Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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[redacted]

[redacted]

RE Official Information Act request CDHB 9852

I refer to your email dated 2 May 2018 requesting the following information under the Official Information Act from Canterbury DHB.

a. **The number of complaints or allegations of bullying and/or harassment in each of the last five calendar years made within the Canterbury District Health Board. And the number in each of those years that were investigated and held to be substantiated. I am seeking total numbers, not individual details of each case.**

We are declining to provide this information under section 18(f) of the Official Information Act. This information is not held in a central data base and therefore this information cannot be made available without substantial collation or research.

We can however confirm that the Canterbury DHB is committed to being a good employer and providing a working environment which is free of unwelcome behaviour and abuse of power or position.
We believe that everyone has the right to work in an environment which is free from any form of harassment or bullying. Any complaint of harassment or bullying is taken seriously and handled with sensitivity and impartiality.

Complainants are provided with support and information about the options available to assist them to make an informed decision about how to proceed.

Notwithstanding, I seek

2. **The number of complaints of bullying and/or harassment in each of the last five calendar years related to [redacted], and the outcome of each complaint**.

We are declining to provide this information under section 9(2)(a) of the Official Information Act i.e. *"….to protect the privacy of natural persons, including those deceased".*

We refer you to a ruling the Ombudsman made previously on Case number 355627, June 2016, in which the Ombudsman provided general principles to give guidance in responding to requests for the complaint history of a health practitioner. We attach that guidance as **Appendix 1.** We have considered the Ombudsman's decision in deciding to decline your request.

If you disagree with our decision to withhold information you may, under section 28(3) of the Official Information Act, seek an investigation and review of our decision from the Ombudsman.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website.

Yours sincerely

Carolyn Gullery
Executive Director
Planning, Funding & Decision Support

Appendix 1. General principles

1. These general principles have been developed to clarify the application of the Official Information Act 1982 (OIA) to requests made to the Health and Disability Commissioner (HDC) for a health practitioner's complaint history with HDC.[1]

2. The principles may also be a useful guide, by analogy, for District Health Boards (DHBs) responding to OIA requests for a health practitioner's complaint history.

Privacy interest

Patient confidentiality and privacy of complainants

3. When a person (other than the complainant) requests information from HDC about a health practitioner's complaint history, a paramount consideration is the need to protect patient confidentiality and the privacy of complainants. Specific consideration should be given to the extent to which providing the requested complaint history of a health practitioner may affect the privacy of an individual patient or complainant.

Privacy of health practitioners

4. The need to protect the privacy of health practitioners is an important factor, as affirmed in section 9(2)(a) of the OIA, which recognises that there may be good reason to withhold information in order to protect the privacy of natural persons.

General comment

5. It is well established in previous Ombudsman opinions and in advice from the Privacy Commissioner that:

    a. the complaint history of a health practitioner is personal information about that person; and

    b. subject to consideration of the specific factors set out below, it will often be necessary to withhold that information in order to protect their privacy.

6. The Privacy Commissioner has noted that a strong professional reputation is invaluable in the health industry, and the privacy interest in such information will often be very high. The High Court, in *Director of Proceedings v I,* commented that '*the consequences of publicity for a professional ... can be particularity acute*'.[2]

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[1] These principles will also apply to individual health care providers who are not health practitioners (ie, unregistered practitioners), subject to the important qualification that in such cases there is no *'responsible authority'* (under section 5(1) of the Health Practitioners Competence Assurance Act 2003) or regulator to ensure the competence of such practitioners and protect the health and safety of members of the public.

[2] [2004] NZAR 635 at 653.

Specific factors to consider

7. A number of specific factors are relevant considerations when assessing the strength of the privacy interest in a particular case.

Extent to which information is already known to the requester, or in the public domain	• The privacy interest may be diminished by prior knowledge or public availability of the information.
Age and relevance of complaint information	• The privacy interest may be higher if the complaints against the health practitioner are historical and of no current relevance. In this context, the disclosure of personal information about the health practitioner may be unfair.
Whether the complaint was substantiated	• The privacy interest is higher where the complaint against a health practitioner is unsubstantiated—ie, the allegation made against the practitioner in the complaint has not been formally upheld.[3] Conversely, a health practitioner's legitimate expectation of privacy will be diminished where complaints made about them have been substantiated.
Whether the investigation is ongoing	• Health practitioners are likely to have a higher privacy interest while the investigation of a complaint against them is ongoing. Disclosing the existence of a complaint during an ongoing investigation may unfairly suggest that there is substance to that complaint.
Likelihood of harm arising from disclosure	• There may be factors that heighten the risk of personal or professional harm arising from disclosure of a health practitioner's complaint information, for example the physical or mental health of the health practitioner, or the size of the community in which they practise. In some situations, there may be no risk of harm from disclosure, for example where there have been no complaints made against a health practitioner. • Confirmation that no complaints have been received may be to a health practitioner's benefit rather than detriment. However, routine confirmation of the fact that no complaints have been received may give rise to a suspicion, in other cases where information has been withheld, that complaints **have** been received.

[3] Complaints to HDC may only formally be *'upheld'* by a breach finding following a formal investigation.

Minimising harm by placing information in context	• It is important to consider whether any potential harm from disclosure can be mitigated by releasing summary information with appropriate context. For instance, where a complaint does not warrant investigation, or is not substantiated following investigation, the release of contextual information **may** reduce the harm of disclosure.

Public interest

8. Section 9(1) of the OIA requires consideration to be given to whether the withholding of the information is outweighed by other considerations which render it desirable, in the public interest, to make the information available.

General public interest considerations

9. The following factors may heighten the strength of the public interest in disclosure.

Public safety	• Ensuring the safety and quality of health care and the competence of health practitioners. Non-disclosure in a particular case may run the risk of harm to future patients. Disclosure may elicit other complaints or concerns about a practitioner's competence.
Accountability of health practitioners and providers of health services	• Health practitioners are accustomed to being held to account for the standard of care or service they provide. They should expect that some information about complaints may need to be disclosed if serious accountability or health and safety concerns are raised.
Accountability of complaint-handling agency	• An agency receiving complaints about health practitioners is accountable for the proper discharge of its responsibilities in the assessment and investigation of complaints and in taking any necessary remedial action. This factor has particular strength in the context of complaints received by the HDC, given its role as a national public 'watchdog' in relation to complaints against health practitioners.
Public choice	• The right of the public and potential patients to know the complaint history of a particular practitioner so as to be able to make an informed choice whether to engage their services in the future.

Specific factors to consider

10. A number of specific factors may heighten the strength of the public interest in disclosure in a particular case.

Nature of complaints	• Does the complaint raise serious safety or competence concerns? Does non-disclosure raise a risk of harm to future patients? Complaints of a serious, as opposed to trivial or inconsequential nature, will raise stronger public interest considerations in favour of disclosure.
Number of complaints	• A high frequency of complaints or complaints raising recurrent themes may be indicative of wider competence issues, and justify disclosure of additional information in the public interest.[4] As I have noted in academic commentary on the *'frequent flier'* issue:[5] *[A]bove a certain threshold (eg, three or more complaints within three years) commissions and medical boards should make the number and nature of multiple complaints against an individual doctor a matter of public record – a move consistent with public expectations of greater transparency of health information, and with freedom of information laws. Avoiding public naming on an official agency's list of complaint-prone doctors would undoubtedly be a powerful incentive to settling complaints and addressing the underlying problem behaviour. The current veil of secrecy over most complaints (which avoid publicity by never reaching the stage of disciplinary proceedings) allows repeat offenders to continue unheeded.* • Under HDC's protocol with the Medical Council (2009), HDC agrees to notify the Council '*when HDC is aware of three or more similar "low level" matters relating to a registered medical practitioner within the past five years, which may indicate a pattern of conduct indicative of wider competence concerns*'. It is arguable that, if HDC accepts that a pattern of **low level** complaints (three in five years) may indicate wider competence concerns and give rise to an obligation to proactively notify the registration body, there may a public interest in providing some complaint-related information in response to a request under the OIA.

[4] Research found that 3 per cent of doctors accounted for 49 per cent of complaints to Australian healthcare complaint commissions, and that a doctor's complaint history predicts their risk of attracting future complaints. By the time of a third complaint, there is a 57 per cent probability of that doctor facing another complaint within two years. Bismark MM, Spittal MJ, Gurrin LC, et al. *'Identification of doctors at risk of*

Role of practitioner and seniority, degree of responsibility, and ability to impact on members of the public	• In the context of an OIA complaint against a DHB about the withholding of complaint information pertaining to a psychiatrist, former Ombudsman David McGee noted *'the competing public interest is also high, particularly where the employee in question held a position of responsibility in respect of particularly vulnerable members of society'*.[6] In that case, Dr McGee concluded: *… the public interest would be met by release of information in summary form including the number and nature of complaints, a description of steps taken to investigate those complaints, and the outcome of the investigation.*
Action taken in respect of complaint/outcome of complaint	• The public interest in disclosure may be higher where a complaint has been investigated and found to be substantiated. In the case of HDC it will be relevant whether a breach was found and, if so, the seriousness of that breach. However, the lack of an investigation does not necessarily mean there is no public interest in release. The vast majority of complaints made to HDC are not subject to formal investigation,[7] although they *'undergo thorough and extensive assessment, including obtaining and analysing provider responses, clinical records, and expert advice as appropriate'*.[8]
Extent to which information about the complaint is already in public domain	• If information about the complaint is already in the public domain, this may increase the public interest in disclosure of a summary about the outcome of the complaint. The purpose of such disclosure would be to demonstrate that appropriate action has been taken to investigate the complaint and institute any protective measures or remedial action.
Age of complaint information	• The public interest in disclosure may be lower if the complaints are historical and have minimal relevance.

recurrent complaints: a national study of healthcare complaints in Australia'. BMJ Qual Saf 2013; 22:532–540. Retrieved from http://dx.doi.org/10.1136/bmjqs-2012-001691.

5 Paterson, R. *'Not so random: patient complaints and "frequent flier" doctors'.* BMJ Qual Saf 2013; 22:525–527. Retrieved from http://dx.doi.org/10.1136/bmjqs-2013-001902.

6 Opinion of Ombudsman David McGee, January 2013, ref 311710 (unpublished).

7 Approximately 95 per cent of complaints made to HDC are not subject to formal investigation: Health and Disability Commissioner, *Annual Report for the year ended 30 June 2015,* p 13.

8 Information provided by HDC to Ombudsman, April 2016.

Is the public interest met through existence of the HDC and Medical Council?

11. The public interest in disclosure should not be discounted simply because of the assumed proper oversight of the HDC and regulatory bodies such as the Medical Council.

12. The oversight of these agencies is vital in addressing the public interest in patient safety and practitioner accountability. However, there is also a public interest in promoting the accountability of the agency that received the complaint for the performance of its functions in assessing and investigating that complaint and ensuring appropriate remedial action is taken.

13. Other public benefits may accrue from greater transparency in this area, including possible incentives for practitioners to improve and maintain service standards and to take appropriate action to resolve a complaint, and enabling people to make an informed choice before engaging the services of a practitioner.

Relevance of whether the requester is a member of media

14. The public interest considerations in favour of disclosure may differ depending on the nature of the requester. Given the important democratic and constitutional role of the media in informing members of the public, there may be a stronger public interest in disclosure to a media requester. As the courts have recognised (in articulating the rationale for openness in judicial proceedings), the media act as the '*surrogates of the public'*.[9]

Application of general principles

15. A blanket approach to withholding practitioner complaint histories on privacy grounds is not supported by the OIA.

16. In certain circumstances, taking account of the factors set out above, there may be a public interest in 'lifting the veil' on a health practitioner's complaint history sufficient to outweigh their individual privacy interests.

17. The public interest may not necessarily require full disclosure of the precise information sought by the requester. It may instead be appropriate to strike a balance between competing private and public interests by releasing summary information, with contextual statements and subject to any necessary caveats regarding matters such as:

    a. the number and nature of complaints;

    b. the steps taken to assess and investigate or otherwise resolve those complaints; and

[9] *R v Liddell* [1995] 1 NZLR 538, 546-547.

c. the outcome of any investigation, including remedial actions taken.

18. On receipt of an OIA request for information about a health practitioner's complaint history, HDC should weigh the factors set out above in the context of the specific case and consider whether some information needs to be disclosed to meet the public interest.

19. When HDC forms the view that some information does need to be disclosed, it will be best practice to make the practitioner aware of its decision, in advance of any proposed release—giving the practitioner an opportunity to make HDC aware of any relevant factors that it should take into account in its decision making.

20. HDC may also need to weigh the privacy interest of the complainant, if that person is not the requester, and consider consulting them. An extension of the time limit for making and communicating a decision on the OIA request may be made for that purpose.

21. On investigation and review of HDC decisions on requests for health practitioner complaint histories, the Ombudsmen will as a matter of standard practice request a copy of the information at issue. Additional information may also be required to gain a better understanding of the various competing interests. This may include (if it is not already covered by the request):

    a. copies of the previous complaint(s);

    b. copies of the triage form in respect of the provider (including information from their registration authorities); and

    c. copies of HDC's decision letters on the previous complaints.

    In some cases it may be necessary to see the entire HDC file.

    This additional information will assist the Ombudsmen to fully understand the number and nature of complaints, the steps taken to investigate or otherwise resolve those complaints, relevant practitioner history, and the outcome of any HDC assessment and investigation, including remedial actions.