"Fair, Simple, Speedy and Efficient"? Barriers to Access to Justice in the Health and Disability Commissioner's Complaints Process in New Zealand

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Given the absence of a civil damages action for personal injury, the Health and Disability Commissioner's (HDC) complaints process occupies a pivotal role in New Zealand's medico-legal regulatory arrangements. It is designed to address complainants' non-financial motivations in making a complaint after an adverse event in their health care. This article asks whether the HDC complaints process accords its users, particularly complainants and consumers, acceptable and effective legal mechanisms for asserting their legal rights and securing just outcomes. The process is assessed against the original statutory aims of the complaints process ("fair, simple, speedy, and efficient resolution of complaints").[1] *Quantitative and qualitative evidence is marshalled in support of the conclusion that unacceptable barriers to accessing justice are embedded in the*

*Professor of Law, University of Auckland. I wish to acknowledge the complainants, consumers, family members, and providers, who were willing to share their experiences for the purposes of this research. This research was conducted with ethics approval from the University of Auckland Human Participants Ethics Committee. My thanks to an anonymous reviewer for insightful comments on an earlier draft. Of the case studies presented in this paper, some are in the public domain, having been the subject of further complaint about the HDC's handling of their complaint to the Ombudsman. In other cases, complainants, consumers and/or family members, and providers approached, or were approached by, the author and were invited to share their experiences, and gave informed consent to publication in an anonymised form of the details and handling of their complaints. The author made an OIA request of the HDC for a selection of recent, anonymised No Further Action decisions, but the application was refused three times, although a selection of "no breach" findings was released.

1 Health and Disability Commissioner Act 1994 [HDCA 1994], s 6.

complaints process, as currently designed and operationalised. Of particular note are the lack of any means for a complainant to seek review of the merits of a Commissioner's decision to take no further action on a complaint, and for either party to challenge the outcome of an HDC investigation. Four reform options are considered. The author's preference is the inclusion of a mechanism for external review or appeal of adverse HDC decisions.

I Introduction

Parents of an eight year-old boy complained to the Health and Disability Commissioner (HDC), Anthony Hill, about the failure of a specialist ophthalmologist, to whom the boy had been referred by an optometrist, to arrange an MRI or refer him urgently for paediatric assessment after the second, follow-up visit. That follow-up appointment was scheduled two and a half months after the first, by which time he had lost most of his vision and suffered from other troubling symptoms (withdrawn behaviour, clumsiness and muddled thinking, inability to read or trace text, or to find rooms in his home), which were red flags to a serious underlying pathological cause. The boy died of a metabolic brain disease the following year. Had the diagnosis not been delayed, it was possible that he could have had a potentially life-saving bone marrow transplant. Despite the HDC's external expert advising that these symptoms were "all important indications of the severity of his underlying condition" and "would have been sufficient to provoke many ophthalmologists to request an MRI at that stage", a Deputy Commissioner concluded in February 2017 that the doctor's management was reasonable and accordingly that further action in response to the complaint was unnecessary.[2]

Yet, in December the same year, another Deputy Commissioner found that the actions of an optometrist, and the practice at which he worked, had breached Right 4(1) of the Code in similar circumstances.[3] The optometrist saw the six-year-old boy once for a "routine" consultation, and, having tested

2 Letter from Rosemary Wall to complainant comprising HDC's final No Further Action [NFA] decision (28 February 2017).

3 Meenal Duggal *Optometry Practice, Optometrist Mr B, Case 16HDC00646* (6 December 2017). The Deputy Commissioner recommended that the optometrist apologise to the boy and his family, that the Optometrists' and Dispensing Opticians' Board consider reviewing the optometrist's competence, should he return to clinical practice, and that the practice conduct and report to HDC on two audits of patient records and its implementation of quality improvement measures.

his vision, noted his visual acuity in his left eye as 6/10, and in the right eye as 6/x (that is, that he could not read letters on the Snellen chart at six metres with his right eye). The optometrist diagnosed amblyopia (lazy eye) and possible right eye exotropia (outward turning eye), and prescribed glasses.[4] Some 14 months later the boy presented to his GP with a headache and increased vision problems. Very soon after he was diagnosed with a benign brain tumour, for which he was operated on, leaving him completely blind in his right eye and with poor vision in his left. The optometrist was found not to have properly assessed through testing the level of the boy's vision loss in his right eye, nor to have considered other differential diagnoses before making his definitive diagnosis. He had failed to perform appropriate diagnostic testing to rule out pathology; or to refer him to the practice's bigger clinic in a larger centre for further testing, contrary to "his usual practice" of doing so, nor to a specialist ophthalmologist to determine the cause of the two conditions.[5] He did not institute an ongoing treatment plan for regular follow-up for further assessment or investigation of his vision to ensure improvement.

Arguably, the optometrist in the second complaint was less culpable than the ophthalmologist, since the former was non-medically trained, and saw the boy only once, whereas an ophthalmologist is a medical specialist whose scope of practice includes diagnosis of diseases of the eye. He saw the boy twice, and so was in a position to observe the marked deterioration in his vision from the first to the second consultation. Yet only the optometrist complaint resulted in an HDC investigation, leading to findings of breach of the Code in respect of both the optometrist and his practice.

Tellingly, in the second complaint the Commissioner's clinical advisor said repeatedly that he considered these failures were "a severe departure from the level of care expected" which would be viewed by the optometrists' peers with "severe disapproval".[6] Such an assessment is normally considered a signal to the Commissioner to consider a referral of the provider to the Director of Proceedings (DP), who will consider whether further proceedings, such as a disciplinary charge, are warranted.[7] Yet no referral to the DP was made by the Commissioner, nor were reasons given for the decision not to refer.[8]

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4 At 1.

5 At 9.

6 At 11, 17, 18, 22 and 23.

7 Ron Paterson "Assessment and Investigation of Complaints" in Peter Skegg and Ron Paterson *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) at [29.3.10].

8 See HDCA 1994, s 44(3). Compare the giving of reasons for non-referral to the DP, in a case of "woeful" care, in *Locum in General Practice, Dr C, 05HDC07953* (27 February 2007) at 62–63.

In the first, ophthalmologist case, the parents could not get their complaint through the Commissioner's front door to access a complaint resolution option, even a lower-level option such as referral to an advocate. In the optometrist case, the parents did get their complaint investigated, but there was no stated consideration of the public interest in accountability (via disciplinary proceedings) for severely inadequate clinical care. There is on the face of it no explanation for the different *procedural* treatment of these two complaints, and the opposite outcome on such similar facts calls for justification. If the complainant parents in the ophthalmologist case became aware that the complaint in the optometrist case was investigated and resulted in "breach" findings against providers, they could justifiably feel the victims of an injustice and that the HDC's decision not to investigate their complaint accorded insufficient value to their son's life. Whether the HDC's decision that the doctor's management was reasonable was right or wrong, surely these parents should have received a full, independent investigation into the adequacy of their son's care?

What, if any, are the options available to the parents in the ophthalmologist case to challenge or obtain a review of the Commissioner's decision to take no further action (NFA) on their complaint? This article examines the key *legal* barriers to access to justice faced by complainants, consumers and providers challenging decisions of the HDC. The focus is on the question whether and to what extent there are effective mechanisms for review of the merits of unfavourable HDC decisions. In general, it will be shown that a party's ability to challenge the Commissioner's decision on a complaint is extremely limited, both because the governing legislation does not provide an appeal or review mechanism, and because it gives the Commissioner broad, largely unreviewable powers to control the fate of complaints. The HDC complaints process is the only available option for aggrieved patients and their families to have their grievances substantively addressed; there is no alternative means of doing so.[9] The HDC complaints process is virtually the "only game in town" for complainants. Yet they cannot access it as of right, nor can either party seek to correct decisions they consider wrong or unjust.

In part II of the article I provide the definition of "access to justice" I shall use to evaluate the HDC complaints process, and describe what is known empirically about the motives for and needs of patients and families when they make complaints after adverse events in their health care. In part III,

9 Claims for exemplary damages remain available, but they are generally an uneconomic proposition for plaintiffs, given that the threshold for an award is set extremely high (subjective recklessness) and awards are extremely modest. In addition, a live plaintiff is required (Law Reform Act 1936, s 3(2)(a)).

I outline the separate pathways by which a New Zealand patient's financial and non-financial needs are addressed and describe the HDC complaints process and the further proceedings to which it may lead. Part IV considers the kinds, numbers and proportions of decisions taken on complaints, and reasons given for taking no further action or undertaking an investigation and recommending further proceedings. The persistent issue of backlogs of complaints and time delays in resolving them is also discussed. Part V describes the limited means currently available to dissatisfied parties to challenge HDC decisions, compared to that provided in respect of claims pursuant to the Accident Compensation Act 2001, and the two other similar complaints regimes under the Privacy Act 1993 and the Human Rights Act 1993. Finally, in part VI, I set out some options for reform to ameliorate the structural unfairness in the design of the HDC complaints regime and for increasing the accountability and transparency of the exercise by the Commissioner of broad, largely unfettered discretionary powers.

II Access to Justice

First, what do I mean by "access to justice" in this context? The ideal encapsulated by the concept is that each person should have an effective means of accessing the legal system (courts, tribunals and other administrative agencies) to protect and enforce their substantive legal rights and interests. The ideal is seen as an aspect of the fundamental principle of equality before the law. Access to justice is capable of widely different meanings, from narrow to extremely broad. One broad conception focuses on the legal system as a whole as a means of doing justice. It is concerned with matters such as equality of access to legal services and other dispute resolution mechanisms, and the removal of barriers disempowering people from being able to assert their legal rights, so that disadvantaged groups have similar opportunities for obtaining similar outcomes from the legal system for the same legal problems. An even broader approach argues that legal means are merely one (and a severely limited) means of securing justice, and emphasises non-legal means of, and institutions for, doing justice. These include alternative dispute resolution, participation in social and political movements, and political representation.

The concept of access to justice appropriate for this project, however, is narrow, confined to the theory that improvements in *legal* mechanisms are a necessary and significant part of the solution to access to justice problems. I am concerned with the principles of procedural justice to which the HDC complaints process itself should conform in order to improve access to justice for its users.

The overriding purpose of the Health and Disability Commissioner Act 1994 (HDCA) is "to promote and protect the rights of health consumers and disability services consumers".[10] The "rights" in question are the legal rights declared to be possessed by consumers and correlative duties to which providers are subject, stated in the Code of Rights.[11] The complaints regime established by the HDCA is the key *means* of achieving that overriding purpose. Section 6 goes on to say: "and, *to that end [consumers' rights promotion and protection]*, to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights".[12] Thus, since they are legislatively mandated, these are the key criteria against which the complaints regime as it functions in practice are to be assessed.[13] They will be called the doctrinal-legal criteria.

First, however, we might evaluate the appropriateness of the principles selected by the legislature. In reforming the civil justice system Lord Woolf identified four principles that it should meet: that the system should deliver *just results*; be *fair* in the way it *treats* litigants; be capable of dealing with complaints at *reasonable speed and at reasonable cost*; and be *understandable* to those who use it.[14] Similarly, Michael Asimow identified four elements customarily used to evaluate administrative adjudication practices or institutions: *accuracy* (meaning that the adjudicators are likely to arrive at a correct result); *efficiency* (meaning that the system must minimise delays as well as public and private costs, and the body making determinations must be adequately funded and staffed by officials who are capable and independent-minded); *fairness* (meaning that the system is acceptable to those affected by it); and *accessibility* (by ordinary people, even those representing themselves).[15]

The principles identified by Lord Woolf and Asimow map extremely well on to those selected by the legislature to which the complaints regime should strive to achieve in contributing to the overall legal purpose of promoting and protecting consumers' rights:

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10 HDCA 1994, s 6.

11 Code of Health and Disability Services Consumers' Rights 1996, cls 1(1), 1(2) and 2, passed as a schedule to regulations: see Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (reprinted 14 September 2005).

12 HDCA 1994, s 6 (emphasis added).

13 HDC acknowledges complaints resolution as its central function, for which its strategic priority is "to resolve complaints in a fair, timely, and effective way while dealing with the constantly increasing volume and complexity of complaints". See Health and Disability Commissioner *Statement of Intent 2017–2021* at 3.

14 Rt Hon Lord Woolf *Access to Justice: Final Report* (HMSO, London, 1996) at 2.

15 Michael Asimow "Five Models of Administrative Adjudication" (2015) 63 AJCL 3 at 27.

1) Fairness (meaning that the system has a high likelihood of reaching substantively accurate and just results on the merits; and it does so through a process that treats the parties fairly and is accepted by them as such);
2) Simple (understandable to those using it, and accessible by ordinary people, preferably without the need for legal representation);
3) Speedy (the process must be adequately funded and staffed by competent and independent-minded officials, so as to be capable of delivering outcomes without unreasonable delay);
4) Efficient (the process must be capable of achieving just outcomes at a reasonable cost to the parties and the state).

Accordingly, it is suggested that the doctrinal-legal criteria selected by the legislature against which to measure the complaints regime appear both appropriate and complete. Note, however, that these doctrinal-legal criteria will often be incompatible with each other, when applied to individual complaints. The extent to which a substantively accurate and just outcome can be reached will conflict with the extent to which the process can be simple, speedy, and efficient. Trade-offs between these competing procedural principles or a balancing of them will be required when selecting the appropriate resolution process in practice. Nevertheless, the High Court stated in *Meek v Health and Disability Commissioner* that, of the legislatively mandated principles, "the first requirement is that the resolution of complaints be fair".[16] Since the other principles are instrumental to achieving a "fair" outcome, presumably the end sought in all cases, this assertion seems correct.

And so, the doctrinal-legal criteria are sufficient for our evaluative purposes, since they are both legislatively mandated, and appropriate and complete. But, since the overall legislative purpose is to promote and protect *consumers'* rights, we can also gain a useful insight from the empirical studies of patients' and families' motives and the range of needs that they are most likely to seek to have satisfied, when making complaints after an adverse event in their or a family member's health care. A number of studies from different jurisdictions provide consistent insights about what these are. The following elements have emerged as critical in achieving complaint resolution:[17]

16 *Meek v Health and Disability Commissioner* [2016] NZHC 1205 at [62].

17 Jennifer Moore and Michelle Mello "Improving reconciliation following medical injury: a qualitative study of responses to patient safety incidents in New Zealand" (2017) 26 BMJ Qual Saf 788; Marie Bismark and Edward Dauer "Motivations for Medico-Legal Action: Lessons from New Zealand" (2006) 27 J Leg Med 55.

1) *Being heard.* This refers to the therapeutic value of the patient being enabled to tell his/her story and being heard. Careful listening can help the patient feel that the decision-maker or provider understands and validates their loss.
2) *Communication,* including an explanation to enable patients to understand what went wrong and why.
3) *Apology.* Studies stress the importance of appropriately timed, authentic, non-coerced apologies, which acknowledge the harm caused and include an acceptance of responsibility, from practitioners involved in the patient's care.
4) *Learning*, such as a system change or a review of a practitioner's competence. Patients and families commonly express a desire to prevent a recurrence and to protect future patients.
5) *Restoration.* Patient safety incidents can involve immense physical, emotional and financial impacts, for which patients seek restoration, such as compensation for actual losses or to provide for the future care of the injured patient.
6) *Accountability.* A belief that staff or the organisation should have to account for their actions. For some patients, this may include a desire to see erring practitioners sanctioned, such as face an HDC investigation or professional discipline.

It is to be remembered that these criteria, which we might call social-legal criteria, are partial. Providers too have needs and interests, some potentially inconsistent with those of complainants, which they will seek to have satisfied by the process. They too have an equal right to expect procedural justice. Nevertheless, we can evaluate the complaints process in terms of its ability to enable complainants and consumers to have these needs met and achieve these outcomes in appropriate cases. Given the overriding *consumer* rights promotion and protection purpose of the Act, complainants' motivations for engaging in the process offer another, secondary lens through which to evaluate its fairness overall.

There is, however, evidence that these motives and needs are not being satisfied in a large minority of cases. Studies suggest that over one-third of patients and families who make complaints to the HDC express dissatisfaction with the handling or outcome of their complaint.[18] Satisfaction rates reported by complainants are consistently lower than for providers. The last detailed survey published of feedback on the HDC process, in 2008–2009, found 54 per cent of complainants were satisfied with the management of the

18 Marie Bismark and others "Remedies sought and obtained in healthcare complaints" (2011) 20 BMJ Qual Saf 806 at 807; Ann Daniel, Raymond J Burn and Stefan Horarik "Patients' complaints about medical practice" (1999) 170 MJA 598.

complaint, compared to 84 per cent of providers.[19] Bismark has noted that health complaints entities offer a broader range of remedies than a medical negligence action (for example, conciliation and mediation) and seem well placed to respond to complainants' mixed motivations for complaint. Yet there is an "expectations gap" between the remedies of restoration, learning and accountability sought and the outcomes achieved by complainants.[20] It is suggested that the access to justice barriers identified herein may well offer some explanation for this dissatisfaction.

III Separate Pathways for Compensation and Complainants' Non-financial needs: the HDC Complaints Process

More than 35 years ago, New Zealand passed legislation replacing the tort action for damages for personal injury with a state-run, no-fault accident compensation scheme. The impetus for the scheme had nothing to do with the modern patient-safety agenda of wanting to abolish medical negligence cases. Instead, the motivation was the inability of civil proceedings in tort to perform the role of compensating injured accident victims effectively.[21] The scheme provides compulsory cover for accidental death and injury, including that resulting from adverse events in health care.[22] A patient's financial needs are dealt with by a separate process of claims brought by patients to a governmental corporation (the ACC), which provides statutory

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19 Health and Disability Commissioner *Annual Report for the year ended 30 June 2009* (November 2009) at 8. Only 62 per cent of complainants, compared to 85 per cent of providers, considered that their complaint had been dealt with fairly, at 8. The result was interpreted as "likely to reflect outcomes that have not met [complainant] expectations", at 7. In its last published survey result, in 2015, HDC reported 65 per cent "consumer and provider" satisfaction with HDC's complaint management process (without differentiating between consumers/complainants and providers); Health and Disability Commissioner *Annual Report for the year ended 30 June 2015* (October 2015) at 38.

20 Bismark and others, above n 18, at 806. They found less of an expectation gap where complainants sought a communication remedy, such as additional information or apology, which they obtained more often by virtue of the nature of the process.

21 See New Zealand Commission of Inquiry into Compensation for Personal Injury *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (Government Printer, Wellington, 1967) at [171] and [289(c)].

22 See Accident Compensation Act 2001 [ACA 2001], s 32. The current head of cover is "treatment injury" which requires in general that the claimant's personal injury was caused by treatment, which includes some failures to provide treatment or proper or timely treatment, s 33(1)(d). Cover is subject to various exceptions, a key one being that personal injury was not a necessary part or ordinary consequence of treatment, s 32(1)(c).

entitlements to compensation and rehabilitation. In an exchange Parliament itself described as a "social contract represented by the first accident compensation scheme",[23] victims of personal injury are generally barred by the Accident Compensation Act 2001 (and its previous incarnations) from suing for common law damages in return for ACC cover and access to entitlements.[24] Hence, medical negligence actions for damages are almost entirely non-existent in New Zealand's civil justice system.[25]

While addressing patients' needs for monetary compensation, compensation schemes neglect their non-monetary interests. In New Zealand, these are addressed through a separate route: an independent complaints regime, supplemented by professional discipline and a Human Rights Review Tribunal (HRRT). In her report arising out of the unfortunate experiment at National Women's Hospital, Judge Cartwright identified gaps in the accountability mechanisms of health professionals "in a jurisdiction where the financial accountability of the medical profession has been distorted by no-fault Accident Compensation legislation".[26] She advocated for a "simpler, cheaper" procedure as preferable to a return to medical negligence actions. She recommended a statutory statement of patients' rights, and the appointment of a Health Commissioner, to whom grievances in health care could be addressed. The Commissioner could negotiate and mediate a solution to disputes, would have access to the disciplinary procedures for registered health professionals, and would be entitled to seek a ruling or sanctions on behalf of patients from the Equal Opportunities Tribunal (the forerunner to the HRRT). Pertinently, she foresaw the need for the new system to be adequately resourced to service the increased workload.[27] Thus, the HDC complaints regime was a key part of the package intended to honour government's side of the social contract.

The HDCA 1994 was passed to implement these recommendations. The first Commissioner drafted a Code of 10 rights given legal effect in regulations in 1996.[28] By virtue of broad definitions of "provider", "health services" and "disability services", an extremely broad range of health-care and disability services providers are subject to the Code, including public and private hospitals, residential care providers and rest homes, and all

23 See ACA 2001, s 3.

24 Section 317(1).

25 Except for claims for exemplary damages: ACA 2001, s 319(1); and actions for mental injury unaccompanied by physical injury: *Queenstown Lakes District Council v Palmer* [1998] NZCA 190, [1999] 1 NZLR 549.

26 See Silvia Cartwright *The Report of the Cervical Cancer Inquiry* (Government Printing Office, Auckland, 1988) at 172.

27 Recommendation 5(c)(iv) at 214.

28 See the Code of Health and Disability Services Consumers' Rights.

individual health-care and disability services providers, registered and non-registered.[29]

The key means by which Code rights are enforced is the statutory complaints process. The emphasis is on an accessible, inexpensive, informal (without lawyers) process, which would resolve complaints quickly and fairly. Any person, not just the consumer involved, has the right to complain, alleging any action of a provider to be in breach of the Code. All complaints about registered practitioners received by responsible authorities must be forwarded to the Commissioner.[30] No disciplinary action may be taken until the authority has been notified that the matter has been resolved, is not to be investigated or referred to the Director of Proceedings (DP), or that disciplinary proceedings are not to be instituted.[31]

Once made, a complainant loses control over the handling of their complaint. The Commissioner must first make a preliminary assessment to decide whether or not to take action on the complaint, and if so, what course of action. This task is delegated to the complaints assessment team. Typically, a response is obtained from the provider, and a copy of the consumer's clinical records obtained. Preliminary advice as to whether the provider's management was within accepted standards may be obtained from an in-house or external expert clinical advisor in complaints relating to standards of care. The Commissioner's choice of complaint resolution option is discretionary, with no relevant criteria attached, albeit subject to the Act's purposes.[32]

One choice is the Commissioner's decision to take no action or no further action (NFA) on a complaint, where that is considered "unnecessary or inappropriate" subject to a duty to give reasons to the parties.[33] Some NFA decisions are accompanied by an educational comment or recommendations to assist the provider in improving future services.[34] An NFA decision can be made at any time after preliminary assessment, including after deciding to open an investigation. This flexibility and the sole, wide ground ("unnecessary or inappropriate") were added by amending legislation in 2003, implementing the recommendation of a law reform report. The

29 Code of Rights, cl 4.

30 Health Practitioners Competence Assurance Act 2003 [HPCAA 2003], s 64(1).

31 HDCA 1994, s 42(2); and HPCAA 2003, s 70(1).

32 HDCA 1994, s 33(1).

33 Sections 38(1) and 38(3).

34 This occurred in 374 (40 per cent) of 925 NFA decisions in 2016/2017; 389 (51 per cent) of 756 NFA decisions in 2016; 401 (56 per cent) of 713 NFA decisions in 2015: see Health and Disability Commissioner *Annual Report for the year ended 30 June 2017* (November 2017) at 15; Health and Disability Commissioner *Annual Report for the year ended 30 June 2016* (October 2016) at 14; and Health and Disability Commissioner *Annual Report* (2015), above n 20, at 13.

purpose was to enable the better triaging of complaints in order of severity and to address unacceptable delays in complaint resolution at the time.[35]

There is no requirement to consult the complainant as to their preferred form of resolution or remedy sought, although the Commissioner does have power to revisit a preliminary assessment, including an NFA decision, and select a different resolution option.[36] This power is certainly not advertised, and most complainants who receive an NFA decision will likely be unaware of it.[37] In practice, the Commissioner is very unlikely to revisit his assessment, unless the complainant is able to produce new and compelling information or evidence adverse to the provider, or demonstrate a procedural impropriety disadvantaging him or her.

If the need for further action is accepted, there are four options: the first two, intended for less serious complaints, are referral to the two lower-level resolution procedures of advocacy and mediation, in which the advocate or mediator must endeavour to resolve the complaint by agreement.[38] Or the complaint can be referred to another person or agency, who must advise the Commissioner of significant steps taken and the outcome.[39] Common options are referral of the complaint to the provider to resolve directly with the complainant, if it does not raise questions about the health or safety or the public;[40] or to a registered practitioner's responsible authority with a view to it conducting a review of his/her competence or fitness to practise.[41] The fourth option is for the Commissioner to give notice of his or her intention

35 See Helen Cull *Review of Processes Concerning Adverse Medical Events* (Ministry of Health, March 2001) at 18, 40 and 51. At the time the average time for resolving complaints was 18 months to two years.

36 HDCA 1994, s 33(3).

37 No information as to the existence of the power to revisit is on the website, nor is an invitation to request that the preliminary assessment be revisited contained in letters to complainants notifying NFA decisions: see Health and Disability Commissioner "Complaint process" <www.hdc.org.nz>.

38 HDCA 1994, ss 42 and 61.

39 Sections 33(1)(a)(i), 34(1)(a)–34(1)(d) and 35. These include the Human Rights Commissioner, the Chief Ombudsman, or the Privacy Commissioner where the complaint relates to a matter more properly within the scope of their functions (s 36); the ACC if the person appears entitled to ACC cover (s 34(1)(b)); or the Director-General of Health if it appears that failures or inadequacies in the systems or practices of a provider may harm the health and safety of members of the public (s 34(1)(c)).

40 Section 34(1)(d). This option is commonly used for large organisational providers with their own complaints processes, such as public hospitals.

41 Section 34(1)(a). These are confidential processes, the aim of which is primarily remedial and rehabilitative: see pt 3 of the HPCAA 2003.

to investigate the complaint to determine whether the actions of a provider were in breach of the Code.[42]

Like an NFA decision, the Commissioner's discretion whether or not to open an investigation is largely unfettered, with no relevant factors specified, except that the provider's action must be or appear to be in breach of the Code.[43] However, that the complaint raises questions about the health or safety of members of the public must implicitly be considered a relevant factor, since it is a condition attached to the Commissioner's discretion to refer a complaint to the provider for resolution that it *not* raise such questions.[44] It is suggested that this same condition should be explicitly stated as also making an NFA decision, or referral to advocacy and mediation, inappropriate. This would reflect HDC's policy reserving investigations for:[45]

> ... complaints involving potentially significant breaches of ethical and professional boundaries, and major lapses in standards of care that have resulted in death or severe disability.
>
> Public safety concerns, the need for accountability, and the potential for the findings to lead to significant improvement in health and disability services, are also reasons why a complaint may be formally investigated.

The investigation process is inquisitorial. Although there is power to conduct an investigation in public, the practice to date has been for the process to be carried out in private without hearings, on the basis of statements and documents, such as patient records, and occasionally, meetings.[46] The information is gathered by investigation staff, after which the complaint may be referred to an independent expert clinical advisor for advice on matters raised by the complaint, most commonly relating to allegations of failure to exercise reasonable care and skill or otherwise comply with professional standards.

Statutory and common law duties of procedural fairness apply, such as giving the provider notice of the details of the complaint or subject matter

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42 The Commissioner does not have to rely on a complaint to investigate, but can notify an investigation on his or her own initiative: HDCA 1994, s 40(3).

43 Section 40(1).

44 Section 34(1)(d).

45 Health and Disability Commissioner *Annual Report* (2009), above n 19, at 6. See also Health and Disability Commissioner *Annual Report for the year ended 30 June 2013* (November 2013) at 16: "more significant departures from a reasonable standard of care".

46 HCDA 1994, s 59(1).

of the investigation with a right to respond.[47] The Commissioner will form a provisional opinion in a written and reasoned report, which will include any clinical advice obtained, on whether or not the provider's action was in breach of the Code, and if so, any recommendations or further action proposed, importantly flagging a contemplated referral to the DP. This is done to comply with the statutory requirement preventing the Commissioner from making an adverse comment about a person without first giving them an opportunity to answer.[48] The provisional opinion is sent to the party against whom an adverse finding is foreshadowed, with an opportunity to respond. There seems to be inconsistent practices as to whether the whole or part only of the provisional opinion, such as the "information gathered" section, is given also to the complainant, where a "breach" finding is signalled. Procedural fairness would suggest that the whole provisional opinion should be given to the complainant with an opportunity to respond. After all, Commissioners can and sometimes do change their minds after receiving parties' responses. At that point, a party will sometimes submit their own supportive expert opinion, which may then be provided to the Commissioner's expert for a response.

But the parties to a complaint have nowhere near the levels of procedural fairness required in a court. In particular, they do not have the opportunity to present their case in person; to give oral evidence on oath; to select and call witnesses; or to cross-examine opposing witnesses. They cannot influence the selection of or cross-examine the expert, who has significant potential to influence the outcome, given the considerable deference to expert opinion by a lay Commissioner. Conclusions are reached on the papers, including the making of factual findings (also often determinative of the outcome) without the Commissioner being able to assess a witness's reliability or credibility in the usual way.

On completion the Commissioner will report "the results of the investigation" to the parties and various interested others, specifically his or her "opinion" with reasons explaining whether the provider's conduct was in breach of the Code, together with any recommendations and proposed actions.[49] If the outcome is "no breach", that is the end of the complaint. For reasons never publicly explained, "no breach" opinions are never published on the HDC website, even though they too can have educative value. When the outcome is a "breach" opinion, it is usually published. HDC policy is that

47 Section 41(1)(b). See also *Miller v Health Service Commissioner for England* [2018] EWCA Civ 144 at [42].

48 Section 67.

49 Sections 43(1) and 45(1). The word "opinion" is used in s 45(1). Hence, the Commissioner's decision after investigation is commonly referred to as an "opinion".

the names of individual providers are not published, except in exceptional circumstances.[50]

The Act provides no mechanism for a dissatisfied complainant to appeal or seek external review of an NFA decision, nor for either party to influence or challenge the choice of complaint resolution option. Nor does either party have a right of appeal from an adverse Commissioner's "opinion" at the end of an investigation. Having received an NFA decision or been referred to an "unsatisfactory" resolution option, a complainant cannot bypass the HDC and proceed directly to the Health Practitioners Disciplinary Tribunal (HPDT) or the HRRT, since neither has jurisdiction to deal with the complaint instead of the Commissioner.[51] Unlike an NFA decision, there is no statutory power to reopen an investigation and revisit the outcome, though the Commissioner has occasionally done so (asserting a disputed implied power).[52] Its use suggests that the HDCA should expressly provide this power, certainly in the absence of a statutory appeal right.

After a "breach" opinion, the Commissioner can decide to refer a provider to the DP. In practice, this has been reserved for exceptional cases of "major shortcomings in care or communication, or unethical practice", where there is a public interest in further proceedings.[53] Cases of sexual misconduct, involving exploitation of the consumer, are likely to be referred.[54] In clinical negligence cases, one key factor the Commissioner takes into account is the extent to which the provider's conduct fell below expected standards, with the practice being that findings of a "'severe' departure from standards" are likely to lead to referral to the DP.[55] The DP's role is to exercise an independent discretion whether or not to take further proceedings against the provider. The options are: to institute disciplinary proceedings for "professional misconduct" against a registered practitioner before the HPDT; or to institute a civil action against the provider before the HRRT; or both.[56] Establishing "professional misconduct" involves a

50 See Health and Disability Commissioner *Policy Document: Naming providers in public HDC reports* (1 July 2008).

51 See *Perfect v Bay of Plenty District Health Board* [2004] NZHRRT 3; and *Gravatt v Bulmer (Strike-out application)* [2014] NZHRRT 40.

52 An informal practice was developed in exceptional cases by the second Commissioner (Ron Paterson), in reliance on an implied power to reopen, notwithstanding the absence of an express statutory power. But the power is contested and there is a lack of transparency about its existence and the criteria for reopening, see Paterson, above n 7, at [29.3.13].

53 Health and Disability Commissioner *Annual Report for the year ended 30 June 2006* (November 2006) at 1.

54 At 1.

55 Paterson, above n 7.

56 The HDCA permits the DP to pursue both disciplinary charges and a civil action before the HRRT in respect of the same registered health practitioner: see ss 45(2)(f) and

higher standard of proof and threshold of culpability than for the prior HDC "breach" finding. As a result, the Commissioner's prior "breach" opinion has been held to create no presumption of professional misconduct and is seldom referred to by the HPDT.

The DP's other option is to bring civil proceedings against the provider in the HRRT, a tribunal with an eclectic jurisdiction over human rights, privacy and HDC cases.[57] The HRRT considers afresh the same issue as in the Commissioner's investigation: whether the provider's actions amounted to a breach of the Code. Unlike the Commissioner, it does have a power to award damages, including punitive damages, but it cannot award compensatory damages in respect of personal injury covered by the accident compensation scheme.[58] The HRRT hears the matter de novo in a public hearing with the benefit of viva voce evidence, (often) legal representation, and cross-examination. And so, even though the issue is identical, the HRRT does not defer to the Commissioner's factual findings or "breach" opinion. It determines the issue afresh, and can and does depart from the HDC "breach" opinion, which merely establishes its jurisdiction.[59] Once their complaint has proceeded past the HDC, however, parties dissatisfied with HRRT and HPDT decisions do have a general right of appeal to the High Court and the Court of Appeal on a question of law.[60]

Should the DP institute HPDT or HRRT proceedings, the provider may have the opportunity of indirectly challenging the merits of the Commissioner's "breach" opinion in them. But this happens rarely, and comes at the undoubtedly unwelcome expense and stress for the provider of having to defend these proceedings where the stakes are now higher. A complainant or consumer, by contrast, has no means of challenging the merits of a "no breach" finding. They have no party-status to institute disciplinary proceedings. And the Act permits them to institute civil proceedings against a provider in the HRRT (to seek damages or any other remedy) in strictly narrow circumstances: where the Commissioner formed a "breach opinion" after investigation; and either the Commissioner did not refer the provider to the DP; or, having done so, the DP decided not to take HRRT proceedings.[61]

49(1)(a). The HRRT must have regard to the findings of and any penalty imposed by the HPDT: see s 54(5).

57 The latter is the only option available for non-registered providers and for organisations, as there is no disciplinary tribunal for these providers.

58 See HDCA 1994, ss 57(1) and 52(2). The maximum amount of an award is $200,000.

59 See, for example, *ABC v XYZ* [2013] NZHRRT 25 at [97], where the HRRT disagreed with the HDC's "breach" opinion.

60 Human Rights Act 1993 [HRA 1993], ss 123–124; and HPCAA 2003, ss 106 and 113.

61 HDCA 1994, s 51.

The rationale seems to be that a consumer may feel sufficiently aggrieved by a Code "breach" to be motivated to pursue further proceedings for damages. But in practice there is seldom anything further for them to gain, economic or otherwise, since first, the HRRT is barred from awarding compensatory damages where the consumer has suffered physical injury and has ACC cover, almost always the case in serious cases, and secondly, the consumer has already been to some extent vindicated by a "breach" opinion.[62]

The design of the process in this respect seems counterintuitive. It is surely a complainant or consumer on the receiving end of a disputed "no breach" finding who is likely to feel more aggrieved and seek a means of challenging the Commissioner's opinion, than one who has at least been vindicated by a "breach" opinion, but for whom further proceedings are not cost-effective. Perversely, however, the Act withheld any such ability, and a law reform report in 2001, which recommended widening access to the HRRT, did not recommend extending s 51 proceedings to "no breach" findings.[63] In *Perfect v Bay of Plenty District Health Board* the Commissioner, after a preliminary assessment, had referred a complaint by parents about their son's treatment by a DHB to a mediation conference.[64] Dissatisfied with the outcome, they argued that they should be allowed to bring their complaint directly to the HRRT. They urged the Tribunal to assert a broad power to review the Commissioner's decisions. Notwithstanding its sympathy for complainants with no avenue through which to take their concerns about a Commissioner's decisions, the HRRT declined to create a new broader right of access to itself. A Commissioner investigation and "breach" opinion were prerequisites to the HRRT's jurisdiction. Accepting that a change could only be effected by legislative amendment, the result is regrettable in policy terms, given my concerns about unduly restricted access to justice and the lack of accountability for HDC decisions.

The largely redundant nature of the HRRT in respect of HDC complaints was exacerbated by an unfortunate judicial decision, prohibiting secondary victims (family members and other third parties) from bringing HRRT proceedings in their own right and being awarded damages. This was the

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62 See Royden Hindle "Putting it right? Monetary Remedies for Breaches of Patients' Rights" (paper presented to Wellington Medico-Legal Society, Wellington, 22 November 2011).

63 The Cull Report recommended broadening access to the HRRT to include cases where the Commissioner had made a "breach" finding after investigation and not referred the provider(s) to the DP, which was implemented by amendment to s 51. But it did not recommend that proceedings could be brought by providers after "breach" or consumers in "no-breach" cases, saying that the latter proposal required "further discussion": see Cull, above n 35, at 110–111.

64 *Perfect*, above n 51.

result of a narrow and somewhat insensitive[65] interpretation by the Court of Appeal of the phrase "aggrieved person" in s 51 of the HDCA, as confined to a consumer whose rights under the Code have been breached by a provider.[66] Thus, the option of HRRT proceedings is closed to third-party complainants, unless they are acting on behalf of the consumer's estate. Given that not a single, personal, third-party action had been brought at the time and that damages awards in DP-plaintiff cases were unusual and modest, a fear of a multiplicity of third-party actions and excessive damages awards seems misplaced, as the Court itself acknowledged.[67] The Court also recognised that:[68]

> ... allowing a group with a close association to health consumers, as well as health consumers themselves, to claim damages could promote and protect the rights of health consumers, by giving a wider group an incentive to bring health professionals to account for breaches of the Code.

Parliament has so far been unmoved by successive Commissioners' submissions for reversal of this decision on the ground that it unduly restricts access to the HRRT.[69] Thus, as the HRRT has itself observed:[70]

> Parliament has chosen to leave the keys of the gate to proceedings in the [HRRT] in the hands of the Commissioner ... [and] Parliament has set its face against opening up any wider right of access ... .

The same applies to the DP, and to HPDT proceedings.

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65 In the sense that the unfortunate message given to the parents in the index case, whose son had died from a suicide attempt in the context of a psychiatrist's negligent care in breach of the Code and for which he had been found guilty of "professional misconduct", was that they were not "aggrieved persons".

66 Section 51 states that only an "[a]ggrieved person may bring proceedings before Tribunal" in their own right, and is eligible for damages under s 57(1): see *Marks v Director of Health and Disability Proceedings* [2009] NZCA 151, (2009) 3 NZLR 108 (CA). See also *P v Iyengar* [2011] NZHRRT 2 and *P v Iyengar* [2012] NZHRRT 9.

67 *Marks*, above n 66, at [47].

68 At [13].

69 See Ron Paterson *A Review of the Health and Disability Commissioner Act and Code of Health and Disability Services Consumers' Rights: Report to the Minister of Health* (Health and Disability Commissioner, June 2009) at 11–12; and Anthony Hill *A Review of the Health and Disability Commissioner Act and Code of Health and Disability Services Consumers' Rights: Report to the Minister of Health* (Health and Disability Commissioner, June 2014) at 4.

70 *Perfect,* above n 51, at [44] and [48].

IV Numbers and Kinds of Complaints Selected for Different Resolution Processes

What are the characteristics of complaints vulnerable to being discontinued? NFA decisions and their reasons are not made public. Thus, it is difficult to get a flavour of the characteristics of complaints likely to be discontinued. It has been possible, however, to gather a small selection of complaints (in addition to the "ophthalmologist" case) to gain an insight into the kinds of complaints in which NFA decisions are made.

A *The hospitalised patient with COPD*

Two adult children complained to the Ombudsman about the HDC's NFA decision on their complaint of a physician's failure to prescribe antibiotics and high-dose steroids to their mother, aged 81 years, who had presented to North Shore Hospital on 22 April 2013. Their mother was suffering from a week of increased shortness of breath and an acute deterioration of her severe chronic obstructive pulmonary disease (COPD). She was seen by the emergency department (ED) house officer, who consulted with the on-call medical registrar, and the on-call medical team house officer. She was admitted to the medical ward, and reviewed the next day by a consultant internal medicine physician, who was the clinical leader of infectious prevention and control, and his team. Because it was thought her deterioration was due primarily to congestive heart failure with an acute, non-infective and mild exacerbation of her COPD (and not to an infection), she was not prescribed antibiotics, nor a high-dose of a corticosteroid, as she had been in multiple past hospital admissions. She received oxygen and was discharged the next day to continue it at home, with an outpatient appointment with the respiratory team. Three days later she re-presented by ambulance at the ED, feverish and with symptoms of severe respiratory compromise, and died less than an hour afterwards. The HDC obtained a response from the hospital, which included a copy of the hospital's internal review of the case. It indicated a variance of opinion between the clinical director of the ED, the consultant physician who had reviewed her, and the chief medical officer (a respiratory physician) as to whether antibiotics should have been prescribed in the absence of evidence of infection, but did not identify concerns with the standard of care. HDC's in-house GP clinical advisor considered that the care met expected standards. At that point, without obtaining advice from an independent respiratory physician, or giving the complainants the information gathered from the hospital and GP advisor with an opportunity

to comment, the HDC made an NFA decision, on the ground that there was no significant departure from a reasonable standard of care.[71]

After receiving further submissions from the family and further in-house expert advice from a second GP, the HDC agreed to revisit its decision. (In fact, in the face of the family's vigorous challenges, it went on to review the decision twice.) The family submitted two reports from a leading respiratory physician, the second of which was highly critical and stated that most doctors would prescribe antibiotics as a matter of prudence without conclusive exclusion of infection and that the omission to prescribe a course of steroids was "a major and serious departure from the standard of care", concluding that her care had not been "appropriately managed". The HDC then confirmed its initial NFA decision, although advising that its second GP advisor considered that the failure to administer antibiotics, although consistent with some accepted guidelines, was "clinically unwise and inconsistent with accepted practice", and that treatment with an abbreviated course of higher-dose steroids only was also "a moderate departure from the standard of care".

The Ombudsman, a former HDC Commissioner, considered in his report that, while there is no general obligation to provide complainants with the opportunity to comment on proposed NFA decisions, fairness was likely to require such an opportunity where there are factual discrepancies, information that the complainant was not aware of, or in relation to finely balanced decisions about the appropriateness of care. He said:[72]

> ... giving a party adversely affected an opportunity to comment on a proposed decision to take "no action" or "no further action" on a complaint allows that party to feel and to be heard, and ensures that preliminary conclusions can be tested before a final decision.

Although of the view that it was unfair for the HDC not to have provided the family with that opportunity, any procedural unfairness was remedied by the HDC's agreement to review its NFA decision. He accepted that it was open to and not unreasonable for the HDC to obtain expert advice from two in-house GPs at the assessment stage, rather than a hospital-based specialist, though he considered that the latter would have been a more suitable peer. But he remained of the view that:[73]

> In considering the appropriateness of care for a patient who dies soon afterwards, in response to a complaint from a grieving family, facilitating

71 Letter 23 January 2014 Theo Baker to complainants.

72 Ron Paterson *Ombudsman Act Investigation: Complaint: Mrs S* (30 June 2016) at 3.

73 At 6.

> resolution may require HDC to take extra steps — particularly in the face of a vigorous dispute about the standard of care delivered, where a formal investigation is not to be undertaken by HDC. Obtaining independent advice from a hospital-based physician would have provided HDC and the parties with assurance that the key issue — whether Mrs S should have been prescribed antibiotics — had been fully considered.

He agreed that the NFA decision was ultimately a matter for the Commissioner's judgement, and not for an Ombudsman to second-guess. He decided, however, that the discretion had been exercised unreasonably. The HDC's reasons for its final NFA decision confirming the original decision were inadequate. Given that the HDC's own second clinical advisor and the complainant's clinical expert had both identified a moderate or major departure from professional standards, setting the scene for a breach finding had a formal investigation been undertaken, the provision of adequate reasons was required, articulating how the additional expert advice had been assessed and why it remained appropriate to confirm the initial NFA decision. As it was, the reasons given left the family with the impression that HDC had not appreciated the significance of the hospital's failings. He recommended that HDC apologise for its failure to provide adequate reasons and review its internal practices relating to the adequacy of reasons provided.

Two years after the death, the Chief Coroner agreed to an inquest in light of the family's continued sense of grievance.[74] Coroner's courts are not intended to operate as a means of accountability, but to identify "the causes and circumstances, of sudden and unexplained deaths, or deaths in special circumstances".[75] But their ability to identify the circumstances of death and the power to make recommendations and comments has been used to justify a broad approach to the jurisdiction. And so coroner's courts are commonly used as a public forum for broad inquiries into provider fault and for addressing families' non-monetary needs, though this option is only available, of course, when a death has occurred.[76] After a full hearing which included four medical witnesses, including two independent expert respiratory physicians, Coroner Herdson was satisfied that, in light of the divided views of the medical experts about the clinical grounds for prescribing antibiotics and steroids, the physician's management did not constitute a significant or major departure from accepted standards. She concluded that

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74 *Re S*, Coroner's Court, Auckland, CSU-2015-AUK-299, 8 November 2017, Coroner Herdson.

75 Coroners Act 2006, s 3(1).

76 See Morag McDowell in Skegg and Paterson, above n 7, at [24.3.7(3)]. For another instructive example see *Gravatt v Auckland Coroner's Court* [2013] NZHC 390, [2013] NZAR 345.

it was impossible to know whether a prescription of antibiotics and steroids on discharge from the first admission would have altered the outcome.[77]

The key question the case raises is why the HDC did not open a formal investigation of what was undeniably a complaint raising serious concerns held by the family about a consumer who had died, at the very least after the HDC received consistent opinions from both the complainants' expert and its own second advisor that there had been "major and serious" or a "moderate" departure from acceptable standards? This would have saved the coroner from having to address the issue of culpability in an inquest over two years later. It is suggested that substantive fairness (reaching an accurate and just result on the merits) should have been prioritised via a formal investigation, with speed and efficiency, advanced by an NFA, subordinated in this case. As the complainants said in response to the HDC's apology for its failure to provide adequate reasons for its decision, "we need to know why, 'when the scene had been set for a breach finding', HDC decided not to investigate".[78] The HDC appears to have been doing all it possibly could to *avoid* giving this grieving family an investigation of their family member's death, when it is the key agency to whom that role has been assigned.

B *The inter-hospital transfer case*

Another example is a complaint brought by a daughter to the Commissioner about the care her father received after he presented at a hospital ED with chest pain, which was diagnosed as unstable and cardiac in origin, requiring his transfer to another hospital, after which he suffered a cardiac arrest and died the next day.[79] There were breaches of the inter-hospital transfer protocol and a communication error between medical staff at the receiving hospital during the transfer. This resulted in a 30-minute delay in obtaining a CT scan, which, while probably not causative of the patient's death, was described by the HDC's in-house GP advisor as "somewhat excessive".[80] The HDC decided that further action on the complaint was unnecessary, on the ground that the transfer procedure in place had been largely followed in the particular case and that the in-house advisor was not overly critical of the

77 *Re S*, above n 74, at [348] and [442]–[443]. Coroner Herdson did, however, amend the cause of death from that certified by the attending doctor ("infective exacerbation of COPD (hours) and COPD (years)") to "acute severe infection, in association with undetermined complications of COPD", reflecting the expert medical consensus.

78 Letter 29 July 2016 complainants to A Hill.

79 Beverley Wakem *Ombudsman Act Investigation: Complaint about Health and Disability Commissioner assessment process* on 16 December 2010 (October 2013).

80 At [17].

care. Her further complaint to the Ombudsman that the HDC's decision not to investigate her complaint was unreasonable was upheld. It also resulted in some further information about the disciplinary action being provided to her, albeit after it was of any practical use to her, as the NFA decision remained undisturbed.[81] The decision provides a further insight into an NFA decision in a complaint, which identified deficiencies in the standard of care and in which there had been a fatal outcome. The overall impression is of the HDC being in haste to confirm its provisional NFA decision and distinctly unmotivated to get to the bottom of apparent deficiencies in care.

C *The patient on a compassionate use programme*

A man complained to the HDC about the failure of his wife's hospital consultant oncologist to inform her of the possibility of an interruption in the supply of drugs before arranging for her to be admitted to a pharmaceutical company's compassionate use programme (CUP). Under the CUP his wife could access unregistered and unfunded, potentially life-saving medications for her advanced metastatic melanoma.[82] He claimed that the oncologist and the DHB knew about a potential supply issue with one of the medicines, submitting a letter from the company to all DHB oncologists informing them of an actual loss of supply, but that the oncologist failed to inform her of the issue before she started treatment.[83] He was also concerned that the oncologist did not advise her that she could access the drug without any supply issue in the United Kingdom, as she was a citizen of the United Kingdom, thereby depriving her of considering that option. Within a week of taking the drug, the patient's tumours had subsided and her condition greatly improved. After taking the drug for about seven weeks, the oncologist advised that the company's supply of the drug had run out and it was unable to supply any more. His wife's condition rapidly deteriorated, and about six weeks later she died. The complainant also argued that the company had a

81 At [17]. The HDC's assessment of the complaint was unreasonable, in that it should have clarified deficiencies in her father's care (how the delay in arranging the CT scan occurred and the nature of the communication error) *before* it advised the parties of its provisional NFA decision. Failure to do so discouraged the hospital from giving detailed information about the cause of the delay ([28]), and deprived the complainant of the opportunity, to which she was entitled, to respond to the further information from the hospital that there had been a miscommunication error, and the second clinical advisor's advice on that, before HDC made its final NFA decision ([35]).

82 Letter from complainant to HDC (15 April 2016).

83 Letter from pharmaceutical company to all DHBs 24 November 2014, advising all DHB oncologists of problems with supply of the medication.

duty of care to patients on CUPs to protect them from being harmed in the event of supply issues. He was concerned that the real reason the company had stopped supply to the CUP was for self-interested commercial, rather than genuine lack of supply, reasons.

The doctor acknowledged that he was aware through verbal discussions with the company and advice from colleagues that the company had been experiencing ongoing supply issues with that drug in the preceding three months, but he had been advised by the company that these supply issues would be resolved within a month or two. He did not refer to these discussions when he met with the couple, because of that verbal assurance. Also, he had not experienced supply issues with medications supplied under a CUP before.[84] Although acknowledging that the complainant raised a valid concern about the company's abrupt cessation of the supply of a life-saving medication, the HDC issued a provisional NFA decision, to which it invited a response, concluding that it did not have jurisdiction over the company, since it was not a "health provider" as it did not directly provide her with any health services.[85] In addition, the complaint concerned a matter of access to treatment, which was outside the Commissioner's jurisdiction. As for the alleged breach of the right to be fully informed of treatment cessation, the HDC decided that the consent form prior to commencing the programme explained the possibility of this.

In a seven-page letter the complainant vigorously disputed the HDC's arguments in the provisional NFA on all points.[86] He argued that the potential for an interruption in the supply of a life-saving medication was critical information that a reasonable patient in her circumstances would need to make an informed choice whether to enter the CUP, and that there was a heightened duty to provide appropriate information to terminally ill patients. He disputed that they had been ever advised of the possibility of supply issues, and that a fair reading of the consent form did not alert them to that possibility. He argued that it was unfair of the HDC to assume the provider's version of events was correct at the preliminary stage without investigation and decide to take NFA on that basis. He also argued, referring to provisions in the HDCA and Code and case law that, in providing life-saving medications to her, the company was a "health care provider", providing "health services". Thus, the HDC's claim that this was an access issue outside his jurisdiction was "just plain wrong", because his wife had already been admitted to the CUP and was receiving the drugs, and so the

84 Letter from Canterbury DHB to HDC (14 July 2016).

85 Letter from Meenal Duggal to complainant comprising HDC provisional NFA decision (17 February 2017).

86 Letter from complainant to HDC (26 March 2017).

company had a continuing duty of care to her. In the course of his letter, he said:[87]

> I cannot bring a negligence action in the courts to have my grievance considered. ... If the HDC will not properly investigate my concern, which all would agree is not a trivial or insubstantial concern, I have nowhere else to go. I am left with unaddressed and unresolved questions and concerns about the circumstances of [my wife's] death which will persist for the rest of my life. ... It is very important to have a full investigation to understand what happened.

The HDC did not resile from any of its arguments, and said that, given the different factual versions of the parties, further inquiries would not assist it in determining whether the oncologist was aware of the supply issues sooner than he admitted and before the wife's treatment began.[88] While commending the complainant for "advocating for [wife's name] and other people undergoing compassionate use programmes", the Deputy Commissioner confirmed the NFA decision.

In addition to these case studies, the reasons that make a complaint vulnerable to an NFA decision are stated in various HDC Annual Reports:[89]

- the in-house or external expert opinion is that the care provided was of a reasonable standard;
- the conduct departed from accepted practice only to a mild degree and the provider recognises the need for specific improvement;
- the allegation is not serious and the provider has apologised;
- further inquiry will not resolve evidential issues;
- the provider has made the necessary changes to practice to address the issues;
- the matters at issue in the complaint have been addressed appropriately by other means (this may be an in-house DHB inquiry);
- further inquiry will not help resolve the complaint;
- there is no apparent breach of the Code, or the provider has been able to provide information that addresses the issues;

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87 At 2 and 6.

88 Letter from Meenal Duggal to complainant comprising HDC final NFA decision (28 April 2017).

89 Health and Disability Commissioner *Annual Report* (2017), above n 34, at 16; Health and Disability Commissioner *Annual Report* (2016), above n 34, at 14; and Health and Disability Commissioner *Annual Report for the year ended 30 June 2014* (November 2014) at 14.

- the length of time that has elapsed since the events complained of occurred.

How often does the HDC discontinue a complaint? An NFA decision is the means of "resolution" of *most* complaints. In the last four years (2014–2017) the HDC decided to take no further action in 55 per cent of complaints received, approximately 1,072 of approximately 2,000 complaints received per annum.[90] This attests to heavy emphasis on simple, speedy, and efficient resolution. It is open to question whether this has been at the expense of fairness, and whether the pendulum has swung too far in denying complainants access to the process, given that they have no alternative avenue for resolution. Because NFA decisions and reasons are not published, we cannot form a firm conclusion. But from the evidence presented here, there are strong grounds for concluding that on occasion this has indeed been the case. Further, given the large numbers of NFAs, there is reason to suspect that it may not be unusual.

A second barrier a complainant may encounter is being denied an investigation.[91] A decision not to investigate has legal consequences for complainants, since it is only complaints that have been investigated and where a "breach" has been found that can be referred to the DP. It is only those complaints in which the complainant/consumer can take HRRT proceedings if the DP does not act or there is no referral.[92] There has been a strong trend since about 2002/2003 for fewer investigations, with this resource-intensive option reserved for increasingly serious cases. In recent years approximately four per cent of complaints (approximately 80 of about 2,000 complaints closed annually) are formally investigated.[93] While complaint numbers have

90 The HDC decided to take no further action in 925 (46 per cent) of 2,015 complaints closed in 2016/2017; 1,145 (57 per cent) of 2,007 complaints closed in 2015/2016; 1,114 (58 per cent) of 1,910 complaints closed in 2014/2015; and 1,106 (58 per cent) of 1,901 complaints closed in 2013/2014: see Health and Disability Commissioner *Annual Report* (2017), above n 34, at 15; Health and Disability Commissioner *Annual Report* (2016), above n 34, at 14; Health and Disability Commissioner *Annual Report* (2015), above n 19, at 13; and Health and Disability Commissioner *Annual Report* (2014), above n 89, at 14.

91 A significant proportion of complainants express a preference for their complaint to be investigated (personal observation, former Health and Disability Commissioner, Ron Paterson).

92 HDCA 1994, s 45(1).

93 Eighty (4 per cent) of 2,015 complaints closed were formally investigated in 2016/2017, with 61 "breach" opinions; 80 (4 per cent) of 1,958 complaints closed were formally investigated in 2015/2016, with 61 "breach" opinions; 100 (5.2 per cent) of 1,910 complaints closed were formally investigated in 2014/2015, with 70 "breach" opinions; and 115 (6 per cent) of 1,901 complaints closed were formally investigated in 2013/2014,

increased by about 200 complaints each year, this has not been matched by increases in investigation numbers. Where not discontinued, there has been increased use (in approximately 20 per cent of complaints) of referral of the complaint to the provider itself to resolve the matter,[94] and a steady decline in referrals to advocacy.[95] Stable proportions of NFA decisions and numbers of investigations year-on-year despite rising complaint volumes in recent years are strongly suggestive of in-house targets.[96]

What is the explanation for the increase in NFA decisions and the reduced numbers of investigations? A complainant's chances of having their complaint actioned or investigated has depended on which Commissioner was in office. The first Commissioner, Robyn Stent, discontinued 15 per cent (on average) of complaints received; Ron Paterson 34 per cent; and Anthony Hill 50 per cent of complaints received. Similarly, Robyn Stent investigated a much greater proportion of complaints (35 per cent) than the subsequent two Commissioners (8 per cent or less).[97] Yet the explanation

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with 79 "breach" opinions. See Health and Disability Commissioner *Annual Report* (2017), above n 34, at 5; Health and Disability Commissioner *Annual Report* (2016), above n 34, at 5; Health and Disability Commissioner *Annual Report* (2015), above n 19, at 5; and Health and Disability Commissioner *Annual Report* (2014), above n 89, at 6.

94 Referrals to provider have increased from 14 per cent (269) of 1,901 complaints closed in 2013/2014 to 22.7 per cent (457) of 2,015 complaints closed in 2016/2017: see Health and Disability Commissioner *Annual Report* (2017), above n 34, at 15; and Health and Disability Commissioner *Annual Report* (2014), above n 89, at 14.

95 Referrals to the Nationwide Health and Disability Advocacy Service have decreased from 146 (7.7 per cent) of 1,901 complaints in 2013/2014 to 96 (4.8 per cent) of 2,015 complaints in 2016/2017. See Health and Disability Commissioner *Annual Report* (2017), above n 34, at 18; and Health and Disability Commissioner *Annual Report* (2014), above n 89, at 14.

96 The HDC has a performance measure for the number of investigations undertaken and closed per annum. The target is 100 investigations for the 2017/18 year and 120 for the 2019/20 year: see HDC *Statement of Performance Expectations 2018/19* at 12.

97 Investigations were carried out in 32 per cent of complaints closed during Commissioner Stent's term in 1998–1999; 39 per cent in 1999–2000. See Health and Disability Commissioner *Annual Report for the year ended 30 June 1998* (November 1998); Health and Disability Commissioner *Annual Report for the year ended 30 June 1999* (November 1999). Fewer complaints were received annually during Commissioner Stent's term of office, and there were fewer handling options until reforms in 2004. Commissioner Paterson carried out investigations in 7 per cent of complaints closed in 2006/2007, and 8 per cent in both 2007/2008 and 2008/2009. See Health and Disability Commissioner *Annual Report for the year ended 30 June 2007* (November 2007) at 8; Health and Disability Commissioner *Annual Report for the year ended 30 June 2008* (November 2008) at 4; and Health and Disability Commissioner *Annual Report* (2009), above n 19, at 3. Commissioner Hill carried out investigations in 5 per cent of complaints closed in 2014/2015, and 4 per cent in both 2015/2016 and 2016/2017. See Health and Disability Commissioner *Annual Report* (2017), above n 34, at 5; Health

for the increased proportion of NFAs, now approaching 60 per cent, and decreased numbers of investigations is probably more due to a pragmatic and strategic response to dramatic increases in complaint volumes year-on-year than to inconsistent standards between Commissioners. Over the 20 years since 1998 annual complaint numbers have nearly doubled, and the rate of increase has intensified in recent years. In 2016–2017 the HDC received 2,211 complaints, a 13 per cent increase on 2015–2016 and a 41 per cent increase over the preceding five years.[98] The percentage of discontinuances has increased every year since the HDC began operation in 1996. Priority has been given to reducing backlogs of open files and delays in the time taken to resolve complaints. The HDC reports annually on numbers of closed files and average resolution times. Dramatically increasing the proportion of NFA decisions and reducing the numbers of both investigations and advocacy referrals have been used as ways to ration limited staff and other resources.

As the above case studies and these figures indicate,[99] the fact that a complaint raises a prima facie case of a moderate or major departure from expected standards, and that a consumer has suffered significant physical injury or died, does not necessarily mean that the Commissioner will decide to investigate.[100] Certainly, striking an "appropriate" balance between fairness and simplicity, speed and efficiency in selecting the appropriate procedural option in the context of individual complaints is a normative exercise. As

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and Disability Commissioner *Annual Report* (2016), above n 34, at 5; and Health and Disability Commissioner *Annual Report* (2015), above n 19, at 5.

98 Health and Disability Commissioner *Annual Report* (2017), above n 34, at 4.

99 In 2016/2017 HDC closed 2,015 complaints, 71 per cent within three months, 85 per cent within six months, and 92 per cent within nine months; 626 complaints remained open at the end of the year. In 2015/2016 HDC closed 2,007 complaints, 71 per cent within three months, 90 per cent within six months; 430 complaints remained open at the end of the year. See Health and Disability Commissioner *Annual Report* (2017), above n 34, at 11 and 49; and Health and Disability Commissioner *Annual Report* (2016), above n 34, at 12.

100 A further example, not included in the text for space reasons, is an NFA decision case, made almost two years after a daughter's HDC complaint of failures by hospital vascular and medicine registrars to diagnose and treat an iliofemoral DVT, resulting in acute admission requiring life support, the need for surgical removal of blood clots and leg fasciotomies. Her recovery was long and difficult, necessitating further surgery, resignation from her professional career, and leaving her with permanent disability. HDC obtained and accepted expert advice from a vascular surgeon and a general medicine physician, who concluded that her overall care fell well below accepted standards. The hospital undertook to complete various follow-up actions to improve care. In response to the family's protest at the NFA, HDC said it considered the case closed and advised of the option of further complaint to the Ombudsman. The family was aggrieved that they could not take their complaint to the HRRT in the absence of an HDC breach finding (letters on file with author).

well as the subject matter, also relevant are distributive justice considerations vis-à-vis the procedural treatment of other complainants; evidence of risk to public health and safety and its extent; and pragmatic considerations, such as whether this complaint warrants allocating limited resources (time, staff and money) to its investigation. But, calling on the doctrinal-legal and social-legal criteria discussed earlier, I suggest that the combination of serious allegations, initial expert opinion of a moderate or major departure from expected standards commensurate with that found in complaints which were investigated, and serious consequences for the consumer, suggest that greater weight should be attached in the decision to the complainant's needs and interests and the potential risk to public health or safety. The HDC's own policy suggests that these are key factors in deciding to investigate.[101] Where the HDC makes an NFA decision in a complaint with these features, it is submitted that this demonstrates a procedural injustice, and that the inability to challenge the substantive merits of an NFA engages substantive accuracy and justice considerations in a way that ought to be prioritised over speed and efficiency in resolution.

The great majority of investigations where Code breaches are found result in recommendations, but no follow-up proceedings. A Commissioner's "breach" finding, even for serious clinical failings, is increasingly treated as sufficient accountability without the need for further proceedings. Referral to the DP and prosecution is an exceptional step; less than one per cent of all providers complained about per annum are referred to the DP, which amounts to, on average, 10 providers each year in the last three years.[102] The DP took disciplinary or HRRT proceedings in 10 per cent (on average) of investigations concluded each year over the last five years.[103] Since the advent of the complaints regime, discipline in the health field has declined dramatically, from highs of approximately 90 to about 10 to 15 DP-initiated cases annually — a fourfold reduction.[104] Many complaints which formerly

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101 See quotation in the text, above n 45.

102 Eleven providers (0.5 per cent) of 2,015 complaints closed were referred to the DP in 2016/2017; five providers (0.2 per cent) in 2,007 complaints closed were referred to the DP in 2015/2016; and 14 providers (0.7 per cent) in 1,910 complaints closed in 2014/2015. See Health and Disability Commissioner *Annual Report* (2017), above n 34, at 5; Health and Disability Commissioner *Annual Report* (2016), above n 34, at 5; and Health and Disability Commissioner *Annual Report* (2015), above n 19, at 5.

103 Health and Disability Commissioner *Annual Report* (2013), above n 45; Health and Disability Commissioner *Annual Report* (2014), above n 89; Health and Disability Commissioner *Annual Report* (2015), above n 19; Health and Disability Commissioner *Annual Report* (2016), above n 34; and Health and Disability Commissioner *Annual Report* (2017), above n 34.

104 Kim Davies "Fewer Charges are being Laid in the Health Practitioners Disciplinary Tribunal: Should we be Concerned?" (2015) 46 VUWLR 1145. More charges are

would have resulted in a disciplinary charge are now resolved by the HDC process and not referred to the DP. Practitioners are only likely to face prosecution in cases of serious misconduct (typically sexual misconduct, misuse of drugs or fraud).[105] The reduction is explicable partly by the HDC's non-punitive approach, but also by the option, available since 2003, of referral for review of a practitioner's competence or fitness to practise by the registration authorities.[106] The HRRT, too, has a peripheral involvement in the jurisdiction. In the last five years the DP brought on average four civil actions per annum for breach of the Code against providers before the HRRT.[107] The HRRT has only once conducted a defended hearing in an action brought by a consumer-plaintiff pursuant to s 51.[108]

It is hard to accurately calculate average resolution times in recent complaints, including those in which NFA decisions are made or formal investigations carried out. This is for a few reasons: NFA decisions are not published; the HDC publishes less data on complaint resolution times than formerly;[109] and key dates are no longer stated in investigation reports. The last two tactics are surely intended to shield the office from criticism for delays.[110] Nevertheless, resolution times for both preliminary assessments and investigations can be lengthy, typically involving two to three years.[111]

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brought by Professional Conduct Committees than are brought by the DP. These committees are established by the responsible authorities and can lay and prosecute charges on a complaint referred by the Commissioner or on complaints that do not involve a practitioner–consumer relationship and so are outside HDC's jurisdiction.

105 Katie Elkin and others "Doctors disciplined for professional misconduct in Australia and New Zealand, 2000–2009" (2011) 194(9) MJA 452.

106 The philosophy of HDC has emphasised "resolution, not retribution" and "learning not lynching": Ron Paterson "Commissioner's Report" in Health and Disability Commissioner *Annual Report for the year ended 30 June 2002* (November 2002) at 5.

107 These figures include actions settled without the need for a defended hearing: see Health and Disability Commissioner *Annual Report* (2013), above n 45; Health and Disability Commissioner *Annual Report* (2014), above n 89; Health and Disability Commissioner *Annual Report* (2015), above n 19; Health and Disability Commissioner *Annual Report* (2016), above n 34; and Health and Disability Commissioner *Annual Report* (2017), above n 34.

108 *ABC v XYZ*, above n 59. The plaintiff's action failed.

109 HDC stopped including comparative data in annual reports on the number and proportion of complaint files open after 12 months after the Health and Disability Commissioner *Annual Report for the year ended 30 June 2011* (October 2011) at 7.

110 HDC stopped including the date HDC received the complaint in its investigation reports from February 2013 and the date the investigation was commenced from April 2017.

111 The resolution time exceeded two years in eight of 10 complaints decided immediately prior to February 2013, when complaint receipt dates were still being stated. There are media reports of an average of two years to complete investigations, compared with 21 months in 2013/14: see N MacDonald "Complaints rise, two-year wait on health

This is as long as, if not longer than, a civil action.[112] For example, in one complaint made on 29 July 2016, the provisional NFA decision was made on 11 May 2018 and finalised on 22 May 2018, 22 months later.[113] And in a recent complaint about an independent midwife, which was investigated, resulting in a "breach" opinion and referral to the DP, the time between receipt of the complaint and investigation report was two and a half years.[114] These delays are justifiably criticised by both complainants and practitioners.[115] Thus, even absent a concern that fairness may be being routinely subordinated to speed and efficiency, it seems that the latter aims are frequently not being achieved either.

In those few complaints in which there is referral to the DP, and either HPDT or HRRT proceedings, the whole process is lengthy and highly attenuated with multiple assessments and investigations into the same events (preliminary assessment; HDC investigation; DP assessment; HPDT hearing or HRRT hearing (or both); potential High Court appeal processes; potential Ombudsman complaint). In such cases the time taken for the entire process can be well over three years. For example, on 28 June 2013 parents of a young man, who had died of suspected suicide three months earlier, complained about serious deficiencies in his care by a psychiatrist and two nurses. Ten months later an investigation was notified. The expert's first report (for the purposes of the preliminary assessment decision) was received in February 2014 and the second by November 2014. Over a year later (March 2016) the provisional opinion was released to the providers, and three years after the complaint was made (2 June 2016) the "information gathered" section

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watchdog investigations" Stuff.co.nz (online ed, 8 October 2018) <https://www.stuff.co.nz/national/health/107635591/complaints-rise-twoyear-wait-on-health-watchdog-investigations>.

112 The majority of High Court civil cases (84 per cent) are resolved in less than a year (84 per cent of cases resolved in 252 days on average in 2010), but those that proceed and are allocated hearing dates take less than two years (608 days on average). In the District Court, 99 per cent of cases were allocated hearing dates and resolved in less than a year in 2010 (307 days on average), with a small number resolved in less than two years (589 days on average). In the Disputes Tribunal cases are resolved fairly quickly, with cases resolved in 82 days on average. See Law Foundation *A preliminary study on civil case progression times in NZ* (May 2011).

113 Letter from complainant (29 July 2016); HDC provisional preliminary assessment letter 11 May 2018; and HDC final NFA letter 22 May 2018. The circumstances of the complaint are referred to at n 100 above.

114 Health and Disability Commissioner *Midwife, RM B (Case 15HDC00550)* (15 December 2017).

115 See Donna Chisholm "This is a hold up" *North & South* (New Zealand, May 2013); and Gaeline Phipps "Did a three-year investigation into a drug overdose make patients safer?" *New Zealand Doctor* (New Zealand, 13 September 2017).

was released to the complainants.[116] The final opinion, making findings of breach of Right 4(1) by both the psychiatrist and the DHB, was released on 17 February 2017, three years and eight months after receipt of the complaint.[117] In the independent expert advisor's opinion, the psychiatrist's care, in failing to identify the young man's worsening psychotic condition and to initiate appropriate treatment, amounted to a "severe deviation from expected standards".[118] Nevertheless, the Commissioner did not refer the provider to the DP and he made no reference to the expert's assessment and gave no explanation for this departure from usual practice.[119] (Had he made the referral, at least a further year would be added to the timeframe, taking the entire process close to five years.) The provider's first apology to the parents, a recommendation of the HDC's, was unacceptable.[120] The parents complained to the Ombudsman, basing their complaint on additional deficiencies in their son's care communicated to the HDC which were omitted from the final decision. A year later (now nearly five years after the complaint), that decision was released, not upholding their complaint.[121] The parents have now filed a (s 51) civil proceeding in the HRRT, and a coroner's inquest is still to come. The whole process has "almost broken her family", according to the young man's mother.[122]

Complaints referred to the DP are the very ones where prompt and decisive action to protect the public is required. The HPDT may ultimately consider that public protection requires cancellation or suspension of registration. Yet, barring interim suspension of a registered practitioner from practice, such protective action cannot be considered for some three years, after the matter has made its way slowly through HDC's confidential processes.[123]

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116 The complainants argued that some key facts relating to deficiencies in care were omitted and disputed the correctness of other facts in the "information gathered" section of the provisional opinion, but the HDC declined to amend these in the final opinion.

117 See Health and Disability Commissioner *Psychiatrist, Dr C, Southern District Health Board (Case 13HDC00859)* (16 February 2017) ("the Psychiatrist case").

118 At 71.

119 At 71. For another example, see the recent HDC decision in Health and Disability Commissioner *General Practitioner, Dr A, Medical Centre (Case 17HDC00334)* (11 June 2018) at 8–9.

120 See Eileen Goodwin "Mother slams apology from Dunedin psychiatrist for shortcomings of her son's care" *The New Zealand Herald* (online ed, Auckland, 16 June 2017).

121 Leo Donnelly *Final opinion on complaints against the Health and Disability Commissioner* (Ref 436912, 16 March 2018).

122 Charlie Dreaver "Long, 'painful' wait for change following suicides in DHB care" Radio New Zealand (online ed, 22 March 2018).

123 There is a (seldom used) power for a registration authority to suspend or attach conditions to a practitioner's practising certificate at any time, including when an HDC investigation is pending: see HPCAA 2003, s 69.

A law reform report in 2001 into these issues identified the problems of multiple inquiries into the same events, with the same witnesses called time and again, and parties' "complaint fatigue". A recommendation of the HDC becoming a "One-Stop-Shop", conducting the principal investigation for all purposes, financial and non-financial, was seen as a step too far at the time.[124] But, despite the HDC gaining new statutory powers in 2003 designed to give it flexibility in resolving complaints, these issues have not been solved. The complaints process itself needs streamlining for complaints at the most serious end, so that there is a single, timely inquiry for most purposes, leading to prompt and decisive action in the public interest, instead of the current attenuated processes with multiple inquiries into the same events.[125]

V Dissatisfied Party's Means of Challenging Commissioner Decisions

Dissatisfied complainants cannot decide instead (or as well) to take a medical negligence action for damages. This contrasts with the position in Australia, for example, where a number of states have complaints entities like the HDC, with similar broad powers to take no action on complaints. But complainants always have the option of suing the practitioner or hospital in the courts instead of or as well as pursuing their complaint. What other options exist to challenge an adverse HDC decision?

Either party can make a complaint to the Ombudsman "relating to a matter of administration".[126] The Ombudsman has a discretion to investigate on very broad grounds, which include that the HDC action was unreasonable, unjust, oppressive, or wrong.[127] This looks like a broad appellate power on error of facts and law, just what the parents in the ophthalmologist case, for instance, needed. Despite these wide statutory grounds commensurate with appeal on the merits, the Ombudsman has never interpreted its power as such. It has said that it will only intervene if the procedure followed by the Commissioner, for example in the preliminary assessment prior to an NFA decision, was procedurally unfair or the decision itself was substantively unreasonable (in the administrative law sense of irrationality). The key reason proffered for this self-imposed restriction on its own jurisdiction is that, given the Ombudsman's lack of expertise and the HDC's specialist

124 Cull, above n 35, at 86.

125 It is accepted that an ACC claim would still be determined separately, and that a separate coroner's inquest may be required.

126 Ombudsmen Act 1975, s 13(1); the Health and Disability Commissioner is an organisation subject to the Ombudsman's jurisdiction.

127 Section 22.

expertise, it is impracticable and possibly illegitimate for the Ombudsman to substitute its view for the specialist reviewer's view of the substantive merits of the case.[128] And, even if it found that the HDC had handled the complaint unreasonably or unfairly, the Ombudsman would never recommend that the Commissioner change his decision. At most, it would refer the complaint back to the Commissioner to re-decide in light of the report, such that the Commissioner would likely be free to confirm his original decision.[129] The Ombudsman decisions reviewing the HDC in "the hospitalised patient with COPD" and "the inter-hospital transfer" cases illustrate the point.[130] They confirm that the evaluation of expert medical opinion and the NFA decision involve the discretionary exercise of the HDC's judgement, with which an Ombudsman would not interfere, "unless the outcome appear[ed] to be capricious".[131] The focus is studiously on the fairness of the procedure in handling complaints and the adequacy of reasons for decisions. Recommendations address procedural flaws; in one case, the recommendation was for an apology and a self-review of internal practice.[132] In the other, there was a bare finding that the HDC's assessment of the complaint was unreasonable and a recommendation that she be given information withheld from her, but never a suggestion that the HDC notify an investigation or revise its NFA decision, as the complainants sought.

The Commissioner's decisions are amenable to judicial review, but this option is prohibitively expensive for almost all complainants.[133] And it suffers from the same limitations as the Ombudsman's process. A reviewing court will confine itself to defects in procedural fairness and errors of law and will be most reluctant to review the merits or substantive fairness of an HDC decision, unless it meets the high threshold of substantive unreasonableness. A good illustration is provided by *Stubbs v Health and Disability Commissioner*, in which the plaintiff bariatric and liver surgeon, in respect of whom the Commissioner had made a "breach" finding, challenged the finding on grounds which included that it was substantively unfair

128 See D McGee *Review of the reviewers* (unpublished paper, March 2010). The following is "boilerplate" wording commonly included in Ombudsman decisions on HDC complaints: "My investigation is not an appeal process. I would not generally substitute my judgment for that of a specialist decision-maker such as the HDC. Rather, I consider the substance of the act or decision and the procedure followed by the HDC, and then form an opinion as to whether the act or decision was properly arrived at and was one that HDC could reasonably make." See Wakem, above n 79, at 2.

129 See Ombudsman Act 1975, s 22.

130 See Wakem, above n 79, at 4; and Paterson, above n 72.

131 Paterson, above n 72, at 8.

132 At 9.

133 There have been three judicial review actions of the HDC, two brought by providers and one brought by a complainant.

and without a rational factual basis. Latching on to the use of the word "opinion" in s 45 of the HDCA, the High Court held that, assuming the Commissioner's "opinion[s]" were amenable to review, "hard look" judicial review was not appropriate where it was sought to challenge the substance of the Commissioner's opinion, because:[134]

> The Commissioner's opinion is just that, an opinion not directly affecting the rights or liabilities of the heath care provider ... ; the prescribed process has a high level of "fairness" attached with its insistence on referral of any proposed negative comment ... to the health care provider before the final report is prepared; the Commissioner has a high level of expertise in the field ... ; the report of the Commissioner is an opinion albeit well informed but where there may be genuine scope for disagreement ... .

While one can question the accuracy of the description of an HDC "opinion" as "just" "an opinion not directly affecting the rights or liabilities [of the parties]", the Court's approach to judicial review is otherwise entirely orthodox.[135] And, even if successful in establishing a ground of review, the court's remedial power is discretionary, often resulting in a referral back to the original decision-maker to remake the decision taking account of the court's directions.[136]

Meek v Health and Disability Commissioner is the only judicial review case brought by a complainant to date.[137] It is also unusual in that Mr Meek was a litigant in person. He made three complaints to the HDC, alleging that a DHB's Mental Health Team's failure to engage with him and its policy to restrict any medical response to his self-harm and suicide attempts to what was medically necessary was cruel and improper. NFA determinations were made on all three. His case on review was that the Commissioner's assessment *process* was unfair, in that the Commissioner had not given him an opportunity to comment on the DHB's responses before the NFA

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134 *Stubbs v The Health and Disability Commissioner* HC Wellington CIV-2009-485-2146, 8 February 2010 at [35] per Ronald Young J (references omitted).

135 The statement is inaccurate because the legal rights of both parties *are* directly affected by an HDC "opinion". The consumers' right under HDCA 1994, s 51 to take further HRRT proceedings depends on the outcome of the investigation, as does the Commissioner's ability to refer a provider to the DP and the DP's discretion whether to institute further proceedings.

136 But see *Meek*, above n 16, at [80] in which Clifford J took the unconventional step of recommending to the Commissioner that he refer Mr Meek's complaints to advocacy, though no order was made to that effect.

137 Above n 16. Unsurprisingly, the two previous judicial review challenges (both unsuccessful) have been brought by providers, who are more likely to have professional indemnity insurance cover to finance expensive High Court proceedings.

decision, and he did not consider those responses factually accurate. The Commissioner urged on the reviewing court that an NFA decision is highly discretionary, made by him within his area of expertise, and the Court should not subject the decision to "overly intensive review".[138] He said that the "simple, speedy and efficient resolution" purposes pointed against a "procedurally intensive approach", especially at the assessment phase.[139] The Commissioner had limited resources, and he should be "trusted ... to properly 'triage' complaints".[140] The High Court rejected the Commissioner's plea for light-handed review. While preliminary assessment is an important part of the "simple, speedy and efficient" resolution, Clifford J said that "the first requirement is that the resolution of complaints be fair".[141] Where, as here (and in contrast to *Stubbs*), an applicant's challenge on review was "a classic challenge to process", the heartland of judicial review, the Court would not be diffident about subjecting the decision-making process to close scrutiny.[142]

Despite the limits of judicial review, both the Ombudsman and the *Meek* decision have set about strengthening parties' procedural rights in the HDC complaints process. The result is a developing duty for the HDC to give complainants all the information it obtains during the preliminary assessment phase, such as the provider's response and any preliminary advice from a clinical advisor, with an opportunity to respond, before a final NFA decision can be made in reliance on that information.[143] Recent English case law has also affirmed that the common law duty of fairness requires that decision-making bodies, whether administrative or adjudicative, should not consider relevant material in reaching a provisional or final conclusion, whether supportive or adverse to their case, without disclosing it and giving the affected person the right to comment on it.[144] The principle applies both when considering whether to investigate and at the investigation stage. The High Court in *Meek* also held that, where the Commissioner has requested that certain specific, key witnesses provide information during the assessment phase, he should ensure that he first receives and considers it prior to making the NFA decision, in order to gain a balanced perspective of the complaint.[145] The Court held that the Commissioner should clarify all important factual discrepancies before he is in a position to make an NFA decision (a principle

138 At [57].
139 At [58].
140 At [59].
141 At [62].
142 At [61].
143 At [63]–[64]; and Wakem, above n 79.
144 *Miller*, above n 47, at [43], [49] and [50].
145 *Meek*, above n 16, at [73].

presumably applicable also to investigations).[146] This is significant, because the inability to reconcile the factual versions of the parties is a common reason resorted to by HDC for an NFA decision or making "no breach" findings, a ground which will only now be available to the HDC after it has made a reasonable attempt to reconcile the factual inconsistencies and make factual findings. Sympathetic to the absence of an appeal right, reviewing bodies have enhanced parties' procedural rights, recognising the need to do so in a process which, in practice, nearly always represents their only, and certainly their best, opportunity to have their grievance heard and other needs for bringing the complaint met.

The lack of appeal rights in the HDC process contrasts with much greater access to justice afforded to parties dissatisfied with an ACC decision. Anyone declined cover or entitlements can challenge the ACC's decision. The ACC will first attempt to resolve the dispute without a hearing via its own internal dispute resolution mechanisms. It has power to revise decisions it considers in error at any time and for whatever reason.[147] The next step is external review. If dissatisfied with the outcome of review, either party has a broad appeal right on a question of fact or law to a District Court.[148] The hearing is a rehearing at which the claimant is entitled to be heard;[149] the Court has wide powers to admit new evidence, which happens frequently.[150] Thereafter, there are two further levels of appeal to the High Court and the Court of Appeal with leave or special leave, limited to questions of law.[151] This generous access to justice in relation to a patient's financial interest contrasts strikingly with the lack of *any* opportunity for external review or appeal from adverse HDC decisions in a complaints process designed to address their non-monetary needs and motivations after the same adverse event. Given that the studies indicate that compensation may not be the sole or even a dominant motivation for complaining and that complainants attach considerable importance to obtaining non-monetary remedies, the difference is indefensible.[152]

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146 At [67].

147 ACA 2001, s 65.

148 Section 149.

149 Section 155.

150 Section 156.

151 Sections 162 and 163.

152 Bismark's study of New Zealand patients found that only one in four patients or relatives who made a complaint to the HDC after an adverse event also made a claim for monetary compensation. Those who complained to HDC were primarily interested in securing corrective measures (50 per cent) and an explanation or apology (40 per cent): see Marie Bismark and others "Accountability sought by patients following adverse events from medical care: the New Zealand experience" (2006) 175(8) CMAJ 889 at 891.

The Privacy Act 1993 (PA), the Human Rights Act 1993 (HRA), and the HDCA were all passed within a year of each other. All are based on the same broad template, which created a complaints regime with access to the HRRT. The inability to challenge NFA decisions and adverse HDC opinions, and the restrictive access to the HRRT under the HDCA contrast starkly with the complaints regimes under both the PA and the HRA. The complaints regime under the PA is similar in many respects to the HDC's. The Privacy Commissioner can also decide to take no action on a complaint, in which case a complainant cannot then bring HRRT proceedings, as under the HDCA.[153] HRRT proceedings can only be brought, either by the Director of Human Rights Proceedings or the aggrieved person personally, *after* a Privacy Commissioner investigation, no matter how brief. After the investigation the Commissioner forms an "opinion" as to whether an "interference with the privacy of an individual" has occurred.[154] At that point the aggrieved individual can bring proceedings personally in the Tribunal, claiming an interference with privacy and seek a remedy (such as damages), whether or not the Privacy Commissioner has formed an opinion that such an interference has occurred.[155] The key difference to the HDCA is that an aggrieved person can bring a civil action personally after a Privacy Commissioner or DP "opinion" that the complaint "does not have substance", equivalent to an HDC "no breach" opinion.[156] This is effectively an appeal right from an adverse Commissioner decision. And this is despite the fact that a victim of an interference with privacy can still choose to sue the perpetrator for damages for breach of privacy in the courts instead of or as well as complaining.[157]

The HRA governs complaints about discrimination on prohibited grounds by public bodies and private persons. Of the three complaints processes the complainant or aggrieved person has much greater control over their own complaint and the parties have the most liberal access to the HRRT. Under the HRA there is virtually unrestricted access by *both parties* to the HRRT. As Miller J said in the *Child Poverty Action Group* case, the legislative history of the HRA indicates that the legislature has attached greater importance over time to "private enforcement" through HRRT proceedings, compared

153 See Privacy Act 1993, s 71.

154 Section 66 defines an "interference with ... privacy" as breach of an information privacy principle (IPP) plus an adverse consequence to the complainant (such as emotional harm). The exception to this is IPP 6 (access), where breach of that principle alone is enough to amount to an "interference with ... privacy".

155 Section 83; and see also *Perfect*, above n 51, at [42].

156 Section 83.

157 See, for example, *Hosking v Runting* [2005] 1 NZLR 1 (CA).

to the PA and the HDCA.[158] It is not necessary for an aggrieved individual to do more than lay a complaint with the Human Rights Commission before he or she has the right to institute proceedings before the HRRT. This is the case whether the individual is the complainant, the person aggrieved (if not the complainant), or the person against whom the complaint is made.[159] All in all, victims of discrimination and an interference with privacy who make complaints are much better served in terms of access to justice than HDC complainants and consumers.

One could be forgiven for suspecting that the driver of the difference in personal access to the HRRT is pragmatic, rather than principled; that the breadth of party-initiated access to the HRRT is inversely correlated with the extent to which the legislature contemplated that parties to the complaints process in question might utilise it. Under the HRA and the PA the numbers of complainant-initiated proceedings before the HRRT appear still to be manageable,[160] although there were recent rumblings about "beyond acceptable" delays and waits for HRRT hearings.[161] There may well

158 See *Attorney-General v Human Rights Review Tribunal* [2006] 18 PRNZ 295 at [47] (the Child Poverty Action Group had standing as a complainant, even though not a victim of discrimination).

159 See HRA 1993, s 92B. See also *Attorney-General v Human Rights Review Tribunal*, above n 158, at [58]; *Perfect*, above n 51, at [43].

160 See the HRRT database at NZLII "Human Rights Review Tribunal of New Zealand" (2018) <www.nzlii.org>. The largest number of proceedings are brought under the Privacy Act 1993, followed by the HRA, with many brought by complainants personally rather than the DP. The fewest cases emanate from the HDCA jurisdiction, all (except one) brought by the DP. The HRC Annual Report 2016 (the latest available) does not indicate how many complainants take action in the HRRT personally, but states that the Director made 17 decisions to provide representation: 13 for representation in the HRRT; decisions to take NFA were made in 11 cases; and 33 decisions were made not to provide representation. See *Human Rights Commission Annual Report 2015/16* (November 2016) at 34. Under the Privacy Act 1993, 37 complainants took proceedings to the HRRT personally in 2017; in 2016, complainants filed 34 cases on their own account in the HRRT; and in 2015, complainants filed 24 proceedings personally in the HRRT. See Privacy Commissioner Annual Reports 2016/2017 at 9; 2015/2016 at 19; and 2014/2015 at 15.

161 This was due to an unprecedented increase in the Tribunal's workload in 2015 and 2016 and because the HRA 1993 did not allow the appointment of a deputy chair to assist the Chairperson to keep pace with the large inflow of new cases. See *Wall v Fairfax New Zealand Ltd (Delay)* [2017] NZHRRT 8; and Nikki MacDonald "Justice denied — Human Rights Tribunal claim delays balloon to two years" Stuff.co.nz (online ed, 27 July 2018) <https://www.stuff.co.nz/national/105802681/justice-denied--human-rights-tribunal-claim-delays-balloon-to-two-years?rm=m>.

have been a legislative concern that permitting parties to HDC complaints more liberal access to the HRRT might result in a flood of cases, particularly from registered providers, such as doctors, whose insurance would cover litigation costs including legal representation.

VI Options for Reform

In summary, the injustices in the HDC complaints process with which I am principally concerned are that:

1) A complainant or consumer cannot challenge the substantive merits of an NFA decision except by internal review;
2) There is no opportunity for a complainant or consumer to challenge the substantive merits of a "no breach" opinion, and little opportunity for a provider to do so in respect of a "breach" opinion;
3) There are significant numbers of delayed decisions, especially in serious cases in which further proceedings are taken.

I have argued that access to justice in the HDC complaints process is overly restrictive. This is primarily an institutional design issue, in that review and appeal rights were never given in the HDCA when enacted, unlike in the PA and HRA. Wide discretionary powers were created, partly justified by the need to give the Commissioner flexibility and discretion in handling complaints. This has enabled Commissioners to ration access to the publicly funded resource of investigation. Climbing proportions of NFA decisions and ever-fewer investigations is perhaps an inevitable response by an under-resourced state agency to dramatic increases in complaint volumes. When there are high levels of dissatisfied complainants, however, there is the risk that they will boycott the complaints regime, thereby foregoing their only available remedy. Such a result would be contrary to the public interest. The system relies on complainants bringing concerns about poorly performing practitioners and organisations to light, so the HDC and other "patient safety" agencies can identify and take appropriate action. There are a number of reform options, each of which strikes a different balance between fair resolution, on the one hand, and simple, speedy and efficient resolution, on the other.

A *Relevant statutory criteria to confine broad discretionary powers*

The Commissioner's discretions to select a resolution option in s 33(1) and whether to investigate in s 40(1) are especially broad and unconstrained

with no specified factors confining them. So too is the DP's discretion in bringing further proceedings.[162] The HDC's NFA discretion lacks the condition attached to referral of the complaint to the provider: that "the complaint does not raise questions about the health or safety of members of the public".[163] This qualification should be explicitly applied to the NFA discretion, as well as referral to advocacy and mediation. The wishes of the complainant and consumer should be added as a relevant factor to s 33(1), so that complainants have the opportunity to influence the choice. Relevant criteria for s 40(1) should thus include: the wishes of the complainant/consumer; the seriousness of the alleged conduct; and whether "the public interest (whether for reasons of public health or public safety or for any other reason)" requires an investigation.[164]

In the absence of clear criteria specified in the statute, the HDC should be encouraged to develop, consult on, and publish its own policies and guidelines to structure its broad discretionary powers, specifying the criteria it considers relevant to making NFA decisions and the circumstances in which it will notify an investigation, as was done with its *Naming Policy*. The purpose is to assist it in making transparent, consistent, and fair decisions, and to enable parties to address the relevant criteria in submissions to the HDC.

B *Internal dispute resolution*

Significant complainant dissatisfaction revolves around exercise of the discretion to take NFA on a complaint, and whether to refer a complaint for investigation. One initiative adopted by the New South Wales (NSW) Health Care Complaints Commission in response to similar dissatisfaction was an early resolution service, which seeks by a variety of techniques to achieve an early resolution of complaints that do not involve significant issues of public health and safety, which would otherwise be discontinued. In 2015–2016, 11.9 per cent of complaints were resolved during assessment, so that the rate of discontinuances dropped to 45.3 per cent of complaints.[165]

Efficiency would suggest that the HDC should attempt to resolve disputes in the first instance. The NSW Act also provides for a mandatory internal "review" at the request of the complainant, both after a preliminary

162 HDCA 1994, ss 45(2)(f) and 47(1); and HPCAA 2003, s 94(1).

163 HDCA 1994, s 34(1)(d).

164 Adapting s 44(3)(c).

165 Health Care Complaints Commission *Annual Report 2015–16* (2016) at 28.

assessment and an investigation decision.[166] Complainant take-up, especially review of assessment decisions, as well as decision changes after review confirm the value of the mechanism.[167] In the absence of appeal rights, statutory rights to internal review of assessment and investigation decisions merit consideration.

C *External review or appeal*

A mechanism for external review or appeal of an adverse HDC decision is the key change required to significantly improve fairness in handling complaints. Dissatisfied complainants should be extended a right to challenge an adverse NFA decision and both parties the right to challenge the outcome of an investigation. The absence of an appeal right operates particularly harshly on complainants whose complaints are discontinued, and where the Commissioner has made a "no breach" finding after investigation. They have reached the end of the complaint-resolution road, so to speak, with nowhere else to turn. While the finality of the process is consistent with the simple, speedy, and efficient aim of the legislation, it is submitted that the balance struck by the Act compromises the ability to achieve fair outcomes too much.

First, amendment of the HDCA to reverse the *Marks* decision is required, so that third-party complainants, who are not the consumer, are able to bring proceedings pursuant to s 51.[168] Secondly, statutory appeal rights need to be created. A pragmatic solution, which could be accommodated easily within the existing process, would be to expand the HRRT's jurisdiction, an option which would minimise structural changes to the process. And the

166 Health Care Complaints Act 1993 (NSW), ss 28(9) and 41(3). At the assessment stage the review is carried out by staff independent of assessment staff. Providers are entitled to make submissions about proposed post-investigation actions: see s 40.

167 An average of 316 requests for review were made annually, equating to 7.8 per cent of assessment decisions over the last five years. An average of 25 or 7.4 per cent of all reviews annually resulted in a changed assessment decision. Reviews were requested in an average of 1.9 per cent of all investigations over the last five years. In two of the five years, a single investigation decision was changed after review. See Health Care Complaints Commission *Annual Report 2010–11* (2011); Health Care Complaints Commission *Annual Report 2011–12* (2012); Health Care Complaints Commission *Annual Report 2012–13* (2013); Health Care Complaints Commission *Annual Report 2013–14* (2014); and Health Care Complaints Commission *Annual Report 2014–15* (2015).

168 This can easily be achieved by substituting the words "the complainant and aggrieved person (if not the complainant)" for the words "aggrieved person" in ss 51 and 57(1), and wherever else it appears in ss 51–58 of the HDCA 1994.

HRRT already has experience in determining complaints from the HDC.[169] Dissatisfied complainants and aggrieved persons would be permitted to bring HRRT proceedings personally challenging: a Commissioner NFA decision under s 38(1); dissatisfaction with the outcome of any form of resolution; or an HDC "no breach" finding after investigation. Fairness and equal treatment dictates that dissatisfied providers should similarly be given access to the HRRT to appeal "breach" opinions. This would give the HRRT a broad power to review a Commissioner's actions and decisions, as advocated in *Perfect*.

An appeal mechanism such as this has been resisted to date because of concerns about delays and ongoing litigation, threatening the speedy and less formal resolution focus of the Act. It has been argued, however, that the legislative balance between finality and fairness is wrongly struck. A second concern is that appeal rights would favour well-resourced and insured providers with little to lose, who would, it is feared, appeal every "breach" opinion. This "inequality of arms" issue is valid, where the complainant or consumer is bearing the cost of further proceedings personally, but a provider's costs are underwritten. But it is surely perverse to address it by withholding appeal rights altogether. Other options exist to level the playing field. The former medical disciplinary process, for example, addressed the issue through a disciplinary levy on practitioners, out of which it paid a complainant's reasonable legal costs. Or the appeal rights of providers may need to be curtailed.[170] The usual means are through leave requirements, with the prospect of damages and costs awards acting as a disincentive.

D *Delays in serious cases*

Minimising delays in the HDC's investigation processes is partly a matter of appropriate funding. As a $12.5 million per annum organisation employing 67 FTE staff, the HDC is a fairly "lean machine".[171] Adequate resourcing is critical to achieving an appropriate balance between timely resolution and access to justice. It would certainly enhance the accountability of the HDC and help to keep governments honest in terms of allocating sufficient resources to the HDC to enable it to fulfil its statutory mandate, if parties denied access to the state-funded complaints process because of Commissioner decisions

169 An appeal right would dispense with the requirement for parties to file detailed pleadings.

170 It is interesting to note, however, that under the Privacy Act 1993 the person against whom the complaint is made cannot bring HRRT proceedings, if dissatisfied with a Commissioner "opinion" that the complaint has substance.

171 See Health and Disability Commissioner *Annual Report* (2017), above n 34, at 43.

rationing access to it had an alternative avenue to seek resolution, even if at their own cost.

But, I suggest, the problems can to some extent be circumvented through a redesign of the complaints process in order to streamline it. There is a strong argument for adding as a resolution option available to the Commissioner, after preliminary assessment of a complaint, that the Commissioner may refer a provider directly to the DP in clear cases, leapfrogging the Commissioner's investigation. The DP could proceed by laying a disciplinary charge before the HPDT in respect of registered providers, or by taking a civil action straight to the HRRT in respect of unregistered providers. The purpose would be to dispense with the lengthy and confidential HDC investigation, shaving at least two years off complaint resolution times. These are the most serious complaints, the ones likely to end up in the DP's hands in any event, because of the need for action to protect public health and safety. It is suggested that in respect of these complaints the public interest is best served by formal, public proceedings, in which both parties have the full panoply of procedural protections (including appeal rights), brought without delay before tribunals (the HPDT or the HRRT) with appropriate protective powers, rather than the HDC's confidential investigation process followed by unenforceable recommendations.

VII Conclusion

In 2011 medical law doyen Professor Peter Skegg claimed that New Zealand's legislated Code of Rights and the HDC complaints process was "a fortunate experiment", drawing a contrast between these and that other "unfortunate experiment", for which New Zealand is notorious.[172] And, in many ways, this is true. Our health regulatory arrangements are the envy of many thought leaders in health systems the world over, combining: virtually non-existent criminal prosecutions of health practitioners; the absence of the tort action which is so inimical to patient safety initiatives; an accident compensation scheme which takes the humane approach of prioritising injured patients' access to compensation for injury over making compensation dependent on proof of a provider's fault; and a complaints regime that is informal, largely free and lawyer-free, independent, and able to resolve more minor complaints

172 See PDG Skegg "A fortunate experiment? New Zealand's experience with a legislated Code of Patients' Rights" (2011) 19 Med L Rev 235 at 235, referring to the "unfortunate experiment" undertaken by Associate Professor Herbert Green at National Women's Hospital from 1965, leading to the establishment of the Cartwright inquiry and report, see above n 26.

by conciliatory means.[173] Further, the complaints regime and the Code fill a gap in pre-existing health regulatory systems, by extending regulation to unregistered providers. The jurisdiction over health organisations, such as hospitals, means that Commissioners can take a system approach in their investigations when appropriate, making recommendations directed at systemic weaknesses. Because the complaints regime takes care of most complaints, professional disciplinary cases and other legal proceedings against health providers are unusual. New Zealand's is a low-blame, although not entirely a no-blame, system.

There is much here to preserve and protect. But a charge can nevertheless be made with justification that successive governments have been and remain in breach of their side of the social contract underpinning the citizen's loss of the tort action. Access to ACC cover and compensation only partly fulfils the state's side of the bargain, as was recognised by the creation of a complaints regime designed to address consumers' non-financial needs after an adverse event. All too often complainants and consumers who utilise the complaints regime, which is the only avenue available to them to address their grievances, are denied access to justice. Over half of those who make a complaint are turned away without any remedy from the process with nowhere else to turn. If their complaint is accepted into the process, they are not able to choose or influence the choice of resolution option. And if theirs is one of the very small minority of complaints the Commissioner decides he will investigate, neither party can challenge on appeal the merits or substantive fairness of the Commissioner's decision. That decision may depend on fortuities, such as factual findings which have never been forensically tested, or an expert advisor's opinion, the choice of whom they have no influence over and whose opinion they cannot test by cross-examination. These are the very cases in which consumers would have had a right to bring a tort action before the advent of the ACC scheme. There would be less concern if alternative legal avenues existed for complainants to seek a remedy, but there are effectively none, unless a coroner's inquest can be subverted. Persistent backlogs and delays have also dogged resolution, particularly of serious complaints, with lengthy and multiple investigations into the same issues. The complaints process requires streamlining to enable earlier, decisive action to be taken in the public interest, rather than the public and parties having to wait for a tortuous and inflexible procedure to work itself through.

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173 See Ian Kennedy and others *The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995: Learning from Bristol* (The Bristol Royal Infirmary Inquiry, July 2001) ch 26 at [35]; and David Studdert and Troyen Brennan "No-Fault Compensation for Medical Injuries: The Prospect for Error Prevention" (2001) 286(2) JAMA 217.

The complaints process is now 20 years old: there has been plenty of time for processes to evolve and to "bed in". It is time now to take a holistic look at the jurisdiction in light of the aspirations of its creators. The key issues and structural injustices in the process are now clearly apparent, the key one being the lack of any means for parties to challenge the substantive fairness of Commissioner decisions. While retaining its many strengths, it is time to recalibrate the balance between simple, speedy and efficient and fair resolution, so that it can justifiably be claimed that New Zealand's HDC complaints regime and Code of Rights is indeed a fortunate experiment.