MINISTRY OF HEALTH
MANATŪ HAUORA

Summary Report:

Section 95 inquiry into the treatment of a person at Waikato Hospital

June 2026

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Foreword by Director of Mental Health and Addiction

As the Director of Mental Health and Addiction, I am responsible for the general administration of the relevant compulsory assessment, care and treatment legislation under the direction of the Minister of Health, the Minister for Mental Health and the Director-General of Health.

It is my role to make sure that when people are under compulsory care or treatment in New Zealand, they are well cared for, their rights are upheld, and the services providing care or treatment follow all legislative requirements. When I form the view that this might not be the case, I will intervene to ensure that people experience care according to the law. One of the ways I determine what has happened and where changes are needed is through a formal section 95 inquiry under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act), as has occurred in this case.

This report is a public summary report following a section 95 Inquiry (the Inquiry) into an incident at Waikato Hospital. Making this summary report public is necessary for accountability and transparency. The Ministry of Health worked with the inquirers to draft this summary report. The full report, fully written by the inquirers, will not be published because it is necessary to uphold the rights under the Health Information Privacy Code for the individuals who received the treatment examined in the Inquiry. The young person and their family have already suffered significantly because of what happened.

Alongside this summary report, I have provided a statement with my own conclusions after reviewing the full report and consulting with the parties involved, including the family of the young person.

I appreciate the engagement from the family, staff within Health New Zealand – Te Whatu Ora Waikato and nationally, New Zealand Police, and the Health and Disability Commissioner in examining this situation. I will be monitoring Health New Zealand's implementation of the recommendations of the Inquiry. I extend my sincere apologies to the young person and their family for the harm this has caused them. It is important we learn from this to ensure this situation does not occur again.

Dr John Crawshaw
Director of Mental Health and Addiction
Ministry of Health

1. Executive Summary

1.1 Introduction and process

The Director of Mental Health established an independent Inquiry under section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act) to better understand the circumstances surrounding the care and treatment of Person A at Waikato Hospital and to safeguard against any similar incidents in the future.

Health New Zealand – Te Whatu Ora (Health NZ) commissioned a Rapid Incident Review[1] within one week after the incident. It did not include a review of the application of the relevant provisions of the Mental Health Act.

1.2 Findings

Person A, an 11-year-old girl with autism, was brought to Waikato Hospital by New Zealand Police. She was admitted to the Henry Rongomau Bennett Centre and treated based on an incorrect identification as Person B, a 20-year-old woman with a history of mental health issues. Person A was twice restrained and given intramuscular medication during this admission before she was correctly identified and returned to the care of her mother. This experience has understandably had a significant impact on Person A and her whānau.

We acknowledge at the outset that we found all the clinical staff we interviewed to be genuine and to have Person A's wellbeing in mind, and we found no evidence of bad faith.

The key and central failing in this case was the failure to conduct a formal process for confirming the identity of Person A. Existing hospital policies contained safeguards that we believe should have been sufficient to address this situation and to prevent the misidentification from taking place. However, staff were not aware of all these policies at the time of the incident, and the policies did not set out clear responsibilities for confirming identity.

We also did not identify a lawful basis for the two incidents of restraint and medication, even on the basis that Person A had been misidentified and was being treated in good faith as Person B. The threshold for urgent treatment was also not met. These are key failings of essential safeguards that protect people's right to treatment, including their right to refuse treatment.

While this inquiry was into how an individual was treated, we did identify signs of an element of institutionalisation of care in the practice of prescribing antipsychotic medication in the initial stages of admission. This risks prioritising a one-size-fits-all approach when critical thinking is needed for restrictive interventions, opportunities for consent, and de-escalation strategies.

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[1] *Summary Report: Rapid Incident Review: Waikato Hospital* Event: *2 April 2025*. URL: healthnz.govt.nz/publications/rapid-incident-review-and-summary-report-waikato-hospital (accessed 23 April 2026).

1.3 Recommendations

1. Identification:
   - Review, update and integrate existing policies on Patient Identification and Identification of Unidentified Patients at a national level, taking into account the process gaps identified by the Rapid Incident Review Report and this Inquiry.
   - Review Crisis Assessment and Home Treatment (CAHT) and Henry Rongomau Bennett Centre assessment and admission documents to include a routine prompt for confirmation of identification, the method relied on, and a note of any issues or concerns with the identification process since first presentation to the service.
2. Data sharing between police and hospital
   - Review and confirm guidelines for sharing information between police and hospital staff at a national level.
3. CAHT practice
   - Record the outcome of all CAHT assessments and the reasons for any discontinuation of Crisis Team involvement in writing in a format that is readily available to all Crisis Team members.
4. Consecutive detentions
   - Review the underlying legal reasoning for existing practice regarding detention in hospital under section 111 of the Mental Health Act, following detention by Police under section 109 of the Mental Health Act.
   - Review existing processes and the impact of the Police Mental Health Change Programme.
5. Ward practice
   - Update policy documents and guidelines to clarify expectations for medical assessments on admission and for charting and administering medication.
   - Ensure there is a proper lawful basis for detention and compulsory treatment for each admission, particularly relation to patients brought in under section 29(3)(a) of the Mental Health Act.
6. Patient support framework
   - Ensure Emergency Department (ED) peer support role implementation includes access to staff training on children and young person mental health as well as autism.
   - Extend cultural support to Henry Rongomau Bennett Centre wards during weekends.
7. Policy and training
   - Update existing policy and guidelines for use of restraint.
   - Introduce in-service training modules to increase awareness of autism and possibly other neurodiverse conditions that are commonly encountered by frontline staff.

2. Introduction

The Director of Mental Health established an independent Inquiry under section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Mental Health Act – the Act) to better understand the circumstances surrounding the care and treatment of Person A at Waikato Hospital and to safeguard against any similar incidents occurring in the future.

Person A was an 11-year-old girl who was misidentified as a 20-year-old woman (Person B), who was subject to a compulsory treatment order under the Mental Health Act, and then admitted to and treated in an adult mental health ward at Waikato Hospital based on this mistaken identification.

This Inquiry was required under its Terms of Reference to investigate the background circumstances of this incident, to identify the decisions and practices that were adopted, and to assess whether the steps taken or omitted complied with the requirements of the Mental Health Act, the Code of Health and Disability Services Consumers' Rights (the Code), the United Nations Convention on the Rights of Persons with Disabilities (CRPD), and any other applicable standards.

The inquiry team aimed to identify the main contributory factors leading up to this incident and in so doing to answer the questions 'What happened?' and 'What caused it?' We then recorded the responses of the relevant agencies to what happened. We sought to identify which of these contributory factors have the potential to cause future incidents and reflected upon what this incident reveals about gaps and inadequacies in the current healthcare system. Taking all this into account, we have made a series of recommendations that are designed to address and close these gaps, and to improve patient care.

From the outset, we acknowledge that we did not find any evidence of bad faith on the part of any of the clinical staff we interviewed, or any indication that any stage of the process of admission and treatment would have been handled differently if there had been different staff members on duty on that particular day. We found all the staff members we interviewed to be genuine, to have Person A's's wellbeing in mind, and to be acting within the bounds of what they believed to be the normal operating processes of their respective wards and departments in what are often quite challenging conditions. The comments and criticisms made should be read in this way and are directed at identifying the issues that need to be addressed so that appropriate steps can be taken to prevent this sort of error occurring again.

Note that references are made to individuals in this report based on their role to ensure their privacy is protected.

3. Background

3.1 Setting - Waikato Mental Health Services

Health New Zealand – Te Whatu Ora Waikato provides a full range of hospital and specialist services to more than 425,000 people across its catchment area. In-patient mental health services are provided through the Henry Rongomau Bennett Centre, which is on the grounds of Waikato Hospital, Hamilton. This centre houses six forensic and four general mental health wards.

3.2 Brief history – Person A

Person A was an 11-year-old Māori girl (now 12) who had been diagnosed with autism. At the time of the incident under review, Person A was essentially non-verbal, only using a few single words and short phrases. Person A would regularly leave her house and wander from their house for up to several kilometres.

Early in the morning of 9 March 2025, Person A left her home while her mother thought Person A was in her bedroom. When she didn't come out of her room after a while, her mother let herself into Person A's bedroom and discovered she was missing. Person A's mother and whānau searched nearby locations they usually found her, and further afield, however failed to locate her. That evening Person A's mother filed a missing person's report with the Police and provided them with an up-to-date photo of her.

3.3 Brief history – Person B

Person B is a 20-year-old Māori woman known to Waikato-based mental health services. Person B has a history of treatment for psychosis, including intramuscular injection.

In 2024, Person B was placed under a six-month compulsory treatment order and discharged to a supported accommodation service (the NGO). A few days later, Person B went on leave and did not return to the NGO, and did not engage further with mental health services.

Three days before the compulsory treatment order expired, Person A was mistakenly identified as Person B and detained at Waikato Hospital. This mistake was rectified the same day, and the compulsory treatment order with respect to Person B subsequently lapsed.

4. Incident on 9 March: Summary of Relevant Facts

At 6:40 am on Sunday 9 March 2025, Police received a 111 call to report that a person was walking in the middle of the road just before the Fairfield Bridge, which spans the Waikato River, and then climbing on the rails of the bridge. The description they gave included that the person was a woman in her early 20s, together with a description of her clothing. Two police patrols were dispatched to the area and preparations were made to organise a crew and launch a boat, if this was needed to retrieve her from the river.

4.1 Police detention and transport to ED (section 109 of the Mental Health Act)

The police officers located Person A and spoke with her a short distance from the bridge. Police Officer 1 described her as slightly younger, being 'female, Māori or Pacific Islander, late teens/early 20's, very slim build'. They all described Person A as non-verbal, and Police Officers 1 and 2 thought Person A was autistic. Police Officer 3 took a photo of Person A and shared it within their group to see if anyone knew who Person A was. Police Officer 3 detained Person A pursuant to section 109 of the Mental Health Act. Police Officer 1 returned to the Central Police Station, and Police Officers 2 and 3 drove Person A to the Waikato Hospital Emergency Department (ED). As the police car approached the ambulance parking area, Person A became increasingly distressed and tried several times to open the car door.

Police Officer 2 called the Crisis team and briefed them on the background, and two Crisis team members were assigned to attend. When they arrived, the police officers were preparing to transfer Person A from the car. Upon seeing Person A, one of the Crisis team commented that Person A was clearly a child and was autistic, and that she would therefore not be taking Person A to the Henry Rongomau Bennett Centre. The ED senior staff member in charge agreed and said that Person A could remain in ED while further efforts were made to identify Person A. Police Officer 3 handcuffed Person A during the escort from the police car to prevent Person A running away.

In response to the photo and query posted by Police Officer 3, a fellow officer nominated Person B as a potential identification. Their post included a headshot of Person B from police records and a comment, 'Maybe?' Police Officer 3 brought this photo up on their phone, and they, Police Officer 2, and the staff member assigned to Person A were each able to compare this photo of Person B with Person A. They noted similarities, but none of them thought they were the same person. Police Officer 3 then replied to the fellow officer 'Nah don't think so'.

Once Person A was settled, Police Officer 2 completed the ED Handover Form with as much detail as possible. Police Officer 2 left the patient identity fields of the form blank.

After the police officers left, Person A did not try to leave at any time, so hospital staff did not take any steps to formally detain Person A under section 111 of the Mental Health Act until Person A could be assessed. Instead, they considered Person A to be staying there voluntarily and treated Person A informally.

4.2 Police identification

After Police Officer 1 arrived back at the Police Station, they took further steps to identify Person A. They came across a missing person report where Person B had been reported missing from an

NGO. They contacted the NGO and spoke with a staff member. The NGO staff member confirmed that they had briefly worked with Person B several months earlier. Police Officer 1 emailed the NGO staff member the photo of Person A taken earlier that morning. Police Officer 1 said the NGO staff member told them they were confident that the photo was of Person B, but the NGO staff member said they repeatedly told Police Officer 1 they couldn't be certain they were the same person.

Police Officer 1 contacted the ED senior staff member in charge and told them that they had a potential identification for Person A. Police Officer 1 provided Person B's full name and their date of birth (20 years old). Because Person B was known to mental health services, the ED senior staff member in charge referred the matter back to the Crisis Team.

4.3 Detention and admission under section 29 of the Mental Health Act – as Person B

This time, the CAHT co-ordinator assigned two different Crisis Team members. Neither had previously met Person B and both said they understood that the patient's identity had been confirmed. In their assessment of Person A, they noted certain behaviours that they considered to be broadly consistent with Person B's diagnosis of a psychotic disorder.

They contacted the on-call consultant psychiatrist to consider a recall of Person B to hospital pursuant to section 29(3)(a) of the Mental Health Act. This pathway was available to Person B because Person B was already subject to a compulsory treatment order, but not to Person A. The on-call consultant psychiatrist completed the paperwork remotely, and Person A was transported without incident from ED to the Henry Rongomau Bennett Centre admission area. The on-call registrar drew up a medication chart based on the treatment records of Person B, including an antipsychotic medication.

While Person A declined efforts by multiple staff members to persuade her to take oral medication, she did not present with any unmanageable behaviour or a risk of damage or harm to herself or others. After about half an hour, staff initiated a restraint to administer intramuscular medication. Person A was placed on ten-minute checks for the rest of the day. She fell asleep on a couch after being given the first intramuscular medication and was moved to a bedroom, where she remained asleep into the evening.

Person A woke at 8:20 pm. Person A was offered oral medication but didn't get up and refused to take it. Again, Person A did not present with any unmanageable behaviour or immediate risk to herself or others. Staff then initiated a restraint to administer a second dose of intramuscular medication.

At about 6:20 pm the police emergency centre received a report of a missing 11-year-old girl. At about 9:10 pm, Police Officer 1 saw this report after receiving an email notification on their phone. They immediately recognised her as the person they had dealt with early that morning. Police Officer 1 reported this to the Police District Command Centre and waited on the line while they contacted the Henry Rongomau Bennett Centre.

4.4 Discharge process

Once the misidentification was confirmed, a doctor assessed Person A to ensure that they were safe to return home. Person A's mother arrived at the unit and a staff member of the Henry Rongomau Bennett Centre met with her and explained what had happened. Person A's mother

identified Person A, was instructed about potential adverse symptoms and then took Person A home. She was given a 24-hour number to contact medical staff if she had any concerns or questions, or if Person A displayed any symptoms of concern.

The following morning, after a phone call from the Henry Rongomau Bennett Centre to the family, a psychiatrist and four other hospital staff were delegated to make the first of several follow-up home visits.

5. Analysis and Findings

5.1 The core issue – Identification

The core issue is one of identification. An 11-year-old autistic child with no history of mental disorder was misidentified as someone almost twice her age – a 20-year-old adult – with a history of treatment for psychosis. The original error was made during a police-led enquiry and was maintained across three separate departments within the Waikato Hospital. As a result, a child was admitted to an adult mental health unit, a facility that is unanimously accepted as being inappropriate for anyone of Person A's age, and Person A was twice forcibly given intramuscular antipsychotic medication that was prescribed based on this misidentification after she repeatedly refused oral medication.

We met Person A briefly, and we accept that her physical appearance could allow her to be assessed as being in her late teens. We did not meet Person B, but we note that she is described as being of slight build and appearing somewhat young for her age. The physical similarity between Person A and Person B was exacerbated in this case by the fact that Person B's presentation when unwell was not typical of most patients with psychosis, and some of Person A's behaviours were consistent with psychosis.

5.1.1 Police input

We consider the actions of Police, including the deficiencies in the way Police Officer 1 conducted the identification process with the NGO staff member, and then communicated limited information about this exchange to the ED senior staff member in charge, were a significant contributing factor. Police Officer 1 passed on the views that Person A was in fact Person B to the ED senior staff member in charge in a phone call, including that she had a mental health history, without conveying the doubts of their fellow officers as to the accuracy of this information and the identification. Police Officer 1 thereby gave an unbalanced impression of the reliability of this nomination and, further, did not provide any details that would have allowed hospital staff to conduct any independent checks.

However, Person A remained unidentified when police custody under section 109 of the Mental Health Act ended. Because Person A had been handed over to ED, responsibility for confirming her identity no longer lay with the Police but with the hospital. It was wholly appropriate for ED to receive information from the Police, but responsibility for confirming its accuracy and reliability sat with the hospital and could not be delegated to the Police.

5.1.2 Hospital response

When the ED senior staff member in charge received information from Police Officer 1 that Person A could be Person B, Person A was detained in ED. Because the ED senior staff member was told that Person B had a mental health history, they called the Crisis Team and asked them to come back to undertake an assessment. We see this as an appropriate step to take. However, it is our view that at this point the question of Person A's identity needed to be formally addressed by the hospital services.

None of the ED staff, the Crisis Team or Henry Rongomau Bennett Centre staff took any steps to try to independently confirm the Police identification or otherwise confirm Person A's identity. In part, this was because the Police did not provide ED with any information about the identification process that would have permitted them to undertake an independent inquiry with the NGO staff

member or any other NGO staff. But we also note that the staff we interviewed described widespread reliance on information received from the Police confirming identification.

Existing guidance about identification is spread across three policy documents. These have been developed for different purposes and audiences, and there is no comprehensive cross-referencing between them. Staff were not aware of them all, and they do not set out clear responsibilities for confirming identity, particularly as they apply to mental health services.

We conclude that the key and central failing in this case was the failure to conduct a formal process for confirming the identity of Person A. We consider that this central question of identity needed to be raised and addressed as a part of the process of handover of Person A from ED to the Crisis Team before Person A was assessed by the on-call consultant psychiatrist for potential recall under section 29(3)(a) of the Mental Health Act – a path that would not have been available while Person A was considered unidentified. In our view, this handover should only have been completed, and Person A should only have been eligible for admission into the Henry Rongomau Bennett Centre under Person B's NHI number if either the ED staff or the Crisis Team members were willing to sign a document confirming that she had been formally identified in one of the manners set out in hospital policy.

Over the period within which Person A's identification as Person B gradually became accepted, responsibility for Person A's care shifted from ED to the Crisis Team and then to the Henry Rongomau Bennett Centre. We conclude that the three factors that most directly contributed to this adverse outcome were:

a. Staff unanimously relied on information from the Police to confirm identity. This meant that the weaknesses of the Police process were in turn all unintentionally adopted by the hospital staff through their uncritical acceptance of the information they received, despite Person A being under hospital custody and care at the time this information was provided.
b. All staff assumed that a formal identification would take place at some point, but none understood it to be the responsibility of their department or service. The passage of Person A through different departments and services allowed the issue to be passed from one department to the next while always remaining unaddressed; and the lack of any single decision-maker or decision point meant there was no conscious and deliberate analysis of all the available information, including some that was not consistent with the proposed identification.
c. Existing hospital policy is scattered across different policy documents, key parts of which were not known to staff, and none of which directly addressed this situation. Staff therefore did not draw sufficient guidance from existing policy. The existing *Identification of Unidentified Patients* policy was not well known by staff, and none of those interviewed referred to it at any point. The policy also does not clearly answer the question of who had responsibility for identifying the patient in this case.

Existing hospital policies contain processes and safeguards that we believe would have prevented the misidentification from taking place, had they been known to staff and more clearly applicable to the departments involved. These policies need to be overhauled and better integrated. A quick literature search produced a body of material suggesting that 'the misidentification of people in the health system continues to be an issue worldwide.' A further and more comprehensive literature review could be undertaken to identify and collate material to assist in the process of updating policy in this area.

5.2 Police detention and assistance

We consider that the initial detention of Person A by the police officers under section 109 of the Mental Health Act was reasonable in the circumstances. The main factors justifying this decision were the inability of the officers to identify Person A, Person A's young age and lack of known support, Person A's inability to communicate, and the perceived risk of suicide or self-harm. Cumulatively, these were sufficient grounds for the officers to detain Person A to transport her to a suitable place for a medical assessment.

The use of handcuffs to escort Person A into ED was also reasonable in the circumstances. The police officer who was escorting Person A identified several factors justifying this: Person A's behaviour in the car suggesting flight risk, the risk of self-harm, and they faced the likelihood of difficulties locating Person A after flight due to Person A's identity being unknown.

5.3 Hospital detention for assessment and treatment

We did not identify any issues with the care Person A received within ED. Person A was assessed as among the more vulnerable persons in ED at that time (unidentified, unknown age, possible risk of self-harm, flight risk) so was placed in a separate waiting area where Person A was allocated a support person and provided with food and drink.

The second Crisis Team completed a mental health assessment on the understanding that they were assessing Person B. Recall to hospital under section 29(3)(a) of the Mental Health Act was only possible for a patient already subject to a compulsory treatment order, so it could not have been considered if Person A had remained unidentified. We consider that from this point it became considerably more difficult to reverse the identification. Once staff believed they were treating Person B, we accept that they were likely to interpret any inconsistencies as errors of observation or as challenging the accuracy of the earlier diagnosis, rather than as raising a concern about Person A's identity.

We assessed Person A's treatment in the Henry Rongomau Bennett Centre on the basis that staff genuinely believed Person A was Person B. We accept that all staff treated Person A in good faith based on this misidentification.

We accept that Ward 36 was the most suitable ward for Person A on admission, and that allocating Person A a single bedroom and instituting 10-minute observations after she was settled in was appropriate in the circumstances.

Once Person A was admitted to the unit, Person A was offered medication in accordance with what had been charted for Person A (on the mistaken belief that she was Person B). It was common ground that Person A never consented to take any medication.

However, we conclude that, even if this had been Person B, the two instances when staff administered intramuscular medication under restraint would have been without lawful authority. Compulsory treatment is governed by Part 5 of the Mental Health Act. In this case both administrations were made without Person A's consent, took place more than a month after the compulsory treatment order was made and without a second opinion as required under section 59(2) of the Mental Health Act, and were not justified as urgent treatment under section 62 of the Mental Health Act.

The steps taken by the hospital staff in providing support to Person A and Person A's family after they were informed of the mistaken identification were appropriate and made in good faith.

5.4 Experience of Person A and her family after the incident

Because of Person A's disability, we engaged a communication assistant to help Person A communicate about this incident, and how it has affected her. Person A and her family were invited to provide us with a copy of any statement obtained in this way. Person A's family were also assisted by a lawyer who helped in the process of drafting a statement.

Person A did not say anything specific about the incident, but her mother described some clear behavioural changes in Person A that she and others noticed following the incident. Person A's mother also said that she personally found it difficult to process details of the incident as it unfolded, but that over time both she, and her other children, experienced a wide range of emotions about the incident.

> This has had an enduring and detrimental effect on me and on all my kids. Most of all, it has made [Person A] feel unsafe in her daily life when we have worked so hard to help her to be ok in a world not designed for her

The family appreciated some of the support from the hospital in the days and weeks following. However, they also found some of the process to be overwhelming, and at times not considering their needs and concerns. They were particularly upset about the way an apology from Health NZ was handled.

6. Recommendations

Further detail to the full recommendations listed at 0. These recommendations are made to Health NZ, both nationally and in the Waikato district.

Recommendation 1: Identification

Review, update and integrate existing policies on Patient Identification and Identification of Unidentified Patients, taking into account the process gaps identified by the Rapid Incident Review Report and this Inquiry.

Review CAHT and Henry Rongomau Bennett Centre assessment and admission documents to include a routine prompt for confirmation of identification, the method relied on, and a record of any issues or concerns with the identification process following first presentation to a service.

Raise awareness amongst staff of updated policy and procedure. This needs to extend across ED, CAHT, the Henry Rongomau Bennett Centre, and any community services that may refer patients to an in-patient unit, and to include doctors, nurses, and administrators.

There are reasons to believe this could be a national issue, not restricted to Waikato. There was evidence that the risk of over-reliance on Police identification extends beyond the Waikato region. This issue needs to be reviewed nationally and addressed in national policy documents.

Recommendation 2: Data sharing between police and hospital

Police and Waikato Hospital should jointly review and confirm guidelines for sharing information between Police and hospital staff.

Recommendation 3: CAHT practice

The outcome of all CAHT assessments and the reasons for any discontinuation of Crisis Team involvement must be recorded in writing in the call logging system and any other written set of clinical records so that this information is readily accessible to all Crisis Team members.

Recommendation 4: Consecutive detentions

Review the underlying legal reasoning for existing practice regarding detention in hospital following detention by police under section 109 of the Mental Health Act.

Review existing processes in light of the young age and disability of Person A, and the impact of the Police Mental Health Change Programme that has recently been implemented.

Recommendation 5: Ward practice

5.1 Admission assessment

Update policy documents to clarify expectations for medical assessments on admission, including the timeframe for completing assessments, the content of clinical reports and electronic notes, and the level of seniority required (eg, SMO, nurse) in different circumstances (such as after-hours, weekends and public holidays).

Check performance against expectation with periodic unannounced audits of admission records.

5.2 Confirmation of lawful basis for compulsory treatment

It is of fundamental importance to ensure that there is a proper lawful basis for detention and compulsory treatment for each admission. Review the decision-making process for all potential admission pathways to ensure that this is adequately addressed. This should include, but not be limited to, admissions via ED and CAHT, and those directly into the Henry Rongomau Bennett Centre.

This review and ongoing staff training should particularly address the pathways for recall under section 29(3)(a) of the Mental Health Act of patients already subject to compulsory treatment orders, and the requirements for lawfully carrying out compulsory treatment when this pathway is exercised, including the operation of section 59(2) (second opinions) and section 62 (urgent treatment) for recalled patients.

5.3 Charting medication

Review the process of charting medication. Align understanding between clinical staff of methods of charting and the practice and parameters of nursing discretion in administering medication. Record this understanding in either published guidelines or a policy document.

5.4 Records management

Update the computerised records (PiMS) system to include a folder or a link that allows easy access to all key clinical documents relevant to compulsory care and institute a system to allow this material to be easily updated.

Recommendation 6: Patient support framework

6.1 Cultural support

Engage with the Kaitiaki and Kaitakakawaenga cultural services that operate within the hospital service to determine if there is potential to improve service coverage. Potential improvements could be made if Kaitiaki would extend care to patients with comorbid physical and mental health issues and cover weekends and holidays when the Kaitakawaenga service does not operate, or if the service offered by Kaitakawaenga can be extended to seven days a week.

6.2 Peer support

Ensure ED peer support role implementation includes access to staff training on children and young person mental health, as well as autism.

6.3 Whānau and family engagement

Review the process of engagement with families after receiving a complaint.

Recommendation 7: Policy and training

7.1 Identification policies

We refer to recommendations at Recommendation 1.

7.2 Restraint policy and process

Update the Restraint Policy with reference to applicable standards and guidelines.

Review the current version of the restraint form. This process should consider whether a checklist can be included to record that less intrusive options have been considered, and reasons are recorded as to why these have not been attempted or have been ineffective.

7.3 Autism and age-related awareness

Some staff indicated that autism was suspected in Person A, but others did not. The potential for misdiagnosis or misattribution of symptoms was commonly noted as a clinical challenge.

Add training modules for staff on autism and look at extending this over time to cover other conditions under the broader heading of 'neurodiverse' conditions that are commonly seen by frontline services, such as obsessive-compulsive disorders and conduct disorder.

Appendix One: Glossary

CAHT	Crisis Assessment and Home Treatment Team. They provide crisis mental health assessment for individuals who require an urgent response, as part of Health NZ Waikato’s mental health services
ED	Emergency Department
Kaitiaki	Kaitiaki services work in conjunction with hospital clinical and operational teams to strengthen their capability and capacity to achieve health equity and wellbeing for Māori receiving hospital care. Kaitiaki champion and promote Māori Health improvement through their cultural cares to ensure the holistic health needs of whānau are responded to and heard.
Kaitakawaenga	Kaitakawaenga provide a liaison service between Māori patients, whānau and inpatient ward staff to achieve the best health outcome for Māori patients and their whānau.
Neurodiverse	Clinically, neurodiverse conditions are conditions that cover neurological differences, including autism, Attention Deficit Hyperactivity Disorder (ADHD), and learning disabilities (eg, dyslexia). It also describes a natural diversity in how brains engage in learning, perceive information, and organise and communicate thinking.
NGO	Non-governmental organisation. In this instance, the non-governmental organisation that provided community support for Person B.
PiMS	Patient Information Management System

Appendix Two: Terms of Reference

The full Terms of Reference – inquiry under section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 into the treatment of a patient at Waikato Hospital.

1. Background

1.1. On the early morning of 9 March 2025, Police responded to a report of concern about a person in Hamilton. They brought the person to Waikato Hospital and incorrectly identified her as a 20-year-old woman subject to the Mental Health (Compulsory Assessment and Treatment) Act 1992 ('the Act'). Clinical staff treated the patient on that basis and administered medication by injection (intramuscular injection or IMI) on two occasions without the patient's consent. The patient was also restrained.

1.2. Later that day Police advised the hospital that the patient had been misidentified and was in fact an 11-year-old child ('the patient'). A rapid internal review by Health New Zealand – Te Whatu Ora identified clinical and operational failings in the patient's treatment and care, and in the surrounding processes. The internal review did not address the application of the Act.

2. Establishment of Inquiry

2.1. To better understand the circumstances of this incident, and to ensure appropriate steps are put in place to avoid similar incidents in the future, the Director of Mental Health, Dr John Crawshaw, establishes this inquiry under section 95 of the Act.

3. Purpose of Inquiry

3.1. The purpose of the inquiry is:

3.1.1. to investigate and report on the care and treatment of the patient at Waikato Hospital on 9 March 2025, including the circumstances, decision-making, and practices used; and

3.1.2. to assess whether the steps taken or not taken complied with the Act and any applicable standards including the Convention on the Rights of Persons with Disabilities.

3.2. The inquiry may make recommendations for any steps or practice improvements that should be implemented as a result of its findings.

4. Inquirer

4.1. The inquiry is to be carried out by David Niven of Auckland, District Inspector for Mental Health. Mr Niven will be supported by Jane Simperingham, Nurse Director of Mental Health and Addiction Services in Health New Zealand – Te Whatu Ora – Te Tai Tokerau. Mr Niven may seek such other assistance as reasonably required to carry out this inquiry.

5. Scope of the Inquiry

5.1. The inquiry will include, but not be limited to, consideration of the following matters:

5.1.1. Identification and Admission

a. The circumstances leading to the (mis)identification of the patient.

b. The process by which the patient came to be assessed and/or admitted under the Act, including whether the correct mechanisms were used for detention, return to hospital, and assessment and treatment under compulsion.

c. The communication between medical staff and Police, including the adequacy of any protocols or processes for the identification of the patient.

5.1.2. Use of Restrictive Practices

d. The use of restrictive practices including restraint and compulsory care, and whether less restrictive alternatives and de-escalation techniques were adequately considered and documented.

e. What safeguards were in place to protect the patient's rights in relation to the use of force, including whether alternatives were meaningfully explored, what methods were used, and by whom.

f. Whether clinical judgement and critical thinking were appropriately applied in decisions involving the use of restraint or force.

5.1.3. Medication

g. Whether the treatment of the patient complied with legal standards in the Act, and adequately dealt with the interplay between sections 59 and 62 of the Act and Right 7(4) of the Code of Health and Disability Services Consumers' Rights.

5.1.4. Observations and Communication

h. The nature and quality of observations conducted during the period of care – including what observations were carried out, by whom, and in accordance with what protocols.

i. The level and quality of communication attempted with the patient, her family or guardians, and among treating clinicians and staff, including whether methods of communication other than verbal were considered.

5.1.5. Rights of the Patient

j. Whether those involved in the patient's care complied with the patient's rights under Part 6 of the Act, including:
   - Respect for cultural identity (section 65)
   - Right to treatment (section 66)
   - Right to be informed about treatment (section 67).

k. Whether the processes used adequately addressed the Code of Health and Disability Services Consumers' Rights, particularly Right 7.

5.1.6. Systems and Accountability

l. The adequacy of Waikato Hospital's policies, procedures, and staffing in relation to the patient's care.

m. Any systemic, clinical, or organisational issues that may have contributed to failings in care.

n. The adequacy of any steps taken after the incident(s) by Waikato Hospital or Health New Zealand – Te Whatu Ora to address concerns and prevent recurrence.

5.1.7. Any related matters

o. Any other related matters that come to the attention of the inquirer during his work if he considers that investigation of those matters would assist in carrying out the purpose of this inquiry, and they properly fall within section 95(1)(b) of the Act.

5.2. The inquirer may, if he wishes, seek an extension of these terms of reference if he is in doubt whether any additional matter properly falls within the scope.

6. Powers of the Inquiry

6.1. In accordance with section 95 of the Act, the Inquiry has the same powers and authority to summons witnesses and receive evidence as are conferred upon Commissions of Inquiry by the Commissions of Inquiry Act 1908. The provisions of the Commissions of Inquiry Act 1908 Act apply accordingly, except sections 11 and 12, which relate to costs.

6.2. The Inquiry will seek to operate efficiently and to minimise unnecessary trauma to individuals. The Inquiry may receive information from other investigations or reviews into this incident including without limitation work by the Police, Independent Police Conduct Authority, Health New Zealand – Te Whatu Ora, and the Health and Disability Commissioner.

6.3. The inquiry will observe principles of natural justice and procedural fairness at all stages of the process.

7. Confidentiality and Privacy

7.1. Given the patient's age and the sensitivity of the issues, the inquiry must take all necessary steps to protect the privacy of the patient and her family. All identifiable information must be anonymised in any published findings unless legally justified and consented to.

8. Reporting

8.1. The inquiry is to produce a final written report, including:

- A summary of factual findings, including a summary suitable for publication.
- An analysis of whether the care and treatment complied with relevant standards.
- Recommendations to improve clinical practice, legal compliance, and systemic oversight.

8.2. The report is to be submitted to the Director of Mental Health and may be made public subject to appropriate redactions for privacy.

9. Timeframe

9.1. The inquiry is to commence as soon as practicable and a final report shall be delivered within three months from the date of commencement, unless otherwise agreed by the Director.

Dated at Wellington on 5 May 2025

Dr John Crawshaw
Director of Mental Health
Ministry of Health