Crown Health Enterprise

Report on Opinion - Case 96HDC2653

Complaint

The Commissioner received a complaint from a mother about the actions of hospital staff relating to blood tests for her infant daughter.

The details of the complaint were as follows:

- *There was a delay in notifying the complainant of the test results for blood taken from her child in mid-1996.*
- *The manner in which the complainant was notified of the test results was unacceptable.*
- *In mid-October 1996 at the hospital, a staff member and a laboratory worker discussed details of the child's health status in a public waiting room in front of other people.*
- *A senior house officer at the hospital did not fully inform the complainant about the blood collecting procedure to be used on her child in mid-October 1996.*
- *The wrong test was performed on the blood collected from the child in mid-October 1996.*
- *The complainant's request that a correct blood test be repeated elsewhere was declined.*

Investigation

The Commissioner received the complainant's complaint from a Health and Disability Advocacy Service on 5 November 1996 and an investigation was undertaken. Information was obtained from the following people:

The Complainant
The Customer Services Manager, Crown Health Enterprise
The Chief Executive Officer, Crown Health Enterprise
A Senior House Officer, the Hospital
A Nurse, the Hospital
A Paediatrician, the Hospital
The Manager, Diagnostics, Crown Health Enterprise
A Laboratory Technologist
The Complainant's friend

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Investigation, *continued*

Background

The complainant's child ("the consumer") was born in October 1995 at the hospital. A day after the birth, while in the maternity ward, the complainant claimed that her baby was fed another woman's breast milk. This alleged error appeared to occur after a sample of milk expressed by the complainant was placed in a fridge and was confused with that of another patient. Following this, the consumer was tested for HIV infection at the insistence of the complainant and her husband. The test result was negative. Following media reports regarding faulty HIV test kits, the consumer was tested for HIV for a second time in mid-July 1996.

Jurisdiction

As the Commissioner is unable to investigate events which occurred prior to 1 July 1996, the incident involving the breast milk does not fall within the Commissioner's jurisdiction and has not been investigated. The Commissioner's jurisdiction applies to events which occurred after 1 July 1996. The complainant's complaint relating to blood tests concerns events which all occurred after 1 July 1996, beginning with the consumer's second HIV test in late July 1996. These events were investigated by the Commissioner.

Mediation

The Commissioner reviewed the information provided by the parties and in early August 1997 informed all concerned that in the Commissioner's opinion it was appropriate to call a mediation conference to help the parties resolve this complaint. A mediation conference was held in late August 1997, with agreement quickly reached on three out of four issues. The parties were agreed on the matter of an apology to the complainant and her husband, a new HIV test for the consumer, and assurance from the Crown Health Enterprise that the events complained of would not happen again. The parties were unable to agree on the issue of costs or compensation. Mediation was adjourned to enable the parties to consider their position.

A second mediation conference was rescheduled for late April 1998. The sole purpose of the second mediation was resolution of the compensation issue. The Crown Health Enterprise ("CHE") representative at the mediation neither had, nor was able to obtain, any authority to negotiate the matter of compensation and as a consequence the mediation was closed. As no resolution could be reached between the parties, the issue was referred back to the Commissioner on 5 May 1998.

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Outcome of Investigation

Blood test taken July 1996

In mid-July 1996 the complainant's daughter was tested for HIV infection. Blood was collected by heel and toe pricks. The complainant was told that the hospital would let her know the test results.

Eight days later the complainant contacted the hospital laboratory to ask if the test results were available. She was advised that the laboratory staff would not give the test results over the phone.

Delay in notifying test results

The consumer's test result was reported by the diagnostic laboratory six days after the test was taken and reportedly received and viewed by a paediatrician ("the first paediatrician") at the hospital, in mid-September 1996. The Commissioner was advised by the hospital's customer services manager and area co-ordinator, that "*the delay was apparently caused by a unique set of circumstances*".

Initially the Commissioner was advised by the CHE that the first paediatrician was on leave at the time the results were available in July, and therefore the results were not actioned in the usual manner. However in May 1997, the Commissioner was advised by the customer services manager that the first paediatrician was not in fact on leave as originally suggested and his leave dates were, in fact, 22 June - 14 July 1996, and 26 August - 1 September 1996. Therefore, there was no explanation for the delay in the availability of the results.

The customer services manager advised that:

> "*The system is that mail addressed to a specific consultant paediatrician is not opened by the receptionist but placed immediately in his/her pigeon hole. Mail addressed to the Child Health Centre is opened by the receptionist and then put in the appropriate doctor's pigeonhole. In both situations the doctor clears his/her mail daily. If they're out of town at a regional hospital for the day, the mail is cleared the following day. If the requesting doctor is on leave, the receptionist puts the results in the mail of a consultant who is working so as to ensure they are checked.*

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Outcome of Investigation, *continued*

> *...according to the receptionist,* [the first paediatrician] *actioned the test result within 24 hours of them being placed in his mail box... I am at a loss as to why there was a time delay between the diagnostic laboratory stamping the result* [in late] *July and* [the first paediatrician] *seeing them* [in mid-] *September as stated. The suggested original explanation for the delay* [that the first paediatrician was on leave] *has, in fact, not been substantiated.* [The diagnostic laboratory…] *assures me that when they receive mail from* [the hospital] *it is processed within 24 hours. The only conclusion I can come to is that the report was mislaid somehow in the internal mail system. I have asked that diagnostic review the systems for reports being sent to consultant clinics."*

In a letter from the first paediatrician to the chief medical adviser of the CHE, dated early October 1996 the paediatrician states:

> *"I have no idea why this result was not made available to me prior to that time* [mid-September]*."*

Manner of notifying test results

The complainant complained that the first paediatrician left a message with a friend of hers that "*the test is negative*" and asked the friend to refer this information to the complainant.

The paediatrician advised that he received the test results in mid-September 1996 and attempted to contact the complainant the same day. Upon calling her number he got an answering machine and *"...felt it inappropriate to leave the test results as a message on the answering machine. I then attempted to contact* [the complainant] *again on Monday,* [three days later]. *Again unable to get a response. I therefore left a message with* [the complainant's friend], *the grandmother, saying that the test (not specified) was negative."*

The friend named by the paediatrician is the consumer's "honorary grandmother"; she is not a direct relative. The friend's daughter is the consumer's godmother. The paediatrician left the message with the honorary grandmother and not with the godmother. The preferred contact listed on the Inpatient Frontsheet was originally recorded as being the godmother, noted as "G/mother". This was later altered as the surname had been incorrectly spelt.

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Outcome of Investigation *continued*

The paediatrician was aware that the complainant was anxious to receive the test result and had noted the preferred alternative contact on the consumer medical record was her "grandmother". The customer services manager stated:

> *"In retrospect it is acknowledged that this was not the most ideal way of delivering such a result, however this was the second test and only done on the insistence of* [the complainant]. *Hence, the normal protocol for HIV testing that requires a patient to undergo pre and post counselling with results being given at post test counselling session was not followed."*

Blood test taken October 1996

In mid-October 1996 the consumer was scheduled to have a further PCR blood test at the hospital. The complainant and her friend, the consumer's godmother, went to the ward where they spoke to a diagnostic laboratory staff member, ("the laboratory technician"), in the corridor. They identified themselves and the reason for their attendance and were directed to wait in a patient assessment room. Another woman and child were also in this room at that time.

The complainant and the child's godmother were greeted by a nurse, who contacted the senior house officer by telephone. After this conversation the complainant was informed she would have to wait about half an hour before the senior house officer could conduct the blood test. The complainant stated that she would not wait the extra time, as she had been given an appointment time of 10.00am. The nurse phoned the senior house officer a second time and after this call informed the complainant that the senior house officer would see her shortly. The senior house officer arrived within five minutes.

When the senior house officer arrived she informed the complainant that a local anaesthetic cream would be applied to the consumer's skin to alleviate the discomfort of the blood test. The cream would take half an hour to work. The complainant refused to consent to the procedure by which the senior house officer proposed to take a blood sample from the consumer, i.e. venepuncture. The senior house officer complied with the complainant's wishes and the laboratory technologist took a finger-prick blood sample.

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Outcome of Investigation, *continued*

The complainant's complaint relating to the events of this day was that her daughter's health status was discussed in public, that she was insufficiently informed about the proposed blood collecting procedure, and that the blood test subsequently performed was the "wrong" one.

Discussing the consumer's health status in public

The Commissioner was presented with conflicting accounts of this incident.

The complainant advised that she, her daughter, and the child's godmother were waiting in the assessment room. Two other people were also present. The laboratory technologist came in and spoke to the nurse. Their comments included that the complainant and her daughter were *"here for the AIDS tests*". The complainant said that "[the godmother] *and myself clearly heard our child's test results and condition and test results to be obtained, clearly spoken in front of other persons who had no right to this private and confidential information*".

The child's godmother advised the Commissioner that another woman and her child were present in the patient assessment room. The woman was married to a work colleague of the godmother. A nurse was speaking to someone at the door of the room about why the complainant was in the ward and said "*they're here for an AIDS test on the little girl*." The complainant appeared to be very upset about this and had not mentioned the sort of blood test that was going to be done. Other people were passing in the corridor when the nurse was talking about the AIDS test.

Information provided to the Commissioner by the CHE included a file note dated early November 1996 in which the laboratory technologist stated that:

> *"I was standing by* [the] *office of* [the ward]*... Approached by a woman with a child in a stroller. She told me she was here for blood test for her baby 'that this was the third such test for HIV due to a hospital error with breast milk'. This conversation was clearly audible to other people passing along the corridor or in any of the rooms opening into the corridor. I was standing about two metres from* [the complainant…]
>
> *I am well aware of patient privacy needs…*

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Outcome of Investigation, *continued*

In the minutes of the meeting held [in mid-October 1996] *there is a quote: 'The lab technician returned saying I have come to do HIV test on child'. I did not use these words. There was no reason for me to do so as* [the complainant] *had already told me of the nature of the test in the corridor before I came to the assessment room..."*

A letter from the customer services manager to the complainant dated early November 1996 contains the following comments:

"...it would appear that on your arrival in [the ward] *you approached a laboratory technician in the corridor and you explained why you were at the ward, i.e. '*[the consumer] *needs a test to check for the HIV virus'*

…The assessment room nurse then approached you at the door of the assessment room, at which time, again, you apparently stated your reason for being there, namely the need for an HIV test on [the child].

...It is acknowledged that this [discussion] *took place in the hearing of another person who had previously been in range of hearing your reason for the visit. Although the staff were not comfortable with this, they were aware that you had already stated your reason for being there in the hearing of others, i.e. in the corridor and again at the assessment room...*

I am satisfied with the staff's awareness of confidentiality of information and the need to not break this. It appears that your open use of the term HIV in the corridor and the assessment room gave an impression of a degree of comfort with the use of this information. The Crown Health Enterprise offers an apology for this apparent misinterpretation."

Similarly, the customer services manager advised the Commissioner that:

"[The complainant] *did not appear to mind speaking so freely and using the term HIV in this public place… As* [the complainant] *herself had volunteered the information, using the words HIV freely in the corridor and in the doorway of the assessment room close to the entrance of the ward... I do not believe that there was a deliberate act of breaching privacy in this instance.*"

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Outcome of Investigation, *continued*

Provision of full information regarding blood collecting procedure

The complainant said she had been told in a telephone conversation with the senior house officer that the blood for the test would be obtained by way of a heel prick.

However the senior house officer advised that she received a memo from another paediatrician ("the second paediatrician"), dated early October 1996, which said:

> "*…phone mum and ask her to bring the child up at her convenience for a blood test... We have agreed to do a PCR for the HIV virus on the child and we will need at least 1ml of blood in a PCD tube (yellow top for tissue culture). The blood will need to be taken as aseptically as possible…*"

The senior house officer phoned the complainant to arrange a date and time for the procedure and said that "*at this time I also explained the need for an intravenous line to be inserted (luer line) as opposed to a heel or finger prick as 1ml of blood was required to do this test*." This phone call was witnessed by the child health clinic receptionist.

The senior house officer advised that when she went to the assessment room:

> "[the complainant] *was very upset at this time … and was yelling at the nurse in the room on my arrival...* [The complainant] *refused to have a luer line inserted to collect the blood from* [the consumer] *and denied that I had explained the method of blood collection when I phoned her. I again explained why a venepuncture was required. In the end it was agreed to comply with her wishes and a finger prick sample was taken.*
>
> *In summary, I believe that I provided* [the complainant] *with full information during our telephone conversation and dispute her inference that she was not fully informed of the blood collecting procedure.*"

The customer services manager advised the Commissioner that, "*I am satisfied that an explanation was given by phone to* [the complainant, by the senior house officer] *when making the appointment. It would appear that* [the complainant] *was agitated due to* [the senior house officer] *not being available immediately on her arrival in the ward and this set the tone for the rest of her time in the ward, i.e. her being dissatisfied with the service*."

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Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Outcome of Investigation, *continued*

Wrong test and the CHE's declining a request for repeat test

The complainant complained that the wrong type of blood test was conducted on the consumer's blood sample, and that her request for a repeat test to be conducted at a different hospital was declined by the CHE.

The customer services manager advised that because the complainant refused a venepuncture for the consumer, the blood sample taken in October 1996 was inadequate for a PCR test. In notes from a meeting held three days after the test was taken, between the senior house officer, the nurse, the second paediatrician, the customer services manager and the chief medical advisor, it is recorded that:

> "*Mum refused luer and venepuncture - agreed on a finger prick as mother insistent on not having a venepuncture, knew it may not be ideal*."

The second paediatrician wrote to the complainant five days after the meeting saying:

> "*I discussed the incident with* [the senior house officer] *and it is clear that she gave you straightforward instructions with regard to your visit for the test. She informed you that she would be taking the blood and that this would involve a venepuncture, not a finger prick. If you had gone to the nurse in the assessment room or at the desk on the ward on your arrival as instructed, rather than intercepting a laboratory worker in the corridor, none of the unfortunate ensuing events would have taken place and all would have been accomplished as planned. As it happened, a comedy of errors took place and the wrong test was performed. We are only partly to blame for this*."

The complainant was advised that there were insufficient grounds for doing the test again. The second paediatrician advised the complainant that:

> "*...I have had a phone call from the senior virologist at* [another] *public hospital, informing me that a HIV PCR test is a completely unnecessary test on* [the child] *and that she was most reluctant to agree to the performance of the test. I rather imagine that you are also unwilling to let* [the child] *go through this again as we are, but if you want to discuss this further please contact me*."

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Report on Opinion - Case 96HDC2653, continued

Outcome of Investigation, *continued*

The complainant was asked to contact the second paediatrician to discuss the inadequacy of the sample taken but refused to do so.

At a meeting at the hospital in mid-November 1996 between the complainant, the chief medical advisor, the customer services manager and an advocate, the complainant stated that she wanted the consumer to have a PCR test, but did not want the hospital to take the blood sample and requested that this procedure take place in a different city. This request was also made in writing.

The senior virologist's view was that, "*the risk factors in this case are not such as to warrant further investigations which may further traumatise this child*."

In a letter to the complainant from the customer services manager dated mid-November 1996 the complainant was advised that:

> *"Our contractual arrangements with* [this CHE] *and with the* [other] *CHEs give* [this CHE] *access to tertiary services in* [another city]. *It, however, does not give us access to activities that are normally carried out by* [this CHE]. *We are therefore unable to arrange for the PCR test to be carried out in* [the other city.] *I wish to reiterate, however, that in the opinion of the* [hospital] *paediatricians, confirmed by the chief virologist in* [the other city], *this test is absolutely not indicated."*

Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 1
Right to be Treated with Respect

2) Every consumer has the right to have his or her privacy respected.

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided.

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -…

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and…

f) The results of tests…

2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

RIGHT 10
Right to Complain

3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints…

5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.

Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Opinion: Breach - First Paediatrician

In my opinion the first paediatrician breached Right 4(2) and Right 6(1)(f) in respect of the blood test taken in July 1996.

Delay and manner of notification of results

Clause 4 of the Code of Rights defines "consumer" as including a person entitled to give consent on behalf of a consumer for the purposes of Right 6 of the Code.

Accordingly, the complainant is a consumer for the purposes of this complaint, and under Right 6(1)(f) of the Code, was entitled to the results of her daughter's blood tests carried out in July 1996. She was also entitled to receive these in a manner that complied with professional, ethical and other relevant standards under Right 4(2) of the Code of Rights.

The CHE has a protocol in place for advising the test results of HIV tests for consumers. In discussing the delivery of HIV test results, the protocol states that this is to be done in person, face to face (not by telephone or mail). This protocol constitutes a standard that must be adhered to. In my view this protocol was not followed by the first paediatrician and the manner in which the results were notified did not comply with the relevant standard.

It was irrelevant that this was a second test for HIV and that pre and post counselling had not taken place. The first paediatrician was required to give the results of the test to the complainant herself and I am not satisfied that he took all reasonable steps to ensure that this occurred.

In my opinion the delay between the test being taken and the results being advised to the complainant was unacceptable. The CHE is not able to provide a reason for this delay. I am not satisfied that the delay occurred because the paediatrician was on leave. Neither am I satisfied that there was a delay with the mailing system. However, I accept that the delay was outside the paediatrician's control.

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Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Opinion: Breach – First Paediatrician, *continued*

The first paediatrician advised that the test results arrived on his desk by default, as the second paediatrician was not available. He did not wish the complainant to experience further delays in receiving this negative result and contacted her on two occasions and was not able to speak to her because of an answering machine. However, the first paediatrician need not have left the test results on an answer phone message. He had the alternative of leaving a message requesting she contact him at her convenience. It was not appropriate for the paediatrician to give the test results to a person who was not a relative of the consumer. It was inappropriate to leave even a guarded message. Accordingly, in respect of the manner of notification of the test results, in my opinion the first paediatrician breached Right 4(2) and Right 6(1)(f) of the Code of Rights.

Opinion: No Breach - Nurse

In my opinion the nurse did not breach the Code of Health and Disability Services Consumers' Rights.

Discussing the consumer's health status in a public place

I received conflicting accounts of what was said by the complainant when she first approached the laboratory technologist in the corridor. However, I have balanced the evidence before me and do not consider it to be relevant whether or not the complainant used the term "HIV test" when referring to the reason for her visit. It is inappropriate for providers to discuss with consumers the nature and reasons for the blood tests of a sensitive nature, such as HIV, in a public place such as a hospital corridor.

I also received conflicting accounts of what was said by all parties during the discussions held in the assessment room. It is also inappropriate for health professionals to discuss a consumer's health status and the reason for attendance in an assessment room in front of other people. This would have been so whether or not those people were known to the complainant or her support person.

The Nursing Council of New Zealand Code of Conduct Principle Three states:

The nurse respects the rights of patients/clients.

This is further expanded in Criteria 3.4 which states:

The nurse safeguards confidentiality and privacy of information obtained within the professional relationship;

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Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Opinion: No Breach - Nurse, *continued*

The New Zealand Nurses Organisation Code of Ethics states:

In the context of the nurse – client relationship the underlying values are demonstrated by the nurse:……
Confidentiality (privacy).
Being mindful of the privileged nature of client information they gain.
Safeguarding the physical, emotional and social rights of clients from unwarranted intrusion.

The nurse had an ethical responsibility not to discuss the consumer's health status or the reason for her attendance in the ward, in a public place. Due to the conflicting information I received, I am unable to conclude that the nurse discussed these matters on that day in mid-October 1996. Therefore, in my opinion the nurse did not breach the Code of Health and Disability Services Consumers' Rights.

Opinion: No Breach - Laboratory Technologist

In my opinion the laboratory technologist did not breach the Code of Health and Disability Services Consumers' Rights.

Discussing the consumer's health status in a public place

I have considered the comments of the laboratory technologist and the customer services manager regarding their awareness of the importance of patient privacy. In my view the circumstances of this case required extra care to be taken to ensure that information discussed could not be overheard and that the complainant and her daughter could not in fact be either seen or heard by other people in the ward. Indeed, the fact that both staff involved "were not comfortable" discussing matters in the hearing of others indicates an awareness of the need to have taken precautionary measures in this instance. Whether or not the complainant chose to state the actual type of blood test to be performed did not reduce the laboratory technologist's responsibility to only refer to the test in generic terms while in a public place.

The Medical Laboratory Technologists Board Code of Ethics states

4. *Medical laboratory technologists shall respect the confidential and personal nature of professional records and protect the patient's right to privacy by keeping their information in the strictest confidence.*

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Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Opinion: No Breach - Laboratory Technologist, *continued*

The laboratory technologist had an ethical responsibility not to discuss the consumer's health status or the reason for her attendance in the ward in a public place. Due to the conflicting information I received, I am unable to conclude that the laboratory technologist discussed these matters on that day in mid-October 1996 and therefore in my opinion the laboratory technologist did not breach the Code of Health and Disability Services Consumers' Rights.

Opinion: No Breach - Senior House Officer

In my opinion the senior house officer did not breach Right 6 of the Code as follows:

Provision of full information regarding blood collecting procedure

I am satisfied that when the senior house officer spoke with the complainant on the telephone, prior to the blood test being conducted on that day in mid-October 1996, she explained the nature of the blood collecting procedure which was required. I am also satisfied that she again provided information about the proposed procedure and reasons for it at the time of the complainant's appointment that day. In my view this met the requirements of Right 6(1)(b) of the Code, i.e. that the complainant was entitled to information that a reasonable consumer, in that consumer's circumstances, would expect to receive including an explanation of the options available, i.e. venepuncture or a heel prick.

It is also my opinion that the senior house officer provided the complainant with enough information to make an informed choice as is required by Right 6(2) of the Code. Furthermore, I am satisfied that the possibility that a heel prick may provide insufficient blood for the PCR test was raised with the complainant when the blood was collected. This proved to be the case when tests were conducted. The complainant was entitled to refuse consent to venepuncture and in my view she did so knowing that it may not provide sufficient blood to conduct a PCR test.

Accordingly, in my opinion the senior house officer did not breach the Code of Rights in respect of her service to the complainant.

Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Opinion: Breach - Crown Health Enterprise

In my opinion the CHE breached Right 6(1)(f), Right 10(3) and Right 10(5) of the Code as follows:

Delay in notifying HIV test results

In my opinion the delay between the HIV test being taken and the result being notified to the complainant was unacceptable. The CHE is unable to provide a reason for this delay. I am not satisfied that the delay occurred because the first or second paediatricians were on leave. Neither am I satisfied that there was a delay in the mailing system. In my opinion the CHE's failure to provide the complainant with the HIV test results taken on in July 1996 in a timely fashion, is a breach of Right 6(1)(f) of the Code of Rights.

Manner of dealing with complaint and approach to mediation

The CHE's handling of the complainant's complaint and in particular their approach to the second mediation held in April 1998 were not in themselves raised as elements of the complaint. However, the Commissioner's powers include the ability to investigate on the Commissioner's own initiative any action that is or appears to the Commissioner to be in breach of the Code, and to publish reports in relation to any matter affecting the rights of consumers, including statements and reports that promote an understanding of, and compliance with, the Code of Rights. It is in terms of those powers that I make the following comments.

Under Right 10(5) of the Code every provider must comply with all the other relevant rights in the Code when dealing with complaints. This means that the CHE was required to deal with the complainant's complaint and keep her informed of its progress in dealing with it, in a manner which involved effective communication in terms of Right 5, and which complied with legal, professional, ethical and other relevant standards under Right 4(2) of the Code.

In my opinion neither of these rights were observed when the CHE was dealing with the complainant's complaint. In particular, the CHE did not approach the second mediation in good faith and therefore did not meet appropriate ethical standards. The second mediation was reconvened to deal with the outstanding issue of compensation. The CHE's delegated representative at this mediation was vested with the full knowledge that no authority had been given to either offer or negotiate compensation, despite this being the sole reason for the mediation taking place.

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Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Opinion: Breach – Crown Health Enterprise, *continued*

In my view this fact should have been communicated to both the complainant and the mediator, before the mediation conference, as without authority no resolution could be reached. Cancellation would have saved both parties time and money. In my opinion, failing to approach the mediation in good faith constituted a breach of Right 4(2) and Right 10(5) of the Code of Rights.

Furthermore, this non-communicative approach hindered the fair, simple, speedy and efficient resolution of a complaint which had already been subject to lengthy and protracted attempts at resolution and in my opinion this constituted a breach of Right 10(3) of the Code. Indeed, resolution of the complainant's complaint was rendered impossible by the actions of the CHE's management because the failure of the second mediation also caused non-resolution of the three matters agreed upon at the first mediation. The CHE's decision also negatively impacted on their staff subject to this investigation.

Opinion: No Breach – Crown Health Enterprise

In my opinion the CHE did not breach the Code as follows:

"Wrong" test and CHE's declining a request for repeat test

The CHE admitted that the wrong test was performed and on balance in my opinion this occurred partly because the complainant refused to consent to a venepuncture for the consumer.

However, it is my view that the complainant is entitled to have a further test performed as requested. Under the circumstances, it is also my view that a departure from normal arrangements between the CHE and the hospital and health service in the other city is warranted and that it would be appropriate for blood samples to be collected and tested at another hospital, or privately. It is important for the complainant's peace of mind that a PCR test for HIV be conducted, regardless of the views of medical staff involved that the test is "unnecessary".

Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Actions

My recommendations are as follows:

- The Crown Health Enterprise's chief executive officer is to provide a written apology to the complainant for the inconvenience caused to her by the events which took place between July 1996 and April 1998.
- The present chief executive officer of the CHE, and the CHE's previous chief executive officer are also to apologise to the complainant.
- The first paediatrician is to provide an apology to the complainant for the manner in which the results were notified.

These apologies are all to be forwarded to the Commissioner who will forward them to the complainant. Copies will be kept on the Commissioner's file.

The CHE is to make arrangements for an independent review of this case by a paediatrician to determine whether a repeat PCR test for HIV is warranted. The paediatrician is not to practice in the same area as the CHE and is to have read this opinion. The CHE is to meet the cost of the review. If the paediatrician is of the view that another test is warranted then it should be performed. The CHE will then arrange for the test to be conducted either by the next closest hospital or privately, and is to meet the costs of this, including transport costs to and from the other hospital if travel is required.

The CHE is also required to contribute $2000 towards the costs the complainant and her husband incurred as a result of this complaint.

The CHE is to immediately re-evaluate their protocols and procedures for HIV testing and the notification of test results. This is to include a review of the systems for reports and test results being sent to consultant clinics, and the manner in which results are passed on to consumers. The CHE is to advise the Commissioner that the review has been conducted and its outcome.

All staff at the CHE who deal with consumers requiring HIV testing or counselling are to be regularly informed and updated as to the protocols in place at the CHE which cover such matters. In particular staff training must emphasise the importance of protecting consumers' privacy and the importance of effective communication with consumers. In this regard, all staff are to be made aware of their responsibilities under the Code of Health and Disability Services Consumers' Rights.

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Crown Health Enterprise

Report on Opinion - Case 96HDC2653, continued

Actions, *continued*

The CHE is to review its procedures for dealing with complaints and ensure that it has a complaints procedure in place which complies with the Code of Health and Disability Services Consumers' Rights. In particular the CHE should ensure individual consumers who make complaints can meet with the particular health professional(s) and have the opportunity to resolve the complaint at a low level.

Within one month of receiving this opinion, the CHE is to forward confirmation to the Commissioner that each of these reviews has taken place.

Other Actions

The CHE is to contribute $1000 towards the Commissioner's costs of mediation.

A copy of this opinion will be sent to the Medical Council of New Zealand, The Crown Company Monitoring and Advisory Unit, the Health Funding Authority, and the Ministry of Health.