HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failures in care of disabled client placed in a forensic psychiatric unit

21HDC01302

In a report published today, Deputy Commissioner Dr Vanessa Caldwell has found Health New Zealand | Te Whatu Ora breached the Code of Health and Disability Services Consumers' Rights (the Code) for care provided to a client residing in a secure unit.

The client had been diagnosed with Fetal Alcohol Spectrum Disorder (FASD) and had a mild intellectual disability. Despite having no history with mental health services, the client resided in the clinic's forensic psychiatry medium secure unit, as there were no suitable beds in Health NZ's Forensic Intellectual Disability Secure Services (FIDSS).

Concerns were raised with HDC by a lawyer, following a restraint by clinical staff which resulted in the client sustaining an injury that caused pain and required surgery.

The incident occurred while the client was being accompanied to a high-care area, a decision taken because the client had become angry and verbally aggressive. A struggle ensued between the healthcare assistant, registered nurse, and the client. The client was injured when all three fell to the ground.

Dr Caldwell found Health NZ breached the Code for failing to provide an appropriate standard of care | tautikanga.

"I am critical that systemic issues culminated in the client being seriously injured during a restraint," Dr Caldwell said. "Ultimately, Health NZ has an organisational responsibility to provide a reasonable standard of care to its residents. That did not occur in this case."

HDC found several failings in the care of the client, including a failure to employ de-escalation strategies and manage the client's restraint adequately, seclusion being initiated by healthcare assistants without the leadership of a registered nurse, and in breach of the seclusion policy, and a lack of documentation surrounding the events.

Dr Caldwell said it is concerning that the client who had specific vulnerabilities was not cared for appropriately and that staff did not seem to be trained sufficiently to take these needs into account.

She said it highlighted a lack of suitable facilities for people with co-existing conditions and the appropriately trained staff to provide care for them.

“I have raised this matter previously with Health NZ, the Ministry of Health and Whaikaha and expect that as a system we can coordinate resources to better meet the needs of our most vulnerable.”

Dr Caldwell commended Health NZ for undertaking an adverse event investigation in a comprehensive and patient-centred manner and was satisfied that they had appropriately identified six broad areas where things went wrong.

However, she was concerned that some of the key improvements were not implemented in a timely manner. Health NZ updated HDC on its progress towards implementing the recommendations a year after the recommendations were made, and two and a half years since the events.

“Recommendations from an adverse event investigation must be implemented in a timely manner to ensure that the event is unlikely to happen again,” she said.

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Editor’s notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC’s website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC’s naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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