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| Request for draft investigation report into GRSA outbreak at Wellington Hospital’s neonatal unit |
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| Legislation Official Information Act 1982, s 9(2)(ba)(ii)Agency Capital & Coast District Health BoardOmbudsman Dame Beverley WakemCase number(s) 173840Date January 2015 |

*Request for investigation report regarding outbreak of GRSA at Wellington Hospital’s Neonatal Intensive Care Unit—report withheld as not ‘signed-off’—TOR specified confidential two-stage investigation process—disclosure risked compromising this process and would diminish staff confidence that investigations would follow agreed protocols—disclosure would be likely to damage the public interest—final investigation report still not complete nearly one year later—the longer a review process goes on without disclosure of final investigation report the greater the public interest in disclosure of at least an interim statement—in this case s 9(2)(ba)(ii) provided good reason to withhold the draft report.*

In June 2005, the Capital & Coast District Health Board (the DHB) launched an investigation into an outbreak of GRSA at Wellington Hospital’s Neonatal Intensive Care Unit. A reporter submitted numerous requests during the following months for a copy of the investigation report. In March 2006, she complained to the Ombudsman after being told it was *‘not appropriate to forward a draft paper prior to it going to the board for sign off after which time it will be in the public domain’.*

The DHB clarified that the report was withheld because it was incomplete, not because it had not been *‘signed-off’*. The terms of reference (TOR) for the investigation contemplated a two-stage process—internal review, followed by external peer review. The draft at issue represented the findings of the internal review. However, that review was potentially incomplete until the external peer review was finished.

The Ombudsman concluded that section 9(2)(ba)(ii) of the OIA provided good reason to withhold the draft investigation report.

# Obligation of confidence

The TOR stated that *‘the investigation [was] confidential’*, and that it would be *‘conducted strictly in accordance with the [TOR]’*,which specified the two-stage process discussed above. The Ombudsman stated:

Generally speaking, there is an expectation that while audit / investigation processes are ongoing, confidentiality will attach to related information. This is in the interests of fairness to the individuals implicated in the audit / investigation processes, and to ensure the accuracy and validity of the findings and conclusions ultimately reached.

She concluded that the *‘participants in the investigation would have expected confidentiality to be maintained, at least until the conclusion of that process’.*

# Damage to the public interest

The Ombudsman stated that premature disclosure of the draft investigation report posed a number of risks.

There was a risk that the investigation process would be compromised or undermined by disclosure of the draft findings and recommendations. Although the DHB hoped the report would remain substantially the same following completion of the external peer review, this was by no means certain. The external peer review may have required changes to be made, and those changes may have required further consultation with affected parties. The potential for this was reflected in the TOR, which noted the *‘external review report shall be made available as appropriate to allow supplementary comment by the Outbreak Control Team’*. In addition, disclosure of the draft investigation report may have negatively affected the external peer review team’s processes and recommendations—ie, if they had to look at the issues while the matter was the subject of public debate—as well as DHB’s ability to consider and assimilate that team’s recommendations.

There was also a risk that disclosure of the report prior to the conclusion of the two-stage process set out in the TOR would diminish staff confidence that investigations would follow agreed protocols. The investigation was conducted in accordance with the DHB’s serious and sentinel events policy. The DHB advised that it had taken 3-4 years to embed that policy in the operating culture of the DHB. Completing the investigation within the parameters of that policy was key to maintaining staff confidence in it, and hence their continued willingness to cooperate fully with investigations in the future.

The Ombudsman concluded that there was a public interest in the DHB being able to complete a thorough review process, including the external peer review component of that process, while adhering to principles of fairness and natural justice, and without premature disclosure of draft or tentative conclusions. Disclosure of the draft investigation report would be likely to damage that public interest.

# Public interest

The Ombudsman noted that *‘the information at issue here concerns a serious event in the public health system’*, and said:

…there is unquestionably a public interest in disclosure of information to show what happened, and what (if any) remedial steps have been identified and taken to prevent it happening again, or to mitigate / manage its effects if it does.

The Ombudsman also noted that the DHB intended to release the final investigation report, and said that, *‘in most cases, disclosure of “final” audit / investigation reports would be sufficient to meet the public interest’*.

However, the report was still not complete nearly one year later. The complainant argued that:

If hospital management cannot complete all the stages of its report within a reasonable timeframe, in my view they have a responsibility to issue to the public the findings of the first stage of that investigation.

The Ombudsman agreed with the complainant that it was important for the DHB’s review processes to be timely as well as fair and thorough. She commented that:

…the longer a review process goes on without disclosure of the final investigation report, the greater the public interest in disclosure of at least an interim statement addressing the matters identified above.

While the Ombudsman might have been minded to recommend release of an interim statement, this would have served no useful purpose at the time because release of the final investigation report was by then imminent. The Ombudsman therefore concluded that section 9(2)(ba)(ii) provided good reason to withhold the draft investigation report.

*This case note is published under the authority of the* [*Ombudsmen Rules 1989*](http://legislation.govt.nz/regulation/public/1989/0064/latest/DLM129834.html?src=qs)*. It sets out an Ombudsman’s view on the facts of a particular case. It should not be taken as establishing any legal precedent that would bind an Ombudsman in future.*