



Complaint about Health and Disability Commissioner assessment process

Chief Ombudsman's opinion

Legislation:	Ombudsmen Act 1975, ss 13, 22 (see appendix for full text)
Agency:	Health and Disability Commissioner
Ombudsman:	Chief Ombudsman Dame Beverley Wakem DNZM, CBE
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Summary

On 16 December 2010 the Health and Disability Commissioner (HDC) received a complaint about the care the complainant's father had received from two District Health Boards after he presented at the Emergency Department at a hospital with sudden chest pain. The complainant's father died at another hospital after suffering cardiac arrest the next day.

After obtaining information from both District Health Boards and seeking expert advice from its in-house clinical advisor, HDC decided not to investigate the complaint.

A more detailed summary of the care provided to the complainant's father is provided in Appendix 2, and HDC's process is outlined in Appendix 3. [Appendices not included in published version for purposes of anonymity.]

Based on the information before me, I have formed the opinion that there were deficiencies during the HDC's process of assessing the complaint raised by the complainant; in providing her with a reasonable opportunity to comment; and in communicating the decision not to investigate the matter.

Ombudsman's role

1. Under section 13(1) of the Ombudsmen Act 1975 (OA), I have the authority to investigate the administrative acts, decisions, omissions and recommendations of the HDC.
2. My role is to consider the administrative conduct of the HDC, and to form an independent opinion on whether that conduct was fair and reasonable (section 22(1) and (2) of the OA refer).
3. The relevant text of these statutory provisions is set out in Appendix 1.
4. My investigation is not an appeal process. I would not generally substitute my judgment for that of a specialist decision-maker such as the HDC. Rather, I consider the substance of the act or decision and the procedure followed by the HDC, and then form an opinion as to whether the act or decision was properly arrived at and was one that HDC could reasonably make.

Complaint

5. The complainant made a complaint to this Office that HDC should have investigated her concerns about the care provided to her father by two District Health Boards, and that HDC's decision to decline to take further action was unreasonable. After reviewing the information provided by the complainant, I decided to limit my investigation of HDC's assessment of her complaint to the following three issues:

- a. the information HDC obtained about the procedure that was in place for transferring cardiac patients from the first to the second hospital at the time of her father's care, and whether this procedure was followed in his case;
- b. the information HDC obtained about the breakdown in staff communication in relation to her father's care, including about the CT scan that was to take place on his arrival at the second hospital; and
- c. the information HDC obtained about the staff member subject to disciplinary action, and whether a more detailed explanation should have been provided in order to explain why HDC did not consider that this impacted on the care her father received.

Investigation

6. This Office notified HDC of the complaint in the above terms on 19 June 2012. A response was received from HDC on 25 July 2012. After reviewing this information, on 27 August 2012 this Office: asked HDC to obtain further information from the second DHB about the miscommunication issue; invited HDC's comments on whether indicating that no further action would be taken had discouraged the second DHB from providing further information to HDC; and asked HDC to provide further information to the complainant about the disciplinary issue.
7. A reply was received from HDC on 26 October 2012, providing the additional information and comments that had been requested.
8. After discussions between the Ombudsman and HDC on 20 December 2012, HDC agreed to provide the complainant with further information about the disciplinary issue. HDC sent the information to the complainant on 14 January 2013.
9. The complainant responded to this material in an email dated 15 January 2013.
10. A provisional opinion was formed on the complaint, and was sent to HDC on 30 May 2013. HDC responded on 7 August 2013.

Analysis

11. In response to the complaint, HDC stated that it considered its assessment of the matter to be thorough and detailed, and the overall process to be fair and reasonable.

System of transfer (the first issue of this investigation)

12. HDC obtained information about the procedure in place for transferring a patient in the condition of the complainant's father between hospitals, including the communication that must occur between doctors, and the intensive care retrieval team arrangements. HDC reviewed the second DHB's protocol "*Inter-hospital Transfer of Patients and the*

Utilisation of the Emergency Department”, including the requirement that “*the speciality consultant or registrar must communicate with the duty ED consultant as soon as they accept the transfer of an unstable patient who they want to see in ED*”. The protocol also required that the speciality registrar must see the patient on arrival, and be given a handover from the transfer team if an unstable patient was not being transferred to ICU.

13. HDC noted the introduction of the inter-hospital transfer coordinator to manage transfers, and ensure appropriate notification of staff pending patient arrivals.
14. After obtaining some further information about the inter-hospital transfer project, and indicating to the second DHB that greater emphasis was needed on consultant to consultant communication, HDC did not consider the transfer system warranted investigation.

Care provided to complainant’s father (the second issue of this investigation)

15. HDC considered that it had sufficient information to form the view that the transfer procedure in place at the time was largely followed in the particular case of the complainant’s father. While the speciality registrar did not meet her father on arrival, or receive a handover, HDC noted that its own expert, HDC’s in-house clinical advisor, had not criticised this, despite it being a breach of the second DHB’s protocol.
16. However, it is clear that in addition to the breach of the protocol, there was also a failure of communication. This is because ED staff at the time of her father’s arrival were unaware of the arrangement that ED would manage the coordination of the CT scan straightaway. This is demonstrated by the record of the ED registrar contacting the vascular registrar, and the subsequent discussion that took place, before the ED doctor began carrying out those arrangements, rather than making those arrangements straightaway.
17. The communication issue that was identified by the in-house clinical advisor was the failure to contact the radiologist at the second DHB 30 minutes prior to her father’s arrival, which occurred in spite of the radiologist’s instructions to do so. While the clinical advisor considered the delay between her father’s arrival and the CT scan to be “*somewhat excessive*”, HDC noted in later comments that the delay would not have changed the poor outcome in any event. This was due to the fact that her father would not have progressed to surgery by the time of his cardiac arrest, because of the “*structured and considered approach to the complex surgery required*”.
18. HDC requested further information from the second DHB about the delay in contacting the radiologist. However, at the same time HDC notified the second DHB, the first DHB and the complainant of the provisional view to take no further action on the complaint.
19. In response, the second DHB stated that the radiologist was not called due to a “*miscommunication error*”, but did not provide any further details. HDC considered that it had sufficient information at that point to confirm that it was appropriate to take no further action on the complaint.

Disciplinary action (the third issue of this investigation)

20. In regard to the issue concerning the disciplinary action taken against one of the staff members, HDC confirmed that this involved concerns about the staff member's communications with the relevant consultant. However, HDC concluded that this did not affect the timeliness of the transfer of the complainant's father between the hospitals, or the delay in contacting the radiologist. Further, HDC stated that the eventual outcome and standard of care were not materially affected, because it was not clear whether he would be accepted into the vascular or cardiothoracic service until after the CT scan.

Other issues

21. In the course of this investigation two other subsidiary matters arose.

Final decision

22. HDC's letter of 22 August 2011 to the complainant confirming the decision not to investigate did not explain what influence the clinical advisor's second expert advice had on the decision (although it sets out the key points). In addition, the letter did not articulate the actual reasons for taking no further action. This did not occur until the file was reviewed by HDC's Chief Legal Advisor, on 27 October 2011.

Terminology

23. In its letter of 11 July 2011 to the complainant, HDC informed her of its provisional decision which states "*I do not consider that further investigation (emphasis added) by this Office is necessary*". This statement was repeated in the Chief Legal Advisor's letter of 27 October 2012.
24. Given that HDC was assessing the complaint in order to decide whether to investigate the matter, it was pointed out to HDC that the use of the term "*investigation*" during the course of the assessment was not accurate, and may have been confusing for the complainant.
25. HDC considered that this criticism was unwarranted, and that it would not have confused the complainant due to other HDC correspondence with her, such as that advising that her complaint was being "*assessed*", and that the "*assessment process was ongoing*".
26. However, I remain of the view that using the correct terminology during the assessment process is important, for the reasons referred to above.

Ombudsman's opinion

27. Having considered HDC's comments about the general inter-hospital transfer process that was in place at the time of the care of the complainant's father, I am of the view that HDC obtained sufficient information to establish that any deficiencies with the process would be improved.
28. HDC did not consider that indicating in a provisional view that no further investigation was proposed discouraged the second DHB from providing a detailed response to the request for further information about the miscommunication error. However, I am not persuaded that HDC took adequate steps to clarify the nature of how the deficiencies with the care of the complainant's father arose. HDC's approach did not provide any incentive for the second DHB to be forthcoming in providing the additional information, and sufficient steps were not taken to clarify the nature of the error. In the event, the second DHB's response was not informative, and did not explain why the radiologist was not contacted.
29. As HDC had already advised the second DHB that it was not intending to take further action, this may have encouraged the non-specific response it received from the second DHB. But, regardless of whether or not it did so, I consider that clarification about the miscommunication was a significant enough issue to resolve before forming a provisional view on the complaint.
30. The reason provided in HDC's letter of 22 August 2011 to the complainant for taking no further action was that further enquiries will not reveal any new information. However, at the request of this Office, HDC subsequently ascertained from the second DHB that the retrieval team was not informed that it needed to contact the radiologist 30 minutes before it arrived at the second Hospital. This was new information about what happened. It was potentially relevant to an assessment of the care provided to her father by individual medical staff and to complete the narrative of events.
31. HDC stated that when it made the final decision not to investigate, it knew that either the retrieval team was not informed that it needed to contact the radiologist, or that the retrieval team failed to call the radiologist prior to arrival. HDC considered that it was unlikely that it could be established who failed to communicate. Instead, in light of the advice of the second DHB about the implementation of the inter-hospital project, HDC considered that an educational approach to the complaint was appropriate.
32. HDC contended that in these circumstances it was open to it to take no further action. Leaving that aside, I have serious reservations about the manner in which HDC managed its assessment of the complaint. Having decided to make enquiries about the delay in contacting the radiologist, my view is that HDC should have clarified the response of the second DHB before deciding how to proceed.
33. It would also have been open to HDC to have made further enquiries as to why the specialist registrar breached the protocol of the second DHB. Such enquiries may have clarified why the specialist registrar did not attend ED when the complainant's father arrived, or receive a handover from the retrieval team. HDC also did not consider the issue

of ED staff being unaware of the arrangements for ED to undertake the CT scan on her father's arrival. The complainant was surely entitled to have this matter dealt with in any explanation not to take further action.

34. HDC noted that expert advice can be used to finalise a decision without that advice being disclosed to the parties. In this case, HDC said that “[the clinical advisor’s] further advice of 3 August 2011 did not contain any significant new information” that required the complainant’s comment. HDC contended that the response of the second DHB (to HDC’s provisional view) regarding the delay in contacting the radiologist was not a “matter of substance” that warranted disclosure to the complainant for comment, because it “did not elaborate further as to exactly what happened”.
35. Overall, I consider that the complainant was not provided with a full opportunity to comment on HDC’s preliminary decision to take no further action.¹ The better course of action would have been for HDC to seek the further information from the second DHB, then, if necessary, obtain further expert advice from the clinical advisor, before advising the complainant and the second DHB of a provisional view. Instead, the complainant did not have the opportunity to comment on the clinical advisor’s second advice, or the further information provided by the second DHB, before she was advised of HDC’s final decision not to investigate and the file was closed. I consider that HDC should have completed its enquiries, and provided the complainant with the opportunity to comment, before proceeding to a decision not to take further action.² To this extent, I consider that HDC’s assessment of the complaint was unreasonable.
36. In relation to the disciplinary action taken in relation to a staff member of the second DHB, I consider that HDC did obtain sufficient information about the issue in order to form an opinion on whether this had a material impact on the care that the complainant’s father received. However, HDC did not provide sufficient information to the complainant to make this clear to her. For this reason I subsequently asked that HDC provide further information to the complainant on the issue, and this was sent to her.

¹ I note that in this case, the complainant had earlier been provided with a copy of the provisional decision and the first expert advice. Subsequent to receiving the final opinion, HDC submitted that it is not required to share provisional s 38 decisions or expert advice with complainants.

² Subsequent to receiving the final opinion, and in view of the fact that it was due to be published on the Ombudsman website, HDC raised the concern that this sentence may be read to imply that HDC made a final decision without first completing his enquiries. He pointed out that, at the time he made his final decision on the complaint, he had undertaken all enquiries that he considered necessary to undertake in order to make that decision. Although it is considered that this sentence, when read in context, does not lead to the said implication, HDC’s view is recorded here to prevent ambiguity.

Appendix 1. Relevant statutory provisions

Ombudsmen Act 1975

13. Functions of Ombudsmen

- (1) Subject to section 14, it shall be a function of the Ombudsmen to investigate any decision or recommendation made, or any act done or omitted, whether before or after the passing of this Act, relating to a matter of administration and affecting any person or body of persons in his or its personal capacity, in or by any of the departments or organisations named or specified in Parts 1 and 2 of Schedule 1, or by any committee (other than a committee of the whole) or subcommittee of any organisation named or specified in Part 3 of Schedule 1, or by any officer, employee, or member of any such department or organisation in his capacity as such officer, employee, or member.
- (2) Subject to section 14, and without limiting the generality of subsection (1), it is hereby declared that the power conferred by that subsection includes the power to investigate a recommendation made, whether before or after the passing of this Act, by any such department, organisation, committee, subcommittee, officer, employee, or member to a Minister of the Crown or to any organisation named or specified in Part 3 of Schedule 1, as the case may be.
- (3) Each Ombudsman may make any such investigation either on a complaint made to an Ombudsman by any person or of his own motion; and where a complaint is made he may investigate any decision, recommendation, act, or omission to which the foregoing provisions of this section relate, notwithstanding that the complaint may not appear to relate to that decision, recommendation, act, or omission...

22. Procedure after investigation

- (1) The provisions of this section shall apply in every case where, after making any investigation under this Act, an Ombudsman is of opinion that the decision, recommendation, act, or omission which was the subject matter of the investigation—
 - (a) appears to have been contrary to law; or
 - (b) was unreasonable, unjust, oppressive, or improperly discriminatory, or was in accordance with a rule of law or a provision of any Act, regulation, or bylaw or a practice that is or may be unreasonable, unjust, oppressive, or improperly discriminatory; or
 - (c) was based wholly or partly on a mistake of law or fact; or
 - (d) was wrong.
- (2) The provisions of this section shall also apply in any case where an Ombudsman is of opinion that in the making of the decision or recommendation, or in the doing or omission of the act, a discretionary power has been exercised for an improper purpose or on irrelevant grounds or on the taking into account of irrelevant considerations, or that, in

the case of a decision made in the exercise of any discretionary power, reasons should have been given for the decision.

- (3) If in any case to which this section applies an Ombudsman is of opinion—
- (a) that the matter should be referred to the appropriate authority for further consideration; or
 - (b) that the omission should be rectified; or
 - (c) that the decision should be cancelled or varied; or
 - (d) that any practice on which the decision, recommendation, act, or omission was based should be altered; or
 - (e) that any law on which the decision, recommendation, act, or omission was based should be reconsidered; or
 - (f) that reasons should have been given for the decision; or
 - (g) that any other steps should be taken—

the Ombudsman shall report his opinion, and his reasons therefor, to the appropriate department or organisation, and may make such recommendations as he thinks fit. In any such case he may request the department or organisation to notify him, within a specified time, of the steps (if any) that it proposes to take to give effect to his recommendations. The Ombudsman shall also, in the case of an investigation relating to a department or organisation named or specified in Parts 1 and 2 of Schedule 1, send a copy of his report or recommendations to the Minister concerned, and, in the case of an investigation relating to an organisation named or specified in Part 3 of Schedule 1, send a copy of his report or recommendations to the mayor or chairperson of the organisation concerned.