia, delirium or other disability. However, that perception is incorrect.

Contrary to the general perception the law is surprisingly straight-forward and accords with common-sense notions of what is appropriate.

The law is to the following effect:

1. Patients who are competent to make a decision as to their own best interests are able to make those decisions even if their decision is to leave the facility against strenuous medical advice and to forego treatment (with the exception of detention pursuant to the Notifiable Diseases Act).

2. Patients that are NOT competent to make decisions as to their best interests may be restrained and detained if they pose a danger to themselves or others or if leaving the facility would put them in danger.

3. Any person whether a patient or otherwise, competent or not may be restrained if they pose a danger to themselves, others or the good order and conduct of the hospital.

Those principles spring from the law generally and from specific statutes the most relevant of which are extracted below.

DUTY OF CARE

There is the duty of care to exercise reasonable skill and judgment in the care and treatment of patients.

However that is not the extent of the duty one has to patients. All of the duties overlap however a less known but very important version is to be found in the *Criminal Code Act*. The relevance of it being in the *Criminal Code Act* is that a breach of that duty can result in a criminal charge.

Extracted below are a number of the most pertinent parts of sections.

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.***

You might note that section 149 places a positive duty on people having the "charge" or care or children under 16 or those suffering some form of disability or condition such that they are unable to care for themselves.

> ***149 Duty of person in charge of child or others***
>
> *It is the duty of every person having charge of a child under the age of 16 years or 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 child or other person; and*
> >
> > *(b) to use reasonable care and take reasonable precautions to avoid or prevent danger to the life, safety or health of the child or other person and to take all reasonable action to rescue such child or other person from such danger.*

It is quite likely in a hospital setting, that staff would be seen as having the "charge" or care of children and those with conditions affecting their ability to care for themselves (see *Reynolds & Melville v R [2008] NTSC 30 (12 August 2008)).*

Where there is a duty there is a commensurate authority to carry out that duty.

With consideration to:

1. the generally understood duty of care; and
2. the statutory reinforcement of that duty when it comes to minors under 16 years of age and adults unable to care for themselves; and
3. the exclusion in the definition of assault that allows for the "*restraining a person who needs to be restrained for his own protection or benefit*"

it is clear that there is no other authority required for restraining people in a confused state whether caused by dementia or some other condition from wandering or leaving, if to do so would place them in danger.

In addition to the more general duty the law has provided some specific mechanisms for the restraint and detention of patients.

MENTAL HEALTH AND RELATED SERVICES ACT

Where a patient is receiving treatment pursuant to the *Mental Health and Related Services Act* the following is provided:

> ***165. Reasonable force may be used***
>
> *A person may use reasonable force to restrain a person being treated under this Act –*
>
> *(a) to prevent the person harming himself or herself or another person; or*
>
> *(b) to maintain the good order and security of an approved treatment facility or the approved treatment agency.*

Subparagraph (a) is a restatement of the general law. It applies whether the patient is competent or not and voluntary or not.

Subparagraph (b) clearly envisages restraint in circumstances where the good order and security of the facility or agency is threatened.

<u>"SECTIONS"</u>

MENTAL HEALTH AND RELATED SERVICES ACT

The restraint of persons who are "sectioned" is well known and accepted. It takes the form of a written document.

Sectioning refers to the control and detention of a person for a maximum prescribed period of time.

The most relevant section for present purposes is section 34. It is a recommendation for psychiatric examination. It describes the power to enter any place where a person may be for the purpose of controlling and taking a person, holding them at a hospital and detaining them in an approved treatment facility. The section may also specifically authorise the participation of police.

34. Recommendation for psychiatric examination

(1) A medical practitioner, an authorised psychiatric practitioner or designated mental health practitioner must make a recommendation for psychiatric examination of a person if, after assessing the person, he or she is satisfied that the person fulfils the criteria for involuntary admission on the grounds of mental illness or mental disturbance.

(2) A recommendation for psychiatric examination is to be in the approved form.

(3) A recommendation for psychiatric examination authorises the person making the recommendation, an ambulance officer or a person specified in the recommendation to do any of the following:

(a) to take reasonable measures to control and take the person named in the recommendation to an approved treatment facility and, for that purpose, to enter land, premises or a private place;

(b) where the person cannot be taken immediately to an approved treatment facility, to hold the person at a hospital or other place where the person can be safely held until it becomes practicable to take the person to the approved treatment facility;

(c) without the approval of the Tribunal, to administer treatment to the person immediately necessary –

(i) to prevent the person causing imminent harm to himself or herself, a particular person or any other person;

(ii) to prevent behaviour of the person that is likely to cause imminent harm to himself or herself, a particular person or any other person;

(iii) to prevent further physical or mental deterioration of the person; or

(iv) to relieve acute symptomatology;

(d) to detain the person at an approved treatment facility for up to 12 hours.

(4) A recommendation for psychiatric examination may authorise a member of the Police Force to exercise, or to assist a person exercising, the powers under subsection

(3)(a) where the person making the recommendation considers that, under the circumstances, there is no less restrictive alternative.

Longer periods of detention are then authorised by sections 39 and 42 and by the Tribunal in accordance with the Act.

NOTIFIABLE DISEASES ACT

There is power to restrain and detain persons under section 13 of this Act and accordingly from time to time the term "section" gets applied to the mechanism by which people are detained.

The relevant part of the section reads:

(2) Without limiting the generality of subsection (1), the Chief Health Officer may order, either in writing or orally, that –

(a) an infected person or suspect person be removed to and detained at a hospital or other place until a medical officer authorizes the release of the person on the grounds that that person is not an infected person or is no longer a suspect person;

(3) The Chief Health Officer may take whatever steps are necessary to give effect to an order under subsection (2).

To detain a person in a hospital implicitly requires restraint. Accordingly, where there is a current order by the Chief Health Officer to detain a person at the hospital that person needs to be detained there and restrained from leaving.

The policy reasons for the section include a duty of care to the community at large as well as to the patient.

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.*

The relevant parts of section 16 state:

16. Person in charge of hospital

(1) The person in charge of a hospital or nursing home is responsible –

> *(a) for the supervision of all medical services in the hospital or nursing home in such a manner as to ensure the maintenance of good, safe medical care for all patients of the hospital or nursing home;*
>
> *(b) for the maintenance of good order and conduct by staff and patients of, and visitors to, the hospital or nursing home; and*
>
> *(c) to the Secretary, for the administration of the finances and personnel of the hospital or nursing home and the security of all staff, patients and property.*
>
> *(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.*
>
> ...

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.

DIFFERENCES OF INTERPRETATION

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.

However, the law has long recognised that people will have different opinions on such matters. Where there is an employment relationship there can arise a perceived conflict between what is essentially a direction from a superior pursuant to the *Public Sector Employment and Management Act* and personal opinions of the correct interpretation of the law.

As indicated, the law has always provided a solution to this difficulty. In the Northern Territory that solution has been codified in the Criminal Code Act at section 26.

> ***26 Execution of law, &c.***
>
> *(1) An act, omission or event is authorized if it is done, made or caused –*
>
> *(a) in the exercise of a right granted or recognized by law;*
>
> *(b) in execution of the law or in obedience to, or in conformity with, the law;*
>
> *(c) in obedience to the order of a competent authority whom the person doing, making or causing it is bound by law to obey, unless the order is manifestly unlawful; or*
>
> *(d) subject to subsection (3), pursuant to authority, permission or licence lawfully granted.*
>
> *(2) Whether an order is or is not manifestly unlawful is a question of law.*
>
> *(3) A person cannot authorize or permit another to kill him or, except in the case of medical treatment, to cause him serious harm.*

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 s26 of the *Criminal Code Act* (or civilly liable due to the s22A of the *Law Reform (Miscellaneous Provisions) Act).*

COMMUNITY WELFARE ACT

Section 15 of the Act specifically allows the Person in Charge to detain a child (under 18) in hospital. If a child is seeking to leave or the parents of a child are seeking to leave with a child that requires treatment (and if that treatment is not received there is substantial risk of suffering injury or impairment) then the child may be detained (and FACS notified to apply for the holding order mentioned in subparagraph (b)).

> ***15. Child in hospital***
> *A person in charge of a hospital who believes, on reasonable grounds, that a child has suffered or is suffering maltreatment –*
>
> > *(a) may detain the child in hospital, for the purposes of securing medical examination or treatment for the child, for the period that is reasonably necessary to enable the examination or treatment to be carried out; and*
> > *(b) if after the medical examination has been carried out the person is still of that belief – must, not later than 48 hours after detaining the child, apply for a holding order under section 11A.*

Maltreatment is defined in section 4 and is rather long ... so I won't repeat it here but in general it deals with a child suffering physical or emotional maltreatment ... the key to it is in the last few words of each definitional subparagraph where it says "or where there is substantial risk of his suffering such an injury or impairment".

TRESPASS

Not all restraint, or detention for that matter, is about keeping people within the Hospital.

There are those that for various reasons the Hospital may wish are kept away.

The Trespass Act provides a mechanism to achieve that by making it an offence for a person to be on the hospital campus if the person has been warned to stay away (for a period of up to 12 months).

The ability to use force to eject trespassers is again found in the *Criminal Code Act at s29.* It is termed "defensive conduct".

COURT ORDERS

The court Order most likely to be found impacting on considerations relating to restraint is an Order pursuant to the *Adult Guardianship Act* and indicating that restraint might be used to ensure the person the subject of the order remains for treatment or is restrained as part of that treatment. The Public Guardian also has the power to seek that a person under its guardianship be restrained with or without a specific order for restraint.

DEGREE OF FORCE ALLOWABLE

The general law is that the restraint and the force used must be reasonable and appropriate in the circumstances.

Just to make sure it is understood the *Criminal Code Act* includes sections that include a recitation of circumstances where various degrees of force are permissible. The applicable section for present purposes is section 27. "Serious harm" is defined as:

> ***serious harm*** means any harm (including the cumulative effect of more than one harm) –
>
> (a) that endangers, or is likely to endanger, a person's life; or
>
> (b) that is or is likely to be significant and longstanding.

> ***27 Circumstances in which force not being such force as is likely to cause death or serious harm is justified***
>
> *In the circumstances following, the application of force is justified provided it is not unnecessary force and it is not intended and is not such as is likely to cause death or serious harm:*
>
> ...
>
> *(c) to prevent the continuance of a breach of the peace or a renewal of it and to detain any person who is committing or about to join in or to renew the breach of the peace for such time as may be reasonably necessary in order to give him into the custody of a police officer;*
>
> ...
>
> *(e) to prevent the commission of an offence;*
>
> ...

(p) in the case of a parent or guardian of a child, or a person in the place of such parent or guardian, to discipline, manage or control such child;

(pa) to prevent a person reasonably believed to be attempting to, or about to, kill himself, from killing himself;

...

(r) to assist a person to do any of the things aforesaid.

ANNEXURE 8

Detaining Patients against their Will Policy

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Acute Care Division

Detaining Patients against their Will Policy

Policy Purpose

To ensure that correct procedures are followed and fulfilled in line with legislation, if there is a requirement to detain a patient against their will for assessment and/or treatment.

The legislative framework to detain a patient against their will:
- NT Mental Health and Related Services Act 2005
- NT Notifiable Diseases Act 1999
- NT Medical Services Act (section 16) 2006
- NT Emergency Medical Operations Act 2004

Policy Statement

It is unlawful, if a patient has capacity to consent, to provide medical treatment to a person who refuses that treatment. Patients have the autonomy and the right to reasonably refuse care. Thus detaining a patient against their will is an exception to the normal state of affairs.

Implementation

As per the Mental Health and Related Services Act, following needs to be followed and documented within the medical notes.

A patient can be detained under the Mental Health Act if the patient has:
- Mental illness
- Mental disturbance

1. **Section 14:** Involuntary admission on grounds of **mental illness**; the criteria for the involuntary admission of a person on the grounds of mental illness are that:

   - The person has a mental illness

   - As a result of the mental illness, the patient:
     - requires treatment that is available at an approved treatment facility;
     - is likely to cause imminent harm to him/herself, a particular person or any other person or;
     - is likely to suffer serious mental or physical deterioration, unless he or she receives the treatment and;
     - is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment and;

- There is no less restrictive means of ensuring that the patient receives the treatment.

2. **Section 15**: Involuntary admission on grounds of mental disturbance; the criteria for the involuntary admission of a person on the grounds of mental disturbance are that:

   - The patient does not fulfil the criteria for involuntary admission on the grounds of mental illness;
   - The patient's behaviour is, or within the immediately preceding 48 hours has been, so irrational as to lead to the conclusion that:
     - The patient 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;
     - The patient is behaving in an abnormally aggressive manner or is engaging in seriously irresponsible conduct that justifies a determination that the patient requires psychiatric assessment, treatment or therapeutic care that is available at an approved treatment facility.

   - Unless the patient receives treatment or care at an approved treatment facility, he or she:
     - is likely to cause imminent harm to himself or herself, to a particular person or to any other person;
     - will represent a substantial danger to the general community; or
     - is likely to suffer serious mental or physical deterioration.

3. All patients detained under Sections 14 and 15 are required to have a psychiatric assessment.

4. **Section 34a** form allows detention for 12 hours for a psychiatric evaluation and **Section 35a** form allows notification of emergency treatment administered without approval of the tribunal.

5. The critical point is that the patient's mental state is sufficiently altered from their usual state for whatever reason, e.g., drugs, trauma, metabolic state, which deems them unable to make a rational decision regarding treatment.

6. **Section 165:** reasonable force may be used if there is insufficient time to "section" the patient.

   - A person may use reasonable force to restrain a patient being treated under the act:
     - to prevent the patient harming himself or herself or another person; or
       1. to maintain the good order and security of an approved treatment facility or the approved treatment agency.

6. The medical practitioner attending the person should record all details within the medical notes. This provides some measure of protection to staff in that Section 164 states: "*No proceedings, civil or criminal, may be commenced or continued against a person for anything done in good faith and with reasonable care by the person in*

reliance on any authority or document apparently given or made in accordance with this Act".

Notifiable Diseases Act 1999 *(please refer to Notifiable Diseases Act – Detaining Patients Policy)*
Under the *Notifiable Diseases Act* the Chief Health Officer (CHO) of the NT, or an official delegate, has the power to order the detention of a person against their will for treatment of, or to prevent the spread of a notifiable disease.

References

- EQuIP Version 4
  - Quality Improvement and Risk Management Standard (Criterion 2.1.2)
  - Leadership and Management Standard (Criterion 3.1.5)
  - Safe Practice and Environment (Criterion 3.2.1)

- NT Hospital Network Policy Manual
  - Patients who leave hospital without official discharge (Take Own Leave) Policy
  - Informed Patient Consent Policy
  - Competence: Ethics and Law Guidance
  - Notifiable Diseases Act – Detaining Patients Policy

- NT Mental Health & Related Services Act 2005
- NT Medical Services Act (section 16) 2006
- NT Emergency Medical Operations Act 2004
- NT Notifiable Diseases Act 1999

Review due March 2008

Acute Care Division

Patient Restraint Guidelines

These Guidelines should be used in conjunction with the Patient Restraint Policy

The guidelines describe the methods available on how to restrain a patient i.e. control their behaviour. It is not about detaining a patient, although both are often linked.

Controlling Patients:

Staff have four main options of controlling aggression. Often a combination of two or more is necessary.

1. **Verbal de-escalation and distraction**
   Talking the patient down. In general, focus on the "here and now" and do not dwell on long-term issues. Be calm, non-threatening and non-judgmental. Courtesies such as offering a cup of tea (lukewarm!), sandwich, access to phone etc can be very helpful.

2. **Chemical Restraint**
   If it appears the aggression is related to a medical or psychiatric condition AND there is sufficient staff to deal safely with the patient AND it is legally justifiable, restraint and sedation (refer to *NT Rapid Tranquillisation Protocol for Admitted Patients*).

3. **Physical Restraint**
   Mechanical restraint should only be used in extreme circumstances. Brief physical restraint is utilised as part of most acute parenteral sedations for severe behavioral disturbance. The aim is to minimise the ability of the patient to move and injure themselves or others, and at the same time ensure the patient has a patent airway and circulation is not obstructed.

   Effective physical restraint requires appropriate numbers of trained staff. The most effective is usually four-limb restraint (one person per limb) with another controlling the head. (See Physical Restraint Procedure for method).

4. **Calling Security and/or Police**
   Sometimes a display of overwhelming force will have a significant controlling effect. If the situation is not thought to be due to medical or psychiatric problems then hand over to the police.

General Restraint Principles:
(The following points are not necessarily sequential)

a) Minimum restraint only should be used, and for the minimum amount of time.
b) Restraint should be planned, and reasons for restraint explained to the patient and the patient's carer(s)/family.
c) The Medical Officer should undertake assessment of a patient's mental health, and the patient assessed as requiring detention involuntarily under the Mental Health Act, Mental Disturbance Law of Necessity.
d) A Psychiatrist should assess the patient as soon as possible, under the Mental Health Involuntary Admission on grounds of Mental Illness – Section 14.

e) Physical restraint should only be used in an emergency situation, rather than part of a planned intervention. Only minimum force required to prevent action should be used, for the minimum amount of time.
f) The decision to restrain a patient in an emergency situation should be taken by Registered Nurse in Charge, otherwise in consultation with the Medical Officer.
g) The patient should be continuously monitored, and reviewed as clinically appropriate.
h) Observations should be appropriate for clinical need, eg if patient is disoriented.
i) Observations should include appropriateness of time, place and person.
j) Physiological observations should be appropriate to physical health.
k) Full documentation of procedure within the patient's medical notes.
l) Inform the patient's carers/family of the restraint and offer support and counselling if required.

Physical Restraint Principles

a) Mechanical restraint e.g. four point restraint, five man takedown, should only be used in extreme circumstances and only on the order of the senior treating Medical Officer.
b) Safe restraint requires a coordinated team, good timing and practice.
c) Care should be taken not to inflict pain or bruising (particularly in the elderly). However the patient must be held with sufficient firmness to protect patient and staff from sudden movement, flailing limbs or biting.
d) Use of shackles: once the patient has been adequately controlled with appropriate medication given at appropriate intervals with close observation there is usually no need for shackling of patients to their bed.

Physical Restraint Procedure:

1.1 Assemble all staff, equipment and medications **before** approaching the patient.
1.2 Nominate one person 'in charge' of the procedure. Only one person should talk to the patient to avoid 'negotiation breakdown', splitting and confusion amongst the staff.
1.3 Gather sufficient staff; usually one per limb and one for the head and one to give medication, also a scribe. Assign each person his or her role.
1.4 All staff to remove potentially harmful/ hazardous articles i.e. stethoscopes, pens and wear gloves +/- eyewear.
1.5 Approach the patient with team leader talking to the patient with the others behind or flanking. Explain the situation and what is about to happen. Give the patient the choice of tablets or an injection. Reassure the patient that this is only a temporary measure and that they will feel better after they have had the medication. If they take the tablets then withdraw a little and observe.
1.6 If a patient declines the tablets/injection then at a pre-arranged signal, each person acquires his or her designated limb/head. The patient is firmly lowered to the ground to a supine position if possible and the parenteral medication given.
1.7 The team leader continues to talk calmly to the patient.
1.8 Once the medication is administered and working the restraint is released slowly, one limb at a time and the patient placed on a bed. Frequent observations are to be made as per sedation guidelines.

Sedation Principles:

a) The aim of sedation is to control dangerous behaviour sufficiently to facilitate assessment and management.

b) Sedation should generally be titrated to the point of rousable sleep, NOT unconsciousness.
c) Oral medication is preferred as it encourages engagement with staff, allows patient to feel more in control and avoids the hazards with parenteral medication.
d) The advantages of intravenous sedation are the effects are very quick and titratable.
e) Intramuscular sedation is an option when venous access is unavailable (aka "through the jeans").
f) The most common requirement for sedation in the Emergency Department is threatening or aggressive behaviour due to medical or psychiatric disturbance.
g) Where there is an assessment that the patient is mentally ill or mentally disordered a Section 34a should be completed prior to involuntary treatment if possible. However, where care is needed in an emergency situation, the safety of the patient should be addressed first.

Review due March 2008

Acute Care Division

Patient Restraint Policy

This Policy should be used in conjunction with the Patient Restraint Guidelines

Policy Purpose

- To ensure that a standardised approach to use of restraint is adopted to maintain the safety, well being and health of patients.
- To provide guidance to staff in the appropriate use of restraint in the management of patients.
- To protect the patient, or other people, from immediate or imminent risk to their safety.
- To prevent a patient attempting to self-discharge and to provide appropriate clinical care when the patient meets the requirements for involuntary detention under the *Mental Health and Related Services Act (*Sections 32a, 14 and 15) under the *Notifiable Diseases Act*, or where the risk to the patient or others is highly likely. (see Implementation section below).
- This policy relates to the following and staff should refer to these policies:
  - Detaining Patients Against their Will Policy
  - Notifiable Diseases Act - Detaining Patients Policy
  - Informed Patient Consent Policy
  - Competence: Ethics and the Law Guidance
  - Patients who leave hospital without official discharge (Take Own Leave) Policy and Guidelines

Policy Statement

The use of restraint must be considered a safety intervention where the benefits are likely to be greater than the negative effects of the intervention.

The application of restraint should only occur when other preventative measures have been considered and deemed not appropriate, and it is necessary in the circumstances of the individual case. Minimum restraint only should be used and for the minimum amount of time.

All restraint techniques should be aimed at limiting the actions of the patient in specific circumstances, where the patient is at risk of injury or of injuring others.

Implementation

Please refer to the Patient Restraint Guidelines for implementation.

Mental Health and Related Services Act - if a patient meets the requirements for involuntary detention under the Act, please refer to the *Detaining Patients against their Will Policy.*

- Section 34a form allows detention for 12 hours for a psychiatric evaluation.
- Section 14: Involuntary admission on grounds of mental illness.

- Section 15: Involuntary admission on grounds of mental disturbance; patient requires psychiatric assessment, treatment or therapeutic care that is available at an approved treatment facility.
- Section 165: reasonable force may be used if there is insufficient time to "section" the patient.

Notifiable Diseases Act *(please refer to Notifiable Diseases Act – Detaining Patients Policy)*
Under the *Notifiable Diseases Act* the Chief Health Officer (CHO) of the NT, or an official delegate, has the power to order the detention of a person against their will for treatment of, or to prevent the spread of a notifiable disease.

Legal Obligations

- Any intervention should be consistent with the legal obligations and responsibilities of health care agencies and their staff and the rights and protection afforded to patients with mental illness under the Mental Health & Related Services Act 2005 and the Notifiable Diseases Act 1999.

- Working within this legal framework, health services are responsible for the provision of care, including physical restraint/interventions, which are in a patient's best interest.

- No more force than is reasonable or absolutely necessary may be used in restraint, which applies to the application of this policy.

Definitions

Restraint: any work or action that interferes with the ability of the patient to make decisions, or restricts their free movement.

Mechanical restraint: any manual method or mechanical device applied to the body for the primary purpose of preventing or restricting or subduing movement of any part of the patient's body.

Chemical restraint: the use of medication or other substances as prescribed by a medical officer for the sole purpose of behaviour management and control, eg tranquillisers, sedative, antipsychotic drugs.

Physical restraint: the use of physical force to control a patient from taking part in an action that is likely to cause injury to self or to others.

Further Information
NT Hospital Network Policy Manual:
- Detaining Patients Against their Will Policy
- Notifiable Diseases Act - Detaining Patients Policy
- Informed Patient Consent Policy
- Competence: Ethics and the Law Guidance
- Patients who leave hospital without official discharge (Take Own Leave) Policy and Guidelines

Emergency Department Guidelines (RDH):
- Restraining Patients
- Physical Restraint
- Chemical Restraint

Top End Mental Health Service – Restraint Policy (Ref no: 1.25 October 2003)
ASH & RDH Aggression Management Policies
NT Drugs and Therapeutics Rapid Tranquillisation Protocol 2006
RDH – Aggression Management Policy (October 2002)

Legislation

NT Mental Health & Related Services Act 2005:
- Approved forms contained on DHCS Mental Health Services intranet site

NT Medical Services Act 2006 (section 16)
NT Community Welfare Act 2005 (Section 11)
NT Notifiable Diseases Act 1999

References

EQuIP Version 4:
- Continuity of Care Standard (Criterion 1.1.3)
- Quality Improvement and Risk Management Standard (Criterion 2.1.2, 2.1.3)
- Leadership and Management Standard (Criterion 3.1.5)
- Safe Practice and Environment (Criterion 3.2.5)

National Institute for Health and Clinical Excellence (NICE) UK. Violence – short term management of disturbed/violent behaviour in in-patient psychiatric settings and Emergency Departments (February 2005)
Physical restraint in Acute and Residential Care – Joanna Briggs Institute 2002
NT Criminal Code

Review Date March 2008

ANNEXURE 9

OMBUDSMAN REQUEST FOR DOCUMENTS

Ombudsman NT

Our Ref: D090100023
Your Ref:

22 January 2009

Dr Len Notaras
General Manager
Royal Darwin Hospital
PO Box 41326
CASUARINA NT 0811

Dear Len

RE: INVESTIGATION INTO USE OF FORCE AND RESTRAINT AT RDH

I refer to the notice of investigation from me to David Ashbridge dated 20 January 2009.

Under the *Medical Services Act* you are the person in charge of the Royal Darwin Hospital and I am requesting from you the following information and documents. Under the *Ombudsman (Northern Territory) Act* David Ashbridge is the Chief Executive Officer of the agency which is administratively responsible for RDH. This means that to use my powers under the *Ombudsman (Northern Territory) Act* to require this information and these documents I would need to serve summonses on both you and David. I therefore seek your co-operation in providing this information voluntarily and promptly.

The information I seek is as follows:

1. Have security staff working at Royal Darwin Hospital been instructed by any person employed by the Department of Health & Families 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 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.

GPO Box 1344 **DARWIN** NT 0801 Telephone: (08) 8999 1818 Facsimile: (08) 8999 1828
PO Box 2388 **ALICE SPRINGS** NT 0871 Telephone: (08) 8951 5818 Facsimile: (08) 8951 5828
INTERNET: www.ombudsman.nt.gov.au **TOLL FREE NUMBER 1800 806 380**

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.

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

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

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

6. On each occasion when a person was detained or restrained solely relying on Section 16 of the *Medical Services Act*

   6.1 Who authorised the detention or restraint?
   6.2 Who implemented the decision to detain or restrain?
   6.3 What records were created?
   6.4 Where are the records now located?

7. Have you seen, requested or obtained advice from a legal practitioner on the legality of restraining and/or detaining persons 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 or partly 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.

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

9. Is there a Department of Health & Families and/or Royal Darwin Hospital 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.

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.

With respect to documents I would like to see I specify below those which I can envisage may exist. I ask for you to produce all documents relevant to the subject of this investigation and especially any document alluding to, recording any decision about, reporting on or relevant to the circumstances in which and the policies and process for detaining or restraining persons at RDH since 1 January 2006. You are

in the best position to know what exists or ought to exist and I seek your voluntary comprehensive disclosure of those records and documents. The specific records I nominate at this stage, that I want to see, include:

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.

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* to restrain or detain a person.

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

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

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

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

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

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

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

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*.

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

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)

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relying solely on Section 16 of the *Medical Services Act* since 1 January 2006.

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

I look forward to your co-operation and a comprehensive response no later than 10 February 2009.

Yours sincerely

CAROLYN RICHARDS
Ombudsman

END PAGE