Human Resources: Disciplinary Action
Proactive Release: 28 March 2019

22 February 2019

[redacted]

Dear [redacted]

Official Information Act (1982) Request

I write in response to your Official Information Act request, dated 24 January 2019. You requested the following information:

- **The details of any disciplinary action or sanction taken since 2012 against Counties Manukau DHB nurses, healthcare assistants and watches arising from allegations of the nurses, healthcare assistants and watches failing to adequately watch a patient/ patients who then subsequently absconded from Middlemore Hospital.**

We note that, we provided previously (in December 2018) a response regarding the number of incidents related to absconding patients, with the opportunity to view summary information on reported incidents of patients absconding while under watches during 2017-2018. On 24 January 2019, you also submitted a further follow-up request to that response.

- **Please could you provide me with the list of the details of the times that patients absconded – the same list I viewed in the HR office last year? We require it for further proceedings.**

Given the information on these two queries is closely related, we are responding to both requests here.

We are not aware of any formal disciplinary action since 2012 against CM Health staff members that was solely attributed to allegations of failing to adequately watch a patient.

All reported incidents are subject to investigation by the service. This will include consideration of any factors that contributed to the incident occurring. Obviously, a patient requiring a watch is clinically assessed as being vulnerable, and in need of additional assistance. However, there are very few circumstances where we can reasonably detain patients against their will. So whilst a Watch or Tracker can provide additional assurance, ultimately if patients want to leave our services, we cannot usually stop them.

Consequently, any action regarding a incident of absconding should focus on the skills of staff to effectively assess risk, de-escalate and appropriately respond to clinical signals, rather than disciplinary

action. Follow-up on an incident report can include discussion with the affected staff, and may include feedback on their contribution to the incident occurring.

However, if there is a pattern of staff behaviour or attitudes that signal a disregard by an individual for the serious duty of care involved in this work, or for CM Health values and behaviours, then we will take action.

Regarding the list of times of incidents included in the report that you viewed, we are willing to arrange another viewing of the summary report you have already seen, however we note the following points.

Incident Reports are completed after an event, and the timing of logging this event may not directly reflect the incident. The incident system may include multiple reports of the same incident, and be reported by several staff, including the watch/carer. There is a narrative (free-text) section in the reports that staff complete. In some cases, staff do not mention the exact time of the incident in this section, just the date.

We have added the additional detail (**table 1**) that we can to the summary table, which we originally provided in our earlier response.

File ID	Incident Date	Service	Person Classification	Specific Incident Type	Time if noted
114115	06/03/2017	PAEDIATRIC WARDS	IN-PATIENT	AWOL	2035-2400
114329	11/03/2017	PAEDIATRIC WARDS	IN-PATIENT	AWOL	1915-2025
114344	12/03/2017	PAEDIATRIC WARDS	IN-PATIENT	AWOL	2125
116206	06/05/2017	EMERGENCY DEPARTMENT	IN-PATIENT	Patient Left Against Medical Advice	n/a
117207	06/06/2017	CORE MENTAL HEALTH ADULT SERVICES	IN-PATIENT	AWOL	n/a
121062	22/09/2017	EMERGENCY DEPARTMENT	IN-PATIENT	AWOL	n/a
121489	06/10/2017	MEDICAL INPATIENT WARDS	IN-PATIENT	AWOL	n/a
123517	10/12/2017	EMERGENCY DEPARTMENT	IN-PATIENT	AWOL	n/a
124899	22/01/2018	GYNAECOLOGY	IN-PATIENT	Patient Left Against Medical Advice	2030
124928	26/01/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Against Medical Advice	1845
126614	17/03/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Against Medical Advice	n/a
126592	17/03/2018	STROKE WARD	IN-PATIENT	AWOL	1015
126590	17/03/2018	STROKE WARD	IN-PATIENT	AWOL	n/a
129083	31/05/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Without Being Seen	2100-2250
129126	01/06/2018	MEDICAL INPATIENT	IN-PATIENT	Patient Left	1715-2000

File ID	Incident Date	Service	Person Classification	Specific Incident Type	Time if noted
		WARDS		Without Being Seen	
132377	04/09/2018	CORE MENTAL HEALTH ADULT SERVICES	IN-PATIENT	AWOL	1900
132483	07/09/2018	EMERGENCY DEPARTMENT	IN-PATIENT	AWOL	n/a
132703	12/09/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	Patient Left Against Medical Advice	0620
133121	23/09/2018	EMERGENCY DEPARTMENT	IN-PATIENT	AWOL	n/a
134402	29/10/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	AWOL	n/a
134442	30/10/2018	MEDICAL INPATIENT WARDS	IN-PATIENT	AWOL	n/a

Table 1

I trust this information satisfactorily answers your query. If you are not satisfied with this response you are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act.

Please note that this response or an edited version of this may be published on the Counties Manukau DHB website.

Yours sincerely,

Fepulea'i Margie Apa
Chief Executive