HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Māori child with autism incorrectly given compulsory mental health treatment at Waikato Hospital

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Tuia te rangi e tuu
Tuia te papa e takoto
Tuia raa taatou kei te whei ao kei te ao maarama
Tihei mauri ora!

Heoi anoo ki a koe e koohine, koe kua noho mataamua ki roto i ngaa kaupapa koorero e whai ake nei.
Koia teenei te tuku ko ngaa tauwhiro manaakitanga ki runga ki a koe huri noa too whaanau,
Rire, rire hau! Paimaarire.

Foreword

1. The Code of Health and Disability Services Consumers' Rights (the Code) gives rights to all consumers and places obligations on people and organisations providing services. This case is important as it focuses on the incorrect treatment of an extremely vulnerable disabled child and whether the providers' actions were reasonable in the circumstances.

2. Serious mistakes were made, and this investigation has highlighted that the child's rights were severely compromised when she engaged with the health system. She did not receive the quality of care she was entitled to, and services were not provided with reasonable care and skill or in a manner that recognised her specific disability needs. In addition, her right to dignity was not upheld. It is reasonable to assume that this would not have happened had she not had a disability and been nonverbal in this circumstance.

3. Extenuating factors have some bearing on the events that transpired for this child, but equally it is extremely important that changes are made to prevent episodes like this from occurring in the future. I note that the expert who advised on this case commented that discussions with his peers indicated that other services would also be vulnerable to a similar error. This calls for Health New Zealand | Te Whatu Ora (Health NZ) to take leadership and ensure all districts have appropriate systems and processes in place for supporting disabled people and other at-risk consumers who engage with the health system.

Executive summary

4. Miss A (an 11-year-old Māori girl with autism) was taken to Waikato Hospital by the police; she was uncommunicative and incorrectly identified as another patient who was known to mental health services. Miss A was treated as though she were the other patient and admitted to the mental health inpatient unit. She was restrained twice so that intramuscular (IM) psychotropic medications intended for an adult could be administered.

Name have been removed (except the names of Health New Zealand | Te Whatu Ora Waikato, Waikato Hospital and the expert advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. I have found that Health NZ breached Right 4(1) of the Code for failing to provide services to Miss A with reasonable care and skill.

6. I have also found that Health NZ breached Right 4(3) of the Code for failing to provide services to Miss A that took account of her needs and breached Right 3 for failing to provide services to Miss A in a manner that respected her dignity.

Recommendations

7. I support and endorse the recommendations made by Health NZ – Waikato in its Rapid Incident Review (included in **Appendix A**).

8. In addition, I recommend that:

   a. Health NZ – Waikato apologise to Miss A and her whānau for the breaches of the Code identified, within three weeks of this decision.

   b. Given the common co-occurrence of mental health and neurodivergent conditions, Health NZ – National consider opportunities for staff to develop their understanding and use of augmentative and alternative communication tools in emergency departments (EDs) and mental health settings.

   c. Health NZ – Waikato's clinical governance group audit a series of use of restraint/IM medication events when the indication for use of restraint has been 'refusal of oral medications.' This audit should be done to allow the clinical governance group to form a view about whether restraint use in these circumstances is generally appropriate in their services or whether it is used too assertively, or prematurely. Learning points from this audit should be shared with the Health and Disability Commissioner (HDC).

   d. Health NZ – Waikato provide education in its orientation package for psychiatric staff on admission criteria and procedures for admission to psychiatric intensive care units.

   e. Health NZ – Waikato provide an update to HDC on the two recommendations remaining in progress from the Rapid Incident Review.

   f. Feedback on recommendations b–e should be provided to HDC within three months of this decision.

Whānau feedback

9. Miss A's whānau provided feedback ahead of this decision being finalised. They expressed relief that HDC had found that something serious went wrong and that the investigation has assisted them to learn the true nature of the events and the experience for Miss A. They described feeling anger that the Police and Health NZ did not provide simple answers to their questions after the event, which made it difficult to address what happened and move forward.

10. Miss A’s whānau provided statements to assist HDC to understand their perspective on the seriousness of the events, the ongoing impacts on Miss A and the whānau, the detrimental impact on the mana of Miss A and the whānau, and the loss of trust and feeling of safety. The whānau believe the incident and the response of agencies in the aftermath failed to put Miss A at the centre.

11. Miss A’s whānau spoke of the importance to them of accountability and their belief that, to prevent this from occurring to another whānau again, systemic issues must be addressed, with responsibility and accountability sitting at a higher level than Waikato Hospital alone. They wish for this report to disclose that the child involved was 11 years old, Māori, and had autism. They believe that those details are important for the record and for learnings to be fully captured from this incident.

Background

12. At approximately 7am on 9 March 2025, Miss A was taken to the Waikato Hospital ED by the police. Miss A appeared distressed and uncommunicative, was unable to give her name to police, and had no identity documents on her. Police were concerned for her wellbeing as members of the public had seen her standing in the middle of a road and looking over the rails of a bridge into a river.

13. Miss A was triaged at 7.51am. The ED Charge Nurse asked the mental health crisis assessment and home-based treatment team (CAHT) to see Miss A, which they did while she was sitting in the back of the police car. The CAHT initial assessment was that Miss A may be autistic and resembled a child. It was agreed that Miss A would be brought into the ED while the police made efforts to identify her.

14. Miss A was placed in a room in ED with a care partner (a person assigned to provide 1:1 oversight to the patient). An ED nurse recorded that Miss A appeared to be experiencing hallucinations, was hiding in a corner, and appeared scared. The ED nurse and CAHT considered that Miss A may be autistic, given her presentation. It was agreed to keep Miss A in the care of ED and re-refer her to CAHT later if needed.

15. At this point, Miss A’s ED clinical notes are labelled as ‘Unidentified,’ ‘Female 20 years.’

16. At approximately 8.30am, police telephoned the ED to inform staff that they had identified Miss A and said that she was Patient B. Patient B is a 20-year-old woman known to mental health services and was under a compulsory treatment order pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the MHA) at the time of these events.

17. At 9.50am, two CAHT staff attended Miss A in the ED. She was noted to be burying her head into her pillow and plugging her ears with her fingers. The CAHT staff considered that her presentation was consistent with Patient B’s health diagnosis and her appearance was consistent with Patient B’s. The clinical records then refer to Patient B by her first name throughout, and an admission assessment note was completed.

18. CAHT telephoned the on-call consultant psychiatrist, and it was agreed that Miss A would be recalled to hospital under section 29(3)(a) of the MHA for compulsory treatment.

19. Miss A was then transferred to the psychiatric inpatient unit (Ward 36) by CAHT.

20. CAHT then telephoned the on-call psychiatric registrar and asked them to prescribe medication. The registrar identified the medication Patient B had been taking, calculated the dose appropriate to Patient B, and went to the admission area to clarify medication or allergies with Miss A but was unable to engage her in conversation. The registrar then completed the medication chart, which included prescriptions for 'as required' oral and IM medication.

21. The clinical records show that, on Ward 36, Miss A continued to show child-like behaviour and distress by curling up into a ball and covering her ears.

22. The nursing staff tried to give Miss A oral medication multiple times and with different staff assisting but were ultimately unsuccessful, so the decision was made to use IM medications. The registrar prescribed haloperidol (an antipsychotic) as a 'once-only' medication.

23. At 12.20pm, a female restraint team restrained Miss A and administered IM haloperidol 5mg and promethazine 50mg (a sedative). The restraint event form records the indication for restraint as 'inability to administer treatment'.

24. Miss A fell asleep approximately 40 minutes later and slept for the rest of the afternoon. She was regularly observed.

25. A DASA (Dynamic Appraisal of Situational Aggression) score was used to assess Miss A's risk of violence. The scale goes from 0 to 7, with 0 being very low risk and 7 being imminent risk. Miss A was given a DASA score of 0 at 1.56pm and 1 at 6.25pm.

26. At 8.20pm, Miss A was offered oral medication as prescribed but declined it. She covered her ears and rolled toward the wall. The nurse contacted the registrar, who advised the nurse to administer IM medications if Miss A declined her oral medication. The registrar prescribed a further dose of haloperidol as a 'once-only' medication.

27. At approximately 8.45pm, a female restraint team restrained Miss A and administered IM haloperidol 5mg and promethazine 50mg. The restraint event form records the indication for restraint as 'Harm to others. Inability to administer treatment.'

28. At approximately 9pm, the police telephoned Ward 36 to advise that they had misidentified Miss A as Patient B and that Miss A was an 11-year-old girl with autism reported missing by her family earlier that day. Police contacted Miss A's mother, and she attended Ward 36.

29. The on-call psychiatric registrar assessed Miss A and provided advice to Miss A's mother about the medications that had been administered and potential side effects before she was discharged.

30. On 10 March 2025, Health NZ – Waikato staff visited Miss A and her mother and briefed them on the timeline of the events and the medications given.

Rapid Incident Review

31. On 11 March 2025, Health NZ – Waikato commenced a Rapid Incident Review. The review identified the key contributing factors to this incident, which included:

- The assumption that Miss A's presentation was a mental health presentation because the police advised that Miss A had been found on a bridge displaying mental health symptoms.
- Staff accepted the police misidentification of Miss A because it is common for police to confirm patient identity. Miss A displayed limited verbal ability, and no additional information was available to confirm her identity. Further, Patient B did not have a next of kin listed in the system to contact.
- The ED medical team did not assess Miss A, which was a missed opportunity for assessment and consideration of differential diagnoses.
- The Waikato Hospital identification processes in place at the time of these events were inadequate for this situation.
- Medication decisions were made based on Patient B's history of rapid escalation of her symptoms.
- There was no mental health reassessment on admission to Ward 36.

32. Eight recommendations arose from this review, as set out in **Appendix A**. At the time of this report, six recommendations are complete and two remain in progress.

33. In December 2025, Health NZ developed a new national policy for the identification of unidentified patients with communication difficulties. A copy of the policy and the communication to Health NZ staff has been provided to HDC. Health NZ advised HDC that it considers this new policy is fit for use in mental health services, it includes minimum requirements to change a patient's status to 'identified' and provides guidance to staff on how to treat police identification.

Police District Policy Review and Independent Police Conduct Authority (IPCA) Review

34. The Police undertook a review of the circumstances of the police involvement in this incident. It was determined that the initial actions in the police attending Miss A and transporting her to hospital were timely and efficient in the circumstances and done with her needs at the forefront of their decision-making. The police were found to have misidentified Miss A despite making genuine attempts to confirm her identity.

35. The IPCA was satisfied with the police investigation and agreed with the conclusions reached. It stated that, although the processes to identify Miss A were ultimately flawed, the officers' attempts were made in good faith.

Section 95 inquiry

36. Director of Mental Health, Dr John Crawshaw, has commissioned an inquiry into this incident under section 95 of the MHA.

Analysis

37. It is incredibly concerning to me that Miss A, a disabled girl, was misidentified as an older mental health services patient, restrained, and administered IM psychotropic medications intended for an adult. I take this opportunity to further acknowledge how distressing this event has been for Miss A and her whānau, and I recognise that it may influence how they trust and engage with health services in the future. I also acknowledge that Health NZ and the other agencies involved have recognised the seriousness of the situation, and I am satisfied with the rigour of the reviews they have undertaken.

38. My role is to consider whether the health services Miss A received were delivered to an appropriate standard and whether her rights were upheld. I have considered four key points in my assessment of the standard of care provided: the identification process, the assessment process, the treatment given to Miss A, and the adequacy of the hospital policies and procedures. I have also considered whether she was provided with services that took account of her needs and upheld her dignity.

39. To help me determine whether services were of an appropriate standard, I sought expert advice from psychiatrist Dr Clive Bensemann, whose complete advice report is attached as **Appendix B.**

Was it reasonable for the clinicians to rely on the identification provided by the police?

40. In my view, it was not reasonable for the clinicians to rely solely on the identification given by the police, particularly in light of the ramifications of admission under the MHA and the treatment that can be administered to an individual in such circumstances.

41. Dr Bensemann advised me that, although it was common practice for clinicians to rely on police identification, in the context of Patient B being under a compulsory treatment order under the MHA, the 'compulsory care adds further weight to the reasonable expectation of rigorous identification processes.'

42. The Waikato Hospital Patient Identification Policy (issued 3 December 2021) states that the first point of contact into a service provides the opportunity to ensure correct identification information. It says that, where the patient is unable to check their patient details against the admission form, the 'key support person may undertake this responsibility'. This was not possible in Miss A's case as she presented to ED with police, who were unaware of her identity at that point.

43. The Waikato Hospital Identification of Unidentified Patients Procedure (issued 9 August 2024) identifies that, where an unidentified patient is unable to provide their full name, date of birth, and address, 'the next of kin/legal guardian/carer/power of attorney may undertake this responsibility.' In Miss A's case, the next of kin/legal guardian/carer/power of attorney did not provide these details for Miss A. Instead, the staff relied on the police identification, and then her patient status was changed from unidentified to identified (as Patient B).

44. In Dr Bensemann's view, Miss A should have remained under unidentified status until the requirements of the policy and procedure were met to change to identified status. He

advised that changing Miss A's status to identified was a moderate departure from accepted practice but acknowledged that police identification is usually relied on as an authoritative source of information and that the identification policies at Waikato Hospital are not fit for purpose in the mental health service context (discussed further below).

45. I accept Dr Bensemann's advice. I acknowledge that the police identification would have been considered authoritative. However, it is clear that at least some staff considered Miss A to resemble a child, and she did not have next of kin (etc) available to provide confirmation of identity in accordance with the Waikato Hospital policy and procedure before her patient status was changed. In addition, further rigour was required for this identification process given that Patient B required compulsory treatment. In these circumstances, I do not consider it was reasonable for the clinicians to rely solely on the police identification, and Miss A's status should have remained as unidentified.

Was Miss A appropriately assessed by the mental health team?

46. Miss A was seen by two non-medical CAHT staff in the ED after police had identified her as Patient B, and an admission note was completed before she was transferred to Ward 36. The on-call consultant psychiatrist was contacted by telephone to confirm admission under the MHA, and the psychiatric registrar prescribed medications for Miss A based on their review of Patient B's past admission notes. The registrar explained that they went to see Miss A briefly, but this contact is not recorded in the notes.

47. Dr Bensemann reviewed the clinical records and found no record of a comprehensive psychiatric assessment by a psychiatrist or registrar, which in his view would be standard practice on admission to an inpatient mental health ward. In his view, a more comprehensive psychiatric assessment might have challenged the impression that Miss A was psychotic, and a physical examination might have identified that she was not a 20-year-old woman.

48. Dr Bensemann advised that such an assessment is expected to occur before restrictive care such as inpatient assessment under the MHA is used. He stated, 'Hospital care is the highest level of care provided by [mental health and addictions] services, and patients admitted have the highest and potentially most complex psychiatric and physical health needs.' In his view, that such an assessment did not occur was a moderate to severe departure from accepted standards. However, he acknowledged that the registrar in this case appeared to have limited orientation to or understanding of their responsibilities during admissions, with the registrar stating, 'Up until this incident, there had never been any communications to me around expectations that all admissions require psychiatric assessment by the registrar.'

49. Although CAHT staff conducted an assessment in the ED, I accept Dr Bensemann's advice that a comprehensive psychiatric and medical assessment did not occur on admission to Ward 36. I therefore find that Miss A did not have an appropriate psychiatric or medical assessment, as she should have, when she was transferred to Ward 36. This was a missed opportunity to question the identity given by police.

50. In addition, I am concerned that the registrar did not appear to have been orientated to their responsibility in relation to assessment of new admissions.

Was the treatment given to Miss A reasonable in the circumstances?

51. Dr Bensemann advised that, given that Miss A was identified as Patient B, the decision to admit Miss A to Ward 36, and to use section 29 of the MHA to do this, was reasonable. I accept this advice.

52. Dr Bensemann also advised that the choices of medication and the doses as prescribed were reasonable for Patient B, which I accept.

53. However, I do not consider the use of restraint and administration of multiple doses of IM psychotropic medication to Miss A was reasonable in the circumstances of her presentation.

54. Waikato Hospital's Restraint Policy (issued 6 November 2023) states that a situation where restraint may be appropriate is when it is necessary to give essential clinical treatment to an individual who is refusing treatment. It also states that use of restraint must be considered as the option of last resort.

55. Dr Bensemann advised that the use of restraint and administration of IM medication on two occasions in the first several hours after admission was unnecessary and premature. He advised that restraint and IM injections are very distressing for patients and that the threshold for their use is high.

56. Dr Bensemann noted that there was no documentation indicating Miss A was at high and imminent risk to herself or to others, and she was not exhibiting aggressive or high-risk behaviour requiring emergency care. He also noted that the reasoning 'harm to others' that was listed on the second restraint event form is inconsistent with Miss A's recorded DASA score (used to assess risk of aggression/violence). He stated the 'inability to administer treatment is not by itself an indication for use of force at such an early stage of admission' and that using restraint to administer IM medication in this case was a moderate departure from the accepted standard of care.

57. I accept Dr Bensemann's advice, and I am concerned that Miss A was restrained and administered IM medication when this was not essential clinical treatment for emergency care and when, as evidenced by the clinical records, she was not exhibiting high-risk or aggressive behaviour. I am also concerned that the haloperidol was prescribed for Miss A without the registrar seeing her in person.

Were the Waikato Hospital policies and procedures fit for purpose?

58. Waikato Hospital has two key process documents relevant to this circumstance: The Identification of Unidentified Patients procedure (owned by Patient Blood Management), and the Patient Identification Policy (owned by Nursing and Midwifery).

59. Dr Bensemann noted that both documents have sound and reasonable principles; however, his view is that, given where the responsibilities for the policies lay, mental health service staff may not have considered them relevant.

60. I note that neither document refers to how to treat or consider identification given by police or what to do when identification remains in question even after an identity has been proposed by a third party.

61. In my view, these documents have sound principles but do not give sufficient guidance to staff on how to treat identification from police, and they did not support the teams in this case to have confidence to continue treating Miss A as 'unidentified'. Accordingly, they were not fit for purpose in this circumstance.

Did Health NZ provide services to Miss A that took account of her needs?

62. Miss A is an autistic child, and she was given treatment intended for an adult who was subject to a compulsory treatment order under the MHA. When Miss A was taken to hospital, she ultimately needed to be taken care of, in a manner that was appropriate to her age and disability, until such time as she could be reunited with her whānau.

63. I acknowledge that the staff caring for Miss A shortly after her arrival at the ED understood her to be Patient B based on police identification. However, records show that some staff had initially queried whether Miss A was a child, autistic, or intellectually disabled and noted that she was exhibiting child-like behaviour.

64. Despite what may have been the best intentions of the staff once they believed Miss A to be Patient B, Miss A was clearly not given services that met her needs as a child with autism, and the opportunity was missed to consider the validity of the initial impressions of some staff.

Did Health NZ provide services to Miss A in a manner that respected her dignity?

65. Miss A was subjected to compulsory admission to an adult mental health inpatient unit and given IM medications that she did not require, under restraint. It follows that she was not treated in a manner that she deserved, and her right to be treated with dignity was not upheld.

Conclusion

66. I do not consider that Miss A was provided services with reasonable care and skill, and accordingly I find Health New Zealand | Te Whatu Ora in breach of Right 4(1) of the Code for the following reasons:

- Miss A's identification status was changed from unidentified to identified before the requirements of Waikato Hospital's processes were met;
- Miss A was not appropriately assessed by the mental health team;
- The use of restraint on, and administration of IM medication to, Miss A was unreasonable and premature;
- Waikato Hospital's process documents were not fit for this circumstance.

67. I have also found that Health New Zealand | Te Whatu Ora breached Right 4(3) of the Code for failing to provide services to Miss A that took account of her needs and breached Right 3 of the Code for failing to provide services to Miss A in a manner that respected her dignity.

68. Health NZ has confirmed that it accepts these findings and stated: 'we accept that what happened to this young person was unacceptable, and that these failings caused trauma and distress for this young person and their whānau.'

69. The investigation of Waikato Hospital's treatment of Miss A has shown that systemic failings led to serious mistakes occurring. It is important that changes are made so that other people do not have a similar experience to Miss A in the future. At the beginning of this document, I expressed support for the proposed follow-up actions Health NZ – Waikato was instigating after its Rapid Incident Review and included several other recommendations to further bolster the systems in place. The implementation of all the recommendations referred to in this report will be monitored.

Follow-up actions

70. A copy of this report with details identifying the parties removed, except the names of Health NZ – Waikato, Waikato Hospital, and my expert advisor, will be sent to the Director of Mental Health, the Police, the IPCA, and Whaikaha – Ministry of Disabled People and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

71. In light of the significance of this event, and the serious oversights in the care of Miss A I have identified, Health New Zealand | Te Whatu Ora will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Recommendations from Health NZ Rapid Incident Review

1. 'Apologise to [Miss A] and her family. Engage with [Miss A]'s family and provide appropriate support to understand the findings and recommendations, ask any questions, and provide any further feedback into the Waikato Hospital's adverse event process.

2. Undertake a rapid review of international best practice for the identification of unidentified patients, particularly for people with any type of communication difficulty, and create a national policy. This should be done in collaboration with cultural and disability services, and in consultation with the Police.

3. Ensure that all Emergency Departments undertake medical reviews on all unidentified patients.

4. Establish a national restraint group to specifically develop best practice for physical restraint, medication restraint, monitoring after sedation, de-escalation processes and staff training. The scope of this group's work should include developing a checklist for assessment prior to medication restraint and procedures for monitoring vital signs following sedation in mental health facilities.

5. Review admission criteria and procedures for admission to psychiatric intensive care units.

6. Review workforce resourcing in the district's mental health inpatient unit.

7. Ensure cultural support is offered to mental health patients as early as possible in the admission process.

8. Engage cultural and disability services in the actioning of relevant recommendations.'

Appendix B: Independent clinical advice to the Commissioner

The following independent advice was obtained from psychiatrist, Dr Clive Bensemann:

'I have been asked to provide clinical advice to HDC on case number C25HDC00815. I have read and agree to follow HDC's Guidelines for Independent Advisors.
I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.
I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I am a medical practitioner vocationally registered as a psychiatrist and am a Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP). I am also vocationally registered in medical administration and am a Fellow of the Royal Australasian College of Medical Administration (FRACMA). I have been involved in Clinical Leadership and Clinical Governance of services for 30 years. I was previously Director of Mental Health and Addiction (MH&A) services at Auckland District Health Board for seven years (2009–2015) and Clinical Services Director of the Waikato DHB MH&A service (2001–2005). I am currently co-lead for the National Clinical Network for MH&A, a position I have held for the last one year. I was for seven years (until mid-2024) Clinical Lead for the national Quality Improvement Programme for MH&A at the Health Quality & Safety Commission. I currently work clinically as a Psychiatrist in the Mental Health Services for Older Adults (MHSOA) at Health New Zealand – Waitemata and was Clinical Director for that MHSOA service until August 2025. During the last 30 years, I have worked clinically as a consultant in Adult Mental Health services as well as in MHSOAs in four District Health Boards.
Documents provided by HDC:	1. Letter of complaint dated 20 March 2025 2. Health NZ's Rapid Incident Review 3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments 4. Clinical records from Health NZ covering the relevant period
Referral instructions from HDC:	1. Whether it was reasonable in the circumstances for the clinicians to rely on the identification provided by the police? 2. Whether [Miss A] was appropriately assessed by the mental health team? 3. Whether the treatment (including admission to the mental health inpatient unit and administration of medication) provided to [Miss A] was reasonable in the circumstances, which include the clinicians' belief as to [Miss A]'s identity, and her presentation behaviour?

	4. Whether the mental health team complied with their obligations under the Mental Health (Compulsory Assessment and Treatment) Act 1992? 5. Whether Health NZ Waikato's policies and procedures relating to identification of patients are appropriate? 6. Are there any other areas of this case that you consider warrant comment?

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	A *'Submission received for Complaint on behalf of someone else'* (C25HDC00815) was received by HDC on 21/03/2025 from […], Whaanau Advisor Te Whatu Ora Waikato, on behalf of [Miss A] and her parents. The complaint included a comprehensive account of the events and asked for review. *"Situation: Misidentified Patient • A person was found by police and brought to ED under S109 MHA. • The person was initially identified as a missing patient under S29 MHA. • A S29 3 (a) was completed, and she was admitted to LSA ward 36 • There were two episodes of restraint and administration of IMI medication • Contact was made by police in the evening, and they have re-identified her."* My summary of the clinical notes and provider response follows: An unidentified person (patient A) was brought to Waikato hospital Emergency Department (ED) at about 0700 hours by police under S109 MH(CAT) Act after she was *"seen on the […] Bridge rails looking down at the river and standing in the middle of the road"* (4. Clinical records from Health NZ covering the relevant period – Police ED handover). She had not been identified and would not give her name. The Community Assessment and Home Treatment (CAHT) team were contacted by the ED charge nurse, and upon their arrival met a young female sitting in the back of the police car. CAHT spoke with the police officer, who mentioned that members of the public had alerted them because the young female was seen looking over the edge of a bridge. According to the HDC complainant, CAHT then clarified whether she had made any attempt to jump and were told no by the police (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Clinician 1). The Nurse in charge asked about direct admission to the mental health inpatient Henry Rongomau Bennett Centre (HRBC), but this was declined (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Clinician 1). Clinician 1 (interview) states that, during that brief encounter they believed that Patient A was autistic, and this was also the view in the interview of the ED Nurse in Charge (3. Health NZ's response to HDC dated 2 May 2025, and accompanying

	attachments). They agreed for her to be brought into the ED until identified (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Clinician 1). Her ED clinical notes are labelled 'Unidentified' patient of 20 years. She was described in a note by her ED primary nurse as *"appearing to experience hallucinations"* and "*hide(ing) in the corner appearing scared…"*. A set of baseline observations (heart rate, blood pressure, temperature) was recorded. She was in the ED for several hours. At 0731, a community mental health clinical note records the ED contact about police arrival with the unidentified patient, and notes *"may be intellectually impaired".* An update at 0830 records that the patient had now been successfully identified as Patient B, a 20-year-old under a Section 29 Compulsory Treatment Order – MH(CAT) Act. The on-call Psychiatrist was contacted by phone, and he completed an S29 (3) (a) recall to hospital. The summary of interview (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Dr 1) records that *"it was not unusual for the paperwork to be completed remotely with the expectation that the usual admission process would be followed"*. An MH&A admission assessment note was created at 1036 by two CAHT clinicians (4. Clinical records from Health NZ covering the relevant period) and records the referral by ED/police, and the clinicians' assessment of Patient B, *"refusing to communicate"*, *"burying her head in her pillow*", probably responding to *"non apparent stimuli." (*hallucinations); "*laughing incongruently"*; *"talking in a childlike voice and holding her teddy bear"*. The admission notes briefly recorded Patient B's history, including her last admission to HRBC 3 months before in December 2024; her discharge to NGO [non-government organisation] accommodation where she stayed only 2 weeks; her prescription for paliperidone depot antipsychotic with which she was non-adherent; and her loss to follow-up. In 'Risk assessment', they record *"High risk of misadventure – found sitting on edge of high bridge over river and subsequently walking into the road. Disorganised behaviour"* **Note: On this admission note, the patient identification label is no longer 'Unidentified' as was used in the ED notes and is now correctly Patient A, an 11-year-old female. However, the clinical notes themselves describe assessment and treatment of Patient B, a 20-year-old female whom they believed they were treating at that time. I assume this reflects the changes made from 'Unidentified' status to**

	(incorrectly) 'Identified' Patient B, and then correctly back to 'Identified' Patient A and subsequent retrospective changes to the labels used in the clinical files (consistent with my understanding of Health Waikato's 'Identification of Unidentified Patients Procedure'). Medications were charted by the on-call registrar: regular olanzapine 10mg twice daily; PRN ('as needed') olanzapine oral/IM, PRN lorazepam oral/IM, and promethazine oral/IM, as well as zopiclone, nicotine-replacement lozenges, and paracetamol. There were also two single-dose 'once-only' prescriptions for haloperidol IM related to the two restraint events (presumably prescribed by the same registrar as the signature appears the same). The afternoon nurse states that they talked with the registrar about the afternoon 'once-only' prescription (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Clinician 5). Restraint involved only female staff (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – clinician 5 interview). I could see no clinical note in the clinical record from the registrar about assessment/face-to-face review of the patient. However, I note that, in a summary of an interview with the registrar (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Dr 2), the registrar states that he reviewed the patient briefly before prescribing. He also describes nursing staff telling him that there was a shortage of IM olanzapine, and so he prescribed haloperidol as an alternative for the 'once-only' use. According to the later pharmacy feedback (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments), this advice was incorrect. Only the long-acting olanzapine preparation 'Relpreev' was affected at this time. There are further notes completed by nursing staff in HRBC (4. Clinical records from Health NZ covering the relevant period) describing *"childlike behaviour",* recording again the impression that she was responding to hallucinations; and unsuccessful attempts to persuade her to take oral medications. On refusal of oral medications, two episodes of restraint and administration of IM haloperidol/promethazine combination followed at 1218 and 2057 hours. The clinical notes include low 'Dynamic Appraisal of Situational Aggression' (DASA) scores of 0 and then 1. This is a brief actuarial risk assessment instrument designed to assist in appraisal of risk of violence.

Name have been removed (except the names of Health New Zealand \| Te Whatu Ora Waikato, Waikato Hospital and the expert advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	The first restraint event form records under Indications - *"Inability to administer treatment"* and the second *"Harm to others. Inability to administer treatment"*. Staff in HRBC did not seem aware that Patient B had been 'Unidentified' initially in ED (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Clinician 5, interview Dr 2). A phone call was received from police in the evening, stating that the patient they believed to be Patient B was in fact likely to be Patient A, an 11-year-old girl with autism reported missing by her family earlier that day. With a photo from the police, this was confirmed by staff and her family contacted. Patient A's mother attended the ward and met with staff; events during the day were explained, including the use of restraint and medication, and Patient A was taken home after a review by the registrar to confirm that she was safe to do so given the medication administered. The registrar made a clinical note about this interaction and review. Patient A was reviewed again the following day at home by the on-call registrar and senior nursing staff because her mother was worried about *"stiffness*". The registrar indicated this was likely secondary to the haloperidol medication Patient A had received.

Question 1: Whether it was reasonable in the circumstances for the clinicians to rely on the identification provided by the Police?	
List any sources of information reviewed other than the documents provided by HDC:	Nil
Advisor's opinion:	Opinion: it was not reasonable to rely <u>exclusively</u> on identification by the police. The provider in response to HDC (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments) states that "*Pursuant to Waikato's Patient Identification Policy (4.2.3), which states 'Where the patient is unable to verify identification all reasonable attempts should be made to contact the key support person', staff attempted to confirm her identify. However, Patient B did not have a key support person or Next of Kin noted in the clinical record. As a result, this step was not able to be completed, and staff proceeded based on the identification provided by Police"* It is common practice to use police identification as an authoritative source for identification. Both the record of interviews of Clinician 1 and Dr 1 confirm this; both clinicians believed services would usually rely on police

	identification. (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments); In my opinion, more weight will be given to this source (the police) inevitably in the absence of other sources. The interview with the ED Nurse in charge records *"It is a usual process, police helping in the identification of the patient, we rely on them for this. We trust them, this type of thing happens every day. I've never had or known of a situation where police identification has been wrong."* (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview). However, in my opinion, it was not reasonable to rely on this as the only source of identification. The individual who the police and mental health service decided that they were dealing with (Patient B) was also already known to the MH&A services and was under a Compulsory Treatment Order and therefore health services oversight. In my opinion, this compulsory care adds further weight to the reasonable expectation of rigorous identification processes. In my opinion, the two Waikato policies and procedures provided (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments) do reflect best practice, with sound principles. The first documents; the 'Identification of Unidentified Patients Procedure' is the responsibility of Patient Blood Management, and *"provides the minimum standards for identification and a clear pathway to follow for safe identification".* It applies to *"to patients who present for admission who are not immediately identifiable"* and prescribes a *"pre-set UNIDENTIFIED NHI number"* and includes estimated age. Identification of the Unidentified patient then requires *"The patient verbally providing their full name, DOB and address."* or *"If the patient is unable to do this, the next of kin/legal guardian/carer/power of attorney may undertake this responsibility".* The procedure then stipulates *"Identification of unidentified patients must be done in a controlled environment. This means actual identification should only occur once acute and immediate treatment has taken place and the condition of the patient has stabilised".*

	This procedure's requirement for the patient, or next of kin/legal guardian/carer/power of attorney to provide personal details before changing to Identified status was not met in this case. The second document, the 'Patient Identification Policy' is the responsibility of Nursing and Midwifery, and *"Clarify approved patient identifiers that are to be used when providing care, therapy or services"* and *"Clarify the approved ways of verifying identification of the patient and matching the patient with the intended care, therapy or service".* It states that, on entry to the service "*Reception or clinical staff, together with the patient, check patient details"* but also *"Where the patient is unable to do this, the key support person may undertake this responsibility."* The provider has correctly pointed out that neither of these steps was possible in the case of Patient A's presentation to ED with police. The patient was initially given an UNIDENTIFIED NHI number by ED. In my opinion, this was the correct process, consistent with 'Identification of Unidentified Patients Procedure', and Patient A should have remained under this status until the requirements of the 'Patient Identification Policy' were met to change to Identified status. (Please refer further to my opinion Question 5.)
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Generally, the importance of a rigorous process for identification of patients before care or any interventions is well understood in healthcare and by clinicians generally. But services and clinicians also know that at times in emergency situations, they may have to act without such identification. In my opinion, these realities and best practice principles are reflected in the two policy/procedures documents provided by the provider. However, in my opinion, neither document was helpful/fit for purpose for the MH&A services in this situation. (Please refer further to my opinion Question 5)
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure;	Moderate departure. Mitigating factors: • the police identification (usually relied on as an authoritative source of information);

• Moderate departure; or • Severe departure.	• the fact that neither provider policy/procedure is really fit for purpose for MH&A services use. (Please refer further to my opinion Question 5)
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	In my opinion, peers would consider it reasonable to proceed cautiously, providing necessary urgent care for an unidentified patient until further sources confirming identification were available. It is important that people are able to access acute care in a timely way. This is what the Waikato identification policies and procedures anticipate. However, in my opinion, the care provided here was beyond the immediate urgent care needs in this circumstance. I refer particularly to the use of restraint and IMI psychotropic medication. (Please also see my further opinion Question 2)
Please outline any factors that may limit your assessment of the events.	I have not interviewed staff or seen Patient B's past clinical records. Staff initiated care using restraint and IMI medications. The need for urgent care (use of restraint and IMI medications) relies on assessment of clinical risk related to the current presentation, and this assessment will be informed by past presentations and history. I assume staff had access to this information for the patient they thought they were treating, Patient B, although the extent of that access and review is unclear to me. I have not interviewed staff, and I have not seen the clinical records pertaining to previous admission for Patient B, including past risk history. This information would further inform assessment of the need for 'urgent care'. (Please also see my further opinion Question 2)
Recommendations for improvement that may help to prevent a similar occurrence in future.	I support recommendation 2 of the Rapid Review: "*Undertake a rapid review of international best practice for the identification of unidentified patients, particularly for people with any type of communication difficulty, and create a national policy. This should be done in collaboration with cultural and disability services, and in consultation with the Police."* I understand this work is being completed nationally. Health New Zealand – Waikato needs a consolidated policy/procedure explicitly for MH&A services use, informed

	by the work referenced above, and containing the elements in both documents already provided by Health Waikato, for the management of unidentified patients, and minimum requirements to change status to Identified patients.

Question 2: Whether [Miss A] was appropriately assessed by the mental health team?	
List any sources of information reviewed other than the documents provided by HDC:	Good prescribing practice, February 2024 https://www.mcnz.org.nz/assets/standards/Statement-on-good-prescribing-practice.pdf
Advisor's opinion:	In my opinion, [Miss A] was not appropriately assessed by the mental health team on admission. There is an Admission assessment note written by two CAHT clinicians. However, I can see no other record of comprehensive mental health assessment – in particular, there is no record of psychiatric assessment by a psychiatrist or registrar, and no record of physical health assessment by medical staff, which is usually completed by a house officer or registrar (Registered [Resident] Medical Officer – RMO). This is standard accepted practice on admission to an inpatient MH&A ward for many reasons. In this specific case, more comprehensive psychiatric assessment might also have challenged the impression that the patient was psychotic. And physical examination might have identified that this was not a 20-year-old woman. There are several issues to comment further on: • There are no clinical notes documenting review or the clinical rationale of the Responsible Clinician (RC)/on-call Senior Medical Officer (SMO); when changing the MH(CAT) Act status from S29 to 29(3) (a). It is common practice for an on-call SMO acting as RC after hours to rely on information from other clinicians in making RC-related decisions (see Guidelines to MH Act), but in this case nothing is documented in the clinical record other than the signed form. I do acknowledge the short timeframes involved in this episode of care, and documentation may have followed later. I do not know whether contemporaneous off-site 'real-time' access to the clinical record is available for clinicians, ie, are they able to make remote entries into the clinical record or not?

	• There was no psychiatrist/psychiatry registrar review to add to the admission assessment by CAHT staff. The registrar's understanding of their role reflects their lack of involvement in comprehensive admission assessment. The record of interview with the registrar on call (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Dr 2) confirms that, in their minds, assessment by the registrar was not standard. The interview record states the on-call registrar role includes to *"Provide support for admissions when requested by the crisis team"* and that they were *"informed of the admission by the nursing staff and was requested to complete a medication chart."* The registrar (Dr 2) interview record further states *"Until this incident, it was not routine for Registrars to be involved in psychiatric assessments when the Crisis team clinicians had already assessed a patient and discussed the presentation with a consultant directly, as in this case.* *The coordinator will usually mobilise the registrar for assessments where required.* *Psychiatric assessments can take 1½ hours.* *Where a patient has already been assessed and admitted in discussion with the consultant, prior to this incident I have never been asked to do a second assessment routinely unless there was a concern raised by admitting or ward staff."* Further, *"Up until this incident, there had never been any communications to me around expectations that all admissions require psychiatric assessment by the registrar."* • The registrar makes reference in interview to relying on information from Patient B's past admission clinical notes to inform decisions about prescribing (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments – interview Dr 2), but whatever this information was is not documented by the doctor in the clinical record. • Regarding physical examination, the registrar Dr 2 interview records *"Admission physical assessments are routinely completed by the team house officer and there was a house officer on duty at the time in question. The nursing staff and coordinators usually coordinate resources.*

	Ideally, before prescribing medications, a physical assessment would occur. However, when patients arrive acutely unwell in the psychiatric context, completing these assessments can be counter-therapeutic, distressing and unsafe to both patients and staff. As a result, completion of physical assessments is often dependent on the patient's mental state." I agree with this statement in general terms, but again there is no clinical notes documentation that such physical assessment was even considered or was decided against because of patient-related factors. • There was no medical assessment documented prior to charting of medications, which is standard practice before prescribing. In the interview, Dr 2 states they saw the patient briefly, but this is not documented in the clinical notes. The Medical Council guidance states: *"You should only prescribe medicines or treatment when you have adequately assessed the patient's condition, and/or have adequate knowledge of the patient's condition and are therefore satisfied that the medicines or treatment are in the patient's best interests."* Good prescribing practice, February 2024 https://www.mcnz.org.nz/assets/standards/Statement-on-good-prescribing-practice.pdf In summary, Patient B was not comprehensively assessed psychiatrically or medically on admission. In my opinion, this should occur on a new hospital admission. Hospital care is the highest level of care provided by MH&A services, and patients admitted have the highest and potentially most complex psychiatric and physical health needs.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Comprehensive assessment on admission to an MH&A inpatient setting is accepted good practice. This usually involves medical staff with psychiatric expertise (an SMO and/or registrar) and medical staff to complete a physical examination. Some variation on this standard approach might occur depending on workforce. Increasingly, some nursing roles are taking greater responsibility around assessment (Nurse Specialists, Nurse Practitioner) and some prescribing (Nurse Practitioner). This did not apply in this case. The two Waikato procedure/policy documents viewed (3. Health NZ's response to HDC dated 2 May 2025, and

	accompanying attachments) did not speak directly to expectations about admission processes. The closest in my view was a comment in 'Procedure: After Hours Assessment and Admission of Tamariki and Rangatahi to the Henry Rongomau Bennett Centre and Haumaru Ōrite' which states: *"Assessment by the Duty Psychiatric Registrar is required if medication prescribing or acute inpatient admission is considered."* However, this procedure applies to admissions of younger people/adolescents rather than adults.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Moderate–Severe departure Mitigating factors: • Responsibilities and processes for staff seem to have been unclear. The interview with Dr 2 states *"Orientation provided to me as a first-year psychiatric registrar was provided by a clinical nurse specialist. If time and resource allowed, it would also be helpful for registrars to provide orientation for on-call registrars, duty registrars and in relation to after-hours work."*
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	In my opinion, peers would consider this a clear departure from standard practice. Full psychiatric assessment, including medical assessment, is expected as part of admissions to high levels of care such as inpatient care, is expected prior to use of restrictive care such as inpatient assessment under the Act (S29 (3)(a) or (b), and is expected prior to the prescription of medications (except in emergency situations).
Please outline any factors that may limit your assessment of the events.	I have not interviewed the medical staff to clarify their understanding of the situation and particularly the patient's need for urgent care (restraint and IMI medications). I am unclear what they knew/did not know about her past history and risk. Medical staff have made minimal documentation in the notes available to me. I also do not know what ability 'off-site' clinicians (the on-call SMO/RC) have to make contemporaneous clinical notes in 'real time.'
Recommendations for improvement that may help to prevent a similar occurrence in future.	I support the Rapid Reviews recommendation: *"5. Review admission criteria and procedures for admission to psychiatric intensive care units."* Clear expectations need to [be] set and communicated to all staff about admission processes, including medical staff responsibilities for SMOs and for RMOs on call (Registrars, House officers).

	Comprehensive orientation for medical staff would assist this. I note Dr 2's statement about limited orientation and their understanding of responsibilities during admissions.

Question 3: Whether the treatment (including admission to the mental health inpatient unit and administration of medication) provided to [Miss A] was reasonable in the circumstances, which include the clinicians' belief as to [Miss A]'s identity and her presentation behaviour?	
List any sources of information reviewed other than the documents provided by HDC:	No other documents
Advisor's opinion:	In my opinion, some aspects of care were reasonable, but some were unreasonable in the circumstances. • The admission decision was reasonable once the patient was (incorrectly) identified as Patient B. • The decision to use MH Act S29 to recall the patient was also reasonable. (Please see my further opinion re Question 4) • The use of restraint and administration of medication by IMI was <u>unreasonable</u> because it was unnecessary at this point in the admission and use was premature. In my opinion, clinical notes do not record indications for such early use of force. Patient B was restrained twice and received two doses of IMI medications within the first several hours after admission. Restraint and IMI are very distressing for patients, and, in my opinion, the threshold for use is high. The Health New Zealand – Waikato Restraint Policy also sets a high threshold. (3. Health NZ's response to HDC dated 2 May 2025, and accompanying attachments) *(4.3.1)* *"situations where restraint may be appropriate:* *• When a consumer's condition or behaviour indicates an immediate and ongoing high risk of serious self-harm (either deliberate or unintentional).* *• When a consumer's behaviour poses immediate and ongoing serious risk to others, e.g. when an individual makes, or is likely to make a sustained or serious attack on another person.* *• When a consumer seriously compromises the therapeutic environment e.g. by damage to*

	property, social milieu or relationship with other consumers or staff. *• When it is necessary to give essential clinical treatment to an individual who is refusing treatment, and the treatment has been deemed to be clinically necessary by a registered health professional (preferably in consultation with the clinical team) e.g. consumers admitted under the Mental Health Act, …"* and (*4.3.2)* *"Use of restraint must be considered as the option of last resort"* Regarding the indications documented in the clinical notes: o Clinical notes document that she was distressed and was also assessed to be psychotic with hallucinations. However, there was no documentation indicating high and imminent risk to herself or to others. She was not exhibiting aggressive or high-risk behaviour requiring emergency care. o The two Restraint Event Forms record *"Indications: inability to administer treatment"* on the first and *"Indications: Harm to others. Inability to administer treatment"* on the second. o *"Harm to others"* on the second form is not consistent with the rest of the clinical notes, and not consistent with the low scores (0 and 1) on the Dynamic Appraisal of Situational Aggression (DASA) that are recorded in the notes. Note: The DASA is a seven-item observer-rated actuarial risk assessment instrument that is used to assess the likelihood of imminent aggression (within the next 24 hours) in mental health inpatients. o Inability to administer treatment is not <u>by itself</u> an indication for use of force at such an early stage of admission (within the first few hours of admission). The Waikato Restraint policy (quoted above) does state (section (4.3.1) fourth bullet point) that restraint may be necessary to give essential clinical treatment to an individual who is refusing treatment, but in my opinion this would

	usually be refusal over a more extended period. • The choice of medications (oral and IMI) and doses prescribed were reasonable for Patient B in the circumstances and given the (incorrect) advice to the prescriber that olanzapine IMI was not available.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	This use of restraint was a very early use of force and, in my opinion, not clearly consistent with Waikato hospital's own policies on the use of restraint. When to use restraint and IMI medications is always a matter of clinical judgement. A range of approaches are taken in practice between different services and different clinicians. However, restraint is always considered a 'last resort', and this is a consistent theme in clinical practice and in policy and procedure.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Moderate departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	In my opinion, this would be considered premature use of force/restraint by most clinicians. I acknowledge that a range of approaches are taken in practice between different services and different clinicians. However, restraint as a 'last resort' is a consistent theme in clinical practice and in policy and procedure.
Please outline any factors that may limit your assessment of the events.	My assessment of the events is limited by my lack of knowledge of Patient B's past history and past risks, which is relevant in assessing the need for 'urgent' clinical care during this admission. I have not interviewed staff, and I have not seen the clinical records pertaining to previous admission, including past risk history for Patient B, whom staff thought they were treating.
Recommendations for improvement that may help to prevent a similar occurrence in future.	I support recommendation 4 of the Rapid Review: *"Establish a national restraint group to specifically develop best practice for physical restraint, medication restraint, monitoring after sedation, de-escalation processes and staff training. The scope of this group's work should include*

	developing a checklist for assessment prior to medication restraint, and procedures for monitoring vital signs following sedation in mental health facilities." Health New Zealand – Waikato's Clinical Governance group should also audit a series of 'use of restraint/IMI medication' events when indication has been 'refusal of oral medications.' This would allow them to form a view about whether use is generally appropriate in their services or is used very early/too assertively/prematurely.

Question 4: Whether the mental health team complied with their obligations under the Mental Health (Compulsory Assessment and Treatment) Act 1992?	
List any sources of information reviewed other than the documents provided by HDC:	Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992 Revised 2025
Advisor's opinion:	It was an appropriate decision to use S29 (3) to return the patient (Patient B, whom they thought they were treating) to hospital. S29 (3) states*:* *(3) If, at any time during the currency of the community treatment order, the responsible clinician considers that the patient cannot continue to be treated adequately as an outpatient, the responsible clinician may direct that the patient—* *(a) be treated as an inpatient for a period of up to 14 days; or* *(b) be re-assessed in accordance with sections 13 and 14.* However, in my opinion, S29 (3) (b) should have been used rather than (3) (a), in these particular circumstances for compulsory re-admission. Use of force (restraint and IMI medications) was considered necessary, the patient was clearly not consenting to treatment, and the treatment administered was different from previously prescribed depot medications. The Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, Revised 2025 (the Guidelines), state that *"If a clinician makes a direction under section 29(3)(a) after the first month in which the patient's compulsory treatment order applies and the patient does not consent to the treatment proposed, the responsible clinician should obtain the opinion of a psychiatrist appointed by the Review Tribunal that the treatment is considered to be in the interests of the patient.*

Name have been removed (except the names of Health New Zealand \| Te Whatu Ora Waikato, Waikato Hospital and the expert advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

	In urgent situations, where particular treatment is necessary to save a patient's life, to prevent serious damage to their health or to prevent the patient from causing serious injury to self or others, it is not necessary to first obtain the opinion of a psychiatrist appointed by the Review Tribunal (section 62)." In my opinion, this was not an urgent situation. In summary, S29 (3) (a) allows the Responsible Clinician to restart or continue medications that have previously been consented to or previously supported by an approved second opinion – as required under S59. If different medications are used, then new consent or new second opinion is needed. New medications were used here for Patient B without consent, and medications were given using force, and so arguably it might have been better to use S29 (3) (b). S29 (3) (b) should be used if treatment is changed or consent withdrawn by the patient (so treatment no longer meets the expectations of prior S59). With regard to other rights: • S65 Respect for Patient B's cultural identity (Māori), was considered, as evidenced in the clinical file by reference to karakia in one of the Restraint Event forms • S66 Every patient is entitled to medical treatment and other health care appropriate to his or her condition: Please refer to my opinion Question 3 above.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	In my opinion, the standard of care/accepted practice in relation to obligations under the MH(CAT)Act were substantially met. There were only minor issues identified in my review: use of S29 (3) (a) versus use of S29 (3) (b) and limited documentation by the RC. Although the rationale for the SMO's clinical decisions can be inferred from the clinical records of the other team members, the decision made to re-admit the patient was not specifically documented in the clinical file by the on-call SMO/RC. The Ministry of Health's standard forms used for recall, the 'Notice to patient subject to a community treatment order

	directing change to inpatient status under S29 (3) (a) or reassessment under S29 (3) (b)', stipulates: *"The RC must examine the patient, sign the notice to patient indicating a section 29 (3) (a), for the patient to be admitted to hospital for inpatient treatment for up to 14 days from the admission date…."* However, it goes on to say: *"If circumstances are urgent and the patient's RC cannot be contacted, the consultant psychiatrist on call can instruct a DAO over the phone to direct the patient (subject to a community treatment order) to be an inpatient. The RC or consultant psychiatrist on call must sign the notice directing the patient to be an inpatient as soon as practicable…"*
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	No departure – Mild departure: lack of documentation and use of S 29 (3) (a) rather than (3) (b)
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Care would be viewed as reasonable by peers because the technically incorrect use of S29 (3) (a) and (3) (b) is very common in most parts of the country.
Please outline any factors that may limit your assessment of the events.	I have not interviewed the SMO/RC related to documentation options and do not know what contemporaneous access they have to clinical records off site (which facilitates easy 'real-time' documentation in the clinical record).
Recommendations for improvement that may help to prevent a similar occurrence in future.	Nil

Question 5: Whether the Health NZ Waikato's policies and procedures relating to identification of patients are appropriate?	
List any sources of information reviewed other than the documents provided by HDC.	Nil
Advisor's opinion	In my opinion, neither of the two policies provided are appropriate for the Mental Health Services use, although both have sound principles. The first document 'Identification of Unidentified Patients Procedure' lists 'Patient Blood management' as responsible for the procedure, although its purpose is relevant to this case.

	It states purpose as "*details the procedure to be followed in cases where a patient's identity is recorded as 'unknown' at the time of their admission to hospital. This document provides the minimum standards for identification and a clear pathway to follow for safe identification."* The procedure stipulates the process that should be followed to document the patient status as 'Unidentified', and a process to change that to 'Identified'. It states: *"2.5.1 When to identify an unidentified patient* *• Identification of unidentified patients must be done in a controlled environment. This means actual identification should only occur once acute and immediate treatment has taken place and the condition of the patient has stabilised"* These are reasonable principles. However, because 'responsibility' for the procedure is named as Blood Management, it may not be perceived as relevant by MH&A staff or may not even be known about by MH&A staff. The second 'Patient Identification Policy' is the responsibility of Nursing and Midwifery and owned by the Chief Nursing and Midwifery Officer. Its purpose is stated as "*promoting an organisation wide identification process to reduce the risks of adverse events from misidentification."* and *"applies to all employees of Waikato DHB."* It states "*All patients entering a service provided by the Waikato DHB will have their identification checked using three approved patient identifiers"* and *"Only approved identifiers will be used except in exceptional circumstances where there is risk to life."* It states "*staff will ALWAYS identify patients correctly before providing any health care services or interventions."* Approved identifiers are patient first name, patient surname, date of birth, NHI number. In my opinion, if the patient had remained 'Unidentified' (which was initially the case in ED) until the requirements of 'Identification of Unidentified Patients Procedure' were met (confirmation of identity verbally by patient, or by next of kin/legal guardian/carer/power of attorney), then this would probably have changed the staff approach to acute assessment and care planning. (Please also refer further to my opinion Question 1)

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The policies presented are not fit for purpose for the MH&A services, although they have sound principles.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Mild departure Mitigation factors: • the police (incorrect) identification, • the lack of specific MH&A services relevant policy/procedure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	From my observation and discussion with my peers about this high-profile case, most peers have viewed this as a challenging situation that other services would also struggle with and have a view that other services would also be vulnerable to similar error.
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	Please see my opinion on recommendations – Question 1. Note: In my experience, discussions about the use of photo ID in MH&A services have occurred regularly in services over the years but has not been widely supported because of concerns of those with lived experience about stigma and privacy. Photo ID is also not completely foolproof, and errors can still occur.

Question 6: Are there any other areas of this case that you consider warrant comment?	
List any sources of information reviewed other than the documents provided by HDC:	Nil
Advisor's opinion:	Nil
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Not applicable
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Not applicable

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Not applicable
Please outline any factors that may limit your assessment of the events.	Not applicable
Recommendations for improvement that may help to prevent a similar occurrence in future.	Not applicable

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Signature:
Name: Dr Clive Bensemann
Date of Advice: 18 December 2025’

Name have been removed (except the names of Health New Zealand | Te Whatu Ora Waikato, Waikato Hospital and the expert advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person’s actual name.