(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF AGGRIEVED PERSON

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL [2020] NZHRRT 5

Reference No. HRRT 045/2019

UNDER	SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994
BETWEEN	DIRECTOR OF PROCEEDINGS
	PLAINTIFF
AND	SOUTHERN DISTRICT HEALTH BOARD
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms J Foster, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Dr JAG Fountain, Member

REPRESENTATION:
Ms K Eckersley, Director of Proceedings
Ms G Galloway and Ms M Nicol for defendant

DATE OF DECISION: 11 February 2020

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 26 November 2019.

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make a consent declaration. The parties have filed:

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[1] [This decision is to be cited as: *Director of Proceedings v Southern District Health Board* [2020] NZHRRT 5]

[2.1] A Consent Memorandum dated 5 November 2019.

[2.2] An Agreed Summary of Facts, a copy of which is annexed and marked "A".

[3] The Consent Memorandum is in the following terms:

> MAY IT PLEASE THE TRIBUNAL
>
> 1. The plaintiff and defendant have agreed upon a summary of facts, a signed copy of which is filed with this memorandum, together with an anonymised copy.
> 2. The plaintiff requests that the Tribunal exercises its jurisdiction and issues:
>   (a) A declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and
>   (b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter.
> 3. In relation to the declaration being sought in paragraph 2(a) above, the parties respectfully refer to the agreed summary of facts. The parties are agreed that it is not necessary for the Tribunal to consider any other evidence for the purpose of making the declaration sought. The parties request that the anonymised agreed summary of facts be published by the Tribunal as an addendum to the decision.
> 4. The defendant consents to the Tribunal making the above declaration based on the facts set out in the agreed summary of facts, and the non-publication order sought in paragraph 2(b).
> 5. The defendant does not seek any order prohibiting publication of the defendant's name.
> 6. In the statement of claim the plaintiff also sought the following relief:
>   (a) damages pursuant to s 57(1); and
>   (b) costs.
> 7. These other aspects of the relief claimed by the plaintiff have been resolved between the parties by negotiated agreement. There is no issue as to costs.

[4] Having perused the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that an action of the defendant was in breach of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2(a) of the Consent Memorandum.

[5] The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person as sought in paragraph 2(b) of the Consent Memorandum.

DECISION

[6] By consent the decision of the Tribunal is that:

[6.1] A declaration is made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.

[6.2] A final order is made prohibiting publication of the name and any other details which might lead to the identification of the aggrieved person. There is to

be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms J Foster	**Dr SJ Hickey MNZM**	**Dr JAG Fountain**
Deputy Chairperson	**Member**	**Member**

"A"

This is the Agreed Summary of Facts marked with the letter "A" referred to in the annexed decision of the Tribunal delivered on 11 February 2020.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

HRRT 045/2019

UNDER	Section 50 of the Health and Disability Commissioner Act 1994
BETWEEN	**THE DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994
	Plaintiff
AND	**SOUTHERN DISTRICT HEALTH BOARD**
	Defendant

(REDACTED) AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Ms K Eckersley – Director of Proceedings

REDACTED AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings exercising statutory functions under sections 15 and 49 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The "aggrieved person" in these proceedings is Miss D.

3. At all material times the defendant, Southern District Health Board, was a healthcare and disability services provider within the meaning of s 3 of the Act, and was providing health services to the aggrieved person within the meaning of s 2 of the Act.

4. On 22 August 2013 the aggrieved person's mother, Mrs D, complained to the Health and Disability Commissioner ("the Commissioner") about services provided to her daughter by the defendant.

5. On 22 June 2018 the Commissioner (appointed under s 8 of the Act) finalised his opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

BACKGROUND

6. On 20 May 2006, the aggrieved person suffered severe hypoxia (oxygen deprivation) at birth and it took 18 minutes for resuscitation to be effective.

7. Respiratory compromise at birth associated with hypoxia and prolonged ventilation increases the risk of a permanent hearing loss.

8. Due to these identified risk factors for permanent hearing loss, the aggrieved person was referred to the Audiology Department at Dunedin Hospital in July 2006 at two months of age.

9. Dunedin Hospital serves as the major base hospital for the Otago and Southland regions. In April 2010, Otago DHB and Southland DHB were merged and the two DHBs became one entity, Southern DHB ("SDHB").

First appointment – 11 July 2006

10. On 11 July 2006 the aggrieved person was seen for assessment by Mr G, the sole charge audiologist[1] at Dunedin Hospital.

11. A typed assessment report records that Mr G assessed the aggrieved person using the recording of transient evoked otoacoustic emissions ("TEOAEs").[2] The printed results show that TEOAEs were absent in both ears. Mr G's report states that the absence of TEOAEs was most likely due to a middle ear disorder (i.e. fluid). Mr G recommended a course of antibiotics with a repeat of the assessment to be carried out a month later.

12. A temporary middle ear disorder is one possible explanation for the absence of TEOAEs. Permanent hearing loss is another explanation. The absence of emissions did not provide objective information on the aggrieved person's hearing status and her status was not confirmed

[1] Audiologists are not regulated under the Health Practitioners Competence Assurance Act 2003, and therefore are not legally required to have an annual practising certificate or undertake any competency programmes.

[2] There are four types of otoacoustic emissions: (1) Spontaneous otoacoustic emissions (SOAEs) — sounds emitted without an acoustic stimulus. (2) Transient otoacoustic emissions (TOAEs) or transient evoked otoacoustic emissions (TEOAEs) — sounds emitted in response to an acoustic stimuli of very short duration; usually clicks but can be tone-bursts. (3) Distortion product otoacoustic emissions (DPOAEs) — sounds emitted in response to two simultaneous tones of different frequencies. (4) Sustained-frequency otoacoustic emissions (SFOAEs) — sounds emitted in response to a continuous tone. The presence of emissions represents normal function generally consistent with normal or near normal hearing.

though further audiometry testing, for example Auditory Brainstem Response ("ABR").[3] ABR would have been the most effective method of establishing the aggrieved person's hearing status.

Second appointment – 14 August 2006

13. Mr G next assessed the aggrieved person on 14 August 2006 at three months of age and found TEOAEs were of poor quality in both ears and constituted a "fail". Mr G performed high frequency tympanometry (an assessment of middle ear function) which yielded bilateral low volume type B (abnormal) tympanograms.[4] Mr G's letter to the Paediatric Department indicates that the results were consistent with middle ear effusions[5] in both ears. He referred the aggrieved person to the Ear, Nose and Throat ("ENT") Department for management of the middle ear effusions, but did not conduct any further audiological investigation to confirm the aggrieved person's hearing status.

14. As in July 2006, the results of this assessment did not provide objective confirmation of the aggrieved person's hearing status. Further audiological investigation (for example ABR) was required to confirm the aggrieved person's hearing status given her risk factors for permanent hearing loss. Cross-checking allows for a consistent overall picture of hearing and was the expected practice at the time.

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[3] Auditory evoked potential extracted from ongoing electrical activity in the brain and recorded via electrodes placed on the scalp. It tests how the hearing nerves and brain respond to sounds (often performed with sedation to relax a child).

[4] A graphic representation of the relationship between the air pressure in the ear canal and the movement of the ear drum and the tiny bones in the air-filled middle ear space. It also provides useful information about the presence of fluid in the middle ear. Type A tympanograms (normal) are shaped like a teepee on the graph; Type B (abnormal) are flat lines; Type C (abnormal) are also shaped like a teepee but plotted negatively on the graph and indicate negative pressure in the middle ear.

[5] Thick or sticky fluid behind the eardrum in the middle ear.

Audiometry assessment – 1 December 2006

15. The aggrieved person's clinical notes contain an Audiometry Master Sheet ("AMS") with a summary of audiometry assessments performed on her. The AMS records that on 1 December 2006 Mr G performed tympanometry on the aggrieved person (now aged about seven months). The results suggested type A tympanograms (normal middle ear function). However, there are no other clinical notes or history recorded, and there is no report for this assessment. There is no record of any other assessments having been performed.

Audiometry assessment – 11 April 2007

16. On 11 April 2007, the AMS notes that Mr G used conditioned orientation response ("COR")[6] audiometry to assess the aggrieved person's hearing. The results are recorded as "40N at 500Hz, 35NN? at 1000Hz, and 30N at 2000Hz". No other clinical notes or history are recorded, and there is no report of the assessment or its results.

Appointments - 2009 to 2010

17. When the aggrieved person started kindergarten in 2009 at the age of about three years, she was seen by the Vision and Hearing team, who referred her to Dunedin Hospital as she had failed their hearing test.

18. Mr G advised the aggrieved person's mother that he was unable to complete the testing properly because the aggrieved person was not

[6] Although the testing was referred to as "COR testing", it is probably more strictly described as "visual reinforcement audiometry" ("VRA"). VRA is used for developmental ages of six months to two years — the child turns to the sound stimulus and a puppet lights up to reward (reinforce) the child's listening behaviour. Conditioned orientation reflex (COR) audiometry is the same as VRA, but more than one sound source and puppet reinforcer is used. Many parents describe it as a "sound finding game".

willing to do the test, but assured her there was nothing to be worried about.

19. Before the aggrieved person completed kindergarten in 2010, she was tested twice more by the Vision and Hearing team and referred back to Dunedin Hospital each time with the same outcome. Mr G told the aggrieved person's mother that the aggrieved person could hear.

20. In May 2010, when the aggrieved person went for her B4 School Check the aggrieved person's mother declined a further referral to Dunedin Hospital as Mr G had been quite clear that she was wasting his time and there was no issue.

Private audiology assessment - 30 August 2010

21. On 30 August 2010, the aggrieved person was seen privately for an audiological assessment following concerns about her language development. A comprehensive history was recorded, which includes a number of behavioural indicators of hearing loss, such as the aggrieved person asking for repeats, not following basic instructions, talking loudly, and sitting close to the television. The assessment report records the aggrieved person as developmentally delayed by approximately two years.

22. The report also states that the aggrieved person could not be conditioned to perform play audiometry.[7] However, speech discrimination tests using the Kendall Toy Test ("KTT")[8] showed results consistent with a mild to moderate hearing loss in her better ear (she was unable to pick up soft speech). Acoustic reflexes were absent. Tympanometry showed

[7] A behavioural hearing test done with pre-school children where they listen to sounds through interactive playful activities.

type C tympanograms consistent with negative middle ear pressure/eustachian tube dysfunction in both ears.

23. The audiologist raised concerns about the aggrieved person's hearing and was unable to rule out a hearing loss, so referred the aggrieved person back to Dunedin Hospital. The referral requested a repeat hearing assessment as soon as possible and suggested it may be necessary to perform a VRA assessment with two clinicians.

ENT assessment – 5 November 2010

24. On 5 November 2010, the aggrieved person was seen by an ENT registrar. The ENT report records that the aggrieved person had been receiving speech and language therapy for two years, and that there were concerns about her ability to hear softly spoken words. The aggrieved person's parents reported that she spoke loudly. Ear drops were prescribed because of wax in her left ear canal, and a review in two weeks' time was arranged.

Audiometry Assessment - 22 November 2010

25. On 22 November 2010, Mr G saw the aggrieved person to conduct an audiological assessment in conjunction with her appointment with the ENT Department. The ENT registrar recorded that the aggrieved person had bilateral type A tympanograms with normal middle ear function and appearance.

26. The AMS for the aggrieved person indicates that conditioned play audiometry was performed using pegs. Mr G reported that his assessment showed "bilateral hearing thresholds no worse than at the

[8] The child is asked to identify objects, when spoken to at a minimal level, without visual cues. This helps to demonstrate the child's ability to discriminate sounds.

bottom of the normal range". Further testing was done using acoustic reflexes, but only the right ipsilateral reflex at 500Hz was present. Mr G reported that distortion product otoacoustic emissions ("DPOAEs") were absent bilaterally.

27. This was the first occasion when specific frequency thresholds had been obtained for both ears. Objective results suggesting normal hearing had not been obtained prior to this assessment. However, cross-checking was important as the absence of DPOAEs in the presence of normal middle ear movement was inconsistent with the results obtained through play audiometry. There is no record of a cross-check or second test result to support the accuracy of the results obtained through play audiometry, for example KTT or another age appropriate speech identification or discrimination task. According to Mr G, there was no KTT available, as the lack of sound proofing made the reliability of any such test questionable.

28. After this, Mr G had no further involvement with the aggrieved person.

Further audiological testing

29. On 7 March 2011, a Child Development Service Physiotherapist report identified that the aggrieved person had great difficulty with tasks which required verbal instruction or verbal response. The aggrieved person's performance was normal on tasks which did not require a verbal response and little instructions. The results were consistent with auditory process issues.

30. An Advisor on Deaf Children file note in the aggrieved person's clinical records dated 17 May 2011 shows that the speech and language therapist

had expressed concern that the aggrieved person had a hearing loss and speech processing difficulties.

31. The aggrieved person was seen subsequently by a different audiologist at Dunedin Hospital. The aggrieved person's results showed mild low frequency to profound high frequency sensorineural hearing loss on the right, and normal low frequency hearing sloping down to a severe sensorineural hearing loss on the left. Middle ear dysfunction was also a problem and grommets[9] were inserted.

32. The aggrieved person was fitted with hearing aids on 9 August 2011 and on 23 December 2011 the audiologist referred her for cochlear implant assessment. The assessment on 2 April 2012 resulted in the aggrieved person being offered a right cochlear implant.

33. On 28 June 2012, the aggrieved person had surgery for a right cochlear implant.

Impact on aggrieved person

34. The aggrieved person has only been able to hear fully since she was six years of age. The aggrieved person has required a lot of support and assistance with her academic progress and is still several years behind her peers, both academically and socially.

35. A recent Cognitive Educational Assessment Report concludes that the aggrieved person's hearing age is that of a six year old, not a 12 year old, and this "has a huge impact on all areas of her communication". Further, the aggrieved person has "missed out on six years of language and this has also had a significant impact on her social skills." When the

aggrieved person's peers were developing language, communication, social, and foundation academic skills, the aggrieved person was struggling to hear, and consequently she fell significantly behind what was age-expected. The aggrieved person's ability to access early learning across a range of areas was impaired during her preschool years, and this is the primary factor contributing to her current difficulties.

Monitoring of Mr G's performance

36. The defendant did not conduct performance appraisals in relation to Mr G in 2004, 2005, 2008, 2009, and 2010. A statement by the Service Coordinator in Mr G's performance appraisal in 2002 states: "[F]irst review since 1989 approx."

37. Mr G's performance review in 2002 noted that his "continued education needs [are] not being met."

38. In his 2003 performance review, in the section titled: "Give details of any difficulties that you have encountered that have impacted your performance", Mr G stated: "[I]ncreased clerical input by ourselves to detriment of audiological patient base affairs ... [and] conditions of workplace unable to keep up [with] changes in equipment."

39. In his 2006 performance review, Mr G noted a goal of "improved equipment to take us into 21st century" and also raised concerns about appropriate staffing levels for the Audiology Service.

40. In his 2007 review, Mr G again raised concerns about staffing levels and workloads.

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[9] Grommets have a small hole in the centre (like a cotton reel). The hole allows air to pass from the ear canal into the middle ear space, therefore temporarily aerating the middle ear space. This is necessary for

41. Mr G undertook professional development by attending the NZAS annual conference on a number of occasions. There is no documentation that Mr G had clinical supervision from a full member of NZAS.

Review of Audiology Service

42. In July 2010, the defendant arranged for an external review of the audiology service in its region, including Dunedin Hospital. This was partly in response to complaints received by the defendant, and concerns raised internally around its audiological credentials when the new contract for the neonatal hearing screening programme stipulated the audiologist assessing referrals from the programme was required to be NZAS certified.

43. The review identified the following key issues at Dunedin Hospital:

    a. Audiology charts were disjointed and did not contain the full results of testing;

    b. The facility and equipment required upgrading;

    c. There was no personnel with acceptable credentials to carry out the screening programme requirements and aspects of the audiology service provisions, such as fitting hearing aids; and

    d. There was no one with appropriate credentials to supervise the tasks of the audiometrist;[10]

    e. The room that the hospital was using for VRA testing did not meet the requirements for sound testing because it was too noisy. It was "completely unacceptable" to use the room for infant testing;

    f. The audiometrist was untrained, and the ENT service was using a nurse to perform air conduction audiograms. The ENT service should ensure that a trained audiometrist/audiologist performed

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normal hearing.

[10] An audiometrist is a healthcare technician trained in the use of audiometry equipment.

diagnostic audiograms, and that "it is highly likely that inaccurate audiograms are being made as a result of this practice".

Peer review of Mr G

44. In October 2010, Mr G was peer reviewed by Ms K, who is a member of NZAS. Ms K said that she did not believe that it was safe for Mr G to perform VRA. She said that the testing rooms and equipment being used were part of the problem, but a further issue was Mr G's belief that his long experience meant that he could tell whether there was a response or not from a child without other evidence.

45. Ms K said that the "cross-check principle is basic to good clinical practice", and noted that cross-checking had not been a consistent part of Mr G's practice.

46. Ms K said that Mr G had frequently identified ABR responses in what were essentially random noisy recordings. She said that this was "very dangerous" as Mr G was "drawing unwarranted conclusions from these recordings, usually from children who are not able to be co-operative in other ways".

47. Ms K said that the working environment in the Audiology Department was cramped, dark, stuffy and shabby, with disproportionately large office space. She recommended purchasing additional equipment to assist with hearing assessments.

DEFENDANT'S RESPONSE TO COMPLAINT

48. The defendant has acknowledged it did not take adequate steps to ensure that Mr G received supervision and peer support. Given that Mr G was working as a sole charge audiologist and did not meet requirements for membership of the NZAS, the defendant has accepted

it should have done more to satisfy itself that Mr G was competent to perform the role for which he was employed, and that it was not proactive in supporting Mr G and addressing earlier the concerns raised in his performance reviews.

49. The defendant has acknowledged that the inadequate level of audiology practice and unprofessional communication with the aggrieved person's mother was unacceptable and did not meet its expected high standards of patient care.

50. In August 2013 a further external review of the defendant's audiology services was undertaken. The resulting report concluded that the defendant had made significant positive changes to its audiology service, the most important of these being the employment of qualified staff to ensure all infant ABR testing and infant hearing aid fitting is now carried out by appropriate staff. Additionally, the facilities at Dunedin Hospital have been substantially upgraded to a level that should comply with standards for audiological testing and the Universal Newborn Hearing Screening and Early Intervention Programme. The service and facilities offered at the Dunedin site would now be comparable to or higher than many DHB clinics in New Zealand.

BREACH OF RIGHT 4(1) OF CODE

51. Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill".

52. The defendant acknowledges the facilities within which the audiometry service was operating at the time were suboptimal, and the equipment was inadequate. Both the facilities and the equipment required

upgrading, and the room being used for VRA testing did not meet the requirements for sound testing. This was a systemic failing that contributed to the aggrieved person not receiving care of an appropriate standard with regard to her hearing status. Mr G was working as sole charge audiologist. The defendant failed to ensure that Mr G was supervised appropriately, provided with peer support, and provided with checks on his performance. The defendant accepts it failed to provide services to the aggrieved person with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

53. The defendant acknowledges its responsibility for the delay in diagnosis of the aggrieved person's deafness and the impact this has had on her education.

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Kerrin Eckersley
Director of Proceedings

Date:

I, _____, agree that the facts set out in this Summary of Facts are true and correct

_____

For or on behalf of
Southern District Health Board

Date: