AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

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[redacted]

Re: Official Information Act request – unreliable Lift

I refer to your Official Information Act request dated 13 May2019 requesting the following information

Copies of any reports, documents, memoranda, correspondence, legal advice or emails regarding the unreliable function of the link lift 2 (the sole lift required for safe transfer of patients from the Paediatric Cardiac Ward (23b) to PICU, Theatre and Radiology), and any related incidents (such as a patient transfer being delayed).

For each incident, a summary of what happened, when, why the patient was being transferred and whether the incident resulted in any harm or potential harm.

The functioning of ADHB's fleet of lifts is the subject of regular communication and documentation, including reports and internal emails. It is also a matter of public record, including regular reporting to the Hospital Advisory Committee (HAC) in public meetings. See:

https://www.stuff.co.nz/national/health/110535020/sole-lift-connecting-starship-hospitals-cardiac-ward-to-icu-theatre-and-radiology-poses-significant-risk

The historic and on-going situation regarding ADHB's large fleet of lifts is that it has always contracted for third party providers to undertake comprehensive maintenance of the fleet, the contract covering both preventative and corrective maintenance in respect to incidents. These contracts involve day-to-day reporting as to maintenance and incidents across the fleet; we have made the assumption that you are not requesting us to undertake research and collation for all the maintenance and lift reports for lift link2.

The functioning of a fleet of lifts used by thousands of people each day does produce a significant volume of "reports, documents, memoranda, correspondence, legal advice or emails" in addition to routine contractual reports, and reports to HAC. You have not designated a period, but to collate the information regarding "the unreliable function of the link lift 2" for any period would involve a computerised search of generic ADHB databases. That is not a sophisticated activity, so it would inevitably produce a significant volume of information which would then need to be reviewed to establish what related to this one lift, and what related to 'unreliable function'. Then any personal information, for patient related details, would need to be redacted.

Your first request is therefore declined under s18(f) OIA – any information cannot be provided without substantial collation and research.

There has been one incident. This was in 2015 where a transfer involving link lift 2 was delayed. That incident is a matter of public record. See:
https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11437629

As noted, the incident was reported to WorkSafe, and the coroner sought information about the delay when investigating the death of the infant being transferred. After consideration of the medical circumstances WorkSafe determined an investigation was not required; similarly the coroner issued a determination under s64(1) of the Coroners' Act *Not to Open an Inquiry*. A redacted copy of her conclusion is attached.

All clinical information about the infant is withheld pursuant to s9(2)(a) OIA – to protect the privacy of the family; reports provided to the coroner and WorkSafe are also withheld under s6(c) OIA - to avoid prejudice to the maintenance of the law.

Finally, a review of callout records provided by the service provider show the number of call outs for this lift in the two years before the incident were 9 and 8 respectively; industry expectations would be a callout rate of 5/6 per lift per year, so this level is considered 'Average Performance'.

I trust this information answers your questions.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

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

Yours faithfully

A Claire

Ailsa Claire, OBE
Chief Executive

[32] I am satisfied that all matters required to be established by a Coroner have been done so on the currently available information. In this respect, I noted the following:

(a) 's cause of death was from underlying natural congenital abnormalities.

(b) The circumstances of death have been adequately established. I accept Dr comments that the severe nature of abnormalities is likely to have been fatal even if initial collapse had not occurred during transport, and that the difficulties experienced during transport would have been unlikely to change the clinical outcome.

(c) I am satisfied that Auckland District Health Board through its review and investigation processes, has adequately identified factors to be remedied, and has made appropriate recommendations to reduce the chances of similar circumstances occurring in the future.

[33] Accordingly I do not consider it necessary or desirable to open a Coroner's inquiry.

Signed at Auckland on 23rd day of August 2018

Coroner Morag McDowell