REPORT OF
THE COMMITTEE OF INQUIRY
INTO PROCEDURES AT
OAKLEY HOSPITAL
AND RELATED MATTERS

JANUARY 1983

THE COMMITTEE OF INQUIRY INTO PROCEDURES AT OAKLEY HOSPITAL AND RELATED MATTERS

CHAIRMAN:

R.G. Gallen Esquire, Q.C., LlB

MEMBERS:

Miss R. McEwan M.B.E., R.Comp.N., Dip.N (S.A.N.S)

Dr B.J. Shea O.B.E., O.St J., MB BS Adel, DPM Melb, FRANZCP, FRCPsych, FRACMA, FHA, FAIM

COUNSEL ASSISTING THE COMMITTEE:

P.J. Davison Esquire, LlB

STAFF:

Secretary: Miss V. Taylor

Assistant: Miss B.M. Anderson

Secretarial: Mrs D.C. Roderick

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APPOINTMENT OF COMMITTEE OF INQUIRY INTO PROCEDURES AT OAKLEY HOSPITAL AND OTHER RELATED MATTERS

To all to whom these presents shall come, and to:

RODNEY GERALD GALLEN, Ll.B. of Napier, One of Her Majesty's Counsel Learned in the Law;
RITA McEWAN, M.B.E., R.COMP.N., DIP.N.(S.A.N.S.) of Paremata, retired Principal Nurse; and
BRIAN JOSEPH SHEA, O.B.E., MB BS Adel, DPM Melb., FRANZCP, FACMA, FRCPSYCH, FHA, FAIM, Director of Mental Health, South Australian Health Commission:

PURSUANT to section 13 (3) of the Hospitals Act 1957, I **ANTHONY GEORGE MALCOLM**, Minister of Health, hereby appoint you the said Rodney Gerald Gallen, Rita McEwan, and Brian Joseph Shea to be a Committee of Inquiry—

(1) To inquire into and make recommendations on procedures at Oakley Hospital as they relate to the care, treatment, and management of patients:

(2) As part of the inquiry specified in paragraph (1), to investigate allegations in a certain affidavit concerning Michael Watene deceased which has been brought to the attention of the Auckland Hospital Board:

(3) To inquire into and make recommendations on such other matters as appear relevant:

And I hereby appoint you, the said Rodney Gerald Gallen, to be the Chairman of the Committee:

And, in accordance with section 13 (3) of the Hospitals Act 1957, I direct that the Committee shall have the powers of a Commission under the Commissions of Inquiry Act 1908, and the provisions of that Act, except sections 11 and 12 (which relate to costs), shall apply as if the inquiry where an inquiry under that Act:

And for the better enabling you to carry these presents into effect you are hereby authorised and empowered to make and conduct any inquiry under these presents in accordance with the Commissions of Inquiry Act 1908, at such times and places as you consider expedient, with power to adjourn from time to time and from place to place as you think fit, and so that these presents shall continue in force and the inquiry may at any time and place be resumed although not regularly adjourned from time to time or from place to place:

And you are hereby strictly charged and directed that you shall not at any time publish or otherwise disclose, save to me in pursuance of these presents or by my direction, the contents or purport of any report so made or to be made by you, or any evidence or information obtained by you in the exercise of the powers hereby conferred upon you, except such evidence or information as is received in the course of a sitting open to the public:

And it is hereby declared that the powers hereby conferred shall be exercisable notwithstanding the absence at any time of any one of the members hereby appointed so long as the Chairman, or a member deputed by the Chairman to act in his stead, and one other member, are present and concur in the exercise of the powers:

And it is hereby declared that you have liberty to report your proceedings and findings from time to time if you shall judge it expedient to do so:

And, using all due diligence, you are required to report to me in writing under your hands not later than the 1st day of November 1982 your findings and opinions on the matters aforesaid, together with such recommendations as you think fit to make in respect thereof.

Dated at Wellington this 2nd day of August 1982.

A.G. MALCOLM, Minister of Health.

EXTENDING THE TIME WITHIN WHICH COMMITTEE OF INQUIRY INTO PROCEDURES AT OAKLEY HOSPITAL AND OTHER RELATED MATTERS MAY REPORT

To all to whom these presents shall come, and to:

RODNEY GERALD GALLEN, Ll.B. of Napier, One of Her Majesty's Counsel Learned in the Law:
RITA McEWAN, M.B.E., R.COMP.N., DIP.N. (S.A.N.S.) of Paremata, retired principal nurse; and
BRIAN JOSEPH SHEA, O.B.E., MB BS Adel, DPM Melb, FRANZCP, FACMA, FRC PSYCH, FHA, FAIM, Director of Mental Health, South Australian Health Commission:

WHEREAS, by Warrant dated the 2nd day of August 1982*, I appointed you, the said Rodney Gerald Gallen, Rita McEwan, and Brian Joseph Shea, to be a Committee of Inquiry to inquire into procedures at Oakley Hospital and other related matters:

And whereas by the said Warrant you were required to report not later than the 1st day of November 1982 your findings and opinions on the matters aforesaid:

And whereas it is expedient that the time for so reporting should be extended as hereinafter provided:

Now, therefore, pursuant to section 13 (3) of the Hospitals Act 1957, I, **ANTHONY GEORGE MALCOLM**, Minister of Health, hereby extend until the 31st day of December 1982 the time within which you are so required to report without prejudice to the continuation of the liberty conferred upon you by the said Warrant to report your proceedings and findings from time to time if you should judge it expedient to do so, and hereby confirm the said Warrant dated the 2nd day of August 1982 and the Committee thereby constituted, save as modified by these presents.

Dated at Wellington this 8th day of October 1982.

A.G. MALCOLM, Minister of Health.

*Gazette 1982 p. 2561

FURTHER EXTENDING THE TIME WITHIN WHICH COMMITTEE OF INQUIRY INTO PROCEDURES AT OAKLEY HOSPITAL AND OTHER RELATED MATTERS MAY REPORT

To all to whom these presents shall come, and to:

RODNEY GERALD GALLEN, Ll.B. of Napier, One of Her Majesty's Counsel Learned in the Law:
RITA McEWAN, M.B.E., R.COMP.N., DIP.N. (S.A.N.S.) of Paremata, retired principal nurse; and
BRIAN JOSEPH SHEA, O.B.E., MB BS Adel, DPM Melb, FRANZCP, FACMA, FRC PSYCH, FHA, FAIM, Director of Mental Health, South Australian Health Commission:

WHEREAS, by Warrant dated the 2nd day of August 1982*, I appointed you, the said Rodney Gerald Gallen, Rita McEwan, and Brian Joseph Shea, to be a Committee of Inquiry to inquire into procedures at Oakley Hospital and other related matters:

And whereas by the said Warrant you were required to report not later than the 1st day of November 1982 your findings and opinions on the matters aforesaid:

And whereas by a further Warrant dated the 8th day of October 1982† the time for so reporting was extended until the 31st day of December 1982:

And whereas it is expedient that the time for so reporting should be further extended as hereinafter provided:

Now, therefore, pursuant to section 13 (3) of the Hospitals Act 1957, I, **ANTHONY GEORGE MALCOLM**, Minister of Health, hereby extend until the 31st day of January 1983 the time within which you are so required to report without prejudice to the continuation of the liberty conferred upon you by the said Warrant to report your proceedings and findings from time to time if you should judge it expedient to do so, and hereby confirm the said Warrant dated the 2nd day of August 1982 and the Committee thereby constituted, save as modified by these presents.

Dated at Wellington this 8th day of October 1982.

A.G. MALCOLM, Minister of Health.

*Gazette 1982 p. 2561 †Gazette 1982 p. 3376

LETTER OF TRANSMITTAL

The Honourable The Minister of Health
Office of the Minister of Health
WELLINGTON

Dear Minister

By warrant under your hand dated 2 August 1982, we the undersigned, **RODNEY GERALD GALLEN, RITA McEWAN,** and **BRIAN JOSEPH SHEA** were appointed, pursuant to section 13 (3) of the Hospitals Act 1957, to report under the terms of reference stated in the Warrant.

We were required to present our report by 1 November 1982, but this was later extended to 31 December 1982, and further extended to 31 January 1983.

We now submit our report for your consideration.

We have the honour to be your most obedient servants.

R.G. GALLEN, Chairman

RITA McEWAN, Member

B.J. SHEA, Member

Dated at Wellington this 26th day of January 1983.

" ... there is no mans minde of such discordant and jarring a temper to which a tuneable disposition may not strike a harmony."

Sir Thomas Browne

"It may seem a strange principle to enunicate as the very first requirement in a hospital that it should do the sick no harm."

Florence Nightingale

"An undue emphasis on security will in many cases trigger off a reaction in a patient which both militates against proper treatment and necessitates even more security."

C.P. Hutchinson Esq. Q.C.

SECTION 1

1. INTRODUCTION

1.1 Appointment and initial proceedings of the Committee

1.1.1 On 22 February 1982 Mr Michael Percy Watene died at Oakley Hospital following the administration of Electroconvulsive Therapy (ECT).

1.1.2 An inquest was held into his death, the inquest being completed on 3 June 1982. The finding of the Coroner was, "That the deceased died at Oakley Hospital on 22 February 1982, death being due to failure to adequately observe the deceased following electroconvulsive therapy."

1.1.3 Subsequently, certain affidavits regarding the treatment of Mr Watene were sworn and as a result of these the Auckland Hospital Board, which has overall responsibility for Oakley Hospital, requested an inquiry under the provisions of the Hospitals' Act 1957.

1.1.4 As a result of this request we were appointed by the Minister of Health as a Committee of Inquiry with the following terms of reference:-

1. To inquire into and make recommendations on procedures at Oakley Hospital as they relate to the care, treatment and management of patients.

2. As part of the inquiry specified in paragraph 1 to investigate allegations in a certain affidavit concerning Michael Watene deceased which has been brought to the attention of the Hospital Board.

3. To inquire into and make recommendations on such other matters as appear relevant.

1.1.5 Before the Committee was able to commence its sittings two matters received extensive publicity. The first was a dispute over whether or not the Inquiry should be held in public, and the second involved allegations of threats and intimidation against prospective witnesses.

1.1.6 The Committee held a preliminary hearing on the 3rd day of August 1982 and at this a general indication was given of the procedure which we intended to follow. We raised the question of whether or not the hearing should be held in public and sought submissions on this from interested parties.

1.1.7 After considering these submissions we concluded it was desirable that the hearing should be held in public. We were aware of the extent of public concern which already existed regarding the situation at Oakley Hospital, whether that concern was justified or not, and we appreciated that such concern would not be allayed by a hearing held in private. In addition, with a background of alleged threats and intimidation it was in our view important that the public should be aware as far as possible of the material which was produced to the Committee. Accordingly, we decided that the hearings would be held in public.

1.1.8 At the same time there would be questions of confidentiality which could not be avoided in respect of patients and former patients so that it was necessary to ensure that the names of such persons were not disclosed. This could have had the consequence of creating great unfairness to staff who could have been faced with allegations which from the point of view of the public were anonymous and for that reason we also determined that unless they specifically wished their names to be published, the names of members of staff would also be suppressed.

1.1.9 The hearing proceeded on this basis, and in order to preserve this approach, except in special circumstances the names of neither patients nor staff have been set out in this report.

1.1.10 Conducting the hearing in this way created some problems for the news media and we should like to say at the outset that we appreciate the responsibility of reporters who observed the confidentiality aspect scrupulously.

1.1.11 The Inquiry was advertised nationally and submissions were called for. In order to expedite the hearing we indicated that as far as possible submissions should be submitted in writing before the hearing commenced but we were aware that other submissions could be expected during the course of the hearing either because their preparation had been delayed or because they were prompted by material which received publicity during the course of the hearings. In fact, this occurred and a substantial amount of material was forwarded or presented to us during the course of the hearings, including additional and updated material to that which had been originally filed.

1.1.12 As far as possible we received and considered all such material. However, in the very last stages of the hearing and towards the close of the evidence given by the Medical Superintendent, an attempt was made to bring forward further material by way of submission. We refused to accept or to consider this material since it would have been quite inappropriate to do so at a time when it would have no longer been possible for it to be commented on by witnesses or parties who had completed their evidence and made their submissions earlier. In particular, we considered it imperative that in the interests of natural justice, bearing in mind the criticisms of the operation of the hospital and the philosophy behind its operation made during the course of the hearing, the Medical Superintendent should have the final opportunity at the end of the Inquiry to give evidence and comment and effectively to have the last word.

1.1.13 At the preliminary hearing we were advised that a number of parties particularly interested in the hospital and its operation sought representation with the right to take an active part in the Inquiry. In view of the very contentious nature of some of the issues which we expected to be raised before us, we had already concluded that it would be desirable for such parties to be represented and had indicated that cross-examination would be permitted. The nature of the allegations which were contained in the affidavit which initially caused the Auckland Hospital Board to seek the Inquiry were such as to require the searching testing which cross-examination should normally provide. Mrs Lorraine Smith appeared for the family of Mr Michael Watene, and Dr Rodney Harrison entered an appearance for the Auckland Civil

Liberties Organisation. Dr Harrison indicated at an early stage that it was not the intention of his organisation to be represented throughout the hearing or to cross-examine witnesses, but it was intended to make a formal submission at the appropriate time. At a later stage during the course of the hearing, Dr Harrison sought leave to appear and to cross-examine certain witnesses and we granted him this concession. The medical staff at Oakley Hospital were represented by Mr David Lee, and the senior administrative and nursing staff by Mr Kevin Ryan who also entered an appearance on behalf of the Mayor of Mount Albert. The Auckland Hospital Board was represented by Mr David Morris and Mr Roy Ladd. Mr John Haigh and Mr L. Colgan represented the nursing staff at Oakley Hospital other than those represented by Mr Ryan. In addition, the Public Service Association, to which nursing staff at Oakley Hospital belong, was represented by Mr Webster. Mr Paul Davison appeared as counsel assisting the Committee. Other interested persons and groups were present throughout the hearing but did not seek to cross-examine witnesses. During the course of the hearing Mr Mangu Awarau sought leave to cross-examine witnesses on behalf of a Maori group which had expressed an interest in the treatment of Maori patients at Oakley Hospital. He indicated his intention to produce a submission in due course and we agreed to allow him to question witnesses as we could see an advantage in having the particular point of view before us. Later, it appeared that one of the staff nurses who was required to give evidence might need separate representation and he was accordingly represented by Mr Alan Galbraith and Mrs Burnett.

1.1.14 We received a considerable number of submissions both oral and written, and these are listed in Appendix II.

1.1.15 The hearing of the Inquiry itself commenced on the 10th day of August 1982 and concluded on the 12th day of November 1982. During this period the number of sitting days amounted to 34. We were conscious of the strains imposed upon all those involved and these were not lessened by an extended sitting. We also appreciated the need to report urgently. At the same time, it appeared to us to be of the greatest importance that anybody who felt he or she had some contribution to make should be given an opportunity to do so and that we should explore to the fullest extent we were able, consistent with reasonable expedition, the various points of view which were raised. For that reason we heard all persons who wished to give evidence or make oral submissions, and received and considered all submissions, save two already referred to which were tendered at the very end of the hearing.

1.1.16 Before the actual hearing commenced we took the opportunity to visit Oakley Hospital so that we should be familiar with the setting in which the events had occurred and could visualise the evidence in context. We had already asked the Auckland Hospital Board to advise patients of the Inquiry but although several patients did approach us during our inspection there was no formal indication that we saw anywhere, drawing the attention of patients to the Inquiry. We arranged for Mr Davison, counsel assisting the committee, to visit Oakley Hospital and he spent a full day there, interviewing any patients who wished to see him or had any comments to make. Mr Davison ascertained that no

patient actually wished to give evidence to the committee but he took into account the comments made to him by patients during the course of his visit. We also received a submission from a person held at Paremoremo Prison and apart from considering his submission we arranged for him to be visited by Mr Davison.

1.1.17 Just before the Inquiry concluded we took the opportunity to again visit Oakley Hospital. On both visits we received total co-operation from the staff. We were able to freely inspect all those parts of the hospital which we wished to see and were also able to speak quite freely to patients.

1.2 Scope of the Inquiry

1.2.1 In submissions relating to the terms of reference of the Committee, counsel for the medical staff at Oakley Hospital pointed out correctly that the powers of the Committee were circumscribed by its terms of reference. Under those circumstances it is desirable that we should at this stage of the report indicate our view of the scope of those terms.

1.2.2 The first term of reference involves an inquiry into, and recommendations on, procedures insofar as they relate to the care, treatment and management of patients. The term "procedures" is not a particularly clear one, but it is clearly enough coloured by the references to care, treatment and management of patients. We believe that this is a reasonably wide term of reference, and that it is in any event, widened by the third term of reference which, even if it be construed eiusdem generis, in our view, justifies inquiry into, comment upon, and consequent recommendations on any activities at Oakley Hospital which reasonably have a bearing on the care, treatment and management of patients.

1.2.3 Throughout the inquiry reference was made to the forensic emphasis which exists at Oakley Hospital and to the particular kind of patients who are received and treated at the hospital. For this reason we were unable to consider the care, treatment and management of patients without also taking into account the special factors which caused their admission, and the relationship to other insitutions, including other hospitals, as well as the prison system and the Courts. In addition, we could not escape some concern with the civil rights of patients.

1.2.4 For these reasons such matters were canvassed before us as the remand facilities at Oakley Hospital and the general practices in the Auckland area with regard to remands for psychiatric reports. We were also obliged to consider in making recommendations for the future whether other institutions should provide complementary or substitute facilities to those which now exist, or we recommend should in the future exist, at Oakley Hospital.

1.2.5 Because we are required to make recommendations, we believe such recommendations if they are to have any validity or value must be made in the round, taking into account those related matters which make them possible and effective. They cannot simply be made and left in the air.

1.2.6 Finally, as was suggested in a number of submissions, if the recommendations are to be effective they must be implemented in such a way as to ensure that there are safeguards and supervisory provisions to ensure that if implemented they are complied with. As Dr Walker said, in the setting of a mental hospital the concern expressed by the question, "Quis custodiet ipsos custodes" has a special application.

1.2.7 The second term of reference is specific in nature but it is related, we assume quite deliberately, to the first term and obviously has a bearing on the third.

1.2.8 It refers specifically to the investigations of allegations contained in a particular affidavit. This involves allegations of physical ill-treatment and improper medication.

1.2.9 In our view the inter-relation of the three terms of reference required us to investigate, comment upon, and arrive at conclusions relating to all the care, treatment and management which affected Michael Watene as a patient, not merely the specific allegations contained in the affidavit.

1.2.10 For all these reasons we have felt it both necessary and desirable to deal with every aspect of the treatment which Mr Watene received, and to move from this into a more general consideration of practices and procedures at Oakley Hospital, proceeding then to the recommendations which arise from these considerations.

1.2.11 The submissions we received and the evidence called before us made it clear that concerned parties had interpreted our terms of reference in the same way we had.

1.3 The Scheme of the Report

1.3.1 The second of our terms of reference was specific in nature and related to the death of Mr Watene and the events leading up to that. Both the other terms of reference were general. It appeared to us that the easiest way to approach the matter would be to deal with the specific matter first. Accordingly the hearing proceeded on this basis, dealing first with the evidence adduced in respect of Mr Watene's treatment and death, and moving then into more general areas.

1.3.2 Generally speaking, we have followed the same scheme in the report, considering that it is best to proceed from the specific to the general. We have therefore dealt first with the particular events in which Mr Watene was involved, setting these out in narrative form as a basis for the comments, conclusions and recommendations which appear later in the report.

1.3.3 This narrative is then followed by comments and conclusions on various aspects of the treatment which Mr Watene received while at Oakley Hospital.

1.3.4 We then proceed to deal with the more general aspects which fall under either the first or the third terms of reference, and in doing so have commenced with a series of Sections which deal generally with conditions and approaches at Oakley Hospital, with comments and conclusions in respect of these.

1.3.5 Finally, since we do not believe that criticism has any value unless it is constructive in nature and as we later indicate, we do not see any advantage in merely apportioning blame, we have proceeded to make general recommendations in respect of the future of Oakley Hospital and other related matters. In doing so we have borne in mind the various proposals and suggestions which were made during the course of the hearing either in evidence or by way of submission. We desire to stress that while we appreciate that some of the recommendations are long term in nature and require more consideration than we have been able to give them, others draw attention to situations which at present exist and which in our view in the interests of patients and staff should be remedied with the utmost expedition.

SECTION 2

2. GENERAL PRELIMINARY COMMENTS

2.1 Inspection of Other Institutions

2.1.1 During the course of our investigations we were able to visit the Northfield Security Hospital in Adelaide, and took the opportunity while there to visit Hillcrest and Glenside Hospitals, as well as the Flinders Medical Centre which is associated with Flinders University. In New Zealand, apart from Oakley Hospital itself, we inspected the ECT (Electroconvulsive Therapy) unit at Carrington Hospital and visited also the maximum security unit at Lake Alice Hospital. We also went to Mount Eden Prison and Paremoremo Prison.

2.2 Criticism

2.2.1 It will be clear from our comments that we consider that in a number of areas criticisms are justified. We have avoided as far as possible spelling out detailed criticisms against individual persons. Our reason for adopting this approach is not because we do not consider such criticisms justified, but we believe that significant changes should and must occur at Oakley Hospital. We are concerned that such changes should not be deferred or avoided by the appropriate authorities merely taking action against individual persons. Such an approach would not effect the changes in system and attitude which we believe to be necessary. The care of patients is more important than finding scapegoats.

2.2.2 We also wish to point out at the outset that, as Dr James stressed in his submission, there are aspects of penal policy and penal reform which could and should have a bearing on the future of Oakley Hospital or indeed any similar institutions. Our Inquiry is not wide enough to embrace such matters except peripherally. We have not inquired into them but we are aware that in some cases our recommendations involve a consideration of such matters. We merely point out that in these areas further study will be necessary by those appropriately qualified.

2.2.3 We record too that a group of relatives of past or present patients sought the opportunity to make submissions to us in support of the present regime and of the approach of the Medical Superintendent in particular. When we visited Oakley Hospital more than one patient took the opportunity to approach us and to indicate support for the Medical Superintendent and gratitude for the assistance they had received from him. These are matters which should not be lost sight of when others are taken into consideration.

2.2.4 It is appropriate that we should comment that while there are matters which give rise to grave concern, it is also proper to say that we are aware that there are staff working at Oakley Hospital who are concerned for the patients within their care and who endeavour to do their job with compassion under the circumstances which exist.

2.2.5 We were impressed by the fact that a number of members of the staff had gone so far as to establish a planning committee designed to elicit ideas for improvement at Oakley Hospital. We record with concern that it appears to us that this approach does not seem to have met with the support and encouragement that could reasonably have been expected. These nurses came forward publicly at the Inquiry to express opinions which were unlikely to endear them to their present superiors. In addition, they took part in the hearing when they were aware that there was considerable public concern over Oakley Hospital, and to that extent identified themselves with the hospital. We believe that this approach took courage and deserves recognition.

2.3 Context

2.3.1 The matters with which we are concerned can only be considered in the context of the physical condition and history of Oakley Hospital as an institution. Any criticisms which we make must be considered in the light of the limitations imposed by the physical facilities at the Hospital as well as those imposed by shortages of qualified staff.

2.3.2 It is also fair to say that Oakley Hospital has been expected to take, and has taken, many patients which other hospitals consider disruptive or unsuitable. It has also cared for most prisoners from the Auckland area who have developed psychiatric problems. Both these factors have played their part in the development of Oakley Hospital and its manner of operation. These aspects have been referred to elsewhere in the report on a number of occasions.

2.4 History of Oakley Hospital

2.4.1 We were informed by the Medical Superintendent that a psychiatric hospital existed in the grounds of the Auckland General Hospital from 1853.

2.4.2 In 1867 a mental hospital was established on the present Carrington/Oakley site and there has been a mental hospital on that site ever since.

2.4.3 The buildings which now constitute Ward M7 at Oakley Hospital were erected in 1896 and the buildings which now constitute Ward M3 at Oakley Hospital were erected at the time of the First World War.

2.4.4 Until approximately 1960 the whole complex was known as the Auckland Mental Hospital. It was then renamed as the Oakley Hospital.

2.4.5 In 1965 this hospital was operated under the control of the Mental Health Division of the Department of Health, and in this year the Medical Superintendent of the present Oakley Hospital was appointed as Medical Superintendent of the whole hospital which then contained approximately 1,200 beds.

2.4.6 Subsequently, on the initiative of the Medical Superintendent an extra-mural service was established which had an effect on the rate of admission and re-admission, gradually reducing the number of beds by 1971 to 850.

2.4.7 In 1971 industrial action was taken by the nursing staff and in the same year a Commission of Inquiry under the chairmanship of C.P. Hutchinson Esq., Q.C., was set up to report on psychiatric services at Oakley Hospital. This report will be referred to subsequently.

2.4.8 On 1 April 1972 the Mental Health Division of the Department of Health handed over responsibility for psychiatric hospitals to local Hospital Boards and the Auckland Hospital Board thereupon became responsible for the control of a number of psychiatric hospitals in the Auckland area, including the Oakley Hospital.

2.4.9 In 1973 Oakley Hospital was completely reorganised by the Auckland Hospital Board which effectively divided it into two hospitals. Wards M3 and M7 of the old Oakley Hospital became the new Oakley Hospital and the bulk of the old hospital was renamed as Carrington Hospital.

2.4.10 We were informed that the first the Medical Superintendent of the old Oakley Hospital knew of this move was when he was advised on the afternoon of 14 July 1973 that the reorganisation was taking place and that he was being placed in charge of the new Oakley Hospital, that is, Wards M3 and M7. He was informed that he would not be permitted to apply for the position of Medical Superintendent of the new Carrington Hospital and that the decisions would all take effect on the following Monday, 17 July. He was informed that the new Oakley Hospital would be a "forensic type hospital". We consider that the failure to give adequate notice to the Medical Superintendent was quite extraordinary.

2.4.11 Staff at the old Oakley Hospital were given an opportunity to decide whether they wished to remain at the new Carrington Hospital or to transfer to the new Oakley Hospital. A number of staff exercised the option to make the transfer and eventually did so.

2.4.12 Since that time the present Oakley Hospital has existed as a separate entity, accepting only male patients. Although it takes committed and voluntary patients and operates a substantial outpatient service, it appears from the beginning to have predominantly served as an institution associated with the Courts and the prisons. It takes and has taken most prisoners from the Auckland area who have developed psychiatric problems and has a substantial number of persons referred to it on remand for psychiatric observation and report. It has also been the practice for a number of persons to be referred directly to Oakley Hospital by the Courts and it contains a number of persons who have been acquitted on criminal charges on the grounds of insanity and been thereafter directed to be held.

2.4.13 In addition, we were informed that it has been the practice for other psychiatric institutions in the Auckland area to send patients to Oakley who for one reason or another were considered too difficult or disruptive to manage in those institutions.

2.4.14 It is and has been the proud boast of Oakley Hospital that it does not decline to receive any patient, no matter how difficult or unwanted.

2.5 Previous Inquiries

2.5.1 The Hutchinson Report

2.5.1.1 Reference has already been made to the 1971 Commission of Inquiry chaired by C.P. Hutchinson Esq., Q.C.

2.5.1.2 That inquiry was into psychiatric services at the then Oakley Hospital, a much larger institution.

2.5.1.3 The report contains forty-two recommendations, all of which are discussed in detail in context, in the report itself.

2.5.1.4 It was claimed that a major reason for the re-organisation of Oakley Hospital in 1973, referred to in the history set out earlier in this report, was the failure of the administration of Oakley Hospital to adequately implement the recommendations of the Hutchinson report.

2.5.1.5 During the course of this report we have referred on a number of occasions to material which appeared in the Hutchinson report. Such references are to areas of specific concern. Nevertheless, in an overall sense it is most disturbing to us that we consider a substantial number of deficiencies to which attention was drawn in the Hutchinson report still exist with little apparent improvement. In many cases these deficiencies could have been remedied at least to some extent if those responsible had had the will to attempt to remedy them and in some cases if funds had been made available for this purpose.

2.5.1.6 In re-reading the report of the Hutchinson Commission this Committee has a strong sense of deja vu. We note that many of the matters which we consider unacceptable were referred to as unsatisfactory in that report.

2.5.1.7 Rather than set out these in detail we illustrate our concern with two examples. Paragraph 26 of the Hutchinson Report on page 27 contains the following:-

> "... The day room in M7 Ward is expected to cope with up to 120 patients. The M3 day room copes with something in the region of 80 patients who are totally unoccupied except for television for a large percentage of their time and with disturbed patients and patients of social nuisance value mixed together in boredom, frustration, and despair."

Paragraphs 37 to 39 inclusive of the Hutchinson Report on Page 31 reads as follows:-

> "37. In addition, we realise that a dynamic balance has to be found between the protection of the patient and the encouragement of his freedom, initiative, and independence. It is very easy, however, to err on the side of overprotection, and we have evidence presented to us that there may well be a tendency at Oakley to overcaution and a reluctance to take some justifiable risks with patients' independence.

38. The Commission recognises that the community is entitled to protection from the dangerous and the particularly obnoxious patient and that it is frequently difficult to reconcile a hospital's duty in this regard with the rights of individual patients. But we believe that a psychiatric hospital has a clear duty to allow its patients as much freedom as possible, even although this may on occasions be flying in the face of uninformed public opinion.

39. We feel that patients at Oakley Hospital do not, in many cases, enjoy either the freedom or the privacy to which they are entitled. There appear to be two main reasons for this: that the placement in Oakley of remand patients and court referrals, with the consequent need for security measures, has had an influence on the hospital as a whole out of all proportion to the numbers of patients involved; and that staffing shortages make it impossible to allow patients the freedom and privacy that they could expect if better supervision were available. In another Section of this report we have dealt with problems associated with the reception at Oakley of remand patients and Court referrals admitted under the Criminal Justice and Alcoholism and Drug Addiction Acts. For the moment, we would simply observe that a psychiatric hospital cannot be expected to fulfil its proper role in the community and have due regard for the rights of patients at the same time as it acts as a penal institution."

2.5.1.8 The references to the day rooms are as applicable today as they were in 1971, although the day rooms are now less crowded than at that time. We do not think that the perpetuation of these conditions, which bear directly on the quality of life of patients, reflects credit on those concerned. We consider also that the attitudes referred to in Paragraphs 37, 38 & 39 appear to have changed but little.

2.5.2 Other Inquiries

2.5.2.1 We were informed that our Inquiry was the fourteenth undertaken since 1971. We understand this comment included internal investigations resulting from complaints.

2.5.2.2 An attempt was made during the hearing effectively to re-open certain of these complaints and investigations. We were not prepared to do this.

2.5.2.3 From our point of view however, it is difficult to escape the conclusion that the number of incidents which have led to Inquiries or investigations indicates an accumulation of concern which cannot be overlooked, regardless of the results of those investigations.

2.5.3 Inquiry by the Ombudsman

2.5.3.1 As a result of a complaint received in November 1981, the Ombudsman undertook an investigation concerning Oakley Hospital. We were not aware of this investigation at the time our Inquiry commenced but we were however informed of it during the course of the Inquiry. Our initial reaction was to indicate that we were

not prepared to take it into consideration. The reason for adopting this view was that the Ombudsman operates in a completely different way from a Committee of Inquiry. His method of investigation is different, the material he obtains is not tested by cross-examination, and there is not the same opportunity for individuals to refute specific allegations which may be made to the Ombudsman in private. In addition, at that stage the report had not been made public.

2.5.3.2 Subsequently, the Ombudsman's report was made available to the news media and formed the subject of a television programme. Since the report was then publicly available we indicated it was our intention to read it and we have done so.

2.5.3.3 The Ombudsman was concerned specifically with a complaint that the Auckland Hospital Board had not implemented certain of the recommendations of the Hutchinson Committee of Inquiry as they related to Oakley Hospital.

2.5.3.4 The material in the Ombudsmans report and the conclusions to which he came have not influenced us in any way. We have proceeded solely on the basis of the material which was adduced in evidence or placed before us by way of submissions, and from our own observations. We consider that it would not be competent for us to rely upon the conclusions of the Ombudsman, based as they are on a completely different complaint and method of investigation.

2.5.3.5 Nevertheless, we note that the conclusions which we have quite independently reached are not in conflict with the conclusions to which he came.

SECTION 3

3. THE ADMISSION, TREATMENT AND DEATH OF MICHAEL PERCY WATENE

3.1 Occurrences Before Admission

3.1.1 On 12 February 1982 Michael Percy Watene appeared before Judge Blackwood in the Whangarei District Court, was convicted on a charge of offensive behaviour, and sentenced to seven days' imprisonment. He was remanded in custody on a charge of robbery to appear on 1 March 1982.

3.1.2 On 15 February 1982 a registered nurse at Mt Eden Prison made an application for a reception order under the provisions of Section 42 of the Mental Health Act 1969. Clause 1 of the application read as follows:-

> "1. I believe that the said person is mentally disordered on the following grounds ... A very sullen, morose 25 year old man who is depressed and uncommunicative. He barricaded himself in his cell because he is scared of other inmates. A knife was on his person which he said was for his protection. In his present mental state he could be dangerous and it seems psychiatric treatment is warranted at this stage."

3.1.3 Mr Watene was seen by two doctors.

3.1.4 The first stated as follows:-

> "1. The following are the facts observed by me on the occasion of the said examination, on which my opinion is based:
>
> A 25 year old Maori who is dull, apathetic withdrawn and preoccupied to a pathalogical degree. It is very difficult to gain his attention. He cerebrates slowly and replies to repeated questioning are in the main irrelevant.
>
> 2. In persuance of Section 31 of the said Act, I make this further statement with respect to the said person:
>
> (a) The following facts, indicating the mental disorder on the part of the said person, have been observed by me on occasions other than the date of the said examination: 14.2.82. Dull, apathetic, withdrawn. He had in his possession a modified knife prepared for defence or attacks but he could give no coherent account of his motives.
>
> (b) The following facts concerning the said person indicating mental disorder have been communicated to me by ..... Medical Unit, H.M. Prison, Mount Eden:-
>
> "Watene is dull, withdrawn, and unable to give any account of himself or his behaviour."

(c) In my opinion the said person may be properly classified as being mentally ill.

(d) In my opinion the said person could be suicidal. In my opinion the said person could be dangerous.

(e) The following treatment has been employed for the said person in respect of his mental condition: Nil."

Sections 2(f) and 3 of this form were not provided to the Committee.

3.1.5. The second doctor, in his certificate, said as follows:-

"1. The following are the facts observed by me on the occasion of the said examination on which my opinion is based:

A withdrawn, depressed, young Maori man. It is not really possible to have a conversation with him but he does indicate his fear of being left alone in the cell and wished me to stay with him. Says he is "mixed up".

2. In pursuance of Section 31 of the said Act I make this further statement with respect to the said person:-

(a) The following facts indicating the mental disorder on the part of the said person have been observed by me on occasions other than the date of the said examination: Nil

(b) The following facts concerning the said person indicating mental disorder have been communicated to me by: Nurse ..... Prison Medical Section, tells me he barricaded himself in his cell in fear.

(c) In my opinion the said person may be properly classified as being mentally ill.

(d) In my opinion the said person could be suicidal. In my opinion the said person could be dangerous.

(e) The following treatment has been employed for the said person in respect of his mental condition: Nil.

(f) The said person's bodily health and condition are as follows: Satisfactory.

3. In my opinion the said person requires detention because: He is fearful, depressed, and inaccessible to reason. Needs specialist supervision."

3.1.6 On 15 February 1982, following receipt of the certificates and application, a reception order was made by a District Court Judge, ordering that Mr Watene be received and detained as a mentally disordered person in Oakley Hospital.

3.2 **Admission**

3.2.1 In the late afternoon on 15 February 1982 Mr Watene arrived at the Oakley Hospital Administration Centre in the charge of prison warders. He was seen by a doctor who was unable to communicate with him. The doctor concerned, having read the application for reception order and the accompanying certificates and discussed the matter with the prison officers, made out an admission form which contained the following comments:-

"Patient considered to be suicidal - Yes ?
dangerous - Yes,
prob.
impulsive
epileptic - Yes ?
Section 42 sentence expires soon -> Section 21.
Had barricaded himself in a cell with a knife.
Withdrawn, etc.? hallucinated."

3.2.2 The doctor also indicated interim medication as follows:-

1. Mist Chloral 10 - 20 mls nocte
and/ 2. Largactil mg 100) x IMI S.O.S.
or 3. Paraldehyde 10 - 20 mls.) Agitation

3.2.3 Mr Watene was then taken to Ward M3 and the admission form taken with him as instruction for the nursing staff. Although the form included sections regarding observation (dormitory/single room), full privileges, and ward parole, these sections had not been completed.

3.2.4 It is important to note that Mr Watene did not become the patient of the doctor who admitted him. At Oakley Hospital patients are allocated on a strictly rotational basis, and in fact Mr Watene was allocated to another doctor who was not at the time on duty and who did not see Mr Watene until the following day.

3.2.5 It is also important to note that the interim medication instruction to staff insofar as it referred to Largactil and Paraldehyde was a discretionary instruction, staff having a discretion to administer the medication referred to as they deemed it necessary.

3.2.6 When Mr Watene arrived at Ward M3 the psychiatric nurse in charge received him. He stated that Mr Watene was in charge of five or six prison officers, he was handcuffed with his hands behind his back, and he also stated that his feet were secured. The doctor who had admitted Mr Watene did not accept that Mr Watene's feet were secured and no other witness referred to this. The nurse concerned stated that the prison officers indicated to him they had had considerable difficulties with Mr Watene.

3.2.7 The nurse concerned received the application for reception and supporting certificates which he read in the presence of the prison officers. At the discretion of the nurse concerned Mr Watene was then placed in seclusion. He was in fact placed in what is known as Strongroom No.7. The only furniture in this room was a mattress on the floor and a plastic chamber pot.

3.2.8 Mr Watene was locked into the room. He would have been unable to see into the corridor or to communicate with staff or other patients except by banging on the door or shouting.

3.2.9 Another psychiatric nurse who had been on duty was going off duty when Mr Watene arrived in the ward which he says was at about a quarter to four on 15 February. He stated that Mr Watene looked to him to be physically very strong. He was calm when he spoke to him. The nurse informed him that he would catch up with him later. He was in fact off duty on the following two days.

3.2.10 An entry was made in the ward Day Book by the senior nurse in the following terms:-

> "Watene, Micheal (sic) Percy:
> Section 42 ex Mount Eden. Depressed? Hallucinated? Had a knife on him in jail. Can be dangerous. Place in S/R for observation meantime. (Suicidal?)"

3.2.11 A psychiatric assistant gave evidence that he was present when Mr Watene was admitted. Staff records which were produced indicated that the assistant in question had not worked on 15 February. He was unable to produce any evidence to refute this, and we could not in the circumstances rely upon comments he made with regard to Mr Watene's admission.

3.2.12 There is no record that Mr Watene was given any of the medication indicated by the admitting doctor. There is also no record that he was given any physical medical examination or that he received a bath or shower or any medical attention.

3.3 **16 February 1982**

3.3.1 The Day Book for A shift for 16 February reads as follows:-

> "Watene M.P. Appeared to sleep well without requiring medication. Vague, not very communicative this morning. Caution is advised.

A similar entry was made in the nursing notes.

3.3.2 On the morning of the 16th there is no record that Mr Watene refused food and the nurse on duty gave no evidence of any refusal.

3.3.3 On the morning of 16 February Mr Watene was interviewed by the doctor to whom he had been assigned. The doctor states that this occurred in a strongroom in M3 in the presence of the charge nurse and two or three other staff members.

3.3.4 The Report of this psychiatric examination (although incorrectly recorded as being conducted on 15 February 1982) reads as follows:

> "The patient is a 26 year old Maori admitted from prison having apparently become very withdrawn, sullen and suspicious stating that he feared for his life and he apparently had a knife in his possession for his own protection. He was serving a seven day sentence and this expires on 17.2.82.
>
> He appears slow, silent, he is aware of his surroundings and of others but is uncommunicative. When attempts of conversing with him were made he merely responded by asking if he could smoke a cigarette.

He is viewed with some caution as being unpredictable and he is nursed in a single room at this stage.

He takes his meals quite normally.

Nothing is known of his previous psychiatric or criminal history at this stage except that it is the belief that he is due to appear in Whangarei on further charges of robbery and possession of firearms.

PROVISIONAL DIAGNOSIS: Paranoid reaction not otherwise specified.

CODE: 297.9

BODILY HEALTH: Appears as satisfactory but adequate examination is not possible."

3.3.5 In his evidence the doctor stated that he introduced himself and asked a number of questions such as, "How are you feeling? Do you know where you are? Is anything troubling or bothering you? Do you know why you are here? Where have you come from? Is there anything that you would like to ask me about?" Mr Watene did not reply to these questions.

3.3.6 The doctor stated that Mr Watene was clearly aware of his presence and appeared mentally alert but avoided eye contact. He says that Mr Watene glanced around the room and towards the door in a furtive and suspicious manner. He appeared tense but not obviously anxious and was neither sweating nor tremulous. He gave the impression of being on guard and made no response or reaction to the questions. The doctor states that Mr Watene moved around the room slowly and was aware of the open door. The doctor says that he concluded the interview by saying, "I will come and see you again. Will you let me know if there is any way in which we can help you?" As the doctor was about to leave the room Mr Watene asked for a cigarette. The doctor replied that this would be given to him as soon as staff were available to be with him. The doctor states that Mr Watene spoke in a low voice without much expression.

3.3.7 The doctor stated that Mr Watene's whole manner suggested suspicion, sullenness, tension, and the likelihood of sudden impulsive action, for example, suddenly rushing out of the room or being violently resistive.

3.3.8 As a result of his observations and the material which had been contained on the committal papers, the doctor considered that Mr Watene needed to be nursed with great caution and that he should remain in the strongroom and be attended by adequate staff numbers. He states that this opinion was shared by the charge nurse and that the doctor's intention was to carry out further observation and assessment, reviewing Mr Watene's condition on the following day and ascertaining whether nursing staff had been able to establish any sort of relationship with him. He was concerned to know whether any evidence would appear of thought disorder, delusions, hallucinations, or any other abnormal behaviour. His view was that medication would be restricted to sedation if required as had been ordered by the admitting doctor.

3.3.9 No physical examination was carried out because the doctor believed he was dealing with a very unpredictable, muscularly strong, and potentially violent person. He also assumed that Mr Watene had been given a physical examination while in prison. No information appears to have been available to him to suggest what physical examination had been given to Mr Watene in prison or what the results of such an examination might have been.

3.3.10 Another staff nurse who was able to speak fluent Maori was on duty on 16 February and was corridor nurse in charge of the corridor. He stated that on 16 February Mr Watene was given a shower, was exercised, and was able to use the toilets. The nurse concerned attempted to converse with Mr Watene in Maori. He received no response and considered that Mr Watene was quite uncommunicative. He stated he saw Mr Watene approximately six times while on duty and it was on the third occasion that he took him for a shower. He considered that Mr Watene appeared to understand what was going on but was not prepared to answer any questions.

3.3.11 The same nurse later stated that on the 16th Mr Watene seemed uncertain about everything and was suspicious of the nurse. He did not speak but nodded. The nurse observed no evidence of hallucinatory behaviour.

3.3.12 The ward charge nurse first saw Mr Watene on the 16th. He was then in strongroom 7. That morning the charge nurse considered that Mr Watene appeared to be hallucinated. He stated Mr Watene was looking around and appeared to be listening to voices. He was moving around the room, appeared to be suspicious, and was continually looking at the ceiling as though he were hearing something. In the Day Report he stated, "Still very vague and uncommunicative." The nursing notes have a similar entry. No reference was made in either report to the presence of hallucinations.

3.3.13 The charge nurse concerned stated that they had opened the door to speak to Mr Watene and tried to get him out for a shower and converse with him. Mr Watene stood at the back of the room completely inaccessible and in the opinion of the charge nurse out of touch with reality. He said there was no communication with Mr Watene at all. He considered it would not be possible to arrange for him to have a shower. This is in conflict with the statement of the nurse already referred to who indicated he had taken Mr Watene for a shower on the 16th, that he was given exercise, comforts, and allowed to attend the toilets.

3.3.14 There are two entries on the nursing care sheet for 16 February. The first, apparently made at 4 p.m., reads as follows:-

> "This young Maori arrived here depressed and apparently in prison locked himself, barricaded? They found a knife on him which he said was for his own protection. In his present mental state he could be dangerous. Is withdrawn and could be hallucinated. Placed in strongroom and observed."

This entry was made by the nurse who admitted Mr Watene on the 15th and the date is clearly wrong.

3.3.15 The D shift notes for the 16th have the following comment regarding Mr Watene:-

> "Caution definitely advised with this patient as he is totally unpredictable and non-communicative."

3.3.16 At 11.45 p.m. he was given 20 mls of Mist Chloral. The reference in the ward report is as follows:- "Given 20 mls Mist Chloral at 11.45 p.m. with little effect. Poor night's sleep and his actions suggest he's experiencing hallucinations of a persecutory nature."

3.4 <u>17 February 1982</u>

3.4.1 The ward charge nurse on the 17th at 7 a.m. considered that Mr Watene's condition had deteriorated from the day before. He stated that Mr Watene was more active, moving round the room, pushing himself off the wall. He appeared to be hallucinated. He looked suspiciously at the door while the charge nurse was looking through the observation panel and when the door was opened and a meal was offered to Mr Watene he stood at the back of the room inaccessible and uncommunicative and backed off as if to say, "Don't come near me." There is no reference in the ward report nor any nursing note to the effect that Mr Watene refused food.

3.4.2 A staff nurse who was present on 16 February when an attempt was made to communicate with Mr Watene in Maori recalled taking Mr Watene his breakfast around about 8 a.m. He stated that in his opinion Mr Watene was very withdrawn and he considered him to be paranoid.

3.4.3 This nurse commenced work on the 17th at 8 a.m. He stated that on the 16th Mr Watene may not have had a shower because there was a general P.S.A. meeting at 2 p.m. so that the ward staff was cut down to a bare minimum.

3.4.4 His doctor did not see or examine Mr Watene on 17 February but was informed that staff had made no progress in communicating with or relating to him. He was advised that the charge nurse considered Mr Watene to be a dangerous patient to manage. The doctor was also informed that Mr Watene had been observed apparently talking to imaginary persons, that is, probably experiencing auditory hallucinations. The doctor concluded that there had been no improvement in Mr Watene's condition from the previous day and decided to consult with a colleague with the idea of prescribing ECT. He considered that the indications were that Mr Watene had a psychotic condition with paranoid and depressive features, possibly some schizophrenic features, withdrawal from reality, and the potential to be dangerously violent. He considered that he was not amenable to other methods of treatment because he was not sufficiently co-operative or accessible mentally for a course of anti-psychotic medication to be very practicable. In making this decision he considered there were difficulties of administering regular medication to a resistive patient and accordingly he considered the possibility that ECT should be administered.

3.4.5 A charge nurse stated that on the morning of the 17th Mr Watene appeared to be more hallucinated and when the door of the room was opened and he was offered a meal he stood at the back of the room inaccessible and uncommunicative and backed off as if to say, "Don't come near to me."

3.4.6 This information was communicated to Mr Watene's doctor who discussed the matter with his colleague who without a physical examination of Mr Watene agreed that a course of ECT should be started.

3.4.7 Mr Watene's doctor stated that he considered that ECT might bring about the desired improvement more quickly so that medication could later be given safely.

3.4.8 ECT is normally administered at Oakley by this colleague who agreed to administer the treatment in the afternoon of the 17th. The doctors considered it was of some urgency in view of the management difficulties which Mr Watene was believed to be posing and the continued necessity to nurse him in a strongroom.

3.4.9 The administering doctor informed the charge nurse in charge of the ward that ECT would be administered to Mr Watene and the initial arrangement was for this to take place at 2 p.m.

3.4.10 The charge nurse informed the staff that Mr Watene was to receive ECT in the afternoon. It was necessary to do this because he could not be given food before the treatment took place.

3.4.11 The evidence indicates that Mr Watene was kept under observation during the course of the morning but there is no evidence as to the extent of this observation or what it revealed. It is not clear whether the chamber pot from Mr Watene's room was removed and emptied in the morning. This may have been done when food was offered in the morning but there is no evidence of this. It is certainly clear that the chamber pot had not been emptied before treatment was contemplated.

3.4.12 Mr Watene was not advised of the treatment which was proposed because he was believed to be inaccessible.

3.4.13 Because some patients in M3 at Oakley have access to the occupational therapy and hobbies room at 2 p.m. the nurse in charge of the ward wished to arrange for the ECT treatment to be given earlier than the 2 p.m. originally scheduled and requested the doctor to come earlier.

3.4.14 At Oakley hospital ECT treatment has customarily been administered by one doctor with the assistance of nursing staff. An anaesthetist has not been involved nor is a special area set aside for this treatment, the equipment being brought to the patient on what is known as the ECT trolley.

3.4.15 By about 1.50 p.m. on the 17th the corridor had been cleared, any patients in the area having been taken to the Day Room or locked into their rooms.

3.4.16 Mr Watene was in strongroom 7.

3.4.17 A staff nurse brought the ECT trolley and equipment down to the room and parked it just past the door of strongroom 7.

3.4.18 It was not clear how many staff were present but it seems likely that there were eight to nine members of the nursing staff as well as the doctor.

3.4.19 The door was then opened by one of the nurses. It is not certain who this was.

3.4.20 As soon as the door was opened an incident occurred with the chamber pot from the room. Some witnesses say that the chamber pot full of urine was thrown out of the room across the corridor striking a nurse across the nose and spraying staff in his vicinity with urine. Another account suggests that Mr Watene held on to the pot, using it as a weapon rather than throwing it. Since the nurse who was struck seems to have been some distance from the door and since the door was immediately shut, it seems more likely that the chamber pot was thrown and this would accord with the testimony of the majority of the witnesses.

3.4.21 The intention had not been to administer ECT in strongroom 7 but in strongroom 5. There is better light in strongroom 5 and the mattress on the floor was made up there for the purpose of administering the ECT.

3.4.22 The door of strongroom 7 was then opened again and a nurse stood in the doorway talking to Mr Watene, endeavouring to calm him and indicating that the intention was only to give him treatment. There is no evidence that the nature and purpose of the treatment was discussed and it is stated by the charge nurse that Mr Watene appeared to be completely out of touch with reality.

3.4.23 ECT is normally administered at Oakley in what is known as modified form, that is, an anaesthetic and a muscle relaxant are administered to the patient, this being done to avoid the more unpleasant aspects of the convulsions which follow on the treatment and are a part of its purpose.

3.4.24 Both the anaesthetic and the muscle relaxant need to be administered by injection into a vein. The doctor decided that Mr Watene's state was such that it would not be possible to administer with safety an injection of this kind on the basis that if there was violent or uncontrolled movement the needle could be broken or it might be impossible to properly administer the injection at all.

3.4.25 The doctor also decided that in view of Mr Watene's state it was desirable to proceed to administer the treatment and that this would be done unmodified, that is, without the administration of an anaesthetic or a muscle relaxant.

3.4.26 In order to pursue the treatment he directed that Mr Watene be forcibly restrained so that it could be administered. He indicated that this was to be done by the use of a mattress. A charge nurse stated that he decided to get and use the mattress without being instructed to do so but it is clear that those involved contemplated that Mr Watene would be restrained in this way.

3.4.27 The charge nurse then went to strongroom 5 and got the mattress which he took to the room in which Mr Watene was confined. Mr Watene was then approached with the mattress and in the course of a violent struggle, subdued and brought to the ground.

3.4.28 There is a considerable conflict of evidence with regard to this struggle, although all present agree that it was extremely violent.

3.4.29 A psychiatric assistant who was present stated in evidence that during the course of, or following, the struggle Mr Watene was both kicked and punched by members of the nursing staff. Another assistant in his initial evidence denied that he had seen incidents of this nature but later returned to the witness box and indicated on oath that his earlier evidence was incorrect and that he had seen such incidents.

3.4.30 Other members of the staff present strenuously denied that such actions had taken place and the doctor denied that incidents of this nature had occurred. We shall return to this aspect of the matter later.

3.4.31 After Mr Watene had been overpowered he was placed on the mattress in the room and this was brought to the doorway. The ECT trolley is of such a size that it will not go through the doorway and it was necessary for the mattress to be moved so that the treatment could be administered.

3.4.32 Mr Watene was held immobile by a number of members of the staff.

3.4.33 Mr Watene's head was held at an angle of 45 degrees.

3.4.34 The ECT box was placed on the floor and the electrodes were then placed on his temples and the ECT was administered by a staff nurse. The treatment was administered once.

3.4.35 Mr Watene then went through what are known as the tonic and clonic stages of the seizure induced by the ECT.

3.4.36 After the completion of these stages the charge nurse ascertained that Mr Watene was breathing. He claimed that although "not unconscious" Mr Watene was "dazed and confused". There is no indication that Mr Watene was aware of the comments that were made to him.

3.4.37 The charge nurse said that the room was awash with urine and he arranged with staff to mop the room out, the charge nurse staying with the patient while that was done. He says that staff were with Mr Watene for a good ten minutes after the administration of the treatment while the room was cleaned up.

3.4.38 Mr Watene was then left locked in the room.

3.4.39 During the course of the incident the charge nurse had sustained an injury to a finger. The nurse who had been struck by the chamber pot on the nose appeared also to have been injured. A number of members of the staff had received urine on their clothes or person and were told to go and have showers and change their clothes.

3.4.40 Evidence was given that at approximately 2 p.m. after the administration of the ECT Mr Watene was given an injection of Paraldehyde of 20 mls.

3.4.41 The entry in the Register of Narcotics for the administration of Paraldehyde on that day states that it was given under the authority of the Medical Superintendent, who was in fact away on holiday at the time.

3.4.42 Having regard to the ward records and the evidence given, we conclude that an injection of 20 mls of Paraldehyde was given to Mr Watene and that that was given immediately after the administration of the ECT. This too is a matter to which we shall return.

3.4.43 There is no indication that following the incidents referred to, Mr Watene showed on recovery any violence or uncontrolled activity.

3.4.44 The entry in the Day Report book reads as follows:-

> "Watene M. Remains as previously reported - To have ECT this p.m. (2 p.m.) Given. Pt had to be forcibly restrained - Two staff injured in process - ECT tomorrow. TREAT WITH CAUTION."

3.4.45 An accident report form (S.379) was completed by the doctor, containing the following statement:-

> "This dangerous psychotic attacked nurses when strongroom door opened. He was subdued. He sustained no injuries."

3.4.46 Mr Watene had been in seclusion in a strongroom since his admission. No seclusion order was signed by a doctor until the doctor signed such an order on 17 February with extensions commencing on the 18th. He stated in the order that the reason for restraint or seclusion was "Unprovoked attack upon staff causing two staff members injury."

3.4.47 The doctor ordered Modecate to be administered to Mr Watene. He was given 25 mg of Modecate at 5 p.m. The first ward note for D shift on the 17th reads as follows:-

> "M. Watene. 1700 hours. Became violently active while being administered modecate 25 mgms. Given 20 mls Paraldehyde I/M (with difficulty) as charted. As per previous reports, treat with caution. This patient is deceptively strong and violent at the present."

The second note reads as follows:-

> "2130. Again active necessitating further 10 mls Paraldehyde I/M (two extra staff from M7). It has been advised that he has been serving a sentence of 7 days expiring this day but also due to appear in Court for
>
> (a) Unlawful taking of a motor vehicle
> (b) Discharge of a firearm
> (c) Possession of a firearm and
> (d) Use of a firearm to prevent lawful arrest."

3.4.48 At 11.30 p.m. Mr Watene was given a further 20 mls of Paraldehyde. The ward note reads as follows:-

"Watene Michael. Disturbed and unpredictable at 11.30 p.m. D shift staff held back to help sedate this patient as he can be extremely difficult to control. Paraldehyde 20 mls I/M at 11.50 p.m. with good effect, slept soundly. No fluids this shift, inaccessible."

3.5 **18 February 1982**

3.5.1 On the morning of 18 February Mr Watene was given multiple unmodified ECT. According to a charge nurse the doctor called for a third application of the treatment while Mr Watene was still in the clonic stage. This was denied by the doctor, who stated that only two treatments were given, the second being given after restoration of normal breathing and colour.

3.5.2 The charge nurse states that in approximately 5 to 6 minutes Mr Watene had recovered sufficiently to sit up. He was disorientated and groggy and didn't know where he was but he was able to sit up, to mumble, and to cough.

3.5.3 Approximately half an hour later Mr Watene's own doctor arrived at the ward and was asked by the charge nurse to examine Mr Watene. The doctor did this. At the time Mr Watene was standing up. The doctor listened to Mr Watene's chest, both back and front with a stethoscope. The nurse says that he made a comment to the effect that there were moist sounds. The doctor stated in the notes there were sounds in the upper part of the lungs and Cilicaine was then ordered and given to Mr Watene in a single dose.

3.5.4 The ward note made by the charge nurse reads as follows:-

"Watene M. Unmodified ECT II this a.m. by doctor. Examined by doctor. I/M cilicaine 1.5 mega units stat ordered. BP chart to be kept BD. 12 noon = 102/80. Medication chart commenced. All shift please note charts in surgery. Haloperidol I/M or orally ordered once patient comes awake. This to be given, 2 hourly, until, a therapeutic level is reached, whereby the attained level is then given in quarterly divided doses, every six hours. All security precautions are to be observed. Ensure fluids are given ad lib once patient awakes. Patient status changed to Section 21. Patient due to appear in Court 1st March. May have further ECT tomorrow - not certain."

3.5.5 Later in the day Mr Watene was taken to the shower block for a shower. The charge nurse refers to a shower. The supervising charge nurse says that Mr Watene was given a bath.

3.5.6 The supervising charge nurse stated that while Mr Watene was in the bath he took a photograph of Mr Watene with a polaroid camera. He subsequently took a second photograph of Mr Watene being supported by two staff members. This photograph was produced to us.

3.5.7 The purpose of taking the photograph was for identification purposes. The supervising charge nurse stated that the first photograph was destroyed. The second was stapled into Mr Watene's file.

3.5.8 The charge nurse stated that he drew the attention of the supervising charge nurse to bruising on Mr Watene's body. This was denied by the supervising charge nurse.

3.5.9 An aid who escorted Mr Watene down to the showers says that Mr Watene was able to walk without being supported.

3.5.10 The charge nurse states that on Thursday, the 18th, Mr Watene had a cough.

3.5.11 The final ward note for the 18th read as follows:-

> "Watene M. Still in a sedated state at 4 o'clock. Did not received Serenace. Pushed fluids 300 mls, milkshake. At 2000 received 20 mls Serenace syrup and 150 mls cordial. BP 120/80; R.28; P.120. Responds to call - Received 20 mgs Serenace syrup plus 150 milkshake 2300."

3.6 <u>19 February 1982</u>

3.6.1 On 19 February a doctor extended the seclusion order. The time of day that this was done is not recorded.

3.6.2 The report of the A shift for the 19th reads as follows:-

> "Drowsy but able to talk and respond to questions. BP 120/80. Resp.28. Pulse 100. Temp. 37.5. Fluids pushed given 1500 mls cordial at 0.12/15 hrs. P/U 6 a.m. B/P 120/80. T/N Resp. 22. Pulse 100. Perspiring freely. Given 1,200 mls cordial. No Serenace given this shift. Slept soundly. Has kept the same position flat on his back all night. Has a cough and is slightly congested. Unable to drink fluids himself."

3.6.3 At 9 a.m. Mr Watene received 20 mg Haloperidol.

3.6.4 The charge nurse wrote in the ward report:-

> "Watene M. Commence on five day course of Cilicaine 1.5 mega units as from yesterday. ECT not given as chest infection procludes. (sic) Manageable and co-operative but heavily sedated. Presented Haloperidol syrup 10-20 mgs QID depending upon level of sedation. Continue to push fluids and record fluid intake and blood pressure. B/D Exercise regularly."

3.6.5 His own doctor examined Mr Watene on 19 February. He reported his findings in the case notes as follows:

> "Due to two episodes of very violent behaviour directed towards nursing staff, completely unprovoked, this patient has now had three E.C.T. and has commenced a rapid tranquillization regime with Haloperidol. Seen today he is certainly adequately stated (sic), he is taking fluids adequately but communication with him is only very limited, e.g. he says "can I get up" and when allowed to do so he is obviously unsteady on his feet and he muttered "not a very good idea". He is to be nursed with extreme caution and heavy tranquillization is to be continued. No further E.C.T. at present. He has some signs of congestion at the base of both lungs and he is accordingly on Parentorol (sic) penicillin."

3.6.6 The two doctors discussed on the telephone the question of further treatment for Mr Watene on Friday the 19th. His own doctor stated that it was then left to the judgment of the second doctor whether further ECT would be given over the weekend. His own doctor indicated it was his intention to reassess the form of treatment on the following Monday and stated that he expected in broad terms that the treatment would have continued with one or two more administrations of ECT and a continuation of Haloperidol, which by then he had reduced to 10-20 mgs to be given four times a day. He was not aware at the time of this discussion, but later approved, the subsequent alteration of the Haloperidol frequency by the other doctor back to a two hourly dose.

3.6.7 The charge nurse spoke to Mr Watene in the corridor when he came out of his room to be taken to have a shower and he appeared reasonably calm.

3.6.8 Some 10 to 15 minutes later the charge nurse was asked by a staff member to come to the bathroom as there was some trouble. He went to the shower room opposite the ward office and found Mr Watene standing back from the others holding a towel and standing in a threatening posture with a threatening attitude. He was not saying anything. He looked angry and upset.

3.6.9 The charge nurse went up to him and spoke with him. He asked him to return to his room and "not make any hassles." The charge nurse states he did not find Mr Watene a difficult patient to handle. Mr Watene accompanied the charge nurse back to his room, went into it without protest, and took medication from a medicine glass with a drink of orange cordial. The charge nurse states that Mr Watene was not happy but was not hostile.

3.6.10 The charge nurse then telephoned one of the doctors and informed him that it was possible Mr Watene was building up for "an anti-staff attitude". He informed the doctor that Mr Watene had had a shower and there had been a little difficulty encountered in getting Mr Watene back to his room but that the charge nurse himself had not encountered any difficulty.

3.6.11 The doctor then ordered that Serenace (Haloperidol) be recommenced at the level of 20 mgs 2 hourly. He also ordered that breakfast be withheld from Mr Watene on the following morning because of the possibility that ECT would again be administered.

3.6.12 The ward note made by the charge nurse is as follows:-

> "Watene M. Given shower 1530 hours. Sullen and withdrawn and seemingly building up an anti-staff attitude. Doctor informed and prescribed Serenace 20 mgs two hourly. Withhold breakfast for possible ECT in morning."

3.6.13 The ward note made by another charge nurse later in the day reads as follows:-

> "Watene M. Up and about. Responds to call and requests. Serenace 20mgs 2 hourly. B/P 120/80. R. 20. P. 70. Still morose - Watch out!"

3.6.14 The ward note made by A shift reads as follows:-

> "Watene M. Apart from 4 a.m., when he was sleeping soundly 2 hourly Serenace continued throughout the night. Even in his drowsy state everyone who enters the room is regarded with suspicion."

3.7 **20 February 1982**

3.7.1 On Saturday morning 20 February, the second doctor examined Mr Watene. He examined his chest and heart and stated he found them to be normal. He considered that his mental condition was again one of suspicion and inaccessibility. He considered that he showed no signs of undue sedation.

3.7.2 As a result of the communication he had had with the charge nurse the day before and following his examination the doctor decided to administer modified ECT. He was able to give Mr Watene an anaesthetic and muscle relaxant without difficulty.

3.7.3 The ward note states:-

> "Watene M. Seen this morning by doctor. Modified ECT given with almost immediate recovery. Walking around within two minutes of treatment. Haloperidol 20 mgs given and taken orally with reluctance. Cilicaine 1.5 mgs as prescribed. Maintain maximum precautions at all times."

3.7.4 A later note reads:-

> "Haloperidol 20 mgs syrup given 2 hourly. This to be maintained throughout. Still remains very quick in his movements."

3.7.5 The D shift note reads:-

> "Received 20 mgs Serenace syrup 2 hourly. Still alert and measuring. Take precautions."

3.7.6 The staff nurse who was in charge of visiting on 20 February indicated that to his knowledge Mr Watene had no visitors on the 20th.

3.7.7 This nurse, who speaks fluent Maori, spoke to Mr Watene on the 20th in Maori. He stated that Mr Watene indicated that he was unable to speak Maori but could understand it. The nurse asked him where he was from and he responded sufficiently to ask where the nurse was from. When the nurse indicated his district Mr Watene commented on this.

3.8 **21 February 1982**

3.8.1 The A shift note for the 20th/21st reads as follows:-

> "Watene M. Two hourly Serenace continued throughout the night. Remains suspicious. Takes medication with reluctance but showing signs of conversing this morning."

3.8.2 The nursing notes on the 21st read as follows:-

> "Mental condition improved. Less suspicious and more communicative. Exercised in corridor without any problems. IMI. Cilicaine course maintained. Haloperidol syrup 20 mgs maintained 2 hourly throughout the day. T.P. and B.P. chart continues. For possible ECT tomorrow.

3.8.3 The ward note reads:-

> "Watene M. Showing signs of improvement this morning. Appears less suspicious. Able to converse. Exercise period of upwards of half an hour given frequently. Still maintaining 2 hourly medication."

3.8.4 The charge nurse stated that on Sunday afternoon Mr Watene was still on his feet, still walking around, still smoking, and still able to converse. He appeared to be a man who was able to absorb or tolerate a high level of medication with Haloperidol. The charge nurse talked to Mr Watene for approximately half an hour. Mr Watene talked about his life in the north, talked about his family, and talked about sport. The charge nurse asked him if he had any knowledge of the martial arts because of his pattern of movement but Mr Watene indicated he did not. He was given a packet of cigarettes. He asked the charge nurse what was meant by being held under the provisions of Section 21 of the Mental Health Act. He was resentful at this but appeared to understand the position.

3.8.5 The D shift note reads:-

> "Watene M. Received 20 mgs Serenace syrup 2 hourly. Regular exercise. Polite but morose. Bear caution; He maybe is regurgitating the medication? Otherwise a quiet evening."

3.9 **22 February 1982**

3.9.1 The A shift note reads:-

> "Watene M. 2 hourly Serenace continued. observed to swallow it alright. No sign of him regurgitating later. Cordial removed from room at 6 a.m.? ECT this morning."

3.9.2 On the morning of the 22nd Mr Watene was seen by the second doctor. He considered that ECT should not terminate before four treatments and probably should be terminated at about six. He considered that on the Monday morning Mr Watene had progressed very well indeed. The doctor stated that Mr Watene was able to speak to him.

3.9.3 The doctor considered that Mr Watene was not unduly sedated. He was placid and peaceful and spoke quite rationally to him.

3.9.4 The doctor examined his chest and heart and considered both to be normal. He found no signs of a chest infection.

3.9.5 The ECT was administered at approximately 9.15 a.m. Staff assembled outside the door until the doctor arrived.

3.9.6 One staff nurse stated that when the door was opened Mr Watene was lying on his mattress in the corner. While the doctor went out to prepare the anaesthetic injection the mattress was turned round and drawn towards the door so that Mr Watene's head was in the vicinity of the doorway. Two staff nurses and three psychiatric assistants were in the room. The charge nurse and a third staff nurse remained out in the corridor to operate the ECT machine.

3.9.7 A mouth gag was placed in Mr Watene's mouth.

3.9.8 ECT was then administered in modified form. The doctor indicated that respiration began spontaneously no later than 30 seconds and possibly 15 seconds after clonic phase of the modified convulsions had ceased. He considered that to be a very quick recovery.

3.9.9 The doctor stated that he observed normal breathing had returned and that breathing was unobstructed, that the staff had placed Mr Watene in the recovery position, and he then left.

3.9.10 After the treatment Mr Watene was put into the recovery position and the mouth gag fell out. At that stage five staff remained in the room.

3.9.11 The charge nurse left with the doctor. He stated before leaving that the door would have to be closed when Mr Watene had recovered. He stated that he was concerned over Mr Watene being in seclusion and he did not want a repetition of what he considered had happened the previous time when he believed Mr Watene had gone berserk. The charge nurse did not give this instruction to any particular person but just made the comment generally.

3.9.12 A staff nurse then took the ECT trolley away, and it seems likely that another staff nurse then took the emergency trolley away.

3.9.13 A psychiatric assistant asked if he could go and wash his hands. During the course of the treatment Mr Watene had urinated upon his hands and the assistant was given permission accordingly. That left three staff members with Mr Watene.

3.9.14 The staff nurse then stepped outside the door. Two psychiatric assistants were still in the room. The staff nurse stated that he suggested that the two assistants come outside the door. He was concerned that there were only two of them there and he was worried over Mr Watene's previous history.

3.9.15 The staff nurse was to go with an assistant as an escort for a patient who was to go up to Carrington Hospital for a dental appointment. This nurse then went to make a phone call to make sure that it was still all right to go because he believed they were running late for the appointment.

3.9.16 One of the psychiatric assistants stated that while he and the other assistant were standing outside the room Mr Watene awoke. He says that he looked, rolled his eyes, and went to get up. The assistant says he explained to Mr Watene that he would probably be a bit groggy for a while and it would be better for him to lie

there and relax which he says he did. The psychiatric assistant says that Mr Watene pulled his elbow out from under his rib cage, made himself comfortable, and settled down to rest. It is not clear but it seems probable that it was this assistant who ultimately closed the door.

3.9.17 At this time the assistant who had been to wash his hands returned and then went back to duty in the exercise yard.

3.9.18 When the staff nurse returned from telephoning, both remaining assistants were observing Mr Watene through the open door.

3.9.19 The staff nurse told an assistant that they would still be going with the patient to Carrington. The assistant stayed at Mr Watene's door while the staff nurse went to get the patient concerned. At that point the staff nurse says the door was still open.

3.9.20 When the staff nurse returned the door had been closed.

3.9.21 The staff nurse and assistant then left to take the patient to Carrington. The remaining assistant returned to his normal duties elsewhere.

3.9.22 Another psychiatric assistant says that following this, on two occasions he looked through the observation panel into Mr Watene's room. He states that he actually watched Mr Watene's chest rise and fall and was certain that he was breathing. He confirmed this evidence when recalled.

3.9.23 After returning from Carrington Hospital the staff nurse went and looked through the observation window at Mr Watene. He considered that Mr Watene looked too still, that something did not look right.

3.9.24 The staff nurse then called another nurse, unlocked the door, and he and the other nurse both went in. The staff nurse then found that Mr Watene's colour was not good and the other nurse went for the doctor. The first staff nurse then laid Mr Watene on his back and pushed he head back. He began to administer external heart massage.

3.9.25 The air bag was produced and the air administered. The nurse stated that he carried on applying external heart massage for approximately 5-6 minutes before the doctor took over. This was not supported by the doctor who stated that he took over the heart massage at a much earlier stage, immediately after entering the room.

3.9.26 The doctor continued endeavouring to resuscitate Mr Watene for some 10 to 15 minutes and eventually decided that the attempts were unsuccessful and certified that Mr Watene had died.

SECTION 4

4. COMMENT AND CONCLUSIONS ON MEDICAL ASPECTS OF EVENTS PRECEDING THE DEATH OF MICHAEL WATENE

4.1 Admission Procedure

4.1.1 At the time of his admission on 15 February 1982 it is apparent that Mr Watene received only the most cursory of mental state examinations. The Admitting Medical Officer indicated that he attempted to speak to Mr Watene for some 10 minutes but no vocal response could be elicited. No physical examination was conducted.

4.1.2 Despite the evidence of a nurse from the hospital of the presence of manacles on Mr Watene's legs, the admitting Medical Officer did not recall observing any such manacles. While the evidence was inconclusive it is probable that Mr Watene was restrained only by handcuffs on his wrists.

4.1.3 The Medical Officer's comments provided in his admission note to the ward staff were brief and perfunctory in nature. Insufficient information was available at this time on which to base a firm diagnosis of Mr Watene's mental condition.

4.2 Emergency Medication

4.2.1 On the basis of this short initial examination a medical order was issued. This order permitted the ward staff to provide Mist Chloral, Largactil, and/or Paraldehyde at the discretion of the nursing staff. The order indicated that the nursing staff could give the Largactil and the Paraldehyde by intra-muscular injection as required for agitation. The nursing staff were given the option of using their own discretion to administer these two drugs either singly or in conjunction. No limits were placed on the frequency of use or total upper dosage limits of the two drugs.

4.2.2 It was stated in evidence that the prescription of such emergency medication was then a standard procedure at Oakley Hospital.

4.2.3 It may be observed that the two drugs, although both having sedative effects, act in quite different ways. Largactil is an anti-psychotic drug specifically directed towards the therapeutic alleviation of the patient's symptoms, whereas Paraldehyde, while having sedative and hypnotic effects, does not have any specific anti-psychotic action.

4.2.4 When asked to provide his opinion on such an order, Dr Hall in evidence indicated the following -

> "I would have to be critical of that as practice." and,
>
> "If I am correct there has been some comment that it was not a very uncommon practice to prescribe in that sort of way. Leaving it to the nursing staff to make a lot of decisions about which medication would be used and how much and how often, is not a desirable practice." and,

"I think that the initial prescription should have been more specific and not left so much discretion to the nursing staff. It did create a situation where the nursing staff had a particularly wide discretion, as you have mentioned, as to dosage within the parameters of the notation as to choice of drug and again there was no upper limit on the frequency so those are the three areas which you have mentioned where the nursing staff had this discretion."

Dr Hall also agreed that it was not normal to allow nursing staff to have that degree of discretion.

4.2.5 Comment

The Committee endorses the views of Dr Hall on this practice. Too many treatment options were left open by such a prescription. Nursing staff should not be left to decide whether a specific anti-psychotic or hypnotic drug should be used for a patient. The frequency of drug use should be more clearly specified. Upper limits should be defined. It is essential that this form of "blanket" prescribing should cease at Oakley Hospital and that more specific directions be given to nursing staff when emergency medication is needed for a newly admitted patient.

4.3 Admission to Strongroom Without Examination

4.3.1 Mr Watene was placed into a strongroom in M3 upon arrival. This practice is common at Oakley. He was seen by the doctor to whom he had been allocated on the morning after his admission, namely 16 February 1982. A mental state examination was conducted at that time. This examination, however, was only of short duration, possibly some five minutes. Mr Watene was uncommunicative when asked specific questions concerning his whereabouts and background. He was regarded by his own doctor as sullen, suspicious and unresponsive. No physical examination of Mr Watene was undertaken by his own doctor at this time.

4.3.2 Mr Watene's own doctor, after this interview, concluded that continuing care in the strongroom was necessary and indicated to the nursing staff that he wished close observation to be maintained in order that the specific symptoms of a psychological nature could be observed by the attendant staff. At that time Mr Watene had exhibited no signs of violent behaviour towards anyone at Oakley Hospital.

4.3.3 Even allowing for the situation of divided medical authority in this case, it is surprising that a full mental state exploration and physical examination did not take place on the morning of the second day when the doctor responsible for Mr Watene was in attendance at Oakley Hospital.

4.3.4 As indicated in the narrative, only two brief examinations were conducted with Mr Watene by two different doctors in the 48 hours following his admission. He was not physically examined by either of these two medical practitioners during this period. Over this time no information was sought by these doctors from persons external to the hospital who may have had knowledge of Mr Watene's previous mental and physical state prior to him becoming uncommunicative.

4.3.5 Allowing for the fact that the admitting doctor was not the doctor to whom Mr Watene's future care would be allocated, the admission procedures still seem unusual. The normal mode for admission of psychiatric patients is to include a preliminary assessment at the time of admission, followed by a more detailed mental state examination and physical examination by the treating doctor as soon as possible after admission takes place. This normally occurs following the showering of the patient who during the bathing process can be observed by the nursing staff for particular injuries, bruises, scars and other stigmata.

4.3.6 Comment

Because the future treatment of Mr Watene would depend on examinations and assessment made at the time of admission (or shortly thereafter), we consider that the admission procedures and examinations were quite inadequate and provided no proper basis for what followed.

4.4 Isolation - Seclusion

4.4.1 Mr Watene was stated to be uncommunicative when he arrived.

4.4.2 For this reason no real attempt was made to communicate with him.

4.4.3 There was no indication that he was given any explanation as to where he was, why he was there, or what was going to happen to him.

4.4.4 He was immediately taken to Ward M3 and placed in seclusion.

4.4.5 The room in which he was placed was totally plain and bare, having only a mattress on the floor and a chamber pot.

4.4.6 No explanation was given to Mr Watene as to why he was placed in such a position.

4.4.7 No seclusion order was then signed for him.

4.4.8 He was effectively then kept in seclusion for the whole of his stay at Oakley Hospital.

4.4.9 We accept that in the case of uncommunicative patients there may be great difficulties in giving any explanation. It may also be necessary for the safety of the patient, other patients and staff to place a patient in seclusion. Nevertheless, to a person who was already likely to be mentally disturbed and possibly afraid, such treatment is likely to exacerbate any condition rather than to improve it.

4.4.10 Comment

4.4.10.1 **It is our opinion that under no circumstances should a patient be placed in such a position without some explanations being given, even if the patient appears unable to follow or accept these.**

4.4.10.2 **The placing of a person in seclusion whether they agree or not is a serious matter and recognised as such by the requirement that a seclusion order be signed and renewed. In Mr Watene's case the decision seems to have been made sufficiently lightly for nobody**

to be concerned to complete a formal seclusion order for some time after the decision had been taken and put into effect. This is made worse by the fact that no attempt to explain the situation to Mr Watene seems to have been made. We are concerned with the wider implications and the possibility that the placing and retention of a patient in seclusion is too much a matter of course at Oakley Hospital. In every case such a course should be justified and there should in no way be a practice whereby a person on admission to the maximum security ward at Oakley Hospital should be automatically placed in seclusion.

4.5 Diagnosis

4.5.1 As had already been indicated, the examinations carried out by the attending doctors were cursory and inadequate. Mr Watene was uncommunicative and it was impossible to get more than minimal material from him which might have assisted with diagnosis and decisions as to the necessary treatment.

4.5.2 The material made available from the prison authorities (and referred to in the Social Worker's note) was sparse. As stated in another context, an examination in the prison environment presents particular difficulties in making an accurate assessment of mental condition. In instances where it is difficult or impossible to obtain material from the patient directly, it becomes even more important than normally to obtain such material from the patient's family, friends or recent associates. No material of this kind was available when the first decisions regarding diagnosis and possible treatment were made. Not until 19 February was an approach made to the Probation Service. The detailed information later provided did not arrive at Oakley Hospital until after Mr Watene's death.

4.5.3 The first diagnosis recorded is that from Mr Watene's allocated doctor. This provisional diagnosis is entered as "Paranoid Reaction not otherwise specified". The date of the examination leading to this diagnosis is recorded as 15 February 1982. From the evidence it would appear that this examination in fact took place on 16 February.

4.5.4 While there is little specific evidence to support the diagnosis of "Paranoid Reaction" in the case of Mr Watene, it is the opinion of the Committee, supported by the opinions of specialist psychiatrists given during the committee's hearings, that this diagnosis was probably correct.

4.5.5 We draw attention to the evidence of Dr Dobson which we set out in extenso as follows:-

> "The first point I would like to raise is the question of establishing a diagnosis after the patient has been admitted to the care of a psychiatrist. I would like to make the point that it is tremendously important to build a base of relevant information in order that a diagnosis, a decision about the category of disorder present and the goal one is moving towards is that of formulating a treatment plan. As I see the position of the psychiatrist faced with Mr Watene, the first task was to examine his mental status. This means examining in great careful detail and in an accepted way the

features of behaviour, features which one could observe, and of course to communicate with him. Even when one can communicate readily and a good history can be obtained, it is always essential to obtain corrobative information from other sources and resources which can enlarge the information. Particularly in a case such as Mr Watene's where it was extremely difficult to obtain the history from the patient himself, it is essential that great pains should be taken to obtain other information. I would like to make the point that although the information which Dr Hall and I have heard about, presented in evidence, the bits which are relevant, the information is consistent with the diagnosis made, that is the diagnosis of paranoid psychosis with depressive features. Dr Hall and I still feel, perhaps myself even more strongly, that the information was so sparse as to be unsatisfactory. If I could emphasize and make the point, yesterday afternoon I was dismayed when the social worker's report of the 15th and 19th was quoted as an example of the sort of information which was acceptable. I would make the point that looking at the report, the social worker's report of 15 February, this information in these two reports, 15 and 19, simply whetted my appetite to obtain further information. Furthermore it is couched in language which is quite ambiguous. The statement "When he is off he is a really nasty character. He is totally suspicious of everyone and everything". That is a slang statement which is quite inappropriate in a professional report and to me the term "he is off" is a slang used many years ago by nursing staff to indicate the person was suffering a psychotic illness. The suspicion is aroused that Mr Watene had a history of psychotic illness, and this would excite me to urgently move to the telephone and speak to the people in Whangarei who knew him personally. I am also dismayed that the medical certificates which I emphasize I have filled in lots of these in these circumstances, are basically documents to satisfy legal requirements to justify the action taken in moving from one institution to another. I would like to emphasise this very strongly that they are totally inadequate as a means of informing professional people towards making clinical judgments."

4.5.6 Comment

4.5.6.1 **We agree with Dr Dobson and we consider that the enquiries made were not only inadequate for the purposes of diagnosis or for treatment, but also further indicate that the admission procedures at Oakley Hospital leave much to be desired.**

4.6 Treatment

4.6.1 For the diagnosis arrived at, the treatment programme followed becomes difficult to understand.

4.6.2 The various medical treatments administered to Mr Watene have been listed in chronological order at 4.6.12.11.

4.6.3 To ensure consistency each of these treatments will now be dealt with in the same order.

4.6.4 **Mist Chloral**

4.6.4.1 No specific medication was given to Mr Watene until the late evening of 16 February when he was given 20 mls of Mist Chloral. This is a relatively weak hypnotic drug and it was given with little effect.

4.6.5 **Electroconvulsive Therapy**

4.6.5.1 On 17 February Mr Watene's condition had shown no improvement, and if anything, had appeared to worsen. The possible existence of auditory hallucinations was then raised. Acting on information received from the ward staff, Mr Watene's own doctor believed that specific treatment for Mr Watene's psychosis was required. It is significant, however, that no further examination of a medical nature took place on that day.

4.6.5.2 In his evidence the doctor concerned indicated that he believed that Mr Watene had the potential to become dangerously violent, and for this reason had not wished to expose the nursing staff to such possible violence by the ordering of regular anti-psychotic medication to reduce the patient's symptoms. In view of this statement his failure to conduct a further examination of Mr Watene must be regarded as at least unusual.

4.6.5.3 The doctor concerned did however consult with his medical colleague on the posibility of giving ECT in an attempt to treat the patient's symptoms of withdrawal, tension, and potential aggression. As a result of this consultation it was agreed that ECT would be administered at 2 p.m. on 17 February.

4.6.5.4 As indicated in the narrative, while entering the door of the strongroom to administer the ECT the incident involving the chamber pot took place.

4.6.5.5 After Mr Watene's resistance had been at least partially controlled, the ECT was administered unmodified.

4.6.6 **Paraldehyde**

4.6.6.1 It is recorded that immediately after the delivery of the ECT an injection of 20 ml Paraldehyde was given. It has not been possible to determine who gave the specific order for the giving of this Paraldehyde. It could be regarded as being in accordance with the original Largactil and/or Paraldehyde prescription issued to the nursing staff by the admitting doctor at the time of Mr Watene's admission on 15 February. No record of the delivery of this injection of Paraldehyde could be found in the ward day book, or on the treatment chart in the patient's file, although the giving of such an injection is recorded in the narcotics register.

4.6.6.2 The administration of further ECT on the next day was obviously planned in accordance with notes made in the ward day book. However, in the meantime, a series of Paraldehyde injections were given, and an order was issued for the delivery to the patient of an intra-muscular injection of Modecate, a long acting anti-psychotic drug.

4.6.7 **Modecate**

4.6.7.1 The Modecate injection was given at 5 p.m. on 17 February. The injection was at the level of 25 mg. The patient is recorded as being violently active while the injection was being administered, and was accordingly given a further 20 ml of Paraldehyde half an hour later.

4.6.8 **Further Paraldehyde**

4.6.8.1 Further Paraldehyde was administered at 9.30 p.m. and at 11.50 p.m. or midnight on 17 February. Only 10 ml of the drug was given at 9.30 p.m., but a further 20 ml was given on the later occasion. Not unexpectedly, the patient is reported to have "slept soundly".

4.6.8.2 In total Mr Watene received 70 ml of Paraldehyde between 2 p.m. and 12 midnight (at the latest) on 17 February. There is no record that this Paraldehyde was given in distributed sites on the patient's body, and despite specific questioning on this point, staff members appear unconcerned that each injection of Paraldehyde, particularly those involving 20 ml of the drug, was not given in divided doses on separate sites when administered. It may be added that Paraldehyde is a painful drug when delivered intra-muscularly and that large pools of Paraldehyde in the muscle tissue have caused many reported instances of sterile abscesses.

4.6.9 **Further ECT**

4.6.9.1 Further ECT was given in an unmodified form on the morning of 18 February. Two treatments were administered in short succession. It was indicated by the attending doctor that he had waited for normal breathing and colour to resume before applying the second Electroconvulsive Treatment in unmodified form. As indicated earlier in the narrative by a charge nurse present at the time, there was some debate whether a third application of the treatment had been called for.

4.6.9.2 To complete the ECT narrative, it may be noted that further ECT was administered to Mr Watene on 20 February and on 22 February (the day of Mr Watene's death). It should be observed that in these last two instances, the ECT was delivered in a modified form, with the use of an anaesthetic agent and muscle relaxant.

4.6.10 **Haloperidol**

4.6.10.1 Arising from the mental state examination Mr Watene's doctor ordered the drug Haloperidol either by intra-muscular injection or orally, to be given at two-hourly intervals if disturbed. The purpose of ordering this drug was to promote a rapid state of tranquillisation until his behaviour settled. A dosage of 20 mg was stipulated in the prescription.

4.6.11.1 As a result of his physical examination the doctor also prescribed an immediate injection of Cilicaine (Procaine Penicillin) at the level of 1.5 mega units. The Penicillin was ordered in view of the medically observed signs of some congestion in Mr Watene's chest.

4.6.11.2 There is evidence that the chest condition improved over the next several days. The Cilicaine injections were continued on the following three days up to the time of Mr Watene's death.

4.6.12 Further Haloperidol

4.6.12.1 Apart from the Cilicaine, the only regular form of medication then given to Mr Watene from 18 February onwards was the drug Haloperidol (Serenace). Instructions were also given to maintain higher fluid intake levels and to regularly chart blood pressure readings. Mr Watene received his original Haloperidol by mouth at 12 noon on 18 February, and a further oral dose was given at 2 p.m. on that day. The ward notes reveal that the Haloperidol was not administered at 4 p.m. on that afternoon as he was in a sedated state. Haloperidol was given by the evening shift at 8 p.m. and 11 p.m. and Mr Watene was reported to have slept soundly.

4.6.12.2 On 19 February Mr Watene was given a further 20 mg of Haloperidol in oral form at 9 a.m. He was reported in the ward report of that day to be manageable and co-operative, but heavily sedated. Mr Watene's doctor gave instructions that the Haloperidol should now be reduced to four times a day at the level of 10-20 mg. The nursing staff concluded that 20 mg was to be the preferred dose.

4.6.12.3 However, at approximately 3.30 p.m. on 19 February the attention of the ward charge was drawn to Mr Watene's possible threatening behaviour in the bathroom. The ward charge concerned believed that Mr Watene was developing possible anti-staff attitudes, and telephoned his observations to the duty doctor. The duty doctor ordered that the Haloperidol should be immediately reinstated at the level of 20 mg two hourly.

4.6.12.4 From this period onwards the Haloperidol was administered in 20 mg doses at regular two hourly intervals until the time of Mr Watene's death. The only times at which these oral doses of Haloperidol do not appear to have been administered were at 4 a.m. on the 20 February and in the two hours prior to the modified ECT administered on 22 February.

4.6.12.5 The original order for Haloperidol indicated that as soon as sedation had been reached, the dosage could be then reduced to four times a day. This original order also provided the staff with the option of not administering the Haloperidol in the event of the patient showing features of heavy sedation. This original order had been made by the patient's allocated doctor.

4.6.12.6 The original order was then altered by the duty doctor in the late afternoon of 19 February to provide no option to the nursing staff except to administer 20 mg of Haloperidol at two hourly intervals, with no qualifications regarding the levels of sedation. This second order was made in the first instance by telephone.

4.6.12.7 On the morning of 20 February the telephone order for Haloperidol was confirmed in writing by the same duty doctor who examined Mr Watene on the morning of 20 February as part of his ECT procedure. He considered that the patient showed no signs of undue sedation.

4.6.12.8 From Saturday morning 20 February onwards the Haloperidol syrup continued to be given to the patient at two hourly intervals without any further medical examination taking place over this weekend period. As much as 240 mg of Haloperidol was given in a 24 hour period, and the total Haloperidol received by Mr Watene from the date of its initial order on 18 February amounted to 660 mg.

4.6.12.9 Mr Watene's mental condition is reported to have improved over the weekend period, but no alteration was made to the very high levels of Haloperidol being administered.

4.6.12.10 Mr Watene was again examined by the same doctor on the morning of Monday 22 February to determine whether further ECT would be given. This doctor reported that Mr Watene did not appear to be unduly sedated on his examination. ECT was then given in modified form. Mr Watene's death occurred within an hour of this last ECT The possible relationship of the Haloperidol to Mr Watene's death will be discussed at Sections 4.9 and 5.4.7.

4.6.12.11 In order to clarify the treatment regime instituted for Mr Watene, the following Treatment Summary Chart has been prepared:

Treatment Summary Chart

DATE	TIME	MEDICATION	DOSAGE	COMMENT
Admitted Monday 15.2.82				
16.2	23:45	Mist. Chloral	20 mls	
17.2	14:00	ECT	140 x 0.75 Unmodified	
	14:00 aprx	Paraldehyde	20 mls I/M	
	17:00	Modecate	25 mgs I/M	
	17:30	Paraldehyde	20 mls I/M	
	21:30	Paraldehyde	10 mls I/M	
	23:50	Paraldehyde	20 mls I/M	
18.2	?	ECT	140 x 0.75 x 2 Unmodified	
	10:30	Cilicaine	1.5 megaU I/M	
	14:00	Serenace Syrup	20 mgs	} 2-hourly if
	20:00	Serenace Syrup	20 mgs	} disturbed -
	23:00	Serenace Syrup	20 mgs	} until settled
19.2	09:00	Serenace Syrup	20 mgs	now QID
	10:15	Cilicaine	1.5 megaU I/M	
	16:00	Serenace Syrup	20 mgs	now 2 hourly
	18:00	Serenace Syrup	20 mgs	
	20:00	Serenace Syrup	20 mgs	
	22:00	Serenace Syrup	20 mgs	
	24:00	Serenace Syrup	20 mgs	

Treatment Summary Chart cont'd ...

DATE	TIME	MEDICATION	DOSAGE	COMMENT
20.2	02:00	Serenace Syrup	20 mgs	
	06:00	Serenace Syrup	20 mgs	
	08:00	ECT Brev. 3mls Briet 3 mls	140 x 0.75	Modified
	10:00	Cilicaine	1.5 megaU 1/M	
	10:00	Serenace Syrup	20 mgs	
	12:00	Serenace Syrup	20 mgs	
	14:00	Serenace Syrup	20 mgs	
	16:00	Serenace Syrup	20 mgs	
	18:00	Serenace Syrup	20 mgs	
	20:00	Serenace Syrup	20 mgs	
	24:00	Serenace Syrup	20 mgs	
21.2	02:00	Serenace Syrup	20 mgs	
	04:00	Serenace Syrup	20 mgs	
	06:00	Serenace Syrup	20 mgs	
	08:00	Serenace Syrup	20 mgs	
	10:00	Cilicaine	1.5 megaU 1/M	
	10:00	Serenace Syrup	20 mgs	
	12:00	Serenace Syrup	20 mgs	
	14:00	Serenace Syrup	20 mgs	
	16:00	Serenace Syrup	20 mgs	
	18:00	Serenace Syrup	20 mgs	
	20:00	Serenace Syrup	20 mgs	
	22:00	Serenace Syrup	20 mgs	
	24:00	Serenace Syrup	20 mgs	
22.2	02:00	Serenace Syrup	20 mgs	
	04:00	Serenace Syrup	20 mgs	
	06:00	Serenace Syrup	20 mgs	
	09:10	ECT Brev. 3mls Briet 3 mls	140 x 0.75	Modified

4.7 Comment on the Use of ECT

4.7.1 The joint decision of the two doctors at Oakley Hospital at that time to administer ECT to Mr Watene on 17 February must be questioned.

4.7.2 The doctors stated that the decision to use ECT rather than rapid tranquillisation was based on their belief that Mr Watene was not sufficiently co-operative or accessible mentally, that he required urgent treatment for a potentially life threatening condition, and that there could be difficulties in administering regular medication to a resistive patient.

4.7.3 Mr Watene was withdrawn and uncommunicative at the time the ECT was planned, but despite the nursing notes stating that he should be treated with caution Mr Watene had not displayed any prior overt violence at Oakley Hospital. The medical and nursing notes at that time did not indicate that there was a serious

threat to Mr Watene's life or well-being, although the charge nurse on duty on 17 February believed that Mr Watene had refused breakfast on that day. No note to this effect was made in the day report or nursing notes.

4.7.4 There appears to have been no disagreement between the two doctors that Mr Watene was suffering from an acute paranoid reaction and that he was potentially violent. While the evidence to support this diagnosis was relatively scanty, it is accepted by the Committee that this diagnosis was probably correct. As indicated by Drs Hall and Dobson, normal psychiatric practice to treat this condition would have indicated that some form of rapid tranquillisation should have been tried rather than ECT.

4.7.5 However, it was contended by the doctors concerned with the decision to give ECT to Mr Watene that rapid tranquillisation, involving two hourly administration of drugs by injection, could have placed the nursing staff in grave risk of potential violence. It was believed by them that ECT was likely to carry less risk to the staff and might enable anti-psychotic drugs to be used at a later date.

4.7.6 A recent clinical memorandum issued by the Royal Australian and New Zealand College of Psychiatrists does not support this view. The memorandum indicates that ECT is of value in cases of depression, catatonic stupor and schizo-affective psychosis with severe depression. There is little evidence to place ECT within the therapeutic armamentarium of other illnesses apart from its possible use in drug resistant acute schizophrenia.

4.7.7 Despite the violent struggle which occurred when the door to Mr Watene's room was opened on 17 February for the purpose of giving him his initial ECT, no review was made of this earlier planned treatment. Mr Watene's violently expressed objection to any form of treatment or care was disregarded. A confrontation resulted.

4.7.8 In retrospect it must be questioned whether it would have been wiser to have shut the door, let Mr Watene settle and then, after a "cooling off" period, attempt to communicate further with him. There would seem to have been no immediate threat to Mr Watene's safety or life if this procedure had been adopted.

4.7.9 After Mr Watene had been subdued he was given the ECT in an unmodified form as it was believed by his attending doctor that it would be impossible to give Mr Watene an intravenous injection without serious risk of damaging the tissues of the arm with either the needle or the anaesthetic agent because of his violent struggles. Although a large number of nursing staff were present in the room at this time who may have been able to hold Mr Watene's arm firmly it was decided that his struggling was sufficiently alarming to prevent the normal modified ECT procedures being followed.

4.7.10 ECT was also given on the next morning, 18 February. By that time Mr Watene had been given a series of Paraldehyde injections and an injection of Modecate. Additional nursing assistance had been sought at the time of the Modecate injection - given at 5 p.m. on 17 February - but no other episodes of resistance were recorded.

4.7.11 **The Committee considers that there have been no convincing reasons advanced to support the giving of ECT in an unmodified form on 18 February. It is believed that an attempt should have been made to give this second ECT in the normally accepted modified form. This belief is strengthened by the fact that Mr Watene, apart from receiving an earlier series of intramuscular injections without struggling, did not resist the delivery of ECT on the second occasion.**

4.8 Comment on the use of Paraldehyde

4.8.1 Paraldehyde is a drug which was once very frequently used in psychiatric hospitals.

4.8.2 It is comparatively quick acting and induces sleep. It does not cause long lasting side effects and it does not mask symptoms or conditions which may need further identification before specific treatment is given.

4.8.3 Nevertheless, there are a number of reasons why Paraldehyde is no longer commonly used in psychiatric hospitals.

4.8.4 The first and most significant is that it is an unpleasant drug from the point of view of the patient. It has an extremely unpleasant taste and smell and for that reason is not favoured in its oral form. In any event, in most cases when it is used it it is often difficult to persuade a patient to take it orally.

4.8.5 It is therefore normally administered by way of injection but in this form it is painful to the patient. This is so because to be effective, comparatively large quantities need to be injected through a long large-bore needle and this is painful in itself. It is also a corrosive substance which is painful for this reason.

4.8.6 In addition, as it is partly excreted by the lungs it causes an unpleasant smell on the breath.

4.8.7 As has been referred to above, there is ample evidence that the injection of substantial quantities of Paraldehyde can lead to the formation of sterile abscesses. This is a matter for concern and one of the reasons why Paraldehyde is no longer commonly accepted as a drug for general use.

4.8.8 For all these reasons and because there are other drugs which can achieve the effects of Paraldehyde, it is now rarely administered in psychiatric hospitals.

4.8.9 None of the staff of any of the four Australian hospitals we visited had used Paraldehyde during the last 10 years, and the evidence of New Zealand psychiatrists was that it is a drug which is rarely used in psychiatric hospitals in New Zealand.

4.8.10 During the course of the Inquiry a file relating to a patient at Carrington Hospital was produced to us with a view to establishing that Paraldehyde was in use at Carrington Hospital. The particular file indicated that Paraldehyde was used as a last resort when other drugs had failed. The administration of the drug was meticulously recorded and it was administered on the

direct instruction of the Medical Superintendent. In particular, it was recorded that it was administered in 5 cc doses, distributed in various parts of the body, in order presumably to inflict as little pain as possible during the course of the administration. In this particular case an anaphylactic reaction to the Paraldehyde occurred and the use of the drug was discontinued.

4.8.11 By contrast, the material produced to us suggests that Paraldehyde is used almost as a general prescription at Oakley Hospital. In the case of Mr Watene, on admission he was prescribed Paraldehyde to be administered at the discretion of the nursing staff, and it was apparent from other files we perused that this is by no means an uncommon order.

4.8.12 Mr Watene was given over a comparatively short period a very considerable quantity of Paraldehyde and it was given to him on a number of occasions in single doses of 20 cc in one injection. There is no indication on the file that the areas of injection were distributed.

4.8.13 We consider the way in which Paraldehyde was prescribed and administered to Mr Watene to be completely unacceptable and to have indicated an indifference to the sensibilities of the patient.

4.8.14 We also note with concern the practice of prescribing Paraldehyde to be administered at the discretion of the staff.

4.8.15 Such a situation must lead to the apprehension, whether justified or not, by patients that Paraldehyde might be administered by way of control should they fail to conform. A patient is totally defenceless against such a situation since inquiry would always justify a staff member in the use of a drug prescribed at discretion to control agitation or violent behaviour. We do not believe that patients should be subjected to such a risk, nor do we believe that staff should be subjected to the risk of such criticism.

4.8.16 It is our view that Oakley Hospital should follow other institutions and use Paraldehyde only as a last resort and then only when specifically prescribed by the medical advisor of the patient concerned and under his direct instruction in the case of any administration. The practice of blanket prescribing of Paraldehyde should cease immediately.

4.9 Comment on the Use of Haloperidol

4.9.1 Haloperidol (Serenace) is an anti-psychotic drug which can be given orally, intramuscularly or intravenously. It is a potent drug, normally given in small doses at the level of 6 - 10 mg per day.

4.9.2 Its relative potency in small quantities and its non-irritant characteristics make it a useful drug to give in states of acute excitement or in rarer instances of sustained, combative, assaultive behaviour of psychotic origin. In such circumstances it is common practice to institute a programme of rapid tranquillisation by 3-4 hourly injections in doses of 5-10 mg, depending on the clinical state of the patient.

4.9.3 In the case of Mr Watene 20 mg doses of Haloperidol were prescribed in either intramuscular or oral form at 2 hourly intervals "if disturbed until settled". In the event only the oral form of the drug was used.

4.9.4 While it is generally regarded as preferable to initiate tranquillisation by intramuscular or intravenous injection in order to achieve a rapid effect, oral medication is acceptable as long as one can be assured that the patient has ingested the drug. Liquid Haloperidol (Serenace syrup) was used in this instance.

4.9.5 In view of Mr Watene's reported physical size and strength the use of Haloperidol at 2 hourly intervals is also considered to be within acceptable limits, at least for the initial part of the tranquillisation process.

4.9.6 Mr Watene's own doctor clearly envisaged that a rapid build up in drug levels which would calm him and hopefully alleviate his symptoms. The medical order gave the nursing staff discretion to withhold the drug should it be considered that Mr Watene had settled. The normally expected reduction in the prescribed level of the drug was made in the morning of the next day with the medical order stipulating Haloperidol 10-20 mg four times a day.

4.9.7 However, as indicated earlier the duty doctor instructed the charge nurse of Ward M3 to increase Mr Watene's Haloperidol level to 20 mg 2 hourly. The decision was made over the telephone in the late afternoon of 18 February without a further examination of Mr Watene, as a result of the ward charge's report that he believed Mr Watene was building up an anti-staff attitude, although he had been returned to his room from the bathroom without trouble.

4.9.8 This telephone instruction was confirmed in writing by the duty doctor the next morning when he attended and examined Mr Watene for the purpose of giving him further ECT.

4.9.9 The instruction to give Haloperidol remained unaltered from 3.30 p.m. on 18 February until the time of Mr Watene's death on the morning of 22 February. Apart from the duty doctor's attendance on Mr Watene on 19 February for the purpose of giving ECT no medical monitoring of Mr Watene's mental condition took place until approximately 9 a.m. on 22 February despite the high levels of Haloperidol given over this period.

4.9.10 **The failure to maintain regular medical monitoring over this period is strongly criticised. Haloperidol is a powerful antipsychotic drug. When given frequent and repeated high dosages to produce rapid tranquillisation its effects must be monitored medically at frequent intervals. Apart from the well documented extrapyramidal effects of this drug, which were acknowledged by the relevant medical staff at Oakley in their evidence, Haloperidol is long acting in its effects and accumulates over time when repeated at two hourly intervals.**

4.9.11 Patients in states of acute psychotic excitement may well require higher than normal doses of tranquillising drugs such as Haloperidol. In such instances certain risks associated with high drug levels are justifiable if it is believed that there are even graver risks to the safety of the patient or the safety of

members of staff. Nevertheless the extent of drug risks must be known and steps must be taken to minimise these risks by constant vigilance and regular medical review of the patient's physical and mental condition. This did not happen in Mr Watene's case. Using Haloperidol, a very heavy drug regime was re-instituted for Mr Watene lasting for a period of 62 hours. He was clinically examined by the duty doctor only once over this period. After this examination 48 hours elapsed before he was seen again by this doctor.

4.9.12 **We are gravely concerned by this failure to maintain an intensive medical oversight over Mr Watene's clinical condition and the failure to regularly review and adjust the very high levels of medication prescribed for Mr Watene over this period. We believe that such a practice warrants our concern. It is not sound clinical practice to leave such important observations solely to the nursing staff with instructions to record blood pressure.**

4.9.13 Although evidence was given that doctors in Australia and New Zealand have been increasingly aware in recent years of the possible relationship of high Haloperidol doses with unexplained sudden deaths, this information had not been widely circulated to those working in psychiatric hospitals at the time of Mr Watene's death. The reports available while small in number indicate that the risk of sudden death is substantially increased when Haloperidol is given in doses over 100 mg daily. Although the very high doses of Haloperidol given to Mr Watene may have contributed to his death, we accept that the doctors at Oakley Hospital who prescribed Haloperidol to Mr Watene were not in a position to be aware of this possible relationship.

SECTION 5

5. COMMENTS AND CONCLUSION ON THE MEDICAL ASPECTS OF INCIDENTS SURROUNDING THE DEATH OF MICHAEL WATENE ON 22 FEBRUARY 1982

5.1 Delivery of ECT

5.1.1 As indicated above, ECT was administered to Mr Watene in a modified form at approximately 9.15 a.m. on 22 February 1982.

5.1.2 The case file of the patient includes the following case note made by the attending doctor at the time.

> "ECT given at 0920. Heart and lungs checked before anaesthetic given: nil heard. 2 1/2 ml (=mg25) only of Brietal given I.V., followed by 3 ml Brevidil (mg75 Cation). 140 volts x 0.75 seconds. shock given: Immediate partly modified fit ensued. Breathing began almost immediately at cessation of seizure. Patient was placed on his side, was breathing normally and had made an apparent normal recovery when I left. Mr ..... approached me at 0950 to say that Mr Watene required attention. I examined the patient immediately and found absent corneal reflexes, and heart-beat; there was a degree of cyanosis present in the lips. Resuscitation failed."

5.1.3 While the form of ECT, the form of the anaesthetic agent, and the form of the muscle relaxant cannot be questioned, some questions must be raised about the situation in which the ECT was given.

5.1.4 The ECT was administered in a strongroom with the patient being positioned on a mattress on the floor. Only one doctor was present during the administration of the ECT.

5.1.5 Evidence was also given to the Committee that the ECT trolley and its associated equipment could not be wheeled into the room occupied by Mr Watene. It was necessary for the trolley to be placed outside the door, and the ECT box placed on the floor, in order for the electrodes to be applied to the patient's temples. The anaesthetic and muscle relaxant drugs needed to be administered by the doctor kneeling on the floor at the side of the patient's mattress. The physical circumstances under which this treatment was administered can only be described as cramped and awkward for the staff in attendance, and hardly reassuring for the patient.

5.1.6 Apart from the cramped circumstances of the area in which ECT was delivered, serious concern is expressed about the general procedures followed in the use of ECT at Oakley Hospital at the time of Mr Watene's death. The clinical memorandum of the Royal Australian and New Zealand College of Psychiatrists, referred to earlier in this report, clearly describes the procedures which should be followed in the administration of ECT. Although this memorandum has only recently been formally adopted it codifies practices which the College has accepted as standard over the past several years. The document states:-

"All patients selected for the administration of ECT should have the procedure including the side-effects carefully explained to them by the medical and nursing staff involved in the care of such patients.

It is assumed that the amount of detail given to any individual patient will depend on the ability of that patient to comprehend such information and this will often be dependent on the severity of the illness.

We believe that in general there is no place in current clinical practice for the administration of unmodified ECT but that rare exceptions might arise.

ECT shall be given in a special place equipped with anaesthetic and resuscitation equipment.

In all cases there will be two medical practitioners present, one of whom shall be skilled in the administration of ECT and the other a specialist anaesthetist (or his delegate).

A nurse trained in the administration of ECT, anaesthetic and resuscitation procedures shall be present as well as two other nurses who will assist in the care of patients, both preceding and following ECT.

An induction agent and a muscle relaxant will be used in all cases unless there is a positive contraindication as determined by the anaesthetist, and agreed to by the psychiatrist in charge.

The giving of atropine or similar agents and the route will be determined by the anaesthetist.

Following each ECT the anaesthetist will remain in the treatment area until full recovery (response to verbal command) of each patient takes place and will ensure that all patients are observed until he is satisfied that full recovery has taken place.

It is essential that all practitioners administering ECT should be conversant with the indications and side-effects of the treatment, and the anaesthetic emergencies and consequent resuscitation procedures, before they assume such responsibility."

The memorandum also addresses the issue of the medico legal aspects associated with the administration of ECT. In particular, the issue of consent is discussed in the following terms:-

"Irrespective of the Mental Health Act in current use, patients should be advised of the decision to use ECT and their permission for treatment obtained.

It should be made clear to the patient that permission is given for each separate occasion of treatment and that at any time, consent may be withdrawn.

It is not necessary for patients to sign a consent form for each treatment, however, if there is a substantial interval between each group of treatments then permission should again be sought and a new consent form signed.

Those patients who are unwilling to give consent or are unable to do so by virtue of illness pose problems.

Should the specialist psychiatrist decide to proceed in those cases where the treatment is deemed to be the most appropriate and the illness is regarded as life threatening and the patient is of involuntary status and detained under the Mental Health Act, the permission of the nearest relative should be obtained, although this holds no favour in the eyes of the law.

The specialist should then seek the opinion of at least one other senior colleague and, having obtained agreement and the opinion been noted in the case-file, the specialist in charge shall also sign and date the consent form.

A specially designed form should be used to record each treatment and should contain details of the anaesthetic, ECT given and any untoward effects. This should be signed by both practitioners present at the time of treatment."

From the points made in this document it is clear that the ECT procedures carried out at Oakley Hospital were alarmingly deficient at the time of Mr Watene's death. The Committee were pleased to be advised, however, that the medical team at Oakley now recognises the advantages of having a specialist anaesthetist available and that ECT will be administered in future with such specialist anaesthetists present at either Carrington or Oakley Hospitals. The issue of consent must also be attended to.

5.2 Care after ECT

5.2.1 Evidence has been presented that Mr Watene's breathing was satisfactorily re-established after the delivery of the ECT. At this point the attending doctor and the charge nurse left the patient's room and proceeded to the charge nurse's office.

5.2.2 As indicated in the doctor's report, approximately 30 minutes elapsed before he was recalled to Mr Watene's room, although in evidence he amended this to a shorter time of approximately 20 minutes.

5.2.3 He indicated that he believed that Mr Watene had been dead for at least "four to five minutes" when he was recalled to the room by the nursing staff.

5.2.4 Reference is again made to the extracts from the above College memorandum. It is clear the procedures adopted after ECT did not meet accepted professional standards.

5.3 Resuscitation Attempts

5.3.1 When he returned to Mr Watene's room the attending doctor observed that one of the nursing staff was applying external heart massage.

5.3.2 The nurse concerned stated in evidence that he believed that he himself continued external heart massage for five to six minutes before the doctor took over. The attending doctor however indicated that he took over the external heart massage immediately upon entering the room. The doctor's version of these events was supported by the charge nurse on duty at the time.

5.3.3 While the attending doctor delivered the external heart massage another staff nurse checked the patient's airway and used an air-viva bag to assist in ventilating the patient's lungs.

5.3.4 It was the opinion of the attending doctor that the blood flow had ceased to such a degree that it was likely that the blood had reached a "sludged state". However, a third staff nurse present indicated that he had been able to detect significant pulsations in the carotid which were timed synchronously with the external heart massage being applied by the attending doctor.

5.3.5 In his evidence the attending doctor indicated that he continued to apply external heart massage for approximately ten minutes before forming the conclusion that further resuscitation attempts would be of no avail, and that the patient would have already sustained substantial brain damage. Apart from the administration of the external cardiac masssage and the use of the air-viva bag, no other resuscitation measures, such as the introduction of an endo-tracheal tube or the administration of oxygen or the use of certain specific drugs available on the resuscitation trolley, were attempted.

5.3.6 A senior specialist in anaesthesia and intensive care, Dr Trubuhovich, was called before the committee to give comments on the resuscitation techniques used by the staff attending Mr Watene at the time of his death. In the opinion of this specialist, the attending doctor would have been better placed at the head of the patient in charge of the respiratory component of the resuscitation procedures. The specialist concerned indicated that he would personally have attempted to have inserted an endo-tracheal tube into the patient and to have administered oxygen to the patient in preference to circulating air through the agency of the air-viva bag. The attending specialist also stated that if he had been present himself he would have used at least one or two of the drugs available on the resuscitation trolley.

5.3.7 The specialist anaesthetist stressed in particular that he would have continued the resuscitation attempts for a much longer period than the ten to fifteen minutes attempted by the attending doctor. This specialist expressed his viewpoint that if adequate external cardiac massage had been applied associated with continuing forced oxygenation of the blood through vital centres of the body by the artificially induced pulsations generated from the massage, it may have been possible to have re-established life in the patient without necessarily sustaining gross brain damage. The specialist concerned agreed however that the longer it took for natural circulation and respiration to return, the greater the risk of brain damage. The specialist indicated that he believed that the patient's relatively young age and strong bodily condition would normally augur well for some recovery, even should artificial methods be necessary for periods of thirty minutes or longer.

5.3.8 Although the doctor involved in the resuscitation attempt applied external cardiac massage and an air viva bag was used, we believe that these measures were inadequate. It is our view that the attempts to revive Mr Watene fell well short of the standards which would have applied if a specialist anaesthetist had been present. This view is supported by the evidence of Dr Trubuhovich. We are also concerned that there would appear to have been no recognised procedures which would have caused staff to have automatically sought the services of the external life support system in such an emergency. While finding fault in this area, we consider that the system is more to blame than the individuals concerned. We believe that Oakley Hospital should have followed the patterns of other psychiatric hospitals in the Auckland area and elsewhere which have developed specific ECT suites, recovery areas, and well established anaesthetic support services. As indicated earlier, it should be mandatory for a specialist anaesthetist (or his delegate) to be in attendance whenever ECT is given. It is clearly unfair to expect a doctor undertaking psychiatric duties to give modified ECT unaided by a colleague with special skills in anaesthesia and resuscitation.

5.4 Post-Mortem Examination

5.4.1 Following the sudden death of Mr Watene, the Coroner was notified and a post-mortem on Mr Watene's body was conducted by a pathologist of the Auckland Hospital Board, Dr W.M.I. Smeeton.

5.4.2 Dr Smeeton's comments in his report of his post mortem findings are as follows:-

"1. There are no findings in the post-mortem examination which unequivocally indicate the cause of death. There is evidence of a mild respiratory tract infection, but this does not appear significant enough to be a factor contributing to death. There is narrowing of the small arteries which supply portions of the specialised conduction tissues of the heart responsible for the propagation of normal electrical impulses. There have been cases reported in medical literature linking this abnormality with sudden collapse and death.

2. The single scalp bruise is not a contributory factor. The underlying skull and brain show no evidence of injury and no injuries were found elsewhere on the body.

3. The anaesthetic agents used on this occasion appear to have been administered using acceptable techniques and dosages, and there is no indication the apparatus was faulty.

4. In addition to the drugs administered at the time of the anaesthetic, the patient was receiving haloperidol and fluphenizine decanoate. Psychotropic drugs in therapeutic dosages have been occasionally reported as causing sudden abnormalities in heart rhythm.

5. Death following ECT is rare."

5.4.3 The report goes on to state:-

> "The possibility of airway obstruction occurring in the early recovery phase following administration of anaesthetic and ECT has to be considered. This could reasonably be excluded, provided that there had been adequate observation during this period.
>
> Most deaths recorded in recent medical literature have been ascribed to cardiac causes. Such complications are more frequent when heart disease is already present. However, abnormalities in heart rhythm following ECT have also been described in patients with no known heart disease, occasionally resulting in death. The narrowing in the atrio-ventricular node artery and the present of psychotropic drugs could represent factors predisposing to the development of such an arrhythmia."

5.4.4 The report concludes:-

> "In my opinion, death resulted from a cardiac arrhythmia following ECT".

5.4.5 The Coroner having noted the views of the pathologist following his post mortem examination concluded "that the deceased died at Oakley Hospital on 22 February 1982, death being due to failure to adequately observe the deceased following electroconvulsive therapy.

5.4.6 Although Dr Smeeton as the pathologist responsible for Mr Watene's post mortem had not specifically linked the Haloperidol with Mr Watene's reported death from cardiac arrhythmia, there can be no doubt that he considered the use of this psychotropic drug as one of the factors in arriving at his final conclusion. However, we can find no evidence that the full details of the very large doses of this drug administered to Mr Watene over a period of some 4½ days were available to Dr Smeeton when he prepared his report on his post mortem findings.

5.4.7 It may also be worthwhile mentioning at this point the controversial issue of reported bruising of the patient from evidence submitted to the Committee by the undertaker and the other evidence presented by Dr Smeeton. We believe that Dr Smeeton's notes are particularly detailed in respect to the presence of scars, bruising and markings on Mr Watene's body and do not support the observations of the undertaker that extensive bruising was present on the face, trunk and lower limbs. We find no reason to doubt the accuracy of Dr Smeeton's findings.

5.5 It was submitted to us that it was not within the terms of reference of the Committee to substitute a verdict for that of the Coroner. We agree, of course, that we have no power to do this. Nevertheless, a consideration of the treatment which Mr Watene received necessitates some consideration of the cause of death. The validity or criticisms of such treatment cannot be dealt with in vacuo. We heard more evidence than did the Coroner and the views not only of Dr Smeeton but also of Dr Kellaway and in relation to resuscitation, the evidence of Dr Trubuhovich. Mr Watene's death is obviously a significant factor in assessing the treatment he received and we have taken into account, and based

conclusions upon, the medical evidence referred to above. Bearing all this in mind, we note that there are risks associated with high doses of Haloperidol. These risks are increased with the administration of ECT and its associated anaesthetic and muscle relaxant agents. Such a combination involves risks which if acceptable because of the condition and requirements of the patient must be borne in mind by the staff who should take especial care in every aspect of the treatment.

SECTION 6

6. THE NURSING CARE RECEIVED BY MICHAEL WATENE

6.1 Admission to 17 February 1982

6.1.1 The approach and attitude towards Mr Watene appears to have been influenced by information supplied by the Prison authorities, the committing doctors, and the admitting doctor's assessment and instructions to nursing staff.

6.1.2 Mr Watene is said to have been sullen, withdrawn and uncommunicative and was assessed as "possibly dangerous" and "possibly suicidal" by these observers. These facts, together with the knowledge of the offences with which he had been charged, were quite properly taken into account when he was admitted to Oakley Hospital.

6.1.3 Measures were taken to ensure containment of any overt, aggressive behaviour included placing him in seclusion in a strong room where he remained until the time of his death eight days later.

6.1.4 Mr Watene had no means of communicating with staff apart from shouting or banging on the door. He had earlier indicated his fear of being "left alone in cell, and being attacked", and was unclear about his situation. Little was done to reassure him and allay his suspicions, apprehension and anxiety. This must have placed additional psychological strain on him.

6.1.5 The placement of a patient in seclusion over a long period of time requires from nursing staff a heightened awareness of the effect of this measure and an intensification in personal care, contact and concern. Detailed notes of attention given, responses and observation made during the period should be kept.

6.1.6 It is a nursing obligation to carry out close observation of patients and to arrive at nursing conclusions regarding a patient on the basis of all information which is available, supplemented and interpreted by the nursing observations which take place.

6.1.7 Since Mr Watene was confined in a secure room, opportunities for close observation were extremely limited. It would be difficult for even the most experienced professional staff to gain much information from looking through the observation slit into the room in which he was placed.

6.1.8 Mr Watene did not apparently resist admission to the hospital, nor did he at any time during which staff attended to him before 17 February make any threatening gestures or movements to attack staff. Certainly no such gestures or movements were recorded. Nevertheless, the comments which were recorded in the ward day book involve a succession of warnings, based apparently on his lack of response to attempts at verbal communication.

6.1.9 At some time the instruction was given that the door to his room was not to be opened unless four persons were present. This must have reinforced any concerns, would have made observation more, not less, difficult, and was hardly likely to remove any suspicion which Mr Watene had.

6.1.10 The nursing notes during this period continually emphasise that Mr Watene should be approached with caution, therefore restricting those contacts which should have been made to advise, explain and reassure him about his situation.

6.1.11 It does not appear that nurses initiated any move to obtain background information on Mr Watene from friends, family or Maori associates.

6.1.12 Immediately prior to the administration of ECT on 17 February there occurred what has been described by the nursing staff as "a most ferocious struggle" which was distressing for patient and staff alike. No attempt was made to discuss with the doctor the advisability of giving the treatment under such stressful conditions. A charge nurse stated that the floor of strongroom No. 7 was "awash with urine", a result of Mr Watene having thrown the chamber pot before the struggle. This nurse also said that after the ECT treatment the room was mopped out and some staff had to be released to change their clothing. However, no attempt was apparently made to change Mr Watene's clothing or bedding or more appropriately to move him to one of the other strongrooms.

6.1.13 Apart from the throwing of the chamber pot, Mr Watene's attitude appeared to be defensive. He was approached by eight or nine staff behind a mattress. No attempt had been made to prepare him for the ECT, nor was any adequate explanation given to him. In such a situation his reactions were predictable.

6.1.14 It seems to us that the situation was one where the use of random physical force was used to control Mr Watene prior to treatment as opposed to nursing and medical discussion on alternative strategies and intervention.

6.1.15 The method of control used, that is, approach behind a mattress, is not one in common use. We do not believe that the incident reflects any credit on staff.

6.1.16 Mr Watene's respiratory infection developed during this period in Oakley. Penicillin was given and additional fluids ordered. He continued to be nursed on the floor on a mattress. No attempt was made to permit him a bed and pillows for additional comfort and to improve his posture and breathing.

6.1.17 Drug treatment did not commence until after the first ECT treatment at 2 p.m. on 17 February. Although the emergency medication order made out on 15 February included reference to 10-20 mls of Paraldehyde s.o.s. for agitation, no subsequent medical order for this drug was obtained. Despite the fact that Mr Watene was quiet following this ECT and displayed no agitation, the course of Paraldehyde was then immediately started for the first time. Over the next ten hour period 70 mls of Paraldehyde was administered. There appears to have been little concern or sensitivity over the pain and discomfort resulting from the administration of this drug, the amount given, and the frequency.

6.1.18 It is a usual requirement for Nursing Supervisors to visit, observe, advise and report on the condition and care of newly admitted patients who present a major nursing problem, particularly those in seclusion. The Area Supervisor who was on duty on 16 and 17 February stated that he did not see Mr Watene until 18 February when he visited the ward in order to take a photograph of Mr Watene. He also said that "There was no feedback to administration" that there was a patient requiring critical care and causing some concern to staff in Ward M3. Neither the Principal Nurse nor the Assistant Principal Nurse appears to have visited the ward during this period, nor did staff seek to consult with them or obtain their advice in the management of Mr Watene.

6.1.19 There is no indication that attention was paid to Mr Watene's bodily needs in relation to general hygiene, including the removal of excreta from the room and an opportunity for him to wash his hands before giving him food.

6.1.20 Notwithstanding that Mr Watene was unresponsive and unwilling to communicate and also the fact that his behaviour patterns were unpredictable, it would appear that professional nursing standards during this period were not maintained.

6.1.21 The recording of detailed nursing observations normally required on a newly admitted patient was inadequate. Also, despite the fact that Mr Watene was placed in seclusion from the time he was admitted on 15 February at 3.30 p.m., a formal seclusion record did not commence until 17 February 1982, nor does any record appear to exist of nursing assessment, plan of nursing intervention, or objectives for Mr Watene's care.

6.1.22 Comment

A constant emphasis is placed on the need for security at Oakley Hospital to control the dangerous type of patient that tends to arrive there. If this is the case, then it seems to us that it is imperative that more appropriate and up-to-date methods of defusing potentially dangerous situations, handling confrontation and aggression, together with instructions on how to approach and hold a patient when this is necessary should be taught to all staff. We consider that the attitude towards Mr Watene from the time of his admission was based on assumption rather than solid fact, and the consequent treatment he received was unlikely to reassure him.

6.2 18 February - 21 February 1982

6.2.1 Mr Watene appeared to be slightly more responsive during this period. A number of staff had contact with him and in their opinion, although he continued to be withdrawn and suspicious, Mr Watene was responding slowly to treatment. There was no indication that he was resistant, hostile or aggressive, except for an incident in the bathroom when his manner suggested he might be antagonistic to staff.

6.2.2 Nursing care was intensified during this period. Mr Watene was showered, exercised, given cigarettes, food and fluids. He was visited 2 hourly for the administration of Haloperidol. Vital signs appear to have been recorded on some of these visits although the chart recording the details of Mr Watene's temperature, pulse and respiration could not be found in the hospital records.

6.2.3 A charge nurse reported conversations held with Mr Watene during which Mr Watene asked the meaning of his committal to Oakley Hospital.

6.2.4 Seclusion was maintained during this period. Instructions to treat cautiously were continued, and there was an order displayed on the door to his room that 4 nurses were to be present before the door was opened.

6.3 <u>22 February 1982</u>

6.3.1 The charge nurse, three staff nurses and three psychiatric assistants were in attendance on Mr Watene on the morning of 22 February when modified ECT was administered. The charge nurse and one staff nurse remained outside the room to apply the electrodes to Mr Watene's head and administer the ECT. The remaining staff positioned and held Mr Watene on a mattress on the floor. He appeared to understand that he was having treatment and offered no resistance. During the treatment he passed urine. Following treatment, and when the doctor was satisfied that Mr Watene was breathing normally, the charge nurse gave the instruction "close the door ... when he has recovered" and then left the corridor with the doctor to return to the office.

6.3.2 One staff nurse took the equipment trolley back to the clinical room. A second staff nurse left to telephone the dental officer at Carrington.

6.3.3 A third staff nurse said in evidence that he heard the order to "close the door" but not the instruction "... after he has recovered". He also stated that he was not entirely satisfied regarding Mr Watene's level of consciousness but left the area and went to the clinical room to help prepare medications.

6.3.4 A psychiatric assistant went to the bathroom to wash his hands on which Mr Watene had urinated. This left two psychiatric assistants observing Mr Watene. The staff nurse who was to escort a patient to the dentist returned. He advised the assistants to come out of the room, at which point the door was closed, but it is not clear which of the nurses did this.

6.3.5 One of the assistants left with the staff nurse to accompany him to the dental appointment. The other assistant left the area to return to his original place of duty.

6.3.6 It would appear that no one other than a passing psychiatric assistant was in the corridor to observe Mr Watene from this point until the staff nurse returned 15 minutes later from the dental appointment at Carrington. This staff nurse looked through the observation window into Mr Watene's room and was

alarmed at the unnatural stillness and position of the patient. He alerted the nurse in the clinical room, returned to Mr Watene and commenced external cardiac resuscitation. The clinical room staff nurse brought the air-viva bag to the room and applied it to Mr Watene. The oxygen cylinder was not brought to the scene.

6.3.7 The nursing preparation for the ECT treatment on 22 February seems to us to have been inadequate. He was not advised as to the nature or time of the treatment and was apparently given no opportunity to pass urine before the treatment commenced.

There is no evidence that the charge nurse visited Mr Watene before hand to observe his condition which would have been expected as being consistent with a charge nurse's duties, particularly as the charge nurse had only returned from leave on that day.

6.3.8 The standard of care given to Mr Watene following the ECT treatment was inadequate and fell well below professional nursing standards. The charge nurse did not delegate any specific responsibility for the observation of Mr Watene on the basis that three registered nurses were present and one of them would assume their responsibility for after-care. We find it totally unacceptable that no registered nurse remained with him until he was fully conscious and had recovered from the treatment and that no attention was paid to his physical comforts in the way of changing soiled clothing and bedding, of giving him food and drink or of adequately reassuring him.

6.3.9 We are concerned that a full range of resuscitation equipment was not brought to Mr Watene's room at the start of the resuscitation procedure. We also consider that when resuscitation attempts were commenced, immediate contact should have been made with the appropriate external life support system. As stated earlier it was indicated by an expert witness that a broader range and more intensive and prolonged resuscitation strategies could have been expected to be applied.

6.3.10 <u>Comment</u>

The nursing care of Mr Watene from the time of his admission until his death eight days later reflects poorly on nursing leadership, direction and example and fell well below acceptable professional standards.

The continuity of care and the nature of the communications between staff was influenced by the fact that there were three different charge nurses who had responsibility for his care during the eight days he was in hospital and the generally accepted view that he was a dangerous person who had to be treated with caution.

There was no evidence of a personalised plan or attention to the details of care based on an assessment of his particular and special needs. Certain important aspects of his care were poorly recorded or not entered on the nursing notes or documents which form part of the clinical record.

The part played by nursing staff in the methods used to control Mr Watene have to be the subject of severe criticism and disapproval. We are of the opinion that overall the nursing care given to Mr Watene was not in his best interests or in accord with current psychiatric nursing principles and practices.

SECTION 7

7. INVESTIGATION OF THE DEATH OF MICHAEL WATENE AT OAKLEY HOSPITAL

7.1 Clearly the death of Michael Watene in the circumstances in which it occurred was a very serious matter indeed and one which required immediate investigation by the appropriate authorities in order to ensure that if errors had occurred these were not repeated with other patients and to ensure that any unsatisfactory practices or procedures were corrected. In addition, it was desirable to protect the staff involved from the kind of allegations which were certain to be made in the circumstances which had occurred if criticism was not justified.

7.2 In some respects the evidence as to the investigation within the hospital is quite confused. The Medical Superintendent returned from leave on the day that Michael Watene's death occurred. He decided to undertake the investigation himself.

7.3 There is no indication that the Principal Nurse took any part in the investigation then or at any other time. He did not give evidence before us on health grounds but there is no mention of his involvement by any witness at any stage. We think this quite extraordinary.

7.4 Nor was the Assistant Principal Nurse involved. This nurse does not seem even to have made a ward visit in connection with the death. There seems to have been no investigation into nursing procedures or the circumstances surrounding the death from an overall administrative point of view.

7.5 The ward records reveal almost nothing.

7.6 The investigation seems to have been conducted on the authority of the Medical Superintendent through a supervisor who requested certain staff members to make statements regarding the death.

7.7 Statements were obtained from the charge nurse and the three staff nurses who were present during the treatment and the attempted rescusitation.

7.8 Although three psychiatric assistants were also present, none of them was requested to make a statement.

7.9 To complicate the matter still further, the statements which were made at the time were complemented by other statements made on other occasions, and these do not tally. In addition, there seems to have been a delay of some days in collecting and collating all the statements.

7.10 The evidence given before us differs in certain respects from the statements which were made.

7.11 Mr Watene's death was investigated, as one would expect, by the Auckland Coroner. A record of proceedings before the Coroner was produced to us and the accounts given by staff who made statements at the hearing differ from those which are contained in their earlier statements and from evidence before us. We were not impressed with the information made available to the Police Department.

7.12 We can understand and accept that in a matter of some emotional severity and where people were upset and concerned, statements made on different occasions would contain differences in detail and in emphasis. We consider, however, that the administrative practices revealed by the investigation in this case were inadequate. The way in which statements were compiled in this case was thoroughly unsatisfactory and open to misinterpretation.

7.13 We believe that immediately the death occurred the senior nursing staff should have been advised and should have conducted an immediate investigation requiring all staff involved to record their own accounts of what had occurred.

7.14 The senior administration should then have recorded their own conclusions and the whole account been put together and kept securely so that on any subsequent inquiry by any appropriate authority the record would have been available.

7.15 In fact, the investigation was conducted in so inefficient and haphazard a manner that it is now impossible to say exactly what occurred on the basis of such an investigation. Those concerned with the death of Michael Watene are left more unhappy over what has occurred and staff are in the invidious position of being unable to adequately account for or defend their actions.

SECTION 8

8. ALLEGED ILL-TREATMENT OF MICHAEL WATENE

8.1.1 Physical Ill-treatment

8.1.2 Two psychiatric assistants indicated that during the course of the incidents which occurred on 17 February, Mr Watene was assaulted by members of the staff. Allegations were made that Mr Watene was both kicked and punched.

8.1.3 The allegations of punching related to the charge nurse. The allegations of kicking related to a specific staff nurse. The evidence seems clear that the staff nurse did not enter the room, and was in no position to have kicked Mr Watene.

8.1.4 Both allegations were denied by the nurses who were present and the doctor who was present stated that no assaults occurred.

8.1.5 One of the psychiatric assistants concerned gave evidence twice. On the first occasion he denied that assaults had taken place. On the second he indicated that he was concerned and felt under an obligation to indicate the true position. He then gave detailed evidence which was confirmatory of the evidence of the other psychiatric assistant, to whom he is related.

8.1.6 The other assistant gave detailed evidence of the assaults to which he referred. Unfortunately, however, his evidence in a number of respects created difficulties. For example, he stated that he had been present on one other occasion when the records indicated that he was not in fact on duty. He was unable to produce material which would have supported his contention that he was present on the particular day.

8.1.7 On the day following these incidents a staff nurse claimed to have observed bruising on Mr Watene's body. In the circumstances this has to be regarded as equivocal in nature because all parties agree a violent struggle took place. During the course of this, bruising may well have occurred which was not related to deliberate assaults. It has been suggested to us that a photograph of Mr Watene taken on 18 February is support for the allegations of ill treatment. The photograph is a distressing one, and we comment at the end of this Section on practices relating to the taking of photographs of Mr Watene at Oakley Hospital. We are concerned over the condition which appears from the photograph, but the quality of the photograph and the surrounding circumstances make it, in our view, impossible to regard it as significant evidence on which we could base a finding that criminal assaults had taken place.

8.1.8 The pathologist who examined Mr Watene's body after his death found evidence of bruising in the right parietal region but stated that this was comparatively fresh and would have occurred subsequent to the events of the 17th.

8.1.9 Evidence was also called from the undertaker who referred to bruising on the body. It was impossible to reconcile the evidence of the pathologist and that of the undertaker.

8.1.10 The allegations are serious. They refer to assaults which must be regarded as criminal in nature. We consider that in reaching any conclusions with regard to such assaults we are obliged to adopt the standard of proof which is appropriate in allegations of a criminal nature, that is, that they are proved beyond reasonable doubt.

8.1.11 In all the circumstances we cannot find that the allegations were proved to such a standard. Undoubtedly, a violent struggle occurred. During the course of this, incidents may well have taken place which could have been misconstrued. We are left in a position where we find it impossible to arrive at conclusions that assaults took place.

8.1.12 Nevertheless, there are certain comments which need to be made. There are a number of aspects of this whole distasteful incident which are quite unacceptable and which have been referred to elsewhere in the report. The lack of preparation of Mr Watene for any forthcoming treatment, the method of approach adopted towards him, the way in which he was overpowered, and the way in which the ECT was administered to him are all, in our opinion, open to strong criticism.

8.1.13 We accept it is inevitable that in institutions such as Oakley Hospital there will from time to time be incidents which could give rise to allegations of the kind which were made here. There are bound to be patients whose behaviour requires restraint and it may well be that such restraint involved at times quite violent incidents. It is therefore essential that systems and safeguards be devised which protect both patients and staff - patients against ill-treatment and staff against unfounded allegations.

8.1.14 It appears to us that no such adequate systems of safeguards exist at Oakley Hospital and they should be established as soon as possible.

8.1.15 Any incident of this nature must be immediately reported to the senior administration and fully and properly recorded. Statements must be taken on the same day if at all possible from all those who participated or observed the incident, including patients.

8.1.16 A full written report must be made available to the District Inspector or his equivalent as soon as possible after the incident has occurred and he must be asked to investigate it and himself record his comments.

8.1.17 Both patients and staff must know that allegations of this kind will be tested independently and in depth immediately they occur. Where incidents are proved to have occurred which are unacceptable, then immediate disciplinary action must be taken.

8.1.18 Where a reasonable degree of suspicion exists that a situation has not been well handled, then staff should be withdrawn from clinical areas and an immediate investigation instituted. It must be clear to patients, staff and the public that incidents of this nature will not be tolerated so that confidence may be restored.

8.2 Photograph of Michael Watene

8.2.1 We were told in evidence that two photographs were taken of Mr Watene by a nurse supervisor.

8.2.2 These photographs are apparently taken so that in the case of an escape, material is available to the appropriate authorities to help in the identification of the person concerned.

8.2.3 The first photograph was apparently taken of Mr Watene with a polaroid camera while he was naked in a bath. We were told by the supervisor concerned that he destroyed the photograph because it showed rather more of Mr Watene's body than was thought necessary or desirable.

8.2.4 We consider that the taking of a photograph under such circumstances was a gross affront to human dignity. More than that, we are concerned that it is an indication of an attitude towards patients which is totally unacceptable and which regrettably is evidenced in other ways. For example, our attention was drawn to the files of two patients where judgmental and condemnatory remarks appeared as observations made by a charge nurse.

8.2.5 A second photograph which was taken of Mr Watene and which actually appears on his file is also objectionable, and evidence of lack of sensitivity by the nurse responsible. This is a further indication of the attitudes to which we have referred. There was no urgency in the matter of taking a photograph, since it appeared that Mr Watene was in no physical condition to attempt to escape. If a photograph for identification purposes was necessary, the obtaining of it should have been delayed until such time as his general health and appearance had improved. We should have thought that nurses whose concern should be the recovery of a patient and his welfare generally would hardly regard such a photograph as evidence of their nursing skill and attention which they should wish other persons to see.

SECTION 9

9. GENERAL COMMENT ON THE TREATMENT AND DEATH OF MICHAEL WATENE

9.1 It will be clear from the above that we consider serious criticism is merited in respect of a number of aspects of the admission and treatment of Michael Watene at Oakley Hospital. Mr Watene's care was seriously affected by the lack of strong professional leadership, direction and example. The standards of treatment and care provided to Mr Watene while a patient at Oakley Hospital fell far below those which could have been expected from a psychiatric hospital in 1982. This criticism applies to both medical and nursing staff involved in his care.

9.2 While individual responsibilities exist, the greatest responsibility rests on a system which has been allowed to be developed and maintained and which is deficient and inadequate in many respects.

9.3 Some, and some only, of these have been identified in connection with the tragic death of Michael Watene. Others will be referred to subsequently in this report where we deal generally with the systems and procedures which pertain at Oakley Hospital.

9.4 What we want to stress, however, is that the system must be so changed that such incidents cannot recur. As we said in the introduction to this report, the answer is not to discipline individual staff members but to change the system. It would be easy and wrong to react to what has occurred by imposing disciplinary sanctions on individuals who may themselves in some cases be the victims of a system within which they have worked. Such action could too easily form an excuse or temporary palliative, avoiding the more difficult necessity to transform the hospital itself. Michael Watene's death will achieve a much greater significance if it results in a transformation of Oakley Hospital, which is possible and we believe long overdue. Mere retaliation might deprive his death of those results which while not justifying it in any sense would give it a significance, which might be some consolation for those who cared about him.

SECTION 10

10. COMMENTS ON PRACTICES AND PROCEDURES AT OAKLEY HOSPITAL GENERALLY

10.1 Oakley Hospital as an Institution

10.1.1 The history of Oakley as an institution has been set out in the introduction to this report.

10.1.2 Ward M3 was the security and forensic section of the old Oakley Hospital and the Medical Superintendent was known to have specialised in forensic psychiatry.

10.1.3 Ostensibly then, the Medical Superintendent was given the control of the forensic and secure section of the old Oakley Hospital in accordance with his own special area of concern. It was submitted to us however, that effectively, he was removed from control of the larger hospital because of a failure to comply with the recommendations of the 1971 Commission of Inquiry. It is clear that at the time the separation occurred the Department of Health and the Auckland Hospital Board were concerned over an alleged failure to implement these recommendations.

10.1.4 The Medical Superintendent was required to take control of that part of the hospital which was expected to, and did, take all the most disturbed and disadvantaged of patients in the Auckland area.

10.1.5 There is also a suggestion that the staff at Oakley Hospital were those who, out of loyalty to the Medical Superintendent or his approach and methods, decided to make the move with him, and therefore it was staffed from the beginning with those who were identified with an alleged failure to implement the recommendations of the Commission and who had some reason for feeling that they had been badly treated in the very establishment of the hospital.

10.1.6 In such circumstances Oakley Hospital commenced and has operated under the most extreme disadvantages, and it is perhaps not surprising that it has been the subject of constant criticism and complaint ever since.

10.2 Land and Buildings

10.2.1 Oakley Hospital consists substantially of three buildings; a small administration building and two large ward buildings, M3 and M7. All these buildings are set in what was originally farm land and are isolated.

10.2.2 The administration block is small and inadequate and gives the impression of being a temporary building which has been allowed to become permanent.

10.2.3 Ward M3 is described by the Medical Superintendent in the following terms:-

> "Ward M3 is a large brick double-storeyed structure built about the time of the First World War and in good condition. Doubtless it has a further century of useful life in it.

Basically it consists of 70 single rooms each containing one patient, sleeping quarters and 50 of these are upstairs and those 20 beds downstairs are divided into 10 maximum security beds and 10 admission area beds, of which 7 are standard bedded rooms and 3 are strong rooms.

Admission beds consist inter alia of 3 strongrooms, i.e., rooms with especially strong doors and usually with foam rubber mattresses made up into beds on the floor so as to avoid projections.

Furniture is absent as it can be turned into weapons or stood upon to interfere with sprinkler systems (quite a dangerous procedure as the volume of water and the intensity of the spray can be almost asphyxial).

Absence of projections are an important matter for the safety of both patients and staff should struggles develop, and not a few do in these rooms.

One strongroom with subdued light is designed to facilitate sleep under sedation by day or night; the other two have large windows and all have excellent artificial lighting. The other 7 beds are basically furnished with beds and in some cases with bedside lockers.

The attrition rate of furniture in these other admission rooms tends to be fairly high due to occasional violence to the furniture or with it.

Violent, potentially violent, and potentially suicidal cases are admitted to the strongrooms as special bedclothes such as sewn blankets are available to prevent violence to oneself or others.

Some of the patients are so disturbed that urine and faeces tend to be spread around the room.

The strongrooms are fitted with special ventilation systems with a strong air exhausting duct to reduce odours from rooms. Warmth comes from a ceiling heater.

The 10 maximum security rooms, following a riot in there some years ago, do not have beds but have two foam mattresses per patient, making the equivalent of a low divan.

Ward M3 also has one large dayroom; a 50 seat in-built picture theatre which doubles as a TV room with a colour TV; at present a craft room which handles 16 patients and a large dining room; a new craft room which it is hoped will accommodate another 12 patients is under construction.

Downstairs there is a large ablution area and upstairs a smaller ablution area with toilets and washbasins. In the admission area there is also a toilet and washbasin area whilst the maximum security wing has showers, toilets and handbasins.

Both the maximum security area and the main part of the ward have airing courts.

The maximum security wing airing court is about 1 square chain and contains a volleyball court and a 20 x 15 foot swimming pool, all enclosed by a precast, inward curving 14 foot concrete wall.

The main medium security part of the ward is about an acre and a half of space, some in grass and some tarmac, with a larger swimming pool, volleyball court, basketball practice area, open sided sheds to sit in all enclosed by a 12 foot wire fence of powerful steel mesh.

At the entrance to the ward there are waiting rooms and toilets for visitors and an office.

Patients visit their relatives in the dining room Ward M3 from 2 to 4 p.m. daily.

Visitors undergo the screening usual for air passengers before entering.

Supporting accommodation consists of the ward office, the ward medicine room, a small medical surgery and two interview rooms."

10.2.4 The Medical Superintendent described Ward M7 in the following terms:-

"Ward M7 houses 76 patients of whom 60 are completely free to roam the grounds and enjoy parole while about 12 to 16 are too disturbed and wandering to do so.

These 12-16, known as "C" Group, have to be confined within an area known as the "C" group area which consists of two large airing courts, one about 90 feet x 90 feet tarmac enclosed by a concrete wall and the area, and the other about 150 feet x 150 feet being a grassed area with trees. There is a "C" dayroom as well.

"C" group patients are highly psychotic, subnormal or deteriorated. Many are rejects from other hospitals. Largely they are out of place in a forensic hospital.

As much as possible during daylight hours the disruptive and somewhat subnormal patients of "C" group are kept apart from the now nearing normal, convalescent, patients of the parole group. However at 4 p.m. a drop in nursing numbers means that some "C" group patients have to mix with others in the dayroom.

This is highly unsatisfactory and not fair to the less disturbed patients who get annoyed. (Unfortunately it is simply a question of nursing availability).

The sleeping facilities consists of three dormitories known as "Upstairs" - (largest and the best lighted) - two downstairs dormitories known as the "RSA" and "Office" dormitories.

Each of these lower dormitories has four single rooms at each end, giving a total of 16 single rooms for patients.

The other patients all sleep in two or four-bed cubicles. The upstairs dormitory has curtains for cubicles but the lower floor dormitories do not, for reasons of patients' safety, preventing threat and assault, etc.

All these dormitories have lavatories nocturnally accessible to them and single rooms all have chamber pots.

There are two washbasin rooms and toilet rooms upstairs; downstairs are larger facilities for the toilets and bathing for each downstairs dormitory, these being also used by upstairs patients.

There is one large dayroom for the parole patients and a smaller dayroom for the "C" group disturbed patients.

There is a small sick bay available downstairs, a ward office, an interview room and a well-lit medicine and surgery room.

There is also a small craft room accommodating 10, and administrative accommodation."

10.2.5 Comment

The buildings in their present state are inadequate and thoroughly unsatisfactory. They do not reflect what is considered desirable in a psychiatric hospital in the 1980s. They require substantial and urgent changes and upgrading in order to meet the needs dealt with in our recommendations. We believe, however, that they are capable of such upgrading.

10.3 Isolation

10.3.1 As has already been indicated, Oakley Hospital is isolated in the sense that the buildings are quite apart from any part of the Carrington Complex.

10.3.2 Oakley Hospital as an institution is, however, much more significantly isolated as a result of its history.

10.3.3 As was earlier indicated, the hospital was constituted in 1973 when effectively the two maximum security wards of the old Oakley Hospital were taken away from the balance of the hospital and remained known as Oakley Hospital, the balance and larger hospital becoming quite separate and known as Carrington Hospital.

10.3.4 The then Medical Superintendent of the old Oakley Hospital was not consulted over the change and was in fact appointed as Medical Superintendent of the much smaller, new Oakley Hospital.

10.3.5 Although this did not involve any reduction in salary or privileges, it was clearly understood by all concerned, as appears from the evidence before us, to involve a loss in status.

10.3.6 It seems clear that the present Oakley Hospital was born in an atmosphere of resentment and suspicion.

10.3.7 Predictably, relations between Carrington Hospital and Oakley Hospital have remained at best cool and at worst hostile. Comments were made to us which clearly indicated the attitude felt by one group towards the other.

10.3.8 Although the two hospitals share the same administration and a number of facilities it is clear that neither the nursing nor the medical staff have generally speaking very much to do with each other or accept even a remotely similar philosophy of running a psychiatric hospital.

10.3.9 Oakley Hospital has become, rightly or wrongly, identified with a particular style of conservative treatment of patients and clearly seems to be out of the main stream of current psychiatric practice in the Auckland Area. Professor Werry in his evidence, indicated that psychiatrists in Auckland were subject to criticism for having in effect turned their backs on Oakley as an institution.

10.3.10 The Medical Superintendent is a member of the Royal Australian and New Zealand College of Psychiatrists, but the other two medical practitioners involved at Oakley are not.

10.3.11 The evidence of Professor Werry indicated that there has been a degree of isolation as far as the medical staff are concerned and the evidence given by the five independent psychiatrists who were called before us would suggest that the methods of treatment adopted differ from those which pertain to the hospitals where those five psychiatrists are professionally engaged.

10.3.12 Oakley is not a teaching hospital or a training hospital. It does not have trainee nurses and it does not have Registrars qualifying in psychiatry. It therefore suffers from the lack of stimulation and the challenge of questions which young students of all disciplines - nursing, medical, O.T., social work, psychology etc., would bring to the situation. Thus the need to keep abreast with current developments and practices does not appear to many of the staff to be a priority requirement.

10.3.13 Persons in charge of educational programmes are unlikely to expose students to sustained learning experiences in Oakley Hospital until it can be demonstrated that these would be of a positive nature.

10.3.14 Staff who are willing to develop nursing on a different level feel they cannot put their knowledge into practice under the restraining influence of an administration which appears unable or reluctant to initiate or support change.

10.3.15 The isolation experienced by staff is detrimental to the development of their full professional skills. Many at Oakley Hospital seem to believe that they are in a unique situation, fraught with dangers and difficulties not understood by outside professional groups or the public. They consider that modern psychiatric practices cannot be applied within Oakley, despite the fact that security units in other New Zealand hospitals, as well as overseas, have successfully demonstrated to the contrary.

10.3.16 All professions suffer if they are cut off from the mainstream of developments in their particular field and nursing is no exception. If isolated from contact and the intellectual stimulation of dialogue with colleagues, or participation in and observation of a variety of therapeutic strategies and treatment programmes, adequate library resources and exchange of views with para-medical associates, nurses are likely to be defensive, resistant to and unconvinced of the need for change, and unwilling to take the professional risks required to bring about change.

10.3.17 To a large extent nursing in Oakley reflects the effects of isolation and the methods and style would appear to be attributable to this. Few outside professionals visit or observe in Oakley. Because communications are poor, staff largely feel neither they nor the situation in which they work are understood.

10.3.18 There is little movement of staff between Oakley Hospital and other hospitals and effectively little movement of registered staff from Oakley Hospital itself. The whole institution appears to have become quite isolated and to have a beleaguered mentality with regard to Carrington Hospital and the Auckland Hospital Board. The Auckland Hospital Board is perceived by administration and staff at Oakley as ill-informed, insensitive and unresponsive to the particular and special needs of patients and staff at Oakley Hospital. Substantial criticisms were made against the Auckland Hospital Board for the infrequency of visits by the Chairman and Board members, and failure to institute such changes as lay within its authority.

10.3.19 A number of witnesses indicated that in their view Oakley Hospital was the Cinderella of the hospitals administered by the Auckland Hospital Board. It was stated that it received less than its fair share of staff, funds, and interest.

10.3.20 There was a constant reference at the Inquiry before us to Oakley Hospital having suffered from media attacks and ill informed criticism. While we can understand the reasoning which lies behind these comments we think these in themselves reinforce the sense of isolation which is felt both inside and outside the institution.

10.3.21 Finally, Oakley has always taken the most unwanted and underprivileged of psychiatric patients in the Auckland area - those referred from prisons and those whom other hospitals did not wish to take or to retain.

10.3.22 For all these reasons Oakley Hospital has become isolated as an institution, as a staff, in its approach to treatment, and from the community as a whole.

10.3.23 Comment

The isolation of Oakley Hospital is serious from the point of view of the medical and nursing staff and from that of the patients. We have endeavoured to set out above a number of areas where we consider this isolation has particular effects on those involved. We believe that this isolation is reflected in other

practices and procedures with which we are concerned at Oakley Hospital. It is our view that this isolation must, in the interests of all concerned, be ended as quickly as possible. A number of the recommendations which we make later in this report are designed to achieve this end.

10.4 Leadership

10.4.1 Dynamic, optimistic and health orientated leadership is essential if the highest standards of care are to be achieved. This can be considered from three aspects.

10.4.2 Administrative Leadership

10.4.2.1 The Medical Superintendent as the Controlling Officer influences and directs almost all activities and issues standing orders controlling the patients' day and behaviour. His style has been described as authoritarian and the systems he imposes appear to allow little scope for decision making at lower levels of professional competence. The Medical Officer and part-time Consultant Psychiatrist have a specific clinical role. They do not appear to contribute to, or exercise any influence on, the administrative or management policies of the hospital.

10.4.2.2 A high level of hierarchical and bureaucratic dependence seems to have been created. The Principal and Assistant Principal Nurses are responsible to the Medical Superintendent and accountable to him for implementation of his instructions and standing orders. Both of these officers have long experience in psychiatric nursing - predominantly in Oakley Hospital - but have not had the advantage of advanced education or recent exposure to situations where different methods of nursing are practised. A great deal of their time is given to non-nursing management and clerical duties.

10.4.3 Supervisory Leadership

10.4.3.1 The Auckland Hospital Board job description for supervisors emphasises the clinical, advisory and teaching aspects of these positions. It implies that persons in these positions should have expertise in nursing, patient care, management, and problem solving at a high level. The list of duties which the supervisors presented to the Committee as those which they actually carried out bears little resemblance to the Board's job description.

10.4.3.2 Of the three present supervisors at Oakley Hospital none has preparation beyond basic psychiatric registration and therefore they are at a disadvantage in relation to professional obligations and responsibilities. They see themselves as liaison communicators - advising the ward staff of the wishes and orders from above and reporting back to the medical and nursing administration on events, problems, reactions and needs in the clinical area.

10.4.3.3 They are largely occupied in activities of a domestic, clerical, and minor administrative nature which should be undertaken by a House Management Department.

10.4.3.4 The supervisory group is strongly identified by ward staff as part of "the administration". They have their offices in the administration block, and there appear to be poor relationships and communication between the two groups. There is no consensus planning or agreement on nursing policies or programme planning which would make better use of nursing knowledge and skills, and improve the patients' situation.

10.4.3.5 Comment

Nursing at the supervisory level appears to have little autonomy in matters of a purely nursing nature, nor does it appear to take the initiative in matters affecting patient care, in the development of standards, guidelines for practice, or in the evaluation of care.

10.4.4 Clinical Leadership

10.4.4.1 The professional nurse in clinical practice is the key person in the patient's life. It is this person to whom others look as a role model, who sets the standards of care, creates the atmosphere in the clinical area, participates in planning and delivery of care, and acts in an advisory and teaching capacity to staff in the ward or in the community services. The fulfilment of this role demands a high level of knowledge, wide clinical experience and familiarity with current therapeutic nursing practice.

10.4.4.2 Professional nurses at Oakley have not had these advantages and are restricted in the scope of their practice by instruction from the administration and the emphasis on their role as security officers.

10.4.4.3 Staff expressed frustration at a system based on a series of orders issued from above and descending by instruction to the lower ranks. The feelings of these staff are well expressed in a letter included in the P.S.A. submissions to the Committee.

"The Secretary,
P.S.A. Sub-Group,
OAKLEY HOSPITAL.

8th June 1981

Dr .....,
Medical Superintendent,
OAKLEY HOSPITAL.

Dear Sir,

Following representations from a member that he was addressed in an unprofessional manner by a senior member of the administration in that he was to act "as if it were the navy ... obey orders first and question them after," we, as sub-group representatives, seek your assurance that such terminology either explicit or implied will no longer be used.

Further, we offer the following comments for your consideration and reply:

(a) As adults in a democratic society we have the right to ask for explanations or the philosophy behind ward procedures.

(b) As professionals in an area implying a responsibility to the public, we have the duty to question any order where we feel that patient or staff welfare or safety is concerned. Unquestioning obedience has no place in a modern therapeutic community and we as a sub-group will resist any attempt to enforce such a philosophy.

(c) We are further concerned that through deprivation of privileges, e.g., films and adequate exercise, the Special Wing is becoming a "defacto" punishment type area quite contrary to the concept of an area of special nursing and security care.

The consequences of these deprivations are an increase in tension in this area with a resulting danger to staff.

It is our opinion that opening the craftroom at the expense of the patients in the Special Wing area, leading to further seclusion of patients already subject to deprivation through ward commitments and staff shortages, indicates an incorrect priority.

Yours faithfully,

(for Sub-Committee)"

10.4.4.4 The Medical Superintendent's response to this letter is not encouraging.

25 June 1981

"The Secretary,
Oakley Sub-Group,
P.S.A.

RE: P.S.A. LETTER 8.6.81 RECEIVED 23.6.81

1. COMPLAINT OF UNPROFESSIONAL ADDRESS

    1. I note your complaint of paragraph 1 of your letter.

    2. Upon investigation I understand that when a charge nurse was asked by the nursing administration to carry out a certain instruction, some discussion arose during which the charge nurse himself used the words, "as if in the Navy" to the supervisor, i.e. implying that he felt that he must.

2. RIGHT TO QUESTION ORDERS

    1. In short a person may reasonably question an order for the following reasons:

        (a) To gain information on the reason for the order. There can be little objection to this, unless of course the situation is an emergency.

        (b) Because he feels that he may have some information which the giver of the order has not, and which may affect the necessity for the order.

        (c) Because the recipient of the order feels that the instruction is not a lawful one.

    2. Of course one would expect staff who wish to discuss an order to use judgement in the place, time and method for discussing such orders.

    3. However, it must be stressed that in an emergency, an order unless it is felt to be manifestly unlawful or rendered inapplicable by some other circumstances, should be rapidly obeyed to prevent something going badly wrong.

    4. However, a person may seek reasons for the order once the emergency situation is under control.

3. MAXIMUM SECURITY WING PROBLEMS

    1. There would probably be no real problems in this area if the hospital was adequately staffed, but it is not, and we must work within the resources available.

4. MAIN FUNCTIONS OF MAXIMUM SECURITY WING ARE:

    (i) A maximum security area for maximum security type patients is in the public interest (which infers the general public, the larger number of patients in the hospital, and the staff).

(ii) A means of separating patients, who are likely to disturb other patients or physically assault them, from one and other; this also includes plotters of escapes or assaults on staff.

(iii) Of providing a place of safety for patients of special types, e.g. paedophiliacs, etc., or who have run foul of other patients, to prevent them from being threatened or assaulted.

(iv) To be a place where a patient who needs special observation to be observed closely by nursing staff when up and about (this occasionally becomes necessary in suspected malingering or where unobserved epileptic phenomena are alleged to occur, etc.).

5. STANDARD OF DIVERSIONAL ACTIVITY IN MAXIMUM SECURITY WING

1. As, inevitably, the inhabitants of this area have to spend more time than is desirable in their rooms, every effort should be made to get them out into the open air (climatic conditions allowing). Once out they should be encouraged to take as much exercise as possible to procure a healthy fatigue, work off tension etc.

2. Unfortunately, a situation arose approximately over the last 12 months when the members of the security wing received a great deal of passive entertainment in the form of films, etc., than other patients, where some patients actually desired to be placed in the security wing.

3. To gain this end they assaulted other patients and in one case perpetrated a violent attack upon the staff. Patients have mentioned to me personally from time to time their intention to put themselves into the wing by this means.

4. It is obvious that if the standards of the maximum security wing are perceived as more comfortable than that of the main dayroom, there is a potential hazard to other patients and staff at the hands of certain unscrupulous psychopathic individuals.

5. Thus, it is important that the standards of the two areas approximate as much as possible in the interests of patient and staff socially.

6. CRAFT ROOM VERSUS MAXIMUM SECURITY WING

1. It is possible, rather than closing this craft area, to balance the time up for the maximum security wing by allowing the security wing patients out of their rooms in the evenings, at a time when the craft room must be closed, thus not really depriving anybody of whatever time up is available.

2. In my opinion it would be unwise at this stage to further reduce craft therapy at a time when the hospital is accused of making little or no effort in this direction.

7. NEED FOR FURTHER STAFF AND PSYCHIATRIC ASSISTANT EDUCATION

1. I can understand the feelings of many staff who would like to try and improve matters if any more staff were available. There are bound to be differences of opinion over priorities etc. however.
2. For instance, I can understand the feelings of a person who, with the best intentions, would like to increase the number of films given in the maximum security wing, but without the full knowledge of the psychodynamics of the whole situation, felt aggrieved when such films were stopped, for what is considered the greater good of all.

3. Regretfully I can only conclude that we must all somehow work together to attract some more staff of all kinds; if nothing else to obtain more unregistered staff to enable the staff margin which will allow us to keep wards going and yet train, more deeply, our own psychiatric aides, many of whom are showing an increasing interest which one would like to foster.

Medical Superintendent."

10.4.4.5 There is evidence that given opportunities for intensive retraining and experience in security units of a different nature there are sufficient professional staff in Oakley Hospital able to effectively change the present system and develop a therapeutic team approach to patient care. As an indication of the attitude of staff, we draw attention to the material set out in Appendix III to the submissions of the P.S.A. This material which discusses psychiatric nursing in a forensic setting is a useful positive document.

10.5 **Staffing**

10.5.1 **Medical Staff**

The present medical staff at Oakley Hospital consists of a Medical Superintendent, a consultant working on a part-time basis (7/10), and a Medical Officer - Special Scale. The effective medical staffing in 1982 was 2.7. In his submission the Medical Superintendent observed that the initial medical staffing following the commissioning of the new Oakley Hospital was four. The establishment was later reduced to three. To cope adequately with the present patient load the Medical Superintendent contended that a medical staffing level of at least 5.5 was necessary. The Committee believes that the present organisation patterns and clinical activities at Oakley Hospital would warrant such an increase. However, later in the report the Committee recommends a different pattern of organisation and duties. Even if the medical establishment at Oakley Hospital was to be increased to the level of 5.5, the Committee entertains serious doubts whether the conditions and circumstances at Oakley Hospital would attract further psychiatric staff to the present institution.

10.5.2 **Nursing Staff**

10.5.2.1 The total number of nursing staff employed in the Board's psychiatric hospitals (1981-82) is 757 (excluding Ward 10A Auckland Hospital). The current level of staffing at Oakley Hospital is as follows:- (figures obtained from Oakley Hospital Administration)

Principal Nurse	1
Assistant Principal Nurse	1
Supervisors	3
Charge Nurses	8
Staff Nurses	29
Psychiatric Assistants	59
TOTAL	101

10.5.2.2 In 1981 a joint working party of the Interboard Liaison Group and the Public Service Association was established and guidelines for staffing levels were established. The figures agreed to were in accordance with the Auckland Hospital Board criteria. (Auckland Hospital Board Resources and Services, p.37).

OAKLEY HOSPITAL

	Base	Application of Criteria	
Category of Staff	Av.No. Employed Y.T.D. 1981/82	A.H.B. Criteria	Working Party Recommendation
Charge Nurse	6	7	7
Staff Nurse	31	64	64
Enrolled Nurse	Nil	36	36
Other	56	Nil	Nil
Supervisors & Above	5	5	5
Community Staff	3	3	3
TOTAL	101	115	115

10.5.2.3 The significant differences in present and future staffing levels are the proposed increase in registered nursing staff and the replacement (at a reduced level) of the psychiatric assistants by enrolled nurses giving a total increase in nursing staff of fourteen.

10.5.2.4 Oakley Hospital has not been active in recruiting or advertising for registered staff, nor does it appear to have attracted many enquiries from professional nurses. Some applicants have been declined on the ground of unsuitability.

10.5.2.5 The administration has strong reservations and views on the employment of female registered psychiatric nurses. This is a view which is not in accord with psychiatric practice in New Zealand and overseas where integration of both staff and patients is an accepted policy and has been successfully implemented. M7

is described as an "Open" ward where female domestics and a craft instructor are employed. It is difficult to understand the logic behind the reservations regarding the employment of professional female nurses and we do not accept that the dangers from patients are so great that nurses who are professionally trained would be at risk.

10.5.2.6 It is also a matter of concern that psychiatric assistants continue to be employed and that their numbers substantially exceed those of registered staff. The assistants receive minimal instruction and to date only one of the total number at Oakley has entered the Board's Enrolled Nurse programme. Because of their numbers they are inevitably called upon to provide nursing service far beyond their level of preparation or competence. We believe, that the need to improve staff competence, to increase the number of registered nurses, to include female nurses in the establishment figures and to replace psychiatric assistants with enrolled nurses or to require suitable assistants to undertake the Enrolled Nurse programme followed by a Psychiatric Nursing Endorsement Certificate, are of high priority and require the most urgent attention of the Auckland Hospital Board.

10.5.2.7 In addition to the nursing staff there are three psychologists at Oakley Hospital, four psychiatric social workers headed by a senior social worker, and three psychiatric home visitors. There is a recreational officer on the Oakley establishment but domiciled at Carrington.

10.5.2.8 Much of the defence to the criticism of the situation at Oakley, e.g. curtailment of patient activities and programmes, going to bed at 8.00 p.m., inadequacies in in-service programmes, task orientated nursing - was alleged to be due to the shortage of staff and the predominance in the nursing staff of untrained psychiatric assistants.

10.5.2.9 More nursing staff would not of itself lead to changes in the nursing system. Professional nurses with appropriate advanced level training are required. Nurses are unlikely to be attracted to an institution where nursing is predominantly under strict medical control and where senior administration is not sympathetic to or supportive of change. Nevertheless the low staff numbers presently employed do substantially contribute to the difficulties in this institution and affect patient care.

10.6 <u>Overtime</u>

10.6.1 In accordance with Public Service Association Policy, overtime is worked on a voluntary basis. The normal working roster is four days on and two off.

A. Shift (Night) - 11.30 p.m. to 8 a.m.

D. Shift (Afternoon) - 3.05 p.m. to 11.40 p.m.

B. Shift (Morning) - 7 a.m. to 4 p.m.

C. Shift (Morning) - 8 a.m. to 5 p.m.

10.6.2 Shortage of staff on D shift requires an extension of hours from

those working on B and C shifts. Shortages on all shifts require that one of the two days off is frequently worked. The Supervisor checks daily on who is available for overtime and adds these names to the duty list.

10.6.3 The extension of working hours for A shift staff from 11.30 p.m. back to 7.30 p.m. was in the main a means of ensuring an evening programme for patients and to allow some patients to stay up until 10.00 p.m. In response to the Auckland Hospital Board's request for savings in the budget (of 3%), this practice was discontinued at Oakley with the result that the majority of patients are required to be in their rooms by 8.00 p.m. Dr Medlicott, in evidence said, "In Ward 3 early bedding due to shortage of staff must be hard for any hospital to justify in terms of common humanity."

10.6.4 We believe the health, interests and efficiency of staff are seriously affected by the demands for overtime and extensions which impose a 12 hour day and reduce their days off to one in five. The short notice of the requirement disrupts family life and restricts the outside interests in which many staff might otherwise engage. Some staff may be willing to do as much overtime as is available but many find it very demanding, and others have withdrawn from the system. It is our view that staff should not (except in unusual circumstances) be required to work these additional hours. It is essential that staff numbers are increased and shifts brought up to full strength.

10.6.5 We note that Mr Corkery, on behalf of the Auckland Hospital Board, stated that Oakley Hospital could engage additional registered nurses on the understanding that overtime was proportionately reduced. We cannot understand why this has not been done.

10.7 <u>Staff Education and Training (Nursing)</u>

10.7.1 On a single discipline or multi-disciplinary basis, staff development (either informal or organised) is not a strong feature at Oakley Hospital. There is contact and discussion between individuals involved in patient care, but no evidence of team conferences on such issues as clinical matters, alternative systems of care, policies, philosophies or new ideas in the field of psychiatry. Nursing administration and clinical staff meet occasionally when particular matters arise but the relationships between the two groups are such that discussions are virtually ineffective. There has been no development in nursing standards, objectives or guidelines to nursing practice. Such policies are commonly adopted elsewhere.

10.7.2 There does not appear to have been any recent training in modern psychiatric nursing skills and strategies, group dynamics and therapy, counselling, or human relationships. These would contribute significantly to improvements in nursing care and give staff confidence in working in a therapeutic inter-active manner.

10.7.3 Registered nursing staff have been included in short 3-5 day management courses, have received instruction in cardio-pulmonary resuscitation, and visited clinical areas (non-psychiatric) in the Board's hospitals. Films from drug companies and other sources have been shown. Many of the films appear to be out of

date and in some cases of doubtful significance. Staff attendance is not compulsory. It is doubtful whether staff on afternoon or night shifts have been involved to any great extent in in-service education.

10.7.4 Only two nurses at Oakley have both general and psychiatric qualifications. One of these holds a Diploma in Nursing. In the last eight years no professional nurse has undertaken any study programme at advanced level. Two applied recently but one withdrew and the other was not accepted.

10.7.5 Psychiatric assistants are seriously disadvantaged since they receive only minimal instruction or training. A three day orientation and a 40 hour programme is given by a supervisor when the time and staffing levels permit. This is often delayed for periods as long as 6 - 9 months after appointment. Supervisors are unable to plan programmes in advanced psychiatric nursing as none of the three present supervisors have qualifications above basic psychiatric nursing registration and are therefore not qualified educationally to meet the needs of nursing staff.

10.7.6 Some staff do not appear to recognise their obligations to keep abreast of developments in their professional field. One staff nurse stated "I don't think they could update my professional education." This nurse is frequently in charge on the afternoon shift.

10.7.7 At best, staff training and continuing education at Oakley is fragmented and episodic and its absence restricts developments of new patterns and styles of nursing and must affect the quality of care offered to patients.

10.7.8 **We note that the Chief Nurse for the Auckland Hospital Board has expressed an intention of providing an In-Service Educator at Oakley Hospital. We believe that such an appointment should be made with the utmost urgency.**

10.8 Ward Regimes

10.8.1 The pattern of the patients' day and the quality of life which they experience within an institution reflect the particular philosophy of its professional staff, the standards, criteria and objectives of care, the practices, procedures and programmes designed and implemented by staff for the benefit of patients, and the resources, facilities and services provided by the employing authority.

10.8.2 Ward regimes, and indeed almost all daily life at Oakley Hospital, is regulated by detailed standing orders which cover almost all daily activities, particularly in M3, from the time of getting up to the time of going to bed. We comment elsewhere in this report on certain aspects of these standing orders.

10.8.3 Professional nurses who have an understanding of patients' psychiatric conditions and their patterns of behaviour are quite capable of designing a ward regime which will meet security requirements for those patients who need it, and will cater for the psychological, social and emotional needs of all patients. They should not need instructions such as are contained in the "Standing Orders", covering all daily activities.

10.8.4 Professional nurses who are able and encouraged in a therapeutic role and have the safety and care of patients at heart do not need to be told where to stand in the ward and have all details of their movements issued as orders from the Medical Superintendent.

10.8.5 Basic physical needs appear to be reasonably met. There is no evidence of neglect in respect of hygiene, meals or clothing. This was observed by the Committee on its inspections of Oakley Hospital and was substantially confirmed by the independent psychiatrists who at the request of the Committee interviewed all patients at Oakley Hospital.

10.8.6 Individual patients cannot be effectively treated by sets of rules and orders to which the whole group has to conform and which do not take into account the individual and his particular and special needs. There was no evidence of personalised nursing assessment, identification of problems, plan of action or evaluation, which is the normal nursing process. This process continues while the patient remains in care and the record becomes part of the clinical file. The patient is involved to the extent that his intelligence and contact with reality permit. He is kept aware of the staff concern for him, informed of the conditions of his hospitalisation and helped to achieve the health and behavioural objectives which are within his capabilities.

10.8.7 Dr Medlicott stated:-

> "Individual psychotherapeutic investigation and support appeared almost non-existent. No patients appeared to have a special psychotherapeutic relationship with a psychiatrist or psychologist or who had a member of the nursing staff designated as a counsellor. In terms of occupation in the broad sense this is grossly inadequate.
>
> The hours of boredom in Ward 3 often appeared extreme. In Ward 7 most patients could sit up until after 10.00 p.m. and watch T.V."

10.8.8 It is essential that all patients, particularly those in continuing care, be regarded as persons capable of growth and change and for some meaning to be given to their daily lives through activities which help to develop their intellectual, technical, artistic and creative abilities and contribute to their physical and mental well-being.

10.8.9 A range of "entertainment" and diversionary resources, e.g., games, radio, T.V., films, etc., is available to which some, but not all, patients have access at varying times during the day and evening. These and other activities which would make the patients' day more meaningful are largely influenced by the number of staff on duty, the demand on staff for escort duties, shortages in other wards, meetings, emergencies, etc. The patients' day appears to have a certain unpredictability about it in that things start, stop, change, or vanish altogether. Such random changes are confusing, anxiety raising and demoralising. They affect the enthusiasm, interest and motivation of both patients and staff.

10.8.10 Management of Disturbed Behaviour

10.8.10.1 Outbreaks of aggressive and occasionally violent behaviour will undoubtedly occur from time to time in an institution in which disturbed patients are confined and are in close contact with other disturbed people. Some of this will be a result of the patient's mental condition but may also arise from anger, frustration, resentment and boredom.

10.8.10.2 Staff are required to handle these situations expeditiously and firmly. If physical control has to be exercised this must be applied in such a way as to avoid any possible injury to staff or patients. The techniques and approaches to be used are a necessary part of the training and in-service education of nurses in security or closed units. There is ample literature available on the subject and this should be brought to the attention of all nursing staff. Even more important is an analysis of the situation and circumstances which preceded the crisis and and the need for careful observations in detecting the early warning signals. We are very concerned that staff when questioned, indicated that they had had no formal instruction or training in techniques of this kind.

10.8.10.3 In addition, a nurse's intimate knowledge of a patient's behaviour patterns will enable preventive action to be taken at the appropriate time. This will minimise the occurrence of violence.

10.8.10.4 Education programmes and problem solving interdisciplinary conferences which focus on social skills training for highly assaultive patients, training in defusing potentially dangerous situations, and methods of understanding and handling aggression, are means which should be employed in preference to tight controls, discipline and rules. These latter practices are no solution to the problems of the individual patient.

10.8.11 In conclusion we quote from Dr Louis E. Kopolow, Chief of Patient Rights and Advocacy, The National Institute of Mental Health, Rockville, Maryland, as follows:-

> "Coercive treatment distorts the therapist's role as caregiver and may be as harmful to the therapist as the patient. A more collaborative, less paternalistic approach is needed for effective treatment."

10.9 Records

10.9.1 General

10.9.1.1 The type of documentation, clinical records and reporting currently used in Oakley make it difficult to obtain a concise, clear and coherent picture of the condition and progress of patients.

10.9.1.2 Dr Medlicott stated, "In terms of documentation this was inadequate. The preliminary statements rarely made the subject live or gave any graphic account of the circumstances that brought him into hospital. The progress notes were brief and scrappy and rarely related how the patient was now to what he had been or told you what the staff had in mind for him.

Unfortunately, I saw few Ward 3 criminal patients. There is no doubt that for ongoing assessments of dangerousness, a day-by-day account of the act, what led up to it, and what the patient felt and did afterwards is essential. At the same time, details of the victim and the family should be entered. What is called the walk through of the act is accepted as proper practice. What I saw of the records fell far short of this."

10.9.1.3 Dr Durie confirmed Dr Medlicott's evidence and indicated that the records kept at Oakley were unsatisfactory to him as a clinician. We agree with these comments.

10.9.2 Nursing Notes and Reports

10.9.2.1 The charge nurse of each shift is required to make daily or periodic entries on the nursing notes attached to each patient's file. He receives verbal reports from his staff and selects what he considers to be relevant for entry on the file.

10.9.2.2 The items generally refer to any special events, occurrences, treatments given or proposed, and are of a documentary nature. The notes do not lend themselves to an ongoing progress report on patients' problems, symptoms, needs, changes in behaviour or responses to treatment.

10.9.2.3 The offensive and derogatory nature of comments written by a charge nurse on patients' files which we read are totally reprehensible, thoroughly unprofessional, and a cause for serious concern. Such practices should be the subject of severe censure. (See also paragraph 8.2.4).

10.9.2.4 In no respect do the nursing notes represent what is generally understood to be a comprehensive, informative, nursing report.

10.9.3 Ward Reports

This book is written up by the charge nurse on each shift for oncoming staff and for the information of the administration staff. It provides advice on items of a general nature and comments on patients receiving or requiring any special attention.

10.9.4 Other Records

An "incident book" is kept in which are written the details of disturbances in the ward and accounts of staff involvement in aggressive incidents with patients where controls of a physical nature have to be imposed. It is difficult to understand the purpose of this record. It was suggested to us that it is kept for industrial purposes. Important observations of this nature belong on the patient's clinical file and should be the subject of special reports for the information of the Principal Nurse and Medical Superintendent.

10.9.5 A narcotics register is kept. It contains a section on the administration of Paraldehyde which is not a narcotic but a hypnotic drug. We accept that a record in respect of the administration of this drug is desirable. We note that in the case of Paraldehyde at least, the authorising Medical Officer was

recorded to be the Medical Superintendent at a time when he was not on duty at the hospital. This was explained by the Medical Superintendent on the basis that the administration of Paraldehyde fell within his general authority to authorise the administration of this drug. We consider such authorisation in absentia to be completely unacceptable.

10.9.6 The standard clinical file used in other of the Auckland Hospital Board's psychiatric hospitals has been rejected by Oakley as unsuited to their needs. The Committee believes it would be desirable for the Oakley administration to review this decision and adapt it to their use. We consider it would be helpful to give Oakley nurses the opportunity to learn the system of problem orientated recording used in Ward 10A Auckland Hospital and in Kingseat Hospital.

10.9.7 Drug Records

In our view the multiplicity of drug records could lead to errors and omissions in proper recording. Information on current medication regimes is recorded in a number of places, and it would be difficult for staff on the various shifts to know exactly where to find precise information on whether changes to the regime had been introduced. The records include a white prescription card written by the doctor, a yellow card recording the administration of the medication, a medication book in which all patients' medication is recorded, the nursing notes on individual patient files, the daily ward report book which is written up on each shift, and the Narcotics Register (Controlled Drugs Register) for narcotic drugs and Paraldehyde. We believe this to be an unnecessarily complicated system which should be immediately reviewed. We understand that the Auckland Hospital Board has already instituted some changes in drug recording.

10.9.8 During the course of the Hearing a file was produced to us which appeared to be a Carrington Hospital file relating to a particular patient. We are gravely concerned that material of this nature, which is clearly confidential, should have been made available otherwise than through proper channels. Similar comments apply to certain Oakley Hospital files which were produced to us. In view of the importance of maintaining confidentiality of patients' records, we recommend that the Auckland Hospital Board should take immediate steps to control access to patients' files.

10.10 Occupational and Recreational Activities

10.10.1 A room at Ward M3 which is presently being enlarged offers a range of craft activities to a limited number of selected patients for certain periods during the day. Its use is affected by the number of staff on duty. It is run by a female psychiatric assistant of whom all staff speak very highly, but she is required to have two male staff in attendance at all times. When this room is open, patients in the Special Wing have to be returned to their rooms. Their main "recreation" seems to be exercise in the airing court or corridor and the use of a small TV room. There is also a small craft room available at Ward M7. When staff numbers are low the craft room cannot be opened.

10.10.2 The Medical Superintendent is reluctant to employ a qualified occupational therapist. The standard and variety of the articles produced in this craft room indicate there is considerable latent artistic and technical talent amongst patients which could be further developed and extended as part of the total therapeutic plan by a professional occupational therapist.

10.10.3 A limited range and variety of recreational activities is provided through the services of a Recreational Officer located in Carrington Hospital. One officer cannot realistically meet the needs of all patients in M3 and M7.

10.10.4 Activities planned by the recreation staff are subject to security precautions which place limitations on the programmes they could offer.

10.10.5 We understand that the present Recreational Officers at Carrington Hospital are registered psychiatric nurses and hold qualifications in their specialty. Nevertheless, it is required that Oakley nurses must always be present at these sessions. If there is a shortage of nursing staff, programmes may be cancelled. Patients cannot look forward to a regular planned programme. Guitar playing, which many Maori and Polynesian patients enjoy, is forbidden unless a nurse is present. This is supposed to prevent patients secreting the guitar strings for their possible use as a garotte.

10.10.6 We draw attention again to the comment of Dr Medlicott on boredom of patients. A number of members of the staff, as well as former patients, indicated to us their concern over the boredom experienced by patients and the lack of available occupation during what must be very long and empty days.

10.10.7 **We strongly recommend that there should be two recreation officers available to Oakley hospital, one for Ward M3 and one for Ward M7 and that two occupational therapy posts should be added to the establishment. Both these steps should be taken immediately.**

10.11 Day Room Conditions

10.11.1 In Ward M3 there is only one day room available for patients. All patients not occupying single rooms in the special wing or corridor have their leisure time in this large room where they are supervised by nurses. In Ward M7 there are two day rooms, one for the "C" Group patients and one for the ward generally. A separate television and film theatrette is adjacent to the day room in Male 3. There is also a small television room off one of the day rooms in Male 7.

10.11.2 The day rooms are large and provide for a number of occupations. In no case however do they allow for the formation of small groups or for any privacy should patients wish to talk with nurses. The nurses are instructed to take up positions near doors or alarm switches and are forbidden to leave these positions. These rooms exemplify one of the worst features of the Oakley environment in that all patients, regardless of their mental status, category, or diagnosis are grouped on behavioural grounds.

10.11.3 In Ward M3 up to 60 patients, depending on the number who are permitted use of the day room, may have to congregate in the room. Some are prisoners, some are committed patients, and some are patients who for one reason or another have been sent to Ward M3 from Ward M7 because greater security is required.

10.11.4 We were told by the Medical Superintendent that the prison hierarchy is a constant problem, that standover tactics and bullying occur and there is a constant need to avoid one patient obtaining the medication of another either forcibly or through gambling and other means.

10.11.5 The Medical Superintendent also indicated his concern that some patients used the privacy of the adjacent toilet facilities to physically abuse and intimidate other patients.

10.11.6 There is no privacy in the room, no opportunity for a patient to have any quiet time by himself, no opportunity to listen to music of his choice, and no possibility of getting away from his fellows.

10.11.7 Because of the pressures which the situation exerts, staff are obliged to take a largely supervisory role, their opportunity to circulate amongst patients is restricted, and their opportunity to express a therapeutic concern on a one-to-one basis, which many of them would be both capable of and willing to do, is extremely limited.

10.11.8 It is scarcely surprising that patients have apparently from time to time expressed the wish to be placed in security or single rooms just to have some degree of peace.

10.11.9 We should have thought that this situation, mixing as it does, the most unsuitable of patients under most depressive conditions, would be a gross hindrance to improvement in mental health, a distressing situation for patients and a frustrating one for staff. We consider that it requires urgent remedy and have recommendations to make in this regard later in the report.

10.12 "C" Group

10.12.1 "C" Group is a specially selected group of those with major intellectual handicaps and regressed behaviour whose irritating mannerisms and behaviour patterns are disturbing to others. It consists of people who require some degree of oversight. They are, generally speaking, unacceptable to other institutions and attempts to place them in other institutions have not been successful. For various reasons, although they are technically in an open ward some restraints upon their freedom are necessary to prevent wandering. There does not appear to be any structured programme of activities of any kind for these patients.

10.12.2 As set out earlier in 10.2.4 the Medical Superintendent described "C" Group as follows:-

> "These 12 - 16 known as "C" Group, have to be confined within an area know as the "C" Group area which consists of two large airing courts, one about 90 feet x 90 feet tarmac enclosed by a concrete wall and the area, and the other about

150 feet x 50 feet being a grassed area with trees. There is a "C" day room as well, 90 feet x 90 feet tarmac enclosed by a concrete wall and the area, and the other about 150 feet x 50 feet being a grassed area with trees.

"C" Group patients are highly psychotic, subnormal or deteriorated. Many are rejects from other hospitals. Largely they are out of place in a forensic hospital.

As much as possible during daylight hours the disruptive and somewhat subnormal patients of "C" Group are kept apart from the now nearing normal, convalescent, patients of the parole group. However at 4.00 p.m. a drop in nursing numbers means that some "C" Group patients have to mix with others in the day room.

This is highly unsatisfactory and not fair to the less disturbed patients who get annoyed. (Unfortunately it is simply a question of nursing availability)."

10.12.3 It was given in evidence and appears in the ward reports that patients are placed in "C" Group for minor infringements of rules and standing orders. In some cases such a course appears to follow where patients are regarded by staff as a nuisance. Examples which appeared in the ward report book or were given in evidence included incontinence, wandering, giving "cheek" to staff, pestering social workers or doctors, placing feet on furniture, or disobeying orders because of a physical handicap which affected the way in which the order could be carried out.

10.12.4 An example produced in evidence was a circular which was issued over the title of the Medical Superintendent and which we believe deserves quoting in full.

"Principal Nursing Officer

Re: M7: Patient Visits of Administration Building

(1) Patient traffic to the above in spite of requiring written permission from the Ward Charge, is far too great.

(2) Large numbers of patients use the foyer of the building as a club and come down here to merely ask whether they have been given leave, to request cigarettes and pester social workers, medical officers, etc.

(3) There is disruption to the work of the receptionist and other members of the administration building staff.

(4) In future the Ward Charge, after hearing the request :-

i. (a) Will not normally issue permission for patients to come down to interview the medical officers, unless the medical officers have so requested the ward.

(b) Medical officers visit the wards daily and consultations with patients will be better there, especially as the examination room is there.

(c) If the Ward Charge feels that there is some special reason why a patient should see the medical officer he should ask the medical officer to see the patient.

ii. The same will apply to the social workers.

iii. (a) The patients who persistently meander in and out of the administration building, without written permission, will be warned that continuation of this will result in their being placed in C Group.

(b) If they repeat the offence the receptionist - or other person will notify the Nursing Administration or the ward.

(c) The patient will then be placed in C Group, unless there are special extenuating circumstances for the rest of the day.

(5) Patients should also be warned that without permission they are not to frequent the car park of the administration building or they will incur the same result as the last paragraph, i.e. "C" Group.

Dr .....
(Medical Superintendent)"

Such a circular is inconsistent with the concern expressed in the material set out at 10.12.2.

10.12.5 It cannot be stated too strongly that the practice of placing patients in "C" Group as a disciplinary measure is totally unacceptable and reprehensible on both professional and humanitarian grounds. Such a practice has no place in a treatment regime of a modern health care institution.

10.12.6 It was variously stated in evidence that placement in "C" Group could be regarded as a corrective measure, a behaviour modifier, and a means of ensuring closer observation. There is no evidence of staff training, understanding, knowledge of or experience in applying the principles of behaviour modification techniques. If placement to "C" Group was to be used as behaviour modication therapy for particular patients we should have expected that the staff psychologists would have been asked to train and supervise staff in this particular therapy. There was no evidence that this was done.

10.12.7 Patients regard placement in "C" Group as a punishment and fear its enforcement. Patients do not always understand why they have to go to "C" Group and may have no control over the behaviour which is regarded as unacceptable. There is evidence on a patient's file of appeals from the patient and a relative against the order, with pitiable promises "not to offend again and be good".

10.12.8 It could have been expected that the nursing staff would have regarded such orders and treatment as inappropriate and unacceptable and would have intervened strongly on behalf of their patients. We were told that some have openly ignored such orders while others more covertly have not enforced them. Out of loyalty to the Medical Superintendent or unquestioning obedience to standing orders, many appear to obey without dissent or question. A nursing supervisor stated in evidence that he would carry out such an order without immediate question. If he disagreed he would question it after obeying it. The order may require the patient to stay with "C" Group for periods varying from days to weeks or even indeterminate periods. Psychiatric assistants are usually in charge of "C" Group. They have no training which would give them full appreciation of the distress which might be experienced by patients, although they work under the direction of professional nurses.

10.12.9 **We cannot accept that this practice has any beneficial effect and can only be regarded as a punitive, humiliating, and repressive act. We consider that the practice must be the subject of severe censure and disapproval and we consider that the Auckland Hospital Board should take urgent action to put a stop to it.**

10.13 Discipline

10.13.1 The general scheme at Oakley involves a progression from the most stringent conditions which exist in the strongrooms in M3 through to eventual trial release from M7 and final discharge.

10.13.2 In theory at least, as the patient's condition improves, then he moves through the progressive stages, ultimately ending with discharge.

10.13.3 During the course of this progression a relapse can, and apparently frequently does, result in a patient moving back to a previous stage.

10.13.4 It is inevitable that such a system would be regarded by patients as one involving rewards and punishments, a reward for conformity being a movement up through the stages, a punishment for regression being a movement down.

10.13.5 Such a view is reinforced by the practice referred to previously in this report of punishing certain infringements by confining patients in "C" Group.

10.13.6 In submission, the New Zealand Council of Social Workers indicated that in their view the system at Oakley depended entirely on a system of rewards and punishments. Every step in the progression did double duty as a reward or punishment. A stage which was a reward from the stage below it was a punishment from the stage above it.

10.13.7 Such a system if viewed in this light has many objectionable features, not the least of which is that conditions and treatment which should depend upon physical and mental health may in fact depend upon behaviour alone. In addition, since most information on which the medical staff would act must come

through the nursing staff, it is dangerously easy for a member of the nursing staff to exercise a degree of disciplinary control by recommending actions affecting patients for other than therapeutic reasons.

10.13.8 Inevitably there must be a degree of progression in a hospital situation and particularly one which deals with mental health. As patients improve then they are able to cope with more relaxed situations and to become involved in much wider activities. It is impossible to avoid such a progression. What is important however is that in no sense must such a progression be related to discipline and control. In our view it is absolutely imperative that the system be so organised that any question of punishment be removed from it in the eyes of both patients and staff. We accept of course that behaviour modification as a technique has a place in the treatment of certain forms of mental illness. Such a technique is however highly sophisticated and requires considerable training and expertise on the part of the staff whose job it is to implement it. The system which exists at Oakley Hospital cannot properly be described as behaviour modification except in the crudest possible sense of that term, and we believe the criticisms made of that system in terms of inappropriate rewards and punishments are justified.

10.13.9 Patients in secure environments need full information and a sensible explanation of the conditions under which they are cared for. The extent of any curtailment of their personal freedoms should be fully explained. The expectations of the staff of responses which are expected of patients under the conditions in which they must live should be fully discussed with patients. Guidelines regarding the rules and organisation and necessary precautions should also be made known. Insofar as they are able to do so, all patients should clearly be helped to understand and to accept the imposed restraints as non-punitive but necessary for their own and other people's safety. We were shown standing orders relating to the special wing which were specifically required to be posted where they were not accessible to patients. In the same document the statement appeared that these rules were minimum instructions and that medical and nursing staff might add any orders they considered necessary. It is difficult to see how any patient in such circumstances could be expected to know what was expected of him.

10.13.10 In situations where patients have been involved in discussion of, and can contribute to, whatever controls and disciplinary measures may be necessary, their resistance to and resentment of such measures is markedly diminished. Patients themselves can indeed help in self-regulating order and discipline in their own behaviour and lives.

10.14 Security

10.14.1 Extraordinary emphasis is given to the security aspects of Oakley Hospital's responsibilities towards the particular group of patients with whose care it is charged.

10.14.2 In the 1971 Hutchinson Report the following statement appears:-

> "The Commission recognises that the community is entitled to protection from the dangerous and the particularly obnoxious patient and that it is frequently difficult to reconcile a hospital's duty in this regard with the rights of individual patients. But we believe that a psychiatric hospital has a clear duty to allow its patients as much freedom as possible, even although this may on occasions be flying in the face of uninformed public opinion."

10.14.3 It is acknowledged that there are some patients in M3 who must have restrictions placed on their personal freedom and be kept within a safe environment. Staff are properly concerned to ensure they meet their obligations in this respect.

10.14.4 Regardless of offences against society, persons, or property which the patient may have committed prior to admission by reason of mental illness, a hospital is not an institution of punishment and correction. These are the concerns of the courts and penal institutions.

10.14.5 A hospital is an institution where safe and understanding care, treatment, habilitation and re-habilitation have priority, albeit within a closed hospital ward or unit.

10.14.6 The objectives of therapeutic care are that the psychiatric aspects of the patient's behaviour be modified, and his physical and mental health restored to the extent that he may be considered as suited for short or long term trial leave, discharged into the community or be returned to the place from whence he came, i.e., in some instances to serve the sentence imposed by the Courts within the legal system.

10.14.7 Patients who must remain in hospital for long term or permanent care are especially vulnerable to a superimposed "institutional neurosis" exemplified by inertia, apathy, disinterest, diminished physical and psychic energy, withdrawal and hopelessness.

10.14.8 All patients need to be helped to gain insight into their behaviour, to modify it to the extent possible, and to be told the reasons for their exclusion from family, work and society.

10.14.9 We are concerned that some of the security measures are unnecessarily stringent. Those of particular concern are:-

> Directions for the use of handcuffs on patients escorted from Oakley to outside clinical services.
>
> Patients' rooms to be changed at irregular intervals, and random searches of patients and rooms conducted at the direction of the Charge Nurse. Dr Medlicott gave evidence to the effect that he did not think this an unreasonable procedure, but we believe it to be undesirable in contributing to patients' disorientation, suspicion and fear, and not conducive to a sense of trust and confidence in nursing staff. We believe there are other nursing measures which would be more effective and still meet the requirements of safety and prevention of fire.

Special Wing and corridor patients to wear pyjamas, dressing gowns, and slippers at all times. This is a measure to prevent escape. Some of the patients in these areas are long-term patients and must find this rule difficult to understand. We do not believe that if a patient is determined in his attempt to escape he will be concerned about what he is wearing.

The use of a metal detector over visitors to M3.

We understand that a previous practice which required patients to strip naked in the corridor before entering their bedrooms has ceased. It should not be re-instituted.

10.14.10 It is interesting to note that in the Hutchinson Report the following appears:-

> "Special visiting rooms, especially those in which notices are prominently displayed warning visitors not to pass dangerous implements to patients, are not conducive to the acceptance of patients as people or to the confidence of visitors in the patients or in the environment in which they are detained."

10.14.11 There is some electronic surveillance in use at Oakley Hospital. We note that there is also surveillance of this kind used extensively at Lake Alice Hospital. We also note however that it was not thought necessary to install it at the Northfield Security Hospital in Adelaide. We consider that it would be better for staff to be in direct contact with patients rather than watching them over closed circuit television. We agree with the decision of the Auckland Hospital Board not to extend this surveillance. We note also that in the submissions made by the Medical Superintendent to the Working Party on Psychiatrically Disturbed Inmates and Remandees, he considered it desirable that Oakley Hospital should have more rather than less security and specifically considered additional closed circuit TV surveillance was desirable. These submissions have not been referred to in the report of the Working Party.

10.14.12 As we have already indicated we accept that security is an important feature at an institution such as Oakley Hospital. It is necessary for the protection of the community and of patients themselves that it should exist in an effective form. However, we are concerned that the security which at present exists at Oakley Hospital appears to be neither acceptable nor particularly effective.

10.15 <u>Allegations of Ill-Treatment</u>

10.15.1 Allegations were made in respect of Mr Watene. These have already been dealt with.

10.15.2 A number of witnesses claimed that incidents of this nature had occurred over the years at Oakley Hospital and evidence was given of specific incidents.

10.15.3 We were impressed by the evidence of one former patient who spoke of an incident some years ago when he received injuries to the chest. The general demeanour of the particular witness and the fact that he was prepared to give credit to staff members in other areas impressed us. We are left with the feeling that an incident along the lines which he described did occur.

10.15.4 In addition, another patient complained of an incident when he alleged he was required, in spite of a long standing physical disability, to attempt to walk a considerable distance. He stated that this incident ended when a sympathetic member of the staff intervened on his behalf but only after he had already reached a stage of considerable distress.

10.15.5 We mention this incident because there was evidence which confirmed that it, or something like it, did occur. The patient was prepared to mention the name of the supervisor (at that time a charge nurse) whom he claimed had required him to either make the attempt or be placed in "C" group. The supervisor gave evidence before us and was able to recollect an incident along the lines of that described but which he claimed in the circumstances was explicable and justifiable. We find it difficult to see how an incident as insignificant as that which the supervisor described should have remained in his memory if there was not at least some element of concern arising from it.

10.15.6 Evidence was also given of certain alleged specific forms of ill treatment which were given particular descriptive names, and incidents illustrating them were described. We accept that it is likely that in an institution such as Oakley Hospital rumour will exaggerate what may have originally been comparatively minor incidents into major occurrences. Such stories tend to grow in the telling. Nevertheless, there were enough specific allegations to leave us with a sense of unease that patients believe such incidents occur and adapt their behaviour accordingly.

10.15.7 There were allegations also of behaviour of staff which fell short of physical ill treatment but which suggested that patients had been subjected to behaviour which extended from teasing, which they found unpleasant, to threats of retaliation designed to ensure conformity.

10.15.8 In this regard there was a suggestion that patients were comparatively routinely threatened with the administration of Paraldehyde 10-20 mls, if their behaviour fell short of the conformity which the staff desired. We note from the narcotics register that Paraldehyde was administered on 67 occasions in the first six months of 1982.

10.15.9 We should emphasise that the three independent psychiatrists who were requested to examine the files of the patients held at Oakley Hospital and who interviewed between them every patient, were at pains to indicate that they had not received any complaints of ill treatment or improper behaviour and found no evidence of such.

10.15.10 Bearing in mind the way in which such allegations must be tested and proved and the lapse of time which has occurred, as well as the circumstances in which such incidents are supposed to have happened, it would be practically impossible to find that specific incidents had occurred. As we have already indicated,

however, we are left with the uneasy feeling that the situation at Oakley is such that such incidents could occur and we believe that it is imperative that staffing and systems be so developed that the possibility of such incidents occurring undetected be reduced to a minimum.

10.15.11 In a situation such as that which exists at Oakley Hospital there must not infrequently be incidents of violence which occur when patients are brought under institutional control. Any such incidents and any allegations of ill treatment made by any person at all should be immediately recorded in full detail by the nursing staff and investigated by the appropriate members of the administration. They should also be referred to the Official Visitor at the first available opportunity so that later there is no possibility of matters of this kind being raised at a time when they are both difficult to establish and to refute.

10.16 Civil Rights

10.16.1 Persons suffering from mental illness are more than most in need of special protection to safeguard their civil rights. Their disabilities frequently of themselves prevent them from looking after their own interests, and because of the nature of the illness from which they suffer, their complaints are likely to be either not taken seriously or substantially discounted.

10.16.2 Prisoners who suffer from mental disability are in a more vulnerable position still and it is therefore of great importance that both law and practice should safeguard their rights.

10.16.3 During the course of the hearing we were asked to look at a file for medication purposes. In examining the file it disclosed that it related to a young man who had committed offences of a sexual nature. It was apparent from the comments made by the sentencing Judge that had the young man concerned been sent to prison he would have received a sentence of four years imprisonment. For reasons of compassion he was in fact sent to Oakley Hospital where he remained until he died some five years later.

10.16.4 It is obvious that in such cases there is a serious risk that persons may for the best of reasons be effectively held in custody for a longer period than would result from the imposition of a criminal sentence.

10.16.5 When the Medical Superintendent was asked about this he implied that the hospital had a duty to society to ensure that persons who were likely to offend against society were prevented from doing so if necessary by being held in hospital. He was asked the question. "You would need to look at that person from time to time and if they were a nuisance to the community along the lines you were saying you might decide for the sake of community security it was not very desirable that they were released on to the community, still having this kind of personality disorder?"

Answer: "Yes, particularly where children are concerned. This is the difference between scientific and legal sentencing with a finite sentence. If at the end of four years this man could be construed as a danger to children it might be wrong to let him loose."

In addition, he was asked the question, "You would need to be careful that for the sort of reasons you were explaining to Dr Shea, that person did not find themselves caught up in the mental hospital for a lot longer than the finite sentence they would have expected in prison."

Answer: "That can be so. It is a matter of behaviour."

10.16.6 We would view such a policy with alarm. In sentencing, a judge does so within the framework and the protections of the criminal law. He does so publicly and in a setting where the individual rights of the person concerned can be protected by legal advice. A decision in a psychiatric hospital that a particular patient should not be released because of a concern for the community is made privately. It is made in a setting where the person concerned is almost entirely powerless, and it is made when he does not have available to him the advantages or support of legal advice. It is made effectively in secret and although made for the best of motives is seriously open to abuse.

10.16.7 At the very least if such a course is to be adopted we believe that the matter should be subject to review in the Courts or by some appropriate independent authority. Such an authority is referred to later in the report.

10.16.8 The Auckland Hospital Board in common with other Hospital Boards has available a leaflet printed in a number of languages which sets out patients' rights in hospital and which draws their attention to safeguards which exist to protect their rights.

10.16.9 This leaflet was not available at Oakley Hospital when we first visited it, and when we asked questions about it of staff members during the course of the Inquiry, some at least were quite unaware of its existence.

10.16.10 We understand that it had been considered inappropriate for display at Oakley Hospital because of the special nature of the hospital and because of the possibility that a conflict existed between the rights of ordinary patients and the rather more limited rights which apply in the case of special patients transferred from the prisons.

10.16.11 During the course of the Inquiry we requested that this information be made available at Oakley Hospital and we were pleased to find on our second visit to the hospital that the leaflet concerned was prominently displayed and obviously available to patients.

10.16.12 As we have had to reiterate in so many contexts, psychiatric patients need more than most to be aware of their rights and the safeguards which exist for them. They need to be aware of these not only so that they themselves can take any action which may appear to be necessary, but so that they can pursue any concerns with the District Inspector or Official Visitor when one is appointed.

10.16.13 We note the concern that exists in respect of a possible conflict with special patients. We agree that there are special needs at Oakley Hospital. Nevertheless human rights remain wherever people happen to be, and civil rights persist even although

perhaps limited by the provisions of the criminal law. If some redrafting of the Auckland Hospital Board leaflet is necessary, then we have no doubt that the legal advisors to the Hospital Board would be more than capable of doing any such redrafting.

10.17 Independent Psychiatric Investigation of Patients

10.17.1 During the course of the Inquiry, concern was expressed over the existing situation at Oakley Hospital and we were actually asked to prepare an interim report because it was submitted to us that urgent action was necessary.

10.17.2 We did not consider it either appropriate or desirable to prepare an interim report but we did have concern as to some of the material which had been raised. Our concern had also been aroused by a perusal of a number of patients' files which we had been asked to read.

10.17.3 Accordingly, we requested the Auckland Hospital Board to arrange for independent psychiatrists and a physician to examine the patients and files of patients who were at that time in Oakley Hospital.

10.17.4 This was done and every patient was interviewed by a team of psychiatrists consisting of Drs Medlicott, Bennett and Durie, and the physician Dr W.A. Lang.

10.17.5 All these doctors prepared reports, and the three psychiatrists gave evidence before us.

10.17.6 There are certain aspects of their conclusions which should find a place in this report.

10.17.7 The first of these is that by and large the psychiatrists agreed with the diagnoses of the mental states of patients which they examined in Oakley Hospital. There was some minor divergence but it was very minor.

10.17.8 Nevertheless, all three psychiatrists expressed concern at certain aspects of the situation which they found.

10.17.9 In another context we have drawn attention to their view that a substantial number of patients at present in Oakley Hospital did not need to be held at that institution. We have referred to this in a subsequent Section of the report.

10.17.10 The three psychiatrists were agreed that in their opinion they had found evidence of excessive use of medication and of inappropriate medication in a substantial number of cases.

10.17.11 Dr Durie, for example, stated that the high doses of injectable major tranquillisors were not justified by diagnosis, nor was there adequate reason given in the notes for using doses well in excess of the recommended dosage. He also expressed concern over the use of anti-parkinsonian medication. He drew attention to his view that high doses of major tranquillisors were being used in cases which he considered to be inappropriate.

10.17.12 Dr Bennett stated that in his view a serious criticism of medication in general needed to be raised. He considered there was overdosage in the use of longacting anti-psychotic drugs, he disapproved of multi-drug prescriptions and mixed drug prescriptions, and he commented on the routine prescription of Paraldehyde for virtually all patients.

10.17.13 Dr Medlicott also drew attention to the reliance on high doses of Fluphenazine and stated that he believed that suggested an undue reliance on chemical control and a regime which made any psychotherapeutic and general therapeutic help difficult.

10.17.14 He was concerned at the use of long acting benzodiazapines with what he considered was no proper appreciation of the potential aggression-releasing and suicidogenic effects of the drugs.

10.17.15 He too drew attention to the use of more than one anti-parkinson drug in the same patient. He stated that in his view a lot of the so called "contentment" found was associated with undue institutionalisation and tranquillisation.

10.17.16 The Medical Superintendent was asked to comment on these views and did so at considerable length.

10.17.17 In our view the comments of the three independent psychiatrists give cause for grave concern. We believe that the practices to which reference has been made should be further investigated by the Auckland Hospital Board in respect of individual patients, and in the absence of any acceptable justification, discontinued.

10.17.18 We appreciate that views were expressed in favour of the consistent use of high dosage medication. We do not consider that on the weight of the evidence before us, such views can be regarded as acceptable in the general climate of psychiatric opinion.

10.17.19 If risks are associated with such dosages, and it appears clear that they can be, then such risks should not be imposed upon patients who are in no condition to make decisions regarding their own medication.

10.17.20 We understand that the visiting psychiatrists kept notes on the individual patients interviewed, and we believe that those notes should be attached to the files of the individual patients concerned. Dr Bennett, in his report, indicated that he was happy to have the notes so dealt with.

10.18 General Comment

10.18.1 The whole of Section 10 has concentrated on certain aspects of psychiatric care at Oakley Hospital and has also considered allegations made about various practices at that hospital. We think in concluding this Section we cannot do better than quote the key principles in the treatment relationship, set out by Dr Louis E. Kopolow, who was previously referred to at 10.8.11, which are as follows:-

"Key Principles in the Treatment Relationship:

1. The patient's humanity must be respected and protected if treatment is to be possible.

2. All mental health treatment carries with it some risks that must be weighed against potential benefits. Mental health professionals should recognize the limits of prevailing knowledge.

3. A therapist should not underestimate a patient's resources to support a strategy with which he is allied or sabotage one he opposes. (Compliance problems are a consequence of failing to recognize this principle).

4. Mental illness is not forever unless the therapist perceives it that way. Expectations influence outcome, so it is crucial that therapists be comfortable with and confident of their skills and as optimistic as possible.

5. It is better to do nothing than to provide inappropriate or inadequate care.

6. Stigmatization may be as great a handicap to the patient as the illness. Therapists should not underestimate its impact on the chances of recovery.

7. A therapist should never impose his or her own value system or bias on the patient.

8. Coercive treatment distorts the therapist's role as caregiver and may be as harmful to the therapist as the patient. A more collaborative, less paternalistic approach is needed for effective treatment.

9. Independence and improved self-esteem are the foundation blocks on which to build the patient's lasting recovery. The therapist must support these goals in all aspects of treatment.

10. Primum non nocere - first, do no harm, is the guiding principle behind all treatment.

While these principles will not guarantee that a patient's rights will be protected, they can provide a famework for bringing about needed changes in professional attitudes and behaviour that can make the mental health system more protective of patients' rights and responsive to their concerns."

SECTION 11

11. THE FUTURE OF OAKLEY HOSPITAL

11.1 Introduction

11.1.1 It is our view that as it is at present constituted, Oakley Hospital cannot provide a health service in keeping with current psychiatric practice.

11.1.2 We believe the Auckland Hospital Board must act positively in instituting changes which will:-

- end the isolation of Oakley Hospital from the main stream of psychiatric services in the Auckland Region.
- improve the conditions and resources which the hospital urgently needs.
- ensure that satisfactory standards of care are offered to patients.

11.1.3 The Committee has given serious consideration to the proposals for the future of Oakley Hospital submitted by:-

- The Auckland Hospital Board.
- Professor J.S. Werry.
- The Public Service Association Planning Sub-Group.
- The Working Party on Psychiatrically Disturbed Prisoners and Remandees.
- The Medical Superintendent.

As well as other proposals put forward during the course of the Inquiry.

11.1.4 Many of the ideas and plans suggested are of a long term nature. They would require Government, Department of Health and Board consensus and acceptance and the allocation of considerable finance.

11.1.5 The Committee notes that the Board has approved the sum of $450,000.00 to be spent on structural changes and internal upgrading of the environment and that this work is currently in progress.

11.1.6 After taking all these matters into account the Committee makes the recommendations set out in the following paragraphs:-

11.2 Separate Institution or part of a larger unit

11.2.1 Oakley Hospital consists of two wards only of the much larger unit which was subdivided into Carrington and Oakley Hospitals.

11.2.2 The question of the isolation of Oakley Hospital has been referred to and discussed earlier in this report. It will be apparent that we regard this isolation as being bad for staff and bad for patients, and a restrictive influence on the development of forensic psychiatry to a level which would attract well-qualified and enthusiastic staff.

11.2.3 We believe that this isolation will continue so long as Oakley remains a separate institution, and it is our belief that it cannot continue to so operate. This is reinforced by our view, discussed later, that the number of patients should be substantialy reduced. It therefore follows that we consider that Oakley Hospital should become part of a larger unit.

11.2.4 Various possibilities were discussed before us in submissions from interested parties. Professor Werry, for example, suggested the interesting concept that the function at present carried out by Oakley Hospital should be transferred to a new 400 bed hospital associated with the school of medicine at the University.

11.2.5 The Auckland Hospital Board for a number of reasons was reluctant to see Oakley reunited with Carrington although the proposals put forward by the Auckland Hospital Board do contemplate an ultimate amalgamation.

11.2.6 In our view Oakley should be amalgamated with Carrington, subject to certain aspects of its operation retaining a degree of independence which is discussed below.

11.2.7 We appreciate and understand the factors put forward in opposition to any proposed re-amalgamation but we believe these are substantially outweighed by other considerations. Oakley is adjacent to Carrington and indeed is situated in part of the grounds of what was once one institution. It already shares certain administrative and other facilities. We believe that the proposals we put forward in this and other parts of the report would best be met by a re-amalgamation and we recommend accordingly.

11.3 The Management of Oakley Hospital

11.3.1 Although we have indicated it as our view that Oakley should be re-amalgamaged with Carrington, we do not believe that Oakley should lose its identity and we do not believe that it should become totally dependent upon Carrington. The functions which we see Oakley as still carrying out are quite different from those which are met by Carrington and require special skills, powers and management.

11.3.2 We believe that it is essential that Oakley Hospital should have at least over the initial period of its reconstruction the advantage of an actively involved, personally committed, individual board of control. The Auckland Hospital Board is responsible for something in excess of 26 hospitals. It does not favour sub-committees with responsibility for individual hospitals and under those circumstances we do not believe that the necessary direct management, guidance and support could be expected from the Auckland Hospital Board, bearing in mind its other responsibilities.

11.3.3 We therefore recommend that a separate board of control be set up to be responsible for the new Carrington/Oakley complex and which would oversee the changes which we believe to be necessary. Such a board of control should be answerable in the ultimate to the Auckland Hospital Board. We believe that because of the special needs it will be required to meet, it should be an appointed rather than an elected board so that persons of the necessary expertise can be assured of a position on it. We believe that such persons should be appointed by the Auckland Hospital Board after consultation with the Minister of Health and should, if possible, include the Director of Mental Health. We suggest also that such a board should have a representative from the Department of Psychiatry of the Medical School of the Auckland University. We believe that such a board should consist of not more than seven persons but we also recommend that in view of the importance which this Committee attaches to the development of forensic psychiatric services in the Auckland region that this board should assume responsibility for planning forensic psychiatric services throughout the whole region.

11.3.4 We note at this point that we were informed that the Auckland Hospital Board has for the last ten years had some concern about practices and procedures at Oakley Hospital but has not been prepared to intervene on the basis that its powers of control did not permit it to intervene in matters which it regarded as being within the scope of the clinical decisions of the Medical Superintendent at Oakley Hospital. We desire to say that we do not accept this conclusion. Even if the view on clinical decisions had validity, this would not have justified a failure to intervene in non-clinical administration and management matters of which examples would have been the provision of administrative and clerical assistance, attention to establishment needs and occupational therapy, recreation, trade training, ward clerks and the provision of maintenance and housekeeping staff. We are however prepared to go further and say that in our opinion a Hospital Board is elected to manage and control institutions under its authority and if it is concerned over clinical practices which exist in such institutions, then it has an obligation to control those as well, whether it does it by means of review or directly in cases which are of sufficient seriousness to justify this. The Auckland Hospital Board has two psychiatric advisory committees which have on them persons appropriately qualified. If they had been requested to intervene in matters at Oakley Hospital and had been unable to implement their conclusions, then we believe it would have been the Board's responsibility to insist upon implementation.

11.3.5 Some suggestions were also made that the institution could be in some way associated with the Justice Department. We consider this entirely inappropriate.

11.4 Medical Superintendent

11.4.1 We understand that the Medical Superintendent is due to retire in March 1983. It is imperative therefore that urgent steps be taken to fill the position which will be left vacant by his retirement, and which in any event will be a somewhat different position if our proposals are accepted. In two submissions it was suggested that in the event of an appropriate appointment not

being made at the time of the retirement of the Medical Superintendent, he should be requested to continue until such time as an appointment has been made. We do not consider that such a suggestion is appropriate or should be accepted. It will be apparent from the material contained in this report that we consider that Oakley Hospital should move in an entirely new direction and adopt an entirely new philosophy of patient care. For the Medical Superintendent to accept such new directions and a new philosophy would be to acknowledge that what has taken place in the past was less than satisfactory, and we believe that he should not be put in a position of having to accept such a situation.

11.4.2 Our proposals involve the re-amalgamation of the two hospitals and it is therefore important to define the status of the person in charge with reference to the overall position of the Medical Superintendent of Carrington Hospital.

11.4.3 We suggest that the person appointed to take responsibility for the reconstituted Oakley Unit as part of the Carrington complex should be given the title of Director of Forensic Services with responsibilities beyond the new Oakley Unit itself. He should have the status of a Medical Superintendent and be remunerated accordingly. On professional matters related directly to forensic psychiatry the Director should report directly to the board of control. In matters of administration he should however be responsible to the Medical Superintendent of the whole complex.

11.4.4 In addition, the Director should be entitled and encouraged to take a University appointment and encouraged to take such appointment as may be available, and further, given the right to and encouraged to undertake limited private practice. Such rights would enable the Director to remain in the main stream of psychiatric practice and would also prevent him from becoming identified solely with the prosecution in criminal proceedings. It is most unlikely that a suitable person with drive and charisma could be found by the time the Medical Superintendent retires but an immediate search should be mounted to find such a person. It is important because of the special requirements that the right person should be appointed and this may mean that there could be a period when no such person had been found.

11.4.5 We believe that there are qualified persons overseas who could if necessary be brought in on a temporary basis, but we also believe that it should be possible to provide suitable people on a temporary basis from psychiatrists in this country, who may have an interest in fostering developments in forensic psychiatry. We do not think there should be any barrier to the appointment of a suitably qualified woman. We appreciate that the present ratio of psychiatrists in New Zealand (one psychiatrist for each 25,000 of population) is at present well below the ratios in other developed countries (e.g. one psychiatrist for each 12,500 of population in Australia).

11.4.6 The Auckland Hospital Board suggested that the post should be filled on a temporary basis by Dr Honeyman, the Medical Superintendent-in-Chief for the Auckland Hospital Board. Without meaning any disrespect to Dr Honeyman, we do not regard this as a

satisfactory proposal. Dr Honeyman has many other responsibilities. Within the administrative framework of the Auckland Hospital Board he could not be responsible to himself. The person responsible for the new Oakley Unit should be in a position to give it his undivided responsibility over the period during which reconstitution takes place.

Also, it is essential that the Director should have appropriate forensic psychiatric qualifications and experience. Without them he is unlikely to claim the loyalty and respect of staff or the support of professional colleagues.

11.4.7 Professor Werry indicated that Auckland psychiatrists have not played their part as far as Oakley Hospital is concerned. If that is so, Professor Werry could well be asked in conjunction with the Director of Mental Health, Dr James, to provide a suitable psychiatrist on a temporary basis to fill the position under the temporary oversight of Dr James until such time as a permanent appointment can be made.

11.5 **Medical and Nursing Staff**

11.5.1 We believe that even on the reduced patient numbers basis we propose, there should be a change in the numbers of medical staff available at the new unit.

11.5.2 In addition to the Director of Forensic Services, already referred to, we believe that there should be one other full-time psychiatrist and one full-time medical officer. We also believe that there should be two psychiatric registrars appointed in consultation with the University and the Royal Australian and New Zealand College of Psychiatrists.

11.5.3 The present Principal Nurse did not choose to appear before the Inquiry and indicated through counsel that his health did not permit him to do so. With impaired health we cannot see that it is appropriate for him to remain as Principal Nurse, for the new unit we envisage. A new Principal Nurse either male or female will therefore need to be appointed and will need to be a person with the appropriate professional background, enthusiasm and imagination. Such an appointment should be made, if at all possible, contemporaneously with the appointment of the Director, and under similar reporting conditions.

11.5.4 As agreed to by the Auckland Hospital Board, nursing staff on present patient numbers should consist of the following:-

Supervisors and above	5	Community staff	3
Charge Nurses	7	Enrolled Nurses	36
Staff Nurses	64		

We recommend later in the report substantial reductions in patient numbers, which must affect staffing, but we believe at the very least the above staff/patient ratio should be maintained. It would also be necessary for the appropriate number of occupational therapists, recreational officers, psychologists and social workers to be appointed in accordance with the criteria of the Auckland Hospital Board.

The staff should consist of both men and women and that the present policy of avoiding the employment of women in the wards should be abandoned. We believe that the interchange of staff between Carrington Hospital and the new Oakley Unit should take place as a matter of course.

11.5.5 In this regard we were told on a number of occasions that it was impossible to allow women to work as nurses in the Oakley Hospital setting without the constant provision of an escort because the type of patient was such as to make it unsafe for women to work. It was said that they are at the risk of assault and are not sufficiently physically strong to exercise the necessary forcible restraints required from time to time in controlling patients.

11.5.6 Northfield Security Hospital in South Australia provides the maximum security psychiatric unit for patients referred through the prison system. As such it takes all prisoners with psychiatric problems requiring hospitalisation from the whole of South Australia. Female nursing staff work in that hospital as do female domestics. They do not have escorts provided. They work on an equal basis with men. We were informed that no assaults of the kind feared at Oakley have taken place. We believe that in the kind of hospital we propose, the changes in number of patients, facilities available, and most importantly in attitudes, would make it desirable that women should be employed on the staff to a far greater extent than is at present the case and we do not believe that they would be at risk in being so appointed.

11.5.7 The changes which we propose would be difficult for the existing staff at Oakley to adjust to without the opportunity of further preparation. We therefore suggest that three nurses should be sent immediately to the Northfield Hillcrest Hospital complex in Adelaide for a period of three months to work a normal shift in the conditions and under the philosophy which pertains at that institution. In the same way, we believe a further three nurses should be sent to Cherry Farm in Dunedin for a similar period. We believe that there is evidence that amongst the staff at Oakley there are persons who would benefit from such an experience and respond to it. Some members of the planning committee are obviously in this category. When the preliminary training referred to had taken place, we suggest that a further six nurses be selected for a similar period of training in the nominated institutions. We believe that this would provide a nucleus of nurses with the appropriate training and outlook to implement the changes which we propose and ultimately to provide forensic nursing services which would be the equal of any. At the time of their return we consider it would be appropriate to introduce a reasonable proportion of female nurses into the new unit.

11.5.8 During the evidence the Chief Nurse indicated that she was prepared to make available an In-Service Educator. We believe that this indication should be taken up immediately and the services of such a person obtained, to begin the in-service training of the staff remaining at Oakley in order to assist them to adjust to a regime which would be rather different from that which at present pertains. Such a proposal would provide support for the persons whom we have suggested should be sent to other institutions and who would otherwise find some difficulty in initiating change on their return.

11.6 **Numbers of Patients**

11.6.1 We believe that there should be a drastic reduction in patient numbers in both Wards M3 and M7 as soon as possible. During the course of the Inquiry we requested three independent psychiatrists to examine the patients at present cared for in Oakley Hospital. We were informed that it was believed three patients had no need to be retained in a hospital at all, and 94 patients could be cared for in a psychiatric hospital other than Oakley Hospital. Elsewhere in this report we have referred to the desirability of other hospitals in the Auckland area maintaining suitable secure units. We have also commented on the practice of sending difficult, disturbed, or unwanted patients to Oakley Hospital. We believe that the numbers of patients at Oakley Hospital could be immediately and substantially reduced by requiring other institutions to take their fair share of those persons assessed as appropriate to be nursed elsewhere, bearing in mind their need to be close to families who do maintain contact and interest.

11.6.2 In addition to the special remand unit which is dealt with elsewhere in this report, we believe that the number of patients in Ward M3 should not exceed 30, and should ideally be limited to 25.

11.6.3 As far as Ward M7 is concerned, we believe that "C" Group should be disbanded as soon as appropriate places can be found for its members in other more appropriate institutions. We have referred to the need to provide a greater degree of security in other psychiatric institutions. At this point we make the observation that it is quite unreasonable for other institutions to expect one hospital such as Oakley to take all the most difficult patients with the consequent effect that has on other patients.

11.6.4 We believe that Ward M7 should remain as an open ward and should also be substantially reduced in numbers of patients.

11.6.5 The main purpose of Ward M7 is as a progressive stage in treatment where an open ward is suitable and security can to that extent be relaxed.

11.6.6 We have stated that we see the future of Oakley Hospital as having an emphasis on forensic psychiatry, an emphasis which is reflected in the establishment of a remand unit and a secure unit for the treatment of psychiatrically disturbed prisoners.

11.6.7 With this emphasis it may well be necessary to retain a more open ward as a part of this particular forensic unit. It may also however be unnecessary to do this since it may be that experience will show when a person no longer requires the security provisions of Ward M3 that in an amalgamated hospital they could move into the appropriate ward at Carrington Hospital, thus avoiding an unnecessary and expensive duplication. This is a matter for the future and may or may not be possible to implement, bearing in mind the special considerations which apply to persons who would otherwise be confined to prison.

11.6.8 One advantage of an early reduction in patient numbers would be to provide the staff at Oakley Hospital, and the Auckland Hospital Board, time to engage in the completion of the necessary and desirable alterations, as well as the renovation of the

buildings. Further, there would be an opportunity to intensify in-service education and reorientation of all nursing staff, and for the formulation of philosophies, policies, objectives, and nursing care plans.

11.6.9 We envisage that for the future the new Oakley Unit will draw its patients from three sources. Firstly, it will take all prisoners from the Auckland region who have psychiatric problems requiring hospitalisation. Secondly, it should provide the secure unit for Carrington Hospital, meeting needs for patients from the region served by Carrington Hospital who require hospitalisation in an acute, secure unit. Thirdly, it should meet the needs of patients who have previously been associated with the psychiatric therapeutic teams operating in the new Oakley Unit whose relationship with that particular patient makes it desirable for that patient to be dealt with in the new Unit rather than some other institution, within whose catchment area that patient may happen to reside.

11.7 Classification and Grouping of Patients

11.7.1 The establishment of a separate remand facility, which is recommended elsewhere in this report, would remove one element which complicates the present classification and treatment of patients.

11.7.2 The need for classification and grouping depends partly on the different needs for differing kinds of treatment, and partly on the differing personal attributes and needs of patients.

11.7.3 It would be over simplistic, for example, to simply divide prisoners from other patients.

11.7.4 The reduction in the number of patients, as already recommended, would mean that the need for classification and grouping is reduced. It nevertheless remains an important and significant part of treatment and has a great deal of effect on the living conditions in which patients find themselves.

11.7.5 It would be inappropriate in a report on this kind to go into detail in terms of classification and grouping. What is important is that within the ward, patients should be classified, grouped and divided into compatible groups. In considering compatibility it is necessary to take into account the kinds of illness from which they suffer, the attributes of their personalities, and their differing needs. In the present situation with the conditions, the numbers of patients, and the staff available, there is little that can be done. Nevertheless, some classification and grouping other than that based on security, which is all that at present seems to exist, could take place and should do so as soon as possible. Such a classification and grouping would involve the spending of sufficient sums of money to enable such rudimentary classifications and groups to be dealt with separately and would involve a subdivision of the building in a number of areas. We believe that money spent on this would be much better spent than the money which has already been spent on lowering ceilings and the like.

11.8 Integration of Sexes

11.8.1 Oakley Hospital takes only male patients.

11.8.2 In doing so it follows the traditional practice based on what were considered to be the special problems associated with very disturbed male patients and in particular prisoners suffering from psychiatric disorders.

11.8.3 In most other settings a separation of patients in this way no longer exists. A division of this kind is artificial and does not reflect the integration which exists in the outside world. It is hardly likely to be therapeutic and may well accentuate the disabilities which have caused the patients to require confinement at a hospital such as Oakley.

11.8.4 Reference has already been made to the Northfield Security Hospital in Adelaide. This takes only psychiatrically disturbed prisoners and it takes both men and women. Apart from the fact that they have separate bedrooms and separate toilet facilities, the wards are otherwise fully integrated.

11.8.5 During our visit there were two women patients in the hospital. One was sitting in the day room with a number of patients. Another was sitting talking to men patients in one of the corridors.

11.8.6 We were informed that there have been no incidents giving rise to concern although there have been women patients admitted to the hospital from the time of its establishment some seven years ago.

11.8.7 We realise that this poses difficulties and that in the present Oakley setup, with the facilities, numbers and shortages of staff which exist, any integration of the sexes in terms of patients is quite impossible. In the institution which we propose however, if our recommendations are accepted, we believe that with the numbers contemplated and the facilities which should be provided it is desirable that the hospital should accommodate both male and female patients. We do not believe that New Zealanders are less likely than Australians to keep their behaviour within reasonable bounds and we believe that there would be many positive advantages to be gained from such a step.

11.9 Clothing

11.9.1 The practice at Oakley Hospital at present is to provide patients with hospital purchased clothing.

11.9.2 This reflects the fact that a number of patients arrive at Oakley with clothing which is unsuitable or unfit, and there is much to be said for a system which provides suitable clothing to patients to replace what may not be so satisfactory.

11.9.3 There is also something to be said for patients retaining their own clothing since this places an emphasis on that degree of independence and individuality which is a part of the treatment programme in respect of mental illness.

11.9.4 We think that as far as clothing is concerned, on balance there is much to be said for the Oakley practice of providing good quality clothing for patients on arrival. There is equally something to be said for the availability of a patient's own clothing when they reach the more relaxed stage of the open ward.

11.9.5 What is totally unacceptable is a sharing of clothing. When a patient arrives at Oakley Hospital, if he is to be outfitted with Oakley Hospital clothing, then this should be allocated to him and should remain his clothing. A complaint was made to us of one incident when a patient is said to have objected to being required to wear clothing which had previously been worn by another patient. In view of the comments made to us about the mental and physical condition of some patients we can understand the repugnance at wearing other people's clothing, and we believe that all patients are entitled to the dignity of their own clean clothing without any suggestion of this being shared with other persons. We consider that clothing assistants should be appointed, and be given full responsibility for the care of patients' clothing in both M3 and M7.

11.10 Buildings

11.10.1 We have already drawn attention to the fact that money is at present being spent on upgrading.

11.10.2 It will be apparent from the recommendations we have already made that we consider substantial changes are necessary to the buildings at Oakley Hospital.

11.10.3 We have not tried to spell out the detailed nature of these changes. We believe that the Auckland Hospital Board should engage the services of an imaginative architect to do this, in consultation with Medical and Nursing staff.

11.10.4 We do not believe however that it is necessary to completely replace the existing buildings. Although they are old and in their present form unsuitable, we believe there is much that could be done to make them more appropriate for the kind of institution which we envisage.

11.10.5 The major work that should be done as urgently as possible is of a subdivisional nature so that there are rooms available for patients for separate occupations and to meet their own individual needs, including privacy. We believe that it would be more important to spend money on this kind of subdivision throughout both wards than in the kind of redecoration which is at present taking place.

11.10.6 We also believe that there is a place for involving patients in an appropriate redecoration. It should not be too difficult for patients to attend to a certain amount of painting and perhaps decorating according to their own inclinations. We note that this has been done at Carrington Hospital and in that institution a similar type of architecture has been made much more conformable to modern notions of psychiatric care and environmental needs.

11.10.7 In addition, we think that immediate consideration should be given to providing more appropriate furnishings than are at present apparent in either of the wards.

11.10.8 We note that there has been a problem in the past with wanton destruction of furniture and that this has been used as a justification for keeping furniture to a minimum. We believe that if patients were encouraged in the ways we have discussed and if the reforms which we suggest were implemented, this kind of destruction would be minimised, as appears to be the case in other institutions.

11.10.9 We believe that patients are entitled to a degree of individuality in their rooms and that there should be the provision of such material as pin boards where they may put items of personal concern and value to themselves.

11.10.10 Finally in this regard, we draw attention to the need for some form of internal communication available to patients confined in a closed room. In the Northfield Security Hospital a patient is able to call for assistance from within his room without the need for banging on the door or shouting to attract attention.

11.11 Overall Philosophy

11.11.1 We were impressed by the submission made by Reverend Roger Hey whose duties as a Chaplain included some oversight at Oakley Hospital.

11.11.2 Mr Hey's submission covered a number of detailed matters and many of these have been referred to separately in the course of this report.

11.11.3 The general philosophy behind Mr Hey's submission was however a wholistic approach to patient care. Mr Hey's approach also proceeded on the basic assumption that decisions turned on a concern for the individual patient.

11.11.4 We think also it is worth drawing attention to the submission made by the Prisoners' Aid and Rehabilitation Society where it was stated that there must be a concern for a situation where intelligence has so little means of expressing itself and building up a sense of self-worth and ability to achieve.

11.11.5 In the present Oakley situation the emphasis has appeared to be rather more on that protection of the community which is considered desirable. In the long term we believe the community is best protected by a concern for the individual patient which results in him becoming an acceptable member of that community.

SECTION 12

12. SPECIAL NEEDS CREATED BY DIVERSE CULTURAL BACKGROUNDS

12.1 During the course of the hearing it became apparent that a comparatively high proportion of patients at Oakley Hospital were of Polynesian background. It appears that this proportion varies between 30% and 70%.

12.2 We appreciate that this very high proportion is a reflection of problems in society generally and involves areas which as a Committee with limited terms of reference we are not empowered to investigate.

12.3 Nevertheless, we note in passing that Dr James, in giving evidence, made a reference to the need for penal reform, a comment which we hope will be taken further by those concerned, and we suggest too that the matters particularly raised before us dealing with the special culturally related needs of Maori patients should be considered in relation to penal reform.

12.4 As a Committee we were fortunate to have positive and helpful submissions made to us on behalf of the Auckland District Maori Council by Dr Ranginui Walker, submissions which were accompanied by a series of recommendations to which reference will shortly be made.

12.5 In addition to the submissions we had evidence from Mr Maniopoto who has been concerned with the treatment of certain conditions in a prison and probation setting, and during the course of the hearing attention was drawn to aspects of concern to Maori people by Mr Awarau. We note that in dealing with questions of mental illness particularly it is very important for those concerned to be aware of spiritual beliefs and cultural patterns which may be misinterpreted or misunderstood in an alien or culturally different context. In this regard we draw attention to those matters relating to Wairua or spiritual beliefs, Makutu or sorcery, Mate Maori, Maori illness and Tapu in its various applications.

12.6 We wish to emphasise that it is important that in dealing with people to whom these matters may be of significance, medical and nursing staff should be constantly aware that attitudes and symptoms which may in some contexts be an indication of mental illness may in others, and particularly in Polynesian contexts, merely be a manifestation of particular beliefs and thought and cultural patterns.

12.7 Such an approach is necessary to avoid not only misunderstanding but the positive application of treatment which may be neither necessary nor helpful.

12.8 In the recognition and sympathetic assessment of such situations it is not only important that medical and nursing staff should be aware of the possibilities involved, but it is also important that other persons whose qualificatins may be appropriate though different should be involved in the analysis and treatment of the conditions causing concern.

12.9 We note that in appropriate cases there is evidence to indicate that the traditional approach adopted by authoratative Tohunga and Kaumatua or Elders has had significant success in restoring Maori people in particular to health, and note too that such methods may have positive applications in respect of other persons.

12.10 We were informed that Michael Watene responded to an approach by a Maori nurse capable of conversing with him in Maori, but there is nothing in the evidence to indicate that apart from this Mr Watene received any medical or psychiatric assessment which took into account his cultural background or the possibility that this may have contributed to his mental state.

12.11 Nor was there any indication on any other file we perused to indicate that such an approach was adopted.

12.12 The purpose of a hospital is to restore patients to health. Any method or approach which can significantly assist in this ought to be pursued even if outside its own cultural context it may not seem so valid.

12.13 We consider that in both diagnosis and treatment there should be an immediate emphasis placed upon particular cultural needs. We do not accept that it is enough that concerned members of the staff should make the empathetic approach which happened in the case of Michael Watene. This is by no means unimportant and credit is due in respect of it but it is not enough.

12.14 In addition, we regard it as important that matters of particular cultural concern relating to food, toilet and excrement be taken into account in respect of accommodation and procedures at Oakley.

12.15 The Auckland District Maori Council made 10 separate recommendations. Some of these have been dealt with elsewhere in this report. It would be appropriate however at this stage to comment on some of these and we now do so.

12.16 Recommendation 1

That psychiatric treatment be broadened to include provision for Maori culture, values and spiritual beliefs.

Comment

It will be apparent from the above that this is a recommendation with which we agree. For such treatment to be broadened it would be necessary for those responsible for deciding upon and administering the treatment to have some understanding of what was involved. We suggest that there are advantages for the psychiatrists concerned, as well as the medical schools, to investigate this matter further in consultation with persons such as Dr Walker who may be in a position to guide the inquiry which is necessary.

12.17 Recommendation 2

That a Maori Social Worker be appointed to the assessment panel for patients remanded by the Courts or referred by penal institutions for psychiatric treatment.

Comment

We believe that any assessment of patients before admission must take into account particular cultural background and beliefs. The screening of patients is referred to in other connections in this report.

12.18 Recommendation 3

That Tohunga and Kaumatua be consulted in the psychiatric treatment of Maori inmates whose abnormal behaviour can be attributed to their Wairua or Taha Maori.

Comment

We agree with this recommendation and note that the recommendation involves consultation which may of course be helpful but not necessarily decisive. This would be the case with any specialist assistance sought.

12.19 Recommendation 4

That Tohunga and Kaumatua who assist in psychiatric treatment be paid their travel cost and a retainer appropriate to the services of a specialist.

Comment

In this area there are practical difficulties over which we have no control. We agree that people called upon in this way to assist should not be out of pocket in respect of their assistance and they should certainly be refunded the expenses in which they are involved by taking part. We are also aware that there are many people involved in this field who would not be prepared for other reasons entirely to accept a monetary payment in respect of the services they rendered. We suggest that it is undesirable to lay down any hard and fast rule but suggest that the Hospital Board is capable of negotiating some appropriate reimbursement on a sensitive basis for persons who assist in this way.

12.20 Recommendation 5

That procedures in Oakley be modified to take cognisance of Maori Tabus relating to food, toilet and excrement.

Comment

It will already be apparent that we agree with this. We believe the recommendation has a wider connotation. Persons other than Polynesians would find the conditions imposed in certain circumstances at Oakley Hospital at the very least distasteful and certainly not conducive to an improvement in mental health.

12.21 Recommendation 6

That Maori staff be increased to 50% at Oakley to raise the level of social and cultural empathy between staff and inmates.

Comment

However desirable such a step may be, it may be difficult to implement if the staff are not available. We suggest that there is much to be said for a concerted effort being made to attract Maori persons to the nursing profession where they may obtain the necessary qualifications. In the same way, persons who may be suitable for employment as psychiatric assistants could be sought out. In these areas an emphasis on seeking people is not unimportant. An approach, for example, to schools, cultural and church groups might identify young people whose capabilities and sensitivities qualify them for this type of occupation but who otherwise might not consider it.

12.22 Recommendation 7

That psychiatric care at Oakley be orientated where possible to rehabilitation rather than containment of inmates. To this end a more normal social environment should be created by the appointment of women to the staff, having female as well as male inmates, granting access to community organisations and development of cultural interests.

Comment

We agree with every part of this recommendation though we should say that, with the exception of the Prison Fellowship Group, we have not been given any evidence that community organisations have been denied access. Concerned community organisations are often stretched to the limits. This observation also bears on the provision of cultural interests. Persons who are capable of imparting instruction and instilling enthusiasm are often involved in so many other situations where their skills are required that they cannot meet the needs which exist. We note too from the evidence of staff members that some attempt has been made to foster cultural concerns. This must be done with sensitivity and understanding. It should not be marred by elements of tokenism. Having said all this we realise the advantages of the proposal but do suggest that it may not be easy to implement what is suggested at least in the short-run. Nevertheless, we believe that the authorities and administration at Oakley should explore these possibilities seriously and in depth. A senior social worker in his submission drew attention to the fact that Dr Walker had been invited to lecture and had lectured at Oakley Hospital. The social worker considered that there was little difficulty in cross-cultural communication. In our view, cross-cultural communication is often a most difficult matter.

12.23 We have put a special emphasis on the needs of Maori patients because these were the subject of special submissions and evidence and because a considerable proportion of the patients at Oakley Hospital are of a Maori background. However, we are aware that there are persons from other cultural backgrounds at Oakley Hospital, not only Polynesian.

12.24 There can be no doubt that the cultural background shapes the mental development of every person and must have a considerable bearing on the way in which mental disorders develop and are treated.

12.25 As we have already indicated in respect of Maori patients, we recommend that wherever possible particular cultural needs be identified and, as far as is possible from the resources of the community, met in the special way which they require. The purpose of any hospital is to cure, and whatever available methods exist should be used.

12.26 We have referred to particular cultural needs and the possibility that patients may respond to particular forms of treatment within such cultural backgrounds.

12.27 Any form of treatment which is effective in improving a psychiatric disorder must be regarded as of value whether it fits into recognised theories and concepts or not. Submissions were made to us by various concerned groups, putting forward various suggestions as to improved methods of treatment. These included orthomolecular psychiatry, certain forms of diet, use of particular colours and the like.

12.28 Our inquiry is limited to the particular situation at Oakley Hospital. We cannot explore general psychiatric theories and practices except in the Oakley context. Nevertheless, we have drawn attention to methods which may be regarded as significant for persons of a Polynesian background but which may not fall within orthodox psychiatric methods or approaches. In the same way, we accept the genuineness of those persons who have put forward any proposals referred to, and hope that persons in a position to determine courses of treatment will, as we are sure they will, keep open their minds in respect of any form of treatment which may lead to the desired result, that is an improvement in the health of the patient.

12.29 We would draw attention to the Prison Fellowship Group mentioned in 12.22. During the hearing of the oral submission to us by this Group we were told that the Group had been called to a meeting with senior nursing staff and a psychiatric assistant, during which they were informed that they were no longer welcome at Oakley, and that they would not in future be permitted access. It was stated that members of the Group had attempted to visit as individuals during visiting hours, but had not been permitted to enter. We believe that any decision to deny access to a Group from which many patients might have derived some pleasure and comfort would be entirely wrong, and should be reversed to permit visits by the Group to continue.

Chaplaincy services to Oakley should be encouraged on a regular basis for those patients who wish to take advantage of them.

SECTION 13

13. **REMAND FACILITY**

13.1 A substantial number of persons are remanded to Oakley Hospital by the Courts for psychiatric observation and report for the purpose of determining criminal responsibility and/or fitness to plead. Also reports are sought in considering the most appropriate sentence or disposition if the accused has been or is subsequently found guilty of the offence with which he or she is charged.

13.2 The statistics indicate that a larger number of persons are remanded in the Auckland area to a psychiatric hospital for psychiatric assessment under the provisions of Section 47A of the Criminal Justice Act 1954, than in other parts of New Zealand. We draw attention here to the report of the Working Party on Psychiatrically Disturbed Prisoners and Remandees 1981.

13.3 The greatest proportion of such remandees are male and all such male remandees in the Auckland area are sent to Oakley Hospital.

13.4 We are aware that the numbers so remanded reflect considerations which may or may not apply elsewhere in New Zealand. The Medical Superintendent in evidence indicated that the facilities available at Mount Eden Prison were such that it was almost impossible to conduct an adequate psychiatric assessment in the prison and that these factors made an assessment obtained under such conditions suspect.

13.5 We are also aware that there is a concern on the part of the judiciary that any relevant mental state should receive the significance which is appropriate and should reflect in the way in which a person concerned is dealt with in the Courts.

13.6 **We are deeply disturbed at the conditions which exist in respect of remandees at Oakley Hospital.**

13.7 The report of the Working Party on Psychiatrically Disturbed Prisoners and Remandeeds stated as follows:-

> "The law has always considered that remandees should only be deprived of their liberty when this is considered absolutely necessary in terms of the legal criteria. A number of the persons remanded by the Courts have not been found guilty of any offence and for a considerable number of those convicted and remanded for sentence there is no certainty that they will receive a custodial sentence. To deprive them of their liberty by detaining them in either a prison or a psychiatric hospital without a careful consideration of the necessity for such a move is wrong in all respects."

13.8 Persons on remand at Oakley Hospital are kept in the M3 Ward, that is the security ward.

13.9 The conditions in the strongrooms and single rooms have already been described. We believe that such conditions may well accentuate some psychiatric problems or mental disturbances and in any event provide a condition which is of itself so unnatural

as to deprive any observation carried out under such conditions of at least some of its validity. We believe that it is not possible to put a person who is not psychiatrically disturbed into a closed psychiatric unit such as M3 and not expect him to react in such a way that he may indicate symptoms which could be misconstrued as evidence of a psychiatric condition.

13.10 Not all persons on remand are of course kept in secure or single rooms. Those who are not are required to endure the conditions which obtain for the committed patients.

13.11 When we visited Oakley Hospital a number of persons were at pains to point out to us the unpleasant nature of the deviant behaviour which had led a number of the patients to be committed to Oakley Hospital. Patients were encouraged to give vivid descriptions of past aberrations and present inclinations. The emphasis on security within the hospital was justified by assertions that many patients were dangerous, or had been dangerous in the past and required secure containment. Persons on remand may not have been convicted and are therefore at least technically innocent. They may also suffer from some psychiatric condition which does not require confinement of this kind. To keep such persons under circumstances such as these where they are expected to associate with persons of the kind described is, in our opinion, a practice which cannot be sustained and should not continue. We note that the report of the Working Party on Psychiatrically Disturbed Prisoners and Remandees indicates that a substantial proportion of persons remanded under the provisions of Section 47A of the Criminal Justice Act 1954 are not subsequently convicted of any offence, and the Hutchinson Report, which of course is now some ten years old, stated that a substantial proportion of persons remanded under the provisions of Section 47A of the Criminal Justice Act 1954 were not subsequently found to suffer from any treatable psychiatric disturbance.

13.12 The report of the Working Party on Psychiatrically Disturbed Prisoners and Remandees recommends that persons should not be remanded to psychiatric hospitals for observation unless there is no alternative or unless there are very special circumstances which require this. We agree with this recommendation and note that it is in fact the situation which pertains in most other parts of New Zealand and is certainly the case in South Australia. We believe that steps should be taken to ensure that as far as possible this recommendation is complied with in the Auckland area as soon as possible, bearing in mind the conditions which pertain at Oakley Hospital.

13.13 From enquiries which were made in New Zealand there do not seem to be any difficulties in most persons being assessed by a psychiatrist while on bail, and the majority are assessed in this way. In some small number of cases the assessment is made under prison conditions.

13.14 This is also the case in South Australia and we were able to ascertain that the system there is acceptable to the judiciary and to practising psychiatrists.

13.15 We have already indicated that the Medical Superintendent suggested that the conditions at Mount Eden Prison are such as to prevent any adequate psychiatric assessment being made.

13.16 We visited Mount Eden Prison but cannot see why appropriate facilities cannot be constructed there, or if this is impossible why prisoners cannot be held for the appropriate period at Paremoremo Prison.

13.17 The Medical Superintendent indicated that there were advantages in having a person who was to be assessed held over a period so that observation could be made of the person over a sufficient time to allow an adequate assessment to be made. This was a view which was accepted by other psychiatrists, in special cases. Nevertheless, we should comment that, as we have already said, the conditions at Oakley Hospital are such that we have reservations over whether or not these conditions may themselves induce behaviour and reactions which will reflect unreasonably in the psychiatric assessment. Further, we believe that the whole operation at Oakley Hospital is such that we have considerable doubts over the efficacy of any observation which is carried out. The strongrooms are so constructed as are the single rooms, that any observation carried out without the door being opened must be suspect to say the least. The atmosphere and conditions of the Day Room in M3 would hardly permit of adequate observation, or valid assessment of an individual patient's state of mental health.

13.18 Clearly however there is a need for a comparatively small remand unit where persons can be sent where it is required that they be observed over a period under secure conditions. We draw attention to the fact that the security at such a unit should be external rather than internal. We consider that no person should be sent to such a unit unless in the opinion of an assessment panel it is more desirable for such a person to be observed in the remand unit than interviewed while on bail or in a prison setting. Such an assessment panel could include the Director of Forensic Services, one independent psychiatrist, and a social worker as referred to in Section 12 of this report.

13.19 We believe that as soon as possible a new unit should be established. It should be completely separate from the rest of the hospital so that persons on remand are not required to associate with longer stay patients or they with them. We note that at present some activity is under way to convert a part of the upstairs area in Ward M3 for a remand unit. We do not believe that Ward M3 is a suitable place for such a unit to be established. In the interim, until a separate unit can be constructed we suggest that that group known as "C" Group, and which is referred to elsewhere in the report, should be disbanded as quickly as possible and the area at present occupied by the "C" Group made available as a separate remand unit, with such additional security as is required.

13.20 When a new remand unit is constructed it must provide reasonable living conditions for persons remanded to it and opportunities for observation. There must be opportunities for recreation and profitable occupation.

13.21 We do not believe that such a unit should cater for more than a maximum of eight patients at any one time.

13.22 It is important to emphasise that the purpose of a remand unit of this kind is quite different from the purpose of the hospital itself. Persons are innocent until they are proved guilty.

Their motives may be affected by the existence of a mental disturbance or psychiatric illness. These things must reflect in the conditions in which they are kept. The conditions and security which are appropriate for patients referred through the prison system are different and remand patients should not have to suffer these.

13.23 Concern was expressed to us that persons remanded under the provisions of the Criminal Justice Act 1954 and who were mentally ill did not receive treatment.

13.24 We understand that there is a reluctance to give treatment to such persons because it is considered that the provisions of the Criminal Justice Act 1954 give only very limited authority to administer treatment, and further, that it is in the interests of a person who may be able to offer mental disorder as a mitigating or excusing factor that they should not have this advantage removed by treatment before the person concerned is dealt with by the Courts.

13.25 Section 39B (8) of the Criminal Justice Act 1954 provides as follows:-

> "An order under this Section for the detention of a person in a hospital under observation shall be sufficient authority for the administration to him of such medical treatment or procedures as in the opinion of the Superintendent are necessary to prevent the deterioration of the person's mental health."

13.26 This subsection has therefore not unreasonably been interpreted as indicating that treatment is permissible only to prevent deterioration, not to achieve amelioration of a condition, while a person is held for observation under the provisions of Section 39B. By contrast we refer to the provisions of Section 47A (5) of the Criminal Justice Act 1954.

> "Nothing in this Section shall operate to prevent the treatment of any person with his consent during the period of his detention pursuant to an order under Paragraph (c) of subsection (2) of this Section."

13.27 We heard evidence from one former patient who was held on remand for a period of months and who claims to have suffered from a condition for which he received no treatment during this period. This caused him great anguish and responded almost immediately when he was treated.

13.28 In our view, on the grounds of common humanity persons who suffer from mental illness or disability should be treated whether they are on remand or not.

13.29 We do not believe that our Courts and judiciary are so insensitive that they would not take into account as a mitigating or excusing factor a mental condition which was established to have existed at the time of the offence or subsequently but which had been properly treated and at the time of sentence cured or alleviated.

13.30 The report of the Working Party on Psychiatrically Disturbed Prisoners and Remandees 1981 recommends the repeal of Section 39B, but specifically in paragraphs 33 and 34 of the report recommends that the provisions contained in Section 39B (8) should be retained.

13.31 Section 39B (8) of the Criminal Justice Act 1954 recognises that a person detained under the provisions of that Section has not been committed and should not therefore be compelled to accept treatment without his consent. It is to that extent a recognition of an important civil right. By contrast, Section 47A, which deals with the power of a Court to require a psychiatric report for slightly different purposes, provides in subsection (5) that nothing in the Section shall operate to prevent the treatment of any person with his consent during the period of detention. In our view, if a person suffers from a treatable mental condition and consents to treatment, then that condition should be treated. The word "suffers" indicates that the person would be better without the condition and we believe that it is inconsistent with the idea of a hospital that a person should be detained in it without receiving the benefit of the procedures which to a large extent justify its existence.

13.32 We believe that there should be in Section 39B an equivalent power to that contained in Section 47A, allowing treatment of a person detained under the provisions of Section 39B where that person consents to treatment. We believe also that it should be made clear that where a person is detained under the provisions of either Section and consents to and requires treatment, that treatment should not be withheld.

13.33 It would also seem desirable for a provision equivalent to that contained in Section 39B (8) of the Criminal Justice Act 1954 to be included in the provisions of Section 47A, so that treatment to prevent deterioration may be given in the case of a person detained under that Section without his or her consent.

13.34 We note that the Auckland Hospital Board proposes that all major psychiatric units in Auckland should be required to accept remandees for assessment and preparation of Court reports. We accept that such assessment and reporting is a highly specialised function and we believe that except in special circumstances it is desirable that it should be performed by persons with expertise in the area. If our proposals for the future of Oakley Hospital are accepted and implemented, then we believe that such expertise is likely to be concentrated at the new Oakley Unit and it is for this reason that we have recommended a remand facility be established there. This would have the added advantage of a greater degree of consistency. In any event, we do not see that it is necessary for so many people to be remanded to hospitals for observation.

13.35 We note that in the Medical Superintendent's proposals for Oakley's future, remandees would be dealt with in a new special 10 bed admission wing which would be quite self contained. However, as we understand the proposal, this would cater not only for remandees but for persons being admitted in other ways and for other purposes. We do not consider that such a mixture of patients is desirable and consider that the remand unit should be, and remain, completely separate.

SECTION 14

14. CLOSED UNITS IN OTHER HOSPITALS

14.1 We were informed on a number of occasions during the course of the hearing that Oakley was a kind of repository for difficult patients.

14.2 It appears that other psychiatric institutions where they have a patient who is difficult or disruptive are inclined to send such a patient to Oakley Hospital because it is generally regarded as maintaining a higher degree of security than is present or considered desirable at other hospitals.

14.3 It is apparent from the report of the independent psychiatrists that a considerable proportion of the present patients at Oakley are not in need of the kind of security which exists at that institution. It would seem that a number of persons may have been transferred from other institutions for reasons which on closer analysis may not be very acceptable.

14.4. In the treatment of mental illness there must be times when disturbed patients must be kept secure in their own interests and that of the community. Except in the quite special case of persons who have been otherwise detained in prison, we see no reason why other hospitals should not accept their fair share of patients requiring such provision. The new Oakley Unit will take its share from those who would come from the region served by Carrington Hospital.

14.5 In other parts of New Zealand they clearly do so, and it was also quite clear that this particular responsibility was accepted in the psychiatric hospitals we visited in South Australia. The average length of stay for patients in the intensive care, closed unit for disturbed patients at Glenside Hospital, South Australia, was only 4.8 days. Patients were then transferred to open wards of the hospital, or, in some cases, discharged.

14.6 We believe therefore that the other psychiatric hospitals in the Auckland area should be required by the Auckland Hospital Board to retain patients requiring security for such time as should be necessary. The practice of sending difficult patients to Oakley Hospital and concentrating them in that hospital should cease.

14.7 The psychiatric hospitals in Auckland are regionally based and there is much to be said for keeping people, during treatment, within the region from which they come so that they may be in touch with their families more easily than would otherwise be the case.

SECTION 15

15. SECURE PSYCHIATRIC UNIT AT PRISON

15.1 At Paremoremo Prison, which we were able to visit, a unit for the detention and treatment of psychiatrically disturbed prisoners was constructed as part of the prison building. In the Hutchinson Report at page 5, the following comment appears:-

> "10. When Paremoremo was built a psychiatric wing was added to the surgical hospital provided for the care of prisoners. This wing was not designed, nor is it suitable, for the curative treatment of psychiatric cases. It was intended to be used only for purposes of observation and accordingly serves only as a place of seclusion to which any prisoner who becomes disturbed can be moved away from other prisoners."

Again, at page 56:-

> "There is no facility in a penal institution in Auckland other than Paremoremo Psychiatric Wing which is unsuitable."

This condition still pertains today.

15.2 We were also informed that it has not been practicable to use this unit because its proximity to the main part of the prison allowed other prisoners to mock and jeer at prisoners held in the unit. Psychiatrically disturbed prisoners have therefore been sent to Oakley Hospital.

15.3 In his submissions the Medical Superintendent suggested that at some time in the future a prison hospital should be constructed as a suitable institution to which psychiatrically disturbed prisoners could be transferred.

15.4 He indicated that such an institution should be so run as not to encourage malingerers or prisoners who merely sought a soft option.

15.5 A hospital and a prison have entirely different purposes, and we believe that the importation of aspects appropriate to a prison to a hospital setting are inimical to the proper purpose of a hospital which is not punishment but the treatment of illness.

15.6 Northfield Security Hospital in Adelaide caters only for prisoners, either convicted or on remand, suffering from psychiatric disorders, or persons who have been acquitted on the grounds of insanity and have been directed to be held at the Governor's pleasure. Its admissions are controlled by the forensic psychiatrist in charge. It is adjacent to a prison which accepts responsibility for its perimeter security and certain services of a domestic nature such as catering and maintenance of facilities. In all other respects it is a hospital subject to and a part of the Hillcrest Hospital, whose staff interchange with those at Northfield.

15.7 We do not believe that a hospital is compatible with a prison as such and we do not support any proposal to construct a hospital which is effectively a prison with hospital overtones.

15.8 In our view, prisoners requiring psychiatric treatment should receive it in a psychiatric hospital where security, though effective, is subordinate to therapy. As we see a reconstituted Oakley Hospital, it could meet the needs which arise through the prison service, but in our view it should be operated and controlled as a hospital and not subject to or incorporated in the prison system.

15.9 Persons suffering from psychiatric disorders should not be kept in prison, and a decision as to whether or not they suffer from such disorders should be made by persons with psychiatric qualifications. In the case of the new Oakley Unit admissions must be controlled by the Director of Forensic Services.

SECTION 16

16. BOARD OF REVIEW

16.1 As well as special patients under the provisions of the Criminal Justice Act 1954, Oakley Hospital caters for committed patients under the provisions of the Mental Health Act 1969.

16.2 As has been stressed in connection with other matters, patients in a psychiatric hospital are in a very difficult and vulnerable position. Once committed on the basis of a psychiatric disorder they carry with them automatically a prejudice in relation to their mental powers and rationality.

16.3 For this reason they can be almost totally dependent on the discretion of the persons whose decision in the first place confirmed their admission to hospital and whose decisions detain them there.

16.4 Non-conforming or eccentric behaviour standing alone is not a justification for involuntary admission to, or detention of, a person in a psychiatric hospital. Many people with a variety of emotional and mental disorders can live in the community without disrupting the lives of others. Committal may be necessary for some persons with treatable mental disorders who are unable to accept that they are truly ill. Nevertheless, the deprivation of a person's liberty or independence is always a serious step to take and committal to a psychiatric hospital for treatment should only take place in the interest of the person's safety or for the protection of others.

16.5 Once committed, regular reviews of the person's mental condition are essential. Responses to treatment must be clearly recorded. Ongoing judgments on the potential dangers to the person concerned or to others must be constantly made.

16.6 The need for continuing detention is partly a clinical issue but also partly a societal issue involving levels of community tolerance and acceptance. The patient's right to freedom must be carefully balanced against the right of society for protection. To enable these sometimes conflicting rights to be properly assessed, a system of regular reviews of committed patients is essential.

16.7 Section 55 of the Mental Health Act 1969 provides that the case of every committed patient is to be kept under review by the Superintendent of the Hospital and in addition there are requirements that the Superintendent shall take certain steps within one month after the expiration of the period of three months following the date of the making of a reception order and within one month before the first anniversary of such date and within one month before the second anniversary of such date.

16.8 While this provides a safeguard it provides a safeguard which is dependent upon decisions being made by the very person who has already made decisions which effectively retain a patient in the hospital.

16.9 Evidence was given before us of patients who had been recalled from leave and held again in Oakley Hospital, so that in some manner the reception order is extended.

16.10 The Medical Superintendent in evidence confirmed this and stated that such was done where it was thought desirable in the interests of the community that a person should not be released into the community until a further period of treatment or observation had expired.

16.11 Section 73 of the Mental Health Act 1969 provides that an inspector or official visitor or any relative or friend of the patient may where he or she disagrees with the conclusion of the Superintendent that a person is not fit to be discharged report his disagreement to the Minister. A committed patient may also apply to the Minister for the holding of an Inquiry by a District Court Judge.

16.12 The Minister then has a discretion as to whether or not an Inquiry should be held before a District Court Judge.

16.13 Since the remedies provided by that Section go only so far as to the provision of an Inquiry, and even this is discretionary, and since the Minister is required to take into account the opinion of the Superintendent who has already indicated his view that the patient should not be discharged, the Section provides only very illusory rights to such a patient.

16.14 Section 74 provides that a Judge of the High Court may make an order directing an Inquiry into such matters relating to a committed patient as the Judge thinks fit and also to have such a person brought before him with powers to direct an immediate discharge.

16.15 While this is a much stronger Section it too can be illusory in nature since it is dependent upon the matter in some way being brought before a Judge.

16.16 We were constantly told during the course of the Inquiry that a considerable proportion of the people who end up in Oakley Hospital are persons who are at best inadequate and at worst assessed by the Oakley administration as being persons who are dangerous to the community. The chances of such people being familiar with their rights are remote to say the least and even if they were, their ability to carry out the comparatively sophisticated manoeuvres necessary to result in an Inquiry under the provisions of Section 74 mean that it is most unlikely any of them will ever be in a position to take any necessary action in their own interests.

16.17 The Act provides that letters addressed to members of Parliament or a Judge of the High Court or an Ombudsman or the Director of Mental health or to an Inspector or Official Visitor are to be immediately forwarded unopened. If the assessment at Oakley of a substantial proportion of the patients is correct, then these people would be incapable of writing such a letter, but even if they were there is no certainty that a letter would reach its destination. One of the complaints made before us by former patients was that letters given to staff were not always forwarded. We do not regard this is necessarily sinister. Staff

must be given a vast amount of material which for one reason or another it would be inappropriate to send on and with the pressures upon them staff may sometimes be excused for not taking action on the basis of the actions of people who are plainly disordered. We should also say that where members of the staff have some reason to believe that the material forwarded may contain a complaint, they must be under considerable temptation to simply destroy such material. However we believe that all staff should be familiar with Section 63 of the Act, and in particular subsection 2, and that the conditions contained therein should be complied with.

16.18 We believe that it is necessary for much stronger safeguards to be included in the Mental Health Act and we believe that these safeguards should be automatic and not depend on action by patients or persons concerned with them. Psychiatrists and other mental health professionals are skilled in the diagnosis, treatment and care of mental disorders. They possess particular expertise in the natural history and prognosis of mental disorders. They are able to provide useful insights into the origins of disturbed behaviour and the likelihood of relapses. Nevertheless, these professionals are not qualified to make the final decisions on society's need for protection or the tolerance of the community of aberrant behaviour. Such decisions need to have regard to expert clinical opinion, but , in our view, should be made independently.

16.19 We believe there is much to be said for the automatic review carried out by a totally independent Board, which is the position which pertains in South Australia, and in our view such reviews should be regular and mandatory.

16.20 During the course of the Inquiry we heard evidence from one person who had twice been committed to Oakley Hospital, and twice, after succeeding in obtaining an independent assessment by an outside psychiatrist, been discharged. We were concerned that these incidents occurred at all and particularly concerned that the person involved had had to resort to subterfuge in order to obtain the assistance of an independent psychiatrist. **Such situations have no place in a civilised community and it is imperative that procedures be devised to prevent them occurring.**

16.21 We therefore recommend that the Mental Health Act be amended to provide for the establishment of independent appointed regional boards of review, similar to that created by Part V of the Mental Health Act 1976-1977 South Australia, which is annexed to this report as Appendix IV.

The responsibilities of such boards of review would be firstly to act as appeal authorities on appeals against committal or detention, initiated by patients or through relatives or other concerned persons, subject of course to safeguards preventing unreasonable applications to such a body.

Secondly, such boards would have the responsibility to carry out regular and automatic reviews of the detention of committed patients. Such reviews should take place at intervals of no more than three months, in order to cover the case of patients who are unable to initiate appeal procedures on their own behalf or through other concerned persons.

We note that in South Australia the equivalent board of review sits approximately once a fortnight for half a day, so that no great burden should be imposed by the proposals we now put forward.

We note also that provision is contained in the South Australian statutory provisions for reimbursement of the persons constituting the board, and similar provision would need to be made in New Zealand.

16.22 It should also be mandatory that every committed patient receive a summary of the rights of committed patients given by the Mental Health Act, which would include inter alia the rights of appeal to which reference has been made.

We point out too that these provisions are at least to some extent a protection for hospital authorities in that when such an independent board of review has indicated that a patient should be discharged, then that patient can be discharged without the hospital authorities or the doctor concerned accepting sole responsibility.

SECTION 17

17. **OFFICIAL VISITORS**

17.1 Section 5 of the Mental Health Act 1969 makes provision for the appointment of District Inspectors and Official Visitors.

17.2 A District Inspector has wider powers than an Official Visitor, and in particular under the provisions of Section 58 of the Act is entitled to conduct enquiries with the powers and authority to summon witnesses and receive evidence as are conferred upon Commissions of Inquiry by the Commissions of Inquiry act 1908.

17.3 Because of these wider powers a District Inspector must be legally qualified.

17.4 As we understand the position, in practice Official Visitors were mainly concerned members of the public who acted more informally that District Inspectors.

17.5 We also would expect that the legal qualifications and special powers of a District Inspector would lead him to conduct his responsibilities rather more formally than would an Official Visitor

17.6 For this reason the functions of the two appointees would tend naturally enough to fall into separate but overlapping activities. On the one hand, the District Inspector is responsible for a comparatively formal set of obligations involving him in inquiries conducted in a legal and formal way. The Official Visitor is much more of a patient's advocate, more readily available and understood by patients, than a person whose professional commitments would normally absorb most of his or her time. The Official Visitor may be much less formidable to a patient than a professionally qualified person.

17.7 Dr James indicated that it appears some years ago the Department of health suggested to Hospital Boards that it was unnecessary to continue and keep reappointing Official Visitors.

17.8 We understand that throughout most of New Zealand this suggestion was accepted, and with the exception of Christchurch where an Official Visitor has a close relationship with Sunnyside Hospital, Official Visitors, have, generally speaking, ceased to exist. There is an Official Visitor appointed to Lake Alice Hospital also.

17.9 We believe that in a situation such as Auckland where the Hospital Board has the responsibility for administering something in excess of 26 institutions, the direct community oversight which may have been anticipated could not exist. For this reason and for the reasons of differentiation of function referred to above, we believe that it was unfortunate that Official Visitors ceased to be appointed.

17.10 A recent article in the New Zealand Listener suggested that all concerned felt that the existence of an Official Visitor at Sunnyside Hospital was of great assistance and benefit to patients.

17.11 We believe that Oakley Hospital is in greater need of an Official Visitor than most. In saying this we do not in any sense wish to criticise the work of the District Inspector. During the course of the Inquiry we requested the Auckland Hospital Board to arrange for regular inspection and we are grateful to the District Inspector for having attended to this request. However, there are limits to the impositions of time which can be placed upon busy professional people, especially in a task such as this which is not adequately remunerated and which involves considerable burdens. In this connection we note that following our request the District Inspector visited Oakley Hospital for approximately three hours every Wednesday afternoon from 22 September to 27 October 1982. On each occasion he interviewed individual patients, visited different parts of the two wards and spoke to many patients while walking round the wards. He walked through the security wing on Ward 3 on three occasions and spoke to all the patients on the security wing on each occasion. Following this, he prepared a detailed report setting out the enquiries he had made and giving a summary of the comments or complaints made by patients. It is interesting to note that in many cases this dealt with matters which have been referred to during the course of this report. They include an emphasis on lack of privacy, lack of recreational activities and lack of group therapy. The District Inspector indicated that since the notice setting out patients' rights had been displayed, he has noticed an increase in enquiries to him by telephone to his office or home or by letter. He confirmed that patients felt staff would do more of a constructive nature if the staff numbers permitted this.

17.12 Oakley Hospital because of its very nature involves a situation where civil rights need protection. As has already been indicated in another part of the report, prisoners suffering from psychiatric disorders are particularly vulnerable and usually in a very poor position to take any action in their own interests. For such people the presence of an Official Visitor who was readily available and conducted informal inspections would be a major and significant safeguard. If a person with the appropriate qualifications were appointed, then it is likely that it would also be a safeguard to the staff since allegations of the kind which were so frequently made during the course of the Inquiry could frequently be disproved by the vigilance of such a person.

17.13 Where incidents which required a more formal or detailed investigation occurred, then the services of the District Inspector with his legal background and wider powers could be called upon.

17.14 We therefore recommend that at least one Official Visitor be appointed for Oakley Hospital as urgently as possible.

17.15 The New Zealand Society for the Intellectually Handicapped drew our attention to the particular needs of intellectually handicapped persons.

17.16 Such a person has special problems of communication and is less likely to communicate even in his limited way with an official he does not know.

17.17 It is suggested that such safeguards as do exist in the Mental Health Act, including the provision of Official Visitors and District Inspectors, do not adequately provide protection for adults who are restricted in their ability to comprehend or to communicate.

17.18 It is suggested that in such cases a particular guardian should be appointed whose obligation is to look after the interests of the particular person.

17.19 While we are not unsympathetic to the point of view it tends to go beyond the scope of the Inquiry. We believe that Oakley Hospital is a quite inappropriate place for intellectually handicapped persons to be cared for. Such people should be looked after in quite separate institutions and it would be beyond our powers to make suggestions regarding the safeguards which persons in such institutions require. We draw attention to the fact that in South Australia, a Guardianship Board provides general support for those suffering from mental illness or mental handicap which would assist in meeting this particular need as well as others, and we suggest that some consideration be given to the establishment of an equivalent body, or bodies, in this country.

SECTION 18

18. **CONCLUSIONS**

18.1 Oakley Hospital from its inception has been obliged and has chosen to take all the most unwanted and disadvantaged psychiatric patients in the Auckland area.

18.2 It is also an extremely isolated institution.

18.3 Partly in consequence of these factors an attitude has developed which places an emphasis on the safety of the community rather than the welfare of the patient and which categorises patients in a most unfavourable light.

18.4 Such an attitude will inevitably manifest itself in the way in which patients are treated, and we believe it has done so.

18.5 Further, a system will develop and has developed which puts treatment for illness in a position where it is subordinate to security.

18.6 It is worth mentioning that these attitudes are not confined to Oakley Hospital. They exist also in the attitudes towards that hospital. It ill behoves those who have not been prepared to shoulder the burden to join in a condemnation of a system which reflects, at least to some extent, their own failure.

18.7 We have had to refer in this report to matters and practices at Oakley Hospital which make sorry reading. More importantly a man has died there who we believe need not have.

18.8 Nevertheless, as we said at the beginning of this report, no good purpose would now be served by singling out individuals for criticism or making scapegoats of staff associated with the hospital. They are in many instances involved in a system which they have been powerless to change.

18.9 A witch hunt at this stage would be unlikely to change the system and might help to perpetuate it.

18.10 What is important is that the system should be changed and in many respects replaced. We have endeavoured in this report to put forward proposals which we believe could convert Oakley Hospital into one where patients would be fortunate to be treated and where staff would be proud to be involved.

18.11 In achieving this, while we accept that proper financial provision and material support will be necessary, by far the most important thing which is required is the optimistic and imaginative involvement of people. We heard evidence which makes it clear to us that such people are involved in and concerned with Oakley Hospital, and we believe also that those with the necessary drive and determination can be recruited from outside to take steps to transform it.

18.12 We note that the Hutchinson Committee had such a vision in 1971. We hope that this will be no longer delayed.

18.13 Until such time as a Board of Control or some equivalent is appointed, the Auckland Hospital Board should accept responsibility to carefully monitor the situation at Oakley Hospital and ensure that such recommendations as are acceptable to the Board are complied with.

SECTION 19

19. **RECOMMENDATIONS**

19.1 **Section 4**

19.1.1 Admission procedures, including mental and physical state examinations of the patients, should be reviewed to provide a more adequate basis for diagnosis and subsequent treatment. (See paragraphs 4.1.3 and 4.3.6).

19.1.2 The frequency of drug use should be more clearly specified. Upper limits should be defined. The form of "blanket" prescribing used at Oakley Hospital should cease, and more specific directions should be given to nursing staff when emergency medication is needed for a newly admitted patient. Nursing staff should not be left to decide whether a specific anti-psychotic or hypnotic drug should be used for a patient. (See paragraph 4.2.5).

19.1.3 In no circumstances should a patient be placed in seclusion without explanations being given, even if the patient appears unable to follow or accept these. There should in no way be a practice whereby a person on admission to the maximum security ward at Oakley Hospital should be automatically placed in seclusion. (See paragraphs 4.4.10.1, 4.4.10.2 and 10.13.9).

19.1.4 Paraldehyde should only be used as a last resort and then only when specifically prescribed by the medical advisor of the patient concerned, and under his direct instruction in the case of any administration. The practice of blanket prescription of Paraldehyde in the discretion of staff should cease immediately. (See paragraph 4.8.16).

19.1.5 The use of frequent and repeated high doses of anti-psychotic drugs to produce rapid tranquillisation in patients should always be associated with medical monitoring at frequent intervals over this period. In such circumstances intensive medical oversight is essential and such oversight cannot be left solely to nursing staff. (See paragraphs 4.9.10, 4.9.11 and 4.9.12).

19.1.6 In view of the possible relationship of high doses of Haloperidol to unexplained sudden deaths reported in recent years, particularly in doses over 100 mg daily, dosages at this level should be avoided when possible, but if used, special and intensive monitoring of the patient's clinical condition by both medical and nursing staff should be mandatory. (See paragraphs 4.9.11 and 4.9.13).

19.2 **Section 5**

19.2.1 Procedures to be followed in the administration of ECT should be those set out in the clinical memorandum of the Royal Australian and New Zealand College of Psychiatrists, and should include provisions made for obtaining consent. (See paragraph 5.1.6).

19.2.2 After-care after ECT should follow the provisions of the clinical memorandum already referred to. (See paragraph 5.2.4).

19.2.3 It should be mandatory for a specialist anaesthetist or his delegate to be in attendance whenever ECT is given (See paragraph 5.3.8).

19.3 Section 6

19.3.1 Guidelines should be provided on the comprehensive nursing care of a patient in seclusion, or nursed in a closed room. These should include reporting on all aspects of care given, and patient response. (See paragraphs 6.1.5 and 6.1.6).

19.3.2 More appropriate and up-to-date methods of defusing potentially dangerous situations, handling confrontation and aggression, together with instructions on how to approach and hold a patient when this is necessary should be taught to all staff. (See paragraph 6.1.22).

19.3.3 The attention of nursing staff should be drawn to the commonly used methods of personalised nursing care plans. Instruction in this practice and orientation to patient assignment nursing should be included in staff education and re-training programmes. (See paragraph 6.3.10).

19.4 Section 7

19.4.1 There should be a standard procedure for the investigation of any incidents or alleged incidents including injury to or ill-treatment or the death of a patient. This should involve the senior nursing staff and should require all staff involved to record their own accounts of what occurred. Senior administration should record their own conclusions and the whole account should be put together and kept securely. (See paragraphs 7.13 and 7.14).

19.5 Section 8

19.5.1 There should be a specific and mandatory procedure for the protection of both patients and staff which allows for the fullest investigation of any allegations of ill-treatment, irrespective of the source of the allegations and that the advice and counsel of the District Inspector should be sought. (See paragraphs 8.1.14 to 8.1.18 inclusive).

19.5.2 The requirement that nursing staff photograph patients for identification purposes should cease. This should be the responsibility of a technician. Under no circumstances should photographs be taken when the patient is at a disadvantage, e.g. under the influence of medication, or undergoing a course of ECT. The taking of the photograph must be delayed until the patient's condition and appearance is such that a realistic likeness can be obtained. (See paragraphs 8.2.1 to 8.2.5 inclusive).

19.6 **Section 10**

19.6.1 The Chief Nurse of the Auckland Hospital Board, in consultation with the senior psychiatric nurse administrators, educators and clinical nurses should consider the submissions made by the New Zealand Nurses' Association, the Nurses' Society and the Public Services Association, on standards for nursing service and practice, with a view to adapting them for use in Oakley Hospital. (See paragraphs 10.4.3.5 and 10.4.4.5).

19.6.2 That selected psychiatric assistants at present employed at Oakley Hospital be required to undertake the Enrolled Nurse Programme, and on completion of this be offered an endorsement programme in psychiatric nursing. (See paragraph 10.5.2.6).

19.6.3 An immediate and urgent effort should be made to increase the registered nursing staff establishment in order to bring all shifts up to full strength, and reduce the need for overtime and extended hours. (See paragraphs 10.6.4 and 10.6.5).

19.6.4 New ward regimes should be devised as soon as possible which will meet security requirements for those patients who need them but will also cater for the psychological and social needs of all patients. (See paragraphs 10.8.3. and 10.8.6).

19.6.5 The standard clinical file used in other Auckland Hospital Board psychiatric hospitals should be used at Oakley Hospital and Oakley nurses should be given the opportunity to learn the system of problem orientated recording used in Ward 10A Auckland Hospital and Kingseat Hospital. (See paragraph 10.9.6).

19.6.6 The system of drug recording in use at Oakley Hospital should be immediately reviewed. (See paragraph 10.9.7).

19.6.7 The Auckland Hospital Board should take immediate steps to ensure that access to patients' files in institutions under the control of the Auckland Hopsital Board is so controlled that improper access to such files cannot be obtained. (See paragraph 10.9.8).

19.6.8 There should be two recreation officers available to Oakley Hospital, one for Ward M3 and one for Ward M7, and two occupational therapy posts should be added to the establishment. Both these steps should be taken immediately. (See paragraph 10.10.7).

19.6.9 The Auckland Hospital Board should take urgent action to stop the practice of placing patients in "C" Group by way of punishment. (See paragraph 10.12.9).

19.6.10 The whole system and philosophy of security at Oakley Hosptial should be immediately examined and reconsidered. There may well be a need to improve external security but certain irritating aspects of the present internal security system should be removed. (See paragraphs 10.14.9 and 10.14.11).

19.6.11 No person should be detained at a hospital such as Oakley Hospital on social grounds alone and in no sense should prison sentences be extended by decisions made which are not subject to control by the Courts. (See paragraph 10.16.6).

19.6.12 The practices referred to by the independent psychiatrists and dealt with in Section 10.17 of this report should be further investigated by the Auckland Hospital Board in respect of individual patients and in the absence of any acceptable justification discontinued. The risk of high dosage medication, except in special circumstances, should not be imposed upon patients who are in no conditions to make decisions regarding their own medication except in special circumstances. The notes made by the visiting psychiatrists on individual patients interviewed should be attached to the files of those individual patients. (See paragraphs 10.17.7, 10.17.18, 10.17.19 and 10.17.20).

19.7 Section 11

19.7.1 Oakley should be amalgamated with Carrington, subject to certain aspects of its operation, retaining a degree of independence. (See paragraph 11.2.6).

19.7.2 A separate board of control should be set up to be responsible for the new Carrington/Oakley complex and to oversee the changes which we propose as necessary. This board of control should be answerable to the Auckland Hospital Board and should be an appointed rather than an elected board. It should be appointed by the Auckland Hospital Board after consultation with the Minister of Health and should if possible include the Director of Mental Health. It should also have a representative from the Department of Psychiatry at the Medical School of the Auckland University. It should consist of no more than seven persons and should assume responsibility for planning forensic psychiatric services through the whole Auckland region. (See paragraph 11.3.3).

19.7.3 The person appointed to take responsibility for the reconstituted Oakley Unit as part of the Carrington complex should be given the title of Director of Forensic Services. He should have responsibilities beyond the new Oakley Unit itself. He should have the status of a Medical Superintendent and be remunerated accordingly. On professional matters related directly to forensic psychiatry he should report directly to the board of control. In matters of administration he should be responsible to the Medical Superintendent of the whole complex. (See paragraph 11.4.3).

19.7.4 The Director should be entitled and encouraged to take a University appointment and given the right and encouraged to undertake limited private practice. (See paragraph 11.4.4).

19.7.5 The Director should have appropriate forensic psychiatric qualifications and experience. (See paragraphs 11.4.5 and 11.4.6).

19.7.6 The post should not be filled on a temporary basis by the Medical Superintendent-in-Chief of the Auckland Hospital Board or by the present Medical Superintendent of Oakley Hospital. (See paragraph 11.4.1).

19.7.7 If by the time of the present Medical Superintendent's retirement no suitable person has been found, then Professor Werry should be asked in conjunction with the Director of Mental Health, Dr James, to provide a suitable psychiatrist on a temporary basis to fill the position under the temporary oversight of Dr James. In considering this temporary appointment consideration should be given to an appointment from overseas if no appropriate person from New Zealand could be found, although we consider that there are eminently suitable persons within New Zealand to fill the position. (See paragraphs 11.4.7 and 11.4.8).

19.7.8 In addition there should be one other full-time psychiatrist and one full-time medical officer. There should also be two psychiatric registrars appointed in consultation with the University and the Royal Australian and New Zealand College of Psychiatrists. (See paragraph 11.5.2).

19.7.9 A new Principal Nurse, either male or female should be appointed. Such an appointment should be made, if at all possible, contemporaneously with the appointment of the Director and under similar reporting conditions. (See paragraph 11.5.3).

19.7.10 The present staff should be increased in accordance with the present guidelines accepted by the Auckland Hospital Board. Such staff should be re-deployed as patient numbers are reduced. (See paragraph 11.5.4).

19.7.11 The staff should consist of both men and women and the present policy of avoiding the employment of women in the wards should be abandoned. (See paragraph 11.5.4).

19.7.12 Three suitable nurses should be sent immediately to the Northfield/Hillcrest Hospital complex in Adelaide for a period of three months to work a normal shift in the conditions and under the philosophy which pertains at that institution. A further three suitable nurses should be sent to Cherry Farm in Dunedin for a similar period. When this has taken place a further six nurses should be selected for a similar period of training in the nominated institutions. At the time of return of the first group so selected, we suggest that a reasonable proportion of female nurses should be introduced into the new unit. (See paragraph 11.5.7).

19.7.13 An In-Service Educator, to be chosen by the Chief Nurse to the Auckland Hospital Board, should be immediately appointed to begin the in-service training of all staff remaining at Oakley Hospital. (See paragraph 11.5.8).

19.7.14 The numbers of patients at both wards at Oakley Hospital should be immediately and substantially reduced by requiring other institutions to take their fair share of those persons assessed as appropriate to be nursed elsewhere, bearing in mind their need to be close to families who maintain contact and interest. (See paragraph 11.6.1).

19.7.15 The number of patients in Ward M3 should not exceed 30 and should ideally be limited to 25. (See paragraph 11.6.2).

19.7.16 "C" Group in Ward M7 should be disbanded as soon as appropriate places can be found for its members in more appropriate institutions. (See paragraph 11.6.3).

19.7.17 Ward M7 should remain as an open ward and should be substantially reduced in numbers of patients to a maximum of thirty. (See paragraph 11.6.4).

19.7.18 For the future the new Oakley Unit should draw its patients from three sources: firstly, all prisoners from the Auckland region who have psychiatric problems requiring hospitalisation; secondly, it should provide the secure unit for Carrington Hospital; thirdly, it should meet the needs of patients previously associated with the psychiatric therapeutic teams operating in the new Oakley Unit. (See paragraph 11.6.9).

19.7.19 Patients should be classified, grouped and divided into compatible groups. In considering compatibility the kinds of illness from which they suffer, the attributes of their personalities, and their differing needs should be taken into account. (See paragraph 11.7.5).

19.7.20 The new Oakley Unit should accommodate both male and female patients. (See paragraph 11.8.7).

19.7.21 Patients are entitled to their own clothing and should not have to share clothing with other patients. (See paragraph 11.9.5).

19.7.22 The Auckland Hospital Board should engage the services of an imaginative architect in consultation with medical and nursing staff to recommend appropriate changes to the buildings at Oakley Hospital in order to meet the new type of hospital which is envisaged. (See paragraph 11.10.3).

19.7.23 The major work that should be done as urgently as possible is of a subdivisional nature so that there are rooms available for patients for separate occupations and to meet their own individual needs, including privacy. Money should be spent on this rather than in redecoration. (See paragraph 11.10.5).

19.7.24 Patients could be involved in appropriate redecoration. (See paragraph 11.10.6).

19.7.25 More appropriate furnishings should be provided. (See paragraph 11.10.7).

19.7.26 Patients are entitled to a degree of individuality in their rooms and there should be some provision for items of personal concern and value to themselves. (See paragraph 11.10.9).

19.7.27 There is a need for some form of internal communication available to patients confined in a closed room. (See paragraph 11.10.10).

19.8 Section 12

19.8.1 There should be an immediate emphasis placed upon particular cultural needs. (See paragraph 12.13).

19.8.2 Matters of particular cultural concern relating to food, toilet, and such matters as excrement should be taken into account in respect of accommodation and procedures at Oakley. (See paragraph 12.14).

19.8.3 Psychiatric treatment should take into account Maori culture values and spiritual beliefs. (See paragraph 12.16).

19.8.4 Any assessment of patients before admission must take into account particular cultural background and beliefs. (See paragraph 12.17 - Comment).

19.8.5 Tohunga and Kaumatua should be consulted in the psychiatric treatment of Maori inmates whose abnormal behaviour could be attributed to special matters within their own cultural background. (See paragraph 12.18).

19.8.6 Tohunga and Kaumatua assisting in such treatment should be paid sufficient by way of expenses to ensure they are not out of pocket. (See paragraph 12.19).

19.8.7 As far as possible there should be a greater recruitment of nurses with a Maori origin, as well as nurses who are able to relate to persons at Oakley Hospital from other cultural backgrounds. (See paragraph 12.21).

19.8.8 Psychiatric care at Oakley should be orientated where possible to rehabilitation rather than containment of inmates. (See paragraph 12.22).

19.8.9 Wherever possible, particular cultural needs should be identified and met from the resources of the community in the special way which they require. (See paragraph 12.25).

19.8.10 Concerned Community Groups should be encouraged to contribute to the services in Oakley, and Chaplaincy services should be strengthened. (See paragraph 12.29).

19.9 Section 13

19.9.1 We agree with, and adopt, the recommendations of the report of the committee on Psychiatrically Disturbed Prisoners and Remandees that a much smaller number of persons should be remanded to a hospital such as Oakley Hospital for observation, and those who are so remanded should be screened before admission by a suitably qualified assessment panel. (See paragraphs 13.12 and 13.18).

19.9.2 As soon as possible a new unit should be established for persons remanded under the provisions of the Criminal Justice Act. It should be completely separate from the rest of the hospital. We do not consider that the upstairs area, or indeed any part, of Ward M3 is a suitable place for such a unit to be established. Until a separate unit can be constructed we suggest that the area at present occupied by "C" Group be made available as a separate remand unit with such additional security as is required. (See paragraph 13.19).

19.9.3 When a new remand unit is constructed it must provide reasonable living conditions for persons remanded to it and reasonable opportunities for observation. There must be opportunities for recreation and profitable occupation. (See paragraph 13.20).

19.9.4 The remand unit should not cater for more than a maximum of eight patients at any one time. (See paragraph 13.21).

19.9.5 Section 39B (8) of the Criminal Justice Act 1954 should be amended to include a provision similar to that in Section 47A of of the same Act, giving power to treat persons remanded under the provisions of that Section with their consent. (See paragraph 13.31).

19.9.6 Where a person is detained under the provisions of either Section 39B (8) or Section 47A of the Criminal Justice Act, and consents to and requires treatment, that treatment should not be withheld. (See paragraph 13.32).

19.9.7 A provision equivalent to that contained in Section 39B (8) of the Criminal Justice Act 1954 should be included in the provisions of Section 47A so that treatment to prevent deterioration may be given without his consent in the case of a person detained under that Section. (See paragraph 13.33).

19.9.8 The remand facility at the new Oakley Unit should cater for all persons requiring such observation within the Auckland region. We do not consider it desirable that persons should be so remanded or observed at other institutions within the Auckland area. (See paragraph 13.34).

19.10 **Section 14**

19.10.1 Other psychiatric hospitals in the Auckland area should be required by the Auckland Hospital Board to retain patients requiring security for such time as should be necessary where those patients originate in the regions served by those other hospitals. (See paragraphs 14.6 and 14.7).

19.11 **Section 15**

19.11.1 We are opposed to any proposal to construct a prison hospital for psychiatric patients. (See paragraphs 15.7 and 15.8).

19.11.2 Persons suffering from psychiatric disorders should not be kept in prison and a decision as to whether or not they suffer from such disorders should be made by an appropriately qualified psychiatrist. In the case of the new Oakley Unit, admissions must be controlled by the Director of Forensic Services. (See paragraph 15.9).

19.12 **Section 16**

19.12.1 We therefore recommend that the Mental Health Act be amended to provide for the establishment of independent appointed regional boards of review, similar to that created by Part V of the Mental Health Act 1976-1977 South Australia, which is annexed to this report as Appendix IV.

The responsibilities of such boards of review would be firstly to act as appeal authorities on appeals against committal or detention, initiated by patients or through relatives or other concerned persons, subject of course to safeguards preventing unreasonable applications to such a body.

Secondly, such boards would have the responsibility to carry out regular and automatic reviews of the detention of committed patients. Such reviews should take place at intervals of no more than three months, in order to cover the case of patients who are unable to initiate appeal procedures on their own behalf or through other concerned persons. (See paragraph 16.21).

19.12.2 It should also be mandatory that every committed patient receive a summary of the rights of committed patients given by the Mental Health Act, which would include inter alia the rights of appeal to which reference has been made. (See paragraph 16.22).

19.13 **Section 17**

19.13.1 At least one Official Visitor should be appointed as urgently as possible to Oakley Hospital. (See Paragraph 17.14).

19.14 **Section 18**

19.14.1 Until such time as a board of control or some equivalent is appointed, the Auckland Hospital Board should accept responsibility to carefully monitor the situation at Oakley Hospital and ensure that such recommendations as are acceptable to the board are complied with. (See paragraph 18.13).

APPENDIX I

EXPERT WITNESSES CALLED AT THE REQUEST OF THE COMMITTEE

Dr H.R. Bennett Q.S.O. MB ChB, DPM Melb, FRANZCP, MCCM

Dr J.R.E. Dobson MB ChB, DPM Lond, FRANZCP, FRCPsych

Dr M.H. Durie MB ChB, DIPL PSYCH MCGILL, MRANZCP

Dr J. Hall MB ChB, DPM, RCP Lond, RCS Eng, FRANZCP, MRCPsych, MCCM(NZ)

Dr G.S. McL. Kellaway MD, MB ChB, FRCP Edin, FRCP Lond, FRACP

Dr R.W. Medlicott MB ChB, FRACP, FRANZCP, FRCPsych

Dr W.M.I. Smeeton MB ChB, FRCPA

Dr R.V. Trubuhovich MB Chb, B Med Sci, MSc, FFARCS Eng, FFARACS

APPENDIX II

SUBMISSIONS

Submissions, either oral or written, were received from:-

The New Zealand Association of Social Workers (Auckland Branch)

The New Zealand Society for the Intellectually Handicapped

The New Zealand Nurses' Association

The Nurses' Society of New Zealand

The New Zealand Public Service Association

The Prisoners' Aid and Rehabilitation Society

The Prison Fellowship of New Zealand

The Auckland Council for Civil Liberties

Dr R.J. Walker for the Auckland District Maori Council

Mr Winston Maniapoto

The Citizens' Commission for Human Rights

Dr B. James for the Department of Health

Professor John S. Werry	Mr A.C. Stegerhoek
Dr H. Bennett	Mr G.R. Wheaton
Mr R.J.K. Sanders	Mr G. Newbold
Mrs L. White	Mr R.G.E. Harrison
Mrs Munday	Ms J. Shaverein
Ms J.A. Moore for "Coping"	Mr S.R. Martyn
Mrs D.M.J. Birks	Mr Wyndham
Mr E.M. Moore	Mrs R.C. Loftus
Mr Charles Le Vard	Mr A. Brooker
Mr S. Fletcher	Mr K. Kaczmarek
Mr J. Arthur	Dr P.P.E. Savage
Mr B.L. Hancock	Mrs H.J. White
Mr J.B. McDonald	Mr F.T. Fletcher

APPENDIX II cont'd...

Mr E.R. Winkfield

Mr B. Rowell

Mr A. Turketo

Mr C. Baker

Mr F. Mardon

Mr E.N. Rout

Mr R. Hey

Mr James R. Tong

For the Auckland Hospital Board

Dr F.W.E. Rutter

Mr L.H. Corkery

Dr A.L. Honeyman

Miss A.E. Murphy

APPENDIX III

MATERIAL IN EVIDENCE

1. Handwritten notes
2. Breakdown of staff levels (computer)
3. Staff organisation chart, etc.
4. Patients' records - medication chart and ECT record
5. Nursing report book (day book)
6. Narcotics register
7. Photocopy of medical card
8. S115 weight chart
9. Nat. 10 TPR chart
10. Nat. 24 nursing care sheet
11. S645 and K21 Hypersensitivities
12. A114 Neurological clinical examination
13. K18 Psychiatric case history and examination
14. S74 initial plan sheet
15. Nat. 8 clinical notes
16. Handwritten training course notes
17. Module evidence
18. Social Worker's report - Whangarei 19.2.82
19. Letters about ECT procedures and drug procedures
20. Report to Carrington Recreation Department
21. Declaration of confidentiality
22. Personal notes relevant to Mr Watene's death
23. Ethics and rules of conduct (psychiatric and psychopaedic)
24. Pay rolls
25. Nursing procedures

APPENDIX III cont'd...

26. Statement about events of 22 February concerning Mr Watene
27. Folder of standard forms for Auckland Hospital Board
28. Deposition of staff ("running sheet") ward sheet
29. Staff nurse notes on the death of Michael Watene (4 documents)
30. Incident report book
31. Diagram of position of Michael Watene at the time of death
32. Duties of Psychiatric Assistant at Oakley Hospital
33. Dental record
34. Statement to the Chief Nurse
35. Staff statements from Auckland Hospital Board
36. Running sheets
37. Signing on book
38. Oakley film register
39. Statement to the Internal Inquiry
40. Photograph of Mr Watene taken approximately August 1981
41. Undertaker's form on Mr Watene
42. Letter to the Coroner about the adequacy of post-operative observation
43. Accident and Emergency report
44. Material from Dr Dobson about drug dosage levels
45. Ethics and rules of conduct of staff - Department of Health
46. Ward rules and duties - M3
47. Hospital group policy
48. "Modecate" - manufacturers' specifications
49. Letter about an ex-patient
50. Job descriptions
51. Patient's file
52. Patient's file

APPENDIX III cont'd...

53. Letter 11.7.74 Auckland Hospital Board to P.S.A.
Letter 10.11.76 staff ceilings at Oakley

54. Letter about the report on the findings of Mr Hutchinson, Q.C., 1971

55. Letters of complaint

56. Letter about findings in the Hutchinson report

57. Letters of complaint

58. Minutes of ward meeting; patients and staff M3

59. Pamphlet "Treatment of Schizophrenia"

60. Various drug information sheets

61. Various drug information sheets

62. Patient treatment chart

63. Ward correspondence

64. Extracts from file

65. Drug order sheets

66. Greenlane Hospital file

67. Capital requirements and works programmes

68. Two press statements

69. Resumè of Oakley Hospital

70. Memo about a patient's visitor

71. Letter to Auckland Hospital Board

72. Letter about attendance at the inquest

73. Investigations Committee minutes

74. Letter to the Police about Mr Watene

75. Letter to Chief Executive, Auckland Hospital Board about the inquest

76. Submission by the Medical Superintendent about the report on remandees.

APPENDIX IV

PART V, MENTAL HEALTH ACT 1976-1977, SOUTH AUSTRALIA

PART V

PART V

THE MENTAL HEALTH REVIEW TRIBUNAL

DIVISION I

DIVISION I—CONSTITUTION AND POWERS OF THE TRIBUNAL

Establishment of the Tribunal.

29. (1) There shall be a tribunal entitled the "Mental Health Review Tribunal".

(2) The Tribunal shall consist of three members appointed by the Governor, of whom—

(*a*) one, who shall be chairman of the Tribunal, shall be—

(i) a person holding judicial office under the Local and District Criminal Courts Act, 1926-1975;

(ii) a special magistrate;

or

(iii) a legal practitioner of not less than seven years standing;

(*b*) one shall be a legally qualified medical practitioner;

and

(*c*) one shall be a person who is in the opinion of the Governor otherwise suitably qualified for membership of the Tribunal.

PART V
DIVISION 1

Terms and conditions upon which members hold office.

30. (1) A member of the Tribunal shall be appointed for such term of office, not exceeding three years, as the Governor may determine and specifies in the instrument of his appointment, and, upon the expiration of his term of office, shall be eligible for re-appointment.

(2) The Governor may, subject to subsection (3) of this section, appoint a suitable person to be a deputy of a member of the Tribunal, and such a person, while acting in the absence of that member, shall be deemed to be a member of the Tribunal, and shall have all the powers, authorities, duties and obligations of the member of whom he has been appointed a deputy.

(3) A deputy of the chairman must be—

(*a*) a person holding judicial office under the Local and District Criminal Courts Act, 1926-1975;

(*b*) a special magistrate;

or

(*c*) a legal practitioner of not less than seven years standing.

(4) The Governor may remove a member of the Tribunal from office for—

(*a*) mental or physical incapacity;

(*b*) neglect of duty;

or

(*c*) dishonourable conduct.

(5) The office of a member of the Tribunal shall become vacant if—

(*a*) he dies;

(*b*) his term of office expires;

(*c*) he resigns by written notice addressed to the Minister;

or

(*d*) he is removed from office by the Governor pursuant to subsection (4) of this section.

(6) Upon the office of a member of the Tribunal becoming vacant, a person shall be appointed, in accordance with this Act, to the vacant office, but where the office of a member of the Tribunal becomes vacant before the expiration of the term for which he was appointed, a person appointed in his place shall be appointed only for the balance of the term of his predecessor.

Allowances and expenses.

31. The members of the Tribunal shall be entitled to receive such allowances and expenses as may be determined by the Governor.

Validity of acts of the Tribunal.

32. An act or proceeding of the Tribunal shall not be invalid by reason only of a vacancy in its membership or a defect in the appointment of a member.

Proceedings and decisions of the Tribunal.

33. (1) The chairman shall preside at the hearing of any proceedings by the Tribunal.

(2) Subject to subsection (3) of this section, a decision concurred in by any two members of the Tribunal shall be a decision of the Tribunal.

(3) The chairman shall determine any question relating to the admissibility of evidence, and any other question of law or procedure.

PART V
DIVISION I
Powers of the Tribunal.

34. (1) In the exercise of its powers and functions under this Act, the Tribunal may—

(*a*) by summons signed on behalf of the Tribunal by a member of the Tribunal, or by the secretary to the Tribunal, require the attendance before the Tribunal of any person;

(*b*) by summons signed on behalf of the Tribunal by a member of the Tribunal, or by the secretary to the Tribunal, require the production of any books, papers or documents;

(*c*) inspect any books, papers or documents produced before it and retain them for such reasonable period as it thinks fit, and make copies of them or any of their contents;

(*d*) require any person to make an oath or affirmation that he will truly answer all questions put to him by the Tribunal, or by any person appearing before the Tribunal, relating to any matter being inquired into by the Tribunal;

or

(*e*) require any person appearing before the Tribunal to answer any relevant questions put to him by any member of the Tribunal, or by any other person appearing before the Tribunal.

(2) Subject to subsection (3) of this section, if any person—

(*a*) who has been served with a summons to attend before the Tribunal fails without reasonable excuse to attend in obedience to the summons;

(*b*) who has been served with a summons to produce any books, papers or documents, fails without reasonable excuse to comply with the summons;

(*c*) misbehaves himself before the Tribunal, wilfully insults the Tribunal or any member thereof, or interrupts the proceedings of the Tribunal;

or

(*d*) refuses to be sworn or to affirm, or to answer any relevant question, when required to do so by the Tribunal,

he shall be guilty of an offence and liable to a penalty not exceeding five hundred dollars.

(3) A person shall not be obliged to answer a question put to him under this section if the answer to that question would tend to incriminate him, or to produce any books, papers or documents if their contents would tend to incriminate him.

(4) In any proceedings, the Tribunal shall act according to equity, good conscience and the substantial merits of the case without regard to technicalities and legal forms and it shall not be bound by the rules of evidence, but it may inform itself on any matter in such manner as it thinks fit.

DIVISION II—FUNCTIONS OF THE TRIBUNAL

Review of detention orders and custody orders.

35. (1) Subject to this section, where, by order under this Act—

(*a*) a patient is detained in an approved hospital;

or

(*b*) a protected person is placed in the custody of another person,

the Tribunal shall, before the expiration of the first two months of that detention or custody and thereafter at periodic intervals of not more than six months, review the circumstances of that detention or custody.

(2) Where, upon a review in respect of the custody of a mentally handicapped person, the Tribunal is of the opinion that the mental handicap of that person is not likely to be ameliorated, the Tribunal may extend the period within which subsequent reviews must be made to a period not exceeding twelve months.

(3) Unless the Tribunal is satisfied in proceedings under this section that there is good cause for the continuing detention of the patient or custody of the protected person, it shall direct that the order for detention or custody be discharged.

(4) The Tribunal is not obliged to make a review in respect of a person under this section if it has heard an appeal under this Act in respect of the same person within the last preceding period of twenty-eight days.

Appeals in respect of patients detained in approved hospitals.

36. (1) An appeal may be made to the Tribunal against the detention of a patient in an approved hospital by any of the following persons:—

(*a*) the patient himself;

(*b*) a relative of the patient;

(*c*) the Director;

or

(*d*) any other person who satisfies the Tribunal that he has a proper interest in the care and protection of the patient.

(2) Unless the Tribunal is satisfied in proceedings under this section that there is good cause for the continuing detention of the patient, it shall direct that the order under which he is detained be discharged.

(3) An appeal may not be instituted under this section in respect of a patient—

(*a*) before the expiration of three days from the day on which he was admitted to the approved hospital;

(*b*) if a previous appeal in respect of the same patient has been determined in the last preceding period of twenty-eight days;

or

(*c*) if a review of his detention has been made by the Tribunal in the last preceding period of twenty-eight days.

(4) The Tribunal shall proceed to hear and determine an appeal as soon as reasonably practicable after the institution thereof.

PART V
DIVISION II
Appeals from orders of the Board.

37. (1) Where the Board has made an order—

(*a*) by which a person is received into the guardianship of the Board;

(*b*) by which an administrator is appointed in respect of the estate of a protected person;

or

(*c*) by which a protected person is placed in the custody of another person,

any of the following persons may appeal to the Tribunal against the order:—

(*d*) the protected person;

(*e*) a relative of that person;

(*f*) the Director;

or

(*g*) any other person who satisfies the Tribunal that he has a proper interest in the care and protection of the person in respect of whom the order was made.

(2) Upon the hearing of an appeal under this section, the Tribunal may affirm, vary or revoke the order of the Board.

(3) An appeal against an order of the Board by which a protected person is placed in the custody of another person may not be instituted under this section—

(*a*) if a previous appeal in respect of the same person has been determined in the last preceding period of twenty-eight days;

or

(*b*) if a review of his custody has been made by the Tribunal in the last preceding period of twenty-eight days.

DIVISION III

DIVISION III—APPEALS FROM DECISIONS OF THE TRIBUNAL

Appeal from decisions of the Tribunal.

38. (1) Any person aggrieved by a decision or order of the Tribunal shall, subject to this section, be entitled to appeal to the Supreme Court against the decision or order of the Tribunal.

(2) The appeal must be instituted within one month of the making of the decision or order appealed against, but the Supreme Court may, if it is satisfied that it is just and equitable in the circumstances to do so, dispense with the requirement that the appeal should be so instituted.

(3) The Supreme Court may, on the hearing of the appeal, exercise one or more of the following powers, according to the nature of the case:—

(*a*) affirm, vary or quash the decision or order appealed against, or substitute, and make in addition, any decision or order that should have been made in the first instance;

(*b*) remit the subject matter of the appeal to the Tribunal for further hearing or consideration, or for re-hearing;

or

(*c*) make any further or other order as to costs, or any other matter, that the case requires.

(4) Where the appellant in proceedings under this section is the person in respect of whom the appeal is brought, no order for costs shall be made against him.

DIVISION IV—REPRESENTATION OF APPELLANTS

DIVISION IV

Representation upon appeals.

39. (1) In every appeal to the Tribunal or the Supreme Court, the person in respect of whom the appeal is brought shall, subject to subsection (2) of this section, be represented by counsel.

(2) Where the Tribunal or the Court is satisfied that a person does not desire to be represented by counsel upon an appeal and that he has sufficient command of his mental faculties to make a rational judgment in the matter, it may dispense with the requirement that he be represented by counsel at the hearing of the appeal.

(3) Unless the person in respect of whom the appeal is brought decides to engage counsel at his own expense, the counsel by whom he is to be represented shall be chosen—

(*a*) by that person himself;

or

(*b*) in default of his making a choice, by the Law Society of South Australia,

from a panel of legal practitioners who have indicated their willingness to represent persons in proceedings under this Act, compiled by the Law Society of South Australia.

(4) A legal practitioner, who is chosen from the panel referred to in subsection (3) of this section, shall be entitled to receive fees for his services from the Commission, in accordance with a prescribed scale, and shall not be entitled to demand or receive from any other person any further fee.

BY AUTHORITY:
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