

# Response of the Director of Mental Health to the section 95 inquiry into Waikato Hospital

As Director of Mental Health and Addiction, I have carefully considered the report by Mr David Niven, district inspector of mental health, on the inquiry under section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act).

I have also reviewed the Health and Disability Commissioner's final report and opinion, which was completed separately from the section 95 inquiry following an independent investigation by the Health and Disability Commission (HDC). I have shared the full anonymised section 95 report with the Health and Disability Commissioner.

I have formed the view that, in addition to the recommendations made in the section 95 inquiry report, Health New Zealand – Te Whatu Ora (Health NZ) needs to take further action at a national level to ensure that essential safeguards are in place to protect the rights of people receiving compulsory care.

On receiving the section 95 inquiry report, I provided it to Health NZ on a confidential basis to allow for natural justice and comment. I also provided it to the family of the young girl at the centre of these investigations, via their lawyer. I have carefully considered their responses and have had additional discussions with senior leaders from Health NZ to raise matters not fully addressed in their initial response.

At the heart of this serious incident, an 11-year-old Māori girl with autism was misidentified and admitted to an adult mental health unit, where she was restrained and given medication without lawful authority.

The primary failure was the absence of a formal process to confirm the patient's identity. This error was compounded by failures in admission processes and by a lack of adherence to the requirements of the Mental Health Act for compulsory treatment.

This incident has had an enduring impact on the young girl and her family and has eroded their trust in the health system. I extend my sincere apologies to them. This should not have happened. The systems and processes that underpin the delivery of health care are designed to ensure safe and effective care for all people. In this instance, that did not happen. The statutory protections for people receiving compulsory care are intended to ensure that their rights, dignity, and mana are upheld. In this case, those protections were not fully applied, and serious harm resulted.

I accept the advice of the district inspector that the staff involved acted in good faith and with the patient's wellbeing in mind, and I recognise the challenging conditions they were operating under. However, the outcome was unacceptable, and the key issues identified were failures in systems and processes.

However, I remain deeply concerned by what occurred and consider that stronger action is required to restore trust and confidence in mental health services. Health NZ must ensure that robust systems and processes are progressively strengthened and put in place to prevent such an incident from occurring again.

I am heartened that Health NZ has already commenced actions following its rapid review and has been implementing changes to address the immediate issues identified. It has provided a comprehensive plan to address the recommendations arising from its rapid review, the section 95 inquiry, and the HDC investigation.

However, having reviewed all available information, I consider that further national-level action is required to ensure consistent system-wide improvement.

Health NZ has agreed to monitor and report back on progress made in implementing the recommendations and strengthening the systems and safeguards identified through these reviews. Health NZ has committed to doing this within three months.

I am pleased with key parts of Health NZ's response. It accepts it must ensure that the culture of its mental health services consistently upholds the rights and dignity of patients, particularly where compulsory care is involved. The findings across the reports point to embedded practices and gaps in policy and accountability that must be addressed across all services. Health NZ acknowledges that addressing culture is essential to fully implementing the recommendations.

Health NZ is also acting to ensure that staff understand their responsibilities and obligations under the Mental Health Act. The inquiry identified gaps in knowledge of legislative requirements and guidance. Health NZ is reviewing the training provided to staff to ensure that all those exercising functions under the Act are fully aware of their responsibilities.

I have requested, and Health NZ has agreed, that service leadership teams meet regularly with district inspectors to address issues arising from statutory inspections and complaints. Where issues cannot be resolved, they will be escalated to my office and within Health NZ to ensure clear accountability for resolving matters that affect the care people receive. This will also support the effective implementation of the recommendations.

I have reinforced, and Health NZ endorsed the importance of cultural support as an essential component of good mental health care. This is a specific requirement under section 5 of the Mental Health Act, which entitles every patient to be treated in a manner that respects their cultural and ethnic identity, language, and religious or ethical beliefs.

Dr John Crawshaw  
Director of Mental Health  
Ministry of Health