# Canterbury District Health Board

## A Report by the
## Mental Health Commissioner

## (Case 18HDC02113)

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## Executive summary

1. This report concerns the care provided to a man during an acute admission to Canterbury District Health Board's (CDHB's) psychiatric hospital between 22 August 2017 and 19 September 2017. The man had a history of severe depression, and was admitted because of suicidal ideation and a significant deterioration in his mood. On 4 September 2017, the man jumped from the roof of the High Care Area (HCA), sustaining fractures to both ankles.

2. There was a four and a half hour delay in transferring the man to the Emergency Department (ED) of the public hospital to have his injuries assessed. The man was transferred to ED in a taxi, which was not appropriate for a person with possible fractures, instead of being transported in an ambulance. The man subsequently underwent a number of operations to repair his injuries.

3. The report highlights the importance of staff demonstrating critical thinking, providing appropriate observation for service users in the HCA, and promptly and safely transferring patients to hospital for care. The report makes a number of recommendations to address issues and opportunities for improvement.

### Findings

4. The Mental Health Commissioner found CDHB in breach of Right 4(4) of the Code. He was critical of the inadequate level of observation assigned to the man before the incident, and considered that the man should have been under closer supervision in the HCA courtyard, and also that his transfer to the public hospital was not effected in a safe and timely manner.

### Recommendations

5. The Mental Health Commissioner recommended that CDHB amend the "Observation including specialling" policy to direct staff to maintain the assigned level of observation whilst a consumer is smoking; review local clinical documentation on observations; undertake an audit of ten hospital transfers to ensure adherence to guidelines; provide a written apology to the man; and consider the recommendations of the expert advisor that a registered nurse remain in the outdoor area of the HCA or maintain continuous line of sight whenever a consumer is in the outdoor area; that CDHB review the outdoor area of the HCA for risk of absconding; that CDHB remind staff that supervision of smoking is not the only factor determining the need for observation in the HCA; and that CDHB review existing policy on transfer to acute medical care.

## Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided by Canterbury District Health Board (CDHB). The following issue was identified for investigation:

- *Whether Canterbury District Health Board provided Mr B with an appropriate standard of care in August and September 2017.*

7. This report is the opinion of Mental Health Commissioner Mr Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

8. The parties directly involved in the investigation were:

| | |
|---|---|
| Mr B | Consumer/complainant |
| CDHB | Provider |

9. Further information was received from:

| | |
|---|---|
| RN A | Registered nurse |
| Mrs B | Consumer's wife |
| Consumer's aunt | |
| Consumer's family member | |

10. Also mentioned in this report:

| | |
|---|---|
| Dr C | Psychiatrist |
| Dr D | House surgeon |
| RN E | Registered nurse |

11. Independent expert advice was obtained from Dr Anthony O'Brien, a psychiatric nurse (Appendix A).

## Information gathered during investigation

### Background

12. Mr B, aged in his thirties at the time of events, was admitted to the psychiatric hospital voluntarily on 22 August 2017 owing to a significant deterioration in his mood, and suicidal ideation. He had a history of severe depression, and presented with depressive features, poor sleep, and a poor appetite. The use of the Mental Health (Compulsory Assessment

and Treatment) Act 1992 (the MHA)[1] was not considered at this time. Mr B had experienced a number of psycho-social stressors in the weeks preceding his admission.

13. Mr B also had a history of Type 1 diabetes[2] and complications associated with this, including previous skin grafting of his right foot for an ulcer, significant reduction in sensation in his left foot secondary to diabetic neuropathy,[3] and a left foot drop[4] following an injury. Prior to being admitted, Mr B had decided to stop taking his regular prescribed insulin, but occasionally he would inject himself with it. Clinical notes indicate that Mr B expressed that he had "given up on looking after his diabetes".

14. When Mr B was admitted to the open, unlocked ward, he was under regular ward observations,[5] as it was felt that his risks could be managed appropriately in this context. The admitting psychiatrist, Dr C, advised that Mr B should not have access to his insulin, and should be supervised during self-administration.

15. During the early stages of Mr B's admission, some improvement in his mental state was noted, and it was agreed that he could go on leave for the weekend beginning 25 August 2017. During a physical examination with the ward house surgeon immediately prior to going on leave, Mr B disclosed that he had been hearing a solitary male voice. He reported that the voice had told him that he should harm or kill a family member. When questioned about this, Mr B denied any desire to carry out the direction, and requested medications to help calm him if he heard the voice. Mr B's disclosure was discussed with his consultant psychiatrist at the psychiatric hospital, who prescribed quetiapine[6] to be taken as needed. Mr B was then placed on leave for that weekend.

16. Mr B returned to the psychiatric hospital at 2pm on 27 August 2017. No concerns regarding his mental state were noted at this time.

17. At 8am on 28 August 2017, staff struggled to rouse Mr B from his sleep. His blood sugar levels were tested and found to be dangerously low. When Mr B regained consciousness, he reported to staff that he had injected himself with a large dose of insulin. As a result, he was transferred to the public hospital so that his blood sugar levels could be stabilised. While in the Emergency Department (ED), Mr B's wife, Mrs B, told staff that he had told her that he believed he had only 6–12 months to live because of his medical issues, and therefore he wished to die. Mr B's risk of suicide and/or self-harm was escalated from moderate risk to high risk. Mr B returned to the psychiatric hospital later that day.

[1] The MHA defines the limited circumstances under which a consumer can be assessed or made to receive treatment without his or her consent.
[2] A condition in which the pancreas produces little or no insulin (a hormone needed to process sugar).
[3] Nerve damage caused by long-term high blood sugar levels.
[4] Muscular weakness or paralysis that makes it difficult to lift the front part of the foot and toes.
[5] Patients are checked every 30 minutes between 7am and 11pm, and hourly outside of these times. If a patient is presenting in a manner that indicates increased risk, these observations can be increased as per the observation policy (discussed further below).
[6] An antipsychotic medication taken to reduce symptoms such as extreme mood swings and the experience of hearing voices/hallucinations.

18. On 29 August 2017, Mr B walked off the open ward at the psychiatric hospital at approximately 11.30am. He was observed walking in the middle of the road near the psychiatric hospital. When staff approached him to question where he was going, he stated that he was trying to find a tall building to jump off. He returned to the ward with staff.

19. In response to Mr B absenting himself from the ward and expressing suicidal ideations, his observation levels were increased to Level 3, requiring him to be sighted by staff once every 5 to 15 minutes. This is the highest level of observation that can be reached without a person being placed under constant supervision.

20. Over the course of the day on 29 August 2017, it was documented that Mr B's mood appeared to be improving, and it was felt that his risk of leaving the ward again or of harming himself had reduced significantly. He was returned to regular ward observations on the morning of 30 August 2017.

21. On 30 August 2017, Mr B attended another psychiatric assessment with Dr C. Mr B reported experiencing some improved days, and told Dr C that he would like to go home on leave and see how he felt, because he wanted to spend some time with his family. During the assessment, Mr B reported that the voice he was hearing had told him to harm himself and his family, but that he was not experiencing suicidal or homicidal ideations at that time. He was placed on overnight leave and advised that he could contact the psychiatric hospital and/or return to the ward if he felt unsafe.

22. At 2.30pm on 31 August 2017, Mrs B telephoned the psychiatric hospital to report that her husband had expressed suicidal ideations with a plan to harm himself and others. She was concerned that he would not be safe at home. Mr and Mrs B did not have access to transport, so Mrs B was advised by staff to order a taxi for his return, and a taxi chit would be provided. Mr B returned to the psychiatric hospital at approximately 3.20pm that afternoon.

23. On the evening of 1 September 2017, Mr B was placed under section 11 of the MHA,[7] owing to his escalating risk to both himself and others. Mr B had stated to the psychiatric hospital staff that he had thoughts of killing his family and then killing himself, with the intention to "be together in heaven". Owing to concern that Mr B might absent himself from the open ward without leave, he was transferred to the locked High Care Area (HCA). The HCA is a three-bed secure area, and at that time Mr B was the only patient in the area. Mr B was on HCA observations, which require a patient to be observed at 5–15 minute intervals with variable timing to avoid predictability. This is an increase from the regular ward observations, which require patients to be checked every 30 minutes between 7am and 11pm, and hourly outside of these times.

[7] If there are reasonable grounds for believing that the patient is mentally disordered and that it is desirable that the patient be required to undergo further assessment and treatment, the health practitioner must require the patient to undergo further assessment and treatment for five days (amounting to compulsory treatment). The health practitioner must give the patient written notice of this requirement.

**Events of 4 September 2017**

24. On 4 September 2017, Mr B remained in the HCA under HCA observations, with observations at intervals of between 5 and 15 minutes.

25. Clinical notes describe Mr B as "feeling low throughout the day". In the morning he was observed flipping and stacking chairs in the HCA to try to climb the fence. He was advised by a nurse to cease this behaviour as it would "not have a desirable outcome". He was described as being "overburdened with frustration" and a high risk to himself owing to suicidal ideations.

26. It is noted in the clinical records that at an unspecified time on the morning of 4 September 2017, Mr B attempted to inject himself with insulin, and later he disclosed that he had hidden it in the ward previously.

27. At an unspecified time during the afternoon, Mr B was granted leave from the psychiatric hospital to attend to some financial matters. He was accompanied by his wife, a social worker, and a registered nurse, and clinical documentation indicates that Mr B managed this well.

28. At 3.10pm, RN A began an afternoon shift in Mr B's unit as the shift lead, with one healthcare assistant under his delegation.[8] At shift handover, RN A was made aware that earlier in the day Mr B had been stacking chairs in the HCA courtyard to attempt to climb the fence. RN A told HDC that he recalls noticing that whilst the door from the HCA to the main ward was locked, the door to the courtyard was unlocked. He looked outside into the courtyard to see whether there was any furniture that could be stacked to enable Mr B to climb the HCA fence. He saw a solitary, small and low-to-the-ground chair in the courtyard area. RN A told HDC that he was not concerned about the chair at the time, as he had been told that Mr B had been stacking multiple items of furniture in the morning, and this chair was less than one metre in height.

29. RN A also told HDC that whilst technically Mr B was on HCA observations, the fact that he and one healthcare assistant had been assigned to care for only him over the afternoon shift meant that effectively Mr B was on Level 2 observations. These require the patient to be within a continuous line of sight, as outlined in the policy below.

30. At approximately 4.10pm, Mr B received a telephone call from his family. They informed him that they were taking a family member to the public hospital for an X-ray. Mr B was distressed at this news, and repeatedly requested that he be granted leave to attend the public hospital with his family. These requests were declined by Mr B's consultant psychiatrist owing to the risk Mr B posed to both his family and himself, given his suicidal and homicidal ideations. Mr B was further distressed by this decision and became agitated and verbally aggressive towards staff, who attempted to de-escalate Mr B by promising that he could telephone his injured family member once he arrived at the ED and he had

[8] At the time of these events, CDHB utilised staff, including healthcare assistants, from nursing bureaux within the area. CDHB was unable to ascertain which agency provided the healthcare assistant who worked on the afternoon shift with RN A. RN A does not recall the name of the healthcare assistant.

been assessed by medical staff. Mr B was not accepting of this, and remained in a state of agitation.

31. RN A moved to the HCA office to telephone staff on the main ward to discuss Mr B's condition and obtain further assistance, as Mr B's agitation was increasing. RN A asked the healthcare assistant to watch Mr B while he did this.[9]

32. At approximately 4.25pm, Mr B moved into the HCA courtyard to smoke. The healthcare assistant observing Mr B was sitting just inside the door of the HCA, and could see Mr B in the courtyard. RN A told HDC that Mr B would have been in the healthcare assistant's line of sight continuously.

33. CDHB has a Smokefree policy that bans the smoking of cigarettes on all of its sites; however, many consumers smoke in the fenced courtyard areas at the psychiatric hospital.[10]

34. CDHB told HDC that there is inconsistency in the approach amongst nursing staff and healthcare assistants to allowing smoking in the inpatient environment. Some will firmly refuse to accompany consumers while they smoke, while others may passively facilitate by remaining present. Mr B told HDC that before he entered the courtyard, the healthcare assistant who was observing him told him in an angry tone that it was "not in her job description to look after patients who smoke".

35. At approximately 4.30pm, the healthcare assistant moved to the HCA office and reported to RN A that Mr B was on the roof of the HCA. He had wedged a chair into the HCA courtyard fence to assist his climb onto the roof. RN A told HDC that there would have been an interval of approximately one minute at the most between his leaving to use the HCA office telephone and the healthcare assistant alerting him to the fact that Mr B was on the roof.

36. Mr B told HDC that whilst on the roof of the building, he suddenly felt "extremely lonely, depressed, [and] emotional" and "became suicidal".

37. RN A and the healthcare assistant then saw Mr B jump from the roof — a drop of approximately 2.5 metres — to the grass next to the building. He attempted to run away but soon collapsed. Mr B was immediately attended by RN A and the healthcare assistant. Mr B voiced his distress that he was unable to see his family, and said that he believed he had broken bones as a result of his jump from the roof. He was unable to mobilise unaided, and a wheelchair was sourced to return him to the ward.

[9] CDHB policy at the time indicated that observations were able to be delegated and directed by a registered nurse.

[10] The Smokefree policy states: "Although staff cannot force a patient/client to stop smoking outside, staff should not actively facilitate or assist patients/clients to smoke on the hospital grounds and not escort any patient/client for the purpose of smoking but should instead offer support and [nicotine replacement therapy]."

38. Mr B was assessed by Dr D, a house surgeon who was working under the direction of senior Specialist Mental Health Services staff. Dr D attempted to mobilise Mr B unsuccessfully. Mr B stated that the pain was unbearable with any weight bearing. Dr D stabilised Mr B's ankles and the soles of his feet and arranged for him to be seen by the Orthopaedics Department at the public hospital for assessment. Mr B was administered codeine for pain management. Whilst waiting to be transferred to hospital, he continued to complain of pain, demand morphine from staff, and request to see his injured family member.

39. Dr D telephoned the Orthopaedics Department at the public hospital (time unknown) and was told that Mr B's injured family member had yet to be seen and would likely be in the department for at least 2–3 hours. She advised the Orthopaedics team that someone from the psychiatric hospital would call again later for an update.

40. CDHB told HDC that because of the significant concerns about Mr B's suicidal ideations and auditory hallucinations instructing him to harm his family, who were at the ED, it was deemed not appropriate to transport Mr B to the hospital immediately. CDHB also reported that following assessment by Dr D and discussion with the orthopaedic registrar at the public hospital, it was determined that the acuity of Mr B's injury was such that he could remain at the psychiatric hospital until his family were no longer there.

41. In addition, it is noted in the clinical record that Mr B's blood sugar levels had destabilised at this time. CDHB told HDC that the staff caring for Mr B after his fall felt that his blood sugar levels needed to stabilise before he could be transferred to the public hospital.

42. Mr B told HDC that he was dropped on the floor while he was being transferred from his wheelchair to a bed after the incident. CDHB told HDC that there is no record of this in the clinical documentation, and that staff do not recall it occurring. Staff are expected to document and report all falls events.

43. While Mr B remained at the psychiatric hospital prior to being transferred to hospital, he continued to be distressed, agitated, and anxious, particularly about not being able to see his injured family member. He complained of pain in his feet, and continued to demand morphine, which was declined. At this time, Mr B's active care included compression, ice, and elevation of his injuries, the administration of pain medication, and observations. Mr B attempted to call the emergency 111 telephone line a number of times. He told HDC that he felt that staff at the psychiatric hospital did not take his injuries seriously enough.

44. Mr B told HDC that his wife, his aunt, and another family member, Ms C, arrived at the psychiatric hospital not long before his transfer to the hospital, as staff had telephoned Mrs B and advised her of the incident. These three family members provided HDC with a statement that when they arrived at the psychiatric hospital, Mr B was in a lot of pain. They said that they offered to transport Mr B to the hospital themselves rather than wait for a taxi, but this was declined. Mr B's family recalled that when the taxi arrived, Mr B was made to climb from his wheelchair into the front seat himself, and that he cried out from the pain and was assisted by Mrs B and another family member.

45. CDHB told HDC that there is no record of Mr B's family attending the psychiatric hospital immediately prior to his transfer to the hospital, and that it would expect staff to document such information. Psychiatric hospital staff do not recall the family being in attendance at this time, but recall that Mr B received a number of telephone calls from them.

46. At approximately 9.15pm, Mr B, accompanied by a registered nurse, was transferred to the public hospital by taxi to obtain X-rays of his injuries, with a plan to return to the ward after being treated. CDHB told HDC that a taxi was used to transport Mr B to the hospital as it was thought that an ambulance might not attend for several hours, given that the acuity level of Mr B's injury was low. Mr B told HDC that he feels that his transfer was not facilitated in a timely manner.

47. Mr B was reviewed by the Orthopaedics registered nurse and house officer at the public hospital at 9.45pm. X-rays completed at 10.15pm identified that Mr B had bilateral fractures[11] on both ankles. It was noted that treatment with casts was likely, and that a need for surgery was possible.

**Subsequent events**

48. On 5 September 2017, Mr B underwent the first of a number of surgeries on his feet at the public hospital. Clinical records indicate that Mr B's recovery was affected adversely by his post-surgery weight-bearing contrary to the advice of the Orthopaedics team, and by his poorly managed diabetes.

49. With continuing support from the mental health service during his time at the public hospital, Mr B made significant improvements in his mental health, and was discharged on 19 September 2017.

**Observation policies at the psychiatric hospital**

50. The observation policy in place at the psychiatric hospital at the time of these events, entitled "Observation including specialling", stated:

> "Policy
>
> Each ward will have a standard level of observation. This will depend on routine observation requirements for each consumer within the ward.
>
> …
>
> The most appropriate clinically safe and effective treatment options will be provided by:
>
> - Effective clinical assessment to determine the level of observation. This include[s] assessment of risks and a clear risk management plan.
>
> …

[11] Fractures on both sides.

The observation should be at the least restrictive level, for the least amount of time within the least restrictive setting.

…

Levels of observation

Level 1: Specialling (arm's length)

Level 1 may be required for a consumer assessed to be at extreme or high risk of sudden and/or unpredictable or impulsive behaviour that presents a danger to themselves or others in the context of their illness and the environment.

…

The consumer must be within arm's reach and in clear sight of the nurse at all times. This includes bathroom and toilet areas.

…

Level 2: Constant Observation (within line of sight)

Level 2 may be required for a consumer assessed as high or increasingly high risk in the context of their illness and the environment. The significant difference between level 1 and level 2 is the immediate and impulsive risk where arm's length is required.

The consumer remains in unobstructed sight and close proximity (in order to react in a timely manner) of the assigned nurse or delegated staff.

…

Level 3: 5–15 minute observations

Level 3 may be required for a consumer whose mental state may be deteriorating and whose risks to themselves or others may be increasing. This may include physical deterioration.

Level 3 is for consumers who require a high level of pro-active engagement and management of risks and/or distress but do not require a constant nursing presence.

Observations must be undertaken at intervals of between 5 and 15 minutes. The timing of the observation should be varied within the timeframe to ensure the observation is not predictable. Each observation will include a discussion and assessment of the consumer's level of distress with the consumer, undertaking any interventions required and discussing any issues with the [Charge Nurse Manager]/delegate.

…

Level 4: 15–30 minute observations

Level 4 may be implemented when risk factors indicate that therapeutic interaction is required at an increased level from standard clinical observation.

> Observations must be undertaken at intervals between 15 and 30 minutes. The timing of the observation should be varied within the timeframe to ensure the observation is not predictable. Each observation will include a discussion and assessment of the consumer's level of distress with the consumer, undertaking any interventions required and discussing any issues with the [Charge Nurse Manager]/delegate.
>
> …
>
> Standard ward and clinical observation
>
> This level is for a consumer whose clinical presentation and risks are not assessed as requiring increased observation. Standard ward observations require observation and immediate intervention as required including reporting any changes in the consumer's health status to the assigned nurse. The Registered Nurse ensures that the consumer is sighted at least hourly. Sighting includes an assessment of the consumer's mental state, level of consciousness and whether extra support for the consumer is required.
>
> This is the standard observation level for inpatient wards.
>
> Inpatient units with more frequent intervals for standard observations include:
>
> …
>
> - Acute inpatient units: 30 minutes 0700–2300 hours and 60 mins 2300–0700 hours …"

51. CDHB also had a policy in place specific to the HCA at the psychiatric hospital, entitled "High Care Areas in [the Adult Acute Inpatient Service] — practice guidelines". It stated the following with regard to observations:

> "4. Observation of consumers within the HCA
>
> Consumers identified as requiring HCA level care will be placed on standard 15 minute observations 0700–2300 hours and 30 minute observations between 2300 and 0700 hours unless formal levels of observations are required."

52. CDHB told HDC that all patients are assessed on an ongoing basis in regards to mental state and, if any, associated risk.

**Further information from CDHB**

53. The incident of 4 September 2017 received a Severity Assessment Code (SAC)[12] rating of 3, and therefore was not recorded as an adverse event and was not reviewed by the CDHB Serious Event Review Team (SERT), in accordance with the Health Quality & Safety Commission (HQSC) framework.

[12] A rating and triage tool for adverse event reporting provided by the HQSC. A rating of 1 occurs when an event is considered severe. A rating of 2 is for a major event, a rating of 3 is for a moderate event, and a rating of 4 is for a minimal to minor event. A rating of 1 or 2 requires that the event is reported to the HQSC and a review is undertaken by the provider, with a summary of the findings sent to the HQSC.

54. CDHB told HDC that there has since been a change in process, with fracture injuries as a result of a fall now to receive an SAC rating of 2 (which involves review by the SERT).

55. CDHB apologised to Mr B that this incident did not receive any formal review, and acknowledged that this should have occurred. Specialist Mental Health Services now escalate incidents such as this to SERT. The change occurred following this incident, and the relevant practice guideline has been reviewed and updated accordingly.

56. The observation records pertaining to the time leading up to the incident of 4 September 2017 were not specific for Mr B's care. Instead, his observations were recorded on the general ward observation form, which includes the HCA rooms. Observations were not recorded in Mr B's personal progress notes. As this incident was also not recorded as an adverse event owing to the practice at the time regarding such incidents, the documents went into the general ward storage. The standard practice for the storing of these records is to do so for six months before destroying them. This is not stipulated by any written protocol or policy.

57. CDHB apologised for the fact that Mr B did not feel his injuries were taken seriously by the psychiatric hospital staff, and stated that the team recognised the seriousness of his injuries but also took into account other critical aspects of his condition and circumstances to facilitate a safe and timely transfer to the public hospital.

**Responses to provisional opinion**

58. Mr B was given an opportunity to respond to the "information gathered" section of the provisional opinion. He reiterated his concerns about the care he received and re-stated that his family were present after his fall.

59. CDHB was given an opportunity to respond to the provisional opinion, and accepted the finding that it failed to provide services to Mr B in a manner that minimised potential harm to him. CDHB commented that Mr B was under observation, and stated:

> "[Mr B's] exit from the courtyard via unexpected means was a rapidly evolving situation with no opportunity to intervene. We consider that the healthcare assistant observing [Mr B] reacted appropriately and in a timely manner by alerting the registered nurse immediately to [Mr B's] attempt to abscond."

60. CDHB considered that it was appropriate for Mr B's transfer to the Emergency Department to be delayed. Mr B was very distressed after he received the news regarding his injured family member, and there were concerns about his recently expressed thoughts of harming his family and himself. CDHB stated that Mr B's condition was considered to be stable, and he received analgesia and supportive care at the psychiatric hospital while he waited. CDHB acknowledged that transfer in a taxi was not appropriate for a person with a possible fracture, and that Mr B should have been transported in an ambulance.

## Opinion: Canterbury DHB — breach

### Introduction

61. During his admission to the psychiatric hospital in 2017, Mr B received care from a range of individual health providers employed by CDHB. CDHB had overall responsibility to ensure that Mr B was provided with services in a manner that minimised any potential harm to him. I am concerned with some aspects of that care.

### Observation levels

62. Whilst admitted to the HCA at the psychiatric hospital, Mr B was under HCA observations, which required him to be sighted at 5–15 minute intervals, with variable timing to avoid predictability. This is the same level of observation required for those patients who are not in the HCA and are on Level 3 observations in other wards of the psychiatric hospital. RN A, the nurse supervising Mr B on the afternoon of 4 September 2017, told HDC that effectively Mr B was on Level 2 observations immediately before he jumped from the roof of the HCA building, because he was in the healthcare assistant's continuous line of sight, as was required by Level 2 observations.

63. My expert advisor, Dr O'Brien, stated that placing Mr B under Level 2 observations would have needed to follow a reassessment of his risk, and be formally delegated by RN A to the healthcare assistant, neither of which appear to have taken place. In addition, the healthcare assistant does not seem to have been in close proximity to Mr B as required by Level 2 observations.

64. Dr O'Brien described the level of observation assigned to Mr B at this time to be a mild deviation from the accepted standard of care. Dr O'Brien accepts that Mr B was under continuous line of sight and probably was being observed more intensively than his assigned level of observation, Level 3, would suggest. I too accept this. However, Dr O'Brien also noted that Mr B's wedging of the chair into the HCA courtyard fence and the scaling of the fence may not have been observed. He commented that either the healthcare assistant did not react when Mr B began his successful attempt to escape, or Mr B was not under continuous line of sight, as was suggested by RN A.

65. Dr O'Brien noted that the CDHB policy "Observation including specialling" in place at the time of these events was fit for purpose.

66. I accept that Mr B was under a higher level of observation than Level 3 at the time of the incident, but consider that it was not equivalent to Level 2 observations. The guidelines for observation levels should be followed consistently, and the designation of Level 2 or 3 observations for each patient should be done carefully and appropriately for their condition at that time.

### Supervision in HCA courtyard

67. On the morning of 4 September 2017, Mr B was observed by the psychiatric hospital staff attempting to stack furniture in the outdoor area of the HCA in an attempt to abscond. He was advised to cease this behaviour.

68. On the afternoon of 4 September 2017, Mr B became agitated and upset after receiving a telephone call from his family advising him that a family member had had an accident and required X-rays. Mr B's requests for leave to visit the ED to be with his family were declined by the psychiatric hospital staff owing to concerns about Mr B's suicidal and homicidal ideations, which involved his family members. Mr B was under a compulsory treatment order pursuant to the MHA at this time. He was being supervised by RN A with the assistance of a healthcare assistant and was on HCA observations, which require a patient to be observed at 5–15 minute intervals with variable timing to avoid predictability.

69. Whilst in a state of agitation, Mr B moved to the courtyard area of the HCA, and was observed at a distance by the healthcare assistant, while RN A relocated to the HCA office to telephone for further assistance to manage Mr B's increasing state of agitation. The healthcare assistant observing Mr B was sitting just inside the door, between the HCA and the outdoor area where Mr B had moved to smoke, and could see Mr B but was not in close proximity to him, as required under level 2 observations. RN A told HDC that Mr B would have been in the healthcare assistant's line of sight continuously. Despite this, Mr B managed to use the single chair that was in the outdoor area to climb onto the roof of the HCA, and he jumped off the building so that he was outside the fenced area.

70. I note that at the time of these events, the policy in place at the psychiatric hospital relating to observations stated:

> "[T]he most appropriate clinically safe and effective treatment options will be provided by effective clinical assessment to determine the level of observation. This includes assessment of risks and a clear risk management plan."

71. I also note CDHB's comments that all patients are assessed on an ongoing basis in regard to mental state and, if any, associated risk.

72. However, Dr O'Brien advised that Mr B should not have been alone in the HCA courtyard, even for the brief time it took for RN A to make the telephone call in the HCA office, and despite being observed by the healthcare assistant from outside the courtyard. Dr O'Brien noted that Mr B had attempted to abscond that morning, there was concern about his suicidality, and he was becoming increasingly more agitated about being detained at the psychiatric hospital. These factors elevated the existing risk, necessitating a higher level of observations, at least in the short term. Dr O'Brien advised that "line of sight" observation by the healthcare assistant from inside the door to the outdoor area was not an adequate level of observation in the circumstances, amounting to a moderate departure from accepted standards of care. I accept Dr O'Brien's advice and agree that the warning signs of Mr B's condition should have been given greater weight by the psychiatric hospital staff.

**Transfer to hospital**

73. After jumping from the roof of the HCA building and sustaining bilateral ankle injuries, Mr B was not transferred to the public hospital ED to have his injuries assessed until approximately four and a half hours later. Mr B remained at the psychiatric hospital during

this time, and was provided with pain medication and first aid treatment for his injuries. He also underwent regular assessment and observations during this waiting period.

74. CDHB told HDC that the reasons for detaining Mr B at the psychiatric hospital included their assessment of the acuity of Mr B's injuries, the fact that his family were in the ED and Mr B's condition meant that he posed a risk of harm to them, the recognition that Mr B could receive appropriate care at the psychiatric hospital whilst waiting for his family to leave the public hospital, and the fact that his blood sugar levels were unstable and required addressing before transfer to hospital.

75. Mr B told HDC that his wife, his aunt, and another family member arrived at the psychiatric hospital not long before his transfer to the ED. A statement provided to HDC by these three family members reported that when they arrived at the psychiatric hospital, Mr B was in a lot of pain. The family members advised that they offered to transport Mr B to the ED themselves rather than have him wait for a taxi, but this was declined.

76. CDHB told HDC that there is no record of Mr B's family attending the psychiatric hospital immediately prior to his transfer to the ED, and it would be expected that staff would document such information. Psychiatric hospital staff do not recall the family being in attendance at this time, but recall that Mr B received a number of telephone calls from them. I am unable to ascertain whether Mr B's family did attend the psychiatric hospital on the evening of 4 September 2017, but this does not affect my decision regarding the appropriateness of the transfer to ED.

77. Eventually, Mr B was transferred to ED in a taxi, accompanied by a registered nurse. There he was reviewed by the orthopaedics registered nurse and house officer and X-rays were completed. It was identified that Mr B had bilateral fractures to his ankles and would require casts and possibly further surgery.

78. Dr O'Brien acknowledged that Mr B was well cared for at the psychiatric hospital while waiting to be transported to the public hospital. Dr O'Brien advised that it is reasonable that the psychiatric hospital staff had concerns about Mr B's behaviour within the ED, but noted that EDs have ways of managing agitated consumers that would have mitigated the risk to Mr B's family adequately. Dr O'Brien noted that Mr B had severe injuries — he was unable to be mobilised and stated that the pain was unbearable with any weight bearing. Mr B's ankles were stabilised and he was administered codeine for pain management. Whilst waiting to be transferred to hospital he continued to complain of pain. Dr O'Brien noted that Mr B already had impaired function of his lower legs owing to complications from his diabetes, which would necessitate a timely transfer.

79. Dr O'Brien does not accept that Mr B's blood sugar level needed to be stabilised prior to transfer to hospital. Dr O'Brien advised that sometimes ambulances are called specifically because of low blood sugar levels and are able to manage the issue, as are EDs.

80. Dr O'Brien also noted that taxi transport was not appropriate in this instance. He advised that Mr B should have been transported by ambulance urgently, as would have happened if his injuries had occurred at his private address or in a public place. Dr O'Brien also

advised that transport by taxi involved Mr B having his legs in a dependent position,[13] which would have contributed to pain and swelling and is not ideal for someone with suspected lower leg fractures with existing damage to his ankles and with circulatory impairment due to diabetes.

81. Dr O'Brien advised that, overall, the delay in transporting Mr B to ED and the mode of transport represent a moderate departure from the accepted standard of care. Dr O'Brien stated that when there is a risk of complications, as there was in Mr B's case, transfer should be effected in a safe and timely manner and not be delayed unduly. Dr O'Brien further advised that Mr B's condition could not have been monitored in a taxi as it could have been in an ambulance.

**Conclusion**

82. I am concerned that several staff at the psychiatric hospital demonstrated a lack of critical thinking with regard to the care that Mr B received leading up to and after the incident of 4 September 2017, when Mr B sustained bilateral injury to his ankles after jumping off a roof. I consider that the overall picture of Mr B's condition was not taken into account in the decision-making of staff to ensure a safe physical environment and prompt action after the incident. In particular, I note the following failings:

- The level of observation assigned to Mr B before the incident did not allow for adequate observation of his behaviour or adequate time to react to this behaviour, especially given Mr B's state of agitation immediately prior to the incident and his attempts to abscond earlier in the day.
- Mr B should have been observed in the courtyard of the HCA by staff who were at close proximity to him, given the clinical risks with which he was presenting.
- Mr B's transfer to the public hospital was not effected in a safe and timely manner. It was delayed unduly, for four and a half hours, and should not have been by taxi but by ambulance.

83. As a result, CDHB failed to provide services to Mr B in a manner that minimised potential harm to him and, accordingly, breached Right 4(4) of the Code of Health and Disability Services Consumers' Rights (the Code).[14]

**Further issues — other comment**

*Fall from wheelchair*

84. Mr B reported that whilst being transferred by the psychiatric hospital staff from his wheelchair to a bed after the incident of 4 September 2017, he was dropped on the floor. CDHB told HDC that there is no record in the clinical documentation that this occurred, and staff do not recall it occurring. Staff are expected to document and report all falls events.

[13] Hanging down.

[14] Right 4(4) states: "Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer."

85. I am unable to reconcile these two accounts. Whilst neither account is preferred over the other, I am unable to make a factual finding as to whether Mr B was dropped by the psychiatric hospital staff. Notwithstanding this, I would be very critical if such an incident had occurred and staff had not documented the incident and taken appropriate action.

*Insulin administration*

86. When Mr B was admitted to the psychiatric hospital, Dr C indicated that he should not have access to his insulin, and that he should be supervised during self-administration.

87. On 28 August 2017, Mr B accessed an insulin syringe in his room, resulting in a low blood sugar level. On 4 September 2017, Mr B attempted to inject insulin from a syringe apparently hidden on the ward. It appears that on both of these occasions, Mr B had secreted insulin within his room. The incidents did not involve staff allowing Mr B to administer insulin unsupervised.

88. Dr O'Brien noted that according to clinical documentation from Mr B's admission, nursing staff seem to have maintained an awareness of the possibility that Mr B might again access insulin and attempt to inject himself unsupervised. Dr O'Brien is satisfied that there was no departure from the accepted standard of care with regard to Mr B self-administering insulin whilst unsupervised. I accept his advice.

## Recommendations

89. I note that since the events in question, CDHB's Specialist Mental Health Services team now consider fracture injuries that occur as a result of a fall to rate as an SAC 2 score, which involves review by the SERT team, and that guidelines have been amended to reflect this. I consider this to be appropriate in the circumstances.

90. I recommend that CDHB:

a) Provide a written apology to Mr B for the breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mr B, within three weeks of the date of this report.

b) Amend the "Observation including specialling" policy to direct staff to maintain the assigned level of observation for a consumer whilst the consumer is smoking, and include guidance on what to do if a situation is escalating. CDHB is to provide evidence of the updated policy to HDC within four months of the date of this report.

c) Review local clinical documentation on how formal observations are recorded, implemented, handed over, and reviewed, and:
   i. Ensure any new systems and tools developed as a result of the review are auditable

ii. Systematically use incident data to track over time the number of occasions when an inability to maintain observations is reported by staff and identify trends, themes, and improvement opportunities

iii. Report back to HDC on the outcome of the review, including follow-up actions, within four months of the date of this report.

91. CDHB has advised HDC that in 2019 it updated its Hospital Health Pathways to ensure that consumers are transferred "in a suitable vehicle depending on their presentation" and are accompanied by a [registered nurse] or enrolled nurse". In light of this, I recommend that CDHB undertake an audit of ten hospital transfers from the past year to ensure that the updated pathway and its guidelines are being adhered to, and provide HDC with the results of the audit within four months of the date of this report.

92. I recommend that CDHB consider the following recommendations from my expert advisor, Dr Anthony O'Brien, and report back to HDC on the outcome of these considerations within four months of the date of this report:

a) To have a registered nurse in the outdoor area of the HCA any time there is a consumer there, or ensure that the area is within continuous line of sight.

b) Review the outdoor area of the HCA for risk of absconding, including the design of the fence and the furniture placed in the area.

c) Remind staff that although the outdoor area of the HCA is used for smoking, supervision of smoking is not the only factor determining the need for observation while in the area, and risk of self-harm, harm to others, and absconding also need to be considered.

d) Review existing policy on transfer to acute medical care, focusing on clearly distinguishing between a simple transfer from one setting to another and when an acute medical event such as a serious injury should be treated as an emergency.

## Follow-up actions

93. A copy of this report with details identifying the parties removed, except CDHB and the expert who advised on this case, will be sent to the Director of Mental Health and Addiction Services, Te Ao Māramatanga — New Zealand College of Mental Health Nurses, and the Health Quality & Safety Commission.

94. A copy of this report with details identifying the parties removed, except CDHB and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from psychiatric nurse Dr Anthony O'Brien:

"September 6, 2019

Report prepared by Anthony O'Brien, RN, PhD, FANZCMHN

**Preamble**

I have been asked by the Commissioner to provide expert advice on case number C18HDC02113. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

**Qualifications**

I qualified as a registered male nurse in in 1977 and as a registered psychiatric nurse in 1982. I hold a Bachelor of Arts (Education) (Massey, 1996), a Master of Philosophy (Nursing) (Massey, 2003) and a Doctor of Philosophy in Psychiatry (Auckland, 2014). I am a past President and current Fellow and board member of Te Ao Māramatanga, the New Zealand College of Mental Health Nurses. I am currently employed as Nurse Specialist (Liaison Psychiatry) with the Auckland District Health Board and a Senior Lecturer in Mental Health Nursing with the University of Auckland. My current clinical role involves assessment and care of people in acute mental health crisis and liaison in relation to people with mental illness in the general hospital. My academic role involves teaching postgraduate mental health nurses, supervision of research projects, and research into mental health issues. In the course of my career as a mental health nurse I have been closely involved with professional development issues, including development of the College of Mental Health Nurses *Standards of Practice*. I have previously acted as an external advisor to mental health services following critical incidents and as advisor to the Health and Disability Commissioner.

The purpose of this report is to provide independent expert advice about matters related to the care provided to [Mr B] by Canterbury District Health Board (CDHB) from 22 August 2017 to 19 September 2017. I do not have any personal or professional conflict of interest in this case.

Instructions from the Commissioner are:

Please review the enclosed documentation and advise whether you consider the care provided to [Mr B] by Canterbury District Health Board was reasonable in the circumstances, and why.

In particular I have been asked to address the following questions:

1. Whether the level of observations [Mr B] was placed on was appropriate once he was placed under the Mental Health Act.

2. Whether it was appropriate to leave [Mr B] unattended in the HCA courtyard when he requested to smoke on 4 September 2017, given he was observed trying to climb the fence that morning.
3. The adequacy of the Observations including specialling policy and Smokefree policy in place at the time of [Mr B's] care.
4. The management of [Mr B's] injuries after his fall.
5. Any other matter which you consider may be a departure from the accepted standard of care.

In relation to the above issues I have been asked to advise on:

a. What the standard of care/accepted practice is;
b. If there has been a departure from the standard of care or accepted practice, how significant a departure it is.
c. How the care provided would be viewed by your peers
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

I have had the following documents available to me for the purpose of writing this report:

1. Letter of complaint from [Mr B], 5 November 2018.
2. Response to [Mr B's] complaint, from [CDHB] 18th February 2019.
3. Further letter of response to [Mr B's] complaint from [CDHB], 23 May 2019.
4. Clinical records from Canterbury DHB covering the period 22 August 2017 to 19 September 2017 (some of these records extend beyond 19 September).
5. Canterbury DHB Smokefree (Auahi Kore) Policy.
6. Canterbury DHB policy on observations, including specialling
7. Incident report, 4 September 2017
8. Canterbury DHB Observation recording forms
9. An email from Canterbury DHB clarifying the observation policy.

**Outline of events**

[Mr B] was admitted to the … Inpatient Unit at [the psychiatric hospital] on 22 August 2017. His psychiatric diagnosis was depression with suicidal thoughts. In addition, [Mr B] had Type 1 diabetes mellitus which was poorly controlled, resulting in several adverse outcomes, including peripheral neuropathy and gastric dysmotility. He had had four previous surgeries to his feet. On September 1, a day after leaving the ward without informing staff, [Mr B] was placed under section 11 of the Mental Health Act. He was assessed as presenting a high risk of self harm and had voiced thoughts that he would harm others, specifically [members of his family]. [Mr B] was moved to the High Care Area of the ward on September 4. At 4.10pm [Mr B] received a phone call to say that [a family member] was in [the] Emergency Department with [an injury]. Because

of his expressed intention to harm [this family member], [Mr B] was refused leave to visit [him] in the emergency department. He did not accept this decision and was agitated about it. That afternoon [Mr B] went to the outdoor enclosed courtyard of the High Care Area. While in the courtyard earlier in the day [Mr B] had been observed stacking chairs against the fence, apparently in an attempt to abscond. He was advised by [RN E] to desist for fear of adverse outcomes. At 4.30 that afternoon, while in the outdoor area [Mr B] wedged a chair into the fence and climbed on to the roof. From there he jumped approximately 2.5 metres to the grass below. After attempting to run he collapsed and was assisted back to the ward using a wheelchair. At this time he voiced distress that he had not been allowed to visit his [injured family member]. Once back at the ward he was examined by a House Officer who assessed his injuries. Although he was assessed as needing treatment in the emergency department, his transfer there was delayed until 9pm (over 4 hours) because of the concerns for safety of his [family member] mentioned above. During that time he was assessed by the House Officer, given pain relief, although he also complained that the analgesics given (60mg codeine) was not adequate. Staff also attempted to address [Mr B's] low blood sugar. [Mr B's] eventual transfer to the Emergency Department was by taxi. He was assessed in the Emergency Department where he was found to have sustained bilateral fractured ankles. [Mr B] remained in [the] general hospital until 19th September when he was discharged home with marked improvement in his mental state. His legal status under the Mental Health Act was changed to voluntary status. The mental health service provided support over that time and followed him up after discharge.

The following section of this report responds to the Commissioner's questions.

Question 1. Whether the level of observations [Mr B] was placed on was appropriate once he was placed under the Mental Health Act (MHA).

a) What is the standard of care/accepted practice?

The level of observations needed is based on risk rather than on legal status only. For example a consumer who is under the MHA could be at any one of the 5 levels of observation in the Canterbury DHB policy. Services should aim to use the least restrictive level of observation that is compatible with the consumer's safety. The level of observation should be regularly reviewed to ensure that it is appropriate. The Canterbury DHB policy is worded to require regular review of level of observation. In [Mr B's] case there were compelling reasons for him to be on at least level 3 observations (observations at 5–15 minute observations) which I understand to be standard practice for consumers in the High Care Area. However, considering that he had attempted to scale the fence earlier in the day and was now distressed about having been refused leave to see his [injured family member], more likely level 2 (within line of sight at all times) was more appropriate while he was in the courtyard. [Mr B] had been placed under the MHA a few days before and was considered to be at high risk of harm to himself or others (who he had named) and had demonstrated intent to abscond.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

It is apparent that [Mr B] was not within line of sight at all times which I believe would be appropriate given the circumstances outlined above. However some steps had been taken to maintain [Mr B's] safety, most notably moving him to the High Care Area. He had also been cautioned about scaling the wall and its possible consequences. Taking all the circumstances into account I believe there has been a moderate departure from the expected standard in determining [Mr B's] level of observations.

c) How the care provided would be viewed by your peers?

I believe my peers would view this as a moderate departure from the expected standard.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

I am reluctant to make a blanket recommendation that would apply to all consumers, including those who do not present the same level and types of risk as [Mr B]. The DHB could consider having a nurse in the outdoor area of the HCA any time there is a consumer there, or whether the area should always be within line of sight. It would be wise to review the outdoor area for risk of absconding, including the design of the fence and the furniture placed in that area.

Question 2. Whether it was appropriate to leave [Mr B] unattended in the HCA courtyard when he requested to smoke on 4 September 2017, given he was observed trying to climb the fence that morning.

a) What is the standard of care/accepted practice?

The standard of care in this situation is that consumers are kept safe, taking account of their known risk factors. [Mr B] was in a High Care Area of the inpatient unit, was under the Mental Health Act and had attempted to scale the fence earlier in the day. Compounding those factors [Mr B] had been refused leave to visit his [injured family member] in the Emergency Department, a refusal he strongly disagreed with. All these factors suggest that he should have been closely observed, especially for any attempt to abscond.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

In my opinion [Mr B] should not have been alone in the High Care Area, and there was a moderate departure from the expected standard in this respect. His documented attempt to abscond and his increased agitation about being detained in hospital increased the existing risk, necessitating a higher level of observations, at least in the short term.

c) How the care provided would be viewed by your peers?

I believe my peers would regard this as a moderate departure from the expected standard.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

Staff should be reminded that although the courtyard is used for smoking, supervision of smoking is not the only factor determining the need for observation while in the courtyard. Considerations of risk of self harm, harm to others and absconding are also considerations.

Question 3. The adequacy of the Observations including specialling policy and Smokefree policy in place at the time of [Mr B's] care.

In my opinion this incident is not about the Smokefree policy. I have made a comment about the Smokefree policy later in this report, but I don't consider the policy contributed to this incident. The correct level of observations (in my opinion level 2) would have made it all but impossible for [Mr B] to scale the wall as he did. The Observations and specialling policy seems adequate, although I have made some comments on some aspects of the policy later in this report.

a) What is the standard of care/accepted practice?

The accepted standard is that policies are clear and flexible and promote the safety of consumers while promoting engagement and avoiding unreasonable intrusion. In practice this can be a difficult balance to strike, but a clear policy allows staff sufficient discretion while maintaining consumers' safety.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

I believe the CDHB Specialling and Observation Policy is fit for purpose. It provides clear operational definitions of each level of observations, emphasises therapeutic engagement rather than simply observing the consumer, and has clear decision making processes around changes in observation levels.

c) How the care provided would be viewed by your peers?

I believe my peers would find the CDHB Specialling and Observation Policy acceptable.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

I saw only sporadic evidence in the clinical notes that [Mr B's] level of observation was recorded as required in the documentation section of the policy. I saw no completed observation forms recording observations made. I understand that the forms are used for Level 3 observations, but [Mr B's] forms were destroyed six months after discharge as per DHB policy. However I did see evidence throughout the clinical records that

staff were aware of [Mr B's] and others' safety, and were attempting to engage with [Mr B] and respond to his needs.

Question 4. The management of [Mr B's] injuries after his fall.

a) What is the standard of care/accepted practice?

In the case of a consumer injuring themselves, whether intentionally or otherwise, the first responsibility is to triage the injury, then, if they can be safely moved, to move the consumer to a safe place where they can be further assessed. From there the accepted standard is to decide if the injuries can be adequately managed in the acute mental health setting, or to transfer the consumer to a care setting (in this case the Emergency Department) where the appropriate care and treatment can be provided. Where there is a risk of complications as there was in this case, transfer should be effected in a safe and timely manner and not unduly delayed. Consumers should receive supportive management until transferred.

b) If there has been a departure from the standard of care or accepted practice, how significant a departure it is.

In relation to triage and moving [Mr B] to a safe place immediately after the injury, it appears that this was done safely and in a timely manner. The care provided was at the expected standard. However there was a delay in transporting [Mr B] to the emergency department, and in my opinion it was not appropriate to use a taxi for the transport. It is reasonable to have concern for [Mr B's] earlier statement of intention to harm his [injured family member] (who was in the Emergency Department for unrelated reasons), but [Mr B] had severe injuries, and already had impaired function of his lower legs due to complications of diabetes. Emergency Departments have ways of managing agitated consumers that would have adequately mitigated the risk to [Mr B's family]. I also note that on September 4, three days after he was considered at risk of killing his family, this risk was considered sufficiently reduced for [Mr B] to be allowed day leave with his wife (in the company of a social worker and nurse) to attend to some financial issues. He is reported to have managed that well, so it is hard to understand how any perceived risk to his [injured family member] would prevent him being transferred to the Emergency Department. In my opinion [Mr B] should have been transported urgently by ambulance, as would have happened if his injuries occurred at his private address or in a public place. Transport by taxi involves having his legs in a dependent position, which would contribute to pain and swelling. In addition any changes in his condition could not be monitored in a taxi as they could in an ambulance. In his complaint [Mr B] states he was asked to stand in order to get into the taxi. While this is not recorded in the clinical notes, transfer from a wheelchair to a car could be quite difficult, and there may have been some weight bearing involved. That is another reason for using ambulance transport. I do not accept the suggestion that [Mr B's] blood sugar level needed to be stabilised prior to transfer. Ambulances are sometimes called specifically because of low blood sugar levels and would be able to manage that, as would the Emergency Department.

In relation to the timing and manner of [Mr B's] transfer to the emergency department in my opinion this was a moderate departure from the expected standard. In relation to supportive care until transport it appears this was provided. [Mr B] was assessed, his injuries were treated as much as they could be in the inpatient mental health setting, and he was given pain relief. Staff attempted to correct [Mr B's] low blood sugar level but [Mr B] was not fully cooperative with that. I note that [Mr B] complained that he was dropped at some point. However I am not able to comment on that as there is no record of it in the clinical notes.

c) How the care provided would be viewed by your peers?

I believe the immediate care (triage and movement to a safe place) provided would be viewed as acceptable to my peers. I believe the delay in transporting to the Emergency Department, and the mode of transport, would be regarded by my peers as a moderate departure from the accepted standard. In relation to care provided while awaiting transport I believe my peers would regard this as acceptable.

d) Recommendations for improvement that may help to prevent a similar occurrence in future.

Canterbury DHB should review any existing policy on transfer to acute medical care, with the focus on clearly distinguishing between a simple transfer from one setting to another, and when an acute medical event such as a serious injury should be treated as an emergency. In emergencies the 111 service should be utilised as it would be in a community setting. Decisions about emergency situations should be made by a clinician, nurse or doctor, with the appropriate level of seniority and experience.

Question 5. Any other matter which you consider may be a departure from the accepted standard of care.

The Smokefree policy appears, as [CDHB] noted, to be potentially confusing for staff, especially as there seems to be a lot of discretion in terms of whether staff accompany consumers who are smoking. My reading of the policy is that this discretion seems intended to apply to consumers going outside the clinical buildings into the hospital grounds. But the courtyard of the High Care Area is actually part of that facility, so not outside the clinical buildings. By that reading the Smokefree policy prohibits smoking in the courtyard of the High Care Area. It would be helpful to clarify this. Other inpatient mental health services do not permit smoking in enclosed outdoor spaces.

The observation and specialling policy uses the term 'formal observations' but it is not clear what that terms means. It seems to mean anything more than standard observations. I also found it hard to understand exactly when written documentation of observations is required. The policy says a Level 3 and 4 Shift Observation Record should be commenced after the formal levels of observation are initiated, but I found this unclear.

Summary

[Mr B] was in [the psychiatric hospital] for 14 days. His hospital course involved fluctuating risk and occasional conflict with staff. Self harm was a theme of the admission, and [Mr B] also had thoughts of harming members of his family. [Mr B's] diabetes was poorly controlled, as it seems to have been for much of his life, and he did not always respond to attempts to help with this. Thoughts of self harm appear to have escalated at times of stress. Hospital staff managed [Mr B's] risks of harming himself and others through use of the Mental Health Act and providing increased containment when risks seemed to be more acute. His medication was reviewed and adjusted to help manage his low mood and agitation. [Mr B] was also given assistance through the specialist diabetes and dental services. Staff also gave [Mr B] opportunities to take responsibility for his decisions through planned and supported leave, even when risks were considered high. For the most part this approach to care was successful in keeping [Mr B] and his family safe. In the context of acutely heightened distress [Mr B] made an attempt to leave [the psychiatric hospital] which had significant consequences for his health. Although he was appropriately treated and supported in the immediate aftermath, there was a delay in transferring him to the appropriate treatment setting, and the manner of his transport was less than optimal. On review, there were some aspects of his care that could have been carried out differently, and some warning signs of an attempt to abscond could have been given greater weight. With continuing support from the mental health service during his time in the public hospital, [Mr B] made significant improvements in his mental health and was discharged on September 19. I hope this report will help in considering how mental health services can best respond to the complex and challenging issues of acute mental health care."

The following further advice was obtained from Dr O'Brien:

"24 February 2020

Further report into C18HDC02113 ([Mr B]).

I have previously provided advice on this case (September 6, 2019). I have been asked to provide further advice following receipt by the Commissioner of a further response from Canterbury DHB.

Documents provided are:

Letter from [the DHB] (17 January 2020).

Practice Guideline for [the] High Care Area. (This document is dated 1 July 2019 almost 2 years after the events concerning [Mr B]. I have assumed the guideline is close enough to that which applied in September 2017 to be relevant to [Mr B's] case.)

Response dated 6 January 2020 from [RN A], the nurse in charge of [Mr B's] care on the afternoon of September 4 2017.

I have read the above documents, and have re-read my original report, and the relevant documentation initially provided.

I have been asked if the information provided changes the advice I provided previously. There are three areas of advice, and my response for each area is given below.

1. Moderate departure with regard to observations after [Mr B] was placed under the MHA — [Mr B] should have been within line of sight at all times given symptoms he was presenting with and risk of harm to himself/others.

As I noted in my initial report the appropriate level of observation for [Mr B] is not based on his status under the MHA, but on his assessed risk at the time of the events. The appropriate level of observation is a balance between the need to provide the least restrictive care compatible with [Mr B's] clinical presentation and risk and the level of observations necessary to manage that risk. This balance is reflected in the CDHB Levels of Observation document. My original impression was that [Mr B] was on Level 3 observations (sighted and level of distress assessed at intervals of between 5 and 15 minutes). I based this impression on the letter from [CDHB] to the Commission (18th February 2019) which states '[Mr B] was on high care area observations, needing to be sighted every 5 to 15 minutes'. The letter does not say which level within the CDHB observation policy this is, but it is clear that it is Level 3. The next highest level is Level 2 which does not specify a time interval but requires 'constant observation'; that is that the consumer is kept within line of sight at all times. My reading of the new documentation provided does not change my assessment of what level of observation [Mr B] was under. In saying this I note that there is no written record of the level of observations, those records apparently having been destroyed as part of an administrative process unrelated to [Mr B's] case.

There is some suggestion in the new documentation that [Mr B] was under a higher level of observation than Level 3. The letter from [CDHB] states that '[Mr B] was not on Level 3 observations, instead he was on HCA observations' which is further defined as 'observed at 15 minute intervals'. [The letter from CDHB] further states that this level of observation is 'an increase from the standard ward observation protocol'. The HCA practice guideline states that 15 minute observations is the standard level for consumers in HCA. The HCA practice guideline does not link this level of observation to the CDHB observation policy, but as noted above standard HCA observation is clearly Level 3 observations, not Level 2.

[RN A] in his response states that [Mr B] 'was on HCA Level 3 observations' but 'effectively under Level 2 Observations' because he was 'under continuous line of sight'. It is my impression that [Mr B] may well have been under continuous line of sight, but that does not mean he was on Level 2 Observations. Placing [Mr B] on Level 2 observations would follow a re-assessment of his risk, and would be formally delegated by [RN A] to the health assistant (HA) who was staffing the HCA with [RN A]. But this does not seem to be the case. In addition, the HA does not seem to have been

in close proximity to [Mr B] as required by Level 2 observations. The HA seems to have been some distance away.

In considering all the above information I accept [RN A's] statement that [Mr B] was under continuous line of sight. It does seem that [Mr B] was being more intensively observed than his assigned level of observation would suggest. Therefore I have revised my earlier advice to say this is a mild breach of the required standard. In saying this I note that one reason CDHB has an observation policy is so that staff are clear about their responsibilities, for example in delegating responsibility for observations. Reconstructing the events of 4 September it is apparent that [Mr B's] actions in wedging a chair into the fence and scaling the fence seem not to have been observed. Either the (unknown) HA did not react when [Mr B] began wedging the chair into the fence, or [Mr B] was not under line of sight as [RN A] believes.

2. Moderate departure with regard to leaving [Mr B] unattended in the High Care Area whilst smoking, given documented attempts to abscond earlier in the day and his increased agitation about being detained in hospital.

[CDHB's] letter states that [Mr B] was not observed while he was in the courtyard, however [RN A's] response states that [Mr B] was 'not unattended' in the HCA courtyard, but could be observed by the HA from just inside the door of the HCA and was within line of sight. [RN A] was with [Mr B] while [Mr B] was smoking prior to receiving the phone call about his [injured family member] at 1610hrs and after that time, when he was attempting to de-escalate [Mr B]. There is some conflict in the timeline here as [CDHB's] letter of 18th February 2019 states that [Mr B] was observed moving into the courtyard at 1625hrs which would have been shortly prior to his jump from the roof at 1630hrs. However [RN A's] account has [Mr B] in the courtyard before 1610hrs and continuously after that time. At some point after 1610hrs [RN A] went to the HCA office to make a phone call. It appears that there was no-one in the courtyard with [Mr B] at this time, but that observation was maintained from outside the courtyard. Over this period of time [Mr B] was agitated about his [injured family member], angry about his own confinement in HCA, and there was concern about his suicidality. I acknowledge that [RN A] had assessed the environment for risk and noted only one chair in the courtyard, making it impossible for [Mr B] to stack chairs against the fence as he had done previously. Taking all the information into account my opinion is that [Mr B] should not have been alone in the courtyard, even for the brief time it took for [RN A] to make his phone call. Line of sight observation from outside the courtyard was not an adequate level of observation in the circumstances. For that reason I have not changed my previous advice that this is a moderate departure from the required standard.

3. Moderate departure with regard to the delay in transporting [Mr B] to the ED and the use of taxis for this.

I accept that [Dr D] was a junior doctor at the time and decision on the timing and mode of transport was made by senior clinicians. I also acknowledge that [Mr B] was

well cared for while waiting for transport in terms of assessment, observation, first aid treatment of his injuries, and pain relief. The reason for the delay in transport is hard to follow as [Mr B] had been considered safe for escorted leave from the ward earlier in the day and that leave, which involved contact with his family, took place without incident. It is reasonable for staff to have concern about [Mr B's] behaviour within ED, but there are ways of managing this. As I noted in my earlier report taxi transport is not ideal for someone with suspected lower leg fractures, with existing damage to his ankles, and with circulatory impairment due to Type 2 diabetes. After reviewing all the relevant documentation my opinion remains that the delay in transport to ED, and the mode of transport represent a moderate departure from the expected standard.

Anthony O'Brien RN, PhD, FNZCMHN"

The following further advice, dated 7 May 2020, was received from Dr O'Brien:

"Further (third) report into C18HDC02113 ([Mr B]).

I have previously provided advice on this case (September 6, 2019 and February 24th 2020). I have been asked to provide further on a specific issue related to this case.

The Commissioner has identified two instances in the clinical notes that suggest that [Mr B] may have had the opportunity to self-administer insulin (normally prescribed by his doctors for Type 1 diabetes). The instances occurred on the 28th August and 4th September 2017. They occurred during the hospital admission which gave rise to [Mr B's] original complaint. I have all the original documentation available. I note that it is accepted practice for patients prescribed insulin to self-administer, usually unsupervised.

I have read the clinical notes from August 22nd, the date of [Mr B's] admission, through to September 4th, the date of the second incident.

[Mr B's] clinical record includes a note by [a nurse] on 22 August which states that [Mr B] was 'not to be independent with insulin administration'. A note to this effect also occurs in [Dr C's] admission note on August 23rd.

The notes of August 28th record an incident where [Mr B] had a low blood sugar level after accessing an insulin syringe in his room. The syringe was discovered by [a nurse] as part of her intervention during [Mr B's] hypoglyaemic episode. On September 4th [RN E] records that [Mr B] attempted to try and inject insulin from a syringe apparently hidden on the ward. On both of these occasions [Mr B] appears to have secreted insulin within his room. The incidents did not involve staff allowing [Mr B] to administer insulin unsupervised. (On the second occasion no insulin was injected; [Mr B] apparently produced the syringe in the presence of [RN E] who took possession of the syringe before it could be used). Throughout the notes from August 22nd to September 4th there are multiple records of [Mr B's] insulin administration. There is no suggestion that this was unsupervised. On 30th August [a student nurse] gave [Mr B] a syringe to self-administer his insulin. [Mr B] attempted to 'wind the dosage up' but [a nurse]

intervened to prevent this. Later that day [Mr B] went on leave from the ward. [A nurse] noted that staff should search his property on his return to the ward 'in case he has any additional insulin pens'. When [Mr B] returned to the ward on 31st August [a nurse] recorded that his property was searched and no insulin found. Over this period nursing staff seem to have maintained an awareness of the possibility that [Mr B] might again access insulin and attempt to inject himself unsupervised. On 3 September [a nurse] noted [Mr B's] history of secreting insulin and self-administering and inquired whether [Mr B] had any insulin in his possession. [Mr B] denied this. The following day (September 4th) [Mr B] produced an insulin syringe and attempted to inject himself but this was prevented by [RN E] (noted above).

In relation to the Commissioner's question I am satisfied that there was no departure from the accepted standard of care. It is obviously not ideal that [Mr B] was able to secrete and access insulin, but this was not sanctioned by nursing staff; indeed they actively sought to prevent this and after the initial incident were able to prevent two further attempts at insulin overdose. The notes indicate that [Mr B's] insulin administration was supervised by nursing staff on every occasion.

Anthony O'Brien RN, PhD, FNZCMHN"