

# Chief Ombudsman’s opinion under the Ombudsmen Act

<b>Legislation</b>	Ombudsmen Act 1975 ss 13 and 22; Protected Disclosures (Protection of Whistleblowers) Act 2022 ss 16 and 37; Children’s Act 2014; Children’s (Requirements for Safety Checks of Children’s Workers) Regulations 2015
<b>Agency</b>	Health New Zealand   Te Whatu Ora
<b>Investigation about Ombudsman</b>	Administration of children’s safety checks John Allen
<b>Case number(s)</b>	CASE-015825
<b>Date</b>	4 July 2025

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## Contents

Summary	3
Ombudsman’s role	3
Background	3
Investigation	5
Analysis and findings	5
Legal framework	5
Health NZ’s responses	6
How this situation was able to arise over the past nine years	7
How responsibility for the safety check requirements was allocated and monitored over that time period	7
What action, if any, will be taken in relation to any issues identified in relation to the allocation and monitoring of responsibility for safety check requirements	7
Further detail of Health NZ’s understanding of the scale of the issue at the national level	8
Which locations were selected for audit and why, and the corrective actions which were put in place as a result of the audits	8
How Health NZ are managing the risk of this issue being present at locations which have not been audited	8
Comment	9
Ombudsman’s opinion	9
Postscript	10
Appendix 1. Relevant statutory provisions	12
Ombudsmen Act 1975	12
Protected Disclosures (Protection of Whistleblowers) Act 2022	13

## Summary

Chief Ombudsman Peter Boshier received a protected disclosure which raised concerns about contractors working at a specific hospital without the requisite safety checks being conducted pursuant to the Children's Act 2014 (Children's Act), and Children's (Requirements for Safety Checks of Children's Workers) Regulations 2015 (Regulations).

Mr Boshier referred the protected disclosure to Health New Zealand (Health NZ) to consider and address the concerns, and provide him with a detailed report back.

While Health NZ acknowledged there were issues, and were working to rectify them, the discloser remained concerned about the apparent lack of accountability for a situation that had occurred over the last nine years.

Mr Boshier then initiated an investigation under his own motion, into Health NZ's compliance with the Children's Act and Regulations. I assumed responsibility for this investigation after Mr Boshier's term as Chief Ombudsman ended.

Based on the information before me, I have formed the opinion that Health NZ and a range of District Health Boards (including Bay of Plenty, Canterbury, Lakes, Nelson-Marlborough and Tairāwhiti) have acted contrary to law by failing to undertake checks required by the Children's Act and Regulations.

## 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 Health NZ.
2. My role is to consider the administrative conduct of Health NZ, and to form an independent opinion on whether that conduct was fair and reasonable (sections 22(1) and 22(2) of the OA refer).<sup>1</sup>
3. I consider the substance of the act or decision and the procedure followed by Health NZ, and then form an opinion as to whether the act or decision was properly arrived at, was in accordance with the law, and was one that Health NZ could reasonably make.

## Background

4. Chief Ombudsman Peter Boshier received a protected disclosure, which alleged that children's safety checks were not being conducted on contractors at a hospital, as required by the Children's Act and Regulations.
5. Mr Boshier considered that these concerns were best addressed by Health NZ. He consulted with discloser, who advised they wished to remain anonymous. On 17 January

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<sup>1</sup> The relevant text of these statutory provisions is set out in the Appendix.

2024, Mr Boshier referred the protected disclosure to Health NZ under section 16(2)(a) of the Protected Disclosures (Protection of Whistleblowers) Act 2022 (Protected Disclosures Act), without revealing the discloser's identity. Mr Boshier sought a detailed report back from Health NZ under section 16(5) of the Protected Disclosures Act.

6. In response to the concerns raised, Health NZ conducted an audit of children's safety checks at the hospital, which identified eight key issues and made 13 recommendations to address these. In summary, the audit report advised that the hospital had a plan to address the identified issues pertaining to staff who work with children and gaps in safety checks. The hospital would start by implementing the smaller recommendations involving new processes (such as safety checks for new staff, training, and recruitment workflow), which management estimated could be done within two months. The other recommendations (such as redoing safety checks for existing staff and fixing documentation) were broader in scale and would require considerable resources to address. Based on this, management estimated that it would take up to eight months to ensure that the new systems and processes were embedded in practice.
7. Mr Boshier provided an update to the discloser regarding the outcome of the audit and actions taken (and intended to be taken) by Health NZ to resolve the issues. The discloser advised that while they were pleased that action had been taken, they were concerned about the apparent lack of consequence or accountability for Health NZ contravening the Children's Act and Regulations for the past nine years.
8. In light of the discloser's concerns, Mr Boshier sought further information from Health NZ about the steps Health NZ were taking. He was advised that:
  - a. there had been staffing changes at the hospital since the issue occurred;
  - b. audits had been undertaken at other locations across the country;
  - c. corrective action plans were being put in place in those places that had been audited;
  - d. there was work underway to look at how these checks are processed nationally for all Health NZ staff;
  - e. the issue has been previously raised with the Minister and their attention would be brought to this latest matter; and
  - f. Health NZ's challenge relates to people systems which have a number of challenges including payroll, which there are remediation plans underway to resolve.
9. On 27 September 2024 Mr Boshier sought further information from Health NZ to understand how this situation was able to arise over the past nine years, how responsibility for the children's safety check requirements was allocated and monitored over that time period, and what action, if any, would be taken in relation to any issues identified in that respect. Mr Boshier also sought details of Health NZ's understanding of the scale of the issue at the national level. In relation to the additional audits, Mr Boshier

sought information about which other locations were selected for audit and why, the corrective actions which were put in place as a result of the audits, and how Health NZ were managing the risk of this issue potentially being present at locations which had not been audited.

10. Health NZ responded on 22 November 2024, providing information in response to those queries (as discussed below).

## Investigation

11. On 27 February 2025, Mr Boshier notified Health NZ of his investigation under his own motion, into compliance by Health NZ with the Children's Act and Regulations. Mr Boshier provided his provisional opinion on the matter, and provided Health NZ the opportunity to comment. Health NZ provided their response on 18 March 2025 (as discussed below).
12. On 16 June 2025, I provided Health NZ with a copy of my opinion in order to understand if there were any further updates as I intended to publish this opinion. Health NZ responded on 1 July 2025. This update is included in the postscript.

## Analysis and findings

### Legal framework

13. The Children's Act introduced measures to reduce the risk of harm to children by requiring all government-funded organisations to conduct safety checks on people employed or engaged in work that involves regular or overnight contact with children. These checks must be updated every three years.
14. The Regulations stipulate the requirements for these checks which are undertaken under the Children's Act. These checks require the following for new children's workers who have not previously been safety checked:
  - a. identity verification;
  - b. New Zealand Police vetting check;
  - c. reference check (professional or personal);
  - d. employment history verification check;
  - e. professional membership check;
  - f. interview with the applicant; and
  - g. risk assessment.

15. For children's workers who have had a previous check in the last three years, the following is required:
  - a. identity verification;
  - b. New Zealand Police vetting check;
  - c. professional membership check; and
  - d. risk assessment.
16. The Regulations came into force from 1 July 2015, in phases, so that organisations would have time to comply. These phases were as follows:
  - a. From 1 July 2015 new core children's workers starting a job or contract must be safety checked before they start work.
  - b. From 1 July 2016 new non-core children's workers starting a job or contract must have been safety checked before they start work.
  - c. By 1 July 2018 existing children's core workers (that is, those currently employed or contracted) must have been safety checked.
  - d. By 1 July 2019 all existing non-core children's workers must have been safety checked.
17. According to the Act, core children's workers are employed to provide regulated services. In the course of that work, the person is either:
  - a. the only person present, or
  - b. is the children's worker who has primary responsibility for, or authority over, the child (such as doctors, teachers, nurses, counsellors and social workers).
18. '*Non-core worker*' simply means a children's worker who is not a core worker (such as non-teaching school workers or general hospital workers).

## Health NZ's responses

19. Health NZ advised that some sites required more due diligence and acknowledged that there should have been appropriate practices in place to comply with the Children's Act and Regulations in every District Health Board. Health NZ also advised that as all District Health Boards have now come together under Health NZ, the joining of Human Resources processes has taken longer than expected due to the variation in the way these checks have been performed across the country.
20. Health NZ advised that they are acutely aware of the importance of safety checks under the Act in protecting children from harm, are committed to meeting the obligations under the legislation, and are taking active steps to ensure they do so.

21. Specific details of Health NZ's response to the questions posed by Mr Boshier are set out below.

### How this situation was able to arise over the past nine years

22. Health NZ advised that the issue at the specific hospital arose over a number of years due to systemic issues with the relevant processes, including variation in how these checks were performed, and lack of oversight of this function. Health NZ advised that a new governance and management structure is now in place.
23. In relation to other locations and districts, Health NZ advised there has historically been variation across the country in the way checks were being performed and acknowledged this was not optimal.

### How responsibility for the safety check requirements was allocated and monitored over that time period

24. Health NZ did not provide any information in relation to who was responsible for monitoring the adherence to these requirements over the years. Health NZ did, however, advise that the responsibility for these checks currently sits with the core People Operations Team and individual Managers.

### What action, if any, will be taken in relation to any issues identified in relation to the allocation and monitoring of responsibility for safety check requirements

25. Health NZ advised that safety checks were made a priority for the specific hospital's Human Resources (HR) coordinator with support from an HR Advisor, and that expired and expiring checks were renewed. Health NZ further advised that hospital management is being strict on obtaining safety check requirements for all new employees, contractors and locums.
26. Health NZ also advised that a central safety hub was established on 17 March 2025, and since then, this hub has managed safety checks for the hospital. A plan to move all safety checks to this hub will be set with each district. It is expected that all districts will have transitioned to the hub by quarter two, 2025.
27. Additionally, Health NZ advised that:
- a. communications have been sent to all Managers reiterating that staff cannot commence or continue work without a current safety check having been completed; and
  - b. a new toolkit and template documents have been created and will be rolled out as soon as possible.

## Further detail of Health NZ's understanding of the scale of the issue at the national level

28. Health NZ advised that it is not yet able to conduct internal audits at a 'national level' for completion of these checks. However, Health NZ's internal audit function is continuing with review of individual districts and spot checks to assess compliance and this will continue until all districts have been reviewed.

## Which locations were selected for audit and why, and the corrective actions which were put in place as a result of the audits

29. Health NZ advised that the five locations were audited from across a range of District Health Boards (Bay of Plenty, Canterbury, Lakes, Nelson-Marlborough and Tairāwhiti) and were selected for audit as they provided a geographic distribution and mixture of large, medium and small locations. The selection also focussed on areas where Health NZ had seen challenges with people related processes. Health NZ also provided a summary of the corrective actions underway at each audited site, such as:
- a. developing protocols to properly implement safety checks;
  - b. who will take responsibility for the checks; and
  - c. retrospective remediation.

## How Health NZ are managing the risk of this issue being present at locations which have not been audited

30. Health NZ advised that the following actions have been taken:
- a. implementation of new policy, forms, systems and processes to streamline all approaches across Health NZ. This includes a centralised filing system to store the safety checks separately from personnel files, and a new toolkit and template documents that will be rolled out as soon as possible; and
  - b. communications have been sent to all Managers reiterating that staff cannot commence or continue work without a current safety check having been completed.
31. In addition to the actions already outlined, Health NZ advised of the following changes and remedial work underway:<sup>2</sup>
- a. the following to be undertaken by internal audit:
    - i. audit of each district's process by checking '*children's worker*' documentation to ensure alignment to the requirements of the Children's Act – six districts

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<sup>2</sup> In addition to what has been outlined at paragraphs 24 – 29.

- are complete and two are in-progress with the intent of auditing all remaining districts;
- ii. spot audits on a weekly basis to evidence new starters have had their safety check completed; and
- iii. review and test safety checking processes for contractors and volunteers;
- b. the implementation of rigorous checking, reporting and a monitoring framework with the following actions:
  - i. staff commencement details will only be sent to Payroll once the safety check has been completed, meaning no staff member can commence or be paid until the check is completed;
  - ii. a weekly progress report to the Commissioner and Chief Executive from the Interim Human Resources Officer;
  - iii. weekly progress reporting to the Executive Leadership Committee (Human Resources Oversight Committee); and
  - iv. a performance measure has been added to all senior Manager Key Performance Objectives that requires them to be aware of and report on required safety checks for their new staff.

## Comment

32. District Health Boards, and since 1 July 2022 Health NZ, have been required by the Children's Act to conduct safety checks on all new core children's workers (including contractors) since 2015 and since 2018 for existing workers.
33. Given the issues identified by the 2024 audit of safety checks at the specific hospital, as well as the issues identified by subsequent audits at other locations, it is evident that a range of District Health Boards and Health NZ locations have not been complying with the Children's Act or Regulations. While Health NZ advise that appropriate processes should have been in place in each district, no specific information has been provided to support this – such as what these processes entailed, who was responsible for conducting the checks, and how these checks were monitored, across the country over the past nine years. I consider it to be wrong, and concerning, that this issue had not been picked up for nine years, despite these checks being a legal requirement.

## Ombudsman's opinion

34. On the information before me, my final opinion is that Health NZ and a range of District Health Boards (including Bay of Plenty, Canterbury, Lakes, Nelson-Marlborough and Tairāwhiti) have acted contrary to law by failing to undertake checks required by the Children's Act and Regulations.

35. I acknowledge Health NZ's commitment to meeting its obligations under the legislation, the extensive changes implemented to date, and actions it will continue to take.
36. I do recommend, however, that Health NZ implement a national audit programme of safety checks in all locations to ensure ongoing compliance with the Children's Act and Regulations, and to provide an opportunity for any issues to be identified in a timely manner going forward.
37. Health NZ has accepted my recommendation, and has agreed to update me on progress with implementing it.

## Postscript

38. On 1 July 2025, Health NZ provided me with an update. Health NZ advised that it is well underway with implementation of a national audit programme, which includes:
  - a. targeted district-level follow up audits;
  - b. continuous monitoring of the vetting for new employees; and
  - c. testing new procedures to ensure that they are effective and sustainable as controls.
39. Health NZ advised that it has been auditing compliance with Children's Act checking requirements for some months along with other actions to ensure compliance and rectify any outstanding checks. Health NZ advised that it is confident that it is complying with the requirements of the Children's Act and checking all core and non-core children's workers and that there are no expired checks for core children's workers in Children's Services.
40. To ensure there is a compliant workforce available in the event of an emergency or clinical roles, while some roles do not meet the definition of a core children's worker, as they may be required to have contact with a child in such an event, Health NZ advised it is also undertaking checks for these staff. These staff will not have any contact with children until the checks have been completed.
41. To provide further assurance that Health NZ are taking this situation seriously, Health NZ advised me of the following actions that have also been taken:
  - a. *Clarification of expectations: We have sent clear communications to people leaders and made this available on national and district intranet sites clarifying that for all Children's Worker roles all the checks including reference checks must be completed before a new employee can start work.*
  - b. *Established a Central Hub for Safety Checks: We have established a Central Hub to process all Children's Worker checks for new and current staff. Currently the Central Hub is processing the checks for new and current staff*

*for five districts and by the end of June 2025 we will move a further two districts into the Central Hub.*

- c. Independent assurance: We are seeking independent assurance from Martin Jenkins that the process for Children's Worker checks being run by the Central Hub is sufficient and requesting that they provide recommendations for any process improvements. We will provide you a copy of that report once it is complete.*
  - d. Updating Children's Act information: We have updated all information and collateral for staff and managers on the Health NZ intranet.*
  - e. Weekly Reporting: Every district and the Central Hub is required to report weekly on the status of the renewal of Children's Worker checks. There are meetings every few days with all districts where checks are close to expiring to ensure action is being taken.*
  - f. Audits: The internal audit team at Health New Zealand has completed a number of audits for each district on the status of Children's Worker checks. The internal audit team are now working to check files for new staff who commenced employment after 1 March 2025 to ensure that all of the safety checks are documented on their files.*
  - g. Stand down: We have advised staff and the unions that staff cannot work in Children's Services unless their safety check is current and has a process to stand down staff without pay. We have provided managers with a process to send staff home if they do not attend work with the required documentation for the checks at 45 days before the check expires.*
  - h. Ongoing governance and oversight: The Human Resources Subcommittee of the Executive Leadership Team, which includes a representative of the Commissioner, has been meeting weekly to review progress and remove any barriers for the completion of all safety checks.*
42. Health NZ advised me that it will continue to provide me with updates on the work going forward.

## 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...

## **Protected Disclosures (Protection of Whistleblowers) Act 2022**

### **16 Receive may refer disclosure**

- (1) A receiver that is the organisation concerned may refer a protected disclosure to an appropriate authority.
- (2) A receiver that is an appropriate authority may refer a protected disclosure to—
  - (a) the organisation concerned; or
  - (b) another appropriate authority.

**37 Ombudsmen's functions and powers**

- (1) The functions and powers of Ombudsmen under the Ombudsmen Act 1975, including the function of each Ombudsman to investigate a matter of their own motion under section 13(3) of that Act, are not limited by this Act.
- (2) The Ombudsmen have the same powers in relation to investigating a protected disclosure made under this Act as Ombudsmen have in relation to a complaint under the Ombudsmen Act 1975, but are not bound to investigate a protected disclosure.
- (3) Sections 19, 20, and 30 of the Ombudsmen Act 1975 apply, with all necessary modifications, to allow an Ombudsman to obtain information, documents, papers, or things that would in the Ombudsman's opinion assist the Ombudsmen to act under this Act in relation to a public sector organisation.