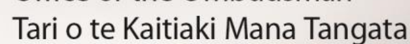
Fairness for all

OPCAT Report

Report on an unannounced follow up inspection of Wards 34, 35 and 36, Waikato Hospital, under the Crimes of Torture Act 1989

March 2020

Peter Boshier
Chief Ombudsman
National Preventive Mechanism



Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

OPCAT Report: Report on an unannounced follow up inspection of Wards 34, 35 and 36, Waikato Hospital, under the Crimes of Torture Act 1989

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Foreword

This report sets out my findings and recommendations concerning the treatment and conditions of service users detained in Wards 34, 35 and 36 (the Wards). The Wards are located in the Henry Rongomau Bennett Centre (HRBC) on the Waiora Waikato Hospital campus, Hamilton.

In the Wards, service users receive acute mental health services provided by the Waikato District Health Board's (DHB's) Mental Health and Addiction Service (the Service). The HRBC also comprises forensic mental health services, which is provided by the Puawai Midland Regional Forensic Service.[1]

This report has been prepared in my capacity as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA). In 2007, the Ombudsmen were designated one of the NPMs under the COTA, with responsibility for examining and monitoring the treatment and conditions of detained service users in the relevant places of detention. My responsibility includes hospital units in which service users are detained.

The report examines the Wards' progress implementing the 12 recommendations I made in 2017. It also includes findings on the conditions and treatment of service users detained in the Wards at the time of my follow up inspection on 16 – 20 September 2019, resulting in 19 recommendations.

I found that of the 12 recommendations I made in 2017, three had been achieved and nine had not been achieved.

During the follow up inspection, I found that:

- All seclusion rooms had natural light.[2]
- The Service had developed a management and contingency plan to address the occupancy levels in the Wards.
- The Service had implemented a structured activities programme in Ward 36 and, to a lesser degree, in the Low Stimulus Area (LSA).

The issues that needed addressing are:

- There continued to be a lack of privacy for service users held in seclusion rooms.
- The Wards were still regularly over occupancy. Seclusion rooms, interview rooms and whānau rooms were still being used to accommodate service users when the Wards were over occupied.
- Restraint data remained inaccurate.

[1] Three reports have also been prepared from my inspection of the Puawai Midland Regional Forensic Service, which includes Puna Maatai, Puna Awhi-rua, and Puna Poipoi.

[2] The seclusion room without natural light in my 2017 report had been decommissioned and is now used as a quiet room.

- Service users being placed on 'sleepovers'[3] to other wards across the Service when the Wards were over occupancy.
- The Service did not record information on the movement (sleepovers) of service users across the Service.
- The high and increasing use of seclusion, particularly for Māori service users.
- The use of 'safety gowns'[4] for service users in seclusion was common practice and documentation on their use did not adhere to the DHB's *Seclusion Procedure*.
- The DHB's *Restraint Policy* and *Restraint – Wrist and/or Ankle Procedure* were out-of-date.
- The Service did not record information on the ethnicity of service users who had been restrained.
- The high and increasing use of restraint, particularly mechanical restraint, across the Wards.
- Contact details for the District Inspector were not displayed in the Wards.
- The process to enter/ exit locked Wards was not visible to service users and visitors.
- Service users being placed in shared bedrooms were afforded little privacy.
- Bathroom facilities were in a poor state of repair.
- Staff were not recording service users' access to fresh air on the Wards.
- The process for service users to access a telephone in Ward 36 and the LSA was not displayed.
- Restrictive practices, such as 'lock downs',[5] on Ward 36 and the LSA when staff suspected that a service user had prohibited items.
- The activities programme on Ward 36 and the LSA was not available to service users on evenings or weekends.
- Service users did not have free access to fresh air.

As a result of my follow up inspection, I make 19 recommendations to improve the conditions and treatment of service users. Disappointingly, nine of these are repeat recommendations.

While it is encouraging that the DHB has announced recently approved funding for a new purpose-built mental health facility, I believe the current situation at the adult acute mental health service is untenable. Lack of privacy, high use of seclusion and restraint, inappropriate placements of service users, restrictive practices, compromised care and limited opportunity for recovery are indicators of a facility in crisis.

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[3] 'Sleepovers' is the term used by staff at the HRBC. Sleepovers involve service users having to move to other wards to sleep. Inspectors observed service users on sleepovers in wards for days at a time as a result of chronic over occupancy in the acute Wards.

[4] A reinforced item of clothing that is tear resistant. It does not reduce movement or limit the service user's/ tangata whaiora's ability to move freely. *The Use of Safety Garments within the Inpatient Mental Health and Addictions Service Henry Rongomau Bennett Centre Guideline 5788* (dated August 2017).

[5] 'Lock down' is a term used by staff at the HRBC where areas of the Ward that service users had access to were locked by staff, such as the courtyard and dining room.

The ongoing issue of over occupancy across the Wards, and the resulting impacts, is not only unsustainable, but unsafe for service users and staff, which I consider to be degrading treatment and a breach of Article 16 of the Convention against Torture.[6]

It is clear that while a long-term plan must be implemented to make service wide and sustainable changes, the Service needs to immediately introduce new ways of collaborating and planning to address the current pressures.

I will be assessing the Service's progress in implementing the recommendations in this report with another inspection at a future date.

I wish to express my appreciation to the Operations Manager and staff of the Wards for the full co-operation they extended to my Inspectors. I also acknowledge the work involved in collating the information they requested.

Peter Boshier

Chief Ombudsman
National Preventive Mechanism

[6] UN Convention against Torture, Article 16(1): "*Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.*"

The facility

Wards 34, 35 and 36

The Henry Rongomau Bennett Centre (HRBC) has three designated wards for service users requiring acute mental health inpatient care; Wards 34, 35 and 36 (the Wards). The Wards are funded and resourced for 53 beds.

The Wards accommodate men and women experiencing an episode of acute mental illness that requires assessment and treatment in a safe hospital environment. Service users are referred to the Wards by community teams and wards within the main hospital.[7]

The Wards are located in the grounds of Waiora Waikato Hospital Campus, Hamilton. It has three main accommodation areas for service users:

- Ward 34 – locked acute ward
- Ward 35 – locked acute ward
- Ward 36 – locked acute ward and low stimulus/seclusion area.

Operating capacity

Ward 34 – 22 beds

Ward 35 – 21 beds

Ward 36 – 13 beds (including three low stimulus beds and two seclusion rooms)

District Health Board

Waikato District Health Board

Region

Waikato, Lakes, Taranaki, Bay of Plenty

Last inspection

The facility was previously inspected on:

Unannounced inspection – April 2017

Unannounced inspection – March 2013

Announced informal visit – August 2009

[7] Waikato District Health Board website.

Occupation at time of inspection

On 16 September 2019, the first day of the inspection, there were 69 service users across the three Wards, comprising 42 men and 27 women. Three service users were on leave at the time of inspection. The Wards were at 130 percent capacity, with an additional 16 service users accommodated on the Wards.

Of the 69 service users in the Wards at the time of the inspection:

- 61 were detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992.
- 8 were voluntary service users.[8]

[8] 'Voluntary' means that the service user has agreed to have treatment and has the right to suspend that treatment. If the service user is being treated in hospital, they have the right to leave at any time.

The inspection

Between 16 and 20 September 2019, Inspectors — whom I have authorised to carry out visits to places of detention under COTA[9] on my behalf — made an unannounced five day follow up inspection of Wards 34, 35 and 36 (referred to in this report as 'the Wards').

The inspection team (the Team) comprised two Inspectors and two Specialist Advisors.[10]

Methodology

The Team inspected all areas of the Wards, assessing:

- Treatment of service users
- Protective measures taken
- Service users' material conditions
- Service users' activities and communications.

The Team looked for progress in implementing the recommendations I made in 2017 and identified any additional issues that need addressing.

During the inspection, the Team met with the Operations Manager and spoke with a number of staff, managers, and service users.[11]

The Operations Manager provided Inspectors the following information:

- Data on all current service users and the legislative reference under which they were being detained at the time of the inspection;
- Data on all service users from 1 March to 31 August 2019, including their gender, age, and ethnicity;
- Seclusion and restraint data from 1 March to 31 August 2019, and a copy of the Wards' seclusion and restraint policies;
- Data on the number of staff trained in Safe Practice Effective Communication (SPEC),[12] and reasons for any training being out-of-date;

9 See page 34 for more detail about my function as a National Preventive Mechanism (NPM) under the Crimes of Torture Act 1989 (COTA).

10 Inspectors have various expertise and backgrounds in mental health and disability, social work, aged care, and prison operation and management. Specialist Advisors have medical, cultural, disability and social expertise, and lived-in experience, or are people who have advocated on behalf of detainees.

11 See page 31 for a list of the people the Team spoke with during the inspection.

12 SPEC training was designed to support staff working within inpatient mental health wards to reduce the incidence of restraints. SPEC training has a strong emphasis on prevention and therapeutic communication skills and strategies, alongside the provision of training in safe, and pain free personal restraint techniques. https://www.tepou.co.nz/initiatives/towards-restraint-free-mental-health-practice/149

- All data relating to sentinel events[13] from 1 March to August 31 2019; and
- Staff data including gender, age, and ethnicity, sickness levels, and turnover from 1 March to 31 August 2019.

The Team also viewed a randomly selected sample of health records and additional documents, provided on request, during the inspection.

Feedback meeting

The Team met with representatives of the Wards' leadership team at the end of the inspection outlining initial observations and seeking any corrections or clarifications.

Consultation

A provisional report was forwarded to the DHB for comment as to fact, finding or omission prior to finalisation and distribution.

District Health Board response

The Waikato District Health Board (the DHB) provided a response to my provisional report on the Wards on 15 January 2020. I have carefully considered the comments made before finalising my report. Where the DHB has provided a specific response to my recommendations, this is recorded below each recommendation. Where necessary, I have responded with further comment.

The DHB's report responded to a number of common themes from my inspections of the Wards and three other wards in the DHB which were conducted at the same time[14], including over occupancy, high and increasing use of seclusion and restraint, and the normalisation of restrictive practices.

The DHB emphasised planned changes or changes that had been made between the inspection in September 2019 and the DHB's comments in January 2020. While I am pleased to hear that the DHB is taking steps to address a number of identified issues, my role as an NPM is to report on the conditions and treatment for people who are being detained, as they are at the time of the inspection. As such, while I acknowledge the further information provided by the DHB, my recommendations relate to the conditions and evidence my Inspectors found during the time of inspection.

I intend to conduct follow up inspections of all the wards, at which point I will be able to assess whether the actions highlighted by the DHB have been successful in addressing my concerns.

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[13] Sentinel events are unanticipated events in the healthcare setting, which have resulted in serious harm to service users.

[14] The wards inspected at the same time were Puna Poipoi, Puna Awhi-rua, and Puna Maatai.

Treatment of service users

Implementation of 2017 recommendations

Seclusion

In 2017 I recommended:

> Seclusion rooms have natural light.

I found that my recommendation was **achieved**:

- Both seclusion[15] rooms on Ward 36 had natural light.
- Inspectors were advised by staff that the seclusion room situated at the end of the Low Stimulus Area (LSA), which had no natural light, had been decommissioned in 2017, and is now being utilised as a quiet room for service user care.

In 2017 I recommended:

> Observation windows in the LSA and seclusion rooms have coverings for privacy.

I found that my recommendation was **not achieved**:

- There were still no coverings to provide privacy for service users in seclusion rooms. While external bedroom windows had mirrored covers to prevent observation from the courtyard, internal windows remained uncovered. Service users in seclusion rooms could be observed when sleeping, or in various stages of undress, through the internal windows.
- Observation windows in the LSA had external coverings for privacy, however these could easily be lifted by other service users.
- Staff had attempted to improve privacy for service users in seclusion by installing another bathroom in the LSA to prevent service users from passing seclusion rooms. The Service had also installed doors between the LSA and seclusion rooms to reduce the number of service users passing the seclusion rooms.
- However, Inspectors observed service users pacing the main corridor in the seclusion area while other service users were in seclusion. On one occasion, another service user was in the area while a room entry was conducted.[16]

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[15] Seclusion is defined as: '*Where a person is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit*'. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[16] An attempt should be made by a suitably qualified clinician at least once every two hours to enter the room to assess the physical wellbeing of the service user. Each entry to the seclusion room is an opportunity to assess the readiness of the service user to reintegrate back into the ward. *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*. Ministry of Health. 2010.

Ward occupancy levels

In 2017 I recommended:

> The issue of over occupancy in the Wards is addressed as a matter of urgency. Day rooms, offices and seclusion rooms should never be used as bedrooms.

I found that my recommendation was **not achieved**:

- Over occupancy remained a significant issue across the Wards. Throughout the inspection, Inspectors observed day rooms, offices, whānau rooms and seclusion rooms being inappropriately used as bedrooms.[17]
- My Inspectors observed a female service user asleep, on a mattress on the floor, in a consultation room at the main entrance to the Ward. The room had no natural light and was located beside the designated male corridor; the room lights were on, the door was unlocked, the door's observation panel had no covering and the service user was not being monitored by staff. I have significant concerns that service users accommodated in rooms, other than designated bedrooms, are being afforded little privacy and are more vulnerable than if they were accommodated in a purpose built bedroom. In this instance, I believe the service user was placed at risk of harm.
- At the time of inspection, the Wards were at 130 percent capacity (including service users on leave).[18] From 1 March to 31 August 2019, the Wards were at an average 114 percent capacity (132 percent capacity including leave). In the same period, Ward 34 had an average capacity of 162 percent (including service users on leave).[19]
- Inspectors observed service users from the Wards being placed on sleepovers in Forensic wards, the Older Persons Inpatient Unit and in general hospital beds due to over occupancy. Inspectors were told that sleepovers were taking place on a regular basis to meet the needs of the Service, not the service user. Service users said they found the sleepover an unsettling and frightening experience.
- Inspectors requested data on the movement of service users across the Service and general hospital for the purpose of sleepovers, however were advised this information was not recorded.
- High occupancy levels were clearly impacting staff's ability to manage acutely unwell service users while continuing to maintain a therapeutic environment. The effects of high occupancy levels appeared to be having a detrimental effect on the health of staff and service users, as well as reducing staffs' ability to provide optimal nursing care to service

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[17] See Appendix 4, Figures 1 to 4.

[18] Leave is a planned clinical intervention used to facilitate safe transition into the community. It allows for assessment of the service users / tangata whaiora's mental state and suitability to be in the community. *Leave Procedure 2184* (dated August 2017). Waikato DHB.

[19] Data provided by the Service.

users. Some staff expressed concerns that, due to ward pressures, they were required to assume additional responsibilities despite a lack of professional experience.

- Due to the high occupancy levels across the Wards, staff were working under pressure and were often unable to facilitate service users' access to courtyards, fresh air and leave, as well as access to personal property.
- It was reported to Inspectors by staff and service users that, due to high demand for acute beds, service users were also being discharged earlier than planned and subsequently readmitted to the Wards. From 1 March to 31 August 2019, there had been a total of 572 admissions to the Wards and a total 575 discharges. The constant pressure for beds and consequent early discharges further limited service users' opportunity for optimal treatment and rehabilitation.
- I consider the ongoing issue of over occupancy in the Wards amounts to degrading treatment and a breach of Article 16 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

In 2017 I recommended:

> A management and contingency plan should be developed to address the occupancy levels in the Wards.

I found that my recommendation was **achieved**:

- Inspectors received a copy of the DHB's *Contingency Plan for Over Occupancy for the Wards* (dated 4 September 2018), which outlined processes to manage the risks of over occupancy. Meetings were held twice daily with senior management to provide current and expected status updates on the Wards' occupancy levels.
- Inspectors also spoke to, and attended a meeting with, the Inpatient Coordination Team (ICT). The ICT was established in 2017 to alleviate occupancy pressures by supporting inpatient clinical teams to facilitate complex transfers of care[20] to community and residential services.
- The ICT comprised a Social Work lead, Occupational Therapist lead, Clinical Psychologist and Clinical Nurse Specialist, who liaised with community treatment teams, non-governmental organisations (NGOs), Disability Support Link (DSL) and residential service providers to coordinate inpatient referrals for supported accommodation.
- At the time of inspection, the ICT was collaborating with inpatient clinical and community teams to transition and relocate seven service users from the Service. The ICT met on a

[20] 'Clients referred to the ICT will present with a number of bio-psycho-social-occupational and cultural complexities that cause barriers to their transition and reintegration from the ward back into the community. These barriers may include factors such as: no identified funding stream available, exited from residential providers due to their behaviour, have a number of medical comorbidities, exhibiting a high risk for residential providers such as excessive illicit drug and alcohol use, and/or having personality traits and/or disorders that interfere with treatment'. *Inpatient Coordination Team Operating Manual.* Waikato District Health Board.

weekly basis. Inspectors observed the meeting they attended was comprehensive, well attended and well run.

- While I note that some work is being done to address the occupancy levels in the Wards, I remain concerned that over occupancy and the associated risks for service users and staff were still evident across all Wards at the time of the inspection.

Restraint

In 2017 I recommended:

> Staff have a greater understanding, and are able to document more accurately when mechanical and physical restraint is undertaken. There should be a robust audit process in place to ensure compliance.

I found that my recommendation was **not achieved**:

- As I found in 2017, the reporting system for restraint incidents, including mechanical or physical restraint, was inaccurate.
- Similar to my previous report, reasons for the errors included lack of understanding of terminology and the combination of paper-based and electronic reporting systems.
- Inspectors reviewed the files of service users who had been restrained and noted there was still confusion amongst staff on the terminology 'personal restraint'[21] and 'physical restraint'.[22] These terms were used interchangeably by staff when reporting restraint incidents.
- The Service's Restraint Committee carried out quarterly audits and changes had been made to the Restraint Event Notification (REN) form[23] to improve restraint documentation, however, compliance had not improved.

Findings of 2019 inspection

In addition, I identified the following issues in my 2019 inspection:

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[21] Personal restraint is when a service provider(s) uses their own body to limit a service user's normal freedom of movement. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[22] Physical restraint is when a service provider(s) uses equipment, devices or furniture that limits the service user's normal freedom of movement. New Zealand Standards. *Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.* Ministry of Health. 2008.

[23] Restraint Event Notification Form, T1738HWF.

Seclusion

Use of seclusion

- The use of seclusion had increased significantly since my last inspection in 2017. From 1 March to 31 August 2019, there were 124 seclusion events in Ward 36 involving 80 service users, and an average of 40 hours per seclusion event. There was an average of 5.2 seclusion events per week, which is an increase of two events per week from my 2017 report. The longest seclusion event lasted for 13.9 days. The Seclusion Elimination Steering Group had identified that overcrowding, competing priorities, the restrictive environment, as well as a lack of resources and service wide support were some of the main contributors to the increasingly high use of seclusion.[24]
- I find the increase in the use of seclusion since 2017 concerning. I am also concerned that the data provided by the Service indicated that approximately two-thirds[25] of service users secluded were Māori.
- I acknowledge that work is underway to reduce the use of seclusion across the Service and information provided shows that a Seclusion Elimination Steering Group has been established and meets regularly. However, the progress of this work is slow and the data indicated that the work is yet to have an impact on the rate of seclusion in the Wards.

Care of service user during seclusion

- During the inspection, my Inspectors observed one service user, upon first presentation to the Service, being held in seclusion wearing a safety gown and with all bedding, including pillows, removed from the room. Staff advised it was due to the service user being at risk of self-harm. However, Inspectors did not observe the service user being nursed on continuous observations despite the stated risk.
- The DHB's *Seclusion Procedure*[26] states that *'there will be a delegated staff member outside the seclusion room for the purpose of engagement and attending to the service users' needs for the duration of the event.'* Inspectors did not observe staff maintaining continuous obervations of service users held in seclusion.
- The *Seclusion Procedure* also states that seclusion '*should only be utilised to prevent imminent violent behaviour compromising safety'* and that '*an assessment of risk must be made relating to items of clothing the person may be wearing at the time of seclusion. Any removal of items must be clearly validated based on a clinical risk assessment… and documented in the clinical file.'* My Inspectors' review of the accompanying documentation did not show a thorough risk assessment had been undertaken before or during the use of the safety gown and removal of bedding.

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24 *Advisory Service; Representation and Co-Design*. Waikato District Health Board.

25 Approximately 66 percent. The remaining 34 percent of services users secluded were non-Māori males (20 percent) and non-Māori females (14 percent).

26 *Seclusion Procedure 1860* (dated 28 August 2017).

- Inspectors were also unable to find any documentation that the use of the safety gown was '*only as a last resort after other interventions were tried and deemed unsuccessful'* or any justification for the removal of all bedding, including pillows, for the service user in seclusion.
- I am concerned that the use of safety gowns and removal of bedding in seclusion does not adhere to the *Seclusion Procedure* and that service users in seclusion are not being nursed on continuous observations.[27]

Restraint

- Inspectors were provided with a copy of the DHB's *Restraint Policy*[28] and *Restraint – Wrist and/or Ankle Procedure,*[29] both of which were out-of-date. They were due for review on 1 July 2019.
- My Inspectors identified several discrepancies in the restraint data provided by the Service. The Service reported 'ongoing issues' with the recording of restraint on the REN form, which it said was resulting in inaccurate data capture. Consequently, I do not have confidence in the data that has been provided.
- The Service also confirmed that they do not record information on the ethnicity of service users who have been restrained. Understanding how restraint is applied to different populations is important to understanding whether it is used equitably. The need to collect this information in relation to Māori arises from the principles of te Tiriti o Waitangi.[30]
- The use of restraint had also increased significantly since my inspection in 2017. Data supplied by the Service showed that for the period 1 March to 31 August 2019 there were 262 restraint events involving 125 service users. Of the 262 restraint events, 24 were mechanical or physical restraints.
- Restraint is a serious intervention that requires clinical rationale and oversight. It is not a treatment in itself but is one of a number of strategies used to limit or eliminate clinical risk.[31] I find the high number of reported restraint events in the Wards concerning and possibly symptomatic of Wards that are over occupancy and therefore under pressure.

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[27] The Use of Safety Garments within the Inpatient Mental Health and Addictions Service Henry Rongomau Bennett Centre Guideline (5788) states: '*the safety garment should be used in conjunction with an increase in the level of observations (high risk to extreme high risk, as applicable)'.*

[28] *Restraint Policy 2162* (dated 1 March 2017).

[29] *Restraint – Wrist and/or Ankle Procedure 2158* (dated 20 November 2017).

[30] Specifically the principles of equity and active protection, which include a requirement to be fully informed of how Māori are treated. See, for example, Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wellington, Legislation Direct, 2019) p 138.

[31] Waikato District Health Board Restraint Policy.

Recommendations

As a result of my 2019 follow up inspection, I recommend the following actions be taken to improve the treatment of service users:

Treatment of service users

1. Observation windows in the LSA and seclusion rooms have coverings for privacy. **This is a repeat recommendation.**
2. The issue of over occupancy in the Wards is addressed as a matter of urgency. Day rooms, offices and seclusion rooms should never be used as bedrooms. **This is a repeat recommendation.**
3. Staff have a greater understanding, and are able to document more accurately when mechanical and physical restraint is undertaken. There should be a robust audit process in place to ensure compliance. **This is a repeat recommendation.**
4. The Service develop a plan to reduce the number of sleepovers.
5. The Service collect data on the movement of service users (sleepovers) across the service.
6. The high and increasing use of seclusion is addressed, with a particular focus on equitable treatment of Māori.
7. The use of safety gowns and removal of bedding adheres to the DHB's *Seclusion Procedure* and documentation surrounding the rationale for their use is robust.
8. The DHB's *Restraint Policy* and the *Restraint – Wrist and/ or Ankle Procedure* be reviewed, and updated.
9. The Service take all necessary steps to enable comprehensive and accurate collection and reporting of restraint data, including by service users' ethnicity.
10. The high and increasing number of restraint events is addressed.

Facility comments

The DHB accepted recommendations 1, 3, 8, 9 and 10.

The DHB partially accepted recommendations 2, 4, 6 and 7.

The DHB rejected recommendation 5.

Recommendation 2 response:

The DHB did not provide a specific response to recommendation 2. However, the DHB's overall response to this report and the inspections of a further three wards[32] contained information

[32] Puna Maatai, Puna Awhi-rua and Puna Poipoi.

concerning the theme of over occupancy in all reports. The DHB commented in its general response that the inspection team may not have been provided full detail of the work underway to address the issues of high occupancy. It stated that an Acute Sustainability Response Plan was implemented in June 2019 to address the significant pressures on inpatient services, and that associated risks had been noted as diminishing.

The DHB also commented in its general response that data relating to occupancy levels was showing a downward trend.

Given the significance of this thematic issue, I also provide an overall response regarding my recommendations on over occupancy.

Ombudsman response:

I acknowledge that work is currently underway to address the issue of over occupancy on the Wards and I support the Service's development of the Acute Sustainability Response Plan.

However, as a repeat recommendation, I remain concerned that over occupancy on the Wards has not been addressed as a matter of priority. I reiterate that recommendations relate to the conditions and evidence my Inspectors found during the time of inspection. The inspection teams' findings, based on Inspectors' observations and information provided by the Service, were that high occupancy levels were an ongoing issue at the time of inspection.

I emphasise my expectation that rooms such as day rooms, offices or seclusion rooms should never be used as bedrooms. The degrading nature of this treatment is a key part of my finding that there has been a breach of Article 16 of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Recommendation 4 response:

The DHB made general comments relevant to recommendation 4, stating that sleepovers are the last resort option to manage extreme high occupancy, and that occupancy levels will be appropriate once the Acute Sustainability Response is in place.

Ombudsman response:

I am pleased that these matters are to be addressed. However, until such time as the sleepovers and high occupancy levels are addressed, my concerns will remain.

Recommendation 5 response:

The DHB commented in its general response that the inspection team appears to have believed that movement of service users was not recorded or reported. It stated that all patient movements are tracked via the electronic patient management system, clinical records, thrice daily shift reports, fire boards and a daily night report.

Ombudsman response:

The inspection team's understanding that no records of sleepovers were kept was not merely an impression formed. Senior managers in the ward expressly advised my Inspectors that no

records of sleepovers are kept, in response to a request for those records. It appears that current data capture processes are not enabling staff to have a full picture of sleepovers.

Recommendation 6 response:

> *All programmes of work within the organisation / service will have a particular focus on equitable treatment of Māori.*

Ombudsman response:

I am pleased to hear of the Service's commitment to the equitable treatment of Māori. I also acknowledge that work is already underway to reduce the use of seclusion across the Service. I remain concerned, however, that this work does not appear to have had a material impact on the levels of seclusion in the Ward. Further, no additional information about measures to reduce seclusion, particularly for Māori, has been provided. I encourage the Ward and Service to act on this issue as a matter of priority.

Recommendation 7 response:

> *An audit to adherence of seclusion room processes will be undertaken prior to the updating of the service seclusion procedure due for review by the 28 August 2020.*

Ombudsman response:

I am pleased to hear that the Service will undertake an audit of seclusion room processes prior to updating the seclusion procedure. I remain concerned that the use of safety garments in seclusion and the removal of bedding did not adhere to the DHB's seclusion procedure. The associated documentation was inadequate, which is also concerning when considering the impact on service users' dignity and comfort.

Protective measures

Implementation of 2017 recommendations

In 2017 I recommended:

> Information and contact details for the District Inspectors should be available in all Wards.

I found that my recommendation was **not achieved**:

- Contact details for the District Inspectors (DI) were not displayed in the Wards.
- While staff advised that DIs regularly visited the Wards, service users my Inspectors spoke with did not have an understanding of the DIs' role or know how to contact them directly – only through the Ward's staff.

- Although it appeared staff were proactive in engaging the DI on behalf of service users, I am concerned that service users and their whānau do not have the information and means to be able to contact the DI directly.

Recommendations

As a result of my 2019 follow up inspection, I recommend the following actions be taken to improve the Ward's protective measures:

Protective measures

11. Information and contact details for the District Inspectors should be available in all Wards. **This is a repeat recommendation.**

Facility comments

The DHB rejected recommendation 11.

Recommendation 11 response:

Providing the contact details of district inspectors on the wards would result in the following:

- *It would not be clear as to which District Inspector is on duty*
- *The District Inspectors would receive calls about matters that are unrelated to the role of the District Inspector*

The District Inspectors are always accessible by staff and will speak to service users put through by a staff member at any time.

Ombudsman response:

I acknowledge the DHB's comments. However, I do not consider the reasons provided justify the restriction on access to District Inspectors' contact information. Service users should be able to contact District Inspectors at any time, independent of staff. There should be practical ways of mitigating the issues raised whilst also improving accessibility and visibility of the District Inspectors' contact information. My Inspectors have observed several facilities where this information is displayed prominently without this proving to be problematic.

Service users' material conditions

Implementation of 2017 recommendations

In 2017 I recommended:

> The DHB should develop a 'locked door policy' which should include the process to exit/enter locked Wards. This process should be visible throughout the Service.

I found that my recommendation was **not achieved**:

- Information on how to enter/ exit locked Wards was not visible to service users and visitors.
- Inspectors were provided with a copy of the DHB's *Locked Door Procedure*[33] for entry and exit of the Wards, which had a review date of November 2019.
- The Procedure states that *'an information sheet*[34] *is provided to informal service users/ tangata whaiora that identifies the process for enabling ease of access and entry to the Ward.'* However, informal service users commented that they did not receive an information sheet on admission or have a clear understanding of how to enter and exit the Wards.
- Inspectors reviewed a draft version of a new inpatient admission booklet for service users. No information was provided for informal service users on the process of entering and exiting the locked Wards.

In 2017 I recommended:

> Privacy in shared bedrooms should be enhanced as a matter of urgency.

I found that my recommendation was **not achieved**:

- Service users were residing in shared bedrooms in the Wards.
- Inspectors observed one shared bedroom that had been separated with curtains and one whānau room that had been converted into a shared bedroom with no privacy screening for service users.
- Attempts had been made to enhance privacy in some shared bedrooms by installing a partial wall. However, the walls only covered approximately three-quarters of the room's height and so did not provide adequate privacy to service users.[35]

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[33] *Inpatient Acute Adult Mental Health wards process for entry and exit of wards 3155* (dated 10 May 2019).

[34] 'Information Sheet: Entry and exit of wards by informal service users' (G3793MHF).

[35] See Appendix 4, Figure 2.

- Service users commented that they did not feel safe in the partially separated shared bedrooms as other service users could easily climb over the wall or throw items over the wall and into the other bedroom.

In 2017 I recommended:

> Renovation of the bathroom facilities should occur regardless of any planned rebuild.

I found that my recommendation was **not achieved**:

- Inspectors were informed by senior management that bathrooms on the Wards had been renovated in 2018, however, due to lack of ventilation, they were once again in a poor state of repair.[36]
- Bathrooms were damp, mouldy and paint and wall linings were deteriorating. Poor ventilation, both within the bathroom facilities and the Wards, resulted in the Wards becoming musty and humid.

Recommendations

As a result of my 2019 follow up inspection, I recommend the following actions be taken to improve service users' material conditions:

Service users' material conditions

12. The DHB should develop a 'locked door policy' which should include the process to exit/enter locked Wards. This process should be visible throughout the Service. **This is a repeat recommendation.**
13. Privacy in shared bedrooms should be enhanced as a matter of urgency. **This is a repeat recommendation.**
14. Renovation of the bathroom facilities should occur regardless of any planned rebuild. **This is a repeat recommendation.**

Facility comments

The DHB accepted recommendation 14.

The DHB partially accepted recommendation 12.

The DHB rejected recommendation 13.

Recommendation 13 response:

[36] See Appendix 4, Figures 5 and 6.

> *There are no other safe options to make changes to the facility currently. The service is in the process of planning a rebuild.*

Ombudsman response:

While I acknowledge the DHB's comments, I find it unacceptable that the Service is unable to find safe options to allow privacy for service users in shared bedrooms. As identified in my report, service users in shared bedrooms are increasingly vulnerable and at risk of harm.

I am further concerned that this is a repeat recommendation from my 2017 report, which was previously said to have been accepted by the Service.

Service users' activities and communications

Implementation of 2017 recommendations

In 2017 I recommended:

> A daily record of service users' access to fresh air should be maintained in all Wards.

I found that my recommendation was **not achieved**:

- Inspectors reviewed documentation which showed that daily records were not regularly made on service users' access to fresh air across all Wards. Inspectors did not see any records on service users' access to fresh air in Ward 36 or the LSA.
- Staff also advised Inspectors that none of the Wards maintained a daily record of service users' access to fresh air.

In 2017 I recommended:

> A structured programme of appropriate activities should be made available to service users in Ward 36 and the LSA.

I found that my recommendation was **achieved**:

- Inspectors were pleased to observe daily structured activities occurring on Ward 36 and the LSA with a full-time equivalent (FTE) Activities Coordinator. Activities included daily whakamoemiti,[37] cooking groups, yoga, gardening, arts and crafts, board games, movie sessions and outdoor sports.
- At the time of inspection, the Activities Coordinator was only employed weekdays during business hours. I would like to see this position expanded to include evenings and weekends.

[37] 'Whakamoemiti' is the Wards' morning meeting. Whakamoemiti means to give praise or express thanks. Definitions and applied examples are available on Māori Dictionary.

In 2017 I recommended:

> The process to access a telephone for service users in Ward 36 and the LSA should be displayed.

I found that my recommendation was **not achieved**:

- Service users in Ward 36 and the LSA did not have free access to a telephone – they had to request a telephone from staff. Usage was approved on a case-by-case basis.
- While staff were proactive in facilitating phone calls for service users in Ward 36 and the LSA, the process to access a telephone was not displayed.
- The majority of service users my Inspectors spoke with had a good understanding of how to access a telephone in Ward 36 and the LSA.
- However, one service user who had recently been admitted to Ward 36 told Inspectors that they had not received any information on how to access a telephone.

Findings of 2019 inspection

In addition, I identified the following issues in my 2019 inspection:

- Restrictive practices were evident on the Wards, particularly in Ward 36 and the LSA; such as 'locking down' the Ward if a service user was suspected of being in possession of a lighter, which is a prohibited item. Inspectors were told by staff that this included limiting courtyard access and locking the dining room until the lighter was located. I am concerned that this blanket approach to managing prohibited items is punitive and negatively impacts all service users.
- Access to the courtyard was limited on the Wards. In my 2017 report, the Service had employed a security guard to supervise courtyard access on weekdays from 9am to 5pm, to prevent service users from climbing over the fence. Senior management informed Inspectors that security guards were no longer employed in the Service and service users had to be accompanied by staff at all times to access fresh air.
- The courtyard doors were locked for the majority of the inspection. The DHB's *Courtyards Procedure* states that *'clinicians will support service users to have reasonable access to fresh air on a daily basis'*. However, my Inspectors rarely observed service users accessing fresh air and spending time in the outdoor areas of the Wards during the day.
- Service users in Ward 36 and the LSA were further restricted from accessing the courtyard when court hearings were in process, which is located beside the courtyard and occurs twice per week.[38]

[38] *Courtyards Procedure 0516* (dated 22 February 2019).

- Staff and service users expressed frustration at the lack of access to fresh air, which was creating tension in the Wards as staff were often unavailable to escort service users outside.
- I am concerned that the practice of locking courtyard doors and restricting access to fresh air is negatively impacting service users across the Wards.

Recommendations

As a result of my 2019 follow up inspection, I recommend the following actions be taken to improve service users' access to activities and communications:

Service users' activities and communications

15. A daily record of service users' access to fresh air should be maintained in all Wards. **This is a repeat recommendation.**
16. The process to access a telephone for service users in Ward 36 and the LSA should be displayed. **This is a repeat recommendation.**
17. 'Lock downs' are not routinely implemented when service users are suspected of having prohibited items.
18. The activities programme for service users in Ward 36 and the LSA is extended to evenings and weekends.
19. All service users have unrestricted access to the Wards' outdoor areas, during the day, unless deemed inappropriate for clinical or safety reasons.

Facility comments

The DHB accepted recommendation 16 and 18.

The DHB rejected recommendation 15, 17 and 19.

Recommendation 15 response:

> *Service users will have access to the courtyards, and approved leave as per the leave programme in order to access fresh air.*

Ombudsman response:

I am pleased to hear that service users will have access to the courtyards. However, at the time of inspection, my Inspectors did not observe service users accessing fresh air and were unable to locate records of service users' access to fresh air.

This is a repeat recommendation from my 2017 report, which was previously accepted by the Service.

Recommendation 17 response:

> *Implementation of 'punishment' for service users suspected of having prohibited items is not an accepted part of the mental health and addictions services practice expectations*

More generally the DHB stated:

> *'it appears from the draft report this practice is considered to occur as a punitive measure in response to prohibited items making their way onto ward areas. This is certainly not acceptable and if accurate must stop immediately …*
>
> *A particular area may be closed off to service users if it is indicated that prohibited or harmful items may be present or concealed in the area. Where that occurs the area is thoroughly searched and then re-opened. This can occur in outdoor or indoor areas. Access to any area where prohibited items may be found presents a risk to staff and patients and is therefore restricted until such time as the area is considered safe'.*

Ombudsman response:

I am pleased that the DHB has acknowledged that using lock down as a punishment is not acceptable.

I acknowledge the safety issues that prohibited items create. However lock downs create tension and consequently also compromise safety. I therefore encourage the Wards and the Service to consider options that allow more flexibility for service users while maintaining robust safety controls.

Recommendation 19 response:

> *The mental health and addictions service will work on consistent opening times of the courtyards throughout day time hours.*

More generally the DHB also noted that since the inspection visit, additional outdoor space has been made available for Ward 34.

Ombudsman response:

I am pleased to see that renovations for the courtyard on Ward 34 have been completed and that the Service intends to facilitate regular access for service users to outdoor spaces.

However, I consider that service users should have *unrestricted* access to the Wards' outdoor areas, during the day, unless deemed inappropriate for clinical or safety reasons.

Appendix 1. Implementation of 2017 recommendations

Listed below are all the recommendations I made in 2017, the Ward's response at that time to my recommendations, and my 2019 findings regarding the implementation of those recommendations:

2017 recommendation	2017 response[39]	2019 finding[40]
1. Seclusion rooms have natural light.	Accepted	Achieved
2. Observation windows in the LSA and seclusion rooms have coverings for privacy.	Rejected	Not achieved
3. The issue of over occupancy in the Wards is addressed as a matter of urgency. Day rooms, offices and seclusion rooms should never be used as bedrooms.	Rejected	Not achieved
4. A management and contingency plan should be developed to address the occupancy levels in the Wards.	Accepted	Achieved
5. Staff have a greater understanding, and are able to document more accurately when mechanical and physical restraint is undertaken. There should be a robust audit process in place to ensure compliance.	Accepted	Not achieved
6. Information and contact details for the District Inspectors should be available in all Wards.	Accepted	Not achieved
7. The Service should develop a 'locked door policy' which should include the process to exit/enter locked Wards. This process should be visible throughout the Service.	Rejected	Not achieved
8. Privacy in shared bedrooms should be enhanced as a matter of urgency.	Accepted	Not achieved
9. Renovation of the bathroom facilities should occur regardless of any planned rebuild.	Accepted	Not achieved
10. A daily record of service users' access to fresh air should be maintained in all Wards.	Accepted	Not achieved

[39] Accepted, Partially accepted, Rejected

[40] Achieved, Partially achieved, Not achieved

2017 recommendation	2017 response[39]	2019 finding[40]
11. A structured programme of appropriate activities should be made available to service users in Ward 36 and the LSA.	Accepted	Achieved
12. The process to access a telephone for service users in Ward 36 and the LSA should be displayed.	Accepted	Not achieved

Appendix 2. Recommendations

Listed below are all my recommendations following the 2019 inspection of Wards 34, 35 and 36, Henry Rongomau Bennett Centre:

Recommendation	Repeat	Ward response
1. Observation windows in the LSA and seclusion rooms have coverings for privacy.	Repeat	Accept
2. The issue of over occupancy in the Wards is addressed as a matter of urgency. Day rooms, offices and seclusion rooms should never be used as bedrooms.	Repeat	Partial
3. Staff have a greater understanding, and are able to document more accurately when mechanical and physical restraint is undertaken. There should be a robust audit process in place to ensure compliance.	Repeat	Accept
4. The Service develop a plan to reduce the number of sleepovers.		Partial
5. The Service collect data on the movement (sleepovers) of service users across the service.		Reject
6. The high and increasing use of seclusion is addressed, with a particular focus on equitable treatment of Māori.		Partial
7. The use of safety gowns and removal of bedding adheres to the DHB's *Seclusion Procedure* and documentation surrounding the rationale for their use is robust.		Partial
8. The DHB's *Restraint Policy* and the *Restraint – Wrist and/ or Ankle Procedure* be reviewed, and updated.		Accept
9. The Service take all necessary steps to enable comprehensive and accurate collection and reporting of restraint data, including by service users' ethnicity.		Accept
10. The high and increasing use of restraint is addressed.		Accept
11. Information and contact details for the District Inspectors should be available in all Wards.	Repeat	Reject

Recommendation	Repeat	Ward response
12. The DHB should develop a 'locked door policy' which should include the process to exit/enter locked Wards. This process should be visible throughout the Service.	Repeat	Partial
13. Privacy in shared bedrooms should be enhanced as a matter of urgency.	Repeat	Reject
14. Renovation of the bathroom facilities should occur regardless of any planned rebuild.	Repeat	Accept
15. A daily record of service users' access to fresh air should be maintained in all Wards.	Repeat	Reject
16. The process to access a telephone for service users in Ward 36 and the LSA should be displayed.	Repeat	Accept
17. 'Lock downs' are not routinely implemented when service users are suspected of having prohibited items.		Reject
18. The activities programme for service users in Ward 36 and the LSA is extended to evenings and weekends.		Accept
19. All service users have unrestricted access to the Wards' outdoor areas, during the day, unless deemed inappropriate for clinical or safety reasons.		Reject

Appendix 3. List of people who spoke with Inspectors

Table 1: List of people who spoke with Inspectors

Managers	Ward staff	Others
Operations Manager	Clinical Nurse Specialist	Service users
Charge Nurse Managers	Registered Nurses	District Inspector
Associate Charge Nurse Managers	Consultant Psychiatrist	Kaitakawaenga[41]
	Clinical Psychologist	Family Facilitator
	Psychiatric Assistants	Recovery Advisor Quality

41 Kaitakawaenga provide cultural support to tangata whaiora (service users) and their whānau and work as part of multi-disciplinary teams to identify and address ways to improve service delivery to Māori. More information on the role of Kaitakawaenga is available on the Waikato DHB website.

Appendix 4. Photos

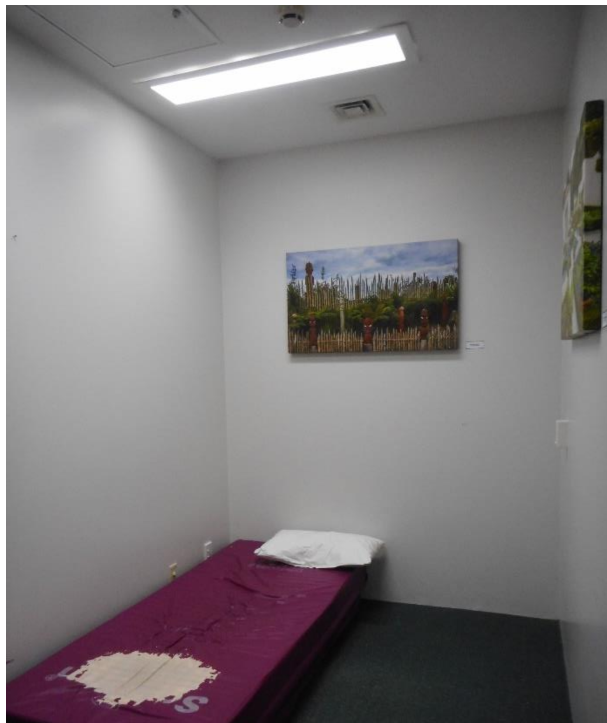

Figure 1: Interview room being used as a bedroom.

Figure 2: Shared bedroom with partial wall for separation.

Figure 3: Whānau room being used as a shared bedroom.

Figure 4: Group room being used as a bedroom.

Figure 5: Ward shower

Figure 6: Ward toilet

Appendix 5. Legislative framework

In 2007 the New Zealand Government ratified the United Nations Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The objective of OPCAT is to establish a system of regular visits undertaken by an independent national body to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.

The Crimes of Torture Act 1989 (COTA) was amended by the Crimes of Torture Amendment Act 2006 to enable New Zealand to meet its international obligations under OPCAT.

Places of detention – health and disability facilities

Section 16 of COTA defines a "place of detention" as:

> *"…any place in New Zealand where persons are or may be deprived of liberty, including, for example, detention or custody in…*
>
> *(d) a hospital*
>
> *(e) a secure facility as defined in section 9(2) of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003…"*

Pursuant to section 26 of COTA, an Ombudsman holding office under the Ombudsmen Act 1975 (Ombudsmen Act) was designated a National Preventive Mechanism (NPM) for certain places of detention, including hospitals and the secure facilities identified above.

The *New Zealand Gazette* of 6 June 2018 sets out in further detail the relevant places of detention:

> *"…in health and disability places of detention including within privately run aged care facilities; …"*

Carrying out the NPM's functions

Under section 27 of COTA, an NPM's functions, in respect of places of detention, include:

- to examine the conditions of detention applying to detainees and the treatment of detainees; and
  - to make any recommendations it considers appropriate to the person in charge of a place of detention:
  - for improving the conditions of detention applying to detainees;
  - for improving the treatment of detainees; and
  - for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention.

Under sections 28 – 30 of COTA, NPMs are entitled to:

- access all information regarding the number of detainees, the treatment of detainees and the conditions of detention;
- unrestricted access to any place of detention for which they are designated, and unrestricted access to any person in that place;
- interview any person, without witnesses, either personally or through an interpreter; and
- choose the designated places they want to visit and the people they want to interview.

Section 34 of the COTA, confers the same powers on NPMs that NPMs have under any other legislation when carrying out their function as an NPM. These powers include those given by the Ombudsmen Act to:

- require the production of any information, documents, papers or things that, in the Ombudsmen’s opinion, relates to the matter that is being investigated, even where there may be a statutory obligation of secrecy or non-disclosure (refer sections 19(1), 19(3) and 19(4) of the Ombudsmen Act); and
- at any time enter and inspect any premises occupied by any departments or organisation listed in Schedule 1 of the Ombudsmen Act (refer section 27(1) of the Ombudsmen Act).

To facilitate the exercise of the NPM function, the Chief Ombudsman has authorised inspectors to exercise the powers given to him as an NPM under COTA, which includes those powers in the Ombudsmen Act for the purpose of carrying out the NPM function.

More information

Find out more about the Chief Ombudsman’s NPM function, inspection powers, and read his reports online: ombudsman.parliament.nz/opcat.