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

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

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2021] NZHRRT 45**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 017/2021
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**WILDING INTERNATIONAL LIMITED (TRADING AS ARMOURDENE REST HOME)**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms GJ Goodwin, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Ms SB Isaacs, Member

REPRESENTATION:
Mr G Robins, Acting Director of Proceedings
Mr B Pohio, director of defendant

DATE OF HEARING: **Heard on the papers**

DATE OF DECISION: **22 September 2021**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v Wilding International Ltd* [2021] NZHRRT 45. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 20 April 2021.

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

[2.1] A Consent Memorandum dated 12 July 2021;

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

[3] In the Consent Memorandum the parties request that the Tribunal exercises its discretion and issues:

> 3 (a) A declaration pursuant to s 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 10(3) (by failing to facilitate the fair, simple, speedy and efficient resolution of a complaint by Mr A's sister-in-law).
>
> (b) A final order prohibiting publication of the name and identifying details of Mr A (deceased). The defendant consents to such final orders being granted.

[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 3(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 Mr A (deceased) as sought in paragraph 3(b) of the Consent Memorandum.

DECISION

[6] 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 10(3) by failing to facilitate the fair, simple, speedy and efficient resolution of a complaint by Mr A's sister-in-law.

[6.2] A final order is made prohibiting the publication of the name and any details which might lead to the identification of Mr A (deceased). There is to be no search of the Tribunal file without leave of the Tribunal or the Chairperson.

.....	.....	.....
Ms GJ Goodwin	**Dr SJ Hickey MNZM**	**Ms SB Isaacs**
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 22 September 2021

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT No. 017/2021

UNDER	Section 50 of the Health and Disability Commissioner Act 1994
BETWEEN	**DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994 **Plaintiff**
AND	**WILDING INTERNATIONAL LTD (trading as Armourdene Rest Home)**, an incorporated company having its registered office at Rubiix Accountants Ltd, 7-9 McColl Street, Newmarket, Auckland 1023 **Defendant**

[REDACTED] AGREED SUMMARY OF FACTS

[REDACTED] AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings, a statutory position created by s 15 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The defendant is a company with its sole director being Barry Edward Pohio. Mr Pohio is a shareholder in the company.

3. At all material times until 20 April 2020 the defendant operated Armourdene Rest Home at 10 Von Tempsky Street, Hamilton East, Waikato ("Armourdene").

4. Mr A was resident at Armourdene from 10 June 2010 until 18 August 2018. He died on 20 August 2018 at Waikato Hospital.

5. At all material times the defendant was a health care provider and disability services provider within the meaning of the Act, and was providing health care and disability services to Mr A.

6. On 20 September 2018 Mr A's sister in law complained to the Health and Disability Commissioner about services provided to Mr A.

7. On 11 March 2021 the Deputy Health and Disability Commissioner finalised her opinion that the defendant had breached Right 10(3) of 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.

8. On 20 April 2021 pursuant to s 49 the plaintiff decided to issue proceedings before the Human Rights Review Tribunal.

BACKGROUND

9. On 10 June 2010 Mr A, then aged 65 years, was admitted to Armourdene.

10. Mr A had a history of a brain injury, stroke and hypertension and a diagnosis of schizoaffective disorder.

11. In 2012 Mr A was diagnosed with prostate cancer. As a result of the cancer, his right leg was swollen, he suffered pain and his mobility was restricted. He had an indwelling urinary catheter.

12. By February 2018 Mr A's family were concerned whether Armourdene could continue to provide the level of care Mr A required.

13. On 18 August 2018 Mr A suffered a fall in his room.

14. On the same day, Mr A was transferred to Waikato Hospital. On admission it was noted: Mr A had a smell of urine and faeces; the permanent indwelling catheter was not secure; the catheter was not draining effectively; there was a smell of infected urine; and there was "poor cleaning" around the meatus of the penis.

15. Mr A was diagnosed with a hip fracture and found to have a urinary tract infection and pressure sore on his sacrum (bone at the base of his spine).

16. On 19 August 2018 a registered nurse at Waikato Hospital made a social work referral for Mr A. The nurse noted Mr A needed an increased level of care, had an existing pressure injury, was "very unkempt" and was "malodorous".

17. Mr A died on 20 August 2018.

18. As noted above, on 20 September 2018 Mr A's sister in law complained to the Commissioner about services provided to Mr A at Armourdene.

19. On 26 October 2018 the Commissioner sent a copy of the complaint to Armourdene and asked for a copy of Mr A's clinical notes from 1 January 2018 onwards. The information was sought to help the Commissioner decide what action, if any, to take on the complaint.

20. The defendant did not provide the clinical notes sought by the Commissioner in response to that correspondence.

21. On or about 13 November 2019 the Deputy Health and Disability Commissioner ("the Deputy Commissioner") commenced an investigation into whether the defendant provided Mr A with an appropriate standard of care in 2018.

22. Pursuant to s 62 of the Act, the Commissioner or her delegates is empowered to require the defendant to furnish such information, and to produce documents in the defendant's control, as in the Commissioner's opinion are relevant to the subject matter of that investigation.

23. On or about 14 November 2019 and pursuant to s 62(2) the Deputy Commissioner sought copies of Mr A's clinical notes from 1 January 2018 onwards. The defendant did not provide the clinical notes sought by the Deputy Commissioner in response to that letter.

THE REQUESTS FOR INFORMATION

24. On several occasions between 26 October 2018 and 14 November 2019 the staff of the Commissioner asked the defendant to provide a copy of Mr A's clinical notes dated from 1 January 2018 onwards, including:

    a. By letter dated 26 October 2018.

    b. By email dated 17 January 2019.

    c. By two emails dated 18 January 2019.

    d. By telephone conversation on 21 January 2019.

    e. By letter dated 29 March 2019.

    f. By email dated 2 May 2019.

    g. By email dated 14 June 2019.

    h. By letter dated 8 July 2019.

    i. By email dated 4 November 2019.

    j. By letter dated 13 November 2019 (and sent 14 November 2019).

25. By way of letter dated 13 November 2019 (and sent on 14 November 2019) the Deputy Commissioner asked the defendant to provide its policies and procedures relating to:

    a. falls;

    b. after hours/weekend medical cover;

    c. transportation of residents;

    d. elimination;

e. wound care;

f. pain; and

g. medication.

26. By the same letter, the Deputy Commissioner asked the defendant to provide (inter alia):

a. statements from the staff members on duty when Mr A fell;

b. a statement from Mr A's GP;

c. information in relation to a meeting between Mr A's family and the defendant in July 2018; and

d. a copy of any incident report or internal investigation concerning that meeting in July 2018, or the fall in August 2018.

27. Before this claim was filed, the defendant did not provide the Commissioner or Deputy Commissioner with a copy of the information at paragraphs [24] to [26] above.

28. Before this claim was filed, the defendant did provide several other documents and submissions to the Commissioner and Deputy Commissioner, including:

a. written responses to the complaint;

b. records relating to Mr A's accounts;

c. incident reports dated August 2010;

d. an all-staff memo relating to communication with Mr A dated June 2010;

e. a letter from a consultant psychiatrist regarding Mr A's cognitive function dated May 2011;

f. a sample roster for Armourdene Rest Home;

g. note from Armourdene Rest Home to the oncology department at Waikato Hospital dated October 2017; letters from the oncology department dated October 2017 and April 2018, and discharge summaries dated May 2017 and September 2017;

h. a GP note from March 2018; and

i. correspondence between the defendant and Waikato DHB.

29. The information provided by the defendant largely pre-dated 2018, being the relevant time period of interest for the Deputy Commissioner's investigation.

30. The defendant is required to hold clinical notes and any other health information relating to Mr A for a period of ten years from the most recent date it provided health services or disability support services to Mr A.

31. Without the information at paragraphs [24] to [26] above the Deputy Commissioner was unable to:

a. objectively assess or analyse other information provided by the defendant and representations made by the defendant;

b. seek independent expert advice about the services and care provided to Mr A by the defendant in 2018; or

c. form conclusions about the matters raised by the complaint.

DEFENDANT'S FURTHER RESPONSE TO THE COMPLAINT AND THIS CLAIM

32. The defendant disputes the content of the complaint made by Mr A's sister in law. There is considerable disagreement between the defendant and the complainant about the standard of care provided by the defendant to Mr A.

33. Soon after this proceeding was filed, the defendant provided to the plaintiff the files it held in relation to Mr A, including clinical notes.

34. The defendant accepts, in hindsight, that the earlier failure to provide the material described at paragraphs [24]-[26] above affected the Deputy Commissioner's ability to conduct an investigation and extended the investigation process. The defendant has apologised for the failure to provide those files. The defendant has also made an offer of compensation to Mr A's family.

BREACH OF THE CODE

35. Right 10 of the Code provides in part:

> RIGHT 10
>
> *Right to complain*
>
> (1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.
>
> (2) Every consumer may make a complaint to—
>
> (a) the individual or individuals who provided the services complained of; and
>
> (b) any person authorised to receive complaints about that provider; and

(c) any other appropriate person, including—

(i) an independent advocate provided under the Health and Disability Commissioner Act 1994; and

(ii) the Health and Disability Commissioner.

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

…

36. The defendant accepts it breached Right 10(3) of the Code by failing to facilitate the fair, simple, speedy and efficient resolution of the complaint to the Commissioner: namely, that the defendant did not provide the information set out at paragraphs [24]-[26] above during the course of the Deputy Commissioner's investigation.

37. The defendant accepts that the breach has caused harm to the estate of Mr A and Mr A's family:

a. The estate of Mr A has not had the benefit of a completed investigation by the Deputy Commissioner into the standards of his care.

b. Mr A's sister in law and children:

i. have not had the benefit of a completed investigation by the Deputy Commissioner into the standards of Mr A's care;

ii. have not been able to rest, seek closure or find resolution to the end of Mr A's life;

iii. cannot understand why the defendant did not produce the records sought by the Deputy Commissioner during the investigation; and

iv. found the extended length of time taken to investigate Mr A's death (due to the lack of documents provided by the defendant) confusing, hurtful and distressing.

_____

Greg Robins
Acting Director of Proceedings

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

_____

Barry Pohio
Director
Wilding International Ltd

Date: June 2021