Health and Community Services
Complaints Commissioner

Summary of the Investigation into the provision of health services by the Women's and Children's Hospital in August 2021.

June 2023

Preface

This is a public summary of the investigation conducted into the Mallee Ward at the Women's and Children's Hospital. It contains most of the information contained in the final Investigation Report, however some information has been removed to protect privacy.

The Health and Community Services Complaints Commissioner (HCSCC) is required to work with a variety of stakeholders and it is important they know their personal information will be kept private. This fosters good working relationships with all parties and is something the HCSCC takes very seriously. The removal of this information does not detract from the overall picture of the investigation into the services provided.

Background

1. On 24 November 2022, the Office of the Health and Community Services Complaints Commissioner (HCSCC) accepted a referral from the Office of the Chief Psychiatrist (OCP) with concerns about treatment provided to Mr J during an admission to the Mallee Ward at the Women's and Children's Hospital (WCH) between 17 August 2021 and 20 August 2021. Referral information from the OCP identified:
    a. Mr J was admitted to the Mallee Ward at the Women's and Children's Hospital (WCH) on 17 August 2021, reportedly following an Inpatient Treatment Order (ITO) issued by his General Practitioner on the same day, however this ITO was not confirmed;
    b. Mr J was discharged from the Mallee Ward into the care of his parents on 20 August 2021;
    c. On 21 August 2021, Mr J's parents presented to their local police station alleging Mr J had been assaulted by Women's and Children's Health Network (WCHN) staff while in the care of the Mallee Ward, however South Australia Police (SAPOL) did not conduct an investigation;
    d. On 16 May 2021, Mr J's stepfather raised the same complaint to the WCHN consumer engagement team;
    e. WCHN completed a Clinical Incident Brief for the Acting Chief Executive Officer of SA Health who, in turn, requested the OCP review the complaint in full;
    f. The OCP completed a 'desktop' review of Mr J's admission to the Mallee Ward; and
    g. On 29 September 2022, the Clinical Director of the Child and Adolescent Mental Health Service (CAMHS) requested the OCP undertake a formal, independent investigation of this matter.

2. On receipt of the OCP's referral, I requested and received a copy of their desktop review. Arising from this review are the allegations:
    a. No evidence exists of the ITO under which Mr J was admitted to the Mallee Ward;
    b. WCHN failed to document either the absence or presence of injuries sustained by Mr J during his admission to the Mallee Ward despite incident reports which describing Mr J hitting doors, walls and objects, sometimes with his head and one documented incident of restraint by security personnel;
    c. Restraint used by security officers was not consistent with standard practice, WCHN procedure or the training WCHN staff are expected to have received;
    d. Mr J was secluded during this admission, with an unclear basis for the seclusion; and
    e. Mr J and his family allege he was racially abused by WCHN security personnel during an incident involving restraint.

3. On 7 December 2022, I determined to conduct an own motion investigation into this matter under Part 6 of the *Health and Community Services Complaints Act 2004* (SA) (the Act).

Allegations under Investigation

Allegation 1: Mr J was detained in the Mallee Ward of the Women's and Children's Hospital on the basis of an ITO issued by his General Practitioner (GP), however no evidence of this ITO exists.

Findings

4. Mr J was transferred to WCH ED from a local hospital by the South Australian Ambulance Service on 17 August 2021 following a situational crisis. Although it was intended Mr J be transferred directly to the Mallee Ward independently of the WCH ED, this did not occur.

5. On arrival to the WCH ED, Mr J absconded and was returned to the hospital by SAPOL. A mental health assessment was then completed.

6. Mr J was transferred to the Mallee Ward where admission documentation was completed at 20:00 hours.

7. A reporting error was made in Safety Learning System (SLS) documentation listing an incorrect date on which Mr J absconded from the WCH ED. This error was corrected on review of the SLS notification prior to approval. Notably, approval of the notification was completed almost one year later on 18 May 2022 at 13:51 hours.

8. A reporting error was made in an SLS notification incorrectly identifying Mr J as being admitted to the Mallee Ward under an ITO which allowed for compulsive treatment, including medication administration. Based on the interviews of senior WCHN staff involved in the creation of these SLS notifications, this error is likely to have been made by conflating previous SLS entries relating to Mr J's January 2021 admission to the Mallee Ward which was under an ITO.

9. I find, on the information before me and on the balance of probabilities, the allegation Mr J was detained in the Mallee Ward of the WCH on the basis of an ITO issued by his GP is not substantiated.

Allegation 2: Mr J was subject to restrictive practices which were not in line with expected standards or the training provided to WCHN staff.

Findings

10. During an admission period of just over 48 hours, Mr J experienced three recorded incidences of seclusion, lasting a cumulative total of five hours and 15 minutes and experienced two recorded incidences of physical restraint prior to seclusion.

11. Each of the seclusion periods experienced by Mr J were well in excess of the 30 minutes set out by the Chief Psychiatrist's *Restraint and Seclusion Standard* (the Standard). While the Standard requires additional seclusion orders for extension of this timeframe, WCHN stated in their response of 14 March 2023 they do not use seclusion orders.

12. On the morning of 19 August 2021, Mr J was physically restrained by two WCHN staff prior to a Code Black being called and an ERT team arriving to assist, contrary to the SA Health 'Restraint and Seclusion in Mental Health Services Policy Guideline.

13. On the morning of 19 August 2021, Mr J was held by a WCHN staff member in prone restraint, contrary to both section 4.7.1 of the SA Health 'Restraint and Seclusion in Mental Health Services Policy Guideline and the Standard.

14. No injury charting or recording of debrief offered to Mr J occurred following each episode of restraint and seclusion, contrary to the Standard.

15. Seclusion records associated with Mr J's admission were not consistently or accurately kept in the manner set out by the OCP's Standard.

16. I have been unable to locate records confirming the use of restraint and seclusion was discussed with Mr J and/or his parents upon admission, or that Mr J's parents gave informed consent for these to be utilised.

17. Documentation provided by WCHN identifies at least one occasion during Mr J's admission where clinical staff requested an ERT member physically restrain Mr J without adequate basis, requiring staff debrief. This is contrary to the legislative requirement for restraint and seclusion to be used as last resorts.

18. I find, on the information before me and on the balance of probabilities, the allegation Mr J was subject to restrictive practices which were not in line with expected standards or the training provided to WCHN staff is substantiated.

Allegation 3: Mr J was assaulted by WCHN staff during his admission and sustained injury/injuries as a result of this assault.

Findings

19. On 19 August 2021, Mr J experienced two episodes of restraint and seclusion. Both of these events proceed in a manner inconsistent with SA Health procedures and the OCP's Standard.

20. Following both events, multiple WCHN staff reported injuries to themselves which were appropriately documented on injury charts and in SLS reports.

21. I am unable to determine whether Mr J sustained injuries following these events, as no contemporaneous injury charts were completed for Mr J.

22. I agree with the OCP's desktop review which suggests bruising sustained by Mr J is likely to be linked to the restraint and seclusion events of 19 August 2021.

23. I do not have the legislative responsibility of determining allegations of assault, which is an offence set out by the *Criminal Law Consolidation Act 1935* (SA). Therefore, I will not make a finding as to the allegation Mr J was assaulted by WCHN staff during his admission and sustained injury/injuries as a result.

Allegation 4: The WCHN did not maintain accurate or contemporaneous records of Mr J's admission.

24. Documentation provided by WCHN shows admission records and care notes were contemporaneously and accurately maintained by clinical staff for the duration of Mr J's admission.

25. In their response of 14 March 2021, WCHN advised the HCSCC they do not use injury charts for consumers.

26. Multiple seclusion records made over the duration of Mr J's admission were not filled in correctly or were missing large sections of information.

27. No records were kept as to whether debrief was offered to Mr J and/or his parents following episodes of restraint and seclusion, contrary to the Standard.

28. An SLS report contains an erroneous reference to Mr J having been admitted to the Mallee Ward under an ITO. Despite this error, the entry was reviewed and approved by WCHN staff as accurate.

29. An additional SLS report contains an incident summary purportedly provided to non-clinical staff by the Nursing Unit Manager (NUM), however, the NUM states she did not provide this information to the non-clinical staff member in question and did not ever see the report prior to its finalisation.

30. Much of the documentation WCHN provided to the HCSCC in relation to Mr J's admission was authored or reviewed well after he had been discharged, with some as late as the following year (2022).

31. There are multiple typographical errors and date discrepancies in WCHN's two response letters to the HCSCC. This includes a reference in their letter of 14 March 2023 to Mr J having been restrained and secluded in June 2021, at which time he was not admitted to the Mallee Ward.

Findings

32. I find, on the information before me and on the balance of probabilities, the allegation WCHN did not maintain accurate or contemporaneous records of Mr J's admission is substantiated.

Recommendations

33. I recommend WCHN retrain all MSS Security Staff and Mallee Ward staff on the SA Health 'Restraint and Seclusion in Mental Health Services Policy Guideline, as well as the OCP's Standard.

34. I recommend The OCP develop a paediatric version of the SA Health 'Restraint and Seclusion in Mental Health Services Policy Guideline' in consultation with WCHN which is then disseminated across all South Australian Local Health Networks.

35. I recommend WCHN adopt the use of injury charts for consumers, especially following incidents of restraint and seclusion.

36. I recommend WCHN consult with the Chief Psychiatrist about their breaches of the Standard and adopting the use of seclusion orders in the future.

37. I recommend WCHN retrain all staff in contemporaneous record keeping and ensure seclusion observations are contemporaneously recorded at the required intervals.

38. I recommend WCHN review its procedures in relation to SLS reporting to ensure inaccurate report content is not approved and any clinical information entered by MSS security staff is reviewed and verified by the relevant Nurse Unit Manager.

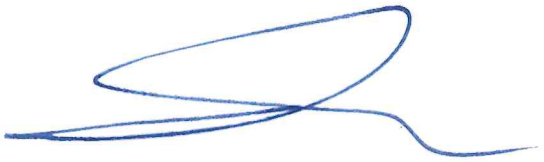
39. I recommend WCHN work with the OCP to develop appropriate procedures for the authorisation of restrictive practices, when required, for young people who have behaviours of concern secondary to a developmental disability as it is understood in these circumstances the MH Act cannot be administrated.

40. I recommend WCHN develop a process for consumer's cultural and disability needs to be communicated to auxiliary staff to ensure continuity of care.

41. I recommend WCHN consult with Mr J's family in conjunction with the Chief Psychiatrist to develop a continued care plan for Mr J should he represent to the Mallee Ward in order to repair the therapeutic relationship with Mr J and his parents.

Notice of Action

42. I require WCHN report to the HCSCC on the implementation of these recommendations at three, six, nine and twelve months from the date of this report.



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Health and Community Services Complaints Commissioner.