Ombudsman
Fairness for all

Case note

Area Health Board and its Review Committee handled complaint inadequately

Legislation	Ombudsmen Act 1975, New Zealand Bill of Rights Act 1990, Area Health Board Act 1983
Agency	Area Health Board
Ombudsman	Nadja Tollemache
Case number(s)	A3350
Date	1992

Inadequacy of complaint procedures and consent procedures for blood products—lack of consultation—revised procedures adopted

At a time when the principle of informed consent to medical intervention had been a matter of public debate the Ombudsman was interested to receive a complaint from the daughter of an elderly Jehovah's Witness woman who died shortly after receiving a blood transfusion. The death occurred in an Area Health Board's hospital following major hip surgery. The complaints were twofold. The first was that the Area Health Board had acted unreasonably in its treatment of the deceased (hereafter referred to as 'Mrs X'). The second concerned the investigation of her treatment by the Board's Review Committee.

Because of the length of time which had passed since Mrs X's treatment it was necessary for the Ombudsman to decline to investigate the first complaint even to the extent that it would have been within jurisdiction as a 'matter of administration'. The Ombudsman explained her reason for this to the complainant. Section 17(2) of the Ombudsmen Act provides an Ombudsman with a discretion to decide not to investigate a complaint if it relates to any decision of which the complainant has had knowledge for more than 12 months. In such cases there is inevitable difficulty in locating records and obtaining versions of events from relevant employees.

In respect of the second complaint it was clear the Review Committee's investigation had not satisfied the complainant. From the documentation made available to the Ombudsman it was not clear that a thorough review had taken place. Accordingly the Ombudsman suggested the

complainant write to the Chairman of the Board. She could request that a special investigation be carried out into the Review Committee's investigation of the complaint, providing details of points of dissatisfaction. If the Board declined to do so, the Ombudsman indicated the matter would be considered again. The file was then closed.

Several months later the Ombudsman received advice that the Deputy Commissioner had reviewed the recent correspondence but declined to take the matter further as the '*Board's complaint procedures have been exhausted*'. The Ombudsman then notified the Board of the complaint that it had acted unreasonably through its Review Committee not conducting, in the complainant's view, a thorough investigation into the complaint about the circumstance surrounding Mrs X's death.

The Board provided the Review Committee's file. Upon reading this material it was clear that several doctors feature prominently in Mrs X's care. There were various statements in their reports of Mrs X's views on blood transfusions. The Ombudsman noted that a recommendation had been made to the Committee that some of its members meet with these doctors. The Ombudsman asked the Board to advise whether this recommendation had been carried out, and if so to provide a brief summary of their contributions to the meeting. She also enquired whether each member of the Committee had been given an opportunity to read the file, and what other enquiries had been made. Finally the Ombudsman asked whether, in circumstances such as these, the Committee ever put its findings to a complainant before the findings were confirmed.

The Ombudsman was advised the discussion with the doctors had not eventuated because members of the Committee decided 'the issue was not capable of resolution'. It was believed from what was recorded on the file that Mrs X was 'ambivalent' about blood transfusions. Further information could be required by Committee members over and above the compiled reports provided to them. The Board advised that complainants were 'frequently' met with by the Committee 'to discuss reports and to clarify points'. In this case members recommended the complainant be sent a copy of the then General Manager's report at the conclusion of the investigation. No meeting took place.

The relevant legislation was examined. The *Area Health Board Act 1983*, sections 9 and 28, referred to primary objectives of Board and functions of Committees respectively. In addition, the *New Zealand Bill of Rights Act 1990*, section 11, was also considered. This legislation had not been enacted at the time of Mrs X's death but was in force at the time of the review and in the Ombudsman's opinion, could have been referred to.

From a summary of events it could be seen that the Board was alerted to the seriousness of the allegation that Mrs X was given blood transfusion contrary to her directions. However, it was also clear that no consent forms, for the purpose of the administration of blood products, had been available. The file recorded Mrs X making more comments expressing a preference not to receive blood products than definite statements of refusal. On the last 2-3 days of Mrs X's life a doctor recorded:

> *In the interests of her health ... her life, she is to be transfused at the discretion of her medical team who will take the responsibility for this decision.*

The Ombudsman noted that information put before the Committee conflicted with that provided by the complainant. For example, the Ombudsman was advised that the Board kept Mrs X's relatives away during the transfusion. The Board reported it had no knowledge of these instructions. However the nurses' record stated that relatives were aware Mrs X was having blood products, but 'do not want to know'. This was vehemently denied by the complainant.

Extracts from Mrs X's diary which had been provided to the Committee by the complainant appeared to have been given lower priority than information contained on the file. The latter was of a more 'hearsay' nature. Had the complainant been interviewed she could have provided the Committee with a statement from her ex-husband who accompanied Mrs X on admission, that the matter of Mrs X's views on receiving blood products had been discussed with the admitting nurse. However, there was no record of the discussion on the file. Other discrepancies on the Committee's file had not been examined. An interview with the complainant could have clarified these. Finally, the Ombudsman noted it took almost three months from receipt of the complaint for it to reach the Review Committee.

It was the Ombudsman's preliminary opinion that the complaint could be sustained. In coming to this view the Ombudsman took particular account of the following factors. The Committee:

1. did not appear to have used existing procedures;
2. dealt insensitively with the complainant by sending a copy of a report without providing an opportunity for an interview;
3. did not explore inconsistencies apparent at the time of investigation; and
4. did not make sufficient effort to learn more accurately the facts through interviewing relevant doctors and the complainant.

When the Ombudsman advised the Board of her preliminary opinion a recommendation was proposed. This was that the Committee formalise its procedures to interview complainants in matters of sensitivity, and provide clear guidelines, with consent forms for the use of blood products. The Board was then given an opportunity to comment. It replied some weeks later conveying that the Committee had adopted a practice of inviting complainants, as a matter of routine, to interview, and has consent forms available for the administration of blood products. In addition, the complainant had now been invited to meet the Committee.

In light of the procedural changes which had been adopted and the invitation to meet with the complainant, the Ombudsman closed the investigation on the basis that the complaint was resolved.

Comment

In October 1994, the *Health and Disability Commissioner Act 1994* was enacted. This established the Health and Disability Commissioner as a complaints resolution body for complaints relating to all providers of health and disability services. When the Ombudsman receives a complaint about the treatment of a patient, this is now referred to the Health and Disability Commissioner.

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