Seclusion of a young woman
17HDC00410, 27 June 2019

District health board ~ Mental health ~ Seclusion ~Dignity ~ Right 3

A young woman was transferred from the psychiatric unit of a public hospital to a clinic that offers services for mental illness and addictions (the clinic). She was under a compulsory in-patient treatment order. Over the previous year, the woman had presented with a significantly depressed and anxious mood associated with repeated self-harm behaviours, suicidal thoughts, and suicide attempts.

Two months later, the woman left the clinic premises. She was found by the police and taken to a psychiatric hospital, where she was assessed by a psychiatrist. No bed was available on the locked unit, so she was transferred to the secure unit under police restraint, as she continued to struggle.

When the woman arrived at the secure unit, her clothing was removed and she was not given a tear-resistant gown to wear. The woman was placed in a seclusion room. Overnight, the lights remained on, and she was left with only a tear-resistant blanket and a cardboard bedpan. She was not provided with a mattress or a pillow.

A "seclusion recording form" details that two-hourly assessments and ten-minute observations occurred. At 4.30am, two nurses recorded an eight-hourly assessment. The room was entered at 8am to provide food and fluids and to assess the woman, and again at 9.35am to provide fluids. At 11.05am, the room was entered again, and the woman was provided with a gown. A mattress was placed in the room, and she was told that staff were working towards moving her to the locked unit.

At 1pm, the room was entered to allow staff to assess the woman's mood and mental state. At 1.10pm, the seclusion was suspended, and at 2pm it was terminated and she was returned to the clinic.

Findings

A number of district health board (DHB) staff failed to comply with the DHB's seclusion guideline and the Ministry of Health's guidelines, and with the accepted standard of care for nursing staff. DHBs are responsible for ensuring that staff comply with its policies and provide care of an acceptable standard, and it was found that the DHB failed in this regard.

Although it was considered that the denial of clothing and bedding was not intended to be a punitive action or to humiliate, nevertheless the Mental Health Commissioner regarded the actions as unacceptable and unkind.

The Mental Health Commissioner considered that manner of seclusion, over a period of approximately 18 hours, including removing the woman's clothes, not providing her with a mattress, pillow or gown, and not dimming the lights overnight, was disrespectful of the woman's dignity and independence. Accordingly, he found that the DHB breached Right 3.

Recommendations

The DHB agreed to provide a written apology to the woman, and to undertake the following steps, with input from a consumer advisor:

a) Provide training to mental health staff on restraint, seclusion, and the Code of Rights.

b) Review its restraint minimisation and seclusion guidelines to ensure that they provide sufficient guidance on seclusion practices in line with the current Ministry of Health guidelines and any guidance from the Health Quality & Safety Commission.
c) Review the seclusion policy to provide specific guidance on the provisions that must be given to consumers when they are placed in seclusion, including clothing and bedding.