Health and Community Services
COMPLAINTS COMMISSION

DE-IDENTIFIED

INVESTIGATION REPORT

1. Legal and rights issues related to
   - Consent - major medical procedures and electroconvulsive therapy (ECT)
   - Use of sedation/restraint
   - Processes for authorisation of ECT
   - Documentation under the MHRSA.

2. Clinical appropriateness of ECT being undertaken when a patient has been kept sedated since the previous ECT session.

8 August, 2019

GLOSSARY

AHPRA	Australian Health Practitioner Regulation Agency
AP	Approved Procedures approved by Chief Executive Officer of NT Department of Health to be used in administration of the MHRSA
APP	Authorised Psychiatric Practitioner (as defined in the MHRSA)
CHO	Chief Health Officer
Cowdy Ward	Lower acuity mental health ward at RDH (managed by TEMHS)
DoH	NT Department of Health
ECT	Electroconvulsive Therapy
ED	Emergency Department, RDH
Form 23	Form 23 Medical Treatment Application/Notification, for provision to the Tribunal – one section relates to applications for approval for major medical procedures; another relates to notification of major medical procedures already performed (referred to in AP 30 - Major Medical Procedure)
Form 27	Form 27 Application and Clinical Details for Authorisation of ECT (referred to in AP 12 – ECT Licensing & Legal Requirements)
Form 28	Form 28 Notification and Clinical Details re ECT Performed (referred to in AP 12 – ECT Licensing & Legal Requirements)
ICU	Intensive Care Unit, RDH
JRU	Joan Ridley Unit – high acuity mental health ward at RDH
MHRSA	*Mental Health and Related Services Act* (NT)
NTLAC	Northern Territory Legal Aid Commission
RACP	Royal Australian College of Physicians
RANZCP	Royal Australian New Zealand College of Psychiatrists
RATT	Risk Assessment Tracking Tool
RDH	Royal Darwin Hospital (managed by TEHS)
TEHS	Top End Health Service
TEMHS	Top End Mental Health Service (managed by TEHS)
'Tribunal'	Mental Health Review Tribunal
'the Act'	*Health and Community Services Complaints Act* (NT)
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UN Principles	United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

TABLE OF CONTENTS

INTRODUCTION

This investigation involves a young Aboriginal woman who was admitted to hospital for involuntary mental health treatment. She was from a remote community and did not speak English as her first language. She did not have a guardian appointed who could consent to treatment if she was unable to do so. It is clear that she was highly vulnerable. It is also clear that her medical and psychiatric circumstances were extremely complex, and that clinicians endeavoured to provide appropriate treatment in a very challenging situation. This treatment included two major medical procedures (intubation and ventilation), and four episodes of electroconvulsive therapy (ECT).

This report draws from reports produced by two professors who reviewed the records – one an expert in the field of psychiatry, the other in the field of law.

The psychiatry professor's opinion is that the types of treatment were appropriately chosen, that a good standard of treatment was provided, and that ECT treatments were properly administered. He has no concerns about the treatment that was provided from a clinical perspective.

The law professor's opinion, however, is that there are significant questions regarding the legality of some episodes of treatment. The key issue is whether these treatment episodes were of such a critical and urgent nature that they constituted what is often referred to as 'emergency' treatment, which could be legally performed without consent from an appropriate decision-maker or approval by the Mental Health Review Tribunal; that is, solely on the basis of decisions made by practitioners themselves.

Objectives set out in the *Health and Community Services Complaints Act* include improving health services and promoting the rights of service users. I have framed the commentary that follows with both of these aims in mind, and hope that the report proves of benefit to both users and providers of mental health services in the Northern Territory.

AUTHORITY

Section 48 (1) of the *Health and Community Services Complaints Act* ('the Act') provides:

> The Commissioner may, as he or she thinks fit, investigate
>
> (a) any matter referred under section 20(1) or 21(1);
> (b) a complaint that the Commissioner has decided to investigate under section 27; or
> (c) an issue or question arising from a complaint or a group of complaints if it appears to the Commissioner
> (i) to be a significant issue of public health or safety or public interest; or
> (ii) to be a significant question as to the practice and procedures of a provider.

This investigation was carried out pursuant to s48(1)(c)(i) and (ii) of the Act as the complaint raised significant issues of public health or safety or public interest and significant questions as to the practice and procedures of providers, namely Top End Mental Health Service (TEMHS) and Royal Darwin Hospital (RDH) (both managed by Top End Health Service (TEHS)).

BACKGROUND TO INVESTIGATION

On 16 February 2017, I received a complaint from the Northern Territory Legal Aid Commission (NTLAC) on behalf of Ms AB about the care and treatment Ms AB received from TEMHS and RDH/TEHS. Ms AB is a young Aboriginal woman from a remote community. She had a diagnosis of schizophrenia and was well known to mental health services. Ms AB's complaint related to services provided during two hospital admissions. This report focuses solely on the second admission, which was from 1 December 2016 to 31 January 2017.

On 1 December 2016 Ms AB was transferred from her community to RDH for involuntary admission and treatment under s 39 of the *Mental Health and Related Services Act* (MHRSA), following what was described as an "acute relapse of psychosis."

Ms AB was admitted involuntarily to the Joan Ridley Unit (JRU)[1] via the Emergency Department (ED) on 1 December 2016. On 2 December 2016 she was transferred to the Intensive Care Unit (ICU) for intubation and ventilation.[2]

Ms AB was extubated on 5 December 2016, at which time she was returned to JRU. On the afternoon of 5 December 2016 a 'Code Blue'[3] was called for reasons including tachycardia and low oxygen saturation levels. Ms AB was re-admitted to ICU that afternoon. At that time ECT was performed, after which Ms AB was intubated and ventilated.

ECT was performed again in ICU on 7 December 2016, while Ms AB remained intubated. A Mental Health Review Tribunal (Tribunal) hearing later that day was adjourned because Ms AB was still unconscious and intubated. She was extubated later the same day. Further ECT was undertaken on 9 and 12 December 2016.

A CT scan[4] performed on 13 December 2016 showed that Ms AB had developed bilateral pulmonary emboli (ie blood clots in both lungs). The Tribunal did not consider her circumstances again until 14 December 2016, when it authorised a course of up to eight further ECT treatments. No further ECT was performed during Ms AB's admission.

While in hospital, Ms AB developed:

- Bilateral (provoked) pulmonary emboli developed in the context of ICU admission;
- VRE UTI (Vancomycin Resistant Enterococci Urinary Tract Infection) developed through catheter insertion in ICU. [5]

Ms AB also developed pneumonia; however there is conflicting evidence about whether it was aspiration pneumonia and when it might have occurred (it is possible that it occurred prior to admission).

[1] Joan Ridley Unit - high acuity mental health ward at RDH.
[2] Intubation is the insertion of a tube through the mouth into the patient's airway. The tube is then connected to a ventilator which moves gases in and out of the lungs.
[3] A Code Blue – Medical Emergency is defined in Australia Standard AS 4083-2010 as "any event in which trained personnel are required to respond to as a medical crisis."
[4] Computed Tomography scan – medical imaging procedure using x-rays and computers to generate 3D images.
[5] Medical Discharge Summary prepared by TEMHS on or after 31 January 2017.

INVESTIGATION SCOPE

PROCESS

After assessing Ms AB's complaint, I referred issues to four separate investigations:

1. Legal and rights issues arising from the admission from 1 December 2016:

    - Consent - major medical procedures and electroconvulsive therapy (ECT)
    - Use of sedation/restraint
    - Processes for authorisation of ECT
    - Documentation under the MHRSA.

2. ECT administered during the admission from 1 December 2016:
    - Clinical appropriateness of ECT being undertaken when a patient has been kept sedated since the previous ECT session (as occurred in relation to Ms AB on 7 December 2016).

3. Coordination of treatment/treatment outcomes during the admission from 1 December 2016:
    - Quality of medical care provided to Ms AB, including unexpected treatment outcomes and coordination of treatment.

4. The decision to discharge Ms AB from the Top End Mental Health Service (TEMHS) Inpatient Unit on her previous admission.

I am yet to investigate the coordination of treatment during the admission from 1 December 2016 or the discharge from hospital on Ms AB's previous admission (3 and 4 above).

The investigation into legal and rights issues involved review of responses previously obtained from TEMHS and RDH/TEHS, medical records, and records from the Tribunal, and consideration of procedural documentation produced by the NT Department of Health (DoH). Professor Bernadette McSherry was asked to provide an expert legal opinion. More information about Professor McSherry's qualifications and report is provided below.

After issuing the draft investigation report dealing with legal and rights issues for comment I received a submission from TEHS seeking an extension of time to allow it to obtain a specialist medical opinion to provide context for elements of Professor McSherry's report.

I also obtained a report from psychiatrist Professor John Tiller in relation to the ECT investigation outlined above (see investigation 2). It was apparent that there were aspects of Professor Tiller's report which were relevant to the first investigation, and that his report discussed the clinical context of events which were being considered. As it seemed artificial to separate the matters I decided to incorporate reference to Professor Tiller's report within this investigation.

While Professor Tiller chose to comment on a range of aspects relating to Ms AB's treatment, his opinion was only sought in relation to the administration of ECT on 5 December and 7 December 2016 (with the episode of 5 December 2016 having been included so that he could consider the two episodes as a clinical sequence). Professor Tiller's report reviews circumstances relating to Ms AB's treatment, but does not provide a detailed analysis of the broader issue regarding the decision to administer ECT when a patient has been kept sedated since a previous ECT session. While I am limited in my ability to make findings in relation to this issue, on the basis of Professor Tiller's report I have decided not to pursue this aspect further via a distinct investigation and will consider the second investigation to be closed on finalisation of this report.

The scope of this investigation is as follows:

1. Legal and rights issues arising from the admission from 1 December 2016:
    - Consent - major medical procedures and electroconvulsive therapy (ECT)
    - Use of sedation/restraint
    - Processes for authorisation of ECT
    - Documentation under the MHRSA.

2. ECT administered during the admission from 1 December 2016:
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EXPERT OPINIONS

Professor McSherry has recently been appointed as Commissioner to the Royal Commission into Victoria's Mental Health System. She is the Director of the Melbourne Social Equity Institute and Adjunct Professor of Law at the University of Melbourne and Monash University. She was a legal member of the Mental Health Review Tribunal of Victoria for seventeen years, and a legal member of the Psychosurgery Review Board of Victoria for five years. Professor McSherry has authored and edited 20 book chapters and over 150 peer reviewed articles.

Professor Tiller is a Fellow of the Royal Australian College of Physicians (RACP) since 1972 and a Fellow of the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Professor Tiller is a member of the Royal Australian and New Zealand College of Psychiatry (RANZCP) Electroconvulsive Therapy and Neurostimulation Working Group which developed the newly released Professional Practice Guidelines for the administration of ECT. From 2001 until 2014, Professor Tiller was Head of the Professorial Psychiatry Unit at Albert Road Clinic and since 2015, Professor Emeritus of Psychiatry at the University of Melbourne, based at Albert Road Clinic. He has been Director of ECT services at the Albert Road Clinic since 1995 and headed the Australasian ECT Training Program. He has authored, co-authored and edited more than 200 publications, including refereed publications, chapters in books, and books.

NATURAL JUSTICE / COMMENT

In relation to the above, attention is drawn to the following section of the Act:

> 67. Adverse comments in reports
>
> (1) The Commissioner must not make any comment adverse to a person in a report under this Part unless –
>
> (a) the person has been given a reasonable opportunity to be heard in the matter; and
>
> (b) the person's explanation (if any) is fairly set out in the report.

A draft report which contained commentary relating to the investigation into legal and rights issues and the expert opinion by Professor McSherry was provided to the parties on 7 February 2019. A revised draft report which incorporated all aspects and both expert opinions was provided to the parties on 15 May 2019.

Although it is not a direct party to the complaint, DoH was provided with both drafts as some commentary and recommendations relate to DoH rather than TEMHS or TEHS/RDH.

While Tribunal operations fall outside the HCSCC's jurisdiction and is not the focus of the investigation, some commentary relates to the Tribunal. On this basis the Tribunal was also provided with the draft reports and expert opinions so that it could provide comment.

DoH responded to the draft reports on behalf of all the health service providers. NTLAC also provided feedback on behalf of Ms AB, and comment was provided by the President of the Tribunal. Explanations and other comments have been incorporated into this report in accordance with the natural justice requirements set out above or as otherwise relevant to the report's conclusions.

ADDITIONAL ACTION

TABLING OF REPORT

The Act states that I may report to the Minister on the results of investigations undertaken under the Act (s 19(2)(c)), and when this occurs the Minister must table a copy of the report in the Legislative Assembly within six sitting days after receiving it (s 19(3)).

The Act states further in s3 that the objective of the Acts is to lead to improvement in health services, promote the rights of service users, and encourage awareness of the rights and responsibilities of users and providers. My decision to provide the report to the Minister is guided by these objectives.

The version of the report provided to the Minister does not identify the complainant and individual practitioners. Submissions were sought from the parties in relation to this proposal prior to the decision being made.

CHRONOLOGY

The following summary of key events is drawn from the clinical records.

1 December 2016

Ms AB was admitted to JRU via ED on her arrival in Darwin.

TEMHS Multidisciplinary Inpatient Unit Ward Round notes of 9:32am on 1 December 2016 state that Ms AB was to be considered for ECT while an inpatient due to deterioration in her mental state.

According to JRU nursing admission notes she was:

> presenting as agitated, fluctuating aggression towards others with intense staring and charging at other co-consumers, rattling doors. Required a safety officer special on arrival. […] unable to attend physical [observations] due to unsettled behaviour.

Ms AB was assessed as moderate-high risk, with the notes stating that she "poses an increased risk of aggression to junior/new staff and co-consumers."

2 December 2016

Ms AB was described in the notes as: "restless kicking and shouting and getting [too] close to other patients putting herself at risk"; and later: "kicking doors, very thought disordered […] punched co-client."

Later that day Ms AB was transferred to ICU, where she was intubated and ventilated. A retrospective ICU note states that Ms AB:

> … now is violent and combative. Psychiatric team are reluctant to give any further sedative for fear of paradoxical reaction. Patient is being considered for emergency ECT. Decision made to transfer to ICU for [intubation and ventilation].[6]

[6] ICU notes 2/12/16 (18:10hrs)

The ICU Admission note states:

> intubated for control of agitation in context of acute psychosis and ketamine administration. […] ICU [review] and decision for further chemical sedation … and then transfer to ICU for 'elective' intubation. […] Plan: […] aim extubate in ? 3 days

The ICU admission note also states that the plan includes sedation with propofol and dexmed (etomidine), and maintenance of a "RASS -3 to 0".[7]

3 December 2016

The psychiatric registrar wrote that:

> extubation on Monday 5/12, can be transferred back to JRU when medically stable post extubation. […] Treating psych team to inform [Tribunal] of emergency [treatment, that is, intubation and ventilation] for acute aggression post ketamine which was not responding to chemical restraint.

5 December 2016

On the morning of 5 December Ms AB was extubated and transferred to JRU. Clinical notes from a review on Ms AB's return to JRU state:

> [Ms AB] remains acutely psychotic – delusional themes, thought disordered; disorganised behaviour. Treating team have formed a view that it would be most appropriate to manage [Ms AB] with PCAs[8] / 1:1 Nurse > Behavioural Management Strategies
>
> High risk of iatrogenic[9] harm if given high dose anti-psychotics. Plan: 2. Request Emergency ECT > Dr [TEMHS] request; > Advise Tribunal.[10]

Later that day a Code Blue was called on Ms AB due to tachycardia[11] and low oxygen saturation levels, and Ms AB was returned to ICU.

[7] Richmond Agitation-Sedation Scale (RASS) measures patient agitation and sedation levels from +4 to -5. -3 indicates moderate sedation; 0 is alert and calm.
[8] Personal Care Assistant (provides one-to-one care).
[9] Harm resulting from the treatment itself.
[10] JRU ward round notes 5/12/16 (1045hrs).
[11] Abnormally high resting heart rate.

Ms AB subsequently underwent ECT, and ICU clinical records from the afternoon of 5 December 2016 state: *"*decision made to intubate post ECT given risk to airway and potential aspiration."

Following the ECT, notes state: *"*[Psychiatric registrar] will put an application to [Tribunal], explaining the need for emergency ECTs and request approval for further [treatment]."

Ms AB remained intubated and ventilated until 10:50am on 7 December 2016.

7 December 2016

On Wednesday 7 December 2016 a second episode of ECT was undertaken, while Ms AB remained intubated and ventilated:

> 2nd emergency ECT administered […] [Tribunal] today- application for approval of further [management] including ECT. […] Next ECT on Fri 9/12/16 (depending on approval from [Tribunal][12]

The Tribunal sat on that day, following the administration of the ECT. The hearing was adjourned until 14 December 2016. Ms AB was extubated later on 7 December 2016.

9 December 2016 and 12 December 2016

Ms AB underwent ECT, while still in ICU.

13 December 2016

Ms AB was moved to a general ward of RDH as a psychiatric 'outlier'. A CT scan performed that day showed that she had bilateral pulmonary emboli.

14 December 2016

A Tribunal hearing took place at which Ms AB's involuntary admission was extended by up to six weeks and a course of up to eight ECT treatments was approved; however no further ECT was performed.

[12] Psychiatry registrar notes 7/12/16 (09:45hrs).

INFORMATION / EVIDENCE

This section of the report provides a summary of information considered during the investigation, including international principles, legislation and procedures. Clinical records from the relevant period are summarised, together with responses provided by TEMHS and TEHS/RDH to the original complaint, information relating to Tribunal hearings, and key content from the expert opinions obtained from Professor McSherry and Professor Tiller, as well as parties' feedback to the draft investigation reports (the DoH response included an expert opinion from Professor Matthew Large). Issues arising from consideration of this information are then discussed prior to my findings and recommendations being presented in the final sections of the report.

INTERNATIONAL LAW

The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care ('UN Principles') underlie many of the requirements in the MHRSA. They set out the rights of people accessing mental health care and cover a wide range of issues, including consent to treatment, which is dealt with in Principle 11. The basic framework of Principle 11 is that no treatment is to be given without the patient's informed consent, other than in certain narrowly defined exceptions (Principle 11(1)).

In relation to these exceptional situations, the UN Principles state (in summary):

- That in non-emergency situations where a person is unable to give informed consent an independent authority or legally empowered personal representative needs to give consent (Principle 11 (6) and (7)).

- That the exception allowing treatment without consent in emergency situations is very narrowly defined, requiring that a qualified mental health practitioner authorised by law determines that treatment is "urgently necessary in order to prevent immediate or imminent harm to the patient or other persons," and stating that "such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose" (Principle 11(8)).

- Where a patient with mental illness is unable to give informed consent to a major medical procedure such a procedure shall only be authorised after independent review; noting that performance of the procedure must also be permitted by domestic law and considered to serve the best interests of the patient (Principle 11(13)).

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), to which Australia is a signatory, includes persons with 'mental impairments' within its scope. It requires health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent (Article 25(d)).

Professor McSherry observed that a strong international consensus regarding the need for States to take "active steps to fully integrate a human rights perspective" into mental health services was indicated by approval of the Resolution on Mental Health and Human Rights by the UN Human Rights Council in 2017. [13]

LEGISLATIVE REQUIREMENTS:
MENTAL HEALTH AND RELATED SERVICES ACT (MHRSA)

The objects of the MHRSA are set out in Appendix A and include providing for the care, treatment and protection of people with mental illness while at the same time protecting their civil rights; and the establishment of provisions for emergency treatment. Emphasis is added to key aspects in the extracts of legislation and procedures which are set out below.

MAJOR MEDICAL PROCEDURES

Section 64 of the MHRSA sets out the provisions governing the performance of major medical procedures, which includes the use of anaesthetic such as that used during intubation and ventilation in this case.[14]

[13] Expert opinion by Professor B McSherry paragraphs 14-16.
[14] See below for extract of Chief Health Officer Guidelines.

64 Major medical procedure

(1) A person **must not perform a major medical procedure** on a person who is an involuntary patient or subject to a community management order.
Maximum penalty: 40 penalty units.

(1A) Subsection (1) does not apply if the procedure is performed in accordance with this section.

(2) Subject to subsection (3), a major medical procedure must not be performed on a person unless:

(a) it is approved by the Tribunal; or

(b) informed consent for the major medical procedure is obtained from a decision maker for the person, or from the Civil and Administrative Tribunal, in accordance with Part 4 of the *Advance Personal Planning Act*.

(3) **An authorised psychiatric practitioner [15] may authorise** the performance of a major medical procedure on a person where it is **immediately necessary**:

(a) to save the life of the person; or

(b) to prevent irreparable harm to the person.

(4) **No later than one day after** authorising the performance of a major medical procedure under subsection (3), the practitioner **must notify**:

(a) the Tribunal; and

(b) the person's adult guardian; and

(c) if the person has a decision maker – the decision maker.

(5) The Chief Health Officer is, from time to time, to specify those medical procedures that are major medical procedures for the purposes of this section.

(6) The purpose of this section is to protect the interests of a person by ensuring the person is not unnecessarily subjected to certain medical procedures.

[15] Section 22 of the MHRSA says that the CEO of DoH can appoint a person to be an 'authorised psychiatric practitioner' if they meet defined criteria relating to qualifications and appointment.

ECT

Section 66 of the MHRSA, set out in full in Appendix A, governs the use of ECT in the Northern Territory. ECT must not be performed without relevant consent, or Tribunal authorisation, unless under subsection (3):

> […] 2 authorised psychiatric practitioners are satisfied that it is **immediately necessary**:
>
> (a) to save the person's life; or
>
> (b) to prevent the person suffering serious mental or physical deterioration; or
>
> (c) to relieve severe distress.

Where ECT is performed under this sub-section, the two authorised psychiatric practitioners (APPs) must make a report to the Tribunal of the therapy performed **as soon as practicable** after it is performed (s 66(4)).

APPROVED PROCEDURES

The CEO of DoH (and his or her delegate) is empowered to approve procedures to be used in the Department's administration of the MHRSA. Those procedures (the 'Approved Procedures') are published internally in DoH and are not publically available. Having been developed under an associated power in the MHRSA, that Act provides that "[a] person must not contravene" them, though no penalty or consequence for contravention is set out under the MHRSA.

The Approved Procedures are not dated. The age of Approved Procedure 12 is evident from the way in which it refers to DHF (Department of Health and Families), a name which has been out of use for some time.

Information about the content of Approved Procedures relevant to the investigation (as provided by TEMHS), is set out below.

MAJOR MEDICAL PROCEDURES

AP 30: CHO Guidelines Major Medical Procedure (Extract)

Pursuant to my power under **s64(5)** of the Act, [Chief Health Officer] have specified the following medical procedures as 'major medical procedures' for the purpose of this section:

- Any surgery performed under a general or regional anaesthetic.
- Use of general or regional block anaesthetic for any purpose.
- Chemotherapy.
- Radiotherapy.

The purpose of **s64** is to protect the interests of a person by ensuring the person is not unnecessarily subjected to certain medical procedures.

Approved Procedure 30 also states that there is a requirement to inform the Tribunal "**as soon as practicable**" if an APP has authorised a major medical procedure. This is to be done via a **Form 23 – Medical Treatment Application/Notification.**[16]

ECT

Approved Procedure 12 (Electro Convulsive Therapy (ECT) Licensing & Legal Requirements) sets out the guidelines for ECT in the Northern Territory. For ease of reference the procedure is included in this report at Appendix C.

Approved Procedure 12 says that "[b]y definition an involuntary patient is not capable of giving informed consent to ECT," and that the Act therefore requires approval to be obtained from the Tribunal.

[16] Approved Procedure 30, p 3.

It describes an exception which applies in emergencies, outlining contents of s66(3) and stating that "[e]mergency ECT is only performed on rare occasions where patients have such severe mental illness that delay may cause significant psychiatric and/or physical consequences and exacerbate acute distress."[17]

Where emergency ECT has been performed, Approved Procedure 12 requires that clinicians lodge a **Form 28 – Notification and Clinical Details re ECT Performed** with the Tribunal as soon as practicable after it is performed. The procedure also states that in this situation a **Form 27 - Application and Clinical Details for Authorisation of ECT** "must be completed and should accompany Form 28." It is not clear what information a Form 27 sent in this situation is required to include, particularly if no further ECT is planned.

TEMHS & TEHS (RDH) RESPONSES / CLINICAL RECORDS

The following information is drawn from the TEMHS and RDH clinical records, and from separate responses provided by TEMHS and RDH during the Commission's initial complaint assessment process.[18]

MAJOR MEDICAL PROCEDURES

INTUBATION AND VENTILATION - 2 DECEMBER 2016

In its response to Ms AB's complaint TEMHS advised that the intubation and ventilation of Ms AB on 2 December 2016 was undertaken pursuant to s64(3)(b) of the MHRSA (ie that it was a major medical procedure immediately necessary to prevent irreparable harm to Ms AB).[19] According to TEMHS the treatment was undertaken to "manage [Ms AB's] extreme aggression as a result of a relapse of psychosis with possibility of further exacerbation of symptomatology" resulting from the use of ketamine in the transfer from her community to Darwin.

[17] AP 12 p 7.
[18] TEHS sent an email to the HCSCC on 16 May 2017 which included a cover letter dated 15 May 2017, to which Attachment A was the TEMHS response to the complaint and Attachment B was the RDH response.
[19] Response provided to the HCSCC on behalf of TEMHS under cover letter dated 15 May 2017, sent via email 16 May 2017, App A p 4.

TEMHS stated that:

> unmanageable aggression and agitation can occur in up to 20% of cases where ketamine is administered in a psychotic patient. Such condition was refractory to usual antipsychotic treatment; in fact there was a high-risk of paradoxical effects, which would have resulted in further exacerbating psychosis and medical compromise.[20]

The Discharge Summary prepared by TEMHS stated that:

> The team at that time had concerns that further doses of antipsychotic medications could be potentially harmful. Her case was discussed with the Intensive Care Unit and Anaesthetics Department, and a decision was made to intubate her in ICU for 72 hours to allow metabolism of medications and determine treatment options following a review on extubation (awakening from deep sleep). [21]

In response to the complaint, TEMHS reiterated these concerns, advising that ongoing use of antipsychotic medications would have posed a risk to Ms AB's health; and that the "deep sedation" followed by ECT would mean that mechanical restraint was not required and so "prevent Ms AB being subjected to irreparable psychological harm."[22]

An ICU summary says that Ms AB was transferred to ICU for "elective intubation" and that "[t]he plan was to allow the various medications recently administered to be cleared, as it was felt these were aggravated or had contributed to her aggressive psychotic state."[23]

Medical records showed that Ms AB was very sedated on arrival in the Emergency Department on 1 December 2016. She was assessed as being a moderate risk of harm to self and others, based on her history.[24] Ms AB was transferred to JRU. Nursing admission notes said that she had become abusive on receiving a phone call from her husband, that staff had been unable to attend to physical observations due to unsettled behaviour, and that she had been "intermittently charging and fly-kicking the doors".

[20] Response provided to the HCSCC on behalf of TEMHS under cover letter dated 15 May 2017, sent via email 16 May 2017, App A p 4.
[21] TEMHS Discharge Summary prepared on or after 31 January 2017.
[22] Response provided to the HCSCC on behalf of TEMHS under cover letter dated 15 May 2017, sent via email 16 May 2017, App A p 4
[23] RDH ICU Summary, 13 December 2016, p 1.
[24] Progress note medical entry 1/2/16, 07:47 hrs.

Ms AB's speech was described as "changeable, intermittently yelling abuse and threatening". She was said to be not engaging at length in English but having "engaged on phone in language." She was described as oriented to person and environment and sporadically recognising familiar staff. The entry stated she had accepted diazepam without issue and had lunch with her mother.

A Risk Assessment Tracking Tool (RATT) used by NT Mental Health Services is used in the psychiatric inpatient units as a tool to assess and record risk. Risks are assessed on a scale of '1' (no apparent risk) to '5' (extreme and imminent risk). On 1 December 2016 and 2 December 2016 Ms AB was assessed as level '4' (serious risk) in relation to self-harm, harm to others, and vulnerability. There are no Riskman entries or incident reports in the hospital records relating to behavioural incidents during this period.

JRU nursing notes said that Ms AB had woken in the early hours of 2 December complaining of hunger as she had missed dinner, that she "began escalating when denied a 'taylor [sic] made' cigarette" but had settled after being given diazepam.[25] Nursing notes at 10:45am said that she had been "high profile, kicking doors, very thought disordered"; that midazolam and diazepam had been given with little effect and that she had punched another patient.

A further entry in the medical record on 2 December 2016 states that the treating team was unable to review Ms AB because she remained "extremely sedated due to Midazolam administration"[26] that morning. The team planned to wait for a response from Anaesthetics regarding any iatrogenic harm which might have been caused by Ketamine administered on route to hospital. A Riskman entry with an incident time of 12:30pm states that security officers were called to assist with transfer to ICU and that "the patient was able to be calmed and was moved to a bed where she was medicated and she was then wheeled in the bed to ICU without incident."

[25] Nursing notes 2/12/16, 0615.
[26] Entry by psychiatric registrar 2/12/16.

INTUBATION AND VENTILATION - 5 DECEMBER 2016

The response provided by TEHS RDH stated that when a Code Blue was called on 5 December 2016 Ms AB was transferred back to ICU due to both the abnormal physiology and the need for emergency ECT, and that she was intubated post-ECT to "optimise respiratory function."[27] RDH stated that there was clinical suspicion of aspiration and that the "need for emergency intubation was to support the patient's ventilatory function" which had been "compromised by the emergency ECT and possible aspiration."[28]

ICU medical notes confirm that intubation took place after ECT had been performed.[29] The response from TEMHS does not directly address the reasons for this episode of intubation and ventilation.

TRIBUNAL DOCUMENTATION – TEMHS

The first Form 23 (Medical Treatment Notification) [30] relating to a major medical procedure submitted to the Tribunal was signed by a psychiatric registrar on 6 December 2016. In its response to the HCSCC, TEMHS stated that a Form 23 should have been completed and sent to the Tribunal within one day of the procedure on 2 December 2016. It said that a Form 23 was left by the registrar for signature by the ICU doctor who performed intubation and ventilation, but that a message about the form was not passed on by the ward clerk and it was not completed.

A Form 23 was signed by the psychiatric registrar on 6 December 2016 and provided to the Tribunal; however this refers to aspiration and the use of antibiotics, which were linked with the decision to intubate and ventilate on 5 December 2016. The only Form 23 clearly relating to the 2 December 2016 major medical procedure is dated **9 May 2017** and signed by the ICU doctor who performed the procedure. It identifies "management of severe aggression as part of Acute Psychosis" as the condition which the sedation and mechanical ventilation was undertaken to address.

[27] Response provided to the HCSCC on behalf of TEHS RDH under cover letter dated 15 May 2017, sent via email 16 May 2017.
[28] There is uncertainty as to when aspiration occurred. The TEMHS discharge summary suggests that it may have been during intubation in ICU on 2 December 2016.
[29] ICU medical notes 5/12/16 (17:10hrs)
[30] See Approved Procedure 30, Major Medical Procedures, which refers to Form 23: 'Medical Treatment Application/Notification'.

The doctor states on the form that the major medical procedure was immediately necessary: "to enable treatment of severe aggression whilst in an acute psychotic state, while other treatment options are considered to be causing paradoxical effects." He goes on to write:

> This form was not completed contemporaneously as the medical officer performing non psychiatric treatment was attending to other clinical responsibilities (doing night shifts, hence the oversight of notification). MHRT was, however notified of this procedure by [psychiatric registrar] on 06/12/16 with submission of Form 23 at that time.

ECT

There was little in the contemporaneous notes to indicate the basis for the decision to commence ECT on 5 December 2016. Nursing notes in ICU recorded that prior to extubation additional sedation was given after Ms AB "sat bolt upright", pointed at nursing staff with a throat slitting gesture and tried to punch nursing staff.[31] On review by the medical team in ICU after extubation on 5 December (and prior to ECT), Ms AB was described as "pleasantly confused" and "intermittently agitated."[32] ICU nursing staff later described her as:

> aggressive at times, wanting to walk around ICU and talking nonstop in language with occasional English words. Generally compliant with requests.[33]

A RATT form completed after Ms AB's return to JRU on 5 December assessed her as being at a level 2 (low) risk of suicidality and self-harm and at a level 3 ('significant' but not 'serious') risk of harm to others and vulnerability.

The RDH response stated that on 5 December 2016 Ms AB was transferred back to ICU for assessment after a Code Blue was called in JRU due to increased heart and respiratory rate, and that "the Mental Health Team requested an emergency ECT treatment for the patient, which was administered."[34]

[31] ICU notes 5/12/16 (06:05 hrs).
[32] Medical notes ICU 5/12/16 (0830hrs).
[33] ICU nursing notes 5/12/16 (written 1450 hrs re morning shift).
[34] Response provided to the HCSCC on behalf of RDH via cover letter dated 15 May 2017, sent via email 16 May 2017, p 1.

The TEMHS response to the HCSCC provided limited information about the basis of the decision to perform ECT on 5 December 2016. It stated that it was performed in accordance with the provision relating to emergency ECT treatment in s 66(3) of the MHRSA, and that "ECT is proven to be effective in quick recovery of treatment refractory psychiatric illness." [35]

Ms AB was still intubated from 5 December 2016 when ECT was performed again on 7 December 2016. In its response to the investigation, TEMHS stated:

> Extubating and withdrawing anaesthesia only to re-anaesthetise would have been increased potential for further side effects. It was also considered that [performing ECT while [Ms AB] remained intubated] would be clinically indicated in that it would assist in ensuring that distress from extubation would be minimised.[36]

There was no discussion in the progress notes of the basis for the decision to continue ECT without Ms AB regaining consciousness.

According to the TEMHS Director of Psychiatry, it "is a rare event for ECT to be given in such circumstances" and that as a result, "there is very little information in published literature about such circumstances."[37]

In relation to the ECT administered to Ms AB on 9 and 12 December 2016, TEMHS stated that treatment was again given under s66(3):

> …in order to prevent [Ms AB] suffering from serious mental or physical deterioration; and also to relieve severe distress, as deemed necessary by two APPs.[38]

TEMHS said that the Tribunal's legal member presiding on the 7 December 2016 had "commented that the Emergency ECT could continue."[39]

[35] Response provided to the HCSCC on behalf of TEMHS cover letter dated 15 May 2017, sent via email 16 May 2017 p 8.
[36] Response provided to the HCSCC on behalf of TEMHS cover letter dated 15 May 2017, sent via email 16 May 2017 p 9.
[37] Response provided to the HCSCC on behalf of TEMHS cover letter dated 15 May 2017, sent via email 16 May 2017 p11.
[38] Response provided to the HCSCC on behalf of TEMHS cover letter dated 15 May 2017, sent via email 16 May 2017 p9.
[39] Response provided to the HCSCC on behalf of TEMHS cover letter dated 15 May 2017, sent via email 16 May 2017 p9.

TEMHS stated in its response that Ms AB's family were kept informed and were part of the decision making in relation to her care. TEMHS stated that Ms AB "responded very well" to the ECT, with the treating team noting "a marked improvement in [Ms AB's] behaviour and thought processes following ECT administration."[40]

TRIBUNAL HEARINGS AND DOCUMENTATION

Ms AB was listed to appear before the Tribunal on 7 December 2016 for consideration of continued involuntary admission and ECT, however as she was unconscious at this time the Tribunal declined to proceed and adjourned the matter until 14 December 2016.[41]

MAJOR MEDICAL PROCEDURES

Documentation held by the Tribunal did not include any contemporaneous Form 23 (Medical Treatment Notification) for the intubation and ventilation of Ms AB on 2 December 2016.[42]

Recordings of the Tribunal proceedings of 7 and 14 December 2016 showed that the major medical procedures performed on 2 and 5 December 2016 were both discussed. Some confusion seemed to have arisen during the hearing of 7 December 2016, with the Legal Member indicating that the Form 23 in front of him referred to management of aspiration pneumonia (relevant to the major medical procedure performed on 5 December 2016 but not a factor on 2 December 2016).

Statements by clinical TEMHS staff at the Tribunal on 7 December 2016 indicated concern for Ms AB's wellbeing and attested to her being extremely disturbed at the time of her admission. At the same time, statements made by clinical TEMHS staff over the course of Tribunal hearings indicated that management of "behavioural disturbance" was key to decision-making in relation to intubation and ventilation,[43] and that the procedure on 2 December 2016 was performed "mainly to counter or control aggression."[44]

[40] Response provided to the HCSCC on behalf of TEMHS cover letter dated 15 May 2017, sent via email 16 May 2017 p8.
[41] HCSCC investigation included review of recordings relating to Tribunal proceedings on 7 December and 14 December 2016.
[42] See Approved Procedure 30, Major Medical Procedures, which refers to Form 23: 'Medical Treatment Application/Notification'.
[43] MHRT proceedings, 7 December 2016
[44] MHRT proceedings, 14 December 2016

The Form 23 signed by the ICU doctor on 9 May 2017, which describes the performance of a major medical procedure for "management of severe aggression as part of Acute Psychosis", was emailed to the Tribunal by the psychiatric registrar on 12 May 2017. It was accompanied by an explanation that the ICU doctor had been away and a request that the form be placed on Ms AB's file.

In relation to the major medical procedure performed on 5 December, the psychiatric registrar told the Tribunal that Ms AB had been taken back to ICU that day for intravenous antibiotics and ECT, and that the plan had been to provide treatment with sedation but without another intubation. He said that after recovery from the ECT Ms AB had become agitated and could not be managed, and that the ICU team decided that she required intubation at that stage due to the need to manage her medical condition. [45]

ECT

At the Tribunal hearing on 7 December the psychiatric consultant said that Ms AB still seemed very unwell after extubation on 5 December. He informed the Tribunal that ECT was the only safe option for treatment of Ms AB's psychiatric symptoms and had been performed on this basis.[46]

At the hearing of 7 December 2016 there was discussion of the fact that Ms AB was unconscious and could not be notified of the hearing or give instructions to a legal representative. The request that the Tribunal approve ongoing ECT was not dealt with formally on that day, although the presiding legal member did proffer an opinion that the practitioners were not restricted from relying on emergency provisions again. The matter was adjourned to 14 December 2016.[47]

ECT was administered on 9 December and 12 December 2016. A Form 28 notifying the Tribunal of all four episodes of ECT, justified on an emergency basis, was presented at the next hearing on 14 December 2016. This listed the dates and times of the ECT treatments already performed rather than dealing separately with each 'emergency' episode of ECT.

[45] MHRT proceedings, 14 December 2016.
[46] MHRT proceedings, 7 December 2016.
[47] MHRT proceedings, 7 December 2016.

Concerns about this approach were raised by the Tribunal.[48] A Form 27 applying for approval to administer ECT was also submitted, though no number of treatments was specified in the application. The Tribunal approved a further course of up to eight ECT treatments.[49]

ECT PRACTICE GUIDELINES

Practice guidelines from the Northern Territory and other Australian jurisdictions do not contemplate a situation in which a patient does not regain consciousness in between each episode of ECT.[50] The Royal Australian and New Zealand College of Psychiatrists' guidelines on the use of ECT state: "The patient must be reviewed **after each ECT treatment** by a medical officer, who should assess the efficacy of treatment and any adverse events, especially delirium."[51]

EXPERT OPINIONS

PROFESSOR TILLER

MAJOR MEDICAL PROCEDURE – INTUBATION AND VENTILATION 2 DECEMBER 2016

When giving his opinion on the performance of ECT, Professor Tiller also commented on clinical management of Ms AB prior to, and during her admission from 1 December 2016. Professor Tiller states:

> The decision to intubate and sedate the patient with propofol, fentanyl and dexmedetomidine, while waiting for other medications to wash out or be metabolised, in my opinion, seemed very appropriate given the history and progress to that time, of this acutely disturbed patient.[52]

[48] MHRT proceedings, 14 December 2016.
[49] Proceedings of the MHRT, 14 December 2016.
[50] See eg ECT Practice NTMHS Acceptable Standards p 38 Queensland Government – 'The Administration of ECT' 2018 p 22
[51] Royal Australian and New Zealand College of Psychiatrists Clinical Memorandum #12 Electroconvulsive Therapy – Guidelines on the administration of electroconvulsive therapy (ECT), para 5.2.1, emphasis added.
[52] Expert opinion by Prof JWG Tiller, p 8 (Appendix B)

When concluding his report, Professor Tiller stated:

> … Acutely disturbed behaviour coupled with a high level of aggression and difficulty in safely containing the patient in a transport setting, or in hospital, appeared to necessitate substantial sedation requiring management in an ICU. Her behaviour required unusual levels of containment and sedation to provide a safe environment in which she could be treated.
>
> She had not responded adequately to anti-psychosis pharmacotherapy, and her reported behaviour presented a substantial risk to her own life, safety and welfare, as well as the safety of others.[53]

ECT

Professor Tiller was asked to comment on the ECT performed on 5 December 2016 and 7 December 2016. He had no concerns about that the way in which ECT was administered on each occasion (eg in relation to the doses applied and method of administration).

> [Ms AB] appears to have had very appropriate treatment using an ECT technique that is likely to be effective while at the same time minimising the risk of cognitive adverse events that could occur with bitemporal treatment.[54]

In relation to the initial decision to use ECT, Professor Tiller stated:

> The choice of ECT is very appropriate for someone who has a severe bipolar disorder with mania, depression, or a mixed state or psychosis, or for schizophrenia. It can be particularly effective in circumstances where pharmacotherapy is proving inadequate and the patient's behaviour, presumably influenced by virtue of their illness and possibly complicated by personal style and/or the effects of illicit substances, is exposing the patient, staff, or others to significant risk of their safety, welfare or lives.
>
> In this context, in my opinion ECT can be life-saving. It is also providing additional effective treatment when established pharmacotherapy had been manifestly inadequate to help treat the patient.[55]

[53] Expert opinion by Prof JWG Tiller, pp 21 – 22.
[54] Expert opinion by Prof JWG Tiller, p 17 p 12.
[55] Expert opinion by Prof JWG Tiller, p 17.

Professor Tiller explained that before considering ECT, the patient should be engaged in the process. He stated that the administration of ECT on **5 December 2016** was:

> … entirely appropriate in these particular clinical circumstances. The situation was unusual, and one which most psychiatrists, even those who have a specialised interest in ECT, would rarely if ever encounter in their practice lifetime. In the circumstances, in my opinion the psychiatrist have acted in what they had assessed as the best interests of the patient, utilising their clinical judgement, and trying to optimise treatment for a very ill patient in extraordinarily unusual and challenging circumstances. In my opinion this was very reasonable care and treatment.[56]

With respect to the administration of ECT on **7 December 2016** without Ms AB having regained consciousness, Professor Tiller stated that, in his opinion: "… it is desirable to have the patient awake and responsive to evaluate their status between each ECT treatment.[57] He said that it was a "very unusual circumstance" for a patient to be "so disturbed in behaviour and ill with psychosis that any reduction in sedation to the degree that would allow a normal pre-ECT evaluation would result in the potential for significant harm for the patient or others."[58] He stated that:

> I take it from the clinical records that it was regarded as inappropriate or unsafe for the patient's level of sedation to be reduced after the first ECT treatment. In those circumstances on clinical grounds it would appear reasonable to continue ECT treatment to the point or extent where some clinical improvement is likely to have been achieved.[59]

Professor Tiller stated that occasionally a single treatment can result in "discernible improvement", but that it is common that improvement only becomes apparent after the 4th to 8th treatment. He stated that in general, treating a patient to full recovery typically involves between 10 and 15 treatments[60].

PROFESSOR MCSHERRY

Professor McSherry was asked to comment on various aspects of Ms AB's patient journey, including issues of consent, sedation, ECT and documentation.

[56] Expert opinion by Prof JWG Tiller, p19
[57] Expert opinion by Prof JWG Tiller, p18
[58] Expert opinion by Prof JWG Tiller, p 15
[59] Expert opinion by Prof JWG Tiller, pp 22
[60] Expert opinion by Prof J Tiller p 12.

MAJOR MEDICAL PROCEDURES

In relation to major medical procedures, Professor McSherry advised that the term "immediately necessary" used in s 64(3) of the MHRSA:

> reflect(s) the common law doctrine of necessity being a justification for what would otherwise be unlawful action. The case law on the defence of necessity in criminal law refers to the doctrine relating to an extraordinary situation. In medical situations, Fryberg J referred to the "requirement of immediacy" as being "quite critical".[61]

With respect to the intubation and ventilation performed on 2 December 2016, Professor McSherry said that her view of the evidence available was that the requirements of s 64 of the MHRSA were not met in relation to performance of a major medical procedure without consent or Tribunal approval. Professor McSherry stated that:

> The weight of evidence is that the major medical procedure was performed to manage Ms AB's aggressive behaviour rather than being immediately necessary to save her life or to prevent irreparable harm to her as specified under section 64(3).[62]

In relation to the immediate necessity of the procedure, Professor McSherry stated that there was, in her view, a lack of evidence to support this conclusion, and that there was no evidence that other options for managing aggression had been considered. With regard to the requirement that the major medical procedure be immediately necessary to prevent irreparable harm to Ms AB, again Professor McSherry stated that she was unable to find any reference in clinical notes to the risk of this level of potential harm.

Professor McSherry stated:

> It is difficult to understand how this major medical procedure could be immediately necessary to save [Ms AB's] life or to prevent irreparable harm to her…In the TEMHS's response to the complaint, there is reference to the treating team being 'extremely concerned about [Ms AB's] physical wellbeing'. However, I cannot find any reference in the notes to a risk of **irreparable** harm and the immediate necessity to prevent this.[63]

[61] [2012] QSC 65 [14] (see expert opinion by Prof B McSherry, p 7).
[62] Expert opinion by Prof B McSherry, para 38.
[63] Expert opinion by Prof B McSherry, p7.

Professor McSherry advised that unnecessarily subjecting Ms AB to a major medical procedure without consent was a:

> …breach of statutory duty as well as breaching the human rights set out in the Convention of on the Rights of Persons with Disabilities, particularly the right to liberty, the right to physical and mental integrity and the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.[64]

Professor McSherry stated that performing a major medical procedure outside the scope of the Act is "technically" an assault, although "in practice, it is unlikely that a criminal charge would be laid." She also expressed a view that there was potential for civil action on the basis of trespass to the person,[65] "and possibly false imprisonment (if the major medical procedure is interpreted as a total and direct restraint on her liberty)."[66]

In relation to the major medical procedure performed on 2 December 2016, Professor McSherry noted that the first object of the MHRSA is "to provide for the care, treatment and protection of people with mental illness *while at the same time protecting their civil rights* [emphasis added]." She expressed the view "that it would seem that Ms AB's rights were not given much weight at all in relation to this episode of treatment."[67]

Professor McSherry expressed the view that the episode of intubation and ventilation on 5 December 2016 "appears to have been performed for medical reasons" and would "seem to have been immediately necessary to save Ms AB's life or to prevent irreparable harm." She concluded that performance of this procedure therefore fell within the scope of s 64 of the MHRSA.[68]

[64] Expert opinion by Prof B McSherry, p 9.
[65] The tort of trespass to the person relates to unauthorised interference with a person's body. It is actionable when the interference occurs, without the need for the claimant to establish damage (see https://www.alrc.gov.au/publications/3-overview-current-law/existing-common-law-causes-action).
[66] Expert opinion by Prof B McSherry, pp 9-10.
[67] Expert opinion by Prof B McSherry, p 14; see s 3(a) of MHRSA.
[68] Expert opinion by Prof B McSherry, p 11-12.

SEDATION/RESTRAINT

Professor McSherry was asked to give her opinion on whether the intubation and ventilation of Ms AB on 2 December 2016 constituted chemical restraint. Noting that such restraint is not covered in the MHRSA, Professor McSherry was of the view that it would have met this threshold in other jurisdictions.[69]

ECT

When considering the ECT performed on Ms AB, Professor McSherry noted that ECT "remains a controversial treatment", and quoted literature which stated that this was the case "particularly because of still unknown mechanism of action and uncertainty about cognitive side effects."[70] As she explains, the use of ECT has been considered in other Australian jurisdictions, with the Supreme Court in Victoria recently quashing orders from the Victorian Mental Health Tribunal approving ECT for two involuntary patients. Professor McSherry stated that:

> The Supreme Court decision was reached on the basis that the patients' views and preferences were not given due consideration and that such views must be taken into account even when patients are considered to lack the capacity to give informed consent.[71] Justice Bell in that case relied on human rights considerations in reaching his decision. [72]

Professor McSherry also explained that this decision by the Supreme Court of Victoria "indicates that capacity to consent is specific to each decision that is to be made."[73]

Professor McSherry's view was that there was no clear justification in the clinical notes for the use of ECT on 5 December 2016, saying that while it could be argued that ECT was required on that date to "relieve severe distress under s 66(3)(c), […] why this was immediately necessary because of extraordinary circumstances is not documented."[74]

[69] Expert opinion by Prof B McSherry, pp 12-13
[70] Dusan Kolar "Current Status of Electroconvulsive Therapy for Mood Disorders: A Clinical Review" (107) 20(1) *Evid Based Mental Health* 12-14 at 13, as cited in McSherry B, Expert Report, Investigation 2018/0006, p 15.
[71] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, as cited in McSherry B, Expert Report, Investigation 2018/0006.
[72] Expert opinion by Prof B McSherry, para 89.
[73] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564, as cited in McSherry B, Expert Report, Investigation 2018/0006, p 18.
[74] Expert opinion by Prof B McSherry, p 16.

Professor McSherry noted that Ms AB had not regained consciousness between the ECT performed on 7 December 2016 and the previous ECT. Her view was that "it is unclear why ECT was considered immediately necessary given Ms AB was still unconscious."[75]

Professor McSherry considered TEMHS' statement that extubating and withdrawing anaesthesia for assessment, and then re-anaesthetising for ECT would have increased the potential for side-effects. She concluded that this "ignores [the] guidelines and the need to protect Ms AB's rights under the processes set out in the MHRSA."[76]

In relation to ECTs administered on 9 December and 12 December 2016, Professor McSherry stated that when TEMHS practitioners sought a view from the Tribunal on 7 December 2016 as to whether they could perform further ECT the Legal Member indicated that emergency provisions could potentially be relied upon. She stated that it was clear from the fact that the hearing was adjourned that no formal approval had been given for further ECT.[77]

Professor McSherry told HCSCC that in her view the ECT administered on 9 and 12 December 2016 seemed "… to have been performed as a course of treatment rather than because of any extraordinary circumstance. The requirements of s 66(3) were therefore not satisfied."[78]

From a legal perspective, Professor McSherry expressed the view that "the weight of evidence is that Ms AB was unnecessarily subjected to ECT without consent" and that there was a breach of statutory duty on four occasions. She said that the events gave rise to possible civil actions in trespass for each episode of ECT and negligence in relation to the first two episodes (which were combined with intubation and ventilation), as well as constituting 'technical' assault (though of a kind unlikely to be prosecuted). Professor McSherry further commented that "[t]he episode of ECT on 7 December also raises a question as to whether the right to freedom from inhuman or degrading treatment was breached."[79]

[75] Expert opinion Prof B McSherry, para 92.
[76] Expert opinion Prof B McSherry, para 91.
[77] Expert opinion Prof B McSherry, p 15.
[78] Expert opinion Prof B McSherry para 92.
[79] Expert opinion by Prof B McSherry, p 17.

Professor McSherry was also asked to comment on the Approved Procedures relating to the use of ECT in the Northern Territory. Professor McSherry raised concerns about the statement in the Approved Procedures that "by definition an involuntary patient is not capable of giving informed consent to ECT," explaining that this was out of step with recent Victorian case law.

Professor McSherry also commented that "the practice of setting all ECT for 8am on Monday, Wednesday and Fridays 'with or without the approval of the Tribunal' seems to go against the notion of emergency ECT under s 66." Noting that the Tribunal sits from 9.30am on Wednesday (in Darwin) and Friday (in Alice Springs), she stated that the requirement for ECT to occur prior to respective Tribunal hearings at 9.30am "raises procedural fairness issues."[80]

RESPONSES TO THE DRAFT INVESTIGATION REPORTS

Interested parties were given an opportunity to read and provide comments on draft reports at two points during the investigation process. Some additional information and comment drawn from the feedback provided is set out below, in accordance with natural justice obligations under s 67 of the Act or where it has been drawn upon in finalising the report.

Ms AB/NTLAC

Ms AB was of the view that the finalised report should be provided to the Minister and Legislative Assembly and indicated through her representatives that she "would like to make sure that the NT government does everything possible to make sure that what happened to her does not happen again to her or anyone else." NTLAC advised that while Ms AB wanted steps taken to de-identify any public version of the report, she wanted it to be clear that she is a young Aboriginal woman from a remote community and does not speak English as her first language.[81] NTLAC explained that "Ms AB continues to have to take daily medication as a result of what happened to her" during this hospital admission.[82]

[80] Expert opinion Prof B McSherry, p 18.
[81] Letter from NTLAC, 21 March 2019, p 1.
[82] Letter from NTLAC, 21 March 2019, p 1.

DEPARTMENT OF HEALTH

DoH's response incorporated a response on behalf of TEHS/TEMHS. DoH advised that TEHS had commissioned an independent review of the matter by Professor Matthew Large. Professor Large is Conjoint Professor at School of Psychiatry UNSW and Clinical Director of Mental Health Services, Prince of Wales Hospital. DoH asked the HCSCC to take Professor Large's report into consideration when finalising the investigation report.[83]

MAJOR MEDICAL PROCEDURE – 2 DECEMBER 2016

Professor Large disagreed with Professor McSherry's view that there were issues with the legality of this episode of treatment. Professor Large said that Professor McSherry had not considered all the relevant facts involved in the decision to perform this major medical procedure, specifically that:

- Notes of the previous inpatient admission of Ms AB "should have led to the conclusion that Ms AB had a highly treatment resistant psychosis" and "a level of aggression that is highly unusual even in a psychiatric ward."[84]

- On presentation at the community clinic Ms AB had "life threatening" complications of hyponatremia and hypokalaemia which were likely to be the result of her drinking excessive water as a result of her psychotic illness,[85] though she was not hyponatremic or hypokalaemic on 2 December 2016 prior to intubation and ventilation.[86] Professor Large said that it was not the case that a patient would ever be intubated to treat hyponatremia or hypokalaemia but said that the presence of "serious electrolyte abnormalities" on presentation at the community clinic indicated that Ms AB had a potentially life-threatening condition if her psychosis was left untreated.[87]

[83] Letter from DoH to HCSCC, 22 June 2019.
[84] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 3.
[85] Hyponatremia occurs when the amount of sodium in the blood is lower than normal, and is often caused by excessive fluids; hypokalaemia occurs where there is an abnormally low level of potassium in the blood serum.
[86] Letter from Prof Matthew Large to HCSCC, 4 July 2019, send by DoH under cover letter of 15 July 2019.
[87] Letter from Prof Matthew Large, 4 July 2019, sent by DoH to HCSCC under cover letter of 15 July 2019.

- Ms AB had an elevated creatine kinase (CK) level, consistent with neuroleptic malignant syndrome (NMS).[88] He said that while this is not in itself a reliable indicator of NMS, the decision not to treat Ms AB with further antipsychotics after her CK level was found to be elevated "was the correct peer acceptable practice."[89]

- On 2 December 2016 Ms AB had ongoing acute behavioural disturbance despite administration of a total of 30mg diazepam orally and 20 mg of midazolam intramuscularly.[90]

Professor Large expressed the view that on 2 December 2016 the treatment team:

> …had no reasonable therapeutic options…other than an admission to ICU for life support (intubation and ventilation) in ICU. It was not reasonable to prescribe further antipsychotic medication because [Ms AB] had evidence of neuroleptic malignant syndrome. [Ms AB] had already been given the most extreme doses of benzodiazepines imaginable…without being on life support. Specifically, it would not have been reasonable on 2 December 2016 to place her in a seclusion room without any prospect of actual treatment for her psychosis.[91]

Professor Large said that he rejected any suggestion that Ms AB received inhuman and degrading treatment and that in his view it "would have been inhuman and degrading to place [Ms AB] in seclusion without treatment" which was "the only other conceivable option on 2 December 2016."[92]

[88] Creatine kinase is an enzyme expressed by a range of cell and tissue types. High CK in the blood may be an indication of various conditions including neuroleptic malignant syndrome, a condition that can occur in response to antipsychotic (neuroleptic) medication and which can be life-threatening.
[89] Letter from Prof Matthew Large, 4 July 2019, sent by DoH to HCSCC under cover letter of 15 July 2019.
[90] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 3.
[91] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 3.
[92] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 6.

Professor Large went on to say:

> If [Ms AB] had been left on the psychiatric ward it is highly likely that she would have suffered irreparable harm as a result of her aggression and psychosis. Patients with extreme levels of aggression can and do injure themselves irreparably due to aggression. Head banging and finger injuries due to punching walls are common but more serious even fatal self-injuries are possible. Further, the greater risk faced by [Ms AB] was that other patients who are also aggressive would assault her. This sort of provoked aggression between patients can cause also permanent injuries of a variety of forms, including head injuries and most commonly orbital injuries. The prevention of patient-on-patient violence is the main reason for sedation on psychiatric wards and aggressive patients are very much more likely to be assaulted than non-aggressive patients.[93]

Professor Large cited a study which he conducted in which it was estimated that the global incidence per admission of violence in psychiatric wards is 17%, and explains that in his view "this figure would be very much higher for [Ms AB] and even more so if she remained untreated."[94]

Professor Large further stated:

> Untreated psychosis of an extreme variety also has a direct mortality, the cause of which is not known. This was no theoretical risk. [Ms AB] had already had a life-threatening electrolyte disturbance as a result of her psychosis at the point of presentation.
>
> To leave [Ms AB] in a state of extreme psychosis would in my view have been a grave medical error with a very high likelihood of serious and irreparable harm and possibly even death.[95]

Further information was sought regarding the description of a direct mortality effect of untreated psychosis. Professor Large stated:

> Much of the literature about the lethality of untreated psychosis is historic because it is simply not ethical not to treat a highly agitated patient with psychosis. There are a number of terms for this used in the literature, historically malignant catatonia and more recently excited delirium syndrome.[96]

[93] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, pp 3-4.
[94] Iozzino L, Ferrari C, Large M, Neilssen O, de Girolamo G, Prevalence and Risk Factors of Violence by Psychiatric Acute Inpatients: A Systematic Review and Meta-Analysis. PLoS One. 2017 Jun 10:10(6): e0128536.
[95] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 4.
[96] Letter from Prof Matthew Large, 4 July 2019, sent by DoH to HCSCC under cover letter of 15 July 2019, p 5.

Professor Large provided two articles related to these conditions. The first describes the condition of 'malignant catatonia'.[97] It states that catatonia may progress from 'simple' to 'malignant' (potentially lethal), and suggests that the term 'malignant' can be applied when "autonomic instability or hyperthermia develops."[98] The second article includes description of Excited Delirium Syndrome, and says that it "[w]hile not recognized as a psychiatric diagnosis, ExDS is an official cause of death in forensic medicine." This syndrome is described as featuring symptoms of hyperthermia and profuse sweating.[99]

Professor Large concluded that involvement of the ICU team by TEMHS indicated that Ms AB's condition was life threatening as "ICU teams are the doctors who are most familiar with life threatening conditions and they do not admit people to ICU who are not in a life threatening position."[100]

ECT – 5 AND 7 DECEMBER 2016

Professor Large expressed the view that "urgent" ECT was justified on 5 and 7 December 2016. He said that there is a "strong argument that ECT should be instituted as soon as possible once a patient is on life support" in ICU, noting that "[l]ife support has its own severe risks including death and should be kept to a minimum duration."[101] He said that it would have been better for ECT to have commenced on 3 December 2016 but that he understood the plan was for extubation and transfer of Ms AB to a psychiatric ward and for authorisation to be sought from the Tribunal. He said that when Ms AB was returned to ICU for medical reasons on 5 December 2016 she still needed treatment for severe psychosis, "and ECT was really the only available treatment option." He said that in his view "the exact timing of the initiation of ECT would be a matter of some professional judgement" but that in his view it should have been started "as soon as possible and no later than 6 December 2016."[102]

[97] Philbrick KL1, Rummans TA, 'Malignant Catatonia', J Neuropsychiatry Clin Neurosci, 1994 Winter; 6(1): 1-13.
[98] Autonomic instability involves variable activity of the autonomic nervous system (which controls aspects such as blood pressure and breathing rate). Hyperthermia is a condition where an individual's body temperature is elevated beyond normal due to failed thermoregulation.
[99] Diaphoresis.
[100] Letter from Prof Matthew Large, 4 July 2019, sent by DoH to HCSCC under cover letter of 15 July 2019, p 7.
[101] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 4.
[102] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 5.

Professor Large went on to say that once ECT had commenced "it was necessary to give more than one ECT treatment." He said that with very few exceptions all patients he has treated or witnessed having ECT required four or more treatments. He said that in his view:

> [i]t would simply not have been rational to give [Ms AB] a single treatment and then remove her from life support in the hope a single treatment would have been successful. I am of the option that the ECT treatments given to [Ms AB] were necessary emergency treatment for her life and safety from irreparable harm. [103]

ECT – 9 AND 12 DECEMBER 2016

Professor Large said that he thought doctors "made the correct call to continue ECT on medical grounds on 9 and 12 December 2016, despite the failure of the mental health review tribunal to make a determination about consent."[104]

DOCUMENTATION

Professor Large said that he disagrees with Professor McSherry's view that the medical record was inadequate to understand what happened and why. He went on to state:

> It is a general feature of medical records that the reasoning behind decisions is not necessarily well documented and it sometimes falls to a medical expert to interpret the notes in legal settings. A simple example of the lack of documented medical explanation is that a doctor would never document that an appendectomy was performed to prevent peritonitis. This lack of documentation [of] the medical reasoning is often greater when the decisions are more complex. While arguably doctors should explain their reasoning a little more in their notes, any increase in explanatory documentation would come at the expense of patient care and could never be adequate to explain medical treatment fully to a non-medical reader.[105]

[103] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 5.
[104] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 5
[105] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, pp 5-6.

MENTAL HEALTH REVIEW TRIBUNAL

The President of the Tribunal provided a response to the draft investigation report. He advised that in his opinion, application of a Victorian Supreme Court decision cited by Professor McSherry (which said that patients' views about ECT need to be taken into account even where they are thought to lack capacity to give informed consent) is uncertain in the NT.[106]

In relation to performance of ECT shortly before the Tribunal is scheduled to consider a patient's case, the President emphasised that this could only be done legally "within the very constrained circumstances identified in s 66(3)". He explained that an application for Tribunal approval could be made at any of the three sittings which are scheduled each week, though the Tribunal currently does not conduct telephone hearings.

The President stated that none of his feedback "should be taken to suggest that questions of capacity to give informed consent under the MHRS Act (whether in respect of ECT or other forms of treatment) should be viewed otherwise than against the background of the very significant interferences with personal liberties that are involved in any form of involuntary treatment."

[106] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564. Several reasons were provided by the President, as follows:

- Differences between Victorian and NT mental health legislation in relation to definitions of capacity and consent:
  - s 68 of the *Mental Health Act 2014* (Vic) defines a test for capacity to give consent; whereas the MRSA provides a definition of informed consent but not 'capacity' (see s 7).
  - The decision stated that there is a 'low threshold' for capacity in the Victorian legislation, but as NT legislation does not define 'capacity' it is not clear that there is a similarly low threshold in the NT.
  - The Court found that though both patients lacked insight into their mental illness this did not mean they lacked capacity to consent to ECT. Evidence of 'lack of insight' is likely to carry greater weight in considering whether a patient is capable of giving consent as defined by s7(2) of the MHRSA.
- The approach of the Victorian Supreme Court being affected by the requirements of the Victorian Charter of Human Rights and Responsibilities, for which the NT does not have an equivalent.

DISCUSSION

Ms AB was very unwell when she arrived in Darwin on 1 December 2016. Practitioners held clear concerns about the ketamine administered to her en route. I accept that this was a difficult situation for Ms AB, her family, and the clinicians involved in her care. All parties accept that intubation and ventilation of Ms AB on 2 and 5 December 2016 constituted major medical procedures under the terms of the MHRSA and that these procedures were performed without authorisation from the Tribunal. Parties also agree that the episodes of ECT carried out on 5 and 7 December 2016 were carried out without the authorisation of the Tribunal and rely for their legality on the emergency provision in s 66(3) of the MHRSA.

MAJOR MEDICAL PROCEDURES

INTUBATION AND VENTILATION - 2 DECEMBER 2016

I am not convinced that the intubation and ventilation performed on 2 December 2016 was undertaken in line with the requirements of s 64(3) of the MHRSA in terms of being immediately necessary to save life or prevent irreparable harm and thus able to be legally performed by medical practitioners without consent or approval. In considering this issue I am guided by Professor McSherry's advice regarding the relevant legal standard. The opinions provided by Professor Tiller and Professor Large do not change my conclusion, for reasons set out below.

Professor Tiller stated that when the decision was made to intubate and ventilate Ms AB she was "a substantial threat to staff and others".[107] As Professor McSherry's report explained, a risk to other persons does not constitute a legal basis for major medical procedures to be performed without consent under s 64(3). The only risk which is of relevance is the risk to the person upon whom the procedure is being performed without consent, and this must be an imminent risk of death or irreparable harm.

[107] Expert opinion by Prof JWG Tiller, p9, emphasis added.

Professor Large stated that there were medical reasons which meant that intubation and ventilation was immediately necessary within the meaning of s64(3).

The service has explained that antipsychotics were thought to be an unsafe treatment for Ms AB at that time due to concerns about NMS. Professor Large expressed the view that electrolyte disturbances which had been present when Ms AB presented at the community clinic showed that she had a potentially life threatening condition if her psychosis was left untreated.

There is no question that Ms AB's psychotic illness required treatment. The area of doubt is whether on 2 December 2016 she met the threshold for the major medical procedure of intubation and ventilation to be performed without consent or Tribunal authorisation, on the basis that this was immediately necessary to save her life or prevent her from suffering irreparable harm.

Three types of risk were described by Professor Large as existing for Ms AB on 2 December 2016: a direct mortality risk created by her psychotic illness; a risk of self-harm; and a risk of harm from other patients. For the reasons outlined below, I am not persuaded that any of these risks created a basis upon which the performance of intubation and ventilation was justified on an emergency basis under s 64(3) of the MHRSA.

DIRECT MORTALITY RISK OF PSYCHOSIS

Professor Large argued that untreated psychosis of an extreme kind can have a direct mortality effect, the cause of which is not known. The articles which he cited provide limited evidence of such a risk, and describe symptoms of hyperthermia, profuse sweating and autonomic instability in reviews of the literature which exists relating to such cases. Medical concerns of this nature were not cited in the medical record or the forms presented to the Tribunal explaining the rationale for this procedure. Intubation and ventilation was not a treatment for Ms AB's psychotic illness. Rather, the TEMHS discharge summary says that Ms AB was intubated and ventilated to allow metabolism of medications while psychiatric treatment options were considered. The ICU summary provides a similar rationale. It is not clear why alternative approaches for allowing metabolism of medications by an aggressive patient (eg seclusion) could not have been attempted until the proposed major medical procedure could be considered by the Tribunal.

While I note the submission made by TEMHS regarding the avoidance of mechanical restraint, management by intubation and ventilation carries its own risks of harm which must be weighed against the harm which might result from acutely disturbed behaviour. Professor Large drew attention to the fact that being placed on life support has significant risks, including death; and it is clear that this course of action resulted in serious adverse medical outcomes for Ms AB.

RISK OF SELF-HARM

In relation to the risk of self-harm, Professor Large said that patients with extreme levels of aggression can cause themselves irreparable harm, and mentioned head banging and finger injuries as specific risks. However on 1 December 2016 and 2 December 2016 Ms AB was assessed as level '4' (serious risk) of self-harm, not a level '5' (indicating an extreme and imminent level of risk).

RISK OF HARM FROM OTHER PATIENTS

I am concerned that the potential for a patient's behaviour to trigger reactions in other people could be regarded as grounds to render them unconscious and place them on life support (and beyond this, to do so without consent or Tribunal authorisation). Other approaches (involving separation and supervision of patients in an inpatient unit) seem to be available to reduce these risks. Again, it is relevant that Ms AB was assessed as having a "serious" but not "extreme and imminent" level of vulnerability prior to the performance of this major medical procedure.

In relation to the risks of self-harm and harm from other patients, the decision to act on an emergency basis meant that the Tribunal did not have opportunity to weigh these risks against the significant risks created by intubation and ventilation. As has been explained, serious adverse outcomes were experienced by Ms AB; outcomes which continue to impact on her health.

CONCLUSION - INTUBATION AND VENTILATION - 2 DECEMBER 2016

On review of the evidence it appears that Ms AB was intubated and ventilated on 2 December 2016 primarily in order to manage her aggression, rather than on a basis which satisfied the requirements for emergency performance of a major medical procedure under s 64(3).

There were clear inadequacies in the documentation relating to this episode of care, which undermined the protection of Ms AB's rights. The MHRSA requires that the practitioner who authorises the performance of a major medical procedure under s 64(3) notify the Tribunal of the performance of the procedure no later than one day after it is performed. In the case of the intubation and ventilation carried out on 2 December 2016 this requirement was not complied with.

Issues with completion of the Form 23 after the performance of this major medical procedure created significant confusion. By the time a Form 23 was signed by the psychiatric registrar on 6 December 2016 a second major medical procedure had been performed, and information on the form reflected the events of this second episode. A Form 23 which provided detail solely about the major medical procedure carried out on 2 December 2016 (indicating that it was performed to control aggression and not for reasons linked to aspiration) was not submitted to the Tribunal until May 2017.

The form signed on 6 December 2016 was prepared as an 'application' as well as a 'notification', despite the fact that the events had already taken place. This demonstrated that clinicians involved did not understand the process of interaction with the Tribunal. It indicates confusion about whether the Tribunal can give retrospective 'approval' in relation to major medical procedures which have already been performed; something which is not provided for in the MHRSA or consistent with the level of protection in relation to such procedures indicated by s 64(3) and (4).

In considering the material provided by the service I have noted that the relevant Approved Procedure incorrectly sets out the requirements of the section, stating merely that the notification should occur "as soon as practicable" rather than "no later than one day" after performance of the procedure as is required by the MHRSA. It is imperative that patient rights are adequately protected, and this can only happen if proper processes are followed.

INTUBATION AND VENTILATION - 5 DECEMBER 2016

Ms AB was intubated and ventilated again on 5 December 2016. The reasons for this action included medical concern about pneumonia. On the evidence available to this investigation I do not have significant concerns regarding this episode, though it is clear that there was again confusion between the practitioners as to which parts of the Form 23 were relevant, with both the 'application' and 'notification' sections being completed.

SEDATION/RESTRAINT

As Professor McSherry noted in her report, if carried out in various other Australian jurisdictions the actions undertaken on 2 December 2016 would constitute chemical restraint. There is a clear gap in Northern Territory legislation, mentioned in previous reports from this office, of a regime to regulate use of such restraint. Regulation might ensure that if chemical restraint is to be used, it is done transparently, with appropriate protections, and only if less restrictive alternatives have been exhausted.

I recognise that there are times when it may be necessary to use a restrictive intervention such as chemical restraint for the protection of the person and/or others. However, without clear legislative guidance on how it can and should be used in the mental health context in the Northern Territory, chemical restraint is an area that is fraught for both patient and practitioner.

ECT

ECT - 5 DECEMBER 2016

STANDARD OF CARE

Professor Tiller concluded that the way in which ECT was performed was appropriate in terms of dosing, method of application and other aspects of how the treatment was delivered. He states that treatment "did depart from the normal standards of care in that you would normally want to administer ECT when you have the opportunity to undertake a more detailed evaluation of the patient's status before ECT…".[108]

[108] Expert opinion by Prof J Tiller p 20.

Professor Tiller concluded that the decision to perform ECT was a reasonable one on the basis of a clinical situation which he describes as "extraordinary".[109] It is reassuring that in his view the treating clinicians administered ECT in a manner likely to minimise adverse cognitive events and was more likely than some other techniques to produce a beneficial therapeutic outcome.[110]

LEGAL AND RIGHTS ISSUES

A separate question for this investigation is whether ECT performed on 5 December 2016 met the threshold for performance on an emergency basis under s 66 of the MHRSA. As has been outlined, this is only permitted where two approved psychiatric practitioners are satisfied that it is immediately necessary to save a person's life, to prevent serious mental or physical deterioration, or to relieve severe distress (s 66(3)).

Professor McSherry stated that she was unable to find any clear justification in the notes for the emergency use of ECT, particularly given that Ms AB had been returned to ICU for medical reasons. She noted that the case law dealing with the provision of treatment without consent on the basis of necessity relates to extraordinary situations with the requirement of immediacy being regarded as "quite critical." She said that while it might be argued that ECT was required to relieve severe distress under s 66(3)(c), "why this was immediately necessary because of extraordinary circumstances is not documented."[111]

It should be stressed that in my considerations I have not been assisted by the clinical notes. The clinical documentation relating to ECT given to Ms AB on 5 December 2016 did not clearly indicate practitioners' decision-making, factors taken into account in discarding other clinical options, or level of consultation with other practitioners or family. While the forms completed for the Tribunal contained a greater level of detail, they are not the primary source of evidence and in the event of any inconsistency it is likely that contemporaneous clinical notes would be preferred. To obtain a clearer picture of these events it was necessary to review Tribunal proceedings, in which psychiatric staff indicated that Ms AB had appeared to remain psychiatrically unwell after extubation and that when medical symptoms developed they decided that sedation and administration of medication and ECT was the safest treatment pathway.[112]

[109] Expert opinion by Prof J Tiller p 12.
[110] Expert opinion by Prof J Tiller p 12.
[111] Expert opinion Prof B McSherry, p 16.
[112] MHRT proceedings, 7 December 2016.

Professor Large expressed the view that “urgent” ECT was justified on 5 December 2016. He said that ECT was the appropriate treatment and that it was advisable for it to be instituted as soon as possible once Ms AB was on life support. He noted that ECT was not performed during the first period of intubation and ventilation. He said that after Ms AB was returned to ICU for medical reasons on 5 December 2016 her psychosis still required treatment, that ECT was the only available therapeutic option and that it should have been commenced as soon as possible, and no later than 6 December 2016.

Questions remain for me as to the urgency of ECT on this occasion. After extubation and before ECT was administered Ms AB had been described in ICU notes as “pleasantly confused” and “generally compliant with requests,” and she was assessed as at low risk of harm to herself and medium risk of harm to others on her return to JRU. The Form 27 provided to the Tribunal and notes in the medical record indicate that the plan had been for Ms AB’s care to be managed without further psychotropic medications via one-to-one care and behavioural management strategies, with an application being made to the Tribunal for ECT approval. There is nothing in the record to indicate that an approach of this kind would not have been adequate after her medical needs were addressed following the Code Blue. It is noted that ECT was performed prior to Ms AB being placed on life support on 5 December 2016, so the issues raised by Professor Large about commencing ECT as soon as possible after Ms AB was placed on life support do not appear of direct relevance.

My ability to consider the legality of ECT in this situation is impeded by the limitations of the medical record. Tribunal proceedings indicated that clinicians thought ECT combined with medical treatment under sedation was the safest treatment option at that time. This view is also expressed by Professor Tiller and Professor Large. Despite the queries outlined above, it seems possible that the psychiatrists involved were satisfied the treatment was immediately necessary within the scope of s 66(3). I do not feel able to draw a conclusion as to whether or not this episode met the threshold required by s 66 of the MHRSA, but would urge the health service to reflect closely on this episode of care.

ECT - 7 DECEMBER 2016

STANDARD OF CARE

Professor Tiller concluded that ECT was performed to a reasonable standard on 7 December 2019. He stated that while it is desirable to have the patient awake and responsive to evaluate their status between each ECT treatment, there may be very unusual circumstances in which the patient being awake could result in severe compromise of their clinical status or a create significant risk to others.

In Professor Tiller's opinion, an assessment of this kind could well have been made in Ms AB's particular circumstances. He therefore regarded the decision to perform ECT on 7 December 2016 without the opportunity to evaluate Ms AB to be appropriate.

The notion that it is desirable for the patient to be awake and responsive between sessions is reflected in the RANZCP ECT guidelines. The Director of Psychiatry for TEMHS has indicated that it is rare for ECT to be given in such circumstances and that there is therefore very little information in published literature about such an approach to treatment.[113] Given these factors, it is my view that this course of action should be avoided wherever possible.

LEGAL AND RIGHTS ISSUES

It was not possible to assess Ms AB's psychiatric status prior to the administration of ECT on 7 December 2016, as she remained unconscious and intubated from 5 December. Given that Ms AB had been sedated for some time I agree with Professor McSherry's conclusion that it is unclear why ECT was considered "immediately necessary" to save her life, prevent serious mental or physical deterioration or relieve severe distress.

I am concerned that the ECT occurred on the same day as the Tribunal was scheduled to consider Ms AB's case. I agree with the concerns Professor McSherry has expressed about the practice of performing ECT on a patient, without consent or Tribunal authorisation, only hours before clinicians have the opportunity to seek direction from the Tribunal.

ECT - 9 AND 12 DECEMBER 2016

The evidence demonstrates that ECT performed on 9 and 12 December 2016 was not authorised by the Tribunal on 7 December 2016, despite the impression which may have been gained by the treating clinicians. The Presiding Legal Member made comments indicating that further ECT could potentially be performed if requirements for emergency ECT were met, and the matter was not resolved as the hearing was adjourned. The performance of ECT without consent or Tribunal authorisation should be a rare exception, as stated in the Department's own approved procedures.[114]

[113] Response provided to the HCSCC on behalf of TEMHS cover letter dated 15 May 2017, sent via email 16 May 2017, p11.
[114] AP12 says that emergency ECT is only performed on "rare occasions" p 7.

I am persuaded by Professor McSherry's opinion that the episodes of treatment on 9 and 12 December 2016 seem to have been performed as part of a course of treatment rather than constituting emergency ECT within the intended meaning of s 66(3). [115]

Professor Large expressed the view that practitioners made an appropriate clinical decision to continue ECT on medical grounds on 9 and 12 of December 2016. This does not resolve the issue of whether it was *legal* to perform ECT on these occasions. Professor Large does not make clear why the treatments performed on 9 and 12 December 2016, once Ms AB had been extubated, were so urgent that they could not have awaited Tribunal authorisation.

The fact that practitioners had sought direction from the Tribunal on 7 December 2016 but were unable to obtain it points to a deficiency in the system. This matter gives rise to concerns that a person in Ms AB's situation could be left 'in limbo' for a lengthy period of time, without any meaningful ability to exercise their rights or express their wishes directly or through a substitute decision maker or representative.

ECT - APPROVED PROCEDURES

Consideration of Approved Procedure 12 (Electro Convulsive Therapy (ECT) Licensing & Legal Requirements) raises significant concerns in relation to safeguarding of patient rights and consistency with the content and intention of the MHRSA.

Professor McSherry noted that the statement that "by definition an involuntary patient is not capable of giving informed consent to ECT" contrasts with a recent decision of the Victorian Supreme Court. This decision emphasised that capacity to consent is specific to each decision that is to be made, and that patients' views and preferences should be given due consideration even when they are considered to lack capacity to give informed consent.[116]

[115] Expert opinion Prof B McSherry, p 16.
[116] *PBU & NJE v Mental Health Tribunal* [2018] VSC 564.

Consistent with this is Principle 3 of the NT Code of Health and Community Rights and Responsibilities, which states in part:

> Where a provider reasonably considers that a user has diminished capacity to consent, the user still has a right to give informed consent to a level appropriate to their capacity.[117]

I am concerned that the way in which the Approved Procedures set down specific times each week for ECT "with or without" approval of the Tribunal has potential to dilute the protections set down in s 66(3) of the MHRSA, which aims to limit unauthorised ECT to situations of genuine emergency. Setting down regular times at which ECT "without approval" can be performed does not seem consistent with the notion that any such unauthorised treatment must be "urgently necessary in order to prevent immediate or imminent harm to the patient or other persons," and "shall not be prolonged beyond the period that is strictly necessary for this purpose."[118]

The MHRSA indicates that when ECT is performed on an emergency basis without consent or authorisation this must be reported to the Tribunal "as soon as practicable after it is performed" (s 66(4)). Evidence provided to this investigation suggests that there is a lack clarity in relation to these processes. Professor McSherry noted that a Form 28 prepared on 13 December 2016 listed four previous 'emergency' treatments by date without a detailed explanation of the basis for each episode of treatment. Concerns were also raised about this by the Tribunal.[119]

The MHRSA states that a report to the Tribunal under s 66(4) of the MHRSA about the performance of emergency ECT must include "the number of treatments performed" (s 66(5)(b)). In my view this is not intended to imply that a sequence of treatments can be performed without consent or authorisation and the Tribunal only notified after multiple treatments have been undertaken. To adequately safeguard patient rights it is crucial that the Tribunal is separately notified of every episode of ECT which is performed on the basis of s 66(3), and that practitioners report **each individual episode** to the Tribunal "as soon as practicable after it is performed" (s 66(4)).

[117] See extracts from the Code at Appendix B.
[118] Principle 11(18), *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN Principles).*
[119] MHRT proceedings, 14 December 2016.

In my view, the potential to list a series of unauthorised ECT treatments on a Form 28 (as per s66(5)(b) of the MHRSA) may contribute to a perception among clinicians that a course of treatment which has already been provided can somehow be 'authorised' after the fact. This perception may also be influenced by the requirement in Approved Procedure 12 that a Form 27 ('Application and Clinical Details for Authorisation of ECT') be submitted together with the Form 28 ('Notification and Clinical Details re ECT Performed') when emergency ECT has been undertaken.[120] The Tribunal is unable to 'authorise' treatment retrospectively. When ECT has already been administered on an emergency basis, it is possible only to **notify** the Tribunal, and the Act makes clear that this must be done "as soon as practicable". In my view a lack of clarity in the procedures relating to the performance of ECT has potential to undermine the high degree of protection intended by s 66 of the MHRSA.[121]

I am also concerned that Approved Procedure 12 does not focus on options for obtaining timely consent (eg from a substitute decision-maker) or urgent Tribunal authorisation in preference to proceeding with unauthorised emergency ECT. Consent or authorisation should be sought wherever possible, leaving any unauthorised ECT as an absolute last resort. It is imperative that all options be explored by the service, in liaison with other relevant agencies, to minimise the use of unauthorised ECT by expediting processes for appointment of substitute decision-makers and/or consideration by the Tribunal.

DOCUMENTATION

Professor Large did not agree that the medical record was "inadequate to understand what happened and why," and said that in his view "[w]hat happened was quite clear."[122] He said that the reasoning behind decisions will not necessarily be well-documented, and gave the example of a doctor not documenting that an appendectomy was performed to prevent peritonitis. He further stated that the lack of documentation of medical reasoning "is often greater when the decisions are more complex" and that "any increase in explanatory documentation would come at the expense of patient care".[123] I have significant concerns about the views expressed by Professor Large in relation to adequacy of documentation, and do not believe that they reflect the approach embodied in DoH policies and guidelines.

[120] AP 12 p 7.
[121] Expert opinion Prof B McSherry, p 18.
[122] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 5.
[123] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, pp 5-6.

For medical procedures performed *with* consent, DoH guidelines require that written consent is obtained for treatments with potentially significant risks or complications. The guidelines recommend use of a consent form, and describe a level of information which must be provided to patients during the consent process.[124] In a situation of an appendectomy performed with consent, therefore, there should (at minimum) be a consent form on the record which sets out reasons for the procedure and the risks which have been explained to the patient.

Guidelines indicate that documentation is of greater rather than lesser importance in relation to procedures performed *without* consent, which may involve particularly complex circumstances and decision-making processes. Clear and thorough documentation is crucial in such situations, both to ensure that patient rights are adequately protected and to demonstrate that medicolegal aspects have been carefully considered.

If the basis for performing a procedure (eg an appendectomy) without consent is provided by the *Emergency Medical Operations Act*, the relevant DoH guideline states that the circumstances constituting the emergency and outlining the patient's lack of capacity should be clearly documented in the medical record.[125] If this Act (and other legislation) does not apply, the DoH *Providing Treatment Where Adult Patient Consent Cannot be Obtained NT Hospitals Guideline* sets down a detailed process relating to both authorisation and documentation.[126] This guideline indicates that patients who are detained under the MHRSA fall under a distinct category, and that a Form 23 must be used to apply for authorisation to perform non-psychiatric treatment and to notify the Tribunal of treatment that was immediately necessary and for which there was insufficient time to apply to the Tribunal.[127]

[124] Consent to Treatment NT Health Guideline Vesion 8.0 p 4.
[125] Consent to Treatment NT Health Guideline Version 8.0 p12
[126] It provides, among other things, a medical officer must obtain and document authorisation, primarily via the *Authority to Provide Treatment to Adults Without Their Consent* form, from the consultant and the senior medical manager (eg Director of Medical Services) to provide treatment. They must document the details of treatment provided in the management plan, and reassess the patient every six hours. The Authority form has a nominal cessation time of 4pm not later than three days from commencement of the treatment, but treatment must be stopped prior to this if imminent harm to the patient has been dealt with. If the form is due to expire but continued treatment is needed a new authorisation must be sought. The medical manager is required to maintain a register of all patients who are provided with treatment without consent on the basis of the common law principle of necessity.
[127] Providing Treatment Where Adult Patient Consent Cannot be Obtained NT Hospitals Guideline V 7.0 p 6. NB: The MHRSA sets down provisions relating to the performance of 'non-psychiatric treatment' (s63), which differ from those relating to 'major medical procedures' (s64). 'Non-psychiatric treatment' can only be performed where consent (from the person or their decision-maker) or approval from the Tribunal *or* an authorised psychiatrist is obtained, unless it is immediately necessary within certain parameters. The Tribunal may determine what kinds of treatment require its approval (s63(7)). Requirements exist which relate to notifying any guardian/decision-maker or the Tribunal as soon as possible after treatment is performed.

In my view the clear intention of relevant DoH policies and guidelines is to ensure that there is comprehensive documentation in relation to all medical treatment performed without consent, and that this intention would extend to major medical procedures and other non-psychiatric treatment performed on involuntary mental health patients (reflecting the existence of special protections in the MHRSA).

Oversight by the Tribunal provides a critical protection of the rights of patients being treated under the MHRSA. While Professor Large stated that documentation "could never be adequate to explain medical treatment fully to a non-medical reader,"[128] in my view it is vital that documentation of relevance to Tribunal proceedings can be clearly understood by both the patient's representative and all members of the Tribunal.

[128] Review of care by Prof Matthew Large, 15 June 2019, sent by DoH to HCSCC via email 24 June 2019, p 6.

CONCLUSION

The expert reports obtained and detailed throughout this investigation report epitomise the tension between a paternalistic, or 'best interests' approach to mental health treatment and a civil libertarian, or 'rights-based' approach. To some degree, this tension is unavoidable. People with mental illness have the right to receive treatment which optimises their health, and sometimes this will involve treatment being provided on an involuntary basis. At the same time, people receiving involuntary treatment are particularly vulnerable. Accordingly, their legal and broader human rights must be stringently protected.

I am satisfied that the clinicians providing care for Ms AB did so with her best interests in mind. However I am not convinced that the care was provided in a manner that met the requirements of the MHRSA or adequately protected Ms AB's rights. Put simply, the legality of performing major medical procedures and ECT without consent or Tribunal authorisation in this situation relied on the treatments being immediately necessary to save Ms AB's life or to prevent her from suffering a severe level of harm. I am not satisfied that this threshold was always met.

International instruments and domestic legislation set out 'immediate necessity' limitations relating to the performance of treatment on mental health patients without consent or independent authorisation. These limitations reflect the significance of the issue in terms of human rights. It is crucial that issues of legality and patient rights are clearly understood by clinicians making decisions about treatment in challenging circumstances. It is also important that efforts are made to minimise the need for emergency treatment, by facilitating appropriate consent or Tribunal authorisation wherever possible; and that processes are in place which enable oversight of emergency treatment by the Tribunal in a manner that reflects mental health legislation. These matters are the primary focus of my findings and recommendations.

FINDINGS

The power to provide treatment on an involuntary basis brings with it the highest level of responsibility in terms of protection of patient rights. Ms AB's level of vulnerability was extreme and evident, but her rights were not adequately protected. The protections set down by the legislature in the MHRSA were not reflected in the approach taken to her treatment. Provisions of the MHRSA were breached, and procedures created under the MHRSA proved flawed in both content and application. These are matters of grave concern.

In relation to the issues discussed in this investigation report, my findings are as follows.

CONSENT (MAJOR MEDICAL PROCEDURES 2 AND 5 DECEMBER 2016)

1. On 2 December 2016 Ms AB was subjected to a major medical procedure which was not performed in accordance with s 64(3) of the MHRSA. I find that, given the procedure was not immediately necessary to save Ms AB's life, or to prevent irreparable harm to her, the procedure should not have been performed without approval of the Tribunal or informed consent (from an appropriate decision maker or in accordance with the *Advance Personal Planning Act*), as per s 64(2) of the MHRSA.

2. On balance, I accept that the major medical procedure carried out on 5 December may have met the requirements of s 64 of the MHRSA.

SEDATION/RESTRAINT

3. The major medical procedure involving intubating and ventilating Ms AB on 2 December 2016 was a major medical procedure undertaken predominantly as a means of behavioural control. This amounts to chemical restraint, a procedure that is not clearly regulated under Northern Territory law.

ECT

4. I find that the dosing and method of administration of ECT on 5 December, 7 December, 9 December and 12 December 2016 was performed to a high standard.

5. I make no finding about the standard of care in relation to the decisions to perform ECT on 5 or 7 December 2016, but note that Professor Tiller described these decisions as appropriate in the circumstances.

6. I make no finding about the legality of the ECT on 5 December 2016, but find that documentation relating to this episode of treatment (demonstrating the basis for it and the decision-making processes involved) was inadequate.

7. I find that the ECT on 7 December 2016 was not performed in accordance with s 66(3) of the MHRSA, given the absence of relevant consent and the failure to seek prior Tribunal authorisation when the Tribunal was to sit later the same day.

8. I find that the ECT performed on 9 and 12 December 2016 was not authorised by the Tribunal on 7 December 2016, as the Tribunal hearing was adjourned without authorisation for further episodes of ECT being given under s 66(2) of the MHRSA. The practitioners concerned continued to deliver the ECT as a course of treatment, rather than the one-off, emergency treatment that s 66(3) of the MHRSA was designed to enable. I accept that practitioners were left in a very difficult position in assessing the legality of these two treatments.

9. The content of Approved Procedure 12 and associated forms relating to the performance of ECT do not adequately reflect s 66 of the MHRSA and international instruments, which emphasise the need for consent or authorisation of treatment in all but the most exceptional situations.

10. It is not appropriate to provide notification of a 'course' of ECT which has been performed on the basis of s 66(3). Instead it should be absolutely clear in the MHRSA, procedures and related forms that the Tribunal must be separately and promptly notified of every occasion when unauthorised ECT treatment is performed on the basis of s 66(3). Such an approach is crucial in order for oversight of a patient's treatment to be appropriately informed, and for the requirement in s 66(4) that performance of emergency ECT be reported to the Tribunal "as soon as practicable" to be satisfied.

11. Ms AB was left in an effective state of limbo when her matter came before the Tribunal on 7 December 2016 and was then adjourned without any resolution. This is clearly unacceptable. Her rights were compromised despite the apparent efforts of many of those present on the day. It is not clear that any steps were taken to initiate urgent appointment of a substitute decision-maker. It is imperative that this situation, unlikely to be a one-off in the Northern Territory, is rectified.

DOCUMENTATION

12. The standard of documentation in Ms AB's clinical notes was inadequate. Discrepancies between the forms presented to the Tribunal and the clinical notes are concerning, and the bases for clinical decision making and plans for treatment and management were frequently unclear. These absences and inconsistencies undermine the ability of bodies such as the HCSCC and the Tribunal to gain a full picture of a patient journey; but more importantly, they undermine good care. They also erode the protection for treating practitioners who need to demonstrate adherence to the law.

13. The forms presented to the Tribunal hearing on 7 December 2016 in relation to major medical procedures were confusing. No form with information solely relating to the intubation and ventilation on 2 December 2016 was provided to the Tribunal until May of the following year. The requirements of the MHRSA are very clear. The practitioner must inform the Tribunal of a major medical procedure **no later than one day** after the procedure is authorised.

On two occasions a Form 23 (relating to a major medical procedure) was incorrectly completed as both an application and notification prior to being submitted to the Tribunal. A Form 28 (relating to ECT already performed) included a list of treatments which had already been undertaken without authorisation; a flawed approach, but one that appears consistent with the relevant Approved Procedure produced by DoH.

It is vital that all who perform actions governed by the MHRSA understand that it does not enable treatment (eg major medical procedures and ECT) to be retrospectively 'authorised' by the Tribunal after it has already taken place. Instead the MHRSA emphasises the need for prompt notification of the Tribunal where treatment is performed without consent or authorisation.

The obligation to report actions promptly to the Tribunal and present accurate documentation is key to safeguarding the rights of people in Ms AB's situation. Misunderstanding these obligations or not ensuring that they are adequately embodied in relevant procedures and forms undermines the rights of vulnerable patients.

While it is outside the scope of my findings, I note that Professor McSherry expressed a view that the ECT performed in this case involved four potential breaches of statutory duty (including on 5 December 2016), and gave rise to possible civil actions in trespass and negligence, and 'technical' assault, albeit of a type unlikely to be prosecuted. She suggested that the episode of ECT on 7 December 2016 which was performed without prior extubation and assessment may have breached Ms AB's right to freedom from inhuman and degrading treatment. She also stated that the major medical procedure performed on 2 December 2016 could have provided grounds for civil action as well as potentially constituting a 'technical' assault. Her views should be of critical concern to the service and I trust that they are given close analysis.

RECOMMENDATIONS

It is recommended that DoH:

1. Prioritise the review of the MHRSA which is currently underway and set down a time-line for the process to be completed.

2. Provide the review of the MHRSA with a comparative analysis of Australian and international best practice in the area of ECT, which considers whether Tribunal approval should be required at all times (as is the case in some jurisdictions), rather than retaining the potential for unauthorised emergency ECT.

3. Provide the review of the MHRSA with recommendations for legislative amendment aimed at removing any ambiguity as to whether each individual episode of ECT performed on the basis of s 66(3) must be reported to the Tribunal "as soon as practicable", as opposed to the Tribunal being notified of a sequence of treatments at the same time (eg via repeal of s 66(5)(b)).

4. Provide the upcoming review of the MHRSA with recommendations for regulating the use of chemical restraint in the mental health context. The MHRSA should include a clear definition of chemical restraint and provision of appropriate safeguards, including oversight and record keeping; and be consistent with existing disability legislation. This should be accompanied by clear policy guidance and training for professionals involved in administration of chemical restraint.

5. Amend Approved Procedure 30, to make it clear that any major medical procedure performed without consent must be brought to attention of the Tribunal within the legislated timeframe.

6. Amend Form 23 to make it more user-friendly, clearer as to the requirements of each part (eg application and notification), and more directly related to the relevant requirements of the MHRSA.

7. Review Approved Procedure 12 and associated forms to ensure that they reflect:
    - the level of protection of patient rights intended by s66 of the MHRSA (including the need for every episode of ECT performed under s 66(3) to be individually reported to the Tribunal as soon as practicable, and the need for consultation with the patient's primary carer);
    - national and international standards relating to performance of ECT;
    - case law relating to 'immediate necessity'; and
    - an approach which prioritises obtaining timely consent from a substitute decision-maker or authorisation from the Tribunal, so that proceeding with ECT on the basis of s 66(3) is truly an option of last resort.

8. Review the DoH Approved Procedures to ensure that they are up-to-date, that their currency is clear, and that they are accessible to the public.

It is recommended that TEMHS:

9. Conduct an audit of compliance with requirements under the MHRSA for Tribunal notifications under ss 64 and 66 (major medical procedures and ECT), covering a twelve month period.

10. Conduct an audit of completeness of clinical records in cases where ECT has been undertaken, covering a twelve month period.

It is recommended that TEMHS and TEHS:

11. Disseminate this investigation report to all team members involved in decision-making about mental health treatment, performance of major medical procedures, ECT or the Tribunal.

12. Provide training to relevant team members on decision making, record keeping, processes and legal requirements in relation to ECT and major medical procedures in the mental health context, with particular emphasis on documentation under the MRSA and the role of the Tribunal and other decision makers.

13. Document and implement processes for expediting the appointment of substitute decision-makers in the mental health context.

Parties have reviewed draft recommendations and provided feedback prior to finalisation of this report. On this basis, I have made slight changes to recommendations one and seven. DoH's response, attached at Appendix D, demonstrates that it has already commenced following up these recommendations.

Stephen Dunham
COMMISSIONER

8th August 19

APPENDICES

Appendix A: Mental Health and Related Services Act (Extracts)

Appendix B: Code of Health and Community Rights and Responsibilities (Extract)

Appendix C: Approved Procedure 12 – Electro Convulsive Therapy (ECT) Licensing & Legal Requirements

Appendix D: Response to Health and Community Services Complaints Commission Draft Investigation Report Recommendations

Appendix A: MHRSA Extracts

Section 3: Objects

The objects of the Act are as follows:

(a) to provide for the care, treatment and protection of people with mental illness while at the same time protecting their civil rights;

(b) to establish provisions for the care, treatment and protection of people with mental illness that are consistent with the United Nations' Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, the Australian Health Ministers' Mental Health Statement of Rights and Responsibilities and the National Mental Health Plan;

(c) to establish provisions for the review of the voluntary and involuntary admission of people into approved treatment facilities and the treatment provided to people in approved treatment facilities;

(d) to establish provisions for obtaining informed consent and the authorisation of treatment;

(e) to establish provisions for emergency detention and treatment;

(f) to provide regulation of specific forms of treatment;

(g) to establish provisions for the administration of involuntary treatment in the community;

(h) to mainstream and integrate, as far as possible, provision for the administration and review of admission, hospitalisation and treatment of prisoners;

(j) to establish the right of people receiving or seeking psychiatric treatment or care to be given oral and written explanations of their legal rights and entitlements under this Act in a form and language that they understand;

(k) to establish the Mental Health Review Tribunal to conduct reviews relating to people subject to this Act;

(m) to establish the right for people who are subject to this Act, their relatives, friends and representatives, and any other people with a genuine interest in particular people who are subject to this Act, to make a complaint;

(n) to provide for approved treatment facilities and approved treatment agencies to establish accessible internal complaints procedures;

(p) to affirm the right of people who are subject to this Act to complain to independent complaint bodies established by or under other legislation;

(q) to provide for a principal community visitor, community visitors and community visitor panels with inquiry, complaints, investigation, visiting, inspection, advocacy and reporting powers and functions;

(r) to provide for the registration of mental health orders made outside the Territory;

(s) to provide a procedure for approved treatment facilities and approved treatment agencies to be approved;

(t) to recognise the continuing appropriate care provided by relatives and friends and other non-professional care givers in the community, and to ensure that therapeutic alliances involving appropriate non-professionals are recognised.

Section 64: Major Medical Procedure

(1) A person must not perform a major medical procedure on a person who is an involuntary patient or subject to a community management order.

Maximum penalty: 40 penalty units.

(1A) Subsection (1) does not apply if the procedure is performed in accordance with this section.

(2) Subject to subsection (3), a major medical procedure must not be performed on a person unless:

(a) it is approved by the Tribunal; or

(b) informed consent for the major medical procedure is obtained from a decision maker for the person, or from the Civil and Administrative Tribunal, in accordance with Part 4 of the Advance Personal Planning Act.

(3) An authorised psychiatric practitioner may authorise the performance of a major medical procedure on a person where it is immediately necessary:

(a) to save the life of the person; or

(b) to prevent irreparable harm to the person.

(4) No later than one day after authorising the performance of a major medical procedure under subsection (3), the practitioner must notify:

(a) the Tribunal; and

(b) the person's adult guardian; and

(c) if the person has a decision maker – the decision maker.

(5) The Chief Health Officer is, from time to time, to specify those medical procedures that are major medical procedures for the purposes of this section.

(6) The purpose of this section is to protect the interests of a person by ensuring the person is not unnecessarily subjected to certain medical procedures.

Section 66: Electroconvulsive therapy

(1) A person must not perform electroconvulsive therapy on another person unless:

(a) the other person gives informed consent to the treatment; or

(b) informed consent for the treatment is obtained from an adult guardian or decision maker for the person, or from the Civil and Administrative Tribunal, in accordance with Part 4 of the Advance Personal Planning Act.

Maximum penalty: 40 penalty units.

(1A) Subsection (1) does not apply if the treatment is performed in accordance with this section and approved procedures.

(2) The Tribunal may authorise electroconvulsive therapy to be performed on a person if it:

(a) is satisfied that the person is unable to give informed consent to the treatment; and

(b) receives a report from 2 authorised psychiatric practitioners that they are satisfied, after considering the person's clinical condition, history of treatment and other appropriate alternative treatments, that electroconvulsive therapy is a reasonable and proper treatment to be administered and that without the treatment the person is likely to suffer serious mental or physical deterioration; and

(c) is satisfied that:

(i) all reasonable efforts have been made to consult the person's primary carer; or

(ii) there is a valid reason for not complying with subparagraph (i).

(3) Electroconvulsive therapy may be performed on a person who is an involuntary patient where 2 authorised psychiatric practitioners are satisfied that it is immediately necessary:

(a) to save the person's life; or

(b) to prevent the person suffering serious mental or physical deterioration; or

(c) to relieve severe distress.

(4) Where electroconvulsive therapy is performed under subsection (3), the authorised psychiatric practitioners must make a report to the Tribunal of the therapy performed as soon as practicable after it is performed.

(5) The report is to contain:

(a) the reasons why the authorisation of the Tribunal was not obtained; and

(b) the number of treatments performed; and

(c) the person's response to the treatment; and

(d) details of any significant side effects of the treatment on the person.

(6) At least 2 medical practitioners are to be present when electroconvulsive therapy is performed, of whom:

(a) one is to be experienced and trained in accordance with approved procedures in performing electroconvulsive therapy; and

(b) one is to be experienced in administering anaesthesia.

(7) Electroconvulsive therapy must be performed only in an approved treatment facility or premises licensed under this Division.

Note for section 66

Proceedings for professional misconduct, unsatisfactory professional performance or unprofessional conduct may be taken against a medical practitioner under the Health Practitioner Regulation National Law because of a contravention of this section. Under section 243 of that Law, disciplinary proceedings may be taken under the Law irrespective of whether proceedings for the offence have been taken.

Appendix B: Code of Health and Community Services Rights and Responsibilities (Extract)

The HCSC Act confers authority on the Commissioner to look into the reasonableness of actions of a health service provider in the provision of that service. In doing so the Commissioner must have regard to the Code of Health and Community Rights and Responsibilities, 'the Code' (see s 5(1)(a)). Relevant provisions of the Code are set out below:

Principle 1: Standards of Service:

1. Users have a right to:

    a) timely access to care and treatment which is provided with reasonable skill and care;

    b) care and treatment which maintains their personal privacy and dignity;

    c) care and treatment free from intimidation, coercion, harassment, exploitation, abuse or assault;

    d) care and treatment that takes into account their cultural or ethnic background;

    e) providers who seek assistance and information on matters outside their area of expertise or qualification;

    f) services provided in accordance with ethical and professional standards, and relevant legislation;

    g) services which are physically accessible and appropriate to the needs arising from an impairment or disability;

    h) services provided without discrimination, as set out in relevant Territory and Commonwealth legislation.

Principle 3: Decision Making

1. Subject to any legal duties imposed on providers, users have a right to:

    a) make informed choices and give informed consent to care and treatment;

    b) seek a second opinion;

    c) refuse care and treatment, against the advice of the provider;

    d) withdraw their consent to care and treatment, which includes the right to discontinue treatment at any time, against the advice of a provider;

    e) make an informed decision about body parts or substances removed or obtained during a health procedure. This includes the right to consent or refuse consent to the storage, preservation or use of these body parts or substances; and

2. In non-emergency situations, providers have a responsibility to seek informed consent from users before providing care and treatment by:

    a) seeking consent specific to the care and treatment proposed, rather than a generalised consent;

    b) discussing the material risks, complications or outcomes associated with each care or treatment option;

    c) ensuring the user understands the material risks, complications or outcomes of choosing or refusing a care or treatment option;

    d) where relevant, explaining the legal duties imposed on providers which prevent users from refusing a type of care or treatment, such as those imposed by the Mental Health and Related Services Act and the Notifiable Diseases Act;

    e) providing users with appropriate opportunities to consider their options before making a decision;

    f) informing users they can change their decision if they wish;

    g) accepting the user's decision; and

    h) documenting the user's consent, including the issues discussed and the information provided to the user in reaching this decision.

3. Providers have a right to treat without the user's consent where:

a) treatment is provided in a life threatening emergency or to remove the threat of permanent disability and it is impossible to obtain the consent of the user or the user's personal representative; or

b) treatment is authorised or required under Territory or Commonwealth legislation.

4. Where a provider reasonably considers that a user has diminished capacity to consent, the user still has a right to give informed consent to a level appropriate to their capacity.

5. Where a provider considers a user lacks the capacity to give informed consent, a provider must, except under specific legal circumstances, seek consent from a person who has obtained that legal capacity under the Adult Guardianship Act or other relevant legislation.

12 Regulated Treatments and Measures – Electro Convulsive Therapy (ECT) Licensing & Legal Requirements

Procedure Summary

Premises have been appropriately licensed to conduct ECT.

An APP has determined the patient meets the criteria for ECT.

Relevant information regarding ECT has been provided to the patient.

All concerns regarding information given about ECT are recorded in the patient's clinical file.

Where ECT is performed on a voluntary patient, informed consent has been obtained via **Form 26 Informed Consent to ECT.**

Where ECT is performed on an involuntary patient immediately and without consent the two APPs involved in its administration have reported to the Tribunal on **Form 28 Notification and Clinical Details re ECT Performed.**

Where ECT is performed on an involuntary patient without consent but is non urgent, two APPs have sent a report to the Tribunal on **Form 27 Application and Clinical Details for Authorisation of ECT.**

ECT has been authorised by the Tribunal.

Where the Tribunal has not authorised ECT, the APP has explored and recommended other treatment options.

At least two MPs were present during the administration of ECT. One experienced and trained in accordance with the Approved Procedures in performing ECT, the other experienced in administering anaesthesia.

All ECT administrations are recorded on the ECT register and in the patient's clinical record.

Monthly ECT returns have been submitted to the CEO as required.

Refer to Flowcharts 13, 14 & 15 at Appendix B for an overview of this procedure.

Flowchart
#13, 14 & 15

Background

Electro Convulsive Therapy (ECT) is a procedure performed under general anaesthesia and muscle relaxation in which modified seizures induced by the selective passage of an electrical current through the brain are used for therapeutic purposes. ECT is most commonly prescribed for the treatment of severe depression, but may also be used for other types of serious mental illness such as mania, schizophrenia, catatonia and other neuropsychiatric conditions. It is most often prescribed as part of a treatment regime in combination with other therapies.

There have been significant advances in the technology and knowledge about ECT over recent years and studies support its use as a safe and effective psychiatric treatment. Guidelines to clinical practice published by organisations such as the Royal Australian and New Zealand College of Psychiatrists and the Australian and New Zealand College of Anesthetists (ANZCA) have contributed to the high standards now associated with the treatment.

Government regulation has also played a major role in setting standards for the performance of ECT. The Act contains detailed legislative provisions regulating consent to treatment, defines the elements of informed consent and strictly prescribes the circumstances and the requirements when ECT may be performed without informed consent. The Act also establishes a framework for licensing premises on which ECT can be performed.

The nature of ECT and the history associated with its use means that some patients may experience distress or fear when it is proposed as an appropriate treatment.

Licencing provides assurance to patients that a service and the practitioners performing ECT meet established standards. Legislation, licensing, guidelines, new technology and advances in clinical knowledge all act to ensure that ECT is used in a safe and effective manner and in a way that is respectful of the person's rights, privacy, dignity and self-respect.

Purpose

ECT is an important treatment in modern psychiatric practice. It is essential that where its use is prescribed that it be administered properly at premises that have been specifically licensed to do so. The purpose of this document is to provide guidance to the legislative requirements relating to the performance of ECT (including licensing, consent, authorisation, reporting and notification).

As such it is intended to assist service planning, guide the clinical practice of medical and nursing staff and provide information for DHF staff administering the licensing procedure. The document may also have a broader educative role for consumers, carers and other members of the community about the performance of ECT.

Licensing

Licensing of ECT premises is fundamental to the regulation of standards under the Act. ECT may only be performed at premises licensed for this purpose. This requirement applies to both public and private services.

The Act provides for inspection of premises prior to licensing and regulates the suitability of the licence holder, the standards and conditions of premises and equipment, and the qualifications of the persons permitted to perform ECT.

The Act also provides penalties in the case of poor practice, including the revocation of a licence.

Administration

Under the Act all the powers, duties and functions relating to licensing of premises are assigned to the CEO, DHF. In practice, all such duties are delegated to the CHO. All enquires about licensing of premises to perform ECT should therefore be directed to the CHO.

Application for a Licence

The occupier of any premises may apply to the CHO for a licence to perform ECT. In most cases the PIC of the premises will make the application. The application is to be made on *Form 29 Application for Licence to Permit ECT to be Performed on Premises.*

Form #29

A floor plan of the premises indicating all suites/areas where ECT is to be performed must be attached to *Form 29*. The floor plan will be incorporated to become part of the ECT licence.

Inspection

Each service must be inspected before a licence can be approved. A qualified psychiatrist, an RN and other staff nominated by the CHO will conduct the inspection. Personnel representing the occupier at the inspection should be familiar with the premises and be able to provide information to address the key licensing criteria.

Inspection Report and Recommendation

Following inspection, a nominated member of the inspection team will prepare a report for the CHO, addressing the key licensing criteria and making a recommendation.

Options are:

- Recommended; or
- Qualified recommendation, subject to specific conditions being met. It must propose such terms and conditions as are necessary to ensure the service meets the key licensing criteria; or
- Not recommended. Where an application is not recommended, a statement of reasons will be provided.

Licence Approval

The CHO determines the application. The decision will be based on the inspection report and the key licensing criteria. The CHO may seek further information as necessary.

Licence Documentation

The licence is prepared in the form of a *Licence Authorising Performance of ECT* instrument prepared by DHF Legal Services which includes details of the:

ECT Licence

- Licence holder.
- Name of the service.
- Address of the premises.
- Period of the licence, which may be for a period of up to three years.
- Licence number.

A plan of the premises showing all areas/suites where ECT can be performed must be contained in Attachment A to the licence.

The terms and conditions to be attached to the licence must be contained in Attachment B to the licence. Standard conditions that the licence holder must observe are to:

- Allow the CHO or nominee to visit and inspect any part of the licensed premises.
- Allow the CHO or nominee to inspect and make copies of any documents kept at the premises relating to the regulation and performance of ECT.
- Provide the CHO or nominee with any reasonable assistance in the performance of any duties or functions relating to the regulation and performance of ECT.

Canceling a Licence

The CHO may cancel a licence if satisfied that:

- There has been a breach of a condition of the licence;
- An offence against **s66** of the Act is committed on the premises;
- The premises are no longer suitable;
- Equipment on the premises does not comply with the prescribed standards and conditions; or
- An unqualified or insufficiently qualified person has been performing ECT on the premises.

Cancellation must be in writing and will give reasons. As a general principle, consultation with the licence holder will occur before a licence is cancelled. Other options such as imposing a specific condition or limitation will be considered.

Review of Certain Decisions (s72)

Where a person (i.e. licence holder) is aggrieved by any decision of the CEO under the ECT provisions he/she may apply to the Ombudsman for an investigation of the decision to be undertaken in accordance with the Ombudsman *(Northern Territory) Act*.

Renewal of Licence

The Act places the onus on the holder of a licence to apply to the CEO of DHF for the renewal of a licence. To assist licence holders, a notice of renewal will be sent to the licence holder about two months before the licence expires. An application for renewal must be made in the approved form *Form 29 Application for Licence to Permit ECT to be Performed on Premises*. Enclosed with the application must be the specified fee, which is an administration fee and will not be refunded if the licence is not renewed.

The CEO must renew the licence unless satisfied that any of the grounds for canceling a licence in **s70** of the Act apply.

Renewal Procedures

On receipt of the application for renewal and the specified fee, the procedure for renewal will be implemented. This parallels the procedure for making a new licence. A service will be inspected and a report will be prepared in accordance with the procedures set out in the earlier part of these guidelines. However, the CEO may renew a licence without an inspection of premises if satisfied that the relevant criteria have been met.

ECT Returns (s73)

The PIC of an ATF licensed to perform ECT must submit a return in the approved form *(Report Template 3 ECT Monthly Returns)* to the CEO after the end of each month (the first week of the following month). The return must contain details of ECT performed during the month on the premises to which the licence relates.

Report Template 2

Legal Requirements

The following procedure and practice notes outline legal requirements associated with the practice of ECT. Detailed clinical and practice guidelines for the administration of ECT are contained in NTMHS Policies and must be strictly adhered to.

The treating APP must assess the patient to determine whether they meet the criteria for ECT outlined in **s66**.

Practice Note:

The decision to recommend the use of ECT must always be based on a thorough physical and psychological evaluation of the individual person, which takes into account:

- The illness;
- The person's history; and
- The degree of the person's distress and suffering.

The patient must receive in the week prior to the commencement of a course of ECT a full physical examination, to include:

- ECG;
- FBC, LFT's, Renal Function Tests, and other tests as indicated; and
- Chest X-ray, if indicated.
- CT Scan, if indicated.

The patient must receive a full anaesthetic review prior to commencement in order to ensure anaesthetic safety.

Specific medical conditions should be reviewed with regard to any hazard that ECT may present.

Current medications must be reviewed to determine compatibility with ECT.

Prior to ECT, unit staff must ensure that:

- Consent form is signed;
- Previous ECT history is recorded;
- Baseline vital signs are recorded;
- All required documentation is completed.

Only staff that have been trained in the administration of ECT as recommended by the RANZCP and RACA are to administer ECT.

Provision of Information

Relevant information regarding ECT must be provided to the patient. Whenever a person, person's family or other health professionals have concerns about the information and advice given these must be recorded on the person's clinical record.

Note in Clinical Record

Voluntary Patients and Informed Consent

If the patient is a voluntary patient, informed consent must be obtained for ECT to be legally administered. Where the patient is willing to give informed consent, *Form 26 Informed Consent to ECT* must be signed by the patient and a witness. The signed form is to be placed on the patient's clinical record.

Form #26

Practice Note:

Informed consent is required for the lawful administration of ECT for voluntary patients. If the person is a voluntary patient and is incapable of giving consent they cannot be given ECT without the approval of the Tribunal.

In signing this form the patient gives consent to receive up to 12 treatments of ECT. This information should also be included in the patient's Individual Care Plan (ICP). If additional treatments are required consent is required for each individual treatment.

If informed consent is obtained, is withdrawn, or if the patient's wishes appear to fluctuate, the APP (in the event that he or she wishes to proceed with the treatment) must comply with the requirements of **s66(2)** or **(3)**, which should be initiated as soon as possible.

Note in Clinical Record

Where a person has given informed consent he or she may withdraw consent at any time. If the person withdraws consent that has been given, the initial consent form is cancelled. All consent forms that have become invalid because the person has withdrawn consent must be clearly marked as cancelled. Where the person withdraws consent he or she should receive a clear explanation (recorded in the person's clinical record) of the likely consequences of not receiving the treatment.

Form #26

Fresh consent is then required before further treatment can be carried out or reinstated. Should consent be once again obtained another *Form 26 Informed Consent to ECT* will need to be completed.

Practice Notes:

The requirements for informed consent are specified in **s7** of the Act:

- Consent must be given freely and voluntarily;
- The effects of giving consent must be understood by the patient;
- Consent must be on the approved form.

The person must be given:

- A clear explanation of the treatment which includes a description of the benefits, discomforts and risks of the proposed treatment;
- Advice about any beneficial and reasonably available alternative treatments;
- Questions asked by the person about techniques or procedures must be answered in a way that can be clearly understood by the person;
- A full disclosure of any financial relationship between the person seeking the informed consent or the APP proposing the treatment and the place in which the treatment is to be administered;
- Written notice about their right to obtain legal and medical advice and to be represented before they give their informed consent and advice that they are free to withdraw consent at any time. If the person is unable to read the notice, it should be read and explained to him or her. If the person does not have a sufficient command of English, an interpreter must be employed;
- A statement of rights as set out in **Part 12** of the Act. It is the duty of the PIC of the ATF to ensure that each of these steps is followed

Where a voluntary patient is not able to or not willing to give consent to ECT, other treatment options should be pursued. If no other treatment option is applicable, advice and/or consent must be sought from the Tribunal.

Involuntary Patients

If a person has been admitted as an involuntary patient and ECT is being considered, an APP must first decide if ECT is immediately necessary or whether the treatment is non-urgent.

Practice Note:

By definition an involuntary patient is not capable of giving informed consent to ECT. Consequently, the Act requires the approval of the Tribunal to be obtained. The Act requires that two APPs must be of the view that ECT has clinical merit, that all alternative treatments have been considered and that ECT is appropriate in the circumstances, that without ECT the patient is likely to suffer serious mental and physical deterioration and that all reasonable efforts have been made to consult the patient's primary carer.

An exception applies in emergencies, where, if two APPs are of the view that ECT is immediately necessary to save the person's life OR to prevent serious physical or mental deterioration OR to relieve severe distress, it can be provided without the Tribunal's advance approval. Emergency ECT is only performed on rare occasions where patients have such severe mental illness that delay may cause significant psychiatric and/or physical consequences and exacerbate acute distress.

The TEMHS ECT timetable conforms to best practice standards with regard to scheduling and occurs at 8am on Mondays, Wednesdays and Fridays. The RDH Anaesthetic Department provides anaesthetists for ECT at the mental health in-patient unit. The timing of ECT delivery allows the anaesthetist and other required anaesthetic staff to be available for their organised operation lists at RDH. These arrangements cannot be altered without a potential significant compromise to the clinical care of patients requiring emergency ECT. Consequently, all ECT, whether with or without the approval of the Tribunal, is to occur at 8am on either a Monday Wednesday or Friday

The Tribunal sits from 9.30am each Wednesday in Darwin and each Friday in Alice Springs. Therefore if a person requires ECT on a Wednesday in Darwin or a Friday in Alice Springs, this will be delivered prior to the respective Tribunal hearings in accordance with this approved procedure.

Where emergency ECT is performed, the two APPs must make a report *Form 28 Notification and Clinical Details re ECT Performed* to the Tribunal as soon as practicable detailing:

- The reasons why the authorisation of the Tribunal was not obtained;
- The number of treatments provided;
- The person's response to the ECT; and
- Any significant side-effects of the treatment provided.

Form #28

If emergency treatment is considered necessary, two APPs must assess the patient and agree that ECT is necessary under the circumstances to:

- Save the patient's life;
- Prevent the patient suffering serious mental or physical deterioration; or
- Relieve severe distress.

Where ECT is performed under emergency treatment circumstances and without Tribunal approval, the two APPs must make a report *Form 28 Notification and Clinical Details re ECT Performed* to the Tribunal as soon as practicable after it is performed. *Form 27 Application and Clinical Details for Authorisation of ECT* must also be completed and should accompany *Form 28*.

Form #27 & 28


Application to Tribunal

If ECT is considered necessary but non-urgent, two APPs must apply to the Tribunal on *Form 27 Application and Clinical Details for Authorisation of ECT*. The assessing APPs must also satisfy the Tribunal that reasonable efforts have been made to consult the person's primary carer in relation to the treatment, or that there is a valid reason for not consulting the person's primary carer.

Tribunal Approval


Form #27

If the Tribunal gives approval, the course of ECT treatments may proceed according to the procedural guidelines contained within the NTMHS Policy regarding the provision of ECT. When the Tribunal authorises the administration of ECT on the person's behalf, it will issue its authorisation in writing by signing off on *Form 27 Application and Clinical Details for Authorisation of ECT.*

If the Tribunal does not approve the course of ECT, the APP should then explore and recommend other treatment options.

When ECT is performed at least two MPs must be present. One must be experienced and trained in accordance with the approved procedures in performing ECT; the other must be experienced in administering anaesthesia.

Adult Guardian Consent

An Adult Guardian with the power to consent to health care also has the power to consent to ECT on the person's behalf.

Attachment 1

Response to Health and Community Services Complaints Commission Draft Investigation Report Recommendations - [redacted]

#	Draft Recommendation	Responsibility	Response
1.	Provide the upcoming review of the MHRSA with a comparative analysis of Australian and international best practice in the area of ECT, which considers whether Tribunal approval should be required at all times (as is the case in some jurisdictions), rather than retaining the potential for unauthorised 'emergency' ECT.	DoH	The review of the MHRSA is currently underway. A jurisdictional analysis of the use of ECT is forming part of the review, and will be considered as well as the specific needs of consumers and clinicians in order to provide the best possible care in the context of the Northern Territory health system.
2.	Provide the upcoming review of the MHRSA with recommendations for legislative amendment aimed at removing any ambiguity as to whether each individual episode of ECT performed on the basis of s66(3) must be reported to the Tribunal "as soon as practicable", as opposed to the Tribunal being notified of more than one 'emergency' treatments at the same time (e.g. via repeal of s66(5)(b))	DoH	This recommendation is noted and will form part of the review of the MHRSA. The repeal of s66(5)(b) will be considered in the consultation process. Any amendments to the provisions relating to ECT will certainly aim to remove ambiguity and to provide clinicians with an appropriate and safe framework in which to provide treatment.
3.	Provide the upcoming review of the MHRSA with recommendations for regulating the use of chemical restraint in the mental health context. The MHRSA should include a clear definition of chemical restraint and provision of appropriate safeguards, including oversight and record keeping; and be consistent with existing disability legislation. This should be accompanied by clear policy guidance and training for professionals involved in administration of chemical restraint.	DoH	The review of the MHRSA is considering the inclusion of chemical restraint in the MHRSA in order to provide appropriate safeguards. Any amendment to the MHRSA in relation to chemical restraint will be accompanied by policy guidance and training for clinicians in order to provide the best possible care to consumers.

APPENDIX D

#	Draft Recommendation	Responsibility	Response
4.	Amend Approved Procedure 30, to make it clear that any major medical procedure performed without consent must be brought to attention of the Tribunal within the legislated timeframe.	DoH	The Approved Procedures and Quality Assurance Committee (APQAC) oversees the development and content of approved procedures and associated forms. Approved Procedure 30 is currently being reviewed by APQAC to ensure that it is clear that any major medical procedure performed without consent must be brought to attention of the Tribunal within the legislated timeframe.
5.	Amend Form 23 to make it more user-friendly, clearer as to the requirements of each part (e.g. application and notification), and more directly related to the relevant requirements of the MHRSA.	DoH	Form 23 is currently being reviewed by APQAC to ensure that it is more user-friendly, clearer as to the requirements of each part (e.g. application and notification), and more directly related to the relevant requirements of the MHRSA.
6.	Review Approved Procedure 12 and associated forms to ensure that they reflect: • the level of protection of patient rights intended by s66 of the MHRSA • (including the need for every episode of ECT performed under s 66(3) to be individually reported to the Tribunal as soon as practicable); • national and international standards relating to performance of ECT; • case law relating to 'immediate necessity' ; • case law relating to capacity for consent being specific to each decision which is made; and • an approach which prioritises obtaining timely consent from a substitute decision-maker or authorisation from the Tribunal, so that proceeding with ECT on the basis of s66(3) is truly an option of last resort.	DoH	Approved Procedure 12 and associated forms are currently being reviewed by APQAC to ensure that they reflect: • the level of protection of patient rights intended by s66 of the MHRSA • the need for every episode of ECT performed under s 66(3) to be individually reported to the Tribunal as soon as practicable; • national and international standards relating to performance of ECT; • case law relating to 'immediate necessity'; • case law relating to capacity for consent being specific to each decision which is made; and • an approach which prioritises obtaining timely consent from a substitute decision-maker or authorisation from the Tribunal, so that proceeding with ECT on the basis of s66(3) is truly an option of last resort.

#	Draft Recommendation	Responsibility	Response
7.	Review the Approved Procedures to ensure that they are up-to-date, that their currency is clear, and that they are accessible to the public	DoH	At the meeting of 22 January 2019, APQAC endorsed the review of all approved procedures and associated forms, and the subsequent publication of the updated Approved Procedures to the Department of Health's internet page. A priority system has been established whereby those procedures identified by members as requiring changes to content will be reviewed as soon as possible. This work is ongoing and likely to take considerable time to complete, however, the suggested amendments highlighted in the Revised Draft Report in relation to approved procedures 12 and 30 and their associated forms have been given priority and are currently underway.
8.	Conduct an audit of compliance with requirements under the MHRSA for Tribunal notifications under ss64 and 66 (major medical procedures and ECT), covering a twelve month period.	TEMHS	TEMHS audit ECT procedures biannually against National Safety and Quality Health Service Standards and a report is provided to the ECT committee. (*July – Dec 2018 report attached for reference - Attachment C).* In accordance with Standard 5, the audit monitors: 1. The consumer's identification was checked on arrival and verified (were a consumer to present without an ID band then identification was verified using the three points of ID & a band fitted on arrival or under sedation as appropriate); 2. The consumers consent (or approval by Mental Health Review Tribunal) is checked & documented; 3. The 'time out' is also completed. The audit checklist will be reviewed and modified to ensure that it monitors compliance requirements for ss64 and 66 of the MHRSA.

#	Draft Recommendation	Responsibility	Response
9.	Conduct an audit of completeness of clinical records in cases where ECT has been undertaken, covering a twelve month period	TEMHS	TEMHS undertakes an audit of completeness of clinical records in cases where ECT has been undertaken, covering a twelve month period. The current TEMHS ECT Audit in accordance with Standard 6, National Safety and Quality Health Service Standards measures: 1. Handover on transfer to/from the wards is completed, and 2. The consumers progress notes updated. The audit is biannual and in the calendar year. TEMHS will evaluate the current audit tool to ensure there is comprehensive information on consent and approval process for continuous service quality improvement.
10.	Disseminate the finalised investigation report to all team members involved in decision-making about mental health treatment, performance of major medical procedures, ECT or the Tribunal.	TEMHS/TEHS	The finalised investigation report will be circulated by the General Manager to all team members involved in decision-making about mental health treatment, performance of major medical procedures, ECT or the Tribunal.
11.	Provide training to relevant team members on decision making, record keeping, processes and legal requirements in relation to ECT and major medical procedures in the mental health context, with particular emphasis on documentation under the MHRSA and the role of the Tribunal and other decision makers.	TEMHS/TEHS	Training for the provision of ECT is included in the approved college psychiatric training programme for new Medical Practitioners. Training records are kept and signed by [redacted], Director of Psychiatry TEMHS. The training will be reviewed to ensure that it adequately addresses issues raised by the HCSCC regarding decision making, record keeping, processes and legal requirements in relation to ECT and major medical procedures in the mental health context, with particular emphasis on documentation under the MHRSA and the role of the Tribunal and other decision makers.

#	Draft Recommendation	Responsibility	Response
12.	Document and implement processes for expediting the appointment of substitute decision makers in the mental health context.	TEMHS/TEHS	The current process in place for substitute decision making, is outlined in ss9 to13 of the MHRSA and various procedures located on the Policy Guideline Centre (PGC) where the Health Service has responsibility for emergency care until the Tribunal confirms the order. The relevant procedures will be reviewed and content regarding the appointment of substitute decision makers in the mental health context will be placed into the one procedure to provide visibility of the information.