



Chief Ombudsman’s opinion under the Ombudsmen Act

Legislation	Ombudsmen Act 1975, ss 13, 22
Agency	Health and Disability Commissioner
Complaint about	Preliminary assessment process and decision to take no further action on complaints
Ombudsman	Peter Boshier
Case number(s)	466864, 482749, 486627
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Summary

It is my opinion that the former Health and Disability Commissioner’s (HDC’s) handling of three separate complaints was unreasonable. I consider HDC’s preliminary assessment processes in these cases stepped beyond what Parliament envisaged a ‘preliminary’ assessment should entail under section 33 of the Health and Disability Commissioner Act 1994 (the Act).¹ This had an undue negative impact on those involved.

It is also my opinion that in two of these cases, HDC’s decision to conclude its preliminary assessment by taking no further action under section 38(1) of the Act was unreasonable. HDC has not persuaded me that it considered all the relevant factors when reaching this decision. I also consider HDC made these decisions in the absence of an adequate complaint-handling policy.

I have recommended that HDC apologise to the two individuals and one provider regarding its separate handling of their complaints. I have also recommended that HDC reconsider its decision to take no further action in two of the cases, and develop a more comprehensive complaint-handling policy.

Background

Ms A

1. Ms A first complained to HDC in November 2013 about the standard of care provided by four healthcare providers² following the stillbirth of her daughter. Ms A had experienced several complications over the course of her pregnancy.
2. On 8 July 2014, after seeking in-house clinical advice,³ HDC wrote to Ms A advising it was taking no further action on the complaint in accordance with section 38(1) of the Health and Disability Commissioner Act 1994 (the Act). However, Ms A challenged this decision as she was not provided an opportunity to comment before HDC closed their

¹ Under section 33 of the Health and Disability Commissioner Act 1994.

² Two separate hospitals (from two separate District Health Boards), a Registered Midwife and a third party healthcare provider.

³ While the in-house medical advice was not critical of the care provided by the first DHB, the Registered Midwife or the third party healthcare provider, the advice did identify a ‘mild to moderate departure’ in the expected standards of discharge planning provided by one DHB.

- file. HDC subsequently met with Ms A, sought further responses from the providers, and received additional clinical advice from an external expert (Expert One).
3. In reviewing the case, Expert One concluded that during Ms A's admission to one particular hospital (the Hospital), she received '*substandard antenatal care because she did not have a scan to assess fetal wellbeing [after an] ongoing and significant [complication]*'.
 4. Expert One advised that it was '*likely, but not certain*' that the scan would have resulted in a different diagnosis that, if made at the time, would most likely have resulted in more intensive fetal surveillance and '*would probably*' have changed the outcome of Ms A's pregnancy. Expert One described not performing a scan as a '*moderate*' departure of the accepted standard of care.
 5. In May 2015, HDC reopened Ms A's complaint and advised the healthcare providers a further assessment would be carried out.⁴
 6. Between May 2015 and April 2016, HDC sought further responses from the providers. HDC also sought further expert advice and sought the providers' comments on this advice.
 7. In Expert One's additional advice on 28 June 2015, they reiterated that '*the single most important mishap*' in Ms A's case was that the Hospital did not perform a fetal wellbeing scan during her admission and that this was a '*breach of the standard of the profession*'.
 8. Expert One also identified a further '*moderately severe departure*' of the standard of care when reviewing the Hospital's discharge processes. In particular, that following the complication, the Hospital failed to contact Ms A's midwife or referring specialist to inform them of the situation and plan of care, or send a discharge letter. Expert One advised that '*these basic omissions are embarrassing and resulted in less than ideal care which does not meet the expected standards of the profession*'. Expert One did not consider that the lack of communication '*per se*' contributed to the overall poor outcome.
 9. On 17 August 2015, HDC's complaints assessor put a memo to an internal steering committee (made up of the Commissioner, Deputy Commissioner, and other senior staff) to discuss next steps with the complaint. In the memo, the assessor identified that there were '*potentially two moderate departures*' in the obstetric care provided to Ms A. The memo did not quote the Expert One's '*moderately severe*' terminology. The assessor asked the steering committee to advise how to proceed in light of these departures, including whether to:

⁴ HDC notes that Expert One's initial advice caused it to question the in-house clinical advice it had received and prompted HDC to reopen the complaint in relation to all providers for a completely new assessment with new expert advice on all care.

- a. send expert advice to providers for comment;
 - b. consider for investigation; or
 - c. draft a provisional letter advising that no further action would be taken (under section 38(1) of the Act).
10. As a result of the meeting, the Commissioner decided to provide the District Health Board (DHB) of the Hospital with the Expert One advice for comment.⁵ The internal steering committee meeting minutes briefly record the outcome of the meeting rather than what was discussed or the factors considered.
 11. After the DHB provided further comments, Expert One was then approached by HDC again to review the DHB's comments and respond.
 12. Expert One advised that they had '*not identified any new or valid and relevant comments*' in the DHB's response to their advice regarding the scan not being carried out. However, Expert One advised that the decision not to perform a scan was likely to be a '*single error judgement*'. On revision, they believed this to be a '*mild "one off" breach ... perhaps a single error of judgement does not constitute a breach. It is a case of human error not uncommon among overworked doctors*'.⁶
 13. Given the conflicting positions between Expert One and the DHB regarding whether a scan was clinically necessary, HDC held another internal steering committee meeting and decided to seek a second expert opinion (Expert Two) about national practice.⁷
 14. In reviewing the case, Expert Two concluded that they would not have undertaken a scan during Ms A's admission to the Hospital, using the same rationale as the DHB. Expert Two considered the decision not to perform a scan in this case was in line with most maternity units in New Zealand.
 15. On 23 December 2015, the HDC assessor discussed the case with the Deputy Commissioner who decided that it was appropriate to proceed with a provisional '*no further action*' decision under section 38(1) of the Act as '*it now seems reasonable that no ultrasound scan was done*'. In terms of the '*moderately severe*' departure Expert One had identified relating to the DHB's discharge management, the meeting record notes that '*[the DHB] has made changes to its discharge practices*'.
 16. On 21 July 2016, HDC provided Ms A with its provisional decision for her comments. In explaining its rationale for taking no further action regarding the DHB's discharge management practices and communication, HDC noted that the DHB had accepted that

⁵ The Commissioner also sought clarification from a midwifery expert on a separate issue.

⁶ This was a revision of Expert One's earlier advice that there had been a 'moderate' departure of care in relation to the scan (paragraph [4] above refers).

⁷ HDC notes that the DHB's view was that a scan was not necessary and was not accepted practice. Expert Two was approached for a second opinion as they were experienced and in a reputable position.

there had been a serious failure in communication and were working on a new regional solution to facilitate better access to electronic records for Lead Maternity Carers (LMC).⁸

17. On 2 November 2016, Ms A provided a detailed response to HDC's provisional decision not to take any further action and included an opinion from her own expert advisor (Expert Three) who agreed with Expert One that a scan should have been provided (contrary to the DHB's and Expert Two's position).
18. As Expert Three was a former consultant at the DHB, HDC sought the DHB's further comments on this point. The DHB clarified that Expert Three was not speaking on behalf of the DHB and that its position remained the same. The DHB also provided further comments on Expert Three's concerns.
19. On 11 April 2017, HDC met to discuss the DHB's response. The meeting record states:

It was agreed that [the DHB's response] ... addresses the points raised. It was decided that we do not need further expert advice. It was discussed how detailed the final section 38 should be and it was agreed that it should be a middle ground between detailed and brief.
20. On 2 August 2017, HDC wrote to Ms A advising it was taking no further action under section 38(1) of the Act and concluded its preliminary assessment of her complaint.
21. HDC's final preliminary assessment report spanned 38 pages.
22. In regard to Ms A's complaint about her Registered Midwife, HDC advised that it had been unable to reconcile the factual disputes and that a formal investigation would be unlikely to enable HDC to make a factual finding. In other respects, HDC advised that it appeared the care Ms A received was largely reasonable. HDC confirmed that it considered where there had been deficiencies identified in the care provided, these would be appropriately addressed by HDC making recommendations and educative comments.
23. Where there had been deficiencies, HDC made comments in its final report ranging from being 'very concerned', 'mildly critical', and 'critical' of particular aspects of the care Ms A received from the different providers.⁹
24. HDC states that it had given extensive consideration to the issue of whether Ms A should have received a fetal wellbeing scan during her last admission to hospital and had thoroughly reviewed the conflicting advice from different sources. HDC states that it had accepted Expert Two's advice and considered it was reasonable in the

⁸ HDC also notes that Ms A's LMC was aware of the care given and her discharge as she had phoned the hospital during Ms A's admission.

⁹ For example, HDC considered that two doctors' specific actions in relation to an earlier request for an ultrasound were 'suboptimal'. HDC was also 'mildly critical' of these doctors' documentation practices. HDC was 'very concerned' about the DHB's discharge management, and was 'critical' of the Midwife's documentation, communication and other actions in relation to Ms A's discharge management.

circumstances for the hospital to have decided not undertake a scan during her admission.

25. In terms of Ms A's discharge planning, HDC stated that it was *'very concerned'* about Ms A's discharge management. However, HDC was pleased that the providers had changed their processes to ensure patients are provided with relevant information on discharge in future.

Ms B

26. On 29 July 2016, Ms B complained to HDC about the standard of care she had received from a particular Hospital. Ms B had presented to the Hospital suffering from what was later found to be a blood clot. Ms B stated she has suffered severe ongoing health consequences as a result of the Hospital's errors and omissions in the care provided.

27. On 11 May 2018, HDC wrote to Ms B in order to:

Summarise the information received during the course of my assessment, advise you of my provisional decision and the reasons for it, and to give you the opportunity to comment or provide additional information before I make a final decision on the matter.

28. HDC also apologised for the length of time it had taken to provide Ms B with an outcome but stated that, given the serious nature of her concerns, it had wanted to ensure that all issues were considered thoroughly.
29. HDC stated that it had obtained expert advice on the standard of care received by Ms B from Expert Four, a vascular surgeon, and Expert Five, a general medicine physician. Their comments to HDC included:
 - a. Expert Four considered that there were *'underlying problems of significance'* in Ms B's second admission to [the Hospital] and that the care she received was a *'moderate departure from accepted standards'*.
 - b. Expert Five considered that, overall, the care Ms B received from the Doctor *'fell short of accepted standards'*, although their criticism was tempered due to the complexity of the situation. Expert Five also considered the referral of Ms B to the general medical service fell *'well below the accepted standard of referral and transfer of care'*.
30. Overall, HDC identified five areas of concern regarding the care provided by the Hospital:
 - a. The reliance on community ultrasound;
 - b. Incorrect diagnosis of sciatica and the referral to general medicine;
 - c. The Doctor's role and his assessment;
 - d. Adequacy of clinical documentation; and

- e. Discharge without consulting the consultant.
31. HDC stated that Ms B's complaint had provided a valuable opportunity to review the systems in place at the Hospital and that it had made five specific recommendations which the hospital had accepted. HDC stated it would be following up extensively with the hospital over the next 18 months, in order to ensure these recommendations were implemented.
 32. The letter concluded with HDC stating that it intended to take no further action on Ms B's complaint and inviting her to provide comment.
 33. Ms B responded challenging an aspect of HDC's summary of the factual background to the complaint – that her vital signs and blood tests were reported as being within normal limits at the first presentation. Ms B also requested an opportunity to meet with HDC to discuss its findings before matters were finalised, as there were aspects of its letter she did not understand.
 34. On 22 May 2018, HDC responded stating that it had referred Ms B to the Nationwide Health and Disability Advocacy Service to assist her in resolving her remaining concerns directly with the Hospital. Aside from this action, HDC advised it would be finalising its decision to take no further action on the complaint pursuant to section 38(1) of the Act.
 35. Following this there was further correspondence between Ms B and HDC. Ms B asked HDC how to apply to the Human Rights Review Tribunal (HRRT). HDC explained that, in order to apply to HRRT, a breach of the Code of Health and Disability Services Consumers' Rights (the Code) must be found. HDC stated that her complaint was not formally investigated, no breach of the Code could be found.

Healthcare Provider C

36. Unlike the first two complaints which were raised by healthcare consumers, this complaint was raised by a healthcare provider.¹⁰
37. In November 2016 a complaint was made to HDC about the services provided by Healthcare Provider C. HDC commenced its preliminary assessment soon after.
38. After seeking additional information from Provider C and complainant (the person who made the complaint against Provider C), HDC engaged the services of Expert Six in May 2017 (8 months later), for expert advice on the issues raised. HDC advises that the delay receiving advice was due to difficulties in finding a suitable expert New Zealand advisor.
39. Expert Six provided their initial report in July 2017. HDC then sought further clarification and advice from Expert Six which was received in August 2017. This advice was put to Provider C for comment in October 2017.

¹⁰ No connection to Ms A's or Ms B's separate cases.

40. In November 2017, HDC identified that Expert Six had a conflict of interest and their engagement with HDC was terminated.
41. HDC then began making initial calls to Australia to seek out another expert advisor.
42. HDC commissioned an Australian advisor who initially sought an extension to provide the requested advice. HDC received the adviser's report on 31 May 2018. HDC then sought further clarification on aspects of this advice and sent a copy of this advice to the complainant and Provider C for comment. Provider C responded in August 2018.
43. In September 2018, another potential conflict of interest was identified, this time concerning the complainant's advocate. After further email correspondence with the advisor, the Deputy Commissioner determined that no conflict existed.
44. The complainant then responded and provided comments on the expert advice in November 2018.
45. In March 2019, Provider C complained to me about the time taken for HDC to complete its preliminary assessment (amongst other concerns).
46. On 30 April 2019, HDC sent its provisional decision to Provider C. Provider C responded on 30 April 2019 raising concerns with HDC's decision. The complainant was sent HDC's provisional decision on 1 May 2019.
47. Between May and August 2019, HDC continued to seek further information from both Provider C and the complainant.
48. On 24 February 2020, HDC finalised its preliminary assessment.¹¹

Complaints to the Chief Ombudsman

49. Ms A, Ms B, and Provider C have all separately complained to me that HDC's process of assessing their complaints was unreasonable.¹²
50. They are concerned about the length of time HDC has taken to complete a 'preliminary' assessment of their complaints and consider that this has had a detrimental impact.
51. The complainants are also concerned that actions taken during HDC's preliminary assessment appear to be of the same level as a formal investigation. In particular, Provider C states that it is not clear whether the legislature intended that such an extensive 'preliminary' assessment be carried out in this way.

¹¹ HDC notes that Provider C brought legal proceedings against HDC during its preliminary assessment and that this affected its ability to progress the assessment.

¹² Ms A's complaint was received on 30 January 2018. Ms B's complaint was received on 20 July 2018. Provider C's complaint was received on 11 November 2019.

52. Ms A and Ms B also raise concerns that HDC decided to take no further action on their complaints under section 38(1) of the Act. They are particularly concerned that:
- a. HDC did not proceed with an investigation of their complaints in light of receiving expert advice that there had been *'moderate'* to *'moderately severe'* departures of care in Ms A's case, and that the care *'fell well below accepted standards'* in Ms B's case. Without a formal investigation being commenced, HDC did not make a formal finding of whether a breach of the Code of Health and Disability Services Consumers' Rights (the Code) occurred.
 - b. As the complaints were not formally investigated, the health providers were not appropriately held to account and they were denied any potential ability to bring proceedings before the HRRT.¹³

Investigations

53. I notified HDC of my investigations of these three complaints in March 2019. I advised my three investigations would be focussing on whether HDC's preliminary assessment process and decision to take no further action under [section 38\(1\)](#) was unreasonable, having regard to:
- a. Whether the time taken to complete the preliminary assessment under [section 33](#) of the HDC Act was unreasonable.
 - b. Whether it can be said that no investigation was undertaken, in light of the Commissioner making findings, gathering extensive evidence, and providing opportunity for comment on adverse findings.
 - c. The effect of a decision to take no further action under section 38(1) of the Act. That is, if an investigation is essentially undertaken but the outcome couched in terms of section 38(1), the complainant may be deprived of a potential ability to bring proceedings before the HRRT to seek a remedy.
 - d. Whether the exercise of the discretion to take no further action, and the preliminary assessment, are appropriately supported by internal policy and procedure.
54. I requested responses to the notification of the three complaints by the end of April 2019. However, HDC requested multiple extensions to provide a response.
55. My staff subsequently wrote to HDC in May 2019 requesting a meeting to discuss the issues raised by the complainants as a first step. This meeting went ahead in July 2019.
56. My staff then sought further comments and clarification from HDC on its internal practices and procedures.

¹³ In the event the complaints were investigated and a Code breach found.

57. HDC provided further written comments in August 2019 and November 2019.
58. I issued my first provisional opinion on 28 April 2020. HDC sought an extension to respond, and provided three letters for my consideration on 10 June 2020 (separately written by Anthony Hill, former Health & Disability Commissioner; Jane King, Associate Commissioner Legal; and Victoria Casey QC). In response, I took into account the arguments raised by HDC and Ms Casey QC and amended my report as appropriate. On 30 July 2020, I provided a further provisional opinion to HDC and a final opportunity to be heard.
59. HDC provided its final comments on 14 August 2020.¹⁴
60. My understanding of HDC's complaint handling processes are outlined below.

Current preliminary assessment process

61. HDC has explained its current preliminary assessment to me as follows.
62. When a complaint is first received, HDC will triage complaints and carry out a preliminary assessment in order to decide what action to take. HDC advises the assessment can be lengthy at times as the process can include obtaining further information from the complainant, seeking a response from the provider concerned, and obtaining expert advice.
63. Complaints are carefully assessed and resolved in the most appropriate manner (in line with its legislative mandate and strategic intent), taking into account the issues raised and the evidence available. The preliminary assessment decisions available to HDC are set out in section 33 of the Act and include a range of resolution options, including referring a complaint to another agency or advocate, investigating a complaint, or taking no further action.
64. While a formal investigation is one of the resolution options available, HDC considers it is only reserved for the most serious cases where the action of the health provider or disability services provider *'is, or appears to be, in breach of the Code'*. This is in reference to section 40(1) of the Act which states:

40 Commissioner may investigate breaches

- (1) *The Commissioner may decide to investigate any action of a health care provider or a disability services provider if the action is, or appears to the Commissioner to be, in breach of the Code.*

65. HDC states that under this section there needs be, at least at first appearance to the Commissioner, a breach of the Code. At present, HDC carries out a thorough

¹⁴ Ms Morag McDowell took up the role of Health and Disability Commissioner on 7 September 2020, taking over from Mr Anthony Hill.

preliminary assessment to determine whether there is, 'prima facie', a breach of the Code that requires investigation.

66. The difference between a preliminary assessment and a formal investigation is that an investigation invokes the powers and requirements set out in section 40-46 of the Act, including:
- a. notifying complainant and provider of the investigation;
 - b. restricting what disciplinary action can be taken while an investigation is ongoing; and,
 - c. requiring HDC to inform the relevant parties of the result of the investigation.
67. Section 45 and 46 also outline procedures after investigation, including making a formal finding of whether there was a breach of the Code and steps the Commissioner may take such as making recommendations or referring the matter to the Director of Proceedings. Where the Commissioner has investigated and finds that there was a breach of the Code, the Director of Proceedings or the aggrieved person may bring proceedings before the HRRT to seek a remedy, including damages.
68. HDC advises that a formal investigation has repercussions for a provider, and on its own processes. In particular, the relevant regulatory oversight body will be notified and certain interim restrictions (such as travel restrictions or professional development restrictions) may be put in place during the investigation process.¹⁵ Additionally, the providers often seek legal representation and that this can affect the quality of information or evidence provided or speed at which it can collect it. HDC notes this also affects the overall relationship with the provider.
69. HDC advises that *'other than the Act, there are no policies/guidance/other material that it refers to when making a decision to investigate'*.¹⁶
70. It states that there is no *'hard threshold'* for putting forward a recommendation for investigation to the relevant decision-maker. Rather, a complaint may be considered for investigation during a preliminary assessment and these decisions are made on a case-by-case basis having regard to the details of the case. As part of this process, the complaint may be discussed at an internal steering committee meeting (made up of the complaints assessor, team leader, legal team and decision maker – Deputy Commissioner or Commissioner) where a decision on whether a complaint should be transferred to the Investigations team is often made.

¹⁵ These are actions taken by the regulatory body and not HDC.

¹⁶ HDC has subsequently advised that it considers it does have adequate guidance for decision-makers outlined in its Standard Operating Manual (SOM) that is discussed further below. I note that at the time final decisions were made on the complaints, while the SOM outlined HDC's complaint-handling process, the SOM did not list what factors decision-makers should take into account when deciding when an investigation should be commenced.

71. More commonly, however, HDC will resolve complaints without initiating a formal investigation, including, where appropriate, to take no further action under section 38(1) of the Act at the conclusion of a preliminary assessment.

Analysis and findings

72. This section is divided into two parts and outlines my views on:
- a. how HDC is currently carrying out a 'preliminary' assessment under section 33 of the Act, and whether this process reasonably reflects Parliament's intentions; and
 - b. how HDC has exercised its use of its discretion to take no further action in Ms A's and Ms B's cases, and whether these decisions are supported by reasonable internal policies and procedures.

What is the purpose of section 33?

73. Section 33 of the Act provides:

33 Preliminary assessment

- (1) *As soon as reasonably practicable after receiving a complaint, the Commissioner must make a preliminary assessment of the complaint to decide—*
- (a) *whether to take 1 or more of the following courses of action:*
 - (i) *to refer the complaint to an agency or person in accordance with section 34 or section 36:*
 - (ii) *to refer the complaint to an advocate:*
 - (iii) *to call a conference, under section 61, of the parties concerned:*
 - (iv) *to investigate the complaint himself or herself; or*
 - (b) *whether to take no action on the complaint.*
- (2) *The Commissioner must promptly notify the complainant and the health care provider or the disability services provider to whom the complaint relates of the Commissioner's preliminary assessment.*
- (3) *This section does not preclude the Commissioner from revising a preliminary assessment and from subsequently exercising 1 or more of his or her other powers in relation to the complaint concerned.*

- (4) *If the Commissioner revises a preliminary assessment, the Commissioner must promptly notify the following persons and agencies of the revised assessment:*
- (a) *the complainant;*
 - (b) *the health care provider or the disability services provider to whom the complaint relates;*
 - (c) *any agency or any person to whom the complaint has, in accordance with section 34 or section 36, been referred;*
 - (d) *any advocate to whom the complaint has been referred.*
74. I have reviewed available material, including Hansard records, to assist in determining how section 33 of the Act should be interpreted.
75. Section 33 was introduced through the Health and Disability Commissioner Amendment Act 2003. [The 1994 Act](#) did not include provision for a 'preliminary assessment'.¹⁷
76. The Amendment Act was introduced to address concerns over the lack of an effective complaints process for victims of the health system, in light of *'The Review of Processes Concerning Adverse Medical Events'* conducted by Helen Cull QC in 2000.
77. The Cull review recognised the multiplicity of agencies processing the same complaint, which was confusing, cumbersome, and costly. Notably, the report recommended the establishment of a *'one-stop-shop'* – the Health and Disability Commissioner – to coordinate the investigation of all health consumer complaints.¹⁸
78. The Cull review recognised the importance of amending the HDC Act to enable the Commissioner to take a flexible approach to complaints to enable the Commissioner to make *'preliminary inquiries prior to the commencement of a formal investigation'*. Such inquiries would allow the Commissioner to adopt the appropriate course of action for each level of complaint.¹⁹
79. The review envisaged the proposed legislative amendments and increased flexibility would enable the *'more timely investigation of complaints'*.²⁰ This would be achieved, in part, by categorising the severity of complaints and identifying early on through a preliminary assessment which low-level complaints (which are appropriate for resolution

¹⁷ Section 35 of the 1994 Act stated that *'it shall be a function of the Commissioner to investigate any action of any health care provider or any disability services provider where that action is or appears to the Commissioner to be in breach of the Code'*. In more limited circumstances, the Commissioner did have the option to refer a complaint or take no further action under sections 36 and 37.

¹⁸ For general background see Scragg, Jonathan "A critique of the review of process concerning adverse medical events (*The Cull Report*)" [2003] *CanterLawRw* 2; (2003) 9 *Canterbury Law Review* 37.

¹⁹ *Review of the Processes Concerning Adverse Medical Events* Hellen Cull QC March 2001, page 16.

²⁰ *Ibid.* Page 16.

and do not raise an issue of a practitioner's competence) could be referred to advocacy. Similarly, Cull recorded that there was a need for serious complaints that raise obvious health risks to be referred directly to the Director of Proceedings.²¹

80. Notably, while the Cull review recognised that some complaints 'may not need a full investigation but require some actions', it was envisaged that those complaints that were assessed as being 'middle-range or serious' would be investigated in a comprehensive manner.²²
81. Hansard records show that the then Associate Minister of Health saw that the role of the Commissioner would change through the amendments and improve the timeliness of the complaints process.²³
82. It was envisaged that proposed amendments would allow the Commissioner to deal with complaints that were made with 'malicious intent' more pragmatically, and for complaints to be dealt with more quickly.²⁴ In particular, Dr Lynda Scott submitted the following in Committee:

*But if all complaints are to go through to the Health and Disability Commissioner, then obviously that agency will need more resourcing. In secret, we heard evidence about what it was like for a person to have somebody become fixated on him or her and make malicious complaint after malicious complaint. Every complaint that had gone through the process was shown to have no grounds, but every single one had to be investigated. The Health and Disability Commissioner needs to have the ability to deal with malicious complaints. The commissioner also needs time lines to speed up the process. Time and time again we heard how long it takes to get through that process, how long it takes for a complaint to be heard, and for there to be a resolution. That is something we have hoped to improve.*²⁵

²¹ Ibid. Page 51.

²² Ibid. Page 108.

²³ Hon Damien O'Connor (Associate Minister of Health), Health and Disability Commissioner Amendment Bill, third reading. See: https://www.parliament.nz/en/pb/hansard-debates/rhr/document/47HansD_20030910_00001510/health-practitioners-competence-assurance-bill-health-and

²⁴ Dr Lynda Scott (NZ National—Kaikoura), Health Practitioners Competence Assurance Bill — In Committee, 26 August 2003. The full quote available at: https://www.parliament.nz/en/pb/hansard-debates/rhr/document/47HansD_20030827_00001060/health-practitioners-competence-assurance-bill-in-committee

²⁵ Dr Scott was also supportive of complainants, in the first instance, being dealt with by the hospitals themselves (and that this would be facilitated by HDC having the flexibility to refer the matter to the healthcare provider following preliminary assessment).

83. The introduction of 33 was accompanied by revised section 38 that provided '*greater discretion*' for the Commissioner to take no further action on a complaint.²⁶ Section 38(1) provides:

At any time after completing a preliminary assessment of a complaint ... the Commissioner may, at his or her discretion, decide to take no action, or as the case may require, no further action on the complaint if the Commissioner considers that, having regard to all the circumstances of the case, any action or further action is unnecessary or inappropriate.

84. Section 38(1) enables the Commissioner to take no further action on a complaint where it would be '*unnecessary or inappropriate*', but only *after* a preliminary assessment.
85. I consider section 38(1) infers that to reach the 'threshold' of determining whether further action is '*unnecessary or inappropriate*', the inquiry required by section 33 would entail *some* information gathering and analysis. However, where extensive inquiries are needed, this would undermine the 'quickness' of the preliminary assessment envisaged by section 33. For reasons discussed below, I consider that Parliament intended this level of inquiry would commonly be conducted in a formal investigation (under section 40).²⁷
86. This is supported in the Cull report where it was noted while a complaint may require '*further inquiry*', this would still be in the context of determining appropriate early triage actions.²⁸ Complaints that require extensive analysis and actions, would appear to fit within the Cull report's middle-range or serious category that require a more '*comprehensive*' review and '*full*' investigation. Importantly, the Act does not prevent the Commissioner from revisiting the section 33 options, or the section 38(1) discretion, after an investigation is commenced.
87. Under the 1994 Act, the Commissioner was only required to deal with events that happened after 1 July 1996. The amendments changed this so that the Commissioner was authorised to deal with those complaints that happened prior to 1 July 1996, thus removing the need for complaints investigation committees who were up until then tasked with assessing pre-1996 complaints.²⁹

²⁶ Health Practitioners Competence Assurance Bill 2002 (230-1), page 27.

²⁷ Section 40 enables the Commissioner to investigate where, following preliminary assessment, other avenues under section 33 for resolving the matter are not appropriate. This would include where, following an initial or preliminary assessment, the matter cannot be closed on grounds that further action is '*unnecessary or inappropriate*'.

²⁸ This is exemplified by Cull in situations where further inquiry may be required to determine whether it may be appropriate to refer a complaint on to a relevant authority, or investigate further (on page 106 of her report).

²⁹ Report from the Health Committee on the Health Practitioners Competence Assurance Bill. See https://www.parliament.nz/resource/en-NZ/47DBSCH_SCR2445_1/cf790dbb729c521121cbd94558ead328b4d138fa at 4 to 5.

88. Discussion of the Amendment Bill in Committee recognised that the investigation process would still reach a high degree of thoroughness, including interviews and rights of reply for parties under investigation.³⁰
89. I also note HDC's other submissions on why it considers the Amendment Bill clearly intended to afford the Commissioner greater flexibility in how they dealt with complaints:
- a. it introduced what is now section 14(1)(da), adding to the functions of the Commissioner to '*act as the initial recipient of complaints about health care providers and disability service providers, and to ensure that each complaint is appropriately dealt with*'. This shows that the function of the Commissioner is to determine how each complaint is to be appropriately dealt with (following preliminary assessment); and,
 - b. the former Commissioner's submissions to the Health Committee noted that it was never intended that the Commissioner resolve all complaints through investigation and that investigation would be reserved for appropriate cases and used as effectively as possible.³¹
90. Altogether, it appears that the inclusion of section 33:
- a. reflected Parliament's intent to have a single agency responsible for healthcare complaints – and in light of this increased responsibility, recognised that the Commissioner was to undertake an assessment function to determine how each complaint should be handled;
 - b. reflected the Commissioner would be responsible for pre-1996 complaints, thus removing the need for independent assessment committees, and thus equipped him with that general function;
 - c. was to enable the Commissioner to deal speedily with complaints that did not require investigation; and
 - d. was to otherwise complement the Commissioner's existing investigative function.³²
91. In sum, section 33 authorised the Commissioner to assess the increased volume of complaints they were expected to receive in a flexible and expeditious way.

³⁰ Phil Heatley (NZ National—Whangarei), Health Practitioners Competence Assurance Bill — In Committee, 26 August 2003

³¹ Submission by the Health and Disability Commissioner to the Health Select Committee on the Health Practitioners Competence Assurance Bill, 27 November 2002, at [23] and [27] – [28]. HDC has drawn my attention to the positive feedback the former Commissioner received during this process.

³² The amended changes were also intended to enable the Commissioner to deal with malicious complaints more pragmatically without investigation.

92. However, there is no indication that Parliament intended this section to restrict the Commissioner's investigation of complaints to only a minority of the most serious of matters.³³

What is a 'preliminary assessment'?

93. The stated aim of the Act is to facilitate the *'fair, simple, speedy and efficient'* resolution of complaints. This relates both to the overall scheme of complaint resolution and the handling of individual complaints.³⁴
94. In light of my comments above, it appears the Parliament intended a preliminary assessment to be an initial evaluation of the complaint, and was included to help the Commissioner facilitate the *'fair, simple, speedy and efficient'* resolution of complaints.
95. In my opinion, the wording in section 33 makes it clear that the assessment is intended to be undertaken expeditiously:
- a. **As soon as reasonably practicable** after receiving a complaint, the Commissioner must make a preliminary assessment.
 - b. The preliminary assessment is **to determine which course(s) of action** the Commissioner should take including referring the complaint on, calling a case conference or to investigate the complaint themselves. This highlights how subsequent actions are dependent on the timely completion of the assessment;
 - c. The Commissioner must **promptly notify the parties** of the preliminary assessment. Again, this highlights the need for promptly communicating the outcome of the assessment so that parties have certainty as to the course of action being proposed; and
 - d. The Commissioner is not precluded from **revising the preliminary assessment**. This shows that the preliminary assessment can change as more information comes to light, including during an investigation that is commenced, and is not intended that information is exhaustively gathered and reviewed before it is completed.
96. HDC states that the Commissioner's role is to assess:

... whether, on the information available to the health providers at the time ... the provider took reasonable actions in the circumstances to give effect to the

³³ HDC notes that in the 16 years since section 33 came into force, it has received approximately 25,606 complaints, and of these 1,290 have been investigated (approximately 5% of complaints received).

³⁴ The Commissioner has recognised that 'speedy' investigations are just one part of the Act's aim. A balance must be struck between simple, speedy resolution, and achieving a fair result. The results of an investigation can often be of considerable significance for those concerned. It is unrealistic to suppose that a fair result will always be a speedy result – see <https://www.hdc.org.nz/your-rights/about-the-code/review-of-the-act-and-code-1999/>

rights, and comply with the duties of in the Code [and] ... acted appropriately and in accordance with accepted standards of practice.

The focus of the assessment is in relation to accountability quality improvement, and patient safety...

97. However, for the reasons above, I consider that the preliminary assessment's purpose is to make a prompt initial determination about how the complaint should be handled. The Commissioner has a specific and prescribed statutory function of investigation. I do not see how the preliminary assessment could have been intended as vehicle for extensive information gathering, nor as a means by which to determine, through a detailed and sustained level of analysis, the standard and appropriateness of care provided to a healthcare consumer as occurred in Ms A and Ms B's complaints.
98. The HDC's interpretation of a section 33 preliminary assessment function appears at odds with its plain meaning, and legislative intent. This, combined with an absence of internal guidance material, appears to have resulted in practices that are out of step with the legislation.
99. In particular, it is not apparent to me that section 40(1) is, or was intended to be, any potential barrier to investigation as HDC has appeared to suggest.
100. Section 40(1) outlines that the Commissioner may initiate an investigation where the action of the healthcare provider *'is, or appears to the Commissioner to be, in breach of the Code'*. This *'investigation'* is a step envisaged after the preliminary assessment (section 33(1)(a)(iv)). The wording of section 40 appears to me to be broadly permissive – it is section 38(1) that enables the Commissioner to take no further action, where a prompt preliminary inquiry or substantive investigation has indicated that is the appropriate outcome.
101. In situations where a complaint is made and a prompt assessment of the supporting information indicates a breach may have occurred, the Act indicates the Commissioner can commence an investigation to establish the facts of the case and make a determination of whether or not a breach under the Code has occurred. If substantive information gathering is required to reach the section 38(1) threshold, this should generally be done via section 40.
102. To the extent that clarification is required to establish whether an action would *'appear'* to be in breach of the Code, as outlined above, I do not consider this would commonly need to entail extensive information gathering and/or obtaining in-depth expert advice. Such actions are the typically the hallmarks of an investigation.

103. Even if the language of section 40(1) poses a potential barrier as suggested by HDC for commencing investigations, there is no internal current policy or guidance on what constitutes an ‘apparent breach’ for the purposes of this section.³⁵

Final opinion on preliminary assessment process

Length of time

104. In Ms A’s case, it took three years and nine months for her to receive a final preliminary assessment decision (from the initial complaint through to the second decision to take no further action).³⁶
105. In Ms B’s case, it took one year and nine months for a preliminary assessment to be completed.
106. In Provider C’s case, it took three years and three months for a preliminary assessment to be completed.
107. HDC has explained that the preliminary assessment process has been lengthy in these cases, in part, because of the complexity of the issues that required a detailed and prolonged analysis.
108. It is not my intention to specify exactly how long a preliminary assessment should take. However, as outlined below, I am concerned about the impact of this lengthy preliminary assessment process has had on the complainants. I do consider the time taken is clearly at odds with the purpose of the preliminary assessment function, which is to be undertaken as soon as reasonably practicable, to determine which course(s) of action is to be taken.
109. HDC has recognised and accepted that in each case the overall assessment processes took too long and has acknowledged this to the parties.

Actions undertaken

110. The assessment process for Ms A, Ms B, and Provider C included seeking: further information from the complainant(s), expert advice (from multiple advisors on multiple occasions) and responses and comments from all parties.
111. In Ms B’s case, she had originally raised significant concerns about the level of care she received, the process of being discharged twice prematurely, and the resulting lasting impact on her health. HDC acknowledged in its initial decision letter to her that, given the complications she suffered and the long protracted recovery that resulted, it was understandable that she sought a review of the care she received. This would appear to

³⁵ HDC has expressed concerns regarding other barriers for initiating an investigation. I have addressed these concerns further below (paragraphs [123]-[131]).

³⁶ HDC notes that this process was not continuous. The first assessment took 8 months. Following a closed file review, a second assessment was undertaken. This began in May 2015 and concluded in August 2017.

indicate that HDC accepted, from the outset, the seriousness of the concerns raised and that there appeared to be *prima facie* a need to scrutinize the actions of the health providers in detail, and which resulted in it carrying out an extensive analysis and information-gathering exercise.

112. Similarly, in Ms A's case, HDC sought in-house clinical advice that revealed '*mild to moderate*' departures of care regarding one DHB's discharge management. Further comments and information received from Ms A prompted HDC to carry out in-depth analysis of the care provided and seek multiple expert opinions.
113. Again, HDC's early assessment actions suggest that an extensive information gathering and investigative analysis was warranted given the serious nature of the concerns Ms A raised.
114. For the reasons already explained, I do not consider that collecting extensive information from the providers, expert advisors, and complainants and then carrying out a comprehensive analysis should form part of the preliminary assessment. Rather these are the types of steps I would expect to see HDC take in the context of an investigation, once a preliminary assessment as to how the complaint should be handled has been promptly completed.
115. I consider it is the purpose of an investigation, not a preliminary assessment, to carry out an in-depth analysis to establish the findings of a case (where possible) and to come to appropriate conclusions.
116. HDC has advised that there was no statutory bar prohibiting it from carrying out an investigation in Ms B or Ms A's cases. Given the level of information gathering and analysis required in relation to their complaints, it appears that a formal investigation would have been a more appropriate vehicle to undertake these steps in these cases.
117. Further, at the time Provider C complained to me, Provider C was concerned by the prolonged and extensive nature of HDC's preliminary assessment and early assessment actions that remained ongoing. Provider C considered that, even if HDC had decided to refer the matter for investigation at the time, it was difficult to see what further information could be required. It appears HDC's actions in this case stepped beyond what a preliminary assessment should entail.
118. In particular, HDC's preliminary assessment actions involved seeking layers of expert advice as well as comments from Provider C and the complainant at multiple stages. HDC then conducted a full analysis and sought further comments on its provisional report before finalising its decision.

Communicating decisions

119. In concluding its preliminary assessment of Ms A's complaint, HDC expressed that it was '*very concerned*' about her discharge management, which appeared, from the complainant's perspective, to endorse Expert One's assessment of the management as a '*moderately severe departure*' of the standard of care. Further, HDC made several

other findings regarding specific aspects of the providers' standard of care with language such as '*mildly critical*', '*suboptimal*' and '*critical*'.

120. In concluding its preliminary assessment of Ms B's complaint, her concerns regarding the standard of care she received were confirmed. Having received expert advice that relatively significant departures from the standard of care had occurred, HDC concluded that '*it is apparent that at times, your care fell well below the accepted standards*' in its decision letter.
121. Ms B considers, quite understandably, that HDC's findings in her case appear to identify breaches of the acceptable standards of care that essentially amount to a breach of the Code.
122. However, as the findings in Ms A and Ms B's cases were made in preliminary assessment, HDC was restricted from making a formal finding as to whether these departures amounted to a breach of the Code. An unavoidable consequence of this approach is that the complainants were denied any potential ability to bring proceedings before the HRRT.
123. HDC has advised that while its expert advisors may use certain language to quantify departures of care they identify, this does not necessarily reflect HDC's views regarding the severity of the departure of care.³⁷
124. Ms A and Ms B's complaints highlight the ambiguity of the language used by HDC in communicating its decisions in a preliminary assessment report, and addressing and quantifying departures of care it identified.
125. In a formal investigation report, HDC uses similar language to that used in these preliminary assessments to quantify departures of care. The difference is that at the conclusion of an investigation, the Commissioner forms a definitive view as to whether these departures amounted to a breach of the Code. Alternatively, as the case may require, the Commissioner may form the conclusion there has been no breach.³⁸ The latter approach can bring much needed clarity and finality to the complaint.

Conclusion

126. It is clear that the length of time taken by HDC to complete an in-depth preliminary assessment has had a significant negative impact on both the complainants (Ms A and Ms B) and Provider C. The parties were left in limbo, causing stress and uncertainty about how the complaints would be handled, over a number of years. Despite HDC's

³⁷ In Ms A's case, HDC advises that its concerns regarding Ms A's discharge management, '*was not of itself enough to find a breach of the Code should an investigation have been undertaken*'. However, I consider it was inappropriate for HDC to retrospectively allude to the outcome of a formal investigation that was never undertaken.

³⁸ For example, I note in HDC's opinion 19HDC003989 HDC made a conclusive 'no breach' finding regarding the actions of a pharmacy. The full report is available at: <https://www.hdc.org.nz/decisions/search-decisions/2020/19hdc00989/>

extensive analysis the complainants were also left with no conclusive finding regarding whether a breach had or had not occurred. Further, as HDC was restricted from ever making a formal finding as to whether a breach of the Code occurred, it was an unavoidable consequence that Ms A and Ms B were left with no potential ability to bring proceedings to the HRRT.

127. Overall, in my opinion HDC's preliminary assessment actions in these cases were unreasonable.

Complicating factors

128. HDC states that a contributing factor to the prolonged and complicated preliminary assessment process was that the complainants were actively engaged, challenging aspects of the expert advice presented, participating in interviews and providing extensive submissions. HDC does not consider that the actions of the complainant, or the Commissioner's willingness to engage in the level of detail that the complainant wishes to put forward, converts a preliminary assessment into a full investigation.
129. If a complainant's actions mean that HDC needs to analyse and engage with information thoroughly at multiple stages, this indicates to me that HDC's assessment may be stepping beyond a 'preliminary' phase. In this situation, it is my view that HDC should be considering whether it is more appropriate to continue this level of inquiry in the context of an investigation. As HDC also points out, the Commissioner still has the same statutory power to take no further investigative action under section 38(1) once an investigation has commenced.
130. Similarly, HDC notes that providers may seek legal representation on notification of an investigation and that this may affect the subsequent information gathering stage, and/or affect the ongoing relationship with the provider. I do not consider these background factors are relevant when deciding whether to initiate an investigation.
131. In my view, there is a need for HDC to develop a more comprehensive complaint-handling policy that:
- a. clarifies the boundary where an assessment of a complaint, and the resulting information gathering and analysis, steps beyond 'preliminary' and would benefit from being put to the relevant decision-maker to consider whether an investigation may be the more appropriate course of action;³⁹

³⁹ As HDC makes clear, any course of action under section 33 would be for the relevant decision-maker to consider in light of the circumstances of the complaint, the overarching purpose of the HDC Act - and in relation to whether an investigation may be appropriate, whether the action complained about '*is, or appears to the Commissioner to be, in breach of the Code*' (section 40(1) of the Act refers).

- b. distinguishes between findings regarding the standard of care received in a preliminary assessment context (as part of a decision to take no further action), as opposed to a finding in an investigation context; and,
- c. specifically reference how a complainant's wishes should be taken into account as a relevant decision-making factor in relation to considering whether an investigation would be more appropriate in the circumstances.⁴⁰ This would include considerations as to whether, based on the outcome sought by the complainant, it is appropriate for an investigation to determine, conclusively, whether the action complained about amounts to a breach of the Code, and would enable the possibility for the complainant to access the 'backstop' provisions bringing proceedings before the HRRT.⁴¹

132. I have elaborated on my general expectations regarding compliant-handing policies and the exercise of discretion in paragraph [151].

Resourcing issues

- 133. A recurring theme throughout HDC's comments to me is that it appears to opt for a more extensive preliminary assessment process in order to avoid a more '*resource intensive*' investigation. HDC notes that it is under increasing pressure with the number of complaints it receives growing by 40% over the last five years.
- 134. HDC advises it also has an obligation to operate in a fiscally prudent manner. In light of these resource constraints, and in the face of an increasing volume of complaints, HDC reserves its investigative function for only the most serious matters.
- 135. Even if it can be demonstrated that an investigation is significantly more resource-intensive, it is difficult to identify a clear basis to suggest that resourcing issues, in and of themselves, would justify an apparent departure from the purpose of the legislation (in relation to what constitutes a 'preliminary' assessment), or avoiding a formal investigation where it might otherwise be warranted.
- 136. On this point, I note that the steps outlined in HDC's investigation guide bear a very close resemblance to the steps taken in assessing Ms A, Ms B, and Provider C's

⁴⁰ HDC states that the complainant's wishes are a relevant factor in its decision-making. However, this not specially mentioned in HDC's decision-making policy when deciding whether to initiate a formal investigation. In any consideration of a complainant's wishes, HDC makes clear the decision-maker would also need to be balanced against HDC's strategic intent and purpose, including a focus on resolution of complaints at the appropriate level.

⁴¹ This is supported by former Commissioner's submissions to the Health Select Committee: '*The Commissioner may and should take the consumer's wishes into account when deciding to take no action on a complaint (proposed section 38(1)(d)). However, ultimately it is for the Commissioner to determine the appropriate action, if any. The Commissioner should not be fettered from taking a certain action where the complainant considers another would be more appropriate.*' (Health and Disability Commissioner to the Health Select Committee on the Health Practitioners Competence Assurance Bill, 27 November 2002, at [28]).

complaints. For example, steps such as: the providers being advised of the complaints received, gathering information, seeking expert advice, interviewing/meeting with parties and drafting of a report and putting this to parties for comment before finalising the report.⁴²

137. Finally, as discussed above, the nature and purpose of an investigation is to analyse the evidence and determine the facts of a case, and then make a formal finding as to whether there has been a breach of the Code. HDC appears to consider that initiating an investigation is a detrimental punitive action against a provider that should generally be avoided unless serious malpractice is identified. However, this strict criteria appears to inflate the threshold for initiating an investigation beyond the statutory requirements and results in HDC conducting a disproportionate ‘preliminary assessment’ instead.

Final opinion decision to take no further action

138. Given the above views I have expressed on the appropriateness of the preliminary assessments undertaken in these cases, I now turn to consider the decisions to take no further action complained about by Ms A and Ms B. Had a preliminary assessment been undertaken in the manner explained above, I consider it would have been likely that the complaints would have been investigated (per paragraph [115]), and the complaints concerning the decision to take no further action would have been unlikely to arise (at least in this way).

Discretion and current policy

139. Section 38(1) of the Act sets out as follows:

38 *Commissioner may decide to take no action or no further action on complaint*

(1) *At any time after completing a preliminary assessment of a complaint (whether or not the Commissioner is investigating, or continuing to investigate, the complaint himself or herself), the Commissioner may, at his or her discretion, decide to take no action or, as the case may require, no further action on the complaint if the Commissioner considers that, having regard to all the circumstances of the case, any action or further action is unnecessary or inappropriate.*

140. HDC refers to its Standard Operating Procedure (SOP) to help inform its decision-making in regards to exercising its discretion under section 38(1). It is noted that the

⁴² Guide for complainant’s on HDC’s Investigation Process. See: <https://www.hdc.org.nz/media/3006/hdc-guide-for-complainants.pdf>

SOP has since been updated.⁴³ At the time the complaints were assessed (and final decisions were made in Ms A and Ms B's cases), in addition to the circumstances listed in the Act,⁴⁴ HDC considered the following factors in its SOP were relevant when determining whether taking no further action is appropriate:

- a. The provider's response to the complaint, either to HDC directly or to the complainant, sufficiently addresses/resolves the matters raised by the complaint.
 - b. The provider has already made changes to his/her/its practice or has taken appropriate corrective actions following the complaint.
 - c. The provider is no longer practicing and is unlikely to return to practice.
 - d. There is a lack of evidence to support or establish the complainant's claims.
 - e. The evidence is such that factual issues cannot be, or are unlikely to be, resolved.
 - f. The evidence largely indicates that the care was generally appropriate or departed from accepted standards to a mild degree only.
 - g. The complaint can be resolved adequately through making recommendations or follow-up action.
 - h. No further value would be added by the Commissioner taking further action on the complaint.
 - i. The complaint has been dealt with by another agency, for example, the Coroner or the Police, and further action by the Commissioner is unnecessary or inappropriate.
 - j. The complaint would be more appropriately dealt with by another agency.
141. The SOP also identifies the following factors that may weigh against taking no further action:
- a. Despite the disinterest of the complainant in continued action, the information available indicates that there could be an ongoing public safety concern.
 - b. The matter is such that a referral to the Director of Proceedings would likely follow if the complaint were upheld following investigation.
 - c. Recommendations arising from an internal or external investigation of the matter have not been implemented.
142. There are multiple decision-making phases throughout HDC's preliminary assessment process where these factors are considered - for example, during steering committee

⁴³ At the time the final preliminary assessment decisions were made, the April 2017 version of HDC's SOP was in effect. HDC updated its SOP on 19 February 2020.

⁴⁴ Under section 38(2).

meetings or where memos are put to decision-makers for guidance (typically when expert advice or comments from the provider are received).

Final opinion

143. In earlier correspondence with the HDC, my staff observed that the SOP⁴⁵ set out that taking no further action may be appropriate when *'the evidence largely indicates that the care was **generally appropriate or departed from accepted standards to a mild degree only**'*.
144. In my opinion, the wording of this guidance appears to presume that where there have been departures of care that are considered beyond *'mild'*, a formal investigation would eventuate. This would also appear to align with Cull's expectation that *'middle-range or serious'* complaints would be investigated.⁴⁶
145. HDC does not consider that this observation is correct and states that the level of the departure of care is only one factor to be considered by the relevant decision-maker.⁴⁷
146. While I accept this was not HDC's intention, I am of the view that the SOP, as it was written at the time, did appear to make the presumption as outlined. I consider this illustrates a lack of clarity in policy at the time.
147. To the extent that level of the departure of care is only intended to be one of a number of factors considered, the SOP does not clearly identify the extent to which other factors listed should factor in the decision to take no further action, or what weight should be attributed to them. Similarly, in cases where there have been moderate departures identified, the SOP does not clearly stipulate what factors are relevant to finding that the care has been *'generally appropriate'*.⁴⁸
148. I note HDC has since updated its SOP in the course of these investigations. However, I understand there is still no current policy that it refers to when determining whether an investigation is warranted.⁴⁹

⁴⁵ Applicable at the time of the final decisions of the preliminary assessments.

⁴⁶ *Review of the Processes Concerning Adverse Medical Events* Hellen Cull QC March 2001, page 108.

⁴⁷ HDC also notes that decision-makers exercise judgement taking into account wider matters such as the prioritisation of resources and the most appropriate way to resolve the complaint.

⁴⁸ HDC has noted that for part of its assessment of Ms A's complaint, the 2013 version of its SOP was relevant. As noted above, the April 2017 SOP was in effect when the final decision to take no further action was made. In any case, I understand that the 2013 version listed similar relevant decision-making factors, including that an investigation may be appropriate where *'there has been a departure of standards that was more than mild, or a series of mild departures'*. For the avoidance of doubt, I do not consider 2013 SOP provided a reasonable policy framework for decision-makers, particularly in dealing with circumstances such as Ms A's where there *'moderate'* departures identified by HDC's expert advisors.

⁴⁹ While HDC's current SOP provides general procedural steps for notifying an investigation, it does not provide guidance for decision-makers on when an investigation may be appropriate.

149. HDC has also advised that, in the absence of a clear policy, the weighing and balancing of factors in Ms A and Ms B's cases was ultimately a judgement call for the relevant decision-maker (Deputy Commissioner or Commissioner), taking into account all of the circumstances.
150. In reviewing HDC's decision-making process to take no further action, I am left without a clear understanding of how the relevant factors were considered. This is particularly concerning given that HDC received advice that there had been moderate lapses in care in these cases.
151. My general expectation in respect of exercising a discretion is as follows:
- a. Discretions should be exercised reasonably and by taking into account relevant factors, and excluding irrelevant factors;
 - b. For this to happen, decision makers require a clear understanding of what those factors are, and should understand how they should go about considering these factors when choosing whether to exercise a discretion;
 - c. For established review agencies, I expect that at a minimum they will have internal policy and guidance to support their staff carrying out functions in this way. However, an apparent omission on the part of HDC in this regard is especially problematic in these cases.
152. I do not agree with HDC that a policy that attributes weight to relevant decision-factors would override the Commissioner's or Deputy Commissioner's discretionary judgement. There is a difference between an appropriately detailed and an overly-prescribed policy. I do not envisage HDC should have a decision-making policy that is rigid, but one that is clearly defined and transparent.
153. Overall, I consider HDC's decision to take no further action under section 38(1) on Ms A and Ms B's complaints was unreasonable as:
- a. the decisions were made in the absence of adequate internal policy or procedures; and
 - b. it is unclear how the relevant factors were considered by the decision-maker when exercising the discretion to take no further action, particularly given expert advice was received that there had been relatively significant departures of care.⁵⁰
154. I note that HDC has since updated its SOP with the latest version dated 19 February 2020. HDC appears to have removed any reference to the other factors it considers (listed in paragraph [140] and [141] above) when determining whether taking no further action is appropriate. At this stage, I do not consider HDC's amendments to its SOP address the administrative deficiencies I have identified above.

⁵⁰ In particular, advice that there had been 'moderate', 'moderately severe' departures of care and findings that the care 'fell well below accepted standards' (in relation to specific aspects of the care received).

Chief Ombudsman's opinion

155. For the reasons set out above, I have formed the opinion that HDC has acted unreasonably.

Recommendation

156. Pursuant to section 22(3) of the OA, I recommend the following:

- a. HDC develops comprehensive guidelines for staff and decision-makers within its SOP on:
 - i. the interplay between sections 33, 38, and 40, with particular guidance on the appropriate extent and duration of preliminary enquiries under section 33; and
 - ii. the factors considered when deciding when to take no further action, and when to instigate an investigation.

I ask HDC to report back on the progress of this recommendation within 60 working days of my final opinion. I would be happy to make relevant members of my staff available to assist with reviewing these guidelines.

- b. Given the maladministration I have identified in Ms A and Ms B's cases, an appropriate remedy is warranted. I recommend HDC:
 - i. reconsider Ms A and Ms B's cases afresh in line with my findings⁵¹ and,
 - ii. Re-engage with the complainants by 19 February 2021 regarding the reconsideration process, and communicate to the complainants and providers (as necessary) what action HDC intends to take.
- c. HDC apologises to the three complainants by 5 February 2021. I would expect the apology to cover the following elements:
 - i. Recognition – an acknowledgement of that the process followed was unreasonable and an acknowledgement of the stress caused by a prolonged assessment in each case.
 - ii. Responsibility – acceptance of the responsibility for the maladministration and harm caused.
 - iii. Reasons – an explanation of why HDC took the action it did, but also an acknowledgement that in light of my opinion, this process was unreasonable.

⁵¹ It is open for HDC to refer to and utilise information already collected as part of this reconsideration.

- iv. Regret – an expression of sincere regret that the process in this case was unreasonable.
- v. Redress – an explanation of the actions taken to redress the matter so that it will not be repeated.

Peter Boshier
Chief Ombudsman

HDC accepted the Chief Ombudsman’s recommendations, apologised to the complainants, and undertook to reconsider Ms A and Ms B’s complaints. HDC also began a review of its internal complaint-handling policies with assistance from the Office of the Ombudsman.

This opinion is published under the authority of the [Ombudsmen Rules 1989](#). 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.