INQUIRY UNDER SECTION 47 OF THE HEALTH AND DISABILITY SERVICES ACT 1993 IN RESPECT OF THE CIRCUMSTANCES SURROUNDING THE DEATH OF MATTHEW FRANCIS INNES

REPORT OF THE COMMISSION OF INQUIRY TO THE MINISTER OF HEALTH HON. JENNY SHIPLEY

SEPTEMBER 1994

FOR MATTHEW INNES

Clevedon,
South Auckland
20 September 1994

Hon. Jenny Shipley
Minister of Health
Parliament Buildings
WELLINGTON

Dear Minister - Tena Koe,

Greetings to you, the Minister of Health. I have pleasure in handing you my report about some of the circumstances surrounding the death of Matthew Innes. My Terms of Reference required me to examine mainly the provision of mental health services to Matthew Innes. In particular, it was not my function to inquire into and comment on the culpability of any person involved with him on the night of 3 / 4 January 1994.

To the extent permitted I have, however, commented on Police involvement, practices and procedures surrounding Matthew's death.

I believe that the process adopted by this Inquiry, in some small way, has been helpful to the Innes family and I am hopeful that the recommendations contained herein will enhance the well-being of those who are mentally disabled and those who assume responsibility for their assessment and care.

I thank you for the opportunity to be of service.

KEN MASON

TERMS OF REFERENCE

TO: KENNETH HECTOR MASON of Auckland, former District Court Judge

INQUIRY UNDER SECTION 47 OF THE HEALTH AND DISABILITY SERVICES ACT 1993

Various concerns have arisen in respect of the circumstances surrounding the death of Matthew Francis Innes.

Now, pursuant to section 47 of the Health and Disability Services Act 1993, you are appointed and requested to inquire into and report to the Minister of Health on the provision of health services by the South Auckland Crown Health Enterprise (South Auckland Health) to Matthew Innes on the evening of 3 January 1994 and the early hours of the morning on 4 January 1994, and the lessons to be learned from the circumstances surrounding the death of Matthew Innes which are relevant to the provision of mental health services to mentally disordered (or suspected mentally disordered) people not only in the South Auckland Health area but also in Crown Health Enterprises elsewhere in New Zealand, including:

1. What lessons, if any may be learned from the actions taken by the duly authorised officer who arranged for Matthew Innes to be transported to Kingseat Hospital. In particular, you are to consider whether the duly authorised officer:

(a) acted within the powers given to that officer by the Mental Health (Compulsory Assessment and Treatment) Act 1992;

(b) used an appropriate strategy in responding to Matthew Innes' condition;

(c) should have called a suitably qualified medical practitioner to the premises where Matthew Innes was staying, to examine him.

2. The response of the mental health services at South Auckland Health to the situation involving Matthew Innes and in particular, to consider whether:

(a) the procedures used by South Auckland Health for transporting or arranging for the transportation of mentally disordered (or suspected mentally disordered) persons to hospital are adequate;

(b) the procedures referred to in (a) above adequately deal with such persons who are violent or disturbed;

(c) the practices of South Auckland Health mental health services staff in relation to the use of force and physical restraint are appropriate;

(d) the procedures used by South Auckland Health mental health services staff for dealing with violent or disturbed patients (or potential patients) in the community are adequate;

(e) the terms of the memorandum of understanding between South Auckland Health and the Police concerning Police assistance are adequate and in particular, whether this memorandum adequately sets out:

(i)when the Police should be called;

(ii)who is to be in charge of the situation when the Police arrive, the Police or the mental health professional who called the Police; and

(iii)the respective roles of the Police officers and the mental health professionals involved.

3. What lessons if any may be learned as to the adequacy of healthcare services provided to Matthew Innes on his arrival at Kingseat Hospital and in particular:

(a) whether Matthew Innes' physical condition was discovered when he first arrived at Kingseat and whether appropriate medical intervention was made at that time and if not, whether it should have been; and

(b) whether the treatment provided to Matthew Innes, when he arrived at Kingseat Hospital, was appropriate.

4. To recommend to the Minister of Health what, if any, action should be taken to implement any findings which may arise from your Inquiry in respect of the death of Matthew Innes, first as to the provision of services to mentally disordered people in similar circumstances by South Auckland Health and second, as to the provision of services to mentally disordered persons in similar circumstances by Crown Health Enterprises elsewhere in New Zealand.

In concluding your inquiry I direct, pursuant to section 47(3) of the 1993 Act, that you have all the powers of a Commission under the Commissions of Inquiry Act 1908.

You are requested to have your final report to the Minister of Health, in writing, no later than 9 August 1994.

Dated this 8th day of June 1994.

Jennifer Mary Shipley
Minister of Health

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CHAPTER ONE

INTRODUCTION

The Mental Health (Compulsory Assessment and Treatment) Act came into force on 1 November 1992. This legislation replaced the Mental Health Act 1969. The new Act created some radical changes and purported to be an Act "to redefine the circumstances in which, and the conditions under which, persons may be subjected to compulsory psychiatric assessment and treatment, to define the rights of such persons and to provide better protection for those rights ...". There are thus multi-stage periods of assessment and / or treatment before a compulsory treatment order may be made.

The Act also creates a new mental health worker, namely the "Duly Authorised Officer". Section 93 of the Act empowers CHEs to " ... designate and authorise sufficient mental health professionals to perform at all times the functions and exercise the powers conferred on duly authorised officers by ... the Act". No person shall be designated as a DAO " ... unless the (CHE) is satisfied that the person has undergone appropriate training and has appropriate competence in dealing with persons who are mentally disordered ...".

Section 37 of the Act sets out the general functions of a DAO. "So far as practicable, duly authorised officers shall act as a ready point of contact for anyone in the community who has any worry or concern about any aspect of this Act, or about services available for those who are or may be suffering from mental disorder; and, at the request of anyone they shall provide all such assistance, advice and reassurance as may be appropriate in the circumstances".

More specifically, if anyone is concerned that a person in his / her care may be suffering from mental disorder the assistance of a DAO may be requested. After investigating the matter the DAO may, if satisfied, take the appropriate legal and clinical steps to ensure that the person to whom the request relates is assessed by a psychiatrist. It is clear therefore, that the duties and responsibilities of DAOs will encompass a vast and varying range of personalities and situations.

On 23 December 1993 Matthew Innes arrived in Auckland from Australia to holiday with his brother Craig and his sister-in-law Natalie. All three, along with a family friend, holidayed in the Bay of Islands from 27 December 1993 until 1 January 1994 on which date they returned to the Innes home in Howick. On the early evening of 3 January Craig and Natalie became concerned about Matthew's behaviour and rang Kingseat Hospital for advice.

Suffice it to say, at this point, that at a later stage in the evening Matthew was transported to Kingseat Hospital by the Police following a request for assistance by a

DAO. The DAO, Alan Gundesen, had been despatched to the Innes home by staff at Kingseat Hospital in response to the request by Craig Innes for advice and assistance.

Matthew Innes died in Middlemore Hospital on 10 January 1994. It is that series of events, culminating in his death, which have prompted this Inquiry.

On receiving my Terms of Reference I met with Eugenie Laracy, a District Inspector under the Act. She provided valuable background information and later allowed me access to her files.

On 20 June 1994 I was briefed by Dr Janice Wilson, Director of Mental Health, Dr Nick Judson and Catherine Coates of the Ministry of Health.

On 27 June 1994 I invited Patrick Driscoll, Barrister, of South Auckland to accept appointment as Counsel assisting the Commission.

A preliminary meeting of parties to the Inquiry was held on 12 July 1994 and advertisements advising of that meeting and inviting submissions, were placed in the public notices column of the New Zealand Herald on 2 and 4 July 1994.

At the preliminary meeting I informed the parties that the Inquiry would be conducted in public. I gave four reasons:

- The matter of Mr Innes' death had already been well publicised.

- The Terms of Reference included matters which were of public interest

- There had been considerable adverse publicity about the so-called "secrecy" of certain events surrounding the death of Matthew Innes. I indicated that I made no judgment as to whether that perception was well founded and expressed concern that if the current Inquiry were to be held behind closed doors the perception would be compounded.

- In any event, it was the wish of the Innes family that the Inquiry be held in public.

Certain procedural matters were also canvassed and finalised at that meeting.

I requested the Police file relating to the death of Matthew Innes. This was made available to me on 2 July 1994.

At my request the Ministry of Health arranged for four independent experts to participate in the Inquiry. They were Brigit Lenihan of Auckland and Steve West of Rotorua, both of whom are DAOs; and Dr Brian Timney of Wellington and Dr Douglas Wilson of Hamilton, both of whom are Consultant Psychiatrists.

The formal hearing commenced in room 8.2 Auckland District Court on Monday 18 July 1994 and concluded on Wednesday 10 August 1994 when final submissions were presented by the parties.
The evidence of fifty witnesses (including recalls) was heard over a ten day period.

It will be noted that my Terms of Reference require me (inter-alia) to make recommendations as to the provision of services to " ... mentally disordered persons ... by Crown Health Enterprises elsewhere in New Zealand".

I was anxious to learn of the practices and procedures adopted by DAOs and other mental health workers "elsewhere in New Zealand" and to make comparison with the events which emerged during the formal Inquiry held in Auckland.

Circumstances did not allow me to meet with all DAOs - that would clearly be a time-wasting and repetitious exercise. Accordingly, I met with DAOs, psychiatrists, registrars and other mental health workers in Lower Hutt, Wellington, Porirua, Christchurch, Dunedin, Hamilton and Auckland (West Auckland, Greenlane and North Shore). I had specifically requested the attendance of rural DAOs since the problems in rural areas would differ from those in the metropolitan centres. The response in this regard was very satisfactory and I believe the findings and recommendations in this report adequately reflect the concerns of those who work in the more remote parts of the country.

A list of those witnesses who gave evidence at the formal Inquiry is annexed as Appendix 1, and those individuals and organisations who made submissions or who were consulted is recorded as Appendix 2. A statement on positional asphyxia is annexed as Appendix 3. The Memorandum of Understanding signed by the Auckland Area Health Board Mental Health Services and the New Zealand Police is annexed as Appendix 4. The draft Memorandum of Understanding between the New Zealand Police and the Ministry of Health is annexed as Appendix 5. The memorandum by Chief Inspector Beattie dated 26 March 1993 is annexed as Appendix 6.

Because of the need to consult elsewhere in New Zealand, my reporting date was extended to 20 September 1994.

My Terms of Reference call for a comprehensive and detailed examination of the events on the night of 3 / 4 January 1994. The best way to describe those events, and the ancillary matters relating thereto, is to allow the participants to tell their own stories in their own words. That approach is more meaningful than any words I could invent.

Accordingly, and where appropriate, I have adopted that approach. Of necessity the evidence has been edited, but without damage to its integrity.

Throughout this Inquiry I have received advice from a variety of sources as to the interpretation of the law and the construction which ought to be placed on the events leading up to the death of Matthew Innes. The four expert witnesses appointed to assist me are included amongst those sources. I am grateful for that advice but emphasise that the findings, judgments and recommendations contained in this report are mine alone and were reached after carefully weighing up all the information placed before me.

It should be noted that earlier this year the Police Complaints Authority dealt with two complaints arising out of the actions of certain Police Officers on the night of 3 / 4 January 1994. I have read the Police Complaints Authority reports of 15 April 1994 and 22 August 1994.

Acknowledgements

I express my thanks to all Counsel and others involved in the formal hearing of this Inquiry. The fact that a large number of witnesses were heard within a relatively short period is a tribute to their co-operative approach.

I particularly thank:

- Helen Takitimu and Treasa Dunworth for their competent attention to secretarial, research and administrative duties;

- Eugenie Laracy, Barrister, for her initial briefing and for providing access to her District Inspector files;

- Ministry of Health which took the necessary steps to ensure that Matthew's parents were legally represented at the Inquiry;

- The Directors of Area Mental Health Services who arranged my visits to Wellington, Christchurch, Dunedin, Hamilton and Auckland;

- Patrick Driscoll who cheerfully and diligently carried out his duties as Counsel assisting the Inquiry;

- Linda Leaf who so competently typed and collated this report;

- Those representatives of mental health consumer groups who attended the Inquiry and demonstrated support for the mentally ill;

- Dr Brian Timney, Dr Douglas Wilson, Brigit Lenihan and Steve West for their patience and expertise;

- And finally I thank Paul and Julie Innes, Matthew's parents, for allowing us, collectively, to intrude into the life of their much loved son. I hope that the process and conduct of this Inquiry, by all involved in it, has been sensitive to their concerns.

CHAPTER TWO

3 / 4 January 1994:Howick

Matthew Innes, his elder brother Craig and his sister-in-law Natalie returned to Howick on 1 January 1994 after holidaying for several days in the Bay of Islands.

Craig Innes describes the events following their return:

> **That night he woke us up in the middle of the night with his coughing. I got up to see if he was okay. I thought his coughing was a silly forced cough, but he kept doing it even though I found it annoying. He didn't look sick or any different but he was just coughing.**
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> **In the morning he said that he had nodded off for a while but he was still in his clothes and hadn't been to bed.**
>
> **I remember he took a shower that day, (this was 2 January) had a shave and put on clean clothes and then took my car and phone and went to see a friend of his who lived in Half Moon Bay. He came back about half an hour later because his friend was away, apparently.**
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> **At about 1.00 pm on 2 January, we went round to see Evan and watched television at his place. Matthew couldn't relax again. He kept wandering around. He didn't have any decent clothes on so we came home before we went to the Howick Club.**
>
> **We left the Howick Club at about 5.30 pm on 2 January and went home. That night Matthew didn't want anything to eat. He had bought some pure orange juice and some marmite and basically he just had marmite on bread as well as orange juice.**
>
> **Matthew wanted to get a video that night. He took ages to choose it. The whole day I had been telling him to get some sleep. That was the last thing I remember telling him that night before we went to bed.**
>
> **I am sure that Matthew stayed awake again all that night. He had nothing to eat other than his marmite sandwich and juice.**

In the morning we tried to get Matthew to have some breakfast but he didn't want anything to eat or drink. That morning we found that Matthew had cut some labels out of his clothing. I think he might have tried to lift the attic hatch as well but I didn't question him about that. Natalie and I talked to him or tried to talk to him and told him that we were concerned for him. We wanted him to get some sleep. We wanted him to eat and we wanted him to drink. I think he had some fruit to satisfy us.

Later that morning Matthew phoned the airlines to confirm his ticket to go home the next day. He became quite upset because something had gone wrong with the flight and he was not now going home until 5 January. He calmed down fairly quickly but he was really upset about not being able to get home. He seemed to really want to get home.

Natalie and I had arranged for a barbecue that evening at home with quite a few of our friends to say goodbye, to Matthew. We had expected he was going home the next day.

When we got home for the barbecue he found out that he had bought the wrong orange juice for himself. He wouldn't drink anything else so I offered to take him up to the shop to get the right orange juice which he liked. I went with him and again he wanted to buy some cigarettes but he couldn't decide on which type. He just wanted his orange. I was getting a bit impatient with him by this stage and told him to sort it out. He was also going on about wanting to buy a hamburger. In the end I think he wound up buying five.

When we got home he seemed to disappear. The next thing I knew was when we were welcoming guests to the barbecue and they said he was on the roof next door.

Natalie and I tried to talk him down off the roof. I got up to try and get him down off the roof by talking to him. I thought he might fall off. He was raving, throwing his hands to the sky. When I got up there he said "Don't touch me" so I got back down. By this stage I was getting pretty concerned about what was happening to Matthew so I decided to phone my dad.

When I phoned he advised me not to treat him aggressively, not to try and push him around, but to use a very soft gentle approach. He also told me to try and get help for Matthew. I think he told me to be careful so that Matthew wasn't hurt. I remember Dad was a bit worried that if we tried to rush Matthew he might run away and either hurt himself or the thing might turn into some sort of man-hunt for Matthew.

Other things happened during this whole process but shortly afterwards Natalie had managed to talk Matthew down off the roof. Matthew soon appeared, dazed, but started acting normal again. He was a bit upset with himself and he gave me a hug. He tried to explain it all away and explain to us the shapes of the clouds that he had seen and told us that he was aware that he had flipped out. I told him that Mum and Dad and we were worried about him and that I had contacted Kingseat Hospital. I think it might have been around 7.00 pm or so by this stage. I said Kingseat was going to send a nurse out to talk to him.

Finally the nurse arrived. It was Mr Gundesen from Kingseat. He came in and spoke to us and also to Matthew. Natalie and I, Mr Gundesen and Matthew were all in the lounge. Mr Gundesen started talking to Matthew and questioning him. I think he was trying to assess his state of mind. Matthew was quite restless and pacing around. He was calm most of the time but sometimes he got irritated about what Mr Gundesen was saying and although he never became threatening or violent, he just became upset and then would calm down again. He appeared quite frustrated at times.

Towards the end of the conversation which would have been half an hour or so at least, Mr Gundesen started asking Matthew questions about whether he would go to hospital to talk to a doctor. At this stage Matthew sometimes raised his voice and was acting quite frustrated. He never looked like he was about to attack anyone, but he made it pretty plain that he was not happy about going.

At about this stage we all got up and Alan asked Matthew again if he would go to the hospital to see a doctor and Matthew refused again, but this time suggested that if the doctor could come and see him where he was that would be okay. Mr Gundesen said it was impossible. It was best if

Matthew went with him to the hospital. Matthew kept refusing to go and insisting that the doctor should come and see him. Natalie and I tried to get Matthew to see that we wanted him to get some help and that if Mr Gundesen said that was the best way, then he should do it. Mr Gundesen said he would have to go out to his car and talk to someone at Kingseat.

Mr Gundesen had used a mobile phone from his car to telephone Kingseat. He said that Matthew was borderline. He had not threatened to hurt himself or anyone else. But he said he would talk to Kingseat again once they had Matthew's records.

A short while later we spoke to Mr Gundesen again outside the house. Mr Gundesen explained to Natalie and I that they had decided it would be best to take Matthew to Kingseat for an assessment by a doctor. He said he had been in touch with the Police and had requested them to assist him to take Matthew away. He said it would take some time for the Police to arrive. He said that we should not tell Matthew that the Police were coming or that he was going to be taken away so as not to upset him or alarm him. He told us to continue to act normal. He explained to us the procedure we had to go through and asked us to fill out a form. He explained that he was not committing Matthew and that Matthew wasn't a patient - they just wanted to have him examined by a doctor. Natalie filled out the form for me and I signed it and gave it back to Mr Gundesen. Mr Gundesen said that he would wait outside until they arrived. We went back inside and kept an eye on Matthew and tried to carry on as if everything was normal.

Matthew was restless but he was no trouble at this stage.

It seemed a long time later, perhaps between two and three hours, before Mr Gundesen telephoned. He was still outside the house. He had phoned to tell me that the Police were there.

Mr Gundesen came to the door and then came inside. I think the Police waited behind him. I am pretty sure that Matthew saw Mr Gundesen and the Police behind him. I think Matthew knew what was going on at that stage. He started

getting anxious. Mr Gundesen explained to Matthew what was happening. he said that he needed Matthew to come with him to see the doctor at Kingseat. He was not being committed he just wanted him to see a doctor for examination or something like that. Perhaps he said assessment.

Matthew said that he wanted a doctor to be brought to him at our place. After a while of talking, Matthew said he would go and see the doctor and went to leave. He went down the hall and out the front door where he saw the Police again and he stopped. He backed up against the wall and said "so where is the doctor". Then we all explained the whole situation to him again.

The three officers, Mr Gundesen, Matthew and I all stood on the front porch. It seemed to take a long time, perhaps it was five or ten minutes. We went through the whole procedure with Matthew again. Matthew was anxious and upset but he wasn't threatening anyone. He said time and time again that he wanted the doctor to be brought to him, and Mr Gundesen and the policeman in charge kept saying that it wasn't possible, and that Matthew had to go with them to see the doctor. It kept going round in circles and I could see that somebody had to try and help to do something. I tried to take Matthew by the arm to lead him away. He took his arm away. Then the biggest policeman tried to grab Matthew and it all happened in a flurry. Matthew was shouting and yelling abuse. We all grabbed hold of him and eventually wrestled him off the porch and down on to the driveway. We laid him down on his back before we managed to get him turned over on to his face. While he was on his face he was struggling. The three policemen were on one side of him. I was on the other. I think Mr Gundesen was up around his head area. I think Mr Gundesen or one of the policemen was trying to keep a hand on his head. Two policemen were trying to grab his left arm. One of them might have been trying to kneel on him or lean on him to keep him down. Martin Thompson had come out from inside the house to help and was struggling with Matthew's legs. I think one of the policemen was also trying to help with the legs. Two of the policemen got a handcuff on Matthew's left arm. He managed to get it free again and was flinging it around with the handcuff flying off it before they grabbed it again. I tried to get his right arm around his back to be handcuffed with the left. He got it away

from me once or twice and put it back underneath his chest. I eventually got it out from underneath him and around behind his back. He was shouting and yelling all the time and struggling to resist but he wasn't trying to attack anyone. He just was trying to resist. Eventually I got his right arm around behind his back and it was handcuffed with the left one. Then I think Martin and I and one of the policemen managed to cuff his ankles. Once we had him like that we picked him up together, I think three or four of us, and carried him down the drive and out on to the footpath toward the police car. It was parked just up the road.

The police car was locked when we approached. We put Matthew on the ground. He was quieter at that stage because he sat on the ground with his feet out in front of him and his hands cuffed behind his back. He was still shouting at times. The police sergeant was on one side of him holding one shoulder and arm and the other big policeman was on the other side. The smaller policeman, who was the driver of the car, unlocked the car. I helped the sergeant and the big policeman put Matthew inside the car feet first from the passenger side so that his feet went behind the driver's seat and his head went behind the passenger seat. His feet, legs, hips and the main part of his body were on the seat. His shoulders and head were just over the edge of the seat in the space behind the passenger seat.

Constable Vincent got into the driver's seat. Constable Schmidt, got into the back of the police car and sat on Matthew around about his hip and waist region. Constable Vincent had wound down the window on the passenger's side on the rear seat but the window on the driver's side was not wound down. The police car, with Matthew in it, then drove off. I understood they were going directly to Kingseat.

I spoke to Sergeant MacGibbon and he thanked me for my help. I then spoke to Mr Gundesen briefly. I asked him whether he wanted me to go straightaway after Matthew or what. Mr Gundesen told me not to worry. He wanted us to stay home. He said he would telephone me from Kingseat as soon as they had managed to get Matthew calmed down and let me know what was going on. The police sergeant drove off in his car. Mr Gundesen later drove off in his car.

Paul Bethune was a guest at the Innes barbecue:

> **I saw Matthew standing on the neighbour's roof, staring at the sky. I went inside the house and spoke to Craig. While Craig was talking to Matthew, trying to get him to come down, I went back inside.**
>
> **I went back outside about twenty minutes later when I heard a commotion outside. Matthew was still up on the roof and Craig was climbing down. At this stage, Matthew was yelling and was preaching to the sun. It was sad to see him like that. He would not respond to Craig, or anyone else, and seemed to be in a world of his own. I think I heard him call himself a Matai.**
>
> **Eventually, Natalie got Matthew to come down from the roof.**

Leigh Anne Hill recalls what happened when Matthew came down from the roof:

> **Matthew came down from the roof after Natalie talked him down. Matthew came out to the deck and said he was sorry. He went back inside the house. He was walking around inside the lounge and was changing his clothes continually. We were all trying to carry on as if there was nothing wrong. Although he would come out on the deck, he seemed to be on edge and had a fiery look in his eyes.**
>
> **The nurse from Kingseat Hospital arrived and Matthew was still inside pacing around the lounge. He seemed weird and uneasy although he wasn't threatening anybody and wasn't violent.**
>
> **I could see the nurse talking to Matthew and I could hear that the nurse was trying to get Matthew to go with him so that they could talk to a doctor. Matthew said he didn't want to go anywhere. Finally, Craig talked him into going and they all went off.**
>
> **I then heard arguing out the front door area.**
>
> **I could hear screaming and shouting. Matthew was screaming and laughing, "sucked in, sucked in". I could also hear other voices shouting. Matthew sounded frantic.**

When everybody came back in after the police had left, Craig was extremely upset.

Martin Thompson arrived at the Innes home at about 6.00 pm on 3 January:

After we had been there for about an hour, we all heard some screaming from the next door neighbour's roof. When we went out to see what was happening, we saw Matthew Innes, Craig's brother, on the roof. He was screaming and seemed to be preaching. He was calling himself Matai and shouted, "I am Jesus". Although we tried to reason with Matthew to get him to come down from the roof, our presence seemed to make things worse, so we went back inside and started to put the barbecue on outside on the deck. After about twenty minutes Matthew came in, having come down from the roof, and apologised to us. He kept saying to Craig how sorry he was for the trouble he had caused.

Shortly afterwards, a man from Kingseat Hospital came out. I know that this was as a result of Craig phoning the hospital. The man from Kingseat called the Police. I could hear Matthew saying that he was all right and that he would not go with anyone to be checked up.

Matthew was inside when the Police arrived, staring into space. We had stayed because Craig was worried that he might need some help.

Two constables and one sergeant arrived at the house. For about twenty to thirty minutes they tried to persuade Matthew to go with them. Evan and I ran out to the front door and I saw Matthew on the ground in the driveway. He was lying face down and going berserk.

The three Police Officers, Craig and the man from Kingseat Hospital were all trying to restrain him. One Police Officer had a knee on Matthew's shoulder blade. I tried to grab one of Matthew's legs. He was really strong and threw me off. I wrapped my arms around his legs and lay on top of his legs. His strength was just incredible. Even with my whole body weight on his legs, he still just threw me off.

After about three or four minutes, the Police Officers managed to get handcuffs on Matthew. One set was on his

arms and the other on his legs. Even handcuffed, Matthew was still struggling and causing problems.

I cannot recall who did exactly what during the struggle to get the handcuffs on. Matthew banged his face on the concrete driveway several times. I could see blood on his face. It was coming from his eyes and nose. Then Matthew started to laugh when the Police Officers turned him over.

There was a struggle to get Matthew into the Police car. He was still struggling against them, but not so much. When they got to the car, parked on the street, they put him down on the grass verge to open the car door. Eventually they got him into the car - one officer was trying to pull Matthew in, another had his legs and was pushing him in. A third had him by the shoulders and I had him by his waist. When they got him into the car, he was lying across the back seat on his left side. One of the officers got into the back seat with Matthew and sat on him to hold him down. He sat on him from his chest area through to his hips

When Matthew had been struggling on the driveway, he had been trying to bite people. I never saw anyone during the struggle grab him around the throat. Throughout the struggle, all anyone did was try to control him.

Evan Lindsay describes the struggle with Matthew in these terms:

I can recall several times Matthew saying he wanted a doctor to come and see him - he was in the lounge with Mr Gundesen, Natalie and Craig. I was on the deck and had come inside to get a drink from the bar.

When he got outside, I heard him getting upset. Craig and Mr Gundesen were explaining that they were only going to Kingseat for a talk. There was a scuffle and at that stage, Martin Thompson and I went to help.

When Martin and I got out to the front, Matthew was lying on the ground face down. There were three Police Officers on top of him. The District Nurse was holding his upper legs and Martin had him by his lower legs. There was one handcuff on Matthew's left arm and they were trying to get his right arm around behind him to put the cuffs on fully. Matthew seemed

to be really strong and three of them couldn't get his arm around. I would say that the scuffle lasted about five minutes.

Craig was trying to help the officers get Matthew's hands behind his back and at the same time, trying to calm Matthew down and get him to co-operate. The Police also put cuffs on Matthew's legs, as he was kicking out. They carried Matthew to the Police car and put him in the back seat. He was still struggling even with both cuffs on. One Police Officer sat on Matthew in the back and the other in the driver's seat.

Natalie Innes, like her husband Craig was concerned to see that Matthew's stay in New Zealand would be well spent and a time of pleasant family reunion. The visit to the Bay of Islands had been an enjoyable experience for all concerned and had passed without incident. On the night of 1 / 2 January Natalie too saw a noticeable change in Matthew's behaviour:

On 2 January he insisted that he would only eat pure food like fruit and 100% orange juice. During the day he kept walking outside every now and again to get fresh air. He was hot and uncomfortable. We went around to Evan Lindsay's place to watch cricket on TV later in the day, and to the Howick Club to play pool. Matthew would not have a beer at all. He did not want to have any food or drink unless it was pure and natural. Although Sunday 2 January was a quiet day, Matthew just was not his normal self and was quieter than he had been. We thought it might have been his tiredness as he had been up all night. I cooked tea that night but Matthew would not eat any of it.

On the night of 2 January we watched a video and played a Nintendo game which Craig and Matthew had hired earlier. Craig and I went to bed early, at about 10.00 pm. Matthew stayed up watching TV. At about 3.00 am Matthew again woke us up with loud coughing. Craig got up to see if he was okay and tried to get him to go to bed, but Matthew apparently refused and continued watching TV and playing the stereo. I think he stayed up all that night as well because he was still watching TV when I got up on 3 January.

The previous day I had washed his clothes and put them in the dryer before going to bed. When I got up I found them scattered all over the floor. I also found two of my jumpers out of the airing cupboard and I found about four clothes

labels scattered on the floor. They were from Matthew's clothes as they were all Australian labels. This concerned me so I told Craig. We then spoke to Matthew together. We told him that we thought something was wrong and that he should sleep and eat or he would get sick again. By this stage, Matthew hadn't slept for two days and two nights and had only had fruit and juice. Matthew just said, "I am all right, I am okay, I am normal" and passed it off as nothing. He told us he had lots of things going through this mind but he would not say what.

We had arranged a barbecue for that night with quite a few friends coming over. As friends arrived for our barbecue, Matthew would say hello, but later I found him standing outside staring at the sun. He did it for about half an hour and I told him to stop as he would get sore eyes. He seemed to me to be getting worse. Shortly after that, he went missing. Another lot of friends arrived and told Craig that Matthew was up on the neighbour's roof staring into the sun. We tried to get him to come down but he had snapped by this time and was saying weird things, shouting at the sun. We couldn't make out what he was saying - it was sort of religious - but he was totally different by then. He began screaming and yelling at the clouds and calling out weird things that I didn't understand. I became really upset and Craig was also getting very upset. I had never seen anyone behave like that before and didn't know that to do. He was up on the roof for about half an hour. Craig went up to try and get him down but he screamed at Craig to get away from him and Craig came back down. That was when Craig went off to phone his parents and tell them what was happening and ask them what they thought we should do. Craig told me later that they advised him to try and get help and he had phoned Kingseat.

While Craig was inside on the phone, I continued trying to talk to Matthew. At one point he seemed to respond and he came down from the roof. He seemed to have snapped out of his mood. I kept talking to him telling him how much we loved him and cared about him, but he was quite upset and embarrassed. He never threatened me or anything. His mood had disappeared. He appeared to be dazed, sort of not knowing what was happening. He was quiet and calm again. I took him inside to the lounge. He was embarrassed and thought he had made an idiot of himself. Craig and I spoke to

him and settled him down. I offered him a drink and something to eat but he refused. We told him that we had phoned his parents and also phoned Kingseat Hospital and that they were sending a nurse out to talk to him. He seemed okay about this and didn't say much. He had settled down quite a lot.

When the nurse from Kingseat Hospital arrived, he spoke to Matthew in the lounge and Craig and I sat in with them. The nurse was Mr Gundesen. He asked Matthew questions. I believe he was trying to assess his mental state. He was asking questions about what Matthew was thinking and asking Matthew to explain what had happened when he was on the neighbour's roof. Matthew would get a little aggressive at times in answer to some questions and then he would take a few deep breaths and calm himself down again. It seemed to me that Matthew was going through some mood swings, from being angry and then calm. I wasn't sure, as it was hard to know exactly what he was thinking.

Mr Gundesen asked Matthew whether he would go to see a doctor for an assessment. Matthew said he didn't want to go. He told Mr Gundesen that he was happy to see a doctor if Mr Gundesen brought the doctor to him. Mr Gundesen explained, while we were there, that this was not possible - in fact I think he said it was impossible. He said it was not the procedure. He said that Matthew would have to go to Kingseat to see the doctor.

I think Mr Gundesen must have spoken to Matthew for about three quarters of an hour before he went outside to contact Kingseat. We later went out to talk to him alone. Mr Gundesen explained to Craig and I the criteria for committing someone as a psychiatric patient. He said Matthew was borderline. He said he understood that Matthew's records from Australia were being faxed through to Kingseat. He said that as Matthew hadn't threatened to hurt anyone or hurt himself, he really was a borderline case. He then went away to phone Kingseat again.

Mr Gundesen came back later to tell us that he had spoken to Kingseat and they had some of Matthew's records from Australia. On the basis of what the records said, they had decided that Mr Gundesen should take Matthew into Kingseat

for an assessment. He gave Craig and me a form to fill out. He explained that he was a duly authorised officer and told us that he could take Matthew against his will. I filled out the form which he had given us and Craig signed it as his brother. We didn't tell Matthew that we were about to have him taken to Kingseat. We did that because Mr Gundesen advised us that he had fears for Matthew's safety and and we shouldn't tell him. He also told us that he had arranged for Police to come to assist him to take Matthew away. He didn't want Matthew to know in advance as he did not want to upset him or scare him. We then waited for two to three hours. Most of our guests left during this period. A couple of Craig's friends stayed behind to help in case of trouble. We tried to act normal and stayed calm.

When the Police arrived, Mr Gundesen phoned to tell Craig they were there and then came to the house. The Police were behind him. Matthew was in the lounge at that stage. Mr Gundesen came in and talked to him and asked him to come with him. I am sure Matthew saw the Police and was upset that they were there. He said he had done nothing wrong and he wanted the doctor to come to him. Mr Gundesen said that Matthew had to go with them..

After some discussion, Matthew agreed to go and walked down the hallway and out the front door. The Police were outside at that point. He then stopped on the front porch and said he wasn't going anywhere. He repeatedly asked for them to bring the doctor to him.

The three Policemen, Mr Gundesen and Craig were all present outside on the front porch. Matthew made it quite plain to all of them that he was happy to see the doctor and requested them to bring the doctor to him. He asked several times. Mr Gundesen and one of the Policemen explained to Matthew that he had to go with them. He refused to go. He made it plain that there would be trouble if they tried to take him. He said, "if you try to take me it will be awesome". Craig came forward then to try and assist the Police. He tried to take Matthew by the arm and lead him away but Matthew pulled his arm back. Then it all happened. I think a Policeman then grabbed Matthew's arm and then they all grabbed Matthew together. They struggled with him and

eventually lifted him off the front porch and down on to the driveway. There was a lot of shouting and yelling.

Matthew was eventually laid down on the driveway on his back and then he was rolled over on to his front. I went back inside and came out shortly afterwards with a torch to shine a light on Matthew for them. While he was face down on the driveway he was struggling. The Policemen were struggling to try and grab his arms and feet. Martin Thompson, who had stayed behind to help us, was also struggling with Matthew's feet. Craig was struggling with one of Matthew's arms. It was his right arm. The Police eventually got one handcuff on Matthew's left arm. They also managed to get handcuffs around his ankles. Matthew was struggling violently. It was Craig who eventually managed to get Matthew's right arm around behind his back so that his two wrists were handcuffed together down behind his back.

Once he was handcuffed the Policemen and Craig picked Matthew up and carried him out to the street to the Police car. The car was locked. While one of the Policemen went around the car and unlocked it, the sergeant and the other Policeman held Matthew sitting on the ground, each with one hand on each shoulder while standing beside Matthew. Matthew was sitting on the ground with his feet out in front of him cuffed together and with his hands cuffed behind his back. He had his jacket on in the normal position.

Once the doors of the Police car were unlocked, Craig helped feed Matthew into the car feet first so that his feet were behind the driver's seat and his head was behind the passenger seat. I was standing at a short distance at that time and could not see exactly what Matthew's position was inside the car before the car drove off. It did not drive away at high speed and did not have any of its emergency lights flashing. The car drove off past our house towards Orangewood Drive. At the time they drove away, the bigger Policeman (Constable Schmidt) was in the back of the car and in the back seat. It looked like he was sitting on Matthew. Mr Gundesen told us to stay behind and wait for him to call us.

Alan Gundesen was the DAO who responded to Craig Innes' call for assistance. He describes his background as a psychiatric nurse, his practices when responding to a call and the events at Howick and later at Kingseat Hospital:

> **I have been working in psychiatric crisis management for the last eleven years. Up until about five years ago I was also involved in continuing psychiatric care. However, the emphasis over the last five years has been almost entirely upon psychiatric crisis management. My day to day work involves the management of crisis in the community of a psychiatric nature.**
>
> **During the last five years I have been working from 3.00 pm to 12 midnight on a four on / two off roster. When I am on duty I am also on call between midnight and 8.00 am.**
>
> **Over the last eleven years I have been dealing with violent or potentially violent persons on an almost daily basis. As a consequence I have had years of experience in dealing with such persons. These people include persons who have threatened to do injury to themselves as well as persons who have threatened to harm others.**
>
> **On the night of 3 January 1994 I was on duty with Dave Murray who is a psychiatric district nurse with over twenty years experience in this area of work. The psychiatric registrar who was on duty in the evening of 3 January 1994 was Dr Marie Israel.**
>
> **It is my practice, and the practice of other psychiatric district nurses, to work in a team situation with the registrar on duty. I carry a mobile phone and as a result, I am able to keep in close contact with the registrar whilst carrying out my duties. Similarly, the registrar is able to communicate with me whenever it is necessary for him or her to do so. It is not my practice, nor has it ever been, to act in isolation.**
>
> **When I am on duty I make a practice of maintaining contact not only with the registrar on duty, but also with my colleagues.**
>
> **As a result of my training as a psychiatric district nurse, I utilise a number of different strategies for dealing with**

persons who are violent or potentially violent. The procedure which I and my colleagues adopt is along the following lines:

- **Before dealing directly with the person concerned, my colleagues and I endeavour to find out, from sources other than the person concerned, the person's past history and particular details of any violent behaviour exhibited by the person in the past. The sources of such information include family and friends, medical practitioners and hospital records. Where possible, I also endeavour to speak with the person by telephone before meeting him or her, to gain a history and consent.**

- **On meeting the person my colleagues and I endeavour to establish a dialogue and rapport with him or her, initiating the start of a trusting relationship. This is part and parcel of the preliminary assessment of the person.**

- **In talking to the person my colleagues and I avoid being confrontational or aggressive in any way towards him or her. We adopt a calm approach, endeavouring to sit where appropriate, and speaking in a quiet and relaxed manner with a view to lowering, as much as possible. the level of tension and anxiety between ourselves and the person. The purpose of the interaction is to determine as accurately as possible the nature of any problem the person had and whether the person is, or may be suffering from, a psychiatric disorder. We are also concerned to determine whether or not the person is, or may be, a danger to him or herself and / or to others. An important predictor is whether or not there is a past history of violence.**

- **If there is a threat of immediate violence it is my practice to either call the Police myself, or arrange for those with the person to do so.**

- **If on arrival it becomes apparent that there is a real risk of violence, I attempt to diffuse the situation by talking to the person and to any family members and friends (who may be perceived to be aggravating the situation) in a way that is intended to lower the tension which exists between the person and those around him or her.**

- **If during my preliminary assessment of the person's mental state I believe that he or she ought to be assessed under the Mental Health Act at Kingseat Hospital, my first priority is to see if I can encourage the person to come to Kingseat voluntarily without having to invoke the Act, and without having to involve the police, because this is the most humane way. If on the other hand it is clear that the proposed patient is unwilling to go to the hospital on a voluntary basis or without the assistance of the police, I nevertheless continue to strive to deal with the matter in a low key, non-threatening and reassuring manner.**

- **If on arrival I find that the person is behaving in a violent manner, I would call the police immediately. My priority is to ensure that nobody is hurt. I do not see it as part of my function to intervene physically to prevent the person from behaving in a violent way. If when the Police arrive the person is still behaving in a violent way, the Police would take charge and restrain the person.**

- **If it is clear that the violent person is not mentally ill, then I would retreat and leave the matter in the hands of the Police. On the other hand, if it is apparent that the person has a psychiatric disorder, I would consult with the Kingseat duty registrar. If the person does not represent imminent danger to themselves or others then I would arrange for a medical practitioner to attend the house. If a medical certificate under Section 8(3) is completed I would then give the proposed patient a Section 9 form with explanation. Following this, he or she would be taken to Kingseat for an assessment examination under the 1992 Act.**

- **If the proposed patient is clearly mentally disordered and safety is a priority, I consult with the Kingseat Psychiatric Registrar about the Medical Certificate Section 8(3) being carried out at Kingseat Hospital. If the person is behaving in a violent fashion, the Police are usually already with him or her when I or my colleagues are called in to assist. Very rarely are we the first persons called to a violent scene where others have been assaulted. Where the person is behaving in a violent way, and the Police attend first and they have reason to believe a psychiatric assessment is required, they contact a duly authorised officer.**

Every single person, without exception, whom I have assessed and for whom I have had to invoke the Mental Health (Compulsory Assessment and Treatment) Act has met the criteria of mental disorder in the opinion of the psychiatric doctor assessing the person at the time under Section 10 of the Act.

In all the years I have been working as a psychiatric district nurse I can only recall three occasions on which I have been actively and physically involved in the restraint of a violent or potentially violent person in the community. I have from time to time gently encouraged persons to the hospital or into a car or out of the house. It is not part of my job, nor the job of psychiatric district nurses, to physically restrain violent persons. On each of the occasions that I was involved I was either assisting the police or family members to restrain a violent person. On each occasion the restraint was no more than necessary to prevent the person from injuring himself or others.

Over the years I have frequently had to work with the Police in dealing with violent or potentially violent persons in the community. During this time my relationship with Police has always been one of support and co-operation. This has not only been my experience but also the experience of other psychiatric district nurses in the South Auckland area.

Throughout the whole of the time I have worked with the Police I have had confidence in them and relied on them to assist me and other psychiatric district nurses in transporting persons to Kingseat Hospital for assessment. I have never had occasion to expect that a person might suffer at the hands of the Police whilst being so transported.

In all my dealings with the Police I have never observed a Police Officer use excessive force in restraining a person or in transporting that person to the hospital.

I have never seen the Police act towards a person in anything but a professional, appropriate and effective manner. Nor have I seen the Police behave in an abusive or inappropriate manner towards persons who are restrained or transported by them to the hospital.

At approximately 7.34 pm on 3 January 1994 I received a telephone call from Dr Marie Israel who was the psychiatric registrar on duty at Kingseat Hospital. She told me that Matthew's brother had phoned her expressing concern regarding Matthew. She told me that Matthew was on the roof of the house yelling at the sun and not making sense. The family, she said, had told her that his mental state had deteriorated over a period of approximately three days. He was not eating or sleeping properly and had a psychiatric history in Australia. The family wanted help, but also wanted a cautious approach adopted to prevent the situation escalating. Dr Israel asked me to visit the Innes home to assess the situation while she obtained details of Matthew's psychiatric history from Australia.

At approximately 7.41 pm I telephoned Matthew Innes' brother, Craig Innes, at his home. Craig told me that it was not convenient to speak and that I should ring him on his cellphone. As soon as he had put down the phone I rang him on his cellphone. At that time I was in my car parked outside the Howick Police Station. Craig told me that his wife Natalie had coaxed Matthew down off the roof of a neighbour's house. He told me that he and Natalie believed that Matthew was unwell. Craig said they did not know what to do and he requested help. Craig confirmed that Matthew had not been sleeping or eating properly over the preceding three days. He also referred to Matthew's irrational and aggressive behaviour whilst he was on the neighbour's roof and the difficulty that he and Natalie had had in coaxing him down from the roof. This behaviour and Craig's fear that Matthew might fall made the situation very precarious.

While at the Howick Police Station, I spoke in person to an officer to whom I indicated that I might need Police assistance in respect of this crisis. The Police Officer advised me to ring the Central Police Station should I require their assistance. I left the Howick Police Station and arrived at the Innes house at approximately 8.00 pm.

When I arrived at the house I was ushered into a front bedroom where I spoke on the telephone to Matthew Innes' father in Australia. His father, Paul Innes, told me that in February 1992 Matthew had become very unwell, had not been eating or sleeping properly and had been admitted to the

Mandala Psychiatric Clinic for assessment. He told me that Matthew was suffering from a schizophrenic condition. He further told me that Matthew had been difficult to manage because of his mental state. He described to me an occasion when Matthew had been next to him in an apparently calm state. Suddenly and without warning, Matthew had propelled himself forward and against a large plate glass window on the second floor of the clinic. The window was shattered and it took approximately eight people to restrain Matthew. According to Matthew's father, the decline in Matthew's mental state had occurred rapidly over a period of approximately four days, immediately prior to admission.

Before I first spoke to Matthew at the Innes house I was aware of the following:

- **That he had been drinking heavily over the New Year period**
- **That his current mental state had deteriorated over a period of approximately three days**
- **That he had not been eating or sleeping properly**
- **That there was a BBQ in progress with a number of people present**
- **That he had a psychiatric history in Australia**
- **That he had been on the neighbour's roof and yelling in an irrational manner**
- **That whilst he was on the roof he had responded in an aggressive manner and had not listened to Craig**
- **That Craig had accordingly retreated**
- **That it was only after some difficulty that Natalie (Craig's wife) was able to persuade Matthew to come down off the roof**
- **That when Matthew acted in an irrational way, he was difficult to calm**
- **That when he was admitted to the Mandala Clinic he was said to be suffering from a schizophrenic disorder**

- **That whilst he was at the clinic he had suddenly and without warning thrown himself at a plate glass window on the second floor of the clinic, had to be restrained by eight people and taken away for treatment**

- **That his father and brother and sister-in-law were all concerned for Matthew's safety and afraid that he might hurt himself**

- **That the family informed me that they believed Matthew was drug free**

Craig, Natalie and I then left the bedroom and entered the lounge where Matthew was, in order to speak to him. Craig and Natalie remained present throughout.

I sat at one end of the lounge whilst Craig and his wife sat together at the other end. When I was speaking to Matthew he was pacing up and down the lounge. He was clearly restless and tense and from time to time flexed his shoulder and upper arm muscles in what I perceived to be a threatening manner. From time to time he glanced sideways at the open lounge window overlooking the street. It seemed to me that he might attempt to jump out of the window. I was concerned about his tendency to be impulsive as exhibited in the past.

Matthew's behaviour on the roof showed that his judgment was clearly impaired. He described to me the psychotic phenomena of having heard voices over the preceding few days. Throughout, Matthew seemed angry. He occasionally raised his voice and stared at me in what appeared to be a menacing way. He displayed paranoid ideation voicing that I might harm him. He continued to pace up and down the room glancing at the ceiling. He seemed to be responding to non-apparent stimuli. Matthew would not talk to me about his behaviour, let alone give me a rational account of it. With apparent lack of insight, Matthew seemed unable to relate his current mental state to his presentation on admission to the psychiatric hospital in Australia.

Matthew denied that he was suicidal and also denied he had used drugs recently. I asked Matthew to go to the hospital with me and he became angry. I suggested that he see a

doctor and he became more angry and said "*no*!" so I immediately stopped questioning him about this.

At approximately 9.17 pm I telephoned Dr Marie Israel on my mobile phone from my car which was parked in a street near the Innes house. I described to her what I had observed, as to the extremely tense state Matthew was in, his pacing up and down and his behaviour which I perceived to be psychotic. I told her that his mental state seemed very fragile and potentially explosive. I was unable to elicit what had triggered his irrational behaviour. I explained that the family were distressed and having difficulty in coping with the situation and that they wanted to have him assessed and treated.

Dr Israel told me that the Sydney medical records had been faxed to her and that she had spoken to a doctor in Sydney who knew Matthew. She summarised the medical records for me. She also summarised what she had been told by the doctor. It was clear from what Dr Marie Israel told me that when unwell, Matthew's behaviour was likely to be both unpredictable and destructive. I understood that he had been dangerously violent on numerous occasions whilst at the clinic. Furthermore, he had attempted on one occasion to hang himself. He had proved to be an extremely difficult patient to manage. I also understood that he had hit nurses without warning.

Dr Israel and I agreed that Matthew was clearly very psychotic and that his behaviour was very likely to be unpredictable and violent and that he urgently needed to be managed in safe secure environment, that being the Kingseat Hospital intensive care ward. Matthew's safety, both physical and mental, was of paramount importance and I decided, in consultation with Dr Israel, to request the assistance of the Police in transporting him to Kingseat for assessment.

It was agreed that I would arrange for Craig Innes to sign an application to have Matthew assessed under Section 8 of the Act. It was further agreed that Dr Israel would arrange for a house surgeon at Kingseat to examine Matthew for a medical certificate pursuant to Section 8(3) of the Act. This house surgeon was due to see Matthew following his arrival at Kingseat.

At this stage it was my intention to have Matthew transported to Kingseat as soon as possible to avoid the situation escalating, that is, the possibility of Matthew running away or injuring himself or others.

Following my telephone conversation with Dr Israel, I had a further telephone discussion with Matthew's father in Australia. He warned me several times of Matthew's unpredictability and of previous spontaneous acts of attempted suicide. The overwhelming message I received from Matthew's father, Paul Innes, was that when Matthew is unwell he is extremely unpredictable and that he feared for his son's safety. That is, that Matthew might attempt to commit suicide. He referred to the occasion on which Matthew ran into a closed plate glass window. At this point I reassured Paul Innes that I would look after Matthew and ensure that he received appropriate treatment.

Craig and Natalie Innes were clearly very concerned and upset and told me that they felt unable to cope with the situation. When Craig signed the application to have Matthew assessed under Section 8 he did so with his parents' support. With the consent of Craig and Natalie Innes, I then telephoned the Police.

I telephoned the Auckland Central Police Station at approximately 9.49 pm and spoke to an officer. I explained the current situation with Matthew and my concerns that his behaviour was unpredictable and possibly violent. I advised the Police to bring extra personnel explaining that on a previous occasion it had taken eight people to restrain Matthew. I was told that the Police would arrive in about twenty minutes' time. About twenty minutes later I received a call from the Police indicating that there would be a short delay.

At approximately 11.01 pm the Police still had not arrived so I telephoned the station again to find out where they were. The officer assured me that they would be there shortly.

Each time I telephoned the Police I used my mobile phone while standing outside further down the street from Craig's house. I had left the house since my presence inside seemed to irritate Matthew.

At approximately 11.12 pm the Police arrived. I met them about one hundred metres down the road from the house. There were two constables in one police car and a sergeant in another car. The sergeant arrived a few minutes after the constables. As arranged they had parked away from the house and out of sight. I was anxious that Matthew should not observe their arrival.

Immediately following the arrival of the constables, I telephoned Craig Innes and told him that the Police had arrived. I told him to keep Matthew away from the window and to close the curtains, which he did.

I then entered the house after being beckoned in by Craig. The Police remained outside. At this stage I don't think Matthew was aware the Police were there. I explained to Matthew that I had spoken to his father in Australia and that I had received confirmation from Mandala Clinic. I explained that everyone was concerned that he was becoming unwell and that I had arranged for him to see a doctor.

When I mentioned the word "doctor", Matthew puffed himself up and stared at me wide-eyed in what I felt was a very threatening way. I said nothing further and stepped backwards because I feared that he was about to hit me. At this stage I beckoned the Police with my hand and they entered the house. Matthew looked up while seeming to respond to non-apparent stimuli, then deflated his chest, said "all right I'll go" or words to that effect and began to walk down the corridor following the Police to the porch outside the front door. He gave every indication that he would go voluntarily to the hospital to see a doctor.

Craig and I followed. I am not sure whether Craig was behind or alongside Matthew as they walked down the hallway.

When Matthew reached the porch he stopped, looked at the stars and said, "I'm not going". Craig said, "Come on" resting his hand on Matthew's arm. Matthew said, "Don't touch me". Then with his back against the wall of the house, he started yelling out more than once, "Bring a doctor". This was the first time that he had made such a statement during the evening. The opportunity to address his request never

arose. At the same time he was puffing himself up and flexing his muscles. He was wide-eyed and in a highly aroused state saying, "Don't touch me". He seemed to be responding to non-apparent stimuli. This is the sort of behaviour that I have seen only in persons suffering form a psychotic disorder. It was not the behaviour of a person in a rational state of mind. Matthew's behaviour appeared to be unpredictable and it was not at all clear what was likely to happen next. Within what seemed like a few seconds of these verbal outbursts, he suddenly became violent. I did not see what triggered the violence. Craig Innes, however, told me a day or so later that he believed that he himself had triggered the violence by reaching out and touching Matthew. Matthew was immediately restrained by the Police Officers with some assistance from myself. I recall holding his left wrist whilst the Police proceeded to handcuff his wrists and ankles.

When the violent outburst occurred the Police took charge. My role was limited to assisting them to restrain Matthew prior to transporting him to Kingseat. During the restraint procedure, I was concerned as to whether Matthew might have been injured.

After he had been completely handcuffed by hand and foot I noticed a small scratch on his nose. Apart from this he seemed to be physically unharmed and was laughing and calling out, "I fooled you! I fooled you!" At this point I tried to reassure Matthew, encouraging him to push aside the thoughts that were disturbing him. This appeared to have no effect.

I did not accompany Matthew in the Police car - I was not invited to do so. It did not occur to me that Matthew would suffer any harm whilst being escorted in the Police car.

Throughout this procedure, the Police were very much in charge when Matthew was carried into the car. The Police sergeant told me to follow the Police car closely. My car was parked further along the street and I was unable to catch up with the Police car after it drove away.

At approximately 11.38 pm, while driving to Kingseat Hospital, I phoned Kingseat on my mobile phone. I spoke to Peter Hull, the nursing supervisor, telling him that Matthew

had needed to be restrained and was handcuffed. I informed Peter that the Police were approximately twenty minutes away and requested as many male staff as possible to be made available in readiness to receive Matthew. I then spoke to Dr Wilson, the Kingseat Hospital House Surgeon, asking her to be in Villa 2 ready to examine Matthew. She said she would advise Dr Chris Warlow, the psychiatric registrar, of Matthew's imminent arrival.

When I arrived at Kingseat Hospital there was a group of nurses around the Police car attending to Matthew. They were in the process of transferring Matthew from the car into the ward. I parked approximately twenty metres from Villa 2. I gathered my hospital keys and paperwork, intending to deliver the Section 8 application form to Dr Wilson.

By this time Matthew had been transferred to the Villa 2 side room. I entered Villa 2 and walked past the side room which contained Matthew. This was full of nurses and police. I then met Dr Warlow and Dr Wilson as they were entering the corridor to the side room. They went straight into the side room.

I heard from the corridor outside the side room someone say that Matthew wasn't breathing. The resuscitation procedure was started immediately. I did not clearly witness this procedure as I was standing outside the side room door in the corridor, keeping clear of the staff engaged in resuscitation.

Sometime later, an ambulance arrived at Villa 2 to transport Matthew to Middlemore Hospital. After the ambulance departed I spoke to Craig Innes on the phone in Villa 2 to inform him that Matthew was in the process of being resuscitated and was being transported by ambulance to Middlemore Hospital. I advised Craig to go to Middlemore A & E Department.

I then left Kingseat Hospital and went to Middlemore where I met Craig and Natalie. Matthew was in the care of Middlemore Hospital's staff.

I left Middlemore Hospital and returned to my office at Papakura. There I wrote my clinical note.

Dr Marie Israel was the psychiatric registrar on duty at Kingseat Hospital on the evening of 3 January 1994 and it was she who requested Mr Gundesen to attend the Innes home. She outlines some of the duties of a registrar and describes, in detail, her part in the events of that night:

> **One of the jobs which I had to attend to as a registrar on call at Kingseat Hospital was to triage (prioritise or screen) incoming phone calls or requests for psychiatric assistance. Not all such requests are crisis calls or emergencies.**
>
> **Of those requests which require psychiatric assistance, it is the job of the registrar to ascertain whether the person is able to be managed safely in their present environment, with or without the intervention of the appropriate community health out-patient service. In other examples the person may be mentally unwell but without the involvement of violence or potential for danger, in which event arrangements may be appropriately made for an informal admission to Kingseat Hospital for assistance.**
>
> **On other occasions, the person may be mentally unwell and present a danger either to himself or to others and therefore require formal assessment and admission under the provisions of the Act.**
>
> **Accordingly, upon receipt of a telephone call or request for psychiatric assistance, the registrar on duty prioritises the calls as is generally described above.**
>
> **One of the prime issues to consider, and at all times assess, is the safety or danger of the situation both for the person and his / her caregiver or those people around him / her. As this information is gained throughout this initial call or contact, it is my practice to constantly reassess the safety of the situation.**
>
> **If, however, the case appears to fall into one of the other categories where either an informal admission is necessary or certainly where there is a presence or potential for danger, then it is my practice to make arrangements to request the assistance of a psychiatric district nurse (DAO) to attend the scene and ascertain details of the crisis and in particular the person's apparent state.**

As a registrar on duty at the hospital, I am unable to leave the premises to attend the scene myself. There are approximately twenty psychiatric district nurses serving the South Auckland region and they are, in my opinion, well trained and well experienced in attending to such an inspection.

I should also emphasise that whilst the registrar is on call at Kingseat Hospital, there are many other duties besides simply answering crisis calls. The registrar is the senior medical practitioner on site and must supervise the management and safety of all the patients at the hospital. He / she is also responsible for the safety of the other staff in the hospital. A house surgeon is also on duty who is junior to, and responsible to, the registrar.

It has also been my practice that when an emergency situation arises, I will invariably discuss the situation with the Consultant Psychiatrist on call - this in order to let him know what is happening and to seek his own input, where appropriate. In addition it was my usual practice to routinely telephone the Consultant Psychiatrist on call at approximately 20:00 during the evening to report in on any events at the hospital - even if there have been no emergencies.

I was the psychiatric registrar on call at Kingseat Hospital on Monday 3 January 1994 from 08:30 to 22:00 hours.

At approximately 19:21 hours I received a telephone call from a Mr Craig Innes of Howick. He requested assistance in the management of his brother Matthew who, he told me, was on top of his neighbour's roof (one storey), screaming and preaching to the sun. He told me he was threatening to jump off the roof. Craig Innes sounded very distressed and alarmed at his brother's conduct.

I immediately regarded the call as a crisis call requiring immediate attention. I obtained from Craig Innes a brief history of his brother.

I reassured Craig Innes that I would do what I could; I would telephone his father as suggested, and also send out a nurse to the address I had obtained from Craig Innes. I also obtained his phone number.

As a result of this telephone conversation with Craig Innes, I telephoned his father, Paul Innes, at approximately 19:22 hours. Mr Innes was already aware that Matthew was unwell and I presumed he had already spoken to his other son, Craig. Paul Innes gave some further information on Matthew's psychiatric history.

Paul Innes told me that his son Matthew had been admitted to Mandala Clinic in 1992, approximately twenty months ago. He told me Mandala Clinic was a psychiatric unit in Australia and that Matthew had been there for approximately six months. I had not previously heard of it. He told me that initially Matthew had been very psychotic and the initial diagnosis was queried to be that of a possible drug induced psychosis (by marijuana and amphetamines). He then told me that this was not so and that the medical staff ultimately decided Matthew suffered from schizophrenia.

Paul Innes also told me that Matthew did not respond to medication and therefore required treatment with ECT (Electro Convulsive Therapy) although he did not know how many ECT treatments he had received. He told me that initially Matthew had been very suicidal and very violent. He emphasised to me that Matthew should be treated with care.

I spoke to Paul Innes for approximately five minutes. I told him that I would contact the Mandala Clinic and endeavour to obtain his discharge summary. I stated I would also send a nurse out to assess Matthew and that Matthew would probably be admitted to Kingseat Hospital.

Paul Innes appeared satisfied with what I proposed.

I then telephoned Alan Gundesen, the psychiatric district nurse, at approximately 19:35. Alan Gundesen is a very experienced psychiatric district nurse and is one whose diligence, conscientiousness and competency I hold in high regard and respect. I informed Mr Gundesen of the above information I had received from Craig Innes and from his father, and I requested that he visit the home of Craig Innes to assess Matthew's mental state and the situation.

I also informed Alan Gundesen that I had the name of the psychiatric clinic where Matthew Innes had previously been

treated and that I would endeavour to contact them to gain further information.

It was implicit in our conversation that we would maintain contact, either by him telephoning me or my calling him on his cellphone.

I then made enquires to track down the telephone number for Mandala Clinic in Australia and I made a telephone call to that clinic at approximately 19:52.

The doctor told me that Matthew had been admitted to hospital acutely psychotic. This is a condition in which one suffers delusions or prominent hallucinations, disorganised speech or catatonic behaviour with impairment that grossly interferes with the capacity of the person to meet ordinary demands of life. I believe it is well accepted in psychiatry that psychosis is the most severe and dangerous condition treated in psychiatry. Psychosis can have a variety of different causes including:

- **schizophrenic illnesses;**
- **affective disorders;**
- **drug induced states and many others**

The doctor at Mandala Clinic also told me that Matthew had been admitted for approximately six months and that his initial diagnosis had been one of a drug induced psychosis. He told me that treatment had been attempted with Matthew as an out-patient, however his symptoms had deteriorated. I was told that a final diagnosis of schizophrenia was made.

The doctor also told me that upon admission Matthew was "self-destructive" and had tried to throw himself head first through a window and in so doing, had also tried to cut his own throat. He told me that Matthew had also attempted to hang himself in their low stimulus environment. He told me Matthew was aggressive and had hit nursing staff whilst in intensive care. He told me Matthew was not responsive to psychotropic medication (that is medication for conditions affecting the mind, e.g. antipsychotic drugs), and required ECT after which medication did have a positive effect. He

also told me that after in-patient treatment for approximately six months, Matthew was transferred to rehabilitation and that since discharge he had been well and working as a bricklayer.

I asked the doctor if he would fax me a copy of Matthew Innes' discharge report and he transferred the phone call through to medical records of Mandala Clinic. There I spoke to a female who said she would send the discharge record to me.

I then received a fax from the records section of Mandala Clinic at approximately 20:50 hours and I telephoned back at 20:52 to acknowledge receipt of the fax.

I carefully read the discharge summary upon its arrival. It reinforced to me that Matthew had suffered a serious mental illness with a diagnosis of schizophrenia with severe psychotic phenomena. The report also emphasised to me that when psychotically unwell, Matthew was unpredictable, violent and extremely dangerous. It was also significant to me that Matthew had, from the report, been a drug user.

After reading the discharge summary, I considered Matthew Innes was both potentially extremely dangerous and unpredictable. I therefore anticipated it would be likely, indeed most probable, that he would require admission to Kingseat Hospital for treatment in our Intensive Care Ward, namely Villa 2. I accordingly commenced making arrangements for him to be so treated by moving patients who were less severely unwell to other villas. I also ensured a side room was available. This is a secure, locked, low stimulus environment. I did this because I anticipated that if Matthew was admitted to Kingseat Hospital, it would be unlikely to be safe to attempt to manage him in anything other than a most secure environment.

At approximately 21:17 I spoke with Alan Gundesen, the psychiatric district nurse at the scene, by telephone. I do not now recall whether I telephoned him or whether he telephoned me. He gave me an update on the situation at the scene. I recall he told me that Matthew was behaving in a manner which he, Alan Gundesen, considered was psychotic - pacing up and down, flexing his muscles in a threatening

manner. He also told me Matthew Innes was responding to non-apparent stimuli (by this I mean he appeared to have been experiencing auditory and visual hallucinations) and that Matthew Innes had told him that he had heard voices - that is he was also suffering from auditory hallucinations.

When discussing this matter with Alan Gundesen, I gained the clear impression that he felt physically threatened and was very concerned at the potential for violence from Matthew Innes.

I formed the opinion that the situation was precarious and I was concerned for the safety of Matthew Innes and those with him, including his family and Alan Gundesen.

In that telephone discussion I also relayed to Alan Gundesen the information that I had received from Mandala Clinic and I told him of the unpredictable, violent and psychotic behaviour of Matthew Innes when he was at that clinic. I informed Alan Gundesen that the doctor in Australia had warned that extreme care was needed as Matthew Innes was very unpredictable.

Alan Gundesen and I then discussed in that same telephone conversation, the most appropriate management of this emergency. We both considered it was most important to transport Matthew Innes to the secure environment of Kingseat Hospital by the most direct and safe route. We decided, in consultation with one another, that the assistance of the Police be obtained to facilitate Matthew Innes' safe transportation to the hospital.

I had considered in my own mind that it was inappropriate to await a medical practitioner to attend the scene and examine Matthew Innes with a view to issuing a certificate pursuant to Section 8(3) of the Act. I considered there was no question that an unnecessary and perilous delay would be incurred were that to happen. I was aware that it was after hours and, moreover, was during the holiday period of the New Year. I also had no idea from where a medical practitioner could be promptly obtained at that time of the evening. I considered that the urgency of the situation demanded an immediate decision to transport Matthew Innes promptly and directly to Kingseat Hospital.

I was also aware, that given the likely psychiatric state of Matthew Innes, the presence of a medical practitioner may well have made matters worse and may have inflamed the situation. It was not a risk I was prepared to take.

It was obviously out of the question for Matthew Innes to be transported by Alan Gundesen or by his own family and I was of the opinion at the time that the assistance of the Police to transport Matthew Innes to Kingseat Hospital was most appropriate.

I informed Alan Gundesen in this telephone discussion that I would make arrangements for the house surgeon at Kingseat Hospital to be available immediately upon Matthew Innes' arrival at Kingseat to complete the medical certificate pursuant to Section 8 of the Act and that the hospital staff would be waiting for Matthew Innes' arrival.

At least on two occasions during the evening I spoke to the consultant psychiatrist who was on call - Dr Greig McCormick. I did this to inform him of the steps I had taken and I recall he was in agreement with what I had done as being appropriate. In reporting to Dr McCormick I was following what was my usual practice as referred to above. I was not calling him for the purposes of ascertaining what should be done, but rather to keep him informed.

From the information I had received from Craig Innes, Paul Innes, the doctor at Mandala Clinic, the discharge summary and from the report of Alan Gundesen as to his observation of Matthew Innes' conduct, behaviour and apparent state, I formed the opinion that Matthew was mentally unwell and significantly so. I considered he was a danger to himself and to others in his immediate vicinity. His history of psychotic behaviour as the most severe and potentially hazardous form of mental illness reinforced this opinion considerably.

Given the extreme nature of the situation, I formed the opinion that Matthew Innes needed most urgent and immediate attention and psychiatric care. In view of this, I had to decide on the spot:

- **how to ensure the safety of all concerned;**

- **how to transport Matthew to Kingseat Hospital as safely and quickly as possible by the most direct route;**

- **how to commence treatment of Matthew as quickly as possible**

In my opinion, at the time, I considered the transportation of Matthew Innes with the assistance of the Police was the safest and most appropriate alternative available.

After the telephone discussion with Alan Gundesen, I then notified all relevant staff that Matthew Innes was being brought to Villa 2 at Kingseat Hospital. I asked the house surgeon to be available upon Matthew's arrival in order to complete the medical certificate. I also informed the nursing staff of his expected arrival.

I informed the staff at Kingseat Hospital that Matthew Innes was expected to be a violent patient who was very unpredictable and that the staff should act with extreme caution. I also advised the house surgeon and nursing staff that Matthew Innes had been a known IV drug user and marijuana abuser. I informed them all that Matthew Innes had, in the past, assaulted nurses.

I was not on duty when Matthew Innes arrived at Kingseat Hospital. I finished my duty on that day at 10.00 pm when I commenced my handover to the registrar on duty who was replacing me. As I recall, the handover process in which I fully updated my replacement registrar, Dr Chris Warlow, took approximately half an hour and I would have left Kingseat Hospital at approximately 22:30 hours.

One other DAO, David Murray, was on duty on the evening of 3 January. He notes:

According to our system of operation, he was on first call and I was on second. That is, Alan would be contacted by the operator first and assess the case. I would be available for back up, transport and to take calls if Alan was occupied.

At around 7.30 pm Alan told me that he had two calls, one involving a young man not known to us who had been on a roof in Howick. Alan said that he would attend that call, and would I see to the other which involved a man known to us in

Mangere who was threatening to plunge a knife into his chest. From that time on I was kept busy.
At 9.32 pm Alan phoned me. We spoke about what I had been doing and he gave me a brief update about the situation at the Innes household.

I phoned Alan again at 10.50 pm. He was, at that time, out in the street waiting for the police to arrive. During the phone calls at 9.32 pm and 10.50 pm we discussed aspects of the situation Alan was dealing with.

I asked Alan what was taking so long. He said that he had requested Police assistance for transport to Kingseat and had asked them to deploy as many constables as they could because his (Matthew Innes') father had said that it had taken eight meant to hold Matthew the last time he had been like this. I offered to assist but Alan assured me that the most use I could be was fielding the other calls as I had been doing.

I asked Alan whether he had considered calling a GP to the house to do a Section 8(3) certificate there instead of at Kingseat. Alan said that at that stage he felt questioning Matthew further would inflame the situation as he was already so tense and paranoid. He said that at one stage Matthew had stood over him and glared at him in such a way that even he had felt threatened, and that the sooner they got Matthew to a safe place, the better. He was concerned that he did not know what it was that was "triggering" Matthew and was in no doubt that Matthew represented an imminent danger to himself or others if he was set off.

At no time was there any suggestion, nor did Alan tell me, that Matthew had demanded a doctor be brought to him.

I reiterated that as soon as I was able, I would come and assist but Alan assured me that everything was in place. The doctors were prepared at Kingseat and it was just a matter of waiting for the Police to arrive. Alan said that he was going to call the Police again to ask for an ETA and I rang off at about 10.56 pm.

CHAPTER THREE

3 / 4 January 1994:The Police Perspective

Three Police Officers attended the Innes home at Howick in response to Mr Gundesen's request for assistance. They were Sergeant (now Senior Sergeant) Brett MacGibbon and Constables Christopher Vincent and Michael Schmidt. By arrangement with Mr Gundesen all three remained out of Matthew's sight until called on to the premises by Mr Gundesen. Sergeant MacGibbon describes what happened:

> **The proposed course of action was that Mr Gundesen would talk to Matthew Innes for as long as possible to try and get his confidence and persuade him to come voluntarily to the hospital. We were to be guided by the DAO's action as he was the person with the knowledge and experience of mentally disordered patients. As far as I was concerned, Mr Gundesen was in charge of the situation. We were there simply to assist him by making sure the patient was transferred from the address to Kingseat Hospital for assessment.**
>
> **A discussion then took place on the front porch, which I was able to hear. Initially the conversation was about the family wanting to help Matthew and for him to see a doctor. It soon became apparent that Matthew was beginning to become upset and angry. He became red in the face and began shouting at everybody. His body was tense and his fists were clenched by his side. He was shouting that he was not going, and that if an attempt was made to take him, he was going to create major problems.**
>
> **I then approached Matthew and spoke to him in an effort to calm him down. I told him that he was simply going to see a doctor and that we were not there to hurt him.**
>
> **Craig Innes was also attempting to calm Matthew down. Matthew asked why a doctor could not come to the address. Mr Gundesen said that Matthew was required to be taken to the doctor, or words to that effect.**
>
> **Matthew's general behaviour and demeanour was that he was very angry and aggressive.**
>
> **I was beginning to be concerned about the situation and I spoke to Craig Innes and Mr Gundesen about it. We were still**

on the porch at that stage. I indicated the present course of action was not getting anywhere and it was agreed by the three of us that force would be used to take Matthew to Kingseat Hospital for assessment. Both Mr Gundesen and Craig Innes agreed to assist in restraining Matthew.

Craig Innes attempted to take hold of Matthew, however Matthew brushed his arm away. I then instructed Constables Schmidt and Vincent to assist Craig to place Matthew in one of the Police cars.

Constable Vincent, Mr Gundesen and Craig Innes assisted to restrain Matthew who had begun to struggle violently.

Matthew was then taken from the porch on to the driveway where he continued to struggle extremely violently. He was, at that stage, still in an upright position and was screaming at us to let him go.

It was soon evident that we could not control Matthew and two other persons who were at the address, whose names I do not know, also came to assist. Matthew exhibited extreme strength and was laughing hysterically. He was also yelling abuse and obscenities. Even with all these people holding him we had great difficulty restraining him.

We managed to get him down on to the ground but he continued to struggle violently. He was spitting and attempting to bite and kick us.

I then said we should handcuff Matthew to restrain him. We were able to secure his legs and arms but he began to twist and roll his body. He was thrashing about with his arms and his legs and attempting to kick us. He was still screaming obscenities at us and laughing hysterically.

We eventually rolled him over on to his stomach where I lay across his shoulder area while attempts were made to handcuff him. Handcuffs were eventually placed on his hands and ankles although, from my position, I was unable to see who secured them. I was close to Matthew's head and was talking to him in an attempt to calm him down.

Once he was secured with the handcuffs, he appeared to calm down considerably and I then believed that there would be no further problems. I did not take particular notice as to how his hands were cuffed but they were behind his back.

I assisted in carrying Matthew to the Police vehicle HII4 and we placed him in the Police car.

He was placed in the vehicle feet first. I believe that Constable Vincent went around to the driver's side of the vehicle and pulled him through so that his feet were behind the driver's position and the head was behind the passenger seat. He was placed on the back seat of the vehicle. He was on his back.

I suggested to Mr Gundesen that he follow immediately behind the Police vehicle. He did not express a wish to travel in the Police vehicle. If he had, I would certainly have agreed to it.

The Police car then left the scene, driven by Constable Vincent. Constable Schmidt was seated in the back with Matthew Innes.

With regard to the Modular Study Unit 'SNG 152' - Mentally Disordered Persons - I have not formally completed this unit, although I have read it a number of times.

I was not aware of any written instruction of Chief Inspector Beattie relating to mentally disturbed persons. At the time it was issued, I was relieving in the Manukau CIB. The instruction only went to uniformed sections.

Constable Vincent recalls events thus:

I waited outside the front door, standing on the porch and I heard the DAO say to Matthew that the Police were waiting outside and it was time to come. At about that stage, Sergeant MacGibbon and Constable Schmidt walked down the hallway. I followed them and stood in the doorway to the kitchen. I could not see inside the kitchen but I could hear the DAO, Craig Innes and Sergeant MacGibbon trying to persuade Matthew to go with them, and eventually he agreed to go with the DAO.

Matthew walked out of the kitchen and down the hallway to the front door. I moved aside to let him pass. I noticed his fists were clenched and his breathing was heavy. Matthew walked out on to the porch and I followed. There were other persons who also went out on to the porch.

When Matthew got outside on to the porch he backed into the wall and refused to go with the DAO. Matthew said he had not done anything wrong and he was not a criminal. He asked why the doctor couldn't come to the house. The DAO said that the doctor couldn't come to the house and Matthew had to go to Kingseat.

Craig Innes was also speaking to Matthew trying to convince him that everything was going to be OK. This continued for several minutes.

I was standing on the driveway, a short distance away from the porch. At that point somebody, I cannot be sure who, grabbed Matthew by the arm and started to pull him towards the driveway. Matthew began to struggle and Sergeant MacGibbon moved in and took hold of his other arm and tried to lay him down on the driveway. Matthew continued to struggle and he was eventually placed on to the driveway, face up.

Up to that point I was not involved in trying to restrain Matthew. Sergeant MacGibbon and Constable Schmidt were assisted by Craig Innes. At that point Sergeant MacGibbon said to roll him on to his stomach so that we could apply the handcuffs. Everyone moved in to assist in turning Matthew over and there would have been approximately six to eight people involved. I did not get involved at that stage as there was no room.

Eventually Matthew was rolled on to his stomach. He was struggling violently and at times laughing hysterically. At one point during the course of the struggle he said, "Go on, break my arm". He was trying to flay his arms about and was kicking out with his legs. I reached for my handcuffs and moved in to try and secure Matthew's wrists.

I moved in at about waist level behind Constable Schmidt who had hold of his right arm. I put my knee into the small of his

back and attached a handcuff to his right wrist. He continued to struggle and I lost my grip on the handcuffs and eventually was attempting to hold it with two fingers. I was anxious not to lose contact with handcuff, however I was unable to hold on to it. I lost my balance and fell forward across Matthew's waist and eventually crawled out between two people.

I moved around to his feet where two other people were trying to hold his legs. At that point Sergeant MacGibbon asked me whether I had any straps to secure his ankles. I replied I didn't and that his ankles would fit into handcuffs. Sergeant MacGibbon then handed me his handcuffs. At that point Mrs Innes came out with a torch. The area was dark and it was difficult to see. Mrs Innes shone the torch in the direction of his legs and I was able to place the handcuffs on his ankles.

After I secured his legs, Matthew stopped struggling for a short time. I did not see who secured the other handcuff to his left wrist, but I believe it was Constable Schmidt. At that stage I did not take any notice of the position of the handcuffs securing his arms.

Matthew was then picked up by a number of people and I ran to the Police car and unlocked it. I opened both back doors. Sergeant MacGibbon told me to wind down the back windows, which I did, and Matthew was placed feet first, face up, into the rear of the vehicle. I grabbed his ankles and fed them through on to the back seat. Matthew's final position was lying on the back seat with his feet on the driver's side of the vehicle and his head resting on the passenger's side armrest. The left passenger door was then closed and Constable Schmidt came around to the other side of the vehicle and positioned himself on Matthew about waist level.

Sergeant MacGibbon said to me, "don't make it a long trip" and the DAO indicated that he would follow us. I then drove off.

CHAPTER FOUR

3 / 4 January 1994: The Journey to Kingseat Hospital

The journey to Kingseat Hospital is but one link in the chain of events surrounding the death of Matthew Innes. The culpability of the two Police officers who transported Matthew from Howick to Kingseat is not an issue which I am required to consider. For the sake of completeness, however, they should be permitted to describe the journey. Constable Vincent takes up the story:

> **At no time did I stop the car during the journey.**
>
> **Prior to reaching the motorway I travelled at speeds of up to one hundred kilometres per hour. I was anxious to arrive at the hospital as quickly as possible. However, I was conscious to drive in a manner which would enable me to stop quickly if necessary and to ensure that the motion of the car would not create difficulties for Constable Schmidt in the back seat.**
>
> **On the motorway I drove at speeds of up to one hundred and forty kilometres an hour. On occasions I used my flashing lights when I needed to signal to traffic in front.**
>
> **Once off the motorway I drove at speeds again of up to one hundred kilometres per hour.**
>
> **Although I was concentrating on my driving, on two occasions I turned the interior light on and glanced into the back seat. This was at East Tamaki Road and Chapel Road.**
>
> **The car windows were down and there was considerable road noise. However I was able to hear, at least in part, what was being said in the back seat. During the journey Matthew Innes, at times, was calm but at other times appeared to work himself up into a state of considerable agitation and anger. He was yelling and swearing. Constable Schmidt was trying to calm him down by talking to him and asking him questions about his family and Australia. At times this approach appeared to work and Matthew would calm down. However he would then wind himself up again and become agitated.**
>
> **At times I heard him spitting at Constable Schmidt. At one point I heard him say words to the effect of "I am gonna die**

on you" but I am unable to say what he was doing when he made this comment.

I am unable to say much about the position of Matthew Innes in the rear of the vehicle during the journey.

I noticed that approximately two hundred metres from the hospital entrance, Matthew Innes stopped struggling and did not speak. I just assumed that he had tired himself out and had calmed down.

When we pulled into the gate at Kingseat Hospital I took a left hand turn by Villa 2 and saw four or five people waiting there. I got out of the car. Someone opened the rear door. I could not see Matthew's final position at that time as I was standing up at the back of the car. I spoke to the person who opened the door and told him that Matthew Innes had been biting and spitting and fighting and instructed them to be careful. The hospital staff pulled Matthew out from the passenger side.

We followed the hospital staff as they carried him in. They held him quite high, at about chest level. He was not struggling or fighting at that stage. The hospital staff then took him into a room where he was placed, face downwards, on to a padded floor.

I have completed the Modular Study Unit 'SNG 152' - Mentally Disordered Persons. I was not, at the time, aware of the written instruction issued by Chief Inspector Beattie on 26 March 1993.

Constable Schmidt assisted in carrying Matthew to the Police car. Constable Vincent went ahead to unlock the car doors and wind down both rear windows and clear the back seat of all articles. Constable Schmidt continues:

Matthew was placed, feet first, into the patrol car and placed across the back seat of the car. He was positioned such that his head was behind the front passenger seat and his feet behind the driver. His head was positioned more or less on the arm rest of the passenger side. The back of his head was not flat on the seat. I got into the vehicle on the driver's side while he was in the back seat. I climbed in, holding his legs in case he kicked me. I sat on his lower abdominal area. It appeared to me that the door was not shut properly and I

asked someone to open the door again and close it properly. I moved Mr Innes' head while this was happening so that the door would not close on to it. The car windows were already wound down. At that stage my left foot was under the passenger seat and my right foot was against the rear of the centre consul of the vehicle. I was in that position when Constable Vincent drove off towards Kingseat Hospital.

I maintained that position for a short time. However, early in the trip Matthew Innes struggled and shifted forward on to the back seat so that my buttocks went behind his body. My weight was therefore on the seat and it was only my legs that were across his body keeping him in position. In effect, Matthew was lying under the back of my thighs. As Matthew struggled he was yelling abuse at me. He worked himself up into a hysterical state. He would repeatedly kick the driver's side passenger door trying to throw me off.

Matthew bent his knees back and tried to kick Constable Vincent while he was driving. I punched Matthew about the knee cap on his left leg in an effort to stop him from kicking Constable Vincent. I did this on three separate occasions. As a result of his repeated struggling, his jacket had ridden up and was partially covering his face. I bent down and asked him whether he was all right and he spat blood and saliva into my face and chest area.

My shirt has been examined by a forensic scientist who confirms that there are traces of saliva and blood on the front of it.

I did not pull the jacket over Matthew's head. The jacket had ridden up by itself as a result of him struggling. Matthew was still on his back. I turned his face towards the rear of the front left passenger's seat so that the palm of my hand was on his temple area holding his head away. The jacket was lying loosely over his face. I used it as a shield to stop him spitting at me but I was able to move it down so I could talk to him and see that he was OK. The jacket did not obstruct his breathing.

He was screaming and yelling obscenities. He was getting difficult to control and he would not stop yelling and screaming. He brought his head up in an attempt to bite my

left thigh. I forced his head back with my left hand and turned his head to one side so that he was again facing towards the back of the passenger seat.

He was screaming and laughing hysterically. He was trying to turn his head to bite my hand. I punched him in the right side of the head above the ear in an effort to prevent him from sinking his teeth into my hand. He then started chanting and working himself into any hysterical state. He repeatedly bent his knees and kicked the driver's side passenger door with both feet. I still had my left hand on the right side of his face. My other hand had grasped his jeans by his knees to stop him from kicking Constable Vincent.

The struggling was fairly continuous but on a few occasions he seemed to calm down. At times he struggled more than others. His calm periods seemed to happen without warning and it was during these periods that I was able to talk to him. I talked to him about his family and about Australia in an effort to keep him calm. At about one hundred metres from the Kingseat Hospital driveway, Matthew appeared to calm down again. I asked him if he was OK and to talk to me, but he didn't respond. I was hesitant to relax my grip on him as I was worried that he was waiting for me to relax, after which he would start yelling, screaming, struggling and kicking again.

Approximately three quarters of the way through the journey he said to me, "I'm going to die on you". I was concerned to hear Matthew say this. I talked to him. I said, "Don't die on me". I said I would have to take time off to go to the funeral if that happened and the Department would not be impressed. I was saying these things in an effort to lighten his mood and to "jolly him along". It was also to keep him talking. At the time he said this, he did not make any complaint of discomfort, nor did he do so at any time during the journey. At no stage did the Police car stop on the trip from Northpark Drive to Kingseat Hospital.

Upon arrival outside Kingseat Hospital, I called out to the group of hospital staff who were waiting outside. I stayed in the car while they took Mr Innes from the vehicle. I stood up on the floor pan at the rear of the car so that Mr Innes could be slid out while I remained standing. I did not assist in

removing him from the vehicle. The hospital staff carried him inside and Constable Vincent and I followed.

I have completed the Modular Study Unit 'SNG 152' - Mentally Disorder Persons. I was not, at the time, aware of the written instruction issued by Chief Inspector Beattie on 26 March 1993.

CHAPTER FIVE

3 / 4 January 1994:Kingseat Hospital

Peter Hull was the night shift supervisor at Kingseat Hospital on 3 January. He arrived at work at approximately 10.30 pm:

> **Upon arrival I spoke with Alison Pinkney, the afternoon shift supervisor. She told me that a man named Innes was on the roof and was proving difficult to get down. She said that once he was off the roof, he would be brought by the Police to Kingseat for assessment and admitted to Villa 2.**
>
> **She said that Villa 2 had been advised and that a side room had been prepared. Innes apparently had a previous psychiatric history in Australia and Alan Gundesen, a Duly Authorised Officer under the Mental Health Act, was in attendance.**
>
> **At 11.40 pm I received a phone call from Alan Gundesen who was calling on his cellphone. I received this call in the supervisor's office where I had remained since the start of my shift.**
>
> **Gundesen advised me that Innes was now off the roof and had been restrained. He said that there had been a violent struggle and it had taken eight people to control him.**
>
> **Gundesen said that Innes was then in the Police car and was heading out to us at Kingseat. He sounded short of breath while he was talking to me on the phone. I remember him saying that he and Innes should be there in twenty minutes. I remember looking at my watch and thinking that they would arrive at Kingseat at midnight.**
>
> **As a result of what Gundesen had told me it was obvious that Innes might cause a few problems when he arrived. I then called the villas and arranged for all the male nurses that I could spare to go to Villa 2 to assist with Innes on his arrival. I again notified Villa 2 of Innes' arrival. I arranged for the staff to meet me in the lounge at Villa 2 between 11.50 and 11.55 pm.**

I saw the two doctors walking past the main office about 11.45 pm. A short time later I walked to Villa 2. On my arrival, the two doctors Christine Warlow (registrar) and Fiona Wilson (house surgeon) were in the office talking to Sally Crene. I did not personally advise these two doctors about Innes' arrival but the operator may have.

When I saw the doctors in the office, they were discussing with Sally Crene what medication they would require for Innes, as it had appeared from Gundesen's report that some sort of medication would be required.

The male staff that arrived in the Villa 2 lounge were John van Beerendonk (who was a staff nurse already on duty in Villa 2), Steve McQuinn, Zane Moka, Shayne Popata and Denis Kirkwood, all of whom are psychiatric assistants.

I briefly outlined the circumstances of Innes' admittance to the staff members. I advised them that he had been violent and could well still be violent on his arrival at Kingseat.

John was watching out the window and said he saw a car pulling up. They all walked off towards the dormitory and the outside door.

Just before I walked out to assist, Sally came out of the clinic with the medication. She asked me to check the medication and the dosage to ensure that it was correct. This is standard practice. I took the kidney dish which contained two empty ampoules and a syringe with the contents of the ampoules in it, to the lounge area where there was more light.

I checked the medication and found it to be haloperidol. There were two 5mg ampoules.

After checking the medication I quickly discussed a few matters with Sally about ward security while we were all down assisting with Innes.

The checking of the medication and the discussion would have taken about one minute.

Sally then left towards the female dormitory and I returned to the lounge where I had left my torch. I picked up my torch

and walked with the medication through the male ward to get into the corridor.

I unlocked the door between the male dormitory and the corridor but had trouble getting into the corridor because two of our staff were on the other side. I got into the corridor and I think it was John and Steve that were standing in front of the door.

I then saw Mr Innes for the first time. He was about half way up the corridor and being carried. I believe Shayne and Denis were carrying his trunk and shoulders and, I think, a Policeman was carrying his legs.

He was face down - I could not see his face. His hands were handcuffed behind his head and a black jacket was pulled up around his shoulders and head.

He was carried into the side room which is about twenty to twenty five feet from the outside doors.

My main thoughts at this point were to check that this patient was Innes and also to see how violent he was.

Before he was taken to the side room, I returned through the dormitory / corridor door to inform Sally and the doctors of Mr Innes' arrival. I saw Sally at the other end of the dormitory and I told her that Mr Innes had arrived. She turned and walked away. I assumed she was going to inform the doctors.

I went back up into the corridor and found that Innes had already been placed on the mattress in the side room.

I made may way into the room and crouched down by Mr Innes' shoulder. I said, "Hello Matthew" but there was no response. This is not at all unusual so I didn't think too much more of it at the time.

When I saw that he had handcuffs on his legs I asked one of the Policemen to remove them.

I was still extremely wary of Mr Innes and thought that he may become violent again.

The Policeman appeared to have trouble taking the cuffs off his legs. Apparently, he was unable to see properly because of the poor light in the side room. I asked someone to grab my torch and shine it on the cuffs to assist the Policeman.

The cuffs came off and then I told the staff to take his jeans off. I thought that if he became violent at all, the removal of his jeans would mean we could give him an injection in his buttocks to settle him. Two of the psychiatric assistants took his jeans off.

They began putting his pyjama pants on when Dr Chris Warlow came into the room. She knelt down by Mr Innes' shoulder and I believe she also spoke to him, but received no reply.

She then rolled Mr Innes from lying on his stomach, on to his right side and looked at his face.

She said, "Fiona, get in here. This man is non-breathing and has fixed dilated pupils" or words to that effect.

As soon as that was said John and I quickly ran out of the room and headed through the dormitory lounge and lobby through to the clinic to get the resuscitation equipment.

When I arrived at the clinic room Sally and John were already in there.

They had gathered up most of the equipment but I took either the resuscitation kit or IV kit. They look the same, both are set up in black briefcases.

I ran back through the dormitory and arrived back at the side room.

When I arrived Mr Innes was on his back. I think the handcuffs had been removed from his hands.

Mr Innes had an oxygen mask on his face and Dr Warlow was pumping the ventilation bag to force oxygen into his lungs.

I can't remember whether John was already giving heart massage or whether he started almost immediately after I got back.

Sally and Fiona were preparing the IV, so I prepared the combined cardiac monitor and defibrillator so we could stimulate his heart with an electric shock if necessary and so we could monitor his heartbeat.

Once I had set up this equipment, I put the paddles on his chest so I could use their monitoring abilities to sense his heart movements.

As soon as I put the paddles on I picked up a slow but regular heart rhythm. The first digital reading I got was 42. This is slow for most people, but it later went up as high as 140 at times. It was not necessary to defibrillate him as he had a regular heartbeat, so I removed the paddles and connected the ECG electrodes.

I yelled out for someone to tell me the time. A Policeman replied and I am sure that he said it was 00:10 hours. I wrote the time that he gave me down on the tracing which is a graphic printout from the cardiac monitor. I assume the tape will now be on the Middlemore Hospital file.

For about twenty minutes there was no spontaneous breathing and he had to be bagged for that time period.

I was not wearing my watch but I would estimate that the ambulance arrived at Kingseat about twenty minutes after Mr Innes was brought in.

By the time Mr Innes left he was still unconscious but had a regular heartbeat and was breathing with assistance as far as I could tell.

As I said, I was not was not wearing a watch when this all occurred but when the Police car arrived I looked at a clock in the lounge and it was about midnight.

I believe it would have taken approximately five minutes from Mr Innes' arrival to when it was first detected that he was not breathing.

Five psychiatric assistants and one Policeman carried Matthew from the patrol car to the side room in Villa 2.

John Van Beerendonk:

All five of us went out to the Police car. I went to open the rear passenger door.

The patient was lying face down on the floor in the back seat area. His stomach was across the axle hump. His legs were behind the driver and his head was on the passenger's side.

The Policeman in the back was positioned on the front passenger's side of the car. He had one knee on the seat and the other knee on the patient's back. He was holding on to the back of the front passenger's seat.

The patient was lying face down with his feet and his arms handcuffed. His arms were handcuffed above his head. He had a nylon jacket on with a fleecy lining. The zip was done up and the jacket was pulled up over his head as if he was going to pull it off over his head.

I opened the door and the Policeman in the back said "Watch him, he is spitting and biting at the moment. He is quieter, the closer we came to the hospital". I started talking to the patient. I said "Hello Matthew, I'm John". I said to the Policeman in the back "can he walk". There had been no response or movement from the patient at all.

The Policeman in the back said his legs were handcuffed. I said to the other staff, "Come on boys, we will have to carry him out". We lifted him out of the door to the car. Steve and Shayne took each of his arms and two other took him by the stomach. One of the Policemen took his legs.

I asked the Policeman why his legs were handcuffed, which was not a common practice. He told me that the patient Innes had tried kicking the driver.

We carried Matthew inside and down to the side room on the left. This side room was about seven metres from the outside door.

We placed Matthew on the mattress. He still hadn't moved. However, it is quite common for psychiatric patients to slump after a psychotic episode. They quite often will not respond to verbal stimuli.

When we put Matthew on the mattress I asked the dark haired Policeman to remove the handcuffs, which he did. When the handcuffs were removed from Matthew's legs, I pulled his jeans off. It was quite easy, I just undid them and pulled them straight down and Shayne and I got a leg each and pulled his pyjama pants on. We do this so many times we know what we are doing and get it done quickly. Steve and Shayne tried to take his jacket off so we could see his face.

Sally, the registrar and the house surgeon then came in. The registrar that night was Chris Warlow and the house surgeon was Fiona Wilson.

Matthew still had handcuffs on his arms. The Policemen were taking off the handcuffs on his legs when the doctors walked in. We were able to see his face at that stage.

I told the doctors that Matthew was not responding to anything. We turned Matthew on to his right side and his jacket was pulled back down so it was back bunched up under his shoulders.

The registrar, Chris Warlow introduced herself to Matthew. She said "Hello, I'm Chris Warlow". Then she said "Something's wrong". She shined a torch into his eyes and also reached for his arm to feel for a pulse. Then she said "get the emergency equipment".

Sally, who was standing by the door, ran to get the emergency equipment as soon as Chris said something was wrong.

Stephen McQuinn was waiting outside Villa 2 for the arrival of the Police car:

I grabbed a torch and went to the north end of Villa 2. Whilst waiting on the steps, I saw headlights approaching from the main entrance. I assumed this was the Police car arriving. I flashed the patrol car down with my torch. The car then stopped outside the door. It stopped about two metres from the bottom of the three steps to the door.

I then went to the left and rear door of the car. The driver of the car got out and said, "Watch him. He bites, he kicks, he spits and he scratches".

I think it was John who opened the rear left hand door of the car. I cannot be sure on that one. There was no time wasting. When the car arrived I saw the Policeman in the rear seat with his back to the left hand door. He was sitting on the seat.

When the door was opened, the Policeman untangled himself from the rear seat. He basically backed himself out of the car.

As soon as he was out of the car, we immediately tried to converse with Matthew. There was no response from him.

Matthew was lying face down on the floor. His head was towards the left hand rear door. He had a nylon jacket over his head. I could not see his face.

We then lifted Matthew out of the car. Shayne, Zane, Dennis, John and I, together with the Police car driver, carried Matthew from the car. I carried Matthew around the shoulders. I think he was face down.

We took him to the side room which officially is the "low stimulus environment" room. The mattress was already set up in the room; it was on the floor lying lengthways as you enter the room.

We placed Matthew on to the mattress on his abdomen. We had been talking to him since removing him from the car, but Matthew had been unresponsive.

As we wanted to put pyjamas on Matthew, someone told the Police driver to take the handcuffs off Matthew's feet. There were no shoes on his feet.

Matthew was then turned on to his right hand side. At this moment the doctor, Chris Warlow, was in the room trying to converse with Matthew.

In order to converse with Matthew we had to remove his jacket which was still covering his head.

Chris then caught a glimpse of Matthew's face. She said, "Get this jacket off. Get these cuffs off. Get the resuscitation unit and call an ambulance". This was said after she checked Matthew's pupils.

From the time we took Matthew from the car until CPR was commenced, three or four minutes had passed. In situations where we have a violent patient, we do not muck around.

The lighting in the "low stimulus environment" is adequate. There is a single light inverted into the ceiling with a perspex covering.

Zane Moka:

I was standing on John's right side and could see into the back seat.

I could see Matthew Innes lying on his stomach on the floor in the back, with his head in the left rear passenger's footwell.

I could see that his head and arms were close to the back left door. I couldn't actually see Matthew's head as it was covered by a nylon jacket. His arms were also covered by the jacket.

His arms were handcuffed behind his head with his elbows up in the air, and his jacket was pulled up and twisted around his arms.

Matthew's jacket was over his head and arms, more of the front of the jacket was over him, and the back of his jacket was scrunched up on his shoulders and behind his head area.

Someone said, "Be careful, he might be playing possum". I don't know who said that.

Shayne Popata:

It would have been between three to five minutes after the Police car arrived that we discovered Innes was not breathing.

Eventually the Kingseat staff got Innes breathing again. I do not remember how much later. I don't wear a watch and I couldn't tell you the time.

Dennis Kirkwood:

I saw the headlights of the car on the driveway by the recreation hall. The car carried on up the driveway and seemed to slow down by the swimming pool. I told Steve that it looked like the Police and he signalled at the car with his torch.

The car then turned towards us and drove in our direction. I did not take too much notice of the speed of the car until it passed me. I then noticed that the car had pulled up and stopped quite quickly.

The car stopped parallel with the north door, with the left hand side of the car closest to the Villa. The car was about two to three metres away from the Villa.

When the car stopped we all moved towards it. Probably ten to fifteen seconds later, the driver got out of the car and walked toward the back. I was standing about one to two metres away from the rear left door. That door opened but I cannot remember whether one of our staff opened it or whether it was opened from inside. When the door opened I remember seeing briefly how the Policeman and patient were seated.

From what I could see, it appeared that the patient's head and shoulders were in the rear left passenger's foot well and that the rest of his body, including his feet, was tilted up towards or on the seat. He was tilted face down.

The Policeman was sitting in a twisted position on the edge of the seat facing the driver's side of the car. He was seated at the left end of the rear seat. It appeared that his knee was pinning the patient's shoulders down.

Either before, or while, we were pulling the patient out, the Policeman in the rear seat said something like, "Watch him, he bites, spits and kicks".

I would estimate that from the time the car arrived until we had the patient out of the car, about one minute would have gone by.

We carried him straight inside the Villa as he was, which was face down, then took him into the side room. The distance to the side room from the north door is only about seven metres or so.
I would estimate that from the time we removed the patient from the car to when he received CPR, would be approximately three minutes or maybe even four. This does not include the minute or so it took to get him out of the car.

Sally Crene is a registered psychiatric nurse and a registered general and obstetric nurse. Just before 11.30 pm on 3 January she went to Villa 2 to take over the role of staff nurse in that Villa. She had been advised of the expected arrival of Matthew whilst working in Villa 8 and because he was to be received at Villa 2 - the intensive care ward - she knew that the arriving patient must have fairly urgent needs:

At about 11.50 pm I received a message that the patient, Innes, was fairly close. The supervisor, Peter Hull, had assembled the usual extra staff to assist. This is standard practice.

I stayed in the body of the ward with Doctors Warlow and Wilson. Dr Wilson was collecting her equipment to commence a physical examination of the patient upon his arrival. Dr Warlow was in the office.

At midnight Peter Hull opened the door into the male lounge and said "He's arrived". I went back to get the Doctors. I saw Dr Wilson come through, and I told her that the patient we had been expecting was there. I then went to the office and told Dr Warlow that he had arrived.

I then returned to Villa 2 to check that everything was all right.

From the time Peter Hull called me to the time I went to the side room, about a minute and a half would have passed, at the most.

On arrival I saw that the patient was in the side room.

The patient was lying on his right side. His hands were handcuffed behind his head. Dr Warlow was having difficulty in assessing his vital signs. She called for help in getting the handcuffs and jacket off.

I noticed that his pyjama bottoms had already been put on him.

When someone moved out of my way, I saw the patient's face. It was very blue with deep cyanosis around his cheeks. I could also see his chest and noted that it wasn't blue.

I immediately recognised the need for emergency medical equipment, in particular oxygen and suction. He obviously had a lack of oxygen.

I yelled, "I will go for the emergency equipment". I did this as I was running. I don't know how many people heard me in the room. One of the Policemen followed me. I don't know who he was and can't even describe him very well, only that he wasn't very big.

I went outside and around the Villa to where the emergency equipment was kept. The equipment is quite heavy and I was glad for the assistance of the Policeman.

I gave the oxygen and suction unit to the Policeman and told him to get it back as fast as he could. He took off very quickly.

We transported the two cases and the defibrillator around to the side room.

When we got back, Fiona Wilson was doing CPR. John took over the compressions so that Fiona could do the IV line. Chris Warlow had an air bag and was ventilating with it. This is more efficient than mouth to mouth. Chris Warlow asked me to connect the oxygen which I did.

From then on everyone fell into a job role. I was very pleased with the way everyone performed - there was no panic.

Peter and John were operating the ECG machine. At some stage Peter changed the oxygen.

As his heart was not going when we first got there, I filled a syringe with atropine which is used for stimulating the heart. However, before it was required, we achieved a heartbeat. The atropine was therefore not administered and was destroyed afterwards.

I set up an IV line with saline solution and handed it to Fiona. I then just handed out equipment as it was required.

I assisted Dr Warlow with the attempted intubation. This is where we tried to get a tube down the patient's throat directly into his bronchial area. She was unable to do so. However, the patient then started regular respiration.

He started regular respiration just as the ambulance was approaching. By that stage he was termed stable. That is, he was breathing, his heart was beating, his blood pressure was obtainable and the IV line was in.

The ambulance arrived at twenty four minutes past midnight. I found this time out later because I had taken my watch off. We always do this when we are expecting a patient who may resist.

Once the ambulance arrived, the ambulance staff took over and carried him to the ambulance.

Dr Christine Warlow was the psychiatric registrar on duty at Kingseat Hospital on 3 January. She commenced duty at 22:00 hours:

On my arrival at 22:00 hours, both I and Dr Wilson (House Surgeon) were given a verbal and written handover by Dr Marie Israel, who had been on duty as psychiatric registrar during the previous shift.

Dr Israel informed me of the expected arrival of a Mr Innes, aged twenty two.

Dr Israel gave me a written summary of the information that she had received from these sources about the patient's past psychiatric history and his current presentation. She also gave me a fax that she had received from the Australian psychiatric services about the patient.

We were given early notice of the patient's expected time of arrival, by phone from Alan Gundesen, who spoke with Dr Wilson at 23:42 hours and told her that the patient was in transit to Villa 2 in the care of Police. (This was not an unusual history for a patient being brought to Kingseat). Dr Wilson phoned me at 23:46 hours to pass on this message.

Dr Wilson and I agreed to meet at Villa 2. She was expecting to assess the patient under Section 8 of the Mental Health Act and I was expecting, in view of the history, to proceed to assessment under Sections 10 & 11 of the Act. We waited in the staff office on Villa 2 for the patient to arrive. This is normal practice and I would have considered it unusual if we had been asked to wait outside the Villa or in the side room itself.

There are two reasons for this. The first is that we had no suspicions that the physical condition of the patient was requiring urgent medical attention. The second is that I believe it is preferable, in establishing rapport with an aggressive patient, that the assessing doctor has not been involved in any restraint procedure.

Dr Wilson went to the clinic room to collect examination equipment. I did not hear the Police car arrive. I was alone in the office when Nurse Sally Crene came to tell me that the patient was in the side room. Nurse Crene did not state that there was any medical problem, suggest any urgency or seem in any unusual hurry.

I put some papers and books away in my bag and went to the side room without hurry or significant delay; the side room is only a short distance away (through several doors) from the office. Dr Wilson joined me and Nurse Crene and we arrived at the side room door at roughly the same time. It might have been a minute or two, or possibly more, between Nurse Crene telling me that he was there and our arriving at the side room door.

I estimate that the time of our arrival at the side room would have been shortly after midnight. I did not check the time.

The lighting in the room was dim which was not unusual as lighting in the side room is usually dim. From the door, I could see the patient lying on the floor mattress with male staff kneeling, I think two either side of him. This was consistent with standard arrangement of staff during a restraint procedure. He was in the prone position and I could not see his face. His wrists were handcuffed in what I recall thinking at the time, was an unusual position, i.e. behind his

head or neck rather than behind his back. I cannot recall the exact position or colour of his hands and arms.

Two Police Officers were present but I do not recall whether they were both in the room or just outside at this time. I think that Peter Hull, who was the nursing supervisor, was just inside the door. There were several people at the door. I do not recall if Mr Gundesen was in the room. There were no signs of ongoing resistance or movement from the patient and he was not talking or making any sounds.

There was no indication from anyone present that there was a suspicion that the patient's level of consciousness or cardio-respiratory status was impaired.

I asked the nursing staff if the situation was such that I could now enter the room and did so. This was all according to standard practice. I knelt at the left side of the patient to introduce myself to him. He did not respond at all. I put my hand on his left shoulder to further invite a response and, as there was none, I asked nursing staff to turn him so that I could see his face.

He seemed limp as he was rolled partially on to his right side by a member of staff. As he was being rolled over, I was gaining information as to when the patient had last been seen to move or speak, and was told by a male voice, I do not recall whose, that this had been in the car just beside the shops on the road just before the hospital driveway, and that he had been carried in a prone position into the ward from the car. I was told that prior to this the patient had been struggling violently in the car, but I was told that there had been no observed head or neck injury. I was not at that stage aware of his reported position in the car during transit.

I do not remember the exact position of the patient's jacket or his arms as he was rolled over. This would most likely be because I was looking towards staff, obtaining information at this time. I cannot say if the jacket was actually over his face or head while he was lying prone.

On first sight of the patient's face, it was so markedly cyanosed (a bluish discolouration), seeming out of proportion to the colour of limbs, that I wondered aloud if the colour

could be due to dirt or mud. There were blood stains over the nose and around the mouth, but no active bleeding.

There was a large torch immediately to hand on the platform in the side room. I called for the lights to be turned up and for Dr Wilson to come into the room and for someone to expose the patient's chest and check for a heartbeat while I reached for the torch and shone it in his eyes. The pupils were equal, fixed (no response whatever to very bright light) and widely dilated. The patient's colour, his fixed dilated pupils and his unresponsive state indicated a likely cardiorespiratory arrest. Staff acted immediately, e.g. running to fetch resuscitation equipment.

There was a negative response to my question about whether there was a palpable heartbeat. Access to the patient's neck was limited by his jacket and by the position of his arms, so I was unable to immediately feel for a carotid pulse, but there was clearly no respiratory movements and on my own initial brief check, I could feel or hear no heartbeat. He was limp and making no response to stimulus. Peripherally he was pale and cyanosed but the degree of facial cyanosis seemed disproportionate to the peripheral cyanosis. These signs indicated a state of cardiovascular collapse.

I had no doubt that the patient was in cardiorespiratory arrest. However, as the fixed dilated pupils might have been due to drug use, and as we had no indication of the length of time he had been in arrest, we proceeded immediately to resuscitation.

I last worked with resuscitation of adult medical patients in Tauranga in February 1990. I have had, however, enough prior experience in basic adult CPR to make me feel confident that my technique and management would still be of the expected standard. Until 1990, since I qualified in 1982, I have worked in adult and paediatric acute medical fields and have been actively involved in a very large number resuscitations, often as the directing medical officer and often in sub-optimal conditions. I had also attended regular CPR refresher courses and within recent weeks prior to Mr Innes' admission, had attended the CPR refresher course for doctors at Kingseat Hospital.

I was the member of the team responsible for directing the resuscitation procedures. The room was poorly lit despite the lighting being increased to maximum. The room was also extremely cramped, especially as a large proportion of the limited floor space was taken up by a raised platform.

Nursing staff and Police responded very quickly to my order to release the handcuffs and free the patient's neck and chest from the jacket. Meanwhile, other staff were fetching resuscitation equipment, which arrived promptly and in the appropriate order of priority. Nurse Sally Crene had, I believe, run to get the resuscitation equipment at the time the patient's face was first exposed and looked blue, so delay was minimal from that time. Resuscitation equipment is never kept in the open ward in psychiatric wards, as even the most basic equipment can be misused by patients, e.g. to harm themselves. In a high care area such as Villa 2 side rooms, even a simple blob mask or respiratory filter cannot be accessible to patients.

I did not feel that we should spend time in transferring the patient to less cramped conditions for resuscitation. I also did not want to move him because I did not feel that I could exclude cervical spine injury. We therefore resuscitated him in the side room.

I would estimate that resuscitation began between one and two minutes after my arrival at the door of the side room, but I had not checked the exact time of my arrival or the beginning of resuscitation. Normally, during an arrest, a member of nursing staff records times of all interventions but I was not aware initially that regular nursing staff were not wearing watches.

I recall clearly that the jacket front midline zip (which may have already been broken as access to chest was quickly available) was stuck at the neckline and seemed tight but did not seem to be compressing the trachea. I did not notice bruising around the neck. The zip lock needed to be torn apart or broken to clear access to the neck - this was done quickly by nursing staff. There were no palpable carotid pulses. I think the rest of the jacket was later cut off. The mattress was removed from under the patient and he was put in position for CPR, I recall. I recall asking early if an

ambulance had been summoned and was told that Police had already gone to do this. I checked that carotid pulses were absent and Dr Wilson confirmed this. I asked Dr Wilson to check that the airway was clear which she did.

I began cardiac compressions before the resuscitation equipment arrived. I made a decision not to start ventilating the patient mouth to mouth before the equipment arrived and I think I said this to Dr Wilson. The reason for this decision was firstly that we had been clearly told at a recent hospital CPR course that it was directly against the health board resuscitation policy for any staff member to use mouth to mouth breathing without the use of protective devices which are normally kept quickly accessible. The second reason was that the patient, in view of his history of previous IV drug use and abnormal LFTs (Liver Function Tests) presented an above average infection risk of Hepatitis B and HIV, especially as there was some blood around the face.

The resulting delay between starting chest compressions and beginning ventilation was in the order of seconds. The bag and mask were as quick to fetch as a "blob mask" or respiratory filter would have been. As soon as the mask was available, Dr Wilson took over cardiac compressions while I ventilated with bag and mask with 100% oxygen. Dr Wilson noted within seconds that the oxygen was not attached to the mask, and this was very quickly remedied. There was no unavoidable or unreasonable delay in the arrival of resuscitation equipment as nursing staff had run to fetch this quickly and it is kept on the ward in a (locked) room only metres away from the side room.

Nursing staff then took over chest compressions while Dr Wilson began to establish IV access in the left antecubital fossa (inside of the elbow). This was difficult due to remaining clothing, the poor lighting and the patient's severely collapsed state, but she succeeded.

Lighting in the room remained inadequate but I do not think that this seriously interfered with the actual efficacy of the resuscitation procedure. Either I or Dr Wilson asked nursing staff to phone to ensure that the ambulance that the Police had called was a proper life support ambulance and was on its

way. This was confirmed at 00:05, according to Kingseat Hospital telephone operator records.

Resuscitation, according to the recommended procedure, was performed. All staff were competent in their roles, responding rapidly and efficiently to the situation and to direction, and the staff assembling and using equipment were familiar with it.

I checked the carotid pulse several times during this initial phase of resuscitation and there was no spontaneous palpable pulse. A good compression pulse was, however, palpable confirming that compressions were adequate. The chest expansion was equal and good and the lungs presented no excess resistance. Dr Wilson listened to the chest for air entry and reported it to be equal and good. The patient's central colour improved rapidly, within a minute I would estimate. The peripheral colour and perfusion took some minutes longer to improve.

Briefly checking, I saw no bleeding or CSF (Cerebral Spinal Fluid) coming from the ears and no active bleeding from the nose, but there had been bleeding as there was some blood around the nose, lower part of the face and a small amount in the mouth. There was no palpable skull fracture. I noted marked leg abrasions, presumably from the ankle cuffs suggesting there had been considerable resistance to restraint. There was no smell of alcohol and no gross external signs suggesting IV drug use. There had been no evident foreign body in the airway and no large volumes of blood or secretions were noted that might have been blocking the airway.

At, I would think, about seven minutes from the initial assessment, the first ECG trace was available on the defibrillator monitor. (Times are somewhat unclear due to failure to record time of starting resuscitation and my unclear watch face). I think this ECG trace would have been recorded accurately at 00:10 hours. We were preparing to use DC shock and I had just asked staff to be ready to defibrillate, but the first trace showed SR (sinus rhythm) at 40/minute (that's slow) so defibrillation was not needed. Checking the carotids, I could now feel a spontaneous pulse for the first time.

Staff were already preparing my order for IV drugs to raise the heart rate, but in fact no drugs were needed or given as the heart rate quickly, over about thirty seconds at most, rose to 110 and then to 140/minute (SR). Cardiac compressions were discontinued and a first BP was recorded at 130/30. Pulse rapidly settled to 115/minute SR with a BP which remained from then onwards at 130 to 150/0 and peripherally, he became pink and vasodilated - good circulation.

Shortly after a pulse was obtained, I made a brief attempt at intubation - this proved unsuccessful. Intubation was made difficult partly because of the very cramped conditions in the room, and partly because I did not want to move the neck because of potential cervical spine injury. I would have preferred to intubate the trachea in order to protect the airway from possible vomitus but I was not overly concerned by the failure to intubate as bag and mask ventilation was effective at expanding the chest and oxygenating the patient. There was no vomiting or regurgitation presenting a risk to the patient.

I noticed bright red / pink frothy secretions at the cords which I felt to be suggestive of pulmonary oedema. I continued hyperventilation by bag and mask with 100% oxygen. There was blood staining inside the mouth but no active bleeding evident and only small amounts had been obtained on suctioning the oropharynx. The IV rate was maintained at slow, as I was concerned about pulmonary and cerebral oedema.

A few minutes later, i.e. at ten to fifteen minutes of resuscitation, and spontaneous respiration having not commenced, I was trying again, with cricoid pressure, to see the vocal chords clearly enough to intubate when the first spontaneous breath was taken by the patient. There was still no regurgitation or vomiting, bag / mask ventilation was effective, and further breaths followed; so I did not try to intubate the trachea.

I asked Dr Wilson to phone Middlemore Hospital to discuss the patient with the emergency medical registrar, both to warn him / her of the expected transfer of the patient to Emergency Department, and to discuss the patient's resuscitation and condition so as to confirm our correct

management. She did this and did not report back that the registrar advised any additions or changes to our management.

Over the next ten or so minutes, spontaneous respirations improved in frequency and volume. Until the patient was himself hyperventilating spontaneously, I continued to use bag / mask ventilation in 100% oxygen between breaths. The patient's pupils reduced to midsize, but response to light stayed very sluggish. He remained deeply unconscious.

Paramedics and ambulance arrived at approximately twenty to twenty five minutes after initial assessment. We gave them a summarised history of events and of the patient's current medical state. At this stage my impression was that there was likely to have been an episode of asphyxia precipitating cardiorespiratory arrest and that the likely time of arrest may have been at the time of last noted movements in the car outside Kingseat Hospital. I estimated to paramedics that if this was so, there would have therefore been at least five to six minutes of anoxia before CPR was started, if not more.

I also discussed the possibilities of other medical cause including head injury and of cervical spine injury, and asked for a cervical collar to be put on. Paramedics did this. I also stated, despite the negative history, that it was possible that substance abuse might have been a factor in precipitating the altered mental state prior to admission and / or the cardiorespiratory arrest.

The patient's condition appeared stable although still very poor at the time of transfer which, I believe, was about forty minutes after resuscitation commenced. He was breathing spontaneously, respiration being very deep and rapid (hyperventilating). Pulse was about 115/minute SR with good volume pulses and good peripheral perfusion. Limbs were warm and pink and he appeared vasodilated. Blood pressure remained stable at 130/0.

He remained unconscious: he had made one slight movement of the head and eyes just prior to being taken to the ambulance, but no other spontaneous movements whatever apart from respiration, and he was non-reactive to stimulus. Pupils were midsize and barely reactive. There had been no

apparent seizure activity and there had been no regurgitation or vomiting. Blood sugar was 17. IV access was patent and a slow saline drip was in place to maintain the line. No drugs had been needed or given during the resuscitation. Kingseat Hospital does not have a laboratory and so blood had not been taken for investigations.

I asked Dr Wilson to accompany the patient to Middlemore Hospital as, after discussion with senior nursing staff, it was decided that it was not appropriate for me to leave the hospital myself for a prolonged period. I asked that extra staff accompany the patient who might regain consciousness en route.

After the ambulance left I phoned Middlemore Hospital emergency department and spoke to the Senior House Surgeon, again outlining the history of events and my impressions, and warning her that the patient was in transit. I also spoke to the Middlemore Hospital psychiatric liaison registrar (Dr Stoyanoff) by phone to ask him to be available as soon as possible after arrival. I also spoke to the psychiatric consultant on call (Dr Greig McCormick).

I also spoke briefly to the patient's father in Australia by phone, outlining the seriousness of his son's condition and advising him to contact Middlemore Hospital staff for more up to date information.

It is unnecessary to reproduce the evidence of Dr Fiona Wilson. In summary she confirms the evidence of Dr Warlow to the extent that she was involved. It is clear that both doctors worked in tandem to carry out the procedures described by Dr Warlow.

CHAPTER SIX

4 / 10 January 1994:Middlemore Hospital

Matthew was taken by ambulance to Middlemore Hospital on 4 January. He died on 10 January 1994.

Craig Innes describes his feelings:

> **The whole experience is one which causes me, my wife and my parents a great deal of pain. We thought we were doing the right thing by Matthew trying to get him help that he needed. We didn't realise that he might die in the process. We thought that they would look after him and help him. Looking back on the events of the night Matthew was taken to Kingseat, we now do not understand why a doctor could not have been brought to see him. There was plenty of time before the Police arrived, for a doctor to have come to the house. We think that if Matthew had been given the chance to see a doctor he might have gone quietly. We also think that if Matthew had not gone quietly, then there should be some other way of taking people in Matthew's condition to Kingseat Hospital in a safe vehicle where they can be prevented from either coming to harm or harming themselves or anyone else.**

Dr Jane Vuletic holds a post graduate qualification in pathology and has been working as a senior lecturer in forensic pathology at the Auckland School of Medicine for five years. She was asked to state the cause of death:

> **I have conducted autopsies on approximately one hundred cases of death due to asphyxia. The majority of these cases have been suicidal hangings. I have also conducted autopsies on two cases of homicidal strangulation. I have diagnosed positional asphyxia on approximately five occasions, all in cases of sudden, unwitnessed death. I have not previously seen a case of positional asphyxia during Police restraint procedures.**
>
> **Sudden death of people who are in a state of excited delirium during prone restraint appears to be a phenomenon that has been recognised for some years, but has been infrequently reported in medical literature. The frequency of sudden death in people restrained prone while in an excited state compared with the rarity of sudden death in such people when not**

restrained implicates restraint as a causative factor in such deaths.

I believe that Matthew Innes died as a result of hypoxic encephalopathy which occurred as a result of positional asphyxiation while restrained in a state of excited delirium which may be succinctly phrased as "restraint asphyxiation in excited delirium".

During the course of this Inquiry witnesses gave three separate descriptions as to the position of Matthew's arms while handcuffed. They were:

- behind the back, i.e. the customary position;

- behind the neck; and

- with the right arm above and behind the right shoulder and the left arm bent at waist level behind the back.

It is neither necessary nor proper for me to determine which version is correct since Dr Vuletic concludes that each of these positions could have contributed to producing positional asphyxia in Matthew Innes.

I am grateful to Dr Vuletic for providing me with a statement on positional asphyxia. That is annexed as Appendix 3. It should be noted that the term "police" in that statement does not refer to any member of the New Zealand Police.

CHAPTER SEVEN

Response to Terms of Reference

1(a) Did the DAO act within the powers given to him by the Act?:

There is widespread disagreement as to the interpretation of, and inter-relationship between, Sections 8, 9, 10, 11, 38 and 41 of the Act. For present purposes only Sections 8, 9, 38 and 41 relate to this term of reference. The question which needs to be answered is whether Mr Gundesen acted lawfully in requesting the Police to use force to take Matthew to Kingseat Hospital for an examination pursuant to Section 8(3) of the Act.

Counsel for South Auckland Health submitted that:

> Section 8 of the Act relates to an application for assessment. Under Section 8(1) Craig Innes made an application for assessment of Matthew Innes. The application has to be accompanied by a certificate given by a medical practitioner under Section 8(3). It was for this purpose that the Duly Authorised Officer took steps to have Matthew Innes transported to Kingseat Hospital. That is, it was determined by the DAO and the psychiatric registrar that the most appropriate course was for a medical practitioner to assess Matthew Innes for the purposes of Section 8(3) at Kingseat Hospital.
>
> The DAO nominated Kingseat Hospital as the place where Matthew Innes should be taken for the purpose of an assessment examination. The term "assessment examination" is not defined in the Act. However, the interpretation given by DAOs throughout the country is that the assessment examination includes the issuing of a Section 8(3) certificate. That is, the assessment examination is not confined to the examination under Section 9.
>
> This interpretation of Section 41(2)(b)(ii) is consistent with the use of the word "person" in that sub-paragraph and throughout the rest of Section 41. If it was intended by Parliament that Section 41(2)(b)(ii) were to apply only to persons for whom a Section 8(3) certificate had already been issued, surely the words "proposed patient" would have been used instead of the word "person". Use of the word "person" would appear to indicate that the section is designed to apply to a mentally disordered or suspected mentally disordered person who is at any stage of the overall assessment

process under the Act, prior to becoming a patient under Section 11. This would include a person for whom a Section 8(3) certificate had not been issued.

Section 9 provides for an assessment examination to be arranged and conducted with a view to giving a preliminary assessment under Section 10. It is important here to note that Section 9 cannot apply until the Section 8 application is made, i.e. until the Section 8(3) certificate has been given. Until that point the provisions of Section 9 do not come into play. In the case of Matthew Innes the Section 8(3) certificate was never given therefore the provisions of Section 9 and Section 10 never applied.

It is submitted the DAO did have the power under the Act to arrange for Matthew Innes to be transported by the Police in a Police car to Kingseat Hospital for the purpose of obtaining a Section 8(3) certificate.

Clearly it is in the interests of Mental Health authorities, Police and potential patients that the powers of the DAOs be clarified by Parliament as such lack of clarity could be inhibiting the proper operation of the Act. In particular, it would be useful if the term "assessment examination" in Section 42(2)(b)(ii) could be clarified.

The Human Rights Commission acknowledges the confusion surrounding the meaning of "assessment" and its relationships to Sections 8, 9 10, 11, 38 and 41 of the Act:

The Act distinguishes between patients and proposed patients. Patient status only accrues after Section 11. This is because the Act no longer makes provision for informal or voluntary patients so a person being treated "informally" for a psychiatric illness is not to be subject to many provisions of the Act.

Presumably the purpose of not extending patient status to people who fall into the Act by reason of Sections 8, 9 and 10 is that people who have not been seen by a psychiatrist, or a doctor with recognised expertise in psychiatry, may not be mentally disordered and therefore should not be treated for mental disorder without consent.

The situation is complicated by the confusion surrounding the use of the term "assessment". From the notes of evidence, particularly of Mr Gundesen, it appears that assessment is used

interchangeably with what is in effect an application for assessment. In the strict sense an assessment only becomes effective as such from the point at which a Section 8(3) certificate is completed. Until that point it is not an assessment for the purposes of the Act.

Section 9 makes it obligatory for a DAO to make the necessary arrangements for an assessment examination, Section 9(2)(e) specifically providing for transport to the place where an assessment examination is to take place, if necessary. Section 9 does not address the situation in which Mr Gundesen found himself, i.e. without the necessary medical certificate for the purposes of Section 8.

The belief that a DAO can arrange to have a patient transported to have a Section 8(3) certificate completed originates with Section 38(2)(b) which provides for a DAO to "arrange ... for a medical practitioner to examine the person with a view to issuing a certificate for the purposes of 8(3)". Section 38(2)(b) in turn allows the DAO to call for Police assistance under Section 41. There is no clarification of what is meant by the term "arranging" which has led to confusion among health professionals as to what the process entails. It is at least arguable that Section 41(1) which refers to a DAO "intending or attempting to do anything specified in Section 38(2)(b)" anticipates a wider purview of the process than limiting it to contacting a Doctor to complete the Section 8(3) certificate. Indeed such an approach may be necessary in order to make this section of the Act workable.

A further complicating factor appears to have been the inconsistency in legal opinions that have been received by the various CHEs. This should have been clarified by the Ministry in Wellington, particularly in view of the frequent requests from the D.A.M.H.S.

Section 41(1) refers to the DAO "intending or attempting to do anything specified" in Section 38(2)(b) which in turn refers to the DAO arranging for a medical practitioner to examine the person with a view to issuing a certificate for the purposes of Section 8(3). Section 41(2)(b) speaks of the Police "taking the person to some other place nominated by the DAO for the purposes of an assessment examination". To argue that the term "assessment examination" does not extend to assessment applications and, by extension, that the Police are not lawfully able to transport people

until a Section 8(3) certificate has been issued is sophistry. The Commission agrees with Dr Patton that for practical purposes the assessment examination could be construed as up to and including Section 11 of the Act.

Mr Jenkin, who represents the Innes family, places a different construction on the law:

> The question arises as to whether the DAO has power to take a person away to a hospital against their will, where that person is not yet a patient, and to use force if necessary in order to do so. It is submitted that unless the Act authorises the use or application of force to an individual then that individual is protected like all others from being subjected to force. The law does not allow someone to use force on another person unless expressly authorised to do so - usually in the course of carrying out some lawful obligation or duty.
>
> The only power which exists in the Act to cater for this situation is provided by Section 41. It is noticeable that in the case of Section 41(3) the Police have power to use force if necessary to take someone (presumably against their will) if that person is already a patient under the Act. In contra-distinction to that Section 41(2) authorises the use of force, if necessary, to enter the premises where a subject may be located but does not expressly authorise the use of force to take that person away against their will - while that person is not yet a "patient" under the Act.
>
> With respect, it appears clear that the Act was designed so that people would be assessed in the community as far as possible and declared to be a "patient" by someone qualified to make that decision while still in the community, before they could be taken away against their will and subjected to "compulsory assessment and treatment" under the Act.
>
> If it was the intention of the legislature to authorise the Police and / or health professionals to use force against people who are not patients under the Act then it has not said so and the Act should be amended to say so clearly if that is the intention of Parliament.
>
> The legal result is that where people have been taken away for compulsory assessment and treatment under the Act by the use of force against their will, at a point in time when they were not a "patient" under the Act, then the use of such force has not been authorised by law and as such, is "unlawful" or "illegal".

> In all respects, the use of force to take Matthew against his will while he was a "proposed patient", and to transport him to Kingseat Hospital in order for a doctor to examine him to provide a certificate under Section 8(3), and then to immediately have Matthew undergo an assessment examination under Section 9, the DAO's actions were outside the Act in the sense that they were not authorised by it.

That view is not supported by Dr Murray Patton of Auckland:

> I understand that a question has been raised as to whether the DAO was acting within his powers in calling in the Police to forcibly restrain Matthew and transport him to Kingseat for a Section 8(3) assessment examination. DAOs working for the Auckland Central Mental Health Services have had occasion to call in the Police to assist in transporting a patient against their will so that a Section 8(3) examination can be done at the hospital. It is my understanding that the DAO has the power to do this under Section 41(2) (b) (ii) of the Mental Health (Compulsory Assessment and Treatment) Act 1992. It is also my belief that this understanding of the powers of the DAO is shared by the Clinical Directors of Mental Health Services in other regions.

The Ministry of Health:

> You will note from Sections 38 and 41 that although there is limited power to take a person to an assessment examination against their will (once a medical practitioner has certified that a person may be mentally disordered) there is no power to use force to take a person to a medical practitioner so that a certificate for the purpose of a Section 8(3) of the Mental Health Act can be obtained (as the Police and Duly Authorised Officer purported to do in the Innes case).

All the above views only serve to emphasise the ambiguity and confusion surrounding the legislation. If there is disagreement amongst lawyers then it is hardly surprising that DAOs are faced with uncertainty when carrying out their duties. What is even more disconcerting is that the uncertainty was not acted on and remedied at a national level before the advent of this Inquiry.

I acknowledge, and sympathise with, those who have been called upon to interpret those sections of the Act I have referred to. The lack of a clear meaning to certain words and phrases, e.g. "assessment" and "arrange or assist in arranging" makes the task a difficult one.

In my view there is no statutory power to transport a proposed patient by force for the purposes of a Section 8(3) examination.

A medical certificate pursuant to Section 8(3) must be obtained before an application under Section 8 is complete. This is clear from Section 8 itself but is further emphasised by the provisions of Section 9(4).

An examination by a medical practitioner for the purposes of Section 8(3) is not an "assessment examination" under the Act.

The issue of a Section 8(3) certificate requires a medical practitioner to examine the proposed patient and form an opinion as to whether or not there are reasonable grounds to believe that the person may be mentally disordered and state reasons for that opinion. The formulation of a Section 8(3) opinion is an entirely different statutory function from an "assessment examination" pursuant to Section 9 et seq. The "assessment examination" requires the practitioner to conclude that the proposed patient is either not disordered or that there are reasonable grounds for believing that he is disordered. The assessment examination requires a more detailed examination and consideration of the proposed patient, by a psychiatrist wherever possible [Section 9(3)(a)] so that a firmer decision about the patient's condition may be reached.

I rely upon the clear wording of the Act. At no point is a Section 8(3) examination referred to as an "assessment examination".

The term "assessment examination" has been intentionally employed in the Act to denote a specific statutory function, namely assessment pursuant to Section 9 et seq.

Where a DAO is called out into the community he or she has various powers (not duties) under Section 38(2)(b). However in my view this section does not confer upon a DAO the power to transport patients from their home, against their will, for the purpose of obtaining a Section 8(3) certificate.

The DAO has the power to "arrange or assist in arranging" for a medical practitioner to examine the person. In my opinion these words cannot be construed as empowering the DAO to detain or transport an unwilling patient for this purpose (with or without Police assistance).

The words "arrange or assist in arranging" should not be read so as to imply or import a power to detain or transport an unwilling proposed patient in the absence of clear words in the statute authorising such action.

If Parliament had intended that DAOs would have such a power, it would have been included in Section 8 or Section 38. The transportation power in Section 9(2)(e) is spelt out in an extremely clear and detailed way and I believe that a similarly detailed

provision would have been included to deal with detention and transportation for Section 8(3) examinations if this had been intended.

The views expressed above accord with the submission of the Youth Law Project (Inc.) who have drawn my attention to the Bill of Rights Act 1990 and comment:

> Section 22 of the Bill of Rights Act provides: "Liberty of the person - everyone has the right not to be arbitrarily arrested or detained".
>
> We believe that the words "arrange or assist in arranging" should be read in a manner consistent with the Bill of Rights Act (Section 6) and that a meaning which prevents a person's detention should be preferred over another interpretation which would not.
>
> Section 41(1) of the Mental Health Act allows DAOs to call the Police to assist them if they are intending or attempting to do anything specified in Section 38(2)(b). Section 41(2) prescribes the duties which Police may perform, having been called to the assistance of the DAO.
>
> Section 41(2)(a) gives a power of entry to the officer and imposes a duty on him or her to identify themselves as a Police Officer.
>
> Section 41(2)(b) gives the Police a power to detain the person until the assessment examination has been conducted or take that person to another place and detain them until the assessment examination has been conducted.
>
> Relying upon our earlier submissions on definition of "assessment examination" it is our view that the powers to detain and transport refer solely to detention and transportation for an assessment examination pursuant to Section 9 et seq.
>
> In our submissions, Section 41(2) does not empower the Police to detain or transport for the purposes of a Section 8(3) examination.
>
> We would ask the Inquiry to consider whether, if our interpretation of the Act is correct, this is a desirable situation. We believe that in general it is, and that in the majority of cases it would be helpful if a Section 8(3) certificate could be obtained before anyone is made to go to hospital for further assessment or treatment. The requirement that a proposed patient be seen by a medical practitioner as well as a DAO is, we believe, reasonable

especially when a young person is being taken away from their home or from some other private premises.

1(b) & 1(c) Did the DAO use an appropriate strategy in responding to Matthew Innes' condition and should he have called a suitably qualified medical practitioner to the premises where Matthew Innes was staying, to examine him?:

It is necessary to explain the services, facilities and personnel available to Mr Gundesen on the evening of 3 / 4 January 1994. Andrew Clarke is the nursing supervisor for all PDNs. He describes the after hours team structure at South Auckland Health and the after hours modus operandi prior to January 1994:

> **During the weekends two DAOs provide crisis cover between 8.00 am and 5.00 pm. On all evenings and extended hours a team of two DAOs provides crisis cover from 3.00 pm to midnight and are then on call from home until 8.00 the next morning.**
>
> **The after hours DAOs have the following staff available in support:**
>
> - **One on-call registrar based at Kingseat Hospital**
> - **One house surgeon based at Kingseat Hospital**
> - **One on-call consultant contactable by phone**
> - **Twenty four hour telephone operators based at Kingseat Hospital receiving Duly Authorised Officers' calls on diversion from the bases at Papakura and the Cottage**
> - **One female psychiatric district nurse on-call from 5.00 pm to 8.00 am for gender appropriate assessments, for example females requiring assistance in the absence of a third party**
> - **One on-call child psychiatrist**
>
> **During weekends and after hours all requests requiring assessments are monitored by a psychiatric registrar. The registrar can than mobilise a DAO if necessary. Consequently during the weekends and after hours, most of the assessments of mentally disordered persons in the community are managed by the after hours DAOs.**

A DAO will attend as soon as practicable, normally within an hour of the initial request for assistance. On arrival the DAO assesses the situation. The DAO introduces him or herself, gets into dialogue with the person and caregivers in order to gain rapport with the person and to calm and reassure the family. The family may be spoken to separately or together with the person. At this stage the DAO's main aim is to get consensus on which of the possible options available to the person and family, is the preferred choice. The DAO then assesses whether the information received from the registrar matches the presentation of the person at the time.

The options available include the following:

- **If there appears to be no evidence that the person is, or will be, a danger to him or herself or to others, and any mental illness identifiable does not warrant admission to hospital, then the person can be managed safely in their present environment. Appointments may be made for the person to see the appropriate Community Health Out-patient Service on the next working day.**

- **If it is clear that the person cannot be safely managed in the community and is mentally unwell, arrangements can be made for informal admission to hospital**

- **If the person appears to be mentally unwell, and a danger to him or herself or others, then he or she may require a formal assessment under the Mental Health Act.**

The options are discussed with the person, any family present and the registrar on-call, and the most appropriate course of action decided upon. Usually the decisions are made by the DAO in consultation with the registrar and the family.

In the event that a formal assessment is required an application is normally made by a family member. The DAO explains to the person and family the assessment process. At the same time the DAO arranges for a supporting Medical Certificate.

The arrangements for the completion of a Medical Certificate under Section 8(3) depend upon the following factors:

- **Whether the person requires urgent assessment and treatment to stabilise his or her mental illness**

- **Whether the Medical Certificate can be completed promptly and the person concerned can be safely contained to ensure that she or he does not harm him or herself or others**

- **If there is no significant urgency or obvious danger and a Medical Practitioner, usually a General Practitioner is reasonably available, then they may be contacted by the DAO for the provision of the Certificate**

- **Where there is urgency and / or danger it is usually necessary for the Medical Certificate under Section 8(3) to be completed at Kingseat Hospital by a house surgeon immediately on arrival.**

  There are several ways a proposed patient can be transported to Kingseat depending on the willingness of that person to accept an assessment as required. They include the following:

- **If the proposed patient is agreeable to go to Kingseat but the DAO considers their mental state requires them to be supervised in the car by an experienced mental health worker, the backup DAO may be called to assist in transportation**

- **If a proposed patient will not co-operate with any of the above options and physical force is expected to be necessary, then the Police will be called to assist**

  Occasionally it becomes clear that the proposed patient cannot be transported without physical restraint. In the community the DAO has no legal power to physically restrain or detain a person unless specifically directed by the Police to assist them in doing so. It is not the function of a DAO to restrain or become involved in physical violence. The role of the DAO is specific in this regard. His or her role during the crisis is to calm, reassure and advise according to the information obtained and the presentation of the proposed patient on site. It is only occasionally that physical restraint is necessary.

  If the proposed patient is violent, then more often than not it is the Police who call the DAO for assistance, rather than vice versa.

Dr Sai Wong is the Director of Area Mental Health Services in South Auckland. He describes the role and availability of registrars in South Auckland:

> **Registrars on call at Kingseat provide, out of hours, the first call medical cover. They are supported by the on-call Psychiatric Consultant. They are responsible for:**
>
> - **assessment of patients under Section 10 of the Act;**
> - **all admissions, including interviewing / reviewing newly admitted patients as necessary;**
> - **dealing with any problems with patients attempting to discharge themselves against medical advice;**
> - **review of inpatient's status, medications and safety;**
> - **supervision of the house surgeon where necessary;**
> - **checking that patients in the seven villas (wards) are stable;**
> - **writing up the paper work;**
> - **dealing with any emergency on site;**
> - **reviewing patients in seclusion;**
> - **monitoring calls requesting DAO services after hours;**
> - **liaising with the Consultant on call.**
>
> **Registrars are rostered so that there is always one registrar (and one house surgeon) on duty after hours between 1630 until 2200 hours, and another registrar and house surgeon to take over from 2200 to 0830 hours. During the weekends and on public holidays there is one registrar (and one house surgeon) covering the period between 0830 until 2200 hours after which a registrar and a house surgeon would take over until 0830 hours the next day. There is a hand over period from 2200 until approximately 2230 hours in which any calls from the community, any pending admissions and how they are being treated, any problems in the hospital and any patient in seclusion who may need reviewing, are discussed. One house surgeon is on call to take care of the physical complaints of patients in the hospital. Two medical**

practitioners are needed on site in case of an emergency occurring at Kingseat.

All admissions to Kingseat Hospital are the responsibility of the registrar on call. In the case of a request being made for psychiatric assistance in the community, the registrar will co-ordinate with the DAO to decide the appropriate action to be taken. During the course of the discussion all appropriate options will be explored.

Registrars work in close partnership with the DAOs. This may involve giving clinical advice, co-ordinating and preparing for the patient assessments if necessary, as well as providing advice on patient management issues if required. This is essentially a team approach with both parties being fully involved with the safety of the patient. Both the registrar and the duly authorised officer have access at all times to the Duty Consultant and to myself as the Clinical Director.

It should be noted that there was widespread and sympathetic approval for the actions of Mr Gundesen on the evening of 3 / 4 January 1994. Professor John Werry provides a succinct commentary about the trend in modern psychiatric services over the past fifty years. These have been characterised by:

- **The principle of <u>least restriction</u>. This means that the care of psychiatric patients should involve the least restriction on their civil liberties possible.**

- **The principle of <u>normalisation</u>. This means that good care should seek to keep the patient's life and living, during psychiatric care, as near normal as possible. The emphasis is therefore on trying, wherever possible, to treat the patient without removing him or her from his normal place of residence.**

- **The principle of <u>responsibility and reasonableness</u>. Patients are assumed to be capable of responding responsibly and reasonably to societal rules and requests by professional staff with respect to accepting assessment and treatment. This means that the emphasis is on persuasion and partnership rather than on force.**

- **The principle that <u>psychiatry is a medical specialty</u>. This means that psychiatrists will act and be expected to act like**

other medical staff, that the basis of treatment shall be derived from medical science and that the usual ethical standards of medical care shall apply.

He then comments on the care which should have been given to Matthew Innes:

What I shall do then is map out what I consider is the ideal treatment he should have been accorded.

I accept that Mr Innes probably required hospitalisation.

I have read Mr Gundesen's evidence and I consider that he acted with a high level of professional skill in all matters where he had the freedom to do so.

I believe that Mr Innes' request to be seen by a doctor was reasonable and that if granted, it may have averted the tragedy. I cannot accept that Kingseat cannot do what pertains in the other two Auckland CHEs and have the on-duty registrar visit the patient at home if required. I also believe that the policy of taking the patient to Kingseat for assessment represents archaic mental hospital care and does not conform to the principles of normalisation stated above. I do not accept either that with a house surgeon in the hospital, it was necessary for the registrar to remain at Kingseat at all times.

Given the fact that Mr Innes was acutely agitated, had not slept, had a history of schizophrenia, was showing similar symptoms including paranoid delusions about his breath being taken away, I believe he would have achieved some benefit from antipsychotic medication administered before transport.

If, when seen by the psychiatric registrar as would likely have been the case in the Auckland Healthcare and Waitemata Healthcare areas, Mr Innes might have been calmed down, persuaded to go to hospital or, if necessary, persuaded to take medication supplied by the doctor.

In the event of the psychiatric registrar being unsuccessful in persuading Mr Innes to take medication and / or to go to Kingseat, she or he could then have completed the Section 8(3) certificate and summoned the psychiatrist on call as

happens, as needed in the Auckland Healthcare district. The psychiatrist would then have carried out the S10 assessment and issued a S11 notice if needed - all at the Innes house. Then if needed, forcible administration of medication could have been carried out as allowed under S11. Usually however, patients when confronted with the need to take medication will do so after some argument.

I believe that the two constables who had to take the patient to Kingseat acted properly. The ride to Kingseat can only be described as a nightmare for all three persons involved. I have the deepest sympathy for all three and the highest admiration for the two constables. However I cannot understand why, given the difficulties in getting Mr Innes into the car, there was not another person in the back seat and thus, why Mr Innes could not have been held in the upright position. I assume this was a decision for the sergeant, not the constables.

I believe that the care accorded Mr Innes does not conform to an acceptable standard in that his request to see a doctor was not granted, too much responsibility was carried by the DAO, the psychiatric registrar was operating from remote control instead of on the spot and the psychiatrist on call was not involved as required by the Act. There was too much emphasis on carrying out the assessment at Kingseat and not enough consideration to doing that in the community and where the patient was. There was insufficient consideration to medicating the patient before transport. I do not blame Mr Gundesen or Drs Israel and Warlow - they were merely carrying out policies enacted by their superiors.

In all these respects, with the possible exception of medication, the care given to Mr Innes was below that which he would in all probability have received from Auckland Healthcare. There may be good reasons for this discrepancy in standards of care, but I personally am unable to think of any except the issue of somewhat greater distances in the South Auckland area. I do not think this a sufficient explanation only a greater inconvenience to doctors working there, which should be compensated financially or in other ways accordingly. To be a doctor is to be prepared to go that extra mile as it were, for the patient - that is what medicine

is all about and why it is an honourable profession in the eyes of the public and why doctors are so generously paid.

I do not accept that compulsory assessment and treatment under the Mental Health Act and ultimate hospitalisation should not have been the final outcome in the best interests of the patient. Mr Innes' developing relapse of his schizophrenia and his past history strongly support this management plan. Thus I support the management plan of the DAO and Dr Israel. It is the speed and the process (principally the lack of direct medical contact), by which it was implemented that causes me concern.

To me, the wish of Mr Innes that should have prevailed was to see a doctor then and there.

However, one thing is clear to me, neither Mr Gundesen nor Dr Israel can be held accountable for this failure since the evidence of Dr Wong makes it quite clear that Dr Israel was under instruction not to leave the hospital.

Dr Brian Timney, psychiatrist of Wellington, sat through the entire Inquiry. He was an independent expert assigned to assist me. He advised me:

Three elements in the pre-admission phase of assessment combined to indicate inpatient treatment was needed, namely:

- **the incident during which Matthew was on the neighbour's roof;**

- **the assessment of Alan Gundesen that Matthew had suffered a relapse of his psychotic illness, based on the history given by Craig and Natalie Innes together with the mental state examination carried out on Matthew;**

- **the information on Matthew's past psychiatric history**

There is, in my opinion, no dispute that hospital treatment was needed. What is far from clear is how this care should have been arranged. In particular, whether a medical practitioner should have examined Matthew at home.

If, as some witnesses have testified, Matthew and other family members asked early on for a doctor to be called, then I think

this request should have been followed. I accept that practical difficulties may have precluded this (possible) request being met.

I have no doubt that a medical practitioner would have issued a certificate under Section 8(3) Mental Health (Compulsory Assessment and Treatment) Act ("the Act"").

The option to take Matthew to Kingseat Hospital made by Alan Gundesen and Dr Israel was, I think, the right clinical decision based on information before them and their collective past experience. Until the tragic death of Matthew Innes it is clear that positional asphyxia was known only to a small group of practitioners (within New Zealand) namely Forensic Pathologists.

In making any clinical decision, the options, risks and benefits of each line of action is considered. Prior to 3 January 1994, sudden death as a consequence of restraint and transportation of a medically fit young man (in New Zealand) was unexpected and without precedent.

Dr Douglas Wilson, psychiatrist of Hamilton, was also an independent expert:

I feel that the DAO did his best under the circumstances but was hampered by inadequate direct support from other mental health personnel. He was alone, and required to deal with a difficult and complex situation for an unduly long period. I cannot think of a situation in any other health field where a nurse (albeit a mature, conscientious and experienced nurse) would be left alone to deal with a complex and changing situation. He should have had another DAO with him and also should have had a medical practitioner there to complement his skills and to help evaluate and direct the situation.

He should have accompanied the Police in the car or whatever other vehicle was appropriate. Young, inexperienced Police Officers can only be expected to have an elementary knowledge of mental and physical health and illness, and should have the benefit of the continuous services of a health professional - nurse or doctor - perhaps both.

Brigit Lenihan, an independent expert DAO, noted:

> **I believe he acted in the most appropriate and professional manner when called to assess Matthew Innes on 3 January 1994. The major concern appeared to be safety due to Matthew's presentation on the night and the history he had received from Dr Israel and Matthew's father.**

Alan Gundesen is adamant that the first and only time Matthew asked for a Doctor to be brought to him was when he was on the porch:

> **This was immediately after Matthew had walked out of the house of his own volition having agreed to go to see the doctor. I am quite sure that Matthew never asked for a doctor to be brought to him while he was inside the house. Furthermore, when I mentioned the word "doctor" Matthew reacted with hostility.**
>
> **On the night of 3 January 1994 I discussed these options with Craig and Natalie. The three of us agreed that Matthew urgently needed to see a psychiatric doctor. If Matthew had at the time asked for a doctor to be brought to him I would have done my best to comply with his request. If a GP had assessed Matthew at the house it is highly likely that he or she would have completed a Section 8(3) certificate. Matthew would then have been transported by the Police to Kingseat Hospital.**
>
> **In fact he reacted negatively to the mention of the word "doctor". This was one of the factors that I discussed with Dr Israel and which led to our joint decision not to call a doctor to the house. We both agreed that to call a doctor would only increase the uncertainty and tension of the situation and might involve a delay which could be dangerous given Matthew's condition.**
>
> **Therefore, considering Matthew's behaviour on the night and his previous actions and history, Dr Israel and I decided that the best option to ensure his safety was to request the Police to transport him to Kingseat for a Section 8(3) assessment. This was not a decision that was taken lightly. It was a clinical decision that was carefully thought out and discussed between us. We chose the option that we agreed was most appropriate to the situation, and most likely to ensure Matthew's safety.**

While Matthew was on the porch he was in a highly aroused state, had puffed up his chest and was yelling. One of the things he shouted was, "bring me a doctor". Things seemed to happen very quickly. There simply was not the opportunity to comply with his request.

As I have said I did not attempt to contact a doctor in the community for the reasons I have outlined above. However, I did make arrangements through Dr Israel for a house surgeon to do a Section 8(3) assessment at Kingseat Hospital immediately upon Matthew's arrival. If Matthew had asked for a doctor inside the house my first option would have been to contact a local GP. GPs can be difficult to get hold of after hours, so quite often I will contact the St Johns Ambulance who can sometimes give me the name of a GP who may be available.

Dr Murray Patton is the Director of Area Mental Health Services for Central Auckland. He commented that it would have been preferable for two DAOs to have attended at the Innes household but continues:

I cannot find fault with the actions of the DAO in dealing with this situation. It is apparent from the evidence that I have read, that Matthew Innes was a young man who, when he was mentally unwell, was unpredictable and an danger to himself and others. In my opinion the DAO acted appropriately throughout. He conferred regularly and was in close consultation with Dr Israel the psychiatric registrar. He obtained a substantial amount of relevant and useful information by talking to members of the Innes family and by observing and talking to Matthew. In my opinion he acted responsibly and reasonably in arranging for the Police to restrain and transport Matthew to Kingseat.

Duly Authorised Officers have a role in facilitating the necessary arrangements for assessment and treatment, these arrangements being based on the clinical presentation of the proposed patient and the clinical judgment of the DAO as to the most appropriate further actions. These arrangements will be made with due consideration of the risks presented by the proposed patient, the urgency of the situation, the necessity of further assessment and interventions and the availability of resources to facilitate the further assessment, particularly the availability of medical practitioners.

Crisis and community treatment services are provided in varying ways across the Auckland region based on service philosophy, resource differences, geographical considerations and the time of day at which services are required. Whether or not therefore, a suitably qualified medical practitioner should be called to the premises will be dependent upon a number of factors which must be taken into account by the DAO at the time the need arises.

It is the general practice of the Auckland Healthcare Mental Health Services to have mobile psychiatric registrars on call which enables them to do the Section 8(3) assessment on site in some circumstances. However, it should be noted that there are many differences between the Auckland Central and South Auckland Mental Health Services circumstances or operations, including the geographical factors and the need in South Auckland to maintain the presence of a qualified medical practitioner at Kingseat Hospital.

In summary it is my opinion that the decision to not call in a doctor to do a Section 8(3) assessment at the house was a reasonable one. It is impossible to say that calling in a doctor would have materially altered the outcome. It is very difficult to predict how someone in Matthew's state would have reacted if his request for a doctor to come to the house had been complied with.

There is no doubt about Andrew Clarke's belief:

In my opinion, Alan Gundesen handled the situation with all the competence, professionalism and sensitivity that I would expect from a DAO with his experience. He followed the standard practice of DAOs operating in the South Auckland area. His diligence in obtaining a considerable amount of information prior to taking any action, and his overall handling of the matter is to be commended rather than criticised.

Nor that of Dr Sai Wong:

In my opinion Dr Marie Israel followed the standard clinical practice adopted at Kingseat Hospital by psychiatric registrars. Moreover her response to the crisis was reasonable, responsible and above all, appropriate.

I have carefully considered the evidence of Mr Alan Gundesen and am of the opinion that like Dr Israel he carefully followed the standard practice adopted by South Auckland DAOs in dealing with crises in the community. He and Dr Israel acted as a team and in my opinion their joint response to the circumstances giving rise to Matthew Innes' death was reasonable, responsible and appropriate.

I agree, for the reasons given by Dr Marie Israel, that it was not appropriate for her or the DAO to have called a suitably qualified practitioner to the Innes household on the night of 3 January 1994.

The provision of a medical certificate under Section 8(3) at the Innes residence would not, in my opinion, have improved the management of the situation. It could have delayed the process of transporting Matthew to Kingseat and have exposed him, the doctor and others to further danger resulting from his unpredictable and potentially violent behaviour. In my opinion if a doctor had been called to the house he would have provided a certificate under Section 8(3). In that event it would still have been necessary to have Matthew transported by the Police to Kingseat Hospital for a Section 10 assessment.

If a medical practitioner who knew Matthew was called, he / she may have been able to defuse the situation. However, a medical practitioner not previously known to Matthew may well have aggravated the situation given Matthew's known history of unpredictability and his refusal to see a doctor when requested by Alan Gundesen to do so.

As Matthew's safety was the first consideration, calling a medical practitioner could have caused significant delay in getting him to a hospital.

The South Auckland Division of Psychiatry submitted:

> In the Matthew Innes situation it was obvious to the consultant on duty, from the information given to him, that Matthew needed to be hospitalised. In the absence of a Section 8 certificate from a local medical practitioner the plan was to transfer Matthew to Kingseat where the Section 8 assessment to be made by the registrar on duty. In the absence of a readily available general medical practitioner this seemed a reasonable course of action in a

difficult situation and within the confines of the Mental Health Act.

Counsel for South Auckland Health dealt at length with the collaboration between Mr Gundesen and Dr Israel and the difficulties in operating an under resourced facility in a rural area:

> Dr Israel had considered in her own mind that it was inappropriate to await a medical practitioner to attend the scene and examine Matthew with a view to issuing a certificate pursuant to Section 8(3) of the Act. She considered there was no question than an unnecessary and perilous delay would be incurred were that to happen. She was aware it was after hours and moreover it was during the holiday period in the New Year. She also had no idea from where a medical practitioner could be promptly obtained at that time of the evening. She considered that the urgency of the situation demanded an immediate decision to transport Matthew Innes promptly and directly to Kingseat Hospital.
>
> She was also aware that given the likely psychiatric state of Matthew Innes the presence of a medical practitioner might well have made matters worse and might have inflamed the situation. It was not a risk she was prepared to take.
>
> It was obviously out of the question for Matthew Innes to be transported by Mr Gundesen or by Matthew's own family and Dr Israel was of the opinion at the time that the assistance of the Police to transport Matthew to Kingseat Hospital was most appropriate.
>
> In the circumstances the decision made by the DAO and the psychiatric registrar to have Matthew transported as quickly and as safely as possible to Kingseat Hospital for a Section 8(3) examination certificate was entirely responsible and appropriate. The issue of bringing a doctor to the house was considered by the DAO and psychiatric registrar and then rejected. Matthew's condition was serious and unstable; he required intensive care in an appropriate hospital setting. It was a carefully considered and not an arbitrary decision. The fact that Matthew required hospitalisation is common ground.
>
> It is clear from the evidence of witnesses to this Inquiry that there are variations in the way that Mental Health Services throughout the country meet the needs of mentally disordered or suspected

mentally disordered persons in the community. Such variations are entirely understandable given geographical considerations, the proximity of other medical services and facilities, the available resources and the differing needs and demands of each community. What is appropriate in Auckland Central and Rotorua may not be appropriate in South Auckland or indeed any other health district in the country.

It is submitted that the policy of keeping one registrar and one house surgeon on site at Kingseat at all times is a sound one and is based on good clinical practice and common sense.

Several witnesses have said that it would be desirable to have an on-call registrar available to go out into the community to do Section 8(3) certificates and provide support and back-up to the DAO. South Auckland Health agrees that the availability of such a mobile on-call registrar would be desirable but this would be impossible with existing resources. We have heard from Doctors Wilson and Wong that Mental Health Services in this country are under-resourced. This lack of resources means that the ideal level of health care for mentally disordered persons is simply not available. In addition, funding has not been available from the Government for the implementation of the Mental Health (Compulsory Assessment and Treatment) Act 1992. It is conservatively estimated that the cost of this implementation to South Auckland is in the region of $250,000 per year. Hard decisions must be made as to the allocation of these resources to ensure the best safety cover possible for all clients. Each region faces the same dilemma in making their own choices as to how best to meet the psychiatric needs of the community.

It is submitted however, that at least the partial solution to this problem may lie in the relocation of the Mental Health Services in-patient unit from Kingseat Hospital to Middlemore Hospital. Several witnesses have stated that it is inappropriate to have a psychiatric in-patient unit in a rural area, geographically isolated from other general medical facilities and from the community which it serves. The Inquiry has also heard that it is the intention of South Auckland Health to relocate services as rapidly as possible. At present the move is awaiting Government approval and funding. If the psychiatric in-patient unit was relocated to Middlemore Hospital this would free up the on-call registrar to enable him / her to do Section 8(3) certificates at the home of mentally unwell or suspected mentally unwell persons. It would

also provide a high level of emergency and general medical care in close proximity to the unit.

The Innes family were less enthusiastic about the strategy adopted by Mr Gundesen:

> The DAO failed to consider alternative strategies to deal with Matthew's condition, at all times. The only strategy which appears to have been considered was to request Police assistance and to take Matthew by force if necessary, against his will. Regrettably, it appears that due to various policy factors of Kingseat Hospital, the DAO had little option. Regardless of the legal constraints imposed on by the Act, he did not in fact have the option of calling a psychiatrist out to the Innes home nor did he in fact have the option of calling a psychiatric registrar due to Kingseat's management policy and / or resources. It appears that he did not have the option of sedating Matthew either. However, he also failed to consider his obligations under Section 9 of the Act and especially failed to actively consider how or who best to accompany Matthew on the journey to Kingseat. Again, the resources available were not sufficient. The sergeant could have gone. Craig Innes would have gone. Natalie Innes could have gone. The DAO could have gone. Mr Evan Lindsay may have gone, if asked. None were even considered.

COMMENT: It will be noted that in Central Auckland and Waitemata DAOs are accompanied by registrars after hours. A crisis intervention team or a variation thereof exists in both places. That comparatively satisfactory state of affairs does not prevail in South Auckland. Dr Sai Wong was asked to comment:

> **We are unable to provide a psychiatrist except at Middlemore and Kingseat Hospitals after hours.**
>
> **We have one registrar covering Middlemore Hospital on a call-back basis. Neither the Middlemore nor Kingseat registrars can attend a patient's house to provide a service to DAOs after hours.**
>
> **I confirm that after hours the Section 10 assessments are undertaken by registrars after discussion with the consultant psychiatrist. The problem in obtaining a psychiatrist after hours is one of distance. Most psychiatrists live forty five minutes away from the hospital.**

A psychiatric registrar or a consultant psychiatrist cannot go out into the community to make assessments or an examination of a proposed patient after hours because of a lack of resources.

In South Auckland there are no roving registrars because there are none available. The problem is one of resources. We have looked at the possibility of a third registrar on call which is not possible within the present contract because, in order to fulfil the terms of the present contract, we would have to employ two registrars for that purpose, i.e. two floating registrars, and that is not possible within the current resources.

Regarding the contract I mentioned above, the contract is about hours registrars are on call. They are not allowed to be on call for more than sixteen hours, i.e. they are not allowed to work for more than sixteen hours including on-call. In practice we have two doctors away from the system at any one time so getting a third registrar would mean we would have three doctors away from the service in the morning and that would affect the service and continuity of patient care very much.

There are no roving registrars in South Auckland because there are none available and because of the contract requirements.

Dr Wong repeated that both Mr Gundesen and Dr Israel believed that calling a doctor to attend Matthew would not have served any useful purpose at the time and noted that examination by a GP usually hinged on one or more factors:-

(i) whether or not a GP was available;

(ii) the calibre of the GP in the sense that many have had little experience in mental health matters

(iii) the time factor. Often GPs have heavy surgery load to deal with and may not be prepared to attend to a DAO request "in haste".

It was suggested that rapid access to a GP was not as simple as first appears for the reasons mentioned. Andrew Clarke elaborates further.

Alan Gundesen had to act within the policies which existed at the time.
In South Auckland, for about 25% of the week, DAOs have psychiatric registrars and psychiatrists who can come out and assist, but it would be rare for the consultant to leave the community mental health centre. For 75% of the time DAOs have to make their calls without the physical presence of a registrar or a consultant.

In Auckland DAOs have mobile registrars coming out to assist them with Section 8(3) examinations. This is not an option available in South Auckland after hours. If necessary the consultant in Auckland will come out and do a Section 9 / 10 assessment in the patient's home. This facility is not available in South Auckland either. These were options not available to Alan Gundesen. It certainly would be of assistance to our DAOs if we had the same options available to us as exist in Auckland.

The South Auckland Division of Psychiatry explains its position:

An adequately manned and equipped "flying squad" to make domiciliary assessments, initiate treatment and, where appropriate, arrange for the hospitalisation of disturbed psychiatric patients would be an ideal. With unlimited resources it would be possible to have a registrar and possibly a consultant psychiatrist attached to such a team. However, this is quite impractical within the current resources of finance and personnel assigned to the South Auckland Mental Health Services. Kingseat Hospital serves a large geographical area and to have flying squads able to respond to each and every possible call in the area would be prohibitively expensive even if sufficient personnel existed in the community - which they do not.

They also comment:

It seems inequitable that clinicians working within the limitations of both staffing and legal constraints should be held in any way to be responsible for a tragedy such as this, or indeed for the shortcomings of the system. Compromise seems to be an inescapable part of life in general, and in our mental health services in particular, in New Zealand.

The Mental Health Foundation correctly observes that before the new Act came into force it had initially been assumed that where possible, patients would be seen in their homes, that psychiatrists, mental health professionals and even judges would be available to visit patients in their homes and that where necessary, there would be the option of crisis support delivered in the home situation.
The Foundation is concerned that:

> In many situations, the DAO is placed in difficult situations without the ability to call in additional resources and support should this be necessary. Often, situations can be life-threatening or uncertainties exist with respect to the safety of patients or others.

Sadly the high ideals conceived before 1992 have not been realised.

I am in no doubt that, with one exception, Mr Gundesen used an appropriate strategy in responding to Matthew's condition.

He quickly responded to the registrar's request to visit the Innes home. He undertook a thorough, professional and dignified assessment of Matthew's condition. He maintained regular contact with Dr Israel and the Innes family. Both he and Dr Israel obtained as much information as it was possible to obtain about Matthew's medical background. He did his best to ensure a rapid Police response to his request for assistance and when the need for hospital care became inevitable, he informed Kingseat staff of the unfolding developments and did what was necessary to ensure Matthew's safe reception.

In an ideal world the treatment regime for Matthew suggested by Professor Werry might very well have brought about a less tragic result, but the simple fact of the matter is that that ideal world did not exist. Alan Gundesen, despite his observations to the contrary, was left to carry out his duties in isolation. I acknowledge the splendid efforts of Dr Israel, towards whom no criticism can be directed, but in one sense she was acting by "remote control". Mr Gundesen did not have the option of the physical presence of a registrar or psychiatrist. The unavailability of those persons immediately removed the possibility - perhaps a remote possibility - of Matthew being medicated. I note Mr Murray's offer of assistance but in my view that was probably a forlorn offer since he also appears to have been fully occupied dealing with other calls.

It has been suggested that Mr Gundesen should have accompanied Matthew in the Police car to Kingseat. I disagree for reasons which I shall explain later in this report.

I am satisfied that Mr Gundesen was correct in concluding that Matthew was in need of hospital care. The evidence points irresistibly in that direction. He did not however, call for a medical practitioner to attend the Howick premises to undertake a Section 8(3) examination because both he, and Dr Israel, believed that such an examination would serve no useful purpose. That of course begs the question as to whether a useful purpose would have resulted had the examination been undertaken at Kingseat rather than Howick. I suggest that a Section 8(3) examination is a statutory check and balance on the actions of a DAO. The protection of the rights of the individual is an important element in the new Act. When an individual is in a private residence and is not "wandering at large" or in an unsupported situation or a "detained person" then it seems to me that the requirements of Section 8(3) must be complied with before removal elsewhere can be contemplated. Matthew Innes fell within that category.

There is disagreement as to whether, at an early stage in the evening, Matthew asked for a doctor to be brought to him. That may well have occurred but I accept Mr Gundesen's evidence that if such a request had been made he was unaware of it. It should be remembered that the scene at the Innes home on this evening was not entirely one of relaxation and calmness - despite the efforts of all concerned. It is hardly surprising that, in carrying out his many tasks, Mr Gundesen may not have been alerted to any such request. Certain it is that a request was made when Matthew was on the porch by which time events had gone past the point of medical intervention at the home.

However I see no real reason why, even in the absence of a request, a medical practitioner was not called to the Howick premises. I acknowledge that the wishes of the proposed patient must be taken into account, but ultimately it is the responsibility of the DAO to exercise his own judgment in deciding when to seek a Section 8(3) examination. In the present case it was established very early in the process that Matthew was "borderline". As the evening progressed Mr Gundesen's continuing observations and the information he received from Dr Israel made the intervention of a medical practitioner inevitable. I have no doubt that it was convenient to carry out the examination at Kingseat but examination in one's own home, in accordance with the ethos of the Act, overrides the issue of convenience. In my view there was sufficient time within which to call for a medical practitioner.

Justice requires comment about Mr Gundesen's actions on the evening of 3 / 4 January 1994. I accept unreservedly that once Matthew's status became apparent to Mr Gundesen, he was motivated to see Matthew's placement in a therapeutic environment quickly and safely. In a clinical sense his judgment cannot be faulted. Mr Gundesen impressed me as a gentle, sensitive, patient and thoroughly professional nurse. His motives were beyond reproach. If there were faults in the system they were not of his making. In simple terms, he was deprived of several options which are available elsewhere in New Zealand (albeit on a limited basis) because those resources were not available to the Mental Health services in South Auckland. Whether that lack of

resources arose at Government, RHA or CHE level, I am unable to say. It was also clear that Mr Gundesen believed, as a matter of law, that he was entitled to divert the Section 8(3) examination to Kingseat and to transport an unwilling proposed patient to that hospital for that purpose. Such a belief, genuinely held, should not now be criticised.

Nothing which Mr Gundesen did on the night of 3 / 4 January 1994 calls for censure or discipline. Rather he deserves community admiration for his efforts in seeking all that was best for Matthew whilst trying to cope with the failures of an under resourced mental health service.

2(a) & (b) Are the procedures used by South Auckland Health for transporting or arranging for the transportation of mentally disordered (or suspected mentally disordered) persons to hospital adequate and do those procedures adequately deal with such persons who are violent or disturbed?

The response to these terms of reference is more fully dealt with under 2(e). Dr Sai Wong describes the procedures before and after 1992:

> **Prior to 1992 the relationship between Mental Health Services in South Auckland and the Police was informal. Each matter of concern was dealt with on a case by case basis in the spirit of mutual co-operation.**
>
> **Around the beginning of 1992 regular meetings with the Police were established to improve liaison and communications.**
>
> **At a meeting held on 26 March 1993 at which I was present, the question of Police providing transport under the Act was discussed. At that meeting an understanding was arrived at whereby, if requested by the Police to do so, the DAO requiring Police assistance would accompany the proposed patient in the Police car.**
>
> **As a result of the present Inquiry I have become aware of a letter written by Chief Inspector Beattie to the senior sergeants in the Manukau Police District. At no time did I receive a copy of this letter (Appendix 6).**
>
> **I produce my copy of the minutes of the meeting of 26 March 1993. My understanding was that if possible, and if requested by the Police, the DAO would travel in the Police car with the proposed patient.**

From the date of the meeting on 26 March 1993, DAOs continued to accompany the proposed patients in the Police car when requested by the Police to do so. This continued until January 1994. Since then, Police procedure has been to require the DAO to accompany the proposed patient.
The procedures used by South Auckland Health for the transportation of persons prior to January 1994 included the following:

- **Where the proposed patient is violent or potentially violent and / or resistant to assessment, the only means of transportation is by Police transport as agreed in the Memorandum of Understanding. The Police are empowered to use force pursuant to Section 41 when providing assistance. If required to accompany, then the DAO will do so.**

Prior to January 1994, the only means of transportation of violent and potentially violent patients to hospital was with Police assistance. Before the case of Matthew Innes this means of transportation proved to be satisfactory.

Currently all violent persons are transported in a Police vehicle with a DAO accompanying the proposed patient.

Andrew Clarke describes current transportation procedures:

There are several ways a proposed patient can be transported to Kingseat depending on the willingness of that person to accept an assessment as required. They include the following:

- **If the proposed patient is agreeable to go to Kingseat but the DAO considers their mental state requires them to be supervised in the car by an experienced mental health worker, the backup DAO may be called to assist in transportation**

- **If a proposed patient will not co-operate with any of the above options and physical force is expected to be necessary, then the Police will be called to assist**

Occasionally it becomes clear that the proposed patient cannot be transported without physical restraint. In the community the DAO has no legal power to physically restrain or detain a person unless specifically directed by the Police to assist them in doing so. It is not the function of a DAO to restrain or

become involved in physical violence. The role of the DAO is specific in this regard. His or her role during the crisis is to calm, reassure and advise according to the information obtained and the presentation of the proposed patient on site. It is only occasionally that physical restraint is necessary.
If the proposed patient is violent, then more often than not it is the Police who call the DAO for assistance, rather than vice versa.

Prior to January 1994 the DAO did not routinely accompany the proposed patient in the Police car unless specifically requested by the Police to do so. It is more efficient for the DAO to travel behind the Police car so that the Police, on arrival at Kingseat, can turn around and be relieved of further duties. If the DAO accompanies the Police, the Police would be required to remain at Kingseat until the DAO has completed his duties under the Act and is able to be taken by the Police back to his vehicle.

Since the DAO is not empowered to use physical restraint this must be applied by the Police. At this point the Police take over control of the situation and the DAO complies with instructions given by the Police until the patient arrives at Kingseat. This method of operating had been successfully employed in South Auckland since the inception of the new Act without any significant problems. I have, and always have had, utmost confidence in the ability of the Police to safely transport proposed patients to hospital.

I was present at a meeting between Police and mental health held on 28 January 1994 at the Cottage. At that meeting it was agreed that the following procedure would apply:

- **The DAO would offer to accompany the proposed patient in the Police vehicle during the transport of that person to hospital**

- **Police may direct any male over the age of eighteen years to assist them. The DAO may be requested to assist in the restraint in this manner**

- **Any problems encountered en route would result in a detour to the nearest Police station**

The current arrangement with the South Auckland Police for the transporting of proposed patients to Kingseat Hospital is as follows:

- **The proposed patient must be seated in the middle of the rear seat of the Police car in an upright position with a constable on each side**

- **A Duly Authorised Officer must be in the front passenger seat beside the driver**

COMMENT:
The current transportation procedures are therefore adequate but will need to be redefined and formalised within the context of national and regional memoranda of understanding - see term of reference 2(e).

2(c) & (d) Are the practices of South Auckland Mental Health staff, in relation to the use of force and physical restraint, appropriate and are the procedures for dealing with violent or disturbed (or potential patients) in the community adequate?

No useful purpose would be served by canvassing the evidence in detail since, to a large extent, the questions posed are of academic interest. It is generally accepted that the use of force and physical restraint towards a patient is a last option and to be exercised only when the patient cannot be "talked down". Dr Sai Wong has given evidence about the training programmes undertaken by mental health staff and produced the policy / procedure memorandum of the (then) Auckland Area Health Board which deals with the management of patients demonstrating violent behaviour, restraint procedures and the method of restraint. These procedures generally accord with those set out in "Challenging Incidents" - a manual of theory for calming and restraint education and "Calming and Restraint" handbook, both of which I have sighted.

I accept Dr Sai Wong's evidence that the existing practices in the hospital setting are both adequate and appropriate.

It is not the function of DAOs or other staff employed by South Auckland Mental Health Services to restrain or to attempt to restrain violent or potentially violent persons in the community who are, or may be, mentally disordered. The role of the DAO is defined in Sections 37 to 40 of the Act. Nowhere in these Sections is the DAO given the power to restrain a violent or potentially violent person in the community. The specific provision relating to the power to detain is contained in Section 41 which states that in certain circumstances the Police may restrain or detain a person. This power is specifically given to the Police and not the DAO. The construction of these

Sections clearly indicates that the DAO was not intended by Parliament to be involved in the restraint and detention of mentally disordered or suspected mentally disordered persons.

Counsel for South Auckland Health submitted:

> If the Police call upon staff to assist the Police in restraining such persons then such staff will do so. Unless the Police call upon the DAO or other staff to help them restrain a potentially violent person, then the DAO clearly does not have the power to do so. Furthermore, it is clear from the evidence of Andrew Clarke, the South Auckland Mental Health Services DAO Supervisor, that DAOs do not want to be given the power to restrain patients. This is also supported by other health professionals giving evidence at this Inquiry. DAOs see their main role as that of a caregiver. They are there to facilitate the treatment of a patient and, if necessary, their transportation to a psychiatric in-patient unit in the most dignified, thoughtful and non-violent way possible. If the DAO were required to have a role in restraining the patient, this would severely impair his / her ability to gain and retain the patient's trust and confidence.

An interesting question was posed by the Mental Health Foundation:

> In respect of whether the procedures used by South Auckland Health mental health services staff for dealing with violent or disturbed patients in the community are adequate, one needs to ask why there was not a mental health training medical practitioner or psychiatrist available to respond to Matthew Innes. If the Police were the only people available to be called in response to the situation where, in the early stages, the patient was not violent, one would have to conclude that the procedures and resources available were not sufficient.

COMMENT:

The practices of South Auckland mental health services staff, in relation to the use of force and physical restraint, are appropriate. The law does not permit mental health staff to use force when dealing with violent or disturbed patients (or potential patients) in the community.

2(e) Is the Memorandum of Understanding between South Auckland Health and the Police concerning Police assistance adequate? In particular does it adequately set out:

(i) when the Police should be called;

(ii) who is to be in charge of the situation when the Police arrive, the Police or the health professional who called the Police; and

(iii) the respective roles of the Police officers and the mental health professionals involved?

In the year 1 July 1993 to 30 June 1994 South Auckland DAOs responded to approximately 415 crisis calls in the community and in 215 of those cases the DAO invoked the Act.

It is estimated that during ordinary working hours Police assistance was requested on 35% - 50% of the occasions on which the Act was invoked. It is estimated that after hours that figure rose to 80% - 100%. Figures maintained by the Mental Health Service are unclear as to the number of occasions on which force has been used but statistics held by Villa 2 at Kingseat Hospital indicate that in the eight month period to August 1994 twelve patients have arrived at Villa 2 in handcuffs.

On 14 May 1993 a Memorandum of Understanding was executed by representatives of the Auckland Area Health Board and the New Zealand Police. That Memorandum is annexed as Appendix 4.

Dr David Chaplow was involved in the creation of that document. He explains:

- **The local "Memorandum of Understanding" was initially executed by the New Zealand Police and the Auckland Area Health Board in early 1991. This followed about eight months of discussion and negotiation between the Regional Forensic Service (for Mental Health Services) and the Auckland Police Region. It was momentous.**

- **Following its execution it was introduced to the three Mental Health Districts (which were set up in anticipation of the Health and Disability Act) and the various Police Districts in the Auckland region which existed (but did not exactly overlap) within these boundaries. Liaison meetings were held with each Mental Health District and with the corresponding Police District between mid April 1991 and mid May 1991.**

- **It was then agreed that each representative Health District, together with their corresponding Police District(s), would be responsible for ongoing liaison and the working through of any practical problems arising in the course of their (respective) work.**

- **Following the introduction of the Mental Health Act 1992, the document was updated and re-signed in early 1993.**

- **Since 1991, the relationship between the Auckland Police and Mental Health Services has been harmonious and faithful. The Innes tragedy (together with some aspects of the Act) has introduced some tension to the practical working relationship between the parties particularly with South Auckland Health, and the "Memorandum" is currently being re-negotiated at various levels, viz. between the Ministry of Health and New Zealand Police and locally. I have yet to see a draft of this document.**

- **The Memorandum was never meant to be a legal document to explain all things. It was and is an attempt to state areas of mutual agreement when the two services work together, how to access each other in a variety of circumstances and how to problem solve and as such, has worked extremely well. I expect, as with the Act, it will need continued reshaping to reflect current reality.**

- **In terms of the Inquiry, viz. 2(e) the Memorandum spells out how each service should access the other (Point 1.0), in what circumstances the Police will respond and assist.**

- **It does not deal with who is "in charge". Point 8.0 of the Memorandum reflects a clinical provision for a mentally ill person if it is considered appropriate.**

- **It does not make explicit the respective roles of the Police or Mental Health Service professionals.**

  I am of the firm belief that Police involvement in responding to a request for assistance <u>is important</u> to the Mental Health Services from a safety, legal and symbolic point of view. Clinicians do not have the statutory right to force their way into peoples' property or to "detain" people nor, in my view,

should they have. Some dangerous situations require the presence of the law (actual and symbolic) as a matter of safety (as in resource) and as a reminder to the index person and onlookers that what is happening is a lawful process.

The paragraph regarding "Transport" in the Memorandum took months to negotiate on the basis that the Police did not and do not see themselves as a "taxi service". We respect this. The agreement was the result of careful consideration of a variety of circumstances and since 1991 has been working well. In brief, I recognise that in general, a nominated "patient" is the responsibility of the Health Authorities and persons apprehended by the Police and "diverted" to Mental Health facilities are the responsibility of the Police. In the possibility of danger, a negotiated position is reached. This occurs in transporting patients between the Mason Clinic and the NSU or when returning a dangerously behaving remandee back to court. The Regional Forensic Service and the Auckland Police have had no difficulty in reaching a sensible, mutually satisfactory agreement on such occasions.

I note that the Police Complaints report concludes that saloon cars are not to be used for the transportation of patients in the future. The issue, in my opinion, is not which type of vehicle is used, but that an individual is transported in safety and in dignity. It should be noted that in the majority of cases the back seat of a saloon, with staff on either side of a patient, remandee or proposed patient, is very satisfactory.

When matters of safe transport arise in our service we utilise a van with a driver and either three or four staff. Mechanical restraints have seldom, if ever, been utilised in the five years of my working in the service. Medication is used where appropriate. The patient is usually seated in the rear seat, medicated and made comfortable (pillows and blankets). Seats can be removed and mattresses placed in the van. In the case of maniacal or dangerous behaviour the individual would be placed in the back seat (van) with staff on either side utilising approved restraint techniques (these are approved and lawful arm and wrist locks). A third staff member is seated in front to care for the patient's head and to talk to the patient. In a very worrying scenario, a fourth member will be present if required. I stress the point that most of our patients are transported safely in a saloon car.

I have been asked to comment on the suitability of "flying squads" using a dedicated vehicle. I have not been able to talk to other Directors of Services about this. Given the availability of resources, it would be an asset providing assistance to the DAO, the provision of the medical certificate, medication and transport. It would not negate the need for the Police to be present nor negate their occasional assistance in the transportation.

Superintendent Brian Hartley of the Manukau Police specifically refers to three parts of the Memorandum:

- <u>Paragraph 2(b)</u>
  This requires the Police to assist a DAO who believes a patient poses a serious threat to persons and property. This is an obvious reflection of the threshold definition of mentally disordered persons for the purposes of the Act.

- <u>Paragraph 2(c)</u>
  This provision requires the Police to detain and take a patient to a place specified by the DAO for assessment or treatment.

- <u>Paragraph 8</u>
  This provides that where practicable the DAO is to directly supervise / accompany the patient while detained in custody and this is to be done through consultation with the Police. The requirement for the DAO to accompany the Police has been raised at the District Liaison Group. Some disagreement as to the interpretation of "accompany" left open the view held by some that it was not necessary to actually physically accompany the suspected mentally disordered person in the Police car. The consensus was that physical accompaniment was the desirable course.

<u>COMMENT:</u>

The Memorandum of Understanding does not specifically set out when the Police should be called. However, that omission is not necessarily a defect since Section 41 of the Act confers on DAOs a statutory right, under certain circumstances, to call for Police assistance. What is more significant is that the Memorandum acknowledges that the Police will respond to such calls for assistance (2.0.b) and outlines the protocols ancillary to that response.

The Memorandum does not spell out who is to be in charge although the use of the term "where required" in paragraph (2.0.c) suggests some form of direction being given by a DAO. However, the position is far from clear and will need clarification. The Memorandum does not adequately set out the respective roles of Police officers and mental health professionals involved.

Notwithstanding its omissions the Memorandum appears to have served as a useful guide for both Police and mental health staff. Professor Werry:

> **I have nothing but the highest praise for the Police assistance that has been given to DAOs for patients under my care under the operation of the 1992 Act. It would be a tragedy indeed if the death of Mr Innes were to impede in any way what has been a most successful co-operation between Police and mental health.**

Dr Murray Patton:

> **The Memorandum of Understanding developed between the Auckland Area Health Board and the Police clearly identifies that the Police will respond to provide assistance to the DAO. Yet it could be argued that there is some ambiguity in the actual terminology used in the Memorandum of Understanding which notes that the Police will "... assist in detaining...".**
>
> **The DAO clearly also has a role in detaining, but it is unclear in the Act whether this includes the use of force. The Act does authorise the Police to use force in certain circumstances, and in those situations in which a DAO has called for Police assistance to assist in controlling a patient and the risks presented by this patient, it appears to be the most sensible and safest practice for the Police to act under the authority of the DAO but to use their own procedures and techniques to contain the risks.**
>
> **It would be risky for clinical staff to be involved in restraining a patient in conjunction with the Police when they are unfamiliar with Police training and techniques in such situation. This "assistance" therefore in detaining and containing dangerous situations is best operated by the DAO remaining in charge with the Police applying their own strategies.**

Aside from this slight ambiguity, the Memorandum of Understanding provides a reasonable framework for the joint relationship between clinical staff and DAOs on the one hand, and the Police on the other. When read in conjunction with the Act, it is clear that the DAO is in charge and that the Police have a specific role as agents for the DAO. The DAO has overall control of the situation, but the Police have the authority with respect to the restraint and the transport of the patient.

Dr Patton believes that the use of Police cars for the transport of proposed patients is entirely satisfactory.

Dr Chaplow notes that the Police have been transporting mentally disordered or suspected mentally disordered persons for years under both the 1969 and 1992 Acts. He is unaware of any major problem occurring prior to 3 January 1994. He also considers the use of ambulances to be inappropriate.

Superintendent Brian Hartley provides a Police perspective:

Members of the Manukau Police, and I am sure that this is a national approach, clearly accept that they have an obligation to assist a a DAO when assistance is sought in dealing with a mentally disordered person whom they are advised will be violent or may be potentially violent. In my experience they do so willingly although it is certainly not a popular assignment.

There is no doubt whatsoever that since the Matthew Innes incident frontline staff are considerably less enthusiastic than they were about being tasked to assist a DAO. This reluctance is obviously a natural one, exacerbated, in my view, by the absence under the present Act of suitable protections for officers acting in good faith.

The Police accept that the DAO is a mental health professional who has a statutory function to perform under the Act. The DAO possesses the knowledge, skill and clinical expertise to make an assessment based on the fact. The DAOs know the provisions of the Act and through it, the best procedures to be adopted. Their knowledge and clinical expertise permits them to determine whether or not the person may be mentally disordered such that the provisions of the Act need to be invoked. Under the Act it is the DAO who determines

whether or not the Police should be called to assist. For obvious reasons the Police play no part in that whole decision making process and the procedure under the Act.

If the DAO determines that this is a case where he or she should utilise the powers under the Act to call for Police assistance the function of the Police must be confined to considerations of how best to achieve the DAO's object in transportation. If necessary (in my experience and researches thankfully infrequently), considerable force is required to control and restrain the person to facilitate transport. Sometimes handcuffs must be applied to the wrists and even more infrequently to the legs. This function is a recognition of the Police expertise in restraining and handling violent persons.

For the purposes of this Inquiry I have endeavoured to calculate the number of mentally disordered persons dealt with by Manukau Police District staff since the introduction of the Act on 1 November 1992. I have searched the district office computer records between 1 November 1992 and 1 July 1994. These records have been searched for the job code IM which designates Police involvement with a mentally disordered or suspected mentally disordered person. These records disclose a total of 277 cases recorded under this category.

As to the number of times the Police have had to use force to restrain a mentally disordered person in my district, the Police files record a total of fourteen cases between 1 November 1992 and 1 July 1994 when force has been necessary to restrain for transporting the person.

Dr Bill Daniels has been a Police surgeon for twenty years:

Once the Police assist a DAO in restraining a violent, mentally disordered person, issues of in whose care and control that person is, arise. I am aware that issues of this type have already been canvassed before the Inquiry.

On a medico-legal / ethical basis, I have no doubt whatsoever that when Police assistance is called for by a health professional acting under the Act, the responsibility of care rests with the health professional rather than the Police. This

the DAO's first introduction to the person and extends to include subsequent decisions as to options under the Act, including preliminary diagnosis, assessment, transport (if appropriate), assessment diagnosis and treatment.

There can be little doubt that the ability under Section 41 of the Act for a DAO to call for Police assistance is a recognition of the latter's expertise in dealing with violent persons. However, the normal training practices and procedure adopted by the Police and the experience which they draw upon to discharge their function, derives from contact and experience with predominantly mentally fit members of the public. These may be violent offenders who are being detained by the Police, having offended under the criminal law.

I see a distinction between the restraint of criminal offenders and the restraint of mentally disordered people who have not committed an offence.

While I accept the mechanism for restraining violent people (whether mentally fit or disordered) is unlikely to be very different, I know from my own dealings with the Police that it is philosophically difficult for many of them to use physical force on a person who has not been involved in violent, criminal offending.

Police Officers, when involved in restraining and transporting mentally disordered persons, are frequently confronted by an extremely violent, unpredictable and irrational individual. The conventional methods of handling violent persons are often of limited use.

In my experience mentally disordered persons in this situation often attempt self mutilation or alternatively, have little regard for pain. It is not uncommon to see a person in these circumstances, handcuffed hand and foot, throwing his / her head against a hard surface, in this situation, apparently oblivious to the pain and injury being caused.

My own observations of the Police in these circumstances is that they find this behaviour extremely upsetting.

Inspector McLeod informed me that it is intended to execute a national Memorandum of Understanding between the New Zealand Police and the Ministry of Health:

> **Although there have been region and district Memoranda of Understanding between local Police and local Mental Health Services previously, there has not been, to date, a global, national memorandum.**
>
> **However, it is desirable for a general, national policy document to be drafted setting out the respective roles (without detail) between the parties.**
>
> **It is intended that this national document will provide the basis for more detailed regional and district memoranda. The responsibility for drafting and executing those will be regional. Some regions, e.g. Auckland (which includes the Manukau Police District), have had local Memoranda of Understanding for some years. Again this is further recognition of the excellent lines of communication which have existed for some time between the Police and the local Health Authorities.**
>
> **I produce the draft national Memorandum of Understanding which, like the draft General Instructions, has yet to be finalised and approved and will not be executed by the respective parties until the conclusions of this Inquiry have been published. The Memorandum has been drafted following intensive consultation between Police and the Ministry of Health at a national level.**

The draft National Memorandum of Understanding is annexed as Appendix 5. I comment on it later in this report.

The issue as to who should be in charge and the respective roles of the Police and mental health professionals prompted this submission from the Commissioner of Police:

> Mr Gundesen in cross-examination accepted that it was for the "DAO to call the shots under the Act". It was for him (the DAO) to determine when or whether it was appropriate to call the Police in. Having called the Police in Mr Gundesen accepted that this indicated a commitment to using the Police to assist. He accepted that he was in charge, but the assistance of the Police was sought recognising their expertise in dealing with violent people. He

conceded that he was in charge of organising and putting in place the plan for the care of the subject person.

In answer to questions from the Inquiry Mr Andrew Clarke agreed that the DAO, as "facilitator", was in overall control of the situation. He also accepted in cross-examination from Miss Gordon that the DAO's responsibility subsisted at least until arrival at the place nominated for assessment and / or treatment.

Mr West, in orally supplementing his written evidence, stated that the DAO should continue to maintain overall responsibility for the person from the time of contact with the DAO until arrival at the place of treatment. He added that in the vehicle the DAO should conduct an ongoing assessment of the person's psychiatric state. This assessment can be conducted discreetly and in a manner unlikely to upset or disturb the patient.

The repetitious use of the word "assistance" in Section 41 recognises that the Police involvement is an adjunct to the exercise of the DAO's statutory powers elsewhere in the Act.

This is not a novel relationship for the Police. The Police in other contexts routinely carry out duties under the control of other agencies, e.g.

Civil Defence
Once an emergency is declared the Police have a defined role but the Civil Defence Controller is accountable and responsible for the entire operation.

Fire Service
At any combined Police / Fire response the Fire Service has total command and control of the "fire ground". Any Police operating within that area (which varies depending on the type of incident) are under the command of the senior Fire Officer present.

Rescue Co-ordination Centre
This co-ordinates all search and rescue activity outside the capabilities of the Police and associated groups. All Police action taken in relation to these searches is under the command and control of the Search and Rescue Co-ordination Centre Co-ordinator, but with the assistance and co-operation of the Police.

> However, the exceptional circumstances which confronted Mental Health Officials and the Police on the evening of 3 January 1994 cannot be over-emphasised. The relevant statistics were considered by Superintendent Hartley where he recorded between 1 October 1992 and 1 July 1994, two hundred and forty four instances of Police involvement with mentally disordered or suspected mentally disordered persons. This statistic was further refined when the Superintendent observed that of those two hundred and forty four cases, only fourteen involved the use of force. This equates to Police callout involving the use of force of less than one incident in every six weeks.

The issue about the type of vehicle to be used in transporting people under the Act aroused much discussion. I note the conclusion reached by the Police Complaints Authority in its report dated 15 April 1994:

> Sedan or saloon motor vehicles are not to be used for transportation of (mentally disturbed) patients in the future. Only in emergencies should a Police van be used, but otherwise patients should be transported by ambulances.
> Conclusion 5(e) P. 30.

Inspector McLeod:

> **It should not be necessary for the Police to provide their resources to transport non-violent persons at the request of mental health professionals. Such transportation must be the sole responsibility of Mental Health Authorities and Police resources should not be used to provide what is otherwise effectively a taxi service. This recognises the implicit diversion of Police resources from other important functions within the community. It also has the potential of stigmatising the mentally disordered person. This philosophy must apply equally to rural and urban areas. If there is no violence or reasonable threat of same, then there is less likelihood of urgency and the mental health professionals can provide such transport as they think appropriate.**
>
> **Every effort must be taken to reduce the risk before a violent person is transported. This is risky, not only to the person being transported, but to those accompanying him or her. As discussed above, this can be affected either by sedation or effective restraint or a combination of both.**

I am aware of the observations of the Police Complaints Authority's report on the Matthew Innes matter where at paragraph 5(e) the recommendation is made that Police cars (saloon or sedan) must never be used and that Police vans should only be used in emergencies.

I have explored with the relevant authorities the availability and appropriateness of the use of ambulances or CHE specialist vehicles.

I am not aware of any CHE prepared to provide suitable vehicles of its own for transporting violent, mentally disordered persons. This would obviously be an expensive item for them to obtain and presumably maintain for relatively infrequent use.

My enquires with ambulance authorities throughout the country is that, in general, they accept they can have a role in transporting violent or potentially violent mentally disordered persons subject to satisfactory restraint and / or sedation, such that they can be assured that the person being transported presents no danger to himself or any other. The practice of transporting such persons in ambulances is presently under way in some parts of the country.

I am aware that Police views are divided on whether, if Police vehicles are to be used, the preference should be for a Police car or a Police van. There are compelling arguments for and against each of those options.

Against the use of Police vans is the claim that they are large and cavernous with sharp metal obstructions and other solid internal structures including seats on which a violently struggling person could easily be injured. It is said that it is exceptionally difficult to restrain a violent person inside such a vehicle, even when they are handcuffed.

If a Police car is used the preferred course should be for the person to be placed upright in the rear seat with officials, either being the Police, DAO or a combination of same, sitting on either side so that some control over his movements can be exercised. In some cases, particularly where only one Police Officer is available to assist the DAO, it may be impossible to have more than one person assisting to restrain the person in

the back seat. In these instances it may be necessary to rely upon relatives of the person being transported to assist, although frequently this is simply not possible. On some occasions a patient can be particularly violent, spitting or head butting, and in these circumstances there can be no choice but to lie the person down in the back seat in order to effectively restrain him.

Whatever the position, where Police, or any other vehicle is used to transport violent mentally disordered persons, an appropriate mental health professional should also physically accompany the patient in the vehicle. The need to stipulate physical accompaniment is necessitated by the reluctance of DAOs in some parts of the country to travel with the person to the hospital. It is now expressly referred to in the draft national Memorandum of Understanding.

By way of example, I have become aware, as a result of my research into this matter, that in some remote rural areas where there is no DAO available outside normal business hours the initial contact between the Police and the DAO is via telephone and facsimile. The DAO purports to exercise his powers under Sections 8 and 9 remotely without physically attending on the person. The Police are then asked by the DAO to assist in transportation. Frequently this is over rough provincial roads for several hours. The first contact which the mentally disordered person has with Health Authorities is when he / she is delivered by the Police to hospital.

It must be emphasised that the prime responsibility for dealing with mentally disordered persons rests with the Health Authorities. The Police involvement is restricted to those limited instances where they are called upon to assist.

Dr Bill Daniels:

In recognition of the health professional's primary responsibility in this area I believe that the most appropriate method of providing care and transport for violent, mentally disordered persons would be through the establishment of a specialist psychiatric "flying squad".

There are plenty of medical analogies in other specialties which demonstrate that such a system is capable of working extremely well, for example obstetric care and coronary care.

I can see no reason, at least in principle, why such specialist facilities in other areas of medicine cannot be extended for the service of those who are mentally disordered.

Dr Brian Timney:

In my view the use of an unmodified ambulance for general use would be unsatisfactory and potentially dangerous for all involved.

The current system of flexibility in the use of vehicles seems to work well in virtually all cases. Evidence given by Dr Vuletic indicates that the position of the individual being transported is of more importance than the vehicle type.

The use of a dedicated and modified CHE vehicle is worth further discussion but would not be a nationwide solution because of the difficulties in remote and rural areas. I have similar thoughts on the notion of a so-called "flying squad" (a term which I hope would be changed if the general idea is pursued).

Superintendent Hartley:

Having consulted widely with my staff and having received observations from others involved I am less convinced that a Police van is the preferable vehicle type. It seems to me that to some considerable extent that the type of vehicle to be used should be dictated by the circumstances as they appear to exist at the time of its need. Where there are threats of violence invariably a Sergeant or acting Sergeant will attend the scene and be in a position, in consultation with the DAO, to select the most appropriate vehicle.

The issue of what sort of vehicle should be used for transporting mentally disordered persons is a matter of very considerable concern to frontline staff. I know one view shared by a good number of Manukau Police staff is that the most appropriate means of transport might be the use of an ambulance-type vehicle suitably equipped to handle a

restrained person. I accept there are some practical difficulties with such a course. It would obviously need to be operated and funded the local CHE and I accept there may be funding difficulties particularly if such a dedicated and specialised facility might only be used within the district relatively infrequently.

The Mental Health Foundation:

> Transportation should be done in as humanely and comfortable a way as possible. It is agreed that in many instances, transportation in the back of a saloon car with one or two people supervising would be adequate. This however, would depend on the level of agitation of the patient. There will be instances where, because of the high level of agitation or distress, safe physical restraints may be required. These could include arm and wrist locks or a restraint stretcher in an appropriate vehicle. The emphasis must remain on people being transported in humane and safe ways. In most instances, a saloon car with adequate support staff will be appropriate. Where not, an appropriate special vehicle which does allow safe humane transportation should be available.

Counsel for the Commissioner of Police echoed the views of others and submitted:

> The uncontradicted and apparently universally accepted fact is that the use of Police vehicles has been an effective method of transport in incidents involving violent mentally disordered people since well before the passing of the present Act. This is not to say that maintaining features of the present system infers complacency. Rather, it is to recognise that a system of co-operation, developed over many years, and refined more recently with various Memoranda of Understanding, is a system which will continue to work well for the vast majority of cases in the future. Modifications such as the development of a "flying squad" or the utilisation of specialist vehicles, are innovations which cater for and recognise the existence of truly exceptional cases such as that involving Matthew Innes.

Mr Jenkin, Counsel for the Innes family submitted:

> Based on the evidence which was presented to the Inquiry it appears to be a commonsense summary that:

- a qualified or experienced health professional should be in charge of any operation involving the transportation of a person who is considered may be mentally disordered to a place where he / she might receive appropriate assistance and / or treatment;

- the health professional involved is the person who should have overall responsibility and control of the operation to ensure the safe transportation of the subject person - with the assistance of the Police if necessary;

- the Police should be better briefed and instructed on how to approach the subject person and to apply restraint to that person, such instruction or briefing being given by the health professional involved at the time;

- it is acknowledged that this may take place against a background of extreme urgency and in a situation where the subject person is posing a serious threat to his / her own life or to the lives of others and / or safety of others. The time spent on briefing and / or instruction may be shortened or negated as circumstances require - but where no life-threatening emergency exists before an attempt is made to take a person away - by force if necessary, then care should be taken on proper briefing and instruction in every circumstance (especially to cater for any new personnel on the job who may not have prior experience in the task);

- the actual application of force to the subject person in the process of applying restraint may be the responsibility of the Police involved in that use of force but nonetheless the overall safety, health and welfare of the subject remains the responsibility of the health professional before, during and after restraint and especially during transportation.

  The health professional at the scene must have power of command and control to the extent of instructing the Police to withdraw - even if only momentarily - in order to do everything possible to avoid a violent response and resistance rather than to provoke one. There should be no preconceived notion that the presence of the Police means that the person will be taken away against their will if they do not come voluntarily at first instance.

  A health professional should accompany a person being transported for treatment at all times. The health professional should have the responsibility and obligation of overall command

> and control of the entire restraint and transportation process including the use of force and / or mechanical restraints as may be necessary. The health professional - and indeed all other people accompanying the person being transported - must have an obligation to monitor the vital life signs of the subject concerned and take emergency action should it be required.

COMMENT: It will be readily apparent that the lack of clarity and precision in the Memorandum of Understanding translated into a confusion of roles at Howick on the evening of 3 January 1994. So far as the Police were concerned they were there "to assist". For his part Mr Gundesen knew that he had no legal power to restrain Matthew and in his view that was the sole function of the Police. He believed that once the Police had effected restraint it was their responsibility to transport Matthew safely and quickly to Kingseat Hospital. I note that Sergeant MacGibbon instructed Mr Gundesen to follow the Police car to Kingseat. Mr Gundesen clearly assumed control before restraint was applied because it was he who asked the Police to wait outside the premises and it was he who later invited the Police on to the property. Although the Sergeant did not say that he was in charge, subsequent to Matthew being handcuffed, his actions suggest that he believed himself to be in charge - that being a function he later handed over to Constables Vincent and Schmidt. I do not overlook Sergeant MacGibbon's evidence that if Mr Gundesen had requested to travel in the Police car that request would have been granted. I believe that is being wise after the event.

Mr Gundesen says:

> **I was aware of the Memorandum of Understanding. From this I took the arrangements to be that a DAO would accompany a person in the Police car when requested to do so by the Police. The Memorandum of Understanding did not include any details about how the patient should be seated. On the night of 3 January 1994 the Police did not request that I accompany Matthew Innes in the Police car. On the contrary, the sergeant instructed me to follow in my hospital car. The sergeant was apparently happy with the way in which Matthew was restrained and saw no reason for either himself or me to also go in the car. Similarly, at the time I had no reason to believe that Matthew would come to any harm while being transported by the Police, not least because in the many times I had asked the Police to transport a person in a Police car, I had never known such person to come to any harm. Nor had I ever heard of any other person being so transported coming to any harm.**

Counsel for the Commissioner of Police noted:

> Notwithstanding the Beattie memo of 26 March, the agreement as at 3 January 1994 for the transportation of violent or disturbed mentally disordered or suspected mentally disordered persons was that the Police would respond to calls for assistance if there was a serious threat to persons or property and that threat continued following the arrival of the Police. Furthermore, the physical presence of the DAO in the police vehicle was not mandatory and was influenced by considerations of practicability and necessity.

I have considerable sympathy for Mr Gundesen and all three Police officers. Had a clearly defined command structure been in place and had the respective roles of the participants been more clearly defined events on 3 January may have taken a different course.

It has been suggested that Mr Gundesen should have accompanied Matthew in the Police car. The advantage of hindsight suggests that that would have been an appropriate option but it needs to be remembered that on 3 January 1994 Mr Gundesen's actions were based on his belief as to the respective roles of the Police and he as a DAO. As he indicated above the restraint and transport had been passed over to the Police and by necessary implication that meant a safe arrival at the hospital. Nine months after the event he should not now be criticised for a failure to do something which is based on current practices. Ironically some of those current practices arise as a direct result of Matthew's death. It should also be noted that neither Mr Gundesen nor the three Police officers were familiar with the term "positional asphyxia" - that knowledge was a rarity in January 1994 - and none were familiar with the information contained in the Beattie memorandum of 26 March 1993. So far as Mr Gundesen was concerned he had no reason to believe that transporting Matthew in a supine position would cause him harm.

I emphatically reject the submission that under certain circumstances DAOs and other health professionals be empowered to use force if necessary in the performance of the duties in the community. The use of force in a community setting must always be the function of the Police. It is not a function which DAOs seek and indeed it does not fit into the role in which DAOs see themselves, i.e. as healthcare providers and advocates. If it is necessary for a DAO to use force under the direction of a Police officer then such authority exists under Section 53 of the Police Act 1958.

It is perhaps trite but necessary to observe that Police officers have few skills in the management and control of mentally disordered persons. Their role, in broad general terms, is the maintenance of law and order. They should not therefore, be compelled to assume a role for which they may be inexperienced. Mental health professionals, on the other hand, are skilled in mental health matters but lack experience and authority in

matters of law enforcement. The responsibility of caring for the mentally disordered or those who may be mentally disordered must always be the responsibility of the mental health professional albeit with assistance from the Police on occasions. In the context of this Inquiry it is the DAO who must be in overall charge of the patient or proposed patient and that responsibility must persist until the patient / proposed patient has been placed in the care of another responsible mental health professional. Restraint must always be a Police function. I would expect the method of restraint to be a consultative process between Police and DAOs but at the end of the day such restraint must be carried out under the overall direction and supervision of a DAO.

I respectfully disagree with the conclusion of the Police Complaints Authority referred to earlier in this report and in so doing I record that I have had the advantage of hearing comprehensive submissions from several sources as to the most appropriate type of vehicle for transporting mentally disordered persons. That information would not have been available to the Police Complaints Authority.

I reject the notion of a dedicated vehicle. In my judgment the resource implications in terms of staff and funding would make such a proposition untenable.

I also have some concerns about the use of ambulances since their use would probably mean that a patient be sedated before transportation and that protocols be in place to ensure adequate protection for ambulance staff in the event of a patient becoming violent.

In general terms, ideally DAOs and Police should have a range of vehicle options available to them, including ambulances, and the decision as to which type of vehicle is to be used is one to be decided as circumstances and availability dictate.

I believe that in the vast majority of cases a Police vehicle (sedan or saloon) will still be the preferred option if only because such vehicles are usually readily accessible and have proven, in the past, to be suitable for the job. The tragic death of Matthew Innes does not mean that an existing system be dismantled. Rather, it needs to be redefined in clear, simple terms.

Restraint must be applied to the least extent possible but consistent with the need to ensure that the safety of the patient and those responsible for transportation is not compromised.

In cases where a DAO has called for the Police assistance it will be the responsibility of that DAO to accompany the patient or proposed patient and to monitor and be responsible for the wellbeing of that person.

3(a) Was Matthew Innes' physical condition discovered when he first arrived at Kingseat and was appropriate medical intervention made at that time. If not should it have been? and

(b) Was appropriate treatment provided to Matthew Innes when he arrived at Kingseat Hospital?

The circumstances surrounding Matthew's arrival and treatment at Kingseat Hospital are set out in Chapter five. The main point in issue is whether or not Matthew's condition should have been discovered immediately he arrived on site, i.e. when John Van Beerendonk opened the car door and saw Matthew on or near the rear seat. Varying opinions have been given as to the time which elapsed from the arrival of the Police car until Matthew's face was seen to be cyanosed. The precise period is uncertain because staff, as is customary when a violent patient is being admitted, were not wearing watches. The best estimate seems to be somewhere between three and five minutes. It was contended by Mr Driscoll, Counsel assisting, that during that period Matthew's airway, breathing and circulation (the ABC) should have been checked by staff who carried him from the car to the side room.

COMMENT:

I am satisfied that Matthew Innes' physical condition was not discovered when he first arrived at Kingseat Hospital in the sense that it was not discovered immediately Matthew was seen by Kingseat staff inside the car and immediately on his removal from the car. I am however, satisfied that his condition was discovered as soon as was reasonably practicable.

Mr Ronald Trubuhovich is a specialist intensivist in the Department of Critical Care Medicine at Auckland Hospital:

> **It is my considered opinion that in the circumstances appertaining at the time, the nursing and medical staff at Kingseat Hospital reacted with all reasonable, prompt and appropriate behaviour. Not only was their conduct, in my opinion, not in any way blameworthy, but they should be commended for the real professionalism they displayed under circumstances of dire emergency in the performance and execution of their duties.**
>
> **Having been alerted to the pending arrival of a patient who had a high potential for violence, was unpredictable and had needed multiple members of the Police and his own family to get him loaded into the police car for transport, they made all prudent preparations and mobilised all male staff who could be made available. Once the patient arrived they**

expeditiously transferred him to a prepared treatment room and once cardiac arrest was detected, they treated that with exemplary skill to get his circulation restored.

The patient arrived in the dark, he was still unresponsive to voice (as such patients can be in between bouts of violent behaviour), he was transferred from the car in the dark to a dim room. When the opportunity was presented to examine him and he was found cyanosed, non-breathing and in cardiac arrest, he was skilfully managed.

The staff, who were also familiar with the patient's previous history, were repeatedly made aware that the patient's behaviour had been violent that day. When he reached Kingseat Hospital the Police reinforced the message that Matthew Innes had been biting, spitting and kicking and was likely to do so again unpredictably. Under such circumstances and with the patient's head being hidden by the upriding jacket, it does not surprise me that the immediate medical examination was not conducted until he was placed in the admitting room.

When the patient was found to be in cardiac arrest, the medical and nursing staff worked very skilfully and efficiently as a team to get his circulation restored. This they managed without "advance life support" (endotracheal intubation, adrenaline, defibrillation). They then referred him for ongoing care at Middlemore Hospital, as was appropriate because he had not recovered consciousness.

Cardiac arrest is an uncommon event in a psychiatric hospital. We are quite familiar with it in an intensive care unit. Yet the staff involved seemed to have carried out their tasks with all expedition and to have run through their drill in an ordered and efficient manner and, judging by the briefs of evidence, to have proceeded without panic and with calm efficiency. These reasons, allied with the smoothness of the reception procedure, earn my admiration for their professional performance.

It is apparent that the true physical condition of Matthew Innes was not discovered until he had reached the side room of Villa 2. Presumably the failure to detect his true state on arrival at Kingseat can be related to the dark interior of the car, the darkness of the night and the dimness of the side

room, allied to wariness on approaching the patient because of the dire forewarnings of violence and unpredictability and an expectation that he could still bite, jerk his legs and spit (blood). Perhaps one would think that a patient in arrest would be totally limp and it might appear puzzling that this was not detected. However this perhaps can be understood by considering that Matthew's weight was shared between five people and thus the significance of his non-reactivity may not have been immediately obvious. It has been mentioned by the Police that the ridden up jacket was left in place to prevent their being spat upon.

A further issue that this Tribunal must consider is whether the treatment provided to Matthew when he arrived at Kingseat Hospital was appropriate. In my opinion the treatment provided was appropriate to Matthew Innes' needs as they were detected. The nursing staff moved as quickly as possible to get him shifted from the car to the side room which had been prepared for his reception and assessment. This begs the question of whether any difference to the final tragic outcome would have occurred if a state of cardiac arrest had been detected immediately he was moved out of the Police car. If it had, the response of the resuscitating team would presumably have been to rush him to the side room where he could be attended to properly. The only real difference that could have come from earlier detection, in my estimation, would be the saving of approximately one minute of time between Matthew's arrival at the side room and the start of resuscitation.

I am quite confident that this period of approximately one minute made no difference to the final result. The common outcome in a patient who does not make a satisfactory cerebral recovery after cardiac arrest, CPR and brain-orientated intensive care, is one of modest to the severest brain damage. However, this patient became brain dead at Middlemore Hospital. Brain death is an uncommon outcome in this setting. The development of brain death usually means the hypoxic-ischaemic insult is very profound.

I would attribute the severity of the hypoxic-ischaemic insult to asphyxia (oxygen deprivation) occurring in someone superfit and active, and with a supranormal oxygen consumption, such as would be associated with struggling or

resisting, against a background of hypermetabolism from acute psychosis producing drastically reduced oxygen reserve. With the benefit of hindsight, and knowing what his condition already must have been on reaching hospital grounds, I find it hard to believe that, if they had been able to detect cardiac arrest soon after removing Matthew Innes out of the car, earlier institution of CPR would have allowed anything other than survival with severe and unacceptable brain damage. I cannot see how any blame can be attached to the nursing or medical staff in this regard.

Support for those views was given by Dr David Galler, a specialist anaesthetist and intensivist at Middlemore Hospital:

My understanding is that as soon as Matthew arrived he was taken from the car to the side room where nurse aids began undressing him and it was whilst he was being undressed that the psychiatric registrar came into the room and discovered he was not breathing and arranged for resuscitation equipment to be brought quickly to the room.

Bearing in mind that Kingseat is a psychiatric hospital and that the staff were expecting a violent patient, I consider that they acted reasonably, responsibly and appropriately to revive him as soon as was reasonably practicable in all the circumstances. In my view it would be unfair and unreasonable to suggest that they should have checked his vital signs in the car or whilst he was being carried into the side room. I take into account the fact that it was around midnight when he arrived. The outside lighting was not good. Furthermore, his head was covered by his jacket and his hands and legs were handcuffed in such a way that it would have been extremely difficult to carry out any check of his vital signs until he had been taken into the side room, the jacket removed and the handcuffs taken off.

There is a variation in the witnesses' estimates of the elapsed time between the arrival of the police car and the discovery of the fact that Matthew Innes was not breathing. However given the very difficult circumstances outlined above, compounded by the belief that the patient had the potential for extreme violence, I consider that the action taken by the Kingseat staff was not unduly delayed.

In summary, it is my view that whilst at Kingseat Hospital the patient, Matthew Innes, received swift, appropriate and effective emergency medical care.

It is my experience that once the heart has stopped as a result of asphyxia a patient will probably suffer severe brain damage and, as in this case, may develop brain death. If Matthew was in a state of toxic delirium, his metabolic rate would have been greatly increased compared to his resting state. His oxygen consumption would also have been greatly increased, leaving him with minimal or no oxygen reserves or even in a state of oxygen debt. Under these circumstances, if the oxygen supply to the brain is cut off as a result of the heart stopping, then brain damage will set in much more quickly than normal.

I adopt the views expressed by Dr Trubuhovich and Dr Galler and the reasons which support those views. To have expected staff to check Matthew's vital signs while he was being carried into the side room would be to demand a counsel of perfection. Kingseat staff were expecting a violent psychiatric patient who may have "been playing possum". They were not expecting a medical emergency. There was no compelling reason why they should have checked Matthew's vital signs while he was being taken to the side room. I am reinforced by this observation from Dr Galler:

The A, B, C should be monitored on a continuing basis. The A, B, C, as a general rule, in a patient who is presenting, should be monitored as soon as is practicable. I use the analogy that if someone collapses in the hospital in an unfortunate place, and that happens all the time, you actually have to get them to a place where you can properly assess them and then treat them. You cannot adequately assess someone who is in a position as Matthew may have been in, and certainly not in the dark. The emphasis should be to assess the A, B, C as soon as is practicable and in this case it was not practicable to do it while he was being carried inside.

I am satisfied that at all material times staff acted appropriately in ascertaining Matthew's physical condition as soon as was reasonably practicable and that thereafter the treatment provided to Matthew was carried out swiftly and to a high standard of professionalism.

CHAPTER EIGHT

THE DAOs COMMENT

"When the Act was implemented in this district there was a lack of funding. We were given $50,000 to implement it - that was hopeless. The DAO duties were tacked on to our existing jobs".

"We need basic effective equipment such as cellphones and pagers. I was speaking on a cellphone to someone who said he was going to top himself. The cellphone died on me".

"We are all members of a rapid response crisis team and therefore we do not carry a caseload. It would be impossible for us to carry out our DAO duties if we had a caseload. We simply do not have the time. We are kept too busy".

"I find it very scary to go and visit someone by myself. The whole matter becomes a safety issue".

"If a patient is acutely unwell and requires two people to be seated alongside him then a Corolla car is totally unsuited for that purpose".

"We have a huge geographical area to cover. It is absolutely essential that we have effective communication with our base even if that means the installation of a radio telephone".

"We try to do things in good faith and yet we are exposed to civil action".

"We do not have access to consistent medical cover for advice".

"It is almost impossible to see a GP during ordinary working hours because they cannot leave their surgeries. It is a little easier after 5.00 pm".

"There must be clear lines of communication between DAOs, medical advice from GPs, registrars, consultants and the local Director. There must be clear protocols as to how that information can be accessed".

"I refused to go out by myself. Management arranged for a hospital orderly to accompany me but that meant I had to wait until he had finished his shift. It was ridiculous".

"There must be consistency on a national basis as to how the Act is interpreted".

"We must create good personal relationships between the Police and mental health services. In this district we have done so and the result is that the Police will get there really quickly if we ask them to".

"The real problem is the GP. They are not available".

"The patient tried to grab the hand brake. After that episode I realised that I must never again transport a patient in a car without some other person being present".

"We have twenty acute beds in (names district) and every time we want to use one they are full. It is a nightmare trying to negotiate a bed. There are no respite beds and there is nothing for children - it is desperate".

"The stupid little things never seem to get sorted out. We are provided with a car but there is no car parking immediately available. We have to park in a building down the road and that creates all sorts of problems when we want to access the car - particularly after hours".

"I don't know the faces in the RHA and yet these people decide our budget".

"We do an enormous amount of overtime and we take time off in lieu. We are underpaid".

"The mental health funding needs to be ring fenced".

"The bottom line is that we are not valued as a clinical person and that is why there is such low morale and cynicism amongst mental health workers. We put an awful lot of care and energy into helping the people we are called upon to help. We have had three managers in the past twelve months and two changes of building. Management and the community expect the Act to be

complied with but the mental health service is not funded and we still continue to be the poor relation of the health system".

"I am getting sick and tired of spending four or five hours in the community, tending to the needs of an acutely ill person and then the same amount of time back at the hospital trying to negotiate a bed. The facilities are just not available".

"Sometimes seven or eight people have to be shifted elsewhere in order to obtain an acute bed for a patient".

"I have had no legal training about this Act".

"About two weeks ago, and after almost one year of trying, I finally managed to get some blankets for the cars which we use to transport people over long distances. Many of the people we deal with are acutely unwell and it is important that we provide them with some reasonable comfort".

"We had a Calming and Restraint course but not all of us could attend because no cover was provided for those who were still working".

"A national training package must be organised".

"Transporting a patient by ambulance is not a good idea. They are too big and they make people sick".

"As a DAO I believe that I work very hard indeed. But it is the psychiatric registrars who do all the work and they are worked to death".

"Funding for community mental health services must be ring fenced. Community services are being set up to fail because they are not adequately resourced. The statistics for re-admission would drop dramatically if good community care services were available".

"We are our own worst enemies because we just get on and do the job".

"The term 'strategic planning' is nothing more than jargon".

"We have cellphones that cut out in certain parts of our region and when that happens we are really left in isolation".

"We all wanted to have our own locator but they said that was too expensive. So now we have to share locators. Already one has been lost".
"There must be a proper certified training programme for DAOs. Even if this means that we have to be uplifted from our job and placed in a residential programme that would be worthwhile. The risks in not having a certified training programme are just too great, not only from the DAO's point of view, but also from the point of view of the public. There must also be updated programmes".

"The bottom line is that we must work within budgets. Our only resource on this team is staff. We have three cars, cellphones, typing services and that sort of thing but our main output is staff. Staff are getting burnt out, tired and disgruntled and I don't know how long we can carry on. Touch wood, no one has yet been assaulted or injured but we have had some fairly close calls. There is a need for constant education and training".

"The caseloads are horrendous. I cannot attend to my clients if I am called out into the community. Sometimes my clients leave in disgust because no one else is available to attend to their needs. I feel that I am not acting in a professional manner".

"We should be paid an adequate remuneration for our additional duties. We do not perform the same functions as a PDN".

"In most cases our present vehicles are satisfactory. But when there are three large people seated in the back seat then a 1300cc vehicle just cannot do the job".

"Please provide us with the basic tools of trade".

"It was only recently, after more than a year, that I was given my personal copy of the Act. The cost was about $9.00."

"I am expected to go out at night to see people who may be mentally disordered. I asked management for some road maps. They photocopied the maps but it was so poorly done that I

couldn't even read the street names. In frustration I went to a service station and bought my own maps".

"We must have ready access to current developments and decisions on legal matters which affect our role. We should have rapid access to legal advice when difficulties in interpretation arise".
"Training, training and more training for both Police and mental health professionals".

"We need a computerised central record system in each CHE instead of our existing paper files. It is frightening to walk from one building in the dead of night, and along a darkened corridor, to uplift a paper file so that I can explain the patient's history to the DAO on the other end of the phone. It's a waste of precious time".

"Resources, resources, resources!!!"

"We should be trained in computer literacy. Ultimately that would be cost effective".

CHAPTER NINE

THE LESSONS TO BE LEARNED:RECOMMENDATIONS

Introduction of Act:

The manner in which the Act was thrust on to mental health services has generated cynicism and frustration. The Mental Health Foundation note that when the Act was introduced in November 1992 there was real concern, across mental health services and within consumer and family groups, that there had been insufficient opportunity for comprehensive training and preparation to have occurred to ensure a smooth transition from the old Act to the new.

Dr David Chaplow informed me that the 1992 Act introduced new terminology, definitions and statutory positions. Those who were charged with introducing the Act to mental health services had many questions which could not be answered and a limited time within which to prepare staff. He notes that twenty of the forty or so forms used in committal and other parts of the Act were received on the evening of 31 October 1992, i.e. the evening before the Act came into force. On that same evening Dr Chaplow wrote the "User Guides" which are still being used to assist DAOs and other staff.

Several mental health workers commented that although the Act had a lengthy gestation period its introduction was done in haste and with little regard for the concerns of those who were responsible for "making it work". The Public Service Association expresses its concerns about the introduction of the Act:

> **DAOs were not simply invited to become DAOs in November 1992. Instead they were directed by their employer that they were to become DAOs, in many instances against the will of individual PSA members. Many of our members had grave misgivings about the setting up of the Act and the DAO role they were expected to perform. These misgivings stemmed largely from the uncertainties surrounding the development of, and the preparation time provided, for the introduction of the Mental Health Act.**
>
> **PSA members working as DAOs not only were directed to pick up these roles but they were also denied any enhanced remuneration for doing these extra duties at the time. Instead these workers, in the interests of the patient and employer, agreed to work under the Act on a goodwill basis expecting that the mechanisms of the Act and any remuneration attached to that would be addressed at a later date. Sadly this**

has not occurred satisfactorily in a general sense for our members working as DAOs across New Zealand.

The Mental Health Act itself was not well prepared because it was not clear or well understood by those who were expected to directly or indirectly implement the Act, including the Ministry of Health or the employers of the DAOs themselves. An illustration of this is that the PSA found in preparing this submission that DAOs across the country have conflicting views and understandings of what the Act means.

DAOs and others have long sought clarification from the Ministry over what the clauses of the Act actually mean, without success. Many DAOs have the impression that they have to wait and see what the judicial process will decide over the meaning of the Act.

It is easy to be wise after the event but it must be recorded that many of the circumstances surrounding the death of Matthew Innes are products of an enactment which bears all the hallmarks of haste and under-funding.

The Law:

My views regarding Sections 8, 9, 10, 38 and 41 of the Act have been referred to earlier in this report.

Section 8:

The spirit and intent of the Act suggests that a medical examination for the purposes of Section 8(3) must be undertaken (generally) at the place where the proposed patient is seen by the DAO. However theory and practice do not always coincide and situations will arise, especially in rural areas, where it may not be possible for a medical practitioner to attend. In that event there is need for an emergency provision to ensure that the proposed patient (by force if necessary) is appropriately examined for the purposes of Section 8(3).

That emergency provision may be invoked when two conditions are present:

(i)The DAO believes on reasonable grounds that the proposed patient is overtly mentally disordered; and

(ii)That all reasonable attempts have been made to obtain a medical examination pursuant to Section 8(3) and that in the circumstances detention

and transport (by force if necessary) to some other nominated place is in the best interests of the proposed patient.

In cases where the proposed patient is unwilling and force has been used there will be a requirement for the DAO to file a report within five working days with the D.A.M.H.S. and the District Inspector detailing the circumstances resulting in the proposed patient's detention and transportation.

The Youth Law Project (Inc.) observe:

> Such a provision would recognise the importance of the individual's liberty and right not to be detained without due process. However the provision would also recognise that there will sometimes be situations in which the requirements of the Act cannot be met. If such reports had to be filed, then the authorities would be able to obtain an overview of the extent to which proposed patients are admitted without having seen a medical practitioner. Similar provisions exist in other legislation, e.g. requirement that officers file a report to the Commissioner of Police where searches are carried out without warrant under the Misuse of Drugs Act, and do provide some checks and balances where there is intrusion upon the liberty of the individual.

Recommendations:

1. That Section 8 of the Act be amended by including therein a proviso that a proposed patient may be detained and taken to a place nominated by a DAO (by force if necessary) for the purposes of a medical examination pursuant to Section 8(3) in the following circumstances:

   (i)The DAO believes on reasonable grounds that the proposed patient is overtly mentally disordered; and

   (ii)That all reasonable attempts have been made to obtain a medical examination pursuant to Section 8(3) and that in the circumstances detention and transportation (by force if necessary) to some other place nominated by a DAO is in the best interests of the proposed patient.

2. That in cases where the proposed patient is unwilling and force has been used there will be a requirement for the DAO to file a report within five working days with the D.A.M.S. and the District Inspector detailing the circumstances resulting in the proposed patient's detention and transportation.

Sections 38, 40 and 41:
The circumstances under which Police assistance under these Sections may be translated into "force if necessary" is problematic. There can be no doubt that compulsory assessment will occasionally proceed more smoothly if the DAO can be assured that a patient attends as required. I am conscious of the need to preserve the liberty and civil rights of the individual but there are occasions when, in his / her best interests, those rights must be curtailed.

Recommendations:

3. That Section 40(2) of the Act be amended by including after the words "all reasonable steps" the words "including force if necessary by any member of the Police".

4. That Section 41(2)(b)(i) of the Act be amended by inserting after the words "Detain the person" the words "by force if necessary".

5. That Section 41(2)(b)(ii) of the Act be amended by inserting after the words "Take the person" the words "by force if necessary".

Note: The term "by force if necessary" in the context of the above recommendations means force by any member of the Police.

The Definition of Mental Disorder:
The definition of mental disorder under the Act differs significantly from that of the 1969 Act. There are two components of the definition. The first limb defines mental illness as an abnormality of the mind. The second limb restricts the definition to conditions that are a serious danger to the person themselves or to other people. It is not enough that a person is mentally ill, they must also be dangerous. This requirement has effectively raised the threshold for entry into the system.

As a result people, such as DAOs, who are involved in dealing with those people who are potentially mentally disordered often wait until those people are very unwell before intervening. This means that although they are dealing with situations in which they are not able to administer medication or use force, they are confronting people whose condition may have deteriorated considerably more than would have been the case under the old Act.

It was urged on me that many people now being committed are very ill indeed and that tragedies have occurred when assistance has not been given to people who may not pose a serious danger but who, nonetheless are mentally disabled to such an extent that

they require care and treatment. In the case of Matthew Innes it will be recalled that at one stage he was "borderline". Later he clearly posed a "serious danger" in terms of the Act.

I acknowledge the need to balance the estimated dangerousness to self or others against the question of public safety. The evidence and the information placed before me persuades me that the present threshold is too high. The inevitable consequence is that people who are in desperate need of assessment and care will not get it.

Recommendation:

6. That the definition of "mental disorder" in the Act be amended by deleting therefrom the word "serious".

Good Faith Provision:

Several submissions invited me to recommend the re-introduction of a "good faith" clause similar to Section 124 Mental Health Act 1969.

Dr David Chaplow:

> **The 1992 Mental Health Act has introduced clinicians to a legal world, more so than previously. It has resulted in the effective diminution of about twenty percent of clinicians' time from clinician work, the expenditure of large sums of money in adversarial processes and an uncertainty as to what terms mean and whether to risk being sued or prosecuted. The reintroduction of such a provision will reassure clinicians who can act in terms of good clinical practice in areas of legal uncertainty to the inevitable benefit of the mentally disordered person.**

Inspector McLeod:

> **Under the Mental Health Act 1969 (refer Section 124) all persons acting in pursuance or intended pursuance of the provisions of the Act were protected from civil or criminal liability unless they acted in bad faith or without reasonable care.**
>
> **By contrast, the only provision touching protection from liability under the Mental Health (Compulsory Assessment**

and Treatment) Act 1992 is Section 122. It is very much more limited in its application and protection.

There is no doubt whatsoever that under the present regime, and bearing mind the limited protections, Police Officers in the field, particularly since the Matthew Innes matter, have been extremely reluctant to become involved in the dealing with and transportation of persons believed to be mentally disordered. I believe that this is presently having an adverse effect on the ability of all those charged to perform their respective duties under the Act.

Whatever the position, it is the mentally disordered person who is ultimately disadvantaged by the Police and medical professionals' natural conservatism in these circumstances.

By way of illustration it seems to me, with respect, absurd for the Police to have to conduct an independent review, on the spot often as a matter of urgency, on the lawfulness or appropriateness of the procedures adopted by the DAO and his assessment of the situation. The DAO is a health professional who is required to make certain clinical judgments based on his expertise in accordance with the provisions of the Act. Under the present regime it may be arguable that for the Police to avoid civil liability they may need to conduct their own audit of the DAOs action. This could never have been the intention of the legislature in terms of the scheme of the Act. The Police's function can only ever be to assist when requested, where the use of force may be needed. The Police must be able to safely assume that the DAO has exercised his powers under the Act properly.

For the Police in the field to be required to review the DAO's decision to call them, or revisit the exercise of his authority to transport the person would be to introduce unacceptable, further complications into an already convoluted procedure. Further unnecessary delays would be incurred in a system which is surely designed to ensure that someone who needs psychiatric help can receive it safely and quickly.

The Human Rights Commission offers a different perspective:

Section 124 of the 1969 Act provided a comprehensive protection against legal proceedings to any person acting "in

pursuance or intended pursuance" of the Mental Health Act. The Section erected both a procedural and a substantive barrier to the bringing of a legal action and acted as a discouragement to patients who wished to assert their rights. Indeed the purpose of the precursor of this provision which was substantially the same as Section 124, was stated as being, "to protect persons undertaking the difficult duties connected with mental defectives from baseless and frivolous actions" - Payne v Angland (1944) G.L.R. 131, 135 per Fair J

In other words psychiatric patients were placed in the class of frivolous or vexatious litigants. The Section was based on the outmoded and unsupported notion that such patients were paranoid and aggressive, inherently likely to abuse the judicial process by bringing unnecessary actions.

Section 124, rather than sheltering the courts and mental health professionals from troublesome litigants, effectively removed the protection of the law from a particularly vulnerable section of society, most of whom are too withdrawn and unsure to protect even their genuine legal interests.

The second reason for retaining the status quo relates to the Act itself. The 1992 Act only requires of professionals that they are reasonably satisfied that a person may be mentally disordered, i.e. the emphasis is on the reasonableness of their actions. This is in marked contrast to the 1969 Act which required that a person acting under the auspices of the Act was to be satisfied that a person was mentally disordered. The criteria that a person is acting reasonably should be sufficient protection in these circumstances.

The Commissioner of Police responds:

If a mentally disordered person is the recipient of less than optimum treatment (whether clinical or otherwise) occasioned by reason of uncertainty on the part of the person providing the services as to the lawfulness of their actions, then that is a state of affairs which must be avoided. There is no evidence to justify a submission, if it were to be made, that the inclusion of a "good faith" clause might derogate from the principles and philosophies behind the Act nor would it operate to the detriment of patients or proposed patients.

All parties assume and perform their functions under the Act with commitment and diligence. It would be facile and insulting to suggest that a more extensive, protective mechanism in the form of a "good faith" clause would mean professionals (whatever their role) would deliver less than an optimal service if protected in this fashion.

I am not persuaded that re-introducing a good faith provision (except in respect of medication) is either necessary or desirable at this stage. In my view the better solution is to clarify the law so that Police and mental health professionals know the parameters within which they can operate. The best protection for such people is to operate within the law. This report may go some way towards clarifying some areas of uncertainty. It will not go all the way since there are other matters in dispute which fall outside my terms of reference. For the present I am persuaded by, and adopt the views of the Human Rights Commission

Memoranda of Understanding:

The relationship between DAOs and Police have already been canvassed in Chapter Seven. I support the notion of a national memorandum of understanding to provide broad, national policies which can then be refined at regional level to reflect specific, local differences and needs. It is pleasing to note that at national level and in some regions liaison has already resulted in draft memoranda. If it is intended to include the ambulance service as a proposed means of transport, then obviously consultation must also include that service.

A memorandum of understanding should not be regarded as a substitute for common sense. The Police should not regard a request for assistance under the Act as an optional extra. It must be seen as a normal part of policing duties. It is equally important for mental health professionals to recognise that most DAO callouts may last for several hours, that Police officers have other responsibilities and should not be used as taxi drivers. If each group is conscious of the needs of the other then I envisage few problems. I note the spirit of co-operation which presently exists between the two services.

My comments below on the draft national memorandum and elsewhere in Chapter Seven may assist in framing memoranda at national and regional level.

Draft Memorandum of Understanding : A critique:

I comment as follows about certain clauses in the draft memorandum.

1.1 Substitute "principle" for "principal".

1.2 Substitute "will" for "should".

1.4 Not strictly correct to say that all people being dealt with under the Act are patients but general tenor of clause is sound. Refer Section 23(5) Bill of Rights Act 1990.

1.5 No need for "... and be prepared ... action".

2.1 Too much uncertainty. Suggest DAO must be in charge.

2.2 Unsatisfactory. It is not the responsibility of the Police to determine matters of clinical appropriateness. That is the responsibility of the health professional. Assistance should not be withdrawn on such grounds. Clinical appropriateness will include methods of restraint. It is the responsibility of the DAO to advise Police when to withdraw.

2.3 Unacceptable. It is the responsibility of the DAO to deal with clinical matters. The Police may indicate an appropriate course of action but the DAO must be in overall charge of matters relating to the wellbeing of the proposed patient / patient.

2.4 Unsatisfactory. If a request for assistance is made the Police must assume that it is properly made and respond accordingly. DAOs should not request Police assistance without good cause. The judgment call as to actual or potential violence is one for the DAO and not the Police.

3.1 Unacceptable. Ideally there should be a range of vehicles. An ambulance should be regarded as one of the least desirable vehicles for transportation. The size and c.c. rating of the vehicle is more important than the ownership of that vehicle.

3.2 Include "potentially violent" after "violent patients".

3.3 Disagree. Ambulances in most cases are highly inappropriate. Most CHE vehicles have a low c.c. rating and are generally inappropriate. If CHEs supply DAOs with larger and higher powered vehicles they would be appropriate for transportation. Suggest a clause which includes a range of vehicles - both Police and CHE.

3.4 Substitute "includes" for "means". Insert a provision that DAO or health professional must monitor wellbeing of proposed patient / patient.

4.1 Insert "and caregiver" after "patient" in line 1.

4.3 Include provision that method of restraint to be undertaken on direction of DAO.

4.4 Doubt validity of last sentence - suggest deletion.

5.2 Query "or in instances of excessive demands on Police time". The Police have an obligation to respond to a DAO request but consistent with their right to prioritise such requests in order to meet other policing requirements. There may well be demands on Police time but all such demands may be justifiable. Use of term "unreasonable and unjustifiable" may clarify the position. Suggest a rethink.

Recommendation:

7. That national and regional memoranda of understanding be executed by the New Zealand Police and Ministry of Health / CHEs so that the parameters of Police operational assistance for DAOs may be established. Those memoranda will include:

   (i)when the Police should be called;

   (ii)who is to be in charge when the Police arrive; and

   (iii)the respective roles of the Police officers and the mental health professionals.

Positional Asphyxia:

According to published articles on positional asphyxia and the evidence before the Inquiry, it is clear that:

- patients or proposed patients should not be transported in a prone position;

- every effort should be made to transport people without provoking a violent confrontation or a violent response;

- if it is necessary to mechanically restrain a person who is behaving violently then they should be kept in an upright position, if at all possible;

- however a person is transported he / she must at all times be monitored by at least one person and be under the charge of a health professional who is responsible for checking the continued existence of the vital signs of life as often as possible.

It is pleasing to note that subsequent to Matthew's death, health and Police authorities have taken steps to alert staff about the dangers of transporting a person in a position known to cause death. For the sake of completeness I make the following recommendation.

Recommendation:

8. That mental health services and the New Zealand Police instruct all staff about positional asphyxia and direct them as to the appropriate method of transporting and monitoring patients or proposed patients.

The General Practitioner:

The availability of medical practitioners was commented on by many DAOs and was referred to by Dr Sai Wong in his evidence. Few DAOs had confidence in those GPs who were asked to undertake a Section 8(3) examination. Many GPs were criticised for their lack of knowledge about mental health services:

> **"He asked me what I thought. He then wrote it down, later collected a fee and went on his way. It all boils down to my making the decision and he collecting the fee".**

The unavailability of many GPs, for a variety of reasons, was also adversely commented on, inevitably resulting in long delays, frustration and potential harm to the proposed patient. I reject the suggestion that the Section 8(3) examination should be the sole responsibility of the DAO. As mentioned earlier an examination by a registered medical practitioner, readily available and properly trained, is an appropriate check and balance on the actions of a DAO. If specified GPs (or emergency clinics) were retained on a similar basis to Police surgeons I believe that would go some way towards ensuring rapid access to medical practitioners for Section 8(3) examinations. If a GP is contractually bound, presumably on the basis of a retainer being paid, then I foresee a quick response to a DAO request. Such an arrangement would have a twofold spin-off:

(i)A GP would be readily available

(ii)This type of relationship would enable the mental health services to be involved in the ongoing training of GPs thereby ensuring the integrity of the Section 8(3) examination.

It necessarily follows that a list of those GPs / clinics who enter into such arrangements will be made available to all regional DAOs.

Recommendation:

9. That each CHE contract with designated medical practitioners / clinics for the provision of services pursuant to the Act. The medical practitioners / clinics

contracted must be of sufficient numbers and geographical location as to ensure reasonable availability to mental health professionals at all times.

Sedation:

Professor Werry painted a scenario as to the ideal care which he believes should have been accorded to Matthew Innes. That scenario includes medical assessments by a registrar and psychiatrist followed, if necessary, by sedation. As the law presently stands a proposed patient cannot be medicated until the Section 10 procedures have been complied with.

Dr Daniels says that in his experience some mentally disordered persons who are extremely violent, unpredictable and irrational often attempt self-mutilation or alternatively, have little regard for pain. He continues:

> **It is in such circumstances such as the above that sedation is, in my view, appropriate.**
>
> **However, under the present legislation I cannot see that there is power to administer it. I believe that there are a number of safeguards which would provide sufficient protection to all concerned if sedation was permitted at the initial scene in limited circumstances.**
>
> **While I accept sedation can have the effect of masking or clouding subsequent clinical assessment, it seems to me that a balance needs to be struck between protecting the violent, mentally disordered person from injuring himself or others and the need to be able to make a subsequent clinical assessment. However, I believe that in situations of extreme dyscontrol where the violent, mentally disordered person is causing himself or others physical harm in his unsedated state, there should be power for a medical practitioner to administer a sedative.**
>
> **I accept the concerns of Dr Chaplow concerning the relative inexperience of most practitioners in regard to psychiatric emergencies. However, our legislature has recognised in other contexts the desirability of approving suitably qualified practitioners as "designated medical practitioners". This is well recognised in various legislation concerning the administration of controlled drugs to addicts. In those**

circumstances designated medical practitioners are permitted to prescribe controlled drugs to addicts in a clinical context for the control and treatment of their addiction. These practitioners have to satisfy certain conditions in terms of training and expertise and are required to undertake relevant, specified courses of continuing education at regular intervals. I can see no reason why an analogous scheme could not be extended in the present circumstances.

There is a wide range of sedatives available. Again the type appropriate for sedating persons in the circumstances I have described above could be limited to certain "approved" medications.

There is no real or effective limitation on the criminal liability of doctors performing their functions under the Act (cf. Section 124 Mental Health Act 1969).

I am conscious that many of my professional colleagues who have been confronted by violent, mentally disordered persons when assisting the Police, are extremely conscious of the practical, legal and ethical difficulties of using sedatives to subdue violent people who are injuring themselves despite restraint.

Even before the passing of the present Act this was a serious concern. It was succinctly expressed by a colleague who wrote to me in confidence in these terms:

"Four to five years ago I was involved in the case of a psychotic patient who I sedated prior to transfer from X to Y hospital. He subsequently laid a charge of assault against me for giving him an injection he had not agreed to. This led to about two years, on and off, for an inquiry by the Police Disciplinary Committee as well as the Medical Council ... the exercise was expensive, exhausting, disconcerting and stressful ... I would have been shattered had the Council not found in my favour".

Prior to the passing of the present Act I had occasion to use sedatives where the Police were confronted by psychotic and extremely violent people. This was necessary, in my view, because even restrained by handcuffs, the person was likely to continue to be a threat to himself and others.

I have noted this phenomenon with people who have taken hallucinogenic drugs. As with mentally disordered people, they frequently appear to be totally oblivious to pain and injury. They continue to struggle with what I can only describe as "super-human strength", often inflicting further significant injuries on themselves and those attempting to restrain them. A strong Police Officer on every limb is usually not enough to effectively restrain such a person. Even with handcuffs applied to wrists and ankles they frequently attempt to damage themselves and others by thrashing around. Head injuries are not uncommon. Attempts to restrain the head carry with them the obvious danger of airway obstruction.

In my experience the only effective means of avoiding this difficulty is the use of sedation. However, under the present legislative regime, this is impermissible.

In my view there needs to be a specific legislative change expressly permitting sedation subject to the imposition of strict conditions, as well as an extensive protection for medical practitioners who act reasonably and in good faith.

Obviously under the present legislation sedation can only be given following arrival at the hospital and subsequent to assessment.

While the transport of unsedated, violent, mentally disordered people is clearly a problem in urban areas, it is, to my knowledge, a much more serious concern in rural or remote areas. The availability of Police Officers to attend is a difficulty and is necessarily compounded by the even less certain prospect of the availability of a DAO. Inevitably, a psychiatric hospital will be many hours away.

The concerns which I express are those which have been relayed to me by other Police surgeons in rural areas. Physically restraining a highly upset, emotionally labile and violent, mentally disordered person in handcuffs, or other physical restraint, is likely to carry additional risks to the detainee and his detainers particularly if that restraint extends over several hours in a vehicle.

From my own experience I am aware of difficulties in a rural area in the southern half of the North Island. In this region,

should a mentally disordered person needing physical restraint require specialist assessment, a DAO from the local, medium-sized service town can be called. Upon completion of the necessary documentation, the mentally disordered person would be transported to the nearest hospital which is situated in a city two and a half hours' drive away. If the local DAO is not available in the local service town then a DAO is required to be brought in from the city two and a half hours away. This means that there is a delay of at least five hours from the time of the first Police contact with the person until he / she can be delivered to the hospital.

In the case of a violently struggling detainee, delays of this kind are simply unacceptable for all concerned. Again, sedation, subject to safeguards, is appropriate.

That broad approach does not find favour with Professor Werry:

I do not agree with Dr Daniels that violent patients should be sedated under certain circumstances before a Section 10 assessment and issuance of a Section 11 Notice have been completed. Most doctors in New Zealand are poorly experienced in both the diagnosis of mental illness and the use of psychoactive medication under these circumstances, which they will encounter most infrequently. It is the responsibility of Government to see that each CHE is able to provide proper psychiatric care to all patients, not to adopt procedures which violate their rights under Section 66 and Section 10.

Dr Chaplow notes:

Generally and clinically speaking, sedation at the scene should not be used except in the most extreme situations of dyscontrol. This is because it "clouds" good assessment obscuring the differences between "upset" and illness.

Its appropriate use is when assessment of all of the facts, including examination / assessment of the person, can lead to a preliminary diagnosis being made and when its use is seen in terms of sensible clinical management strategy, i.e. in terms of being beneficial to the patient.

Sections 57 and 58 of the Act make it clear that medication cannot be given in the absence of informed consent. For a

practitioner to intervene, as in this case, would necessitate the introduction of an "emergency" or "good faith" clause or a more fundamental law change expressly permitting sedation subject to strict conditions.

Dr Timney explains some of the factors which must be addressed before medication can be administered:

If we accept that Matthew was unlikely to have given consent to receive treatment, then the only way he could receive medication lawfully would be after completion of the first stage of assessment namely, under Section 11 of the Act.

Since oral medication is almost always refused in such difficult circumstances, then parenteral administration of medication would be needed. This involves either intra-muscular or intra-venous injection of the drug or drugs prescribed. It follows that before this can happen, restraint and immobilisation of the patient must occur.

Before a clinician reaches a situation in which this can be contemplated, a number of factors must be addressed, namely:

a provisional diagnosis, particularly the exclusion of a number of the organic causes of psychosis, some of the more important causes of which include various drug intoxication or withdrawal states, the various medical causes of delirium and head injury

- **a knowledge of the person's past medical history, particularly cardiac and respiratory problems, and any known allergies (or other adverse drug reactions) and current medication**

- **The person's current physical health**

The main complications and risks are:

- **Respiratory arrest**

- **Cardiac complications, usually profound hypotension (low blood pressure) or cardiac arrhythmia. Both of these conditions may lead to cardiac arrest**

- **Excessive sedation as a result of a combination with either prescribed medication, or medication taken as (an unrevealed) overdose**

- **Allergic reactions**

The general consensus by all the medical experts, best described as a cautious acknowledgement, is that there is a place for sedation at the scene in some cases. I am aware that especially in rural areas the risks in not sedating persons described by Dr Daniels may lead to consequences more harmful than the slight risks associated with appropriately administered medication. In dealing with a topic like this there are psychological and pharmacological elements to be considered. This is outside my area of expertise. I acknowledge that in unusual or emergency circumstances it may be necessary to medicate before the Section 10 / 11 procedures have been complied with and in such circumstances I favour the introduction of a good faith clause.

Recommendations:

10. That where a medical practitioner believes on reasonable grounds that a proposed patient may be mentally disordered and that acute treatment or medication is required, that proposed patient may be managed, and if necessary sedated, in accordance with a designated protocol.

11. That a protocol be drawn up to implement recommendation 10 above. That protocol will include a description of:

    (i)the circumstances under which medication may be administered;

    (ii)those persons who are entitled to administer medication; and

    (iii)the procedures to be followed before, during and subsequent to the administration of medication including, if necessary, the requirement to consult with on-call acute medical staff.

12. That the Act be amended by inserting therein a good faith clause to cover the circumstances contemplated by the protocol referred to in recommendation 11 above.

Recommendation:

14. That each DAO be provided with ready access to a cellphone / radio telephone, personal pager, an appropriate motor vehicle and suitable office and secretarial facilities in accordance with the criteria earlier described and that after hours or on-call DAOs be permitted to take the cellphone / radio telephone, pager and staff vehicle to his / her home.

Training:

Section 93 of the Act permits a board (now CHE) to appoint a DAO once it is "... satisfied that the person has undergone appropriate training and has appropriate competence in dealing with persons who are mentally disordered ...". To date the DAO role has been filled without any clear definition of the role, expected tasks, procedural guidelines, minimum standards of competence or requisite training of DAOs. This is a significant omission by the CHEs since it is they who are responsible for the appointment of people who have "appropriate training and appropriate competence". The present position, if uncorrected, will lead to the adoption of unsafe practices and a lowering of professional skills. Already I have noted a lack of consistency in appointment. Different CHEs have appointed a variety of health professionals to fill the role. It is a nonsense to appoint a community nurse who may possess the appropriate nursing skills but who may be inadequately trained in the legal and technical aspects of the Act. It is inequitable that DAOs should be put in the position of having to make professional decisions in matters which may be outside their training and experience. There must be uniform appointments and standards on a national basis accompanied by accreditation and appropriate auditing and monitoring to ensure the maintenance of standards. A nationally co-ordinated approach is called for.

I have perused the following:

(i)DAO Training Handbook (Mental Health Service - Capital Coast Health)

(ii)DAO Workbook (Mental Health Service - Capital Coast Health Ltd.)

(iii)DAO Handbook (Mental Health Division - Healthlink South)

All three publications may serve as a useful starting point in the development of standards and practice. I am confident that if DAOs and other health professionals are widely consulted their enthusiasm to make progress will see the development of an effective competency and training package.

Recommendation:

15. That a national protocol be formulated, regulating the minimum competency standards and qualifications for appointment as a DAO, the training (including training on an ongoing basis) to be undertaken by DAOs and a provision for national auditing and monitoring to ensure the maintenance of standards. That protocol would include:

    (i)knowledge of assessment procedures;

    (ii)knowledge of the Act and associated legislation; and

    (iii)sufficient information and training to ensure that DAOs adopt practices which are clinically and legally safe in carrying out their functions.

Caseloads:

For years PDNs have complained about excessive caseloads. The advent of the DAO and the requirement to carry a caseload now demands a resolution of the problem. The creation of an enlarged DAO workforce may provide a solution to a limited extent, but essentially there is a need to determine the number of clients who can properly be managed by a PDN. A caseload figure of about twenty five patients per PDN was suggested to me, but I am unable to comment on the validity of that figure since it would vary according to the clinical needs of each client. In some regions DAOs carry no caseload whilst elsewhere, particularly in non-metropolitan regions, they share caseloads with their colleagues. Both options are correct. The best estimate suggests that the average DAO callout may last between four and six hours. It seems to me that there must be some correlation between the time spent responding to DAO callouts and the time available to manage a caseload. The experience and statistics gained since 1 November 1992 should now be sufficient to designate the appropriate caseload to be managed by each mental health professional. That caseload must be at a level which will ensure that "every patient is entitled to medical treatment and other health care appropriate to his or her condition" (Section 66 Mental Health Act 1992).

Recommendations:

16. That DAO caseloads (if any) be restricted to a level which will enable them to carry out their functions under the Act.

17. That where necessary staff levels be increased to ensure that patient needs are appropriately met pursuant to Section 66 of the Act.

DAOs to Work in Pairs:

The safety of DAOs, particularly when dealing with after hours callouts, was emphasised repeatedly during my meetings with mental health professionals. The dangers in operating in isolation are obvious. In addition to the safety component there is at least one other good reason why DAOs should operate in pairs. That reason is well illustrated by the circumstances which confronted Alan Gundesen when he answered the call from Craig Innes. Discussions with DAOs confirm that the events at Howick on 3 / 4 January 1994 were by no means unusual although tragically, the consequences were unique. In many cases DAOs are required to assess the condition of the proposed patient, liaise with and brief Police, maintain contact with headquarters, draft a Section 8 application, tend to the needs of a family which may be distressed, request the services of a GP and deal with all the ancillary paperwork. Those functions, in my judgment, require the combined efforts of a two person team, particularly if the callout occurs after hours. I am persuaded that in many cases the need to attend to disturbed family members is a full time job for one person.

In addition, the advantage of a two person team is that dual professional opinion can be used to determine that which is best for the proposed patient.

I note that in some regions DAOs, justifiably, will not attend a callout in isolation and in many regions they will not, under any circumstances, attend an after hours callout unless accompanied by another health professional. I agree with that approach.

As a general rule all DAOs, when responding to a callout, must be accompanied by another DAO or a suitably qualified health professional. In some regions in which crisis intervention teams operate that other health professional is a registrar.

I acknowledge that on occasions it may be unnecessary for two persons to attend a callout, e.g. occasions will arise when a callout is received during daylight hours from a person who is well known to the mental health service and in respect of whom no potential danger arises. In such cases it would be proper for a sole DAO to respond. I emphasise however, that the general rule of a dual response must apply. If that general rule is to be breached that must be at the sole discretion of the DAO, i.e. the DAO must not respond to a callout in isolation unless by choice. It follows from these comments that staffing levels must be pitched so as to ensure that two DAOs (or one DAO and another health professional) are available to respond to callouts.

I see a further significant spin-off if this recommendation is implemented. DAO caseloads, in some regions, have reached an unmanageable level. With the best will in the world patient needs are being unattended because many DAOs are unable to combine the dual function of a DAO and the manager of a heavy caseload. The creation of an enlarged DAO workforce should reduce the workload of the individual.

Recommendations:

18. That in carrying out their functions under the Act a DAO must be accompanied by another DAO or health professional. This general rule may be dispensed with at the sole discretion of the DAO who is required to respond to a callout.

19. That staffing requirements be set at a level which will ensure recommendation 18 above can be complied with.

Remuneration:

One DAO acknowledged that his duties were identical to those formerly undertaken by a PDN. His was a lone voice amongst many. Without exception DAOs felt they were not appropriately compensated for the additional tasks and responsibilities they have undertaken since 1 November 1992. I am unable to say whether that is correct and in any event remuneration is a topic not captured by my terms of reference.

I am able to record however, that the present role and functions of DAOs differs significantly from the duties and responsibilities of Community and District nurses under the 1969 Act.

Acute and Crisis Beds:

Many wasted hours are spent by DAOs negotiating with hospital authorities for an acute or crisis bed. One DAO commented:

> **"They know that all the beds are full but no one does anything about it until we actually have a patient waiting on the doorstep to be admitted. Only then does the patient-shuffling and phone calls take place and all of this can take hours. No one seems to be capable of looking ahead and doing something about the crisis before it occurs".**

The obvious solution of course is to ensure that patients have access to good community care and accommodation and thereby minimise the need for acute or crisis hospital care. However, if only as an interim measure, there is a need in many areas for additional acute and crisis beds.

Recommendation:

20. Each CHE be directed, in consultation with the Director of Area Mental Health Services, to produce a protocol which will ensure the ready availability of crisis / acute beds as and when required.

Funding:

If the above recommendations are implemented that will necessarily involve additional funding for mental health services, either a Government, RHA or CHE level. Mental health services are already poorly resourced. It would be unfortunate if the implementation of my recommendations resulted in the diversion of one part of the mental health budget to fund the expectations resulting from this Inquiry. Substantial additional funding is called for. That should include additional funding for cover where staff are involved in consultation, training and the other activities contemplated by these recommendations.

Recommendation:

21. That Government / RHAs / CHEs provide additional funding to implement the recommendations in this report. That additional funding must be additional to existing budgets for mental health services.

Calming and Restraint:

Restraining a violent person is not an easy task and requires skill by the restrainer to ensure that the person being restrained is not put at risk of physical harm. There will be times when the violent person will suffer from physical harm as a result of any initial struggle, but use of appropriate restraint techniques will minimise any exacerbation of such injuries. Generally, calming restraint procedures require a minimum of three people trained in restraint techniques to effectively restrain a person for a short period of time, and to transport that person on from one place to another. There is a need for a nationally accepted method of restraint that can be taught to all personnel involved in the restraint of violent people - not only the mentally ill violent person.

The Innes family comment:

> It is acknowledged that the Police have expertise in restraining people who behave in a violent way. Unfortunately their training

> is focused upon restraint of violent people who have, or may have, been involved in a crime or an offence of some sort. Such people are assumed to be sane if not totally rational at the time. Thus, if the Police are to continue to be involved in the transportation of people who are or may be mentally disordered, then they need additional guidance and training in how to restrain such people in as safe a way as possible. There must be additional care for their head, for their body position and for their physical well-being. There must be a greater understanding of the dangers posed to such people through restraint and transportation.

Several DAOs told me that on an informal basis the three person calming and restraint techniques have been demonstrated to Police officers and has met with their approval. Some Police commented that the technique would be a very useful tool, either in addition to or in substitution for, the techniques presently in use. It is a technique which could be applied to restrain any person whether or not that person be mentally disturbed.

I am informed that regular refresher courses for calming and restraint must be held if the practice of the technique is to be retained. If this were the case the resource implications may generate costs out of all proportion to the anticipated rate of use. However the positive features of both Police and mental health services being skilled in a calming and restraint technique with which they are both familiar cannot be over estimated.

Recommendation:

22. That a joint Police / mental health services working party investigate the desirability of Police and mental health staff being trained in calming and restraint techniques which will be acceptable to, and practised by, both services.

Police Mental Health Module (SNG 152):

Module SNG 152 is a Police training module on mentally disordered persons. It is a self learning module comprising sixty nine pages, including eight self progress tests, which explains the provisions of the Act. It is compulsory for all members with under two years service to complete the module. As at 3 / 4 January 1994 Constables Schmidt and Vincent had both completed the module but Senior Sergeant MacGibbon had not then done so. He had however read it several times.

It is pleasing to record that even before the introduction of the Act there was close liaison between Police and mental health officials in the Auckland and South Auckland

regions. That liaison continues. Now that the Act has been in force for two years it is probable that module SNG 152 may need re-evaluation. But in addition the existing mental health component in the Police training scheme may also require modification. The Mental Health Foundation have suggested that:

> Police training be further extended so that all Police, before they take up an active position, are fully aware of those approaches that will be useful in respect of defusing potentially dangerous situations that involve people with a mental illness, in the restraint and control of people who are agitated or disturbed as a result of mental illness, and in the likely physiological responses which could occur in a person who is in a highly agitated state.

The need for additional or modified training is apparent.

Recommendation:

23. That the joint working party referred to in recommendation 22 re-evaluate, and if necessary modify, the training given to Police officers in mental health matters including the manner in which that training is delivered. That working party will be expected to consult with officials from the Ministry of Health and the Mental Health Foundation.

Implementation of These Recommendations:

In dealing with these recommendations regard must be had for those mental health professionals and Police who live and work in remote areas. Such people operate in comparative isolation and often in circumstances where there is no physical medical presence. The implementation of these recommendations must encompass the concerns of such people.

Recommendations:

24. That mental health professionals and Police (when necessary) from rural communities be involved in the consultation which arises in implementing these recommendations/

25. That the Ministry of Health establish consultative groups to formulate the protocols referred to in Recommendations 11, 13 and 15. These consultative groups will report back to the Minister of Health with recommendations by 31 May 1995.

26. That the contracts / protocols referred to in Recommendations 9 and 20 be operational by 31 May 1995.

27. That the joint working party referred to in Recommendations 22 and 23 report back to the Chief Executive Ministry of Health and the Commissioner of Police with its recommendations by 31 May 1995.

28. That Memoranda of Understanding referred to in Recommendation 7 be executed at national and regional level by 31 May 1995.

CHAPTER TEN

SOME FINAL THOUGHTS

I have been an interested, independent observer of developments in mental health for almost twenty five years. There is no denying that considerable progress has been made during that period. The realisation that large mental hospitals were not suited to the delivery of effective services has resulted in a move to care in the community. It is the DAO who is now the community facilitator since it is the DAO who is required to "... be a ready point of contact for anyone in the community and ... provide all such assistance, advice and reassurance as may be appropriate in the circumstances".

Until the DAO role is acknowledged as a new role requiring new skills, protocols, procedures, practices and training and the resources to support that role problems will continue in the recruitment and maintenance of adequately prepared and experienced staff. That view was recorded at a conference of mental health nurses in October 1993. I agree.

If the system fails to encourage, support and resource frontline staff then the term "community care" will have little meaning.

A reading of this report, and particularly Chapter Eight, would suggest that mental health professionals, including DAOs, are little more than self serving complainants. That is far removed from the truth. The psychiatrists, registrars, nurses and allied mental health workers whom I met during the course of this Inquiry impressed me as dedicated people, concerned to see the professional delivery of high quality health care for the mentally ill.

All were concerned that the lack of resources made that impossible. The Mental Health Foundation comment:

> **For years mental health services have struggled with inadequate levels of financial and staffing resources to deliver high quality and professionals services to people with an illness. There are some services that have achieved this and that now offer to mental health consumers a range of services that allow more choice and which ensure high quality medical and personal care. Other services have been slow to take up the challenge of providing high quality, consumer centred, community based choices and options for clients. Some of the barriers to such care do relate to resources and to levels of training for staff. Others relate to deeper, more entrenched attitudes about mental illness and those who suffer from it. While it is not expected that such attitudes will be found with**

those who choose to work in the mental health field, the reality is, they do.

More adequate training of mental health staff and increased emphasis on service quality and its improvement are required if a real and permanent difference is ever to be made to the way in which mental health services are delivered to all. New Zealand prides itself on being a humane and just society. One measure of this is how well we care for those with a mental illness. While there has been great improvement over recent years, particularly in the forensic services area, we still have a long way to go to ensure that those in the community with mental illnesses have access to early support that is delivered in a way which is acceptable to them, safe for all and responsive to their needs

Professor Werry with his customary candour:

I have been in psychiatry thirty five years and in Auckland for the last twenty five of these. I have striven to the best of my ability to see that the standard of care given to psychiatric patients is as good as New Zealand is entitled to expect. In this process I and my psychiatric colleagues have been repeatedly frustrated not by lack of knowledge about what is best care, but the lack of resources by which to implement this knowledge. While everyone is in favour of improving mental health services in New Zealand, psychiatry continues to be the poor relation of medicine.

I have attended many Inquiries like this one and I have grown cynical - indeed some might say bitter and twisted - in the process, since much of my role has had to be undeserved damage control, not advancement of services. Those who allocate resources and / or control the destiny of the mental health services in New Zealand seldom, if ever, appear at Inquiries like these. It is enough of a tragedy that Matthew Innes died but it would be made even worse if the real lesson were to be lost. New Zealand will get the kind of psychiatric service it deserves and which those working in it are able and want to deliver, only if the public is prepared to fight for it and to support those of us who are trying to bring it about. Constant pillorying of the service and its professionals of the type that has gone on in the last few years, not only deflects attention away from the real culprits but demoralises staff and

makes psychiatry even more unattractive to our most able young graduates in medicine, nursing and allied professions without whom the full potential of New Zealand psychiatry in the twenty first century can never be realised.

I do not believe that New Zealand is seized of a mental health service which is managed and staffed by incompetent people, nor indeed that it is one which is barely adequate. Our skills and determination place us in a slightly higher category. Those who work within the service operate on the principle of making do with what is available. It is the No. 8 fencing wire mentality, much loved by New Zealanders but one which has no place in a modern, efficient and compassionate discipline. That attitude should long ago have been discarded.

It would be fair to say that under-funding and resource issues permeated this entire Inquiry and my discussions which followed the formal hearing in Auckland.

I am well aware that the Minister of Health does not possess a bottomless barrel of money and that, however unpalatable, scarce resources "must be made to go round".

I acknowledge the need to bring a balance into the equation when several services are competing for resources and each is trying to justify its position. The mentally disabled often find it difficult to speak for themselves and, to that extent, they must rely on their caregivers and those who deliver services.

In my view the equation balance has not been weighted in favour of mental health services for many years, notwithstanding recent comments about additional purchases of such services by the RHAs. The services will still function at No. 8 fencing wire level. It is axiomatic that unless there is a commitment to provide additional funding the recommendations in this report will remain purely hypothetical.

What is needed is a robust, visionary approach to decide what type of mental health service, and particularly a community care service, New Zealand really needs and whether, as a nation, we are prepared to pay for it. We have personnel and commitment within the mental health service to transform it into the best in the world. That should be the New Zealand objective.

The mentally disabled deserve the best care. It should be our privilege to provide it.

THE LAST WORD

"All persons deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the person"
Section 23(5) Bill of Rights Act 1990

"Julie and I made a couple more calls in attempts to gently talk to Matthew and tell him we loved him and reassure him ...".
Paul Innes, Matthew's father, on the evening of 3 January 1994
(Evidence given at Inquiry)

APPENDIX 1

LIST OF WITNESSES WHO GAVE EVIDENCE AT THE INQUIRY

Bethune: Paul
Chaplow: Dr David
Clarke: Andrew
Crene: Sally
Crozier: Joanne
Daniels: Dr William
Day: Dr Alfred
Galler: Dr David
Gibson: Ian
Gundesen: Alan
Harrington: Gregory
Hartley: Superintendent Brian
Hill: Leigh Anne
Hull: Peter
Innes: Craig
Innes: Natalie
Innes: Paul
Israel: Dr Marie
Kirkwood: Dennis
Koelmeyer: Dr Timothy
Lenihan: Brigit
Lindsay: Evan
MacGibbon: Senior Sergeant Brett
McGregor: Alistair
McLeod: Inspector Anthony
McQuinn: Stephen
Moka: Zane
Murray: David
Patton: Dr Murray
Popata: Shayne
Schmidt: Constable Michael
Thompson: Martin
Timney: Dr Brian
Trubuhovich: Dr Ronald
Vallings: Matthew
Vallings: Vanessa
Van Beerendonk: John
Venning: Maria
Vincent: Constable Christopher
Vuletic: Dr Jane
Warlow: Dr Christine
Webb: Constable Stephen
Werry: Prof. John
West: Steve
Wilson: Dr Douglas
Wilson: Dr Fiona
Wong: Dr Sai

APPENDIX 2
LIST OF INDIVIDUALS AND ORGANISATIONS WHO MADE SUBMISSIONS

Aotearoa Psychiatric Rights Group
Baptist Mental Health
Commissioner of Police
Driscoll: P. J. (Counsel Assisting)
Hetherington-Wilson: Elizabeth R.
Human Rights Commission
Innes Family
Israel: Dr Marie
MacGibbon: Senior Sergeant Brett
Mental Health Foundation
NZ Branch Australian & New Zealand College of Mental Health Nurses Inc.
Patient Advocate Services Auckland Ltd.
Psychiatric Survivors Inc.
Public Service Association
Schmidt: Constable Michael
South Auckland Division of Pyschiatry
South Auckland Health
Te Roopu Pookai Taaniwhaniwha Inc.
Vincent: Constable Christopher
Wong: Dr Sai
Youth Law Project (Inc.)

LIST OF PERSONS WHO WERE CONSULTED

Adams: Sandy
Anderson: Dr David
Anderson: Margot
Annan: John
Arthur: James
Barr: Paulette
Barry: Vince
Baxter: Dr Joanne
Bell: Sandra
Beveridge: John
Bigwood: Stuart
Booth: Ngaire
Boylin: Alwyn
Brizzell: Dan
Calvert: Trish
Carroll: Sandy
Cheesman: Tim
Clarke: Carol
Cockburn: Stuart
Conway: Dael
Cooper: Danny
Cousins: Robyn
Cowley: Jacqui
Katz: Henri
Kelly: Marion
Lancaster: Peter
Lenihan: Brigit
Lewis: Amanda
Lindsay: Frank
Littlejohn: Tony
MacDonald: Harold
MacDonald: Lesley
Mailei: Marlene
Mangai: Rodger
Martini: Vivienne
Mathieson: Paul
McEvoy: K.
McLean: David
McNaughton: Louna
Metcalf: Bryce
Mulholland: Marlene
Muschamp: Kevin
Muschamp: Prue
Mutu: Pat
Napier: Kymberli
Narbey: Nick

Cromie: Brenda
Cullen: Paul
Deever: Lucy
Domigan: Craig
Drysdale: Dr Douglas
Duff: Dr Suzanne
Edmond: Jackie
Edwards: Erika Pirini
Emery: Michael
Etuale: Sue
Farquharson: Janey
Faulkner: Rebecca
Fleury: Jenny
Foley: Dona
Freeman: Mary
Gell: Debbie
Gibb: Frances
Giles: Dave
Grant: Averil
Green: Robert
Greer: Barbara
Gubb: Val
Hall: Sheila
Halligan: John
Hamer: Paul
Harmont: Jan
Harris: Karen
Healy: Christine
Helmer: Brenda
Hemi: Margaret
Hennephof: Rebecca
Hennessy: Julia
Hennessy: Wayne
Hibbard: Yvonne
Holloway: John
Hook: Anne
Huggard: Isobel
Hughes: Frances
Hussey: Wayne
Iversen: Catherine
Jane: Christine
Jardine: Georgina
Jones: Andrew
Jones: Jane
Neave: John
Noema: Aroha
O'Donnell: Eamonn
Parry: David
Perry: Sue
Pinkney: Alison
Plunkett: Felicity
Power: Gordon
Quinlan: Rhonda
Reid: Dianne
Rickerby: Wayne
Riley: Liz
Roberts: Derek
Rose: Debbie
Ross: Wendy
Ryan: Dr Erihana
Sanders: Ron
Sewell: Kate
Sharpes: Heather
Shearer: Robyn
Sorton: Roger
Stewart: Clare
Stewart: Paul
Strachan: Dr John
Sullivan: Terry
Taueki: Ngahina
Taumoepeau: Dr Bridget
Te Rito: Valerie
Thomas: Brian K.
Thompson: Graeme
Thomson: Sybil
Tod: Cathy
Travers: Louise
Tristram: Rosemary
Urlich: Terry
Wade: John
Walker: Noel
Wallace: Pam
Watson: Ray
Webby: Marie
Webster: Rebecca
White: Kathie
Woollacott: Anne
Zonnerylle: John

APPENDIX 3

Statement on Positional Asphyxia

Asphyxia is a broad term encompassing a variety of conditions that result in interference with the uptake or utilisation of oxygen. Because it is the most sensitive to oxygen deprivation, the brain is the organ most intimately affected in all types of asphyxial death.

In all forms of asphyxia, cardiac function usually continues for several minutes following respiratory arrest.

An anatomical classification of the various types of asphyxial deaths is as follows:

- **Obstruction of the External respiratory orifices**
  (Smothering)

- **Obstruction of the Internal respiratory passages at pharyngeal, laryngeal or bronchial level**
  -Hanging
  -Strangulation
  -Aspiration of foreign material
  -"Postural" or "Positional" asphyxia (obstruction due to the abnormal position of the airway)

- **Compression of the chest**

- **Exclusion of oxygen by**
  -Carbon monoxide poisoning
  -Cyanide poisoning

Pathological Findings in Asphyxia

A number of pathological findings may be seen in deaths due to asphyxia. These include petechial haemorrhages, cyanosis and congestion of the organs. These signs are non specific and may be seen in a wide range of conditions not associated with asphyxia. In addition, these findings may be absent in cases of asphyxia.

None of the findings commonly associated with asphyxia are diagnostic of the condition. In asphyxial deaths in general, and custody deaths in particular, the pathology is often less important than are the investigative circumstances.

Definition of Positional Asphyxia

Positional asphyxiation results when a person's bodily position results in partial or complete airway obstruction. The definition requires that the decedent must be found in a position that does not allow adequate breathing. While this may simply involve covering the mouth and nose, it may also involve blockage of the internal respiratory passages by neck compression and or restriction of the chest or abdomen.

When used in this way, the term Positional Asphyxia reflects a variety of anatomical types of asphyxia which all may be involved in causing death in any one case.

In all cases of positional asphyxia one or more contributory factors provide an explanation for the inability of the victim to correct the position, e.g. alcohol / drug intoxication, entrapment, restraint or physical disability.

Pathological findings in positional asphyxia may be present, minimal or absent. Deaths in Police custody often demonstrate less pathological evidence than is the case with most violent asphyxial fatalities (2).

Discussion and Literature Review

A small number of reports have appeared in the literature since 1992 describing deaths due to positional asphyxia including deaths that occur due to this mechanism in police custody. There is also a recent report (3) of eleven cases of sudden death in men restrained while in an excited, delirious state. In the cases mentioned, Police were called because of wild, threatening or bizarre behaviour and in all cases it took several people to control and restrain the subjects. In all cases they continued to struggle while restrained initially and minutes late were noticed to be unconscious or dead. All subjects exhibited behaviour that could be characterised as acute excited delirium and three cases involved breaking glass. All subjects were restrained in the prone position. Drugs precipitated the excited delirium in most cases; in three, an underlying chronic psychosis was present.

Summary

The diagnosis of Positional Asphyxia should be considered when:

- circumstances surrounding death indicate a body position that could interfere with respiration;
- historical information indicates "difficulty in breathing" or other unusal respiratory signs such as cyanosis, gurgling, gasping or any other physical manifestation that could be interpreted as evidence of respiratory distress;
- there is absence of pathological changes that would account conclusively for death; and
- there is evidence of fatal levels of drugs or chemicals (4)

The mechanism of death appears to be a sudden, fatal cardiac rhythm disturbance induced by a combination of at least three possible factors relating to increased oxygen demands. Firstly, the state of agitated delirium coupled with Police confrontation places stress on the heart. Secondly, the hyperactivity associated with the delirium coupled with struggling with Police increases the oxygen demands on the heart and lungs. Thirdly, the restrained position impairs breathing in situations of high oxygen demand by inhibiting chest wall and diaphragm movement.

Because of the increased demand for oxygen in people who are restrained while in an excited delirium, the period during which the brain can withstand oxygen deprivation (traditionally regarded as four minutes) before hypoxic brain damage occurs, may be considerably reduced.

References:

(1) Bell et al. Positional Asphyxia in Adults.Am J Forensic Med Pathol 1992 13(2) 101-7

(2) Luke and Reay. The Perils of Investigating and Certifying Death in Police Custody.Am J Forensic Med Pathol 1992 13(2) 98-100

(3) O'Halloran and Lewman. Restraint Asphyxiation in Excited Delirium.Am J Forensic Med Pathol 1993 14(4) 289-295

(4) Reay et al.Positional Asphyxia during Law Enforcement Transport.Am J Forensic Med Pathol 1992 13(2) 90-97

APPENDIX 4

MEMORANDUM OF UNDERSTANDING
AUCKLAND AREA HEALTH BOARD
MENTAL HEALTH SERVICE
AND
NEW ZEALAND POLICE

MEMORANDUM OF UNDERSTANDING

BETWEEN THE AUCKLAND AREA HEALTH BOARD : MENTAL HEALTH SERVICES

(hereinafter referred to as "the Board")

AND THE NEW ZEALAND POLICE

(hereinafter referred to as "the Police")

RECITAL

IN recognising that the Area Health Board and the Police have separate missions and standards.

AND acknowledging that each party brings to its respective tasks valuable expertise and resources

AND affirming full co-operation between both parties at all levels as essential to ensure co-ordinated, effective and efficient operation:

BOTH PARTIES DECLARE AND AGREE TO THE FOLLOWING:

1.0 COMMUNICATION

1.1 COMMUNICATION FROM THE BOARD TO THE POLICE

(a) All requests from all districts for urgent assistance shall be directed initially to Police Control - Services District, Auckland Central Police Station, Telephone 379-4240 or Facsimile 366-4468.

(b) In the case of any difficulty the Board staff shall liaise direct with the Duty Inspector, Control (or in his absence, the Senior Sergeant, Control).

(c) Non urgent matters shall be directed to the Duty Senior Sergeant at the respective Police District Headquarters.

1.2 COMMUNICATION FROM POLICE TO THE BOARD

(a) All requests for urgent assistance shall be directed to the 24 hour crisis teams for the respective districts. (See Appendix No. 1). The crisis team staff will be appointed as and carry out the duties of a Duly Authorised Officer.

(b) All policy enquiries shall be directed to the Manager - Mental Health Services, for the respective District (South, North West, Central). Policy enquiries relating to the Mason Clinic or Court Liaison Services are to be referred to the Manager, Regional Forensic Services for Mental Health.

(c) Any concern about patient / operational matters shall be directed to the Clinical Director - Mental Health Services for the respective District.

2.0 PATIENTS WHO ARE REQUIRED TO BE TAKEN OR RETURNED TO ANY PLACE FOR ASSESSMENT OR TREATMENT

(a) It is the duty of the Board to arrange the taking or return to any place for assessment or treatment, any patient or proposed patient:

(i)who fails or refuses to attend for assessment or treatment, or
(ii)whose leave of absence has expired or been cancelled.

(b) The Police will respond to calls for assistance by any Duly Authorised Officer, Medical Practitioner or other Board Health Authority who believes that a patient or proposed patient poses a serious threat to persons or property.

(c) Where required, Police responding to a call as in (b) above will assist in detaining and taking the patient to a place specified by the Duly Authorised Officer or Medical Practitioner or other Board Health Authority for assessment or treatment, or return the patient to hospital.

(i)If that patient continues to pose a serious threat to persons or property, the Police will continue to assist in detaining the patient until the assessment is concluded.

(ii)If the patient no longer poses such a threat then the persons at that specified place will be responsible for the detention of the patient until the assessment is concluded.

(iii)If the specified place is a Police Station the Police will be responsible for detaining the patient until the assessment is concluded.

(iv)Police Stations may only be used when the following circumstances apply:

1.The patient or proposed patient presents as mentally ill and with disturbed behaviour

2.The patient or proposed patient poses a serious risk to others, themselves and / or property

3.The patient or proposed patient is refusing to attend for, or physically resisting assessment examination or return to any place for assessment or treatment

4.The patient or proposed patient is likely to abscond

(v)Where a patient or proposed patient is detained at a Police Station, the Duly Authorised Officer shall accompany that person and the Police for the time that the person is in Police custody.

3.0 PATIENTS WHO ABSCOND OR ARE ABSENT WITHOUT LEAVE FROM A BOARD PSYCHIATRIC INPATIENT UNIT

(a) The Board undertakes to notify the Auckland Police Control Room by telephone and facsimile message of patients who abscond or are absent without leave from hospitals, as pertaining to hospital protocols.

(b) The notification to the Police shall include an assessment of the patient's safety in the community or the threat the patient may pose to other persons or property in the community (see appended AWOL Form).

(c) The Duty Inspector or Senior Sergeant in Control receiving the report concerning patients who have absconded or are absent without leave, shall refer the information to the appropriate Police district with a recommendation regarding any Police action required.

(d) The Police district shall then contact the hospital unit involved to inform them of action undertaken.

(e) It is the duty of the Board to arrange the return of patients who abscond or are absent without leave. However, any such patients who are located by the Police and are willing to return, may be returned by the Police. Where any such patient refuses to

return with the Police, the Police will refer the matter to a Duly Authorised Officer. Where necessary and when requested, the Police will assist the Duly Authorised Officer to return the patient to hospital.
(f) The Board undertakes to accept those patients retaken by the Police.

4.0 TRANSPORT

(a) The transport of patients remanded from a Court to the Board psychiatric hospital inpatient unit is the responsibility of the Police.

(b) The transport of patients made subject to a Compulsory Treatment Order as an inpatient from the court or place of the hearing to the Board Psychiatric inpatient unit is the responsibility of the Police.

(c) The transport of remand patients from the Board Unit to the Court, while not the responsibility of the Mental Health Unit or the Police, will be the responsibility of the Board until the matter is formally resolved.

(d) The Police accept responsibility for the transport to Court of any remandee or patient who is considered a danger to themselves or to the public, as assessed by the clinical team.

5.0 INCIDENTS REQUIRING POLICE NOTIFICATION

Board staff shall notify the Police of any incident or offence occurring at hospitals or in the community and involving Board personnel or property which may require Police investigation (see appended flow chart).

6.0 COURT LIAISON SERVICE

(a) The purpose of the Court Liaison Service is to liaise with the Justice Department, the Police and Mental Health Services to facilitate an efficient and responsive system for managing those with mental illness or those suspected of being mentally ill who are presently before the Court.

(b) Assessment of Defendants in Police custody shall occur through consultation with the Police and under Police supervision.

(c) The Court Liaison Nurse will be appointed as and will carry out the duties of a Duly Authorised Officer with regard to any mental health issues or problems that present at the Courts.

(d) Referrals from Police may occur by contacting the Forensic Service Administration between 0800 and 1630 hours.

7.0 AFTER HOURS LIAISON BETWEEN THE POLICE AND THE AREA HEALTH BOARD

(a) Board Contacts: District 24 hour Crisis Teams (See appended contact numbers)

(b) Police Contact: Police Control, Services District Auckland Central Police Station Telephone 379-4240 or Facsimile 366-4468

8.0 SUPERVISION BY DULY AUTHORISED OFFICERS

Where a person is required to be detained by the Police and it is considered that that person is or may be mentally disordered, wherever practicable and necessary the Duly Authorised Officer will directly supervise / accompany that person while they are detained in custody. This will be done through consultation with the Police.

9.0 MEDIA

(a) Both parties accept it is important to ensure that sound media relationships are developed and maintained to mutually benefit the parties to this agreement and the media.

(b) The Police objective is to maintain an open and effective working relationship with all branches of the media.

(c) Whenever practicable, the Police shall liaise with the appropriate Board representative before releasing information

(d) Whenever dealing with matters involving the Board, the Police shall retain the right to comment in respect of any Police investigation of offences or incidents.

(e) Matters of health policy or medical issues shall be referred to the Manager - District Mental Health Services, Area Health Board for appropriate comment.

10.0 AMENDMENT VARIATION

The parties agree that these understandings may be amended / or varied by mutual agreement between partners. Such variations should be raised and addressed through the Standing Police / Mental Health Liaison Committee (convened by the Manager - Community and Liaison Services Regional Forensic Services for Mental Health, and the District Commander - Services for the Police).

SIGNED BY: .....

On behalf of the AUCKLAND AREA HEALTH BOARD
MENTAL HEALTH SERVICES

SIGNED BY: .....

On behalf of the NEW ZEALAND POLICE

DRAFT

APPENDIX 5

MEMORANDUM OF UNDERSTANDING

BETWEEN THE NEW ZEALAND POLICE

(hereinafter referred to as "the Police")

AND THE MINISTRY OF HEALTH

(hereinafter referred to as "the Ministry")

RECITAL

IN recognising that the Police and the Ministry have separate missions and standards.

AND acknowledging that each party brings to its respective tasks valuable expertise and resources

AND affirming full co-operation between both parties at all levels as essential to ensure co-ordinated, effective and efficient operation:

BOTH PARTIES DECLARE AND AGREE TO THE FOLLOWING

1. INTRODUCTION

1.1 The following matters are agreed in principal between the New Zealand Police Department and the Ministry of Health to give guidance to Police staff and health professionals administering the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992, (hereinafter referred to as "the Act").

1.2 This memorandum should form the basis of local agreements made at Police Region and District level with Crown Health Enterprises.

1.3 A spirit of co-operation should prevail in all dealings under the Act between Police and Health Professionals.

1.4 People being dealt with under the Act are **PATIENTS** and should be treated with the due care and dignity afforded to any person. Mentally disturbed persons are

primarily the responsibility of the CHEs. It is further recognised that such persons, while being dealt with purely under the Act, have not broken any rule of law.

1.5 Police and Health Professionals must retain a flexible approach to any incident being dealt with under the Act and be prepared at all times to change their course of action.

1.6 Nothing in this memorandum limits or prevents the Police from carrying out any duties or exercising any powers under other enactments.

2. RESPONSIBILITIES

2.1 The Duly Authorised Officer or registered Medical Practitioner is the official "in charge" at any incident requiring the invoking of the Act.

2.2 The Police may be called upon to assist the Health Professionals but will continually review the appropriateness of the action requested of them and withdraw their assistance should that action be inappropriate.

2.3 If the DAO is not a registered Medical Practitioner the attending Police may (after assessing the urgency of the situation and any potential risks) request the DAO to arrange the attendance of a registered Medical Practitioner to examine and ensure the safety of the patient.

2.4 Police should only be called if there is actual violence or the DAO or registered Medical Practitioner can provide sufficient information to support an assumption that violence is likely to occur.

3. TRANSPORTATION OF PATIENTS

3.1 The most appropriate vehicle for transporting non-violent patients is a CHE vehicle or an ambulance.

3.2 The most appropriate vehicle for transporting violent patients should be negotiated locally between the CHE, Police and Ambulance Services.

3.3 Ambulances or CHE vehicles fitted with restraint devices are more appropriate vehicles for transporting violent patients than Police vehicles.

3.4 Where Police have been called to assist a DAO or registered Medical Practitioner, the DAO or a suitable Health Professional will at all times **PHYSICALLY** accompany the patient. For the purposes of this paragraph "suitable health professional" means a registered Medical Practitioner, a nurse or an ambulance officer.

4. USE OF FORCE

4.1 The wishes of the patient where clearly expressed are to be given the most careful consideration at all times **AND** a patient should only be taken by force after all other alternatives have been exhausted. Every effort must be made to reduce the risk of violence before the patient is transported.

4.2 Other than when executing a warrant to apprehend issued under the Act any taking by force must only be in circumstances where it is likely the patient will be a danger to him or herself, or to others or to cause serious property damage.

4.3 If it is necessary to use force to take and / or detain a patient the DAO or registered Medical Practitioner shall give a clear instruction to Police to do so. Police officers must be certain of the section of the Act they are acting under and that authorises the use of force before applying such force.

4.4 If it is necessary to use force to gain entry to property the DAO or registered Medical Practitioner shall give a clear instruction to Police to do so. Police officers must be certain of the section of the Act they are acting under and that authorises the entry. The appropriate CHE will be liable for the cost of any repairs.

5. CHARGING FOR SERVICES

5.1 The Police will not normally charge CHEs for the provision of assistance under the Act.

5.2 Consideration may be given to charging for pre-planned use of Police services by CHEs where it has been contractually agreed to at a local level or in instances of excessive demands on Police time.

6. AMENDMENT VARIATION

6.1 The parties agree that these understandings may be amended or varied by mutual agreement between partners. Such variations should be raised and addressed through the Officer in Charge - Operations Support for the Police and the Deputy Director of Mental Health for the Ministry.

SIGNED BY: .....
ON BEHALF OF THE NEW ZEALAND POLICE

SIGNED BY: .....
ON BEHALF OF THE MINISTRY OF HEALTH

APPENDIX 6

BEATTIE MEMORANDUM

Manukau District
2 - 6 Princes Street, Otahuhu

26 March 1993

The Senior Sergeants
Section 1, 2, 3, 4 & 5
OTAHUHU

VIOLENT MENTAL PATIENTS

Problems have been experienced in the past in conveying violent mental patients to Kingseat Hospital. At a meeting at The Cottage with Mental Health Workers on date, it was agreed that where possible the Duly Authorised Officer from the Mental Health Services will accompany the patient in the Police patrol car to Kingseat Hospital.

The Duly Authorised Officer (DAO) can be contacted after hours from Kingseat Hospital. They are all issued with cell phones.

The patient should sit in the back seat of the patrol car on a blanket as it is quite normal for patients to soil themselves when in the patrol car. A Police personnel and the Duly Authorised Officer will sit either side of the patients. If necessary handcuffs are to be applied.
Patients who have been given an injection to calm them may be required to be given drinks of water while being conveyed in the patrol car. We will be advised each case by the DAO.

Advise staff of this procedure. If problems are experienced I am to be advised so the matter can be raised at the next meeting with the Mental Health Workers on 18 June 1993.

L.F. BEATTIE
Chief Inspector
Area Controller
OTAHUHU

GLOSSARY

The following abbreviations are used in this report:

ACT:	**Mental Health (Compulsory Assessment and Treatment) Act 1992 (No. 46)**
CHE / CHEs:	**Crown Health Enterprise(s)**
CONSULTANT:	**Consultant Psychiatrist**
DAMHS:	**Director of Area Mental Health Services**
DAO / DAOs:	**Duly Authorised Officer(s) designated and authorised pursuant to Section 93 Mental Health (Compulsory Assessment and Treatment) Act 1992**
PDN:	**Psychiatric District Nurse**
REGISTRAR:	**Psychiatric Registrar**
RHA:	**Regional Health Authority**