Submission on Health and Disability Commissioner's Consultation on Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights

1. These submissions are made on behalf of the Cartwright Collective. The Cartwright Collective (CC) is a group committed to monitoring the implementation of the recommendations of the *Report of the Cervical Cancer Inquiry* 1988 (the Cartwright Report). (A description explaining more fully the mission of the Cartwright Collective and its current members is in Appendix 1). The submissions are written by Professor Joanna Manning, a member of the Cartwright Collective and professor of Law at the Auckland Law School, University of Auckland, specialising in health law, policy, and ethics. Where the submission uses the pronoun "I", it refers to Professor Manning.

2. The Cartwright Collective made a submission to the Health Select Committee (HSC) on the Petition of Renate Schutte: A right to appeal decisions made by the Health and Disability Commissioner; Petition no 2017/535; presented 22 June 2020. I attach it and ask that it be treated as part of this submission. I have assisted numerous complainants and some providers in bringing and responding to HDC complaints. Many have agreed to their names being identified, and their complaints and experiences used to inform this and the HSC submission. I set out some of these case studies in the earlier HSC submission, and I have come across more since. I have not, however, used those experiences as specific case studies in this submission, because I have endeavoured not to be too repetitive and because this submission is directed to the HDC, which is well aware in any event of the sorts of complaints in which NFA decisions are made. But I ask that the case studies in the HSC submission be used to inform this submission.

3. I have published two articles on access to justice in the Health and Disability Commissioner complaints regime, which I attach:

   (i) Manning, J, "'Fair, simple, speedy and efficient'? Barriers to access to justice in the Health and Disability Commissioner Complaints Process in New Zealand" [2018] *New Zealand Law Review* 611-656

   (ii) Manning, J, "Access to justice and accountability: The quest for a right of appeal in New Zealand's Health and Disability Commissioner complaints scheme" (2023) 30 Journal of Law & Medicine 822-838.

On a right to appeal

4. The HDC together with a state no-fault compensation scheme ACC is in principle a good system. It enables decision-makers to take a "system" approach to adverse medical events when appropriate, and is free and ostensibly lawyer-free. Few are seriously advocating a return of a right to sue in the courts for all of the reasons Owen Woodhouse advocated back in 1968! The Cartwright Collective does not.

5. But the HDC complaints system is "broken" and isn't delivering justice in a large number of complaints.

6. Remember the unique context! The civil damages action for personal injury performs three key functions: a compensatory mechanism; an accountability mechanism; prevention & deterrence. ACC is designed to perform the first; HDC is intended to perform the second; and ACC/HDC (and other regulatory agencies, such as in the health sector, the Health Quality and Safety Commission) the third.

   Complainants/patients injured by their health care have relinquished their right to bring a civil damages action in the courts, because of the ACC legislative bar. In return, they have entitlements to ACC compensation & rehabilitation to satisfy the first (compensatory) function; and they have access to the HDC complaints regime to substitute for the second (accountability) function. This exchange is referred to in the ACC legislation and by courts as a "social contract" between the government and its citizens. Given the absence of a right to sue, it is important that the complaints regime, filling the gap, is strong and robust. It is submitted that the HDC, in the way in which it is currently implementing its complaints regime so as to deny access to some 1,000 plus complainants per year to its resolution options, especially an investigation, through its "No Further Action" decisions, is in breach of that social contract, in that it is denying large numbers of complainants access to justice and accountability. For those complainants, a NFA decision is the end of the road for their complaint. They have no alternative option to have their complaint determined on the merits. This dismissal of their complaint, together with a lack of any appeal right from adverse HDC decisions, is egregious when it is recalled that there is no civil damages action for death/personal injury in NZ. If you take rights away (the right to sue), you have to give people *something* in return!

7. Almost 50% of complaints made to the HDC every year are dismissed with a No Further Action decision after a preliminary assessment without investigation or other form of resolution. The 2023 figs are representative of those since about 2008, when the HPCA Amendment came into force: 1,463 NFA decisions of 3,048 complaints; 48%. This brings a complaint to a complete halt; there's nothing further a complainant can do to ensure that their complaint is heard and determined. NFA decisions are not confined to low-level complaints, but often occur in complaints making (1) serious allegations, (2) where an expert advisor is critical in some respects of the care, and (3) there had been a serious outcome (death or serious disability). I refer to complaints with these three incidents as a "serious complaint." The current Commissioner, Ms Morag McDowell, has herself conceded that only 1/3 of NFA decisions occur in truly low-level complaints,[1] leaving approx. 1,000 pa dismissed for NFA in non-low level and/or "serious" complaints. Only approx. 150 complaints pa are investigated. In contrast, over approx. 600 complainants a year are the victim of NFA decisions in non-low level or "serious" complaints. No NZer should have to plead for an HDC investigation in a serious complaint, in which a family member has died or been seriously injured.

[1] See Health and Disability Commissioner, submission letter to Health Select Committee 5 November 2021.

8. Internal review. The HDC's Internal review process is not widely known nor publicised by HDC, and is confined to exceptional cases of new evidence or procedural error. A broader, true internal review is a star, and should be a routine part of any agency's processes in any event. But on its own it is insufficient to satisfy the demands of a fair procedure. Internal review lacks sufficient independence. It involves a review by the same decision-making agency, albeit by different personnel. While a start, it can never substitute for an appeal on the merits to a truly independent decision-maker.

9. Judicial review action and complaint to the Ombudsman not the equivalent of appeal. The "options" for disgruntled complainants and consumers referred to by HDC are nowhere near equivalent to a right of appeal, being prohibitive (judicial review), confined largely to procedural unfairness, having a high threshold for review of the merits (both), confined to recommendation and referral back to HDC (Ombudsman complaint and remedy discretionary for judicial review) and (like the HDC itself) action on the complaint is not as of right (Ombudsman complaint).

10. This contrasts with an invasion of privacy and anti-discrimination complaint, the other two "Commissioner complaint regimes" in NZ, also established in the 1990s. Not only can these complainants challenge a Commissioner NFA decision (in human rights cases) and a "no breach" decision (in privacy cases), complainants disappointed with a Commissioner decision can bring a damages claim in the civil courts.[2] Likewise Australian complainants to their state Health Commissioner regimes, disappointed with the outcome of their complaint, can always resort to a civil action. NZ HDC complainants have the worst of both worlds: they cannot challenge either an NFA or a "no breach" finding after an investigation before the Human Rights Review Tribunal, and they cannot sue in the courts either. By contrast, a medical practitioner can appeal the decision of the Health Practitioners Disciplinary Tribunal to the courts (two levels) and a disappointed claimant can seek a review of ACC's decision and appeal to the courts (three levels), arising, say out of the same episode of care. This is a seriously inconsistent and unfair.

11. It is hard to escape the conclusion that the reason privacy and human rights complaints were treated differently by the Legislature from health and disability complaints, in not being afforded the right to challenge Commissioner NFA and Commissioner "opinions" after an investigation, is that health and disability complainants would be more likely to exercise that right, the fear being that this might overwhelm the appellate body with a flood of appeals.[3] Denying appeals where the right is needed most is seriously back-to-front reasoning. The potential for an appeal is a discipline on a decision-maker. If HDC is doing its job well, appeal volumes will be kept to a minimum.

[2] A *Baigent* action for breach of the NZBORA in respect of discrimination.

[3] See Helen Cull's reasoning for not extending s 51 proceedings to no breach decisions.

12. Complainant's experience during a preliminary assessment leading to an NFA. I have helped numerous complainants trying to resist NFA decisions in serious complaints. My experience is that receiving a NFA decision in such a case adds insult to (often) injury or death and risks turning good people who have had a very distressing experience and a genuine grievance into bitter, vexatious litigants due to a justified sense of injustice from their complaint not being heard and appropriately dealt with in relation to a defining event in their lives.

13. From my experience, it can very much feel to a complainant that, having made their complaint, the HDC thereafter endeavours to keep the complainant very much at arm's length during a preliminary assessment until the draft provisional decision is made. The complainant can feel very shut out of the process and wonder what is going on, despite the monthly advisory update emails. This can be for some 12-18 months. Then the complainant receives the shock of a provisional NFA decision, with a very short, four-week timeframe (relative to the time HDC has taken to date) in which to respond. In retrospect, the complainant only then realises that HDC has been working towards a NFA decision for some time and has been "setting it up" to achieve this end. That can be the beginning of the process of re-victimisation and sense of betrayal that I refer to above.

14. Funding as the driver of high NFA and low investigation numbers. HDC is carrying out the number of investigations that it is able to manage within its funding, not the number it should be carrying out consistently with its legislative purpose. HDC is commendably frank about the fact that the reason for increased NFA decisions and ever fewer investigations is the large and increasing volume of incoming complaints to HDC, so HDC severely rations the investigations it carries out via NFA decisions. From HDC's perspective, this is not just understandable; it seems virtually inevitable that it should strike this balance and end up in this place. It has prioritised "efficient" over "fair" resolution in many serious cases. The cost of this strategic decision is, however, being borne entirely by complainants/patients, who are unable to achieve a fundamental aspect of fairness viz. a full investigation of their (serious) grievance. If HDC is unable to accept as many complaints for resolution that it otherwise would be inclined to do so but for limited funding, there has to be somewhere else for those complainants to turn.

15. Yet, as the Chief Ombudsman has observed, this appeal to rationing of scarce HDC resources is overstated. Many of the steps taken in the preliminary assessment of these complaints are the same as those taken in an investigation. The only difference is that HDC may have to get statements from a few more witnesses, but the Hospital frequently gets these for HDC in a preliminary assessment in any event. Ironically, once the complainant has survived the "fire" of a lengthy preliminary assessment and made it to an investigation, the latter is comparatively short and straight-forward. HDC tends to re-use the same expert advice and statements from witnesses. The fact that the preliminary assessment takes longer and is more complex than the ultimate investigation speaks volumes and attests to the fact that the preliminary assessment is in reality a de facto investigation conducted in the form of preliminary assessment.

16. Accountability for the exercise of statutory power. The Health and Disability Commissioner is virtually unique among official decision-makers in respect of the extensive lack of accountability for the exercise of her powers. The Commissioner (or Deputy) makes many individual judgment calls in the HDC complaints regime. Without appeal there is little accountability for these decisions. Should she or a Deputy reach a decision perceived to be grossly unfair on the merits of a complaint, neither party can attempt to set this to rights on appeal. Even legal errors cannot be corrected on appeal.

17. Appeal rights are the norm. An appeal is a standard and expected aspect of procedural justice. The lack of an appeal right contrasts with virtually every other decision made by official decision-makers in our society. Citizens have appeal rights from all manner of official decisions affecting their lives (tenancy, employment, property disputes, civil disputes about purchasing good and services and money, state benefits privacy, discrimination and ACC claims, professional disciplinary findings), but just not in health and disability services issues. Appeal rights are the norm in relation to rights and interests of citizens of much less moment than complaints about one's life and health. Yet life/health is often regarded as an a priori interest having a special moral importance, because one needs it to accomplish all the other ends you seek in life. Yet there's no appeal from decisions on these complaints.

18. The Chief Ombudsman's report makes expert, knowledgeable and considered criticisms and recommendations of HDC's preliminary assessment procedure. A key criticism was that he considered that the preliminary assessment process leading to NFA decisions was being greatly over-used by the HDC. He was of the view that the Commissioner had been setting the bar of seriousness to warrant formal investigation of a complaint far too high:[4]

> HDC appears to consider that initiating an investigation is a detrimental punitive action against a provider that should generally be avoided unless serious malpractice is identified. However, this strict criteria appears to inflate the threshold for initiating an investigation beyond the statutory requirements and results in HDC conducting a disproportionate 'preliminary assessment' instead.

He indicated that what he called "middle-range or serious" complaints, beyond "mild", not just cases of "serious malpractice" in which the Commissioner may consider a referral to the DP to consider further proceedings, should also be being formally investigated, rather than the subject of NFA decisions.[5] Failure to do so deprives complainants of the opportunity for the Commissioner to hold the provider to account by way of a formal finding of breach of the Code if proven, and of the opportunity to take further proceedings themselves under section 51 before the HRRT if dissatisfied.[6]

[4] Boshier, *Preliminary Assessment Report*, para 137.
[5] Boshier, *Preliminary Assessment Report*, paras 80 & 86.
[6] Boshier, *Preliminary Assessment Report*, paras 122 & 126.

He was concerned about the lengthy preliminary assessment process and its impact on the parties. It is supposed to be an expeditious process, to enable the Commissioner "to make a prompt initial determination about how the complaint should be handled."[7] HDC's processes in these cases has stepped outside what Parliament envisaged a "preliminary" assessment should entail. The process had instead been used as a vehicle for an extensive information-gathering exercise and detailed analysis of the standard of care, which are the hallmarks of an investigation:[8]

> I do not consider that collecting extensive information from the providers, expert advisors, and complainants and then carrying out a comprehensive analysis should form part of the preliminary assessment. Rather these are the types of steps I would expect to see HDC take in the context of an investigation, once a preliminary assessment as to how the complaint should be handled has been promptly completed. I consider it the purpose of an investigation, not a preliminary assessment, to establish the findings of a case (where possible) and to come to appropriate conclusions.

19. In response the HDC did publish its decision-making criteria for NFAs and investigations, but it does not appear to have appreciably changed its processes to convert more preliminary assessments into investigations. Though there has been a modest rise in the number of investigations carried out annually, the numbers of NFAs have increased markedly, not deceased. Complainants continue to pay the price through thwarted complaints. The only way to make HDC accountable in this respect and to afford justice to complainants is to provide them with an alternative avenue to pursue to have their complaint investigated if they are dissatisfied with HDC's decision.

20. The courts also are concerned about the manner in which the HDC has been carrying out its preliminary assessment process leading to NFA decisions.[9] (It is no accident that these remarkable "successes" were both obtained in actions brought by unrepresented litigants, given the unaffordability of judicial review for almost all complainants). The key reason for its concern is its recognition that the stakes couldn't be higher for a complainant; that an NFA brings a complaint to a complete halt, leaving a complainant with no alternative means of achieving a fair outcome on the merits.[10] As a result the courts have resisted the HDC's requests for "light-handed" review of its processes and decisions and have not been prepared to give the HDC a wide, unfettered discretion to "triage" complaints via the preliminary assessment process.[11] Instead the courts have accorded complainants greater

[7] Boshier, *Preliminary Assessment Report*, para 97.

[8] Boshier, *Preliminary Assessment Report*, paras 114-115.

[9] See *Meek v Health & Disability Commissioner* [2016] NZHC 1205 (Clifford J); *S v Health & Disability Commissioner* [2022] NZHC 692 (Duffy J).

[10] See *S v Health & Disability Commissioner*, ibid, para 161.

[11] Meek, para 62 et seq; *S v Health & Disability Commissioner* [2022] NZHC 692, paras 161 et seq.

procedural fairness rights in the process[12] and have submitted NFA decisions to close scrutiny, taking the unusual step in one judicial review action of making findings of *Wednesbury* unreasonableness on the merits.[13] Ironically, the additional procedural protections extend the time a preliminary assessment takes, contrary to the Chief Ombudsman's recommendations, placing HDC in a double bind. If there was an appeal right from adverse decisions, including an NFA decision, there would be greater justification for a less procedurally intensive preliminary assessment process.

21. HDC wants a name change of a "No Further Action" decision to a more emollient name to signal that a great deal of "action" has already been taken on a complaint during the preliminary assessment phase before a NFA is reached, see p 30 of the Consultation Document. This is misconceived. First, if the decision was called a "No Action" decision, as opposed to a No *Further* Action decision, there would be something in the point. The name points exactly to what is occurring – that HDC has decided to take no *further* action (not no action) on the complaint.

22. The HDC has been instructed that it should be taking *less* action during preliminary assessments and conducting more investigations. Instead of seeking to change the name/description of this "resolution" option, HDC should instead be changing its processes, implementing the Chief Ombudsman's advice to make preliminary assessments exactly that, "a prompt initial determination about how the complaint should be handled", and reserving more intensive inquiries for a full investigation. This would certainly result in more investigations, but I question the extent to which it would impact on HDC's resources, as stated by the Chief Ombudsman.

<u>Other criticisms of the complaints process</u>

23. The expert's advice (and any provider's response to it) is not released to the complainant to respond to until the draft provisional decision to take no further action is released. By this time the Commissioner has reached and committed herself to a decision (to take NFA) in principle and is giving the complainant the opportunity to respond to endeavour to persuade the HDC otherwise. By contrast, the provider is given the complaint and an opportunity to respond and then given the full, unredacted expert advisor's report, and can fully address the expert's criticisms in its response before the HDC reaches any in-principle decision in a draft provisional decision. This feels one-sided and unfair. The risk is that this feels to a complainant like collusion between the HDC and the provider.
24. Similarly, during an investigation, a complainant is not given an opportunity to respond to the Provisional Opinion, which the provider is automatically given, only to only to the Information Gathered document. This is procedurally unfair.
25. Use of the OIA. It is a feature of the HDC's cautious approach to the complaints process and greatly lengthens preliminary assessments and investigations that the

[12] Such as limiting HDC's ability to make a NFA decision without first resolving disputed facts and ensuring it receives statements from key witnesses, see *Meek v Health & Disability Commissioner* para 67, cited with approval by Duffy J in S v *Health & Disability Commissioner* [2022] NZHC 692, paras 164-166.
[13] S v *Health & Disability Commissioner* ibid.

HDC invokes the OIA in response to the parties' requests for information. Without reference to or seeking the agreement of the party requesting the information, it simply converts its request into an OIA request. This gives it 20 working days to respond to the request (plus statutory extensions), plus the OIA grounds to decline to release information. By now the HDC should have the confidence and experience to simply respond to the request for the information.

Lack of appeal from Commissioner's decision after an investigation

26. If a complaint is serious enough to clear the high threshold to qualify for an HDC investigation, but there is a no breach finding, the complainant cannot appeal. Neither can a provider who is dissatisfied by a "breach" finding. Often the outcome of a complaint depends on one person's — the Commissioner's judgment call as to what constitutes acceptable practice, informed by a clinical expert. These judgments are normative judgments of what constitutes acceptable standards, not objective, mathematical decisions, about which reasonable minds can disagree. A party should be able to challenge such judgments on appeal.

27. A reason put forward for not naming individual providers found in breach of the Code of Rights has been that the HDC investigation process is a relatively low-level one, based largely on documents, without the natural justice protections of oral evidence and cross-examination and the forensic fact-finding methods used in court proceedings, and that the Commissioner's opinion is not subject to appeal.[14] The Commissioner or Deputy is very often faced with an inability to resolve disputes between parties over different factual versions of the events. The outcome of the complaint frequently depends on which version the Commissioner decides to accept. In the absence of corroborating documentary evidence, the benefit of the doubt often is given to the provider (and properly so). Thus, as the Naming Policy implicitly accepts, there is a greater likelihood of error in decisions reached via such a process. The judgment is that this is a price worth paying for a relatively low-level, low blame process. Nevertheless, there must be a limit to this utilitarian calculus. A low-level process should not be the *only* process available to the parties. It is submitted that the trade-off is that there must be a right of appeal to enable parties to correct mistakes and injustices in decisions made in such a process.

28. What might a right to review of appeal look like?
    The most straight-forward option to include a right of appeal from NFA decisions and from adverse decisions after a formal investigation would be to amend the HDCA to enable complainants, consumers and providers to take proceedings in the HRRT. The HRRT already has jurisdiction over health and disability complaints; that jurisdiction would simply be expanded. It would be a simple matter to amend section 51 of the Act, as follows:
    Aggrieved person may bring proceedings before Tribunal

[14] See Naming Policy, p 15, para 7.

Notwithstanding section 50(2) but subject to section 53, the aggrieved person (whether personally or by any person authorised to act on his or her behalf) may bring proceedings before the Tribunal against a person to whom section 50 applies if he or she wishes to do so, and—

(a) The Commissioner has made a decision under section 38(1) to take no action or no further action on a complaint;

(b) The Commissioner has found no breach of the Code on the part of the person to whom that section applies;

(c) the Commissioner, having found a breach of the Code on the part of the person to whom that section applies, has not referred the person to the Director of Proceedings under section 45(2)(f); or

(d) the Director of Proceedings declines or fails to take proceedings.

29. Balancing low-level resolution with an appeal right.

There are very valuable aspects of the HDC model worth preserving: it is free, largely lawyer-free and informal, able to resolve more minor complaints by conciliatory means. The Commissioner is independent and has access to excellent clinical advice, circumventing the well-known difficulties for patients and consumers to access medical experts. The vast majority of complaints end after the Commissioner's decision after an investigation.

An often-expressed concern about appeal is that insured and well-resourced providers would appeal every breach finding, while consumers, who are bearing the cost of proceedings themselves, would lack the means to do so ("the inequality of arms argument"). This is a valid concern.

There are, however, effective, well-tried options for disincentivising unmeritorious appeals by either party, which could be built into the process. The usual means are cost awards, leave provisions, and subsidising complainant's legal costs (e.g., via levies on providers, as with the disciplinary levy payable by health practitioners under section 131 of the Health Practitioners Competence Assurance Act 2003), not by withholding appeal rights altogether.

In any event, it is submitted that unmeritorious provider appeals from breach findings may be a risk worth running. In 2022/23 there were approx. 1,400 NFA decisions and only 114 "breach" findings against providers. In purely utilitarian terms, the cost of putting complainants through unmeritorious appeals against a proportion of the 114 "breach" findings brought by providers may be worth it for the benefit of 1,400 complainants having the option of appealing NFA decisions with which they are dissatisfied.

Amend the purpose statement of the Act

I consider that the overall purpose of the Act of "promoting and protecting the rights of health and disability services consumers" is absolutely right and appropriate, and should not change.

I consider that the secondary purpose of "facilitating the fair, simple, speedy and efficient" resolution of complaints is important and should remain in the purpose provision of the Act. It encapsulates the balance that has to be struck by the Commissioner in resolving complaints, and is an important constraint on otherwise relatively broad, unconstrained power. The phrase has the important advantage of having been interpreted by the courts, indicating that the first requirement is that complaints resolution be "fair",[15] which would unfortunately be lost if this purpose was removed.

I do not oppose the suggestion to ADD (not substitute) to the purpose a statement about upholding mana into the purpose statement. It could be an important discipline placed on the HDC. In my experience in assisting complainants, HDC is sometimes so intent on bringing providers on board with the outcome that it sometimes seems to lose sight of the complainant and their experience. For example, a complaint outcome that the complainant has established their complaint but no breach finding is made because the Commissioner considers that the provider has reflected on their actions and shown insight, depriving the complainant of the vindication of a breach finding after having persevered for perhaps three plus years with their complaint. Such a result would be harder to justify in the face of a "mana-upholding" purpose. Similarly, the NFA processes and outcomes can feel often "tone-deaf" to complainants' experiences in serious complaints.

<u>Clarify the role of whānau; Legislative overruling of the *Marks* decision</u>

I agree with the criticism that the Code rights and the HDC's complaints process is too atomistic and individualistic as currently configured. I support the overall proposal to extend the Code protections where appropriate and the complaints process to include and involve whanau to a greater extent.

And so I agree that it would be good to clarify Right 10 (Right to Complain) to explicitly allow for complaints to be made by support people on behalf of the consumer. This change, however, does not go far enough.

It is disappointing that the Consultation document does not highlight the unjust and much criticised Court of Appeal decision in *Marks v Health and Disability Commissioner* and recommend its legislative repeal, as have previous Commissioners in their Reviews since the decision. While the creation of a broad appeal right on the merits from adverse HDC decisions would render the *Marks* decision otiose, as submitted, I address the point in the alternative..

Marks prevents family members and whanau of an injured patient from bring section 51 proceedings in their own right before the Human Rights Review Tribunal, because the Court held that non-consumer complainants are not an "aggrieved person" in terms of ss 51 and 57 of the HDCA. This Review should take the opportunity for the Commissioner to press hard to finally achieve its legislative overruling, a change supported by both Commissioners in their previous Reviews of the Act and Code.

[15] See Clifford J in Meek v Health & Disability Commissioner [2016] NZHC 1205, para [62].

A useful discussion of the issues can be found in the Ron Paterson's 2009 Report to the Minister of Health on the Review of the Act and Code. I will not repeat those arguments here.

Consumers are often unable to summon the energy to make their own complaint and pursue further proceedings, because they are struggling to regain their physical and mental health after the events in question, and rely on whanau members to do so in their stead. Young people and people with disabilities might rely on a whanau member to do so. There are good reasons why complaints can be made by third parties, most often whanau.

As matters stand, a third party complainant can make a complaint and "prosecute" it right up until the end of an investigation, but they are barred thereafter from taking further proceedings in the HRRT or being awarded damages in their own right if the DP takes such proceedings. Most importantly, it is simply insulting and to inflict further distress on whanau who are unable to bring s 51 proceedings because of the *Marks* decision, to tell them that the reason they cannot do so is that they are not considered an "aggrieved" person," which is the ultimate message from the *Marks* case. The *Marks* decision unjustly denies whanau members access to justice in the HRRT in the complaints regime, since s 51 proceedings are a part of that process.

Together with the ACC bar on damages for personal injury, this judicially created bar has rendered the HRRT much less effective in contributing to achieving the purpose of the HDCA than it otherwise could be.

If the HDC is serious about the greater involvement of whanau in the complaints process, in recognition of ethnicities whose decision-making practices are more collective for example, this is one practical area which is inconsistent with that approach.

Legislative change is very easy fix. Section 51 and 57 would simply be amended to substitute the phrase "aggrieved person" in those sections with the phrase "the complainant (if any) or the aggrieved person (if not the complainant)".

Joanna Manning
Professor of Law
On behalf of Cartwright Collective

Date: 29 June 2024

Submissions to the Health Select Committee on behalf of the Cartwright Collective

Petition of Renate Schutte: A right to appeal decisions made by the Health and Disability Commissioner; Petition no 2017/535; presented 22 June 2020

"That the House of Representatives amend the Health and Disability Commissioner Act 1994 to give complainants, and those that are the subject of complaints, the right to appeal decisions made by the Health and Disability Commissioner."

The Cartwright Collective supports the above petition.

Executive Summary

1. Complainants and consumers who utilise the HDC complaints process face unacceptable barriers to accessing fair and just outcomes. The injustice is particularly acute in NZ, since they have no alternative avenue for resolution of their grievance.

2. Three key access to justice barriers are:
    1. A complainant or consumer cannot challenge by appeal or review the substantive merits, correctness or fairness of a Commissioner decision to take "no further action" (NFA) after a preliminary assessment, except by internal review, which is inadequate on its own;
    2. There is no ability for a complainant or provider to challenge by appeal the substantive merits, correctness or fairness of a Commissioner's decision after an investigation;

    3. The complaints process established by the HDCA is lengthy and attenuated, leading to significant delays in resolution of complaints, particularly in serious cases in which the public interest in health and safety is at its highest.

    Lack of appeal rights in matters of life and death and serious injury results in process which is not "fair". This contrasts with generous appeal rights in analogous NZ complaint processes, ACC claims, and disciplinary cases in the health sector.

    4. These barriers are embedded in the complaints process as established by the HDCA.

    5. In its current practice the HDC places too heavy an emphasis on simple, speedy, and efficient resolution (even though not always achieved) at the expense of fair resolution.

    6. Nearly half of all complaints, over 1,000 per annum, made the HDC are "resolved" by a decision to take no further action (NFA) after a preliminary assessment. There is evidence that NFA decisions are made in serious complaints, which should instead be being decided after a formal investigation.

7. In a recent decision the Chief Ombudsman is strongly critical of HDC's practice of carrying out lengthy and detailed preliminary assessments and making of NFA decisions in complaints in which it should instead be undertaking formal investigation.

8. NFA decisions on serious complaints cause harm to complainants through their inability to be heard, to hold providers to account, and disadvantage them by denying them access to the HRRT.

9. As NFA decisions have climbed, there has been a dramatic decline (40 percent > 6 percent) in formal investigations in the last 20 years. These twin trends have been a deliberate response by HDC to increased complaint volumes.

10. There is no appeal by either party from a Commissioner decision after a formal investigation, notwithstanding that the investigation process lacks the procedural fairness protections of a court. HDC decisions are therefore likely to be subject to greater levels of error than processes with stronger protections.

11. Lack of an appeal right operates especially harshly in respect of a complainant whose complaint results in a "no breach" finding, as s/he has no other avenue for challenging the substantive fairness of HDC's decision. A provider is able to challenge an HDC "breach" finding if the DP takes further proceedings against him/her and, perversely, a complainant is able to do so if the HDC makes a "breach" finding. This is unbalanced and makes no sense.

12. Complaint to the Ombudsman and prohibitive judicial review proceedings are nowhere near equivalent to an appeal right on facts and law, being limited largely to the fairness of the procedure by which the HDC decision is reached.

13. The HSC should not refer the issues raised by this petition back to the Commissioner, as the barriers to justice in the HDC process are systemic. Their source lies in the complaints process established in the HDCA and as such, are a matter this Committee, the Minister and Parliament to remedy.

14. It is entirely achievable to design a fairer complaints process which balances both low-level resolution with appellate rights from adverse HDC decisions. The most straight-forward option would be to expand parties' access to the HRRT, as it already has jurisdiction over the HDC. A potential downside is that Tribunal's formality. Other models to incorporate appellate rights are worthy of consideration.

Submissions

1. These submissions are made on behalf of the Cartwright Collective. The Cartwright Collective (CC) is a group committed to monitoring the implementation of the recommendations of the *Report of the Cervical Cancer Inquiry* 1988 (the Cartwright Report). (A description explaining more fully the mission of the Cartwright Collective and its current members is in Appendix 1). The submissions are written by Professor Joanna Manning, a

member of the Cartwright Collective and professor of Law at the Auckland Law School, University of Auckland, specialising in medical law, policy, and ethics.

2. The recommendations for a "Health Commissioner," a complaints regime and a "Code of Rights" for consumers and patients, implemented by the Health and Disability Commissioner Act 1994 (HDCA), originated from the *Cartwright Report*. Fertility Action, of which CC members Sandra Coney and Phillida Bunkle were members, was a party to the 1988 Inquiry. It strongly advocated for both a Commissioner and a Code of Rights in its submissions to the Committee of Inquiry. Lynda Williams, a member of the CC and the Auckland Women's Health Council before her death, was appointed the first advocate to National Women's Hospital, implementing a recommendation of the *Report*. Judi Strid was also a member of the CC, until she became the Director of Advocacy, a role in which she served for ten years (2004-14) at before her death.

Hence the CC has a strong interest and continuing stake, as well as expertise, in the Health and Disability Commissioner (HDC) complaints process. The CC supports the office of the Health and Disability Commissioner; we are supportive of the incoming Commissioner and encouraged by initiatives she is considering to improve the complaints process. Nevertheless, the CC supports this petition, because it is committed to ensuring that the Commissioner is delivering fair and just outcomes on consumers' complaints and believes that a right of appeal is essential to a process that is able to do so.

3. In 2018 Joanna Manning published "'Fair, simple, speedy and effecient'? Barriers to access to justice in the Health and Disability Commissioner Complaints Process in New Zealand" [2018] *New Zealand Law Review* 611-656, which is attached. These submissions are based on that paper, updated with additional arguments based on events since.

4. The article interrogated the question whether the HDC complaints regime accords its users, particularly complainants and consumers, access to justice. Did it provide acceptable and effective mechanisms for asserting their legal rights in the Code and securing just and fair outcomes on complaints? It assessed the complaints process principally against the aim of the HDCA, which established the role of Commissioner, provided for the Code of Rights, and established the complaints process. The overriding purpose of the HDCA is:

> To promote and protect the rights of health consumers and disability services consumers

The key means by which consumers' rights are to be promoted and protected is via the complaints process, the legislative aim of which is:[1]

> And to that end [consumer rights promotion and protection], to facilitate the ***fair, simple, speedy, and efficient*** resolution of complaints relating to infringements of those rights; (emphasis added)

Of course, these aims may not always be compatible with each other when applied to individual complaints. The extent to which a substantively fair outcome can be reached may conflict with the extent to which the resolution process can be simple, speedy, and efficient. The Commissioner may have to make trade-offs between these procedural principles when selecting an appropriate resolution mechanism in practice.

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[1] HDCA, section 6.

5. From my study of the HDC complaints process I concluded that it was lacking in meeting these objectives. HDC placed too heavy an emphasis on simple, speedy, and efficient resolution (even though often not achieved) at the expense of fairness. Consumers faced unacceptable barrier to accessing fair and just outcomes, given that they have no alternative avenue for resolution. These barriers were embedded in the complaints process as designed in the HDCA and operationalised. The three key access to justice barriers identified are:

(1) A complainant or consumer cannot challenge by appeal or review the substantive merits, correctness or fairness of a Commissioner decision to take "no further action" (NFA) on a complaint after it has been made and the Commissioner has carried out a preliminary assessment of it, except by seeking an internal review;
(2) There is no ability for a complainant or consumer to challenge by appeal the substantive merits, correctness or fairness of a Commissioner's decision after an investigation of the complaint that the provider has not breached the Code of Rights (a "no breach" opinion), and very limited ability for a provider to do so in respect of a "breach" opinion;
(3) The complaints process established by the HDCA is lengthy and attenuated, leading to significant delays in resolution of complaints, in making decisions, particularly in serious cases in which further proceedings are taken. These are the cases in which the public interest in health and safety is at its highest.

Lack of an appeal right in relation to matters of life and death and serious injury to health is simply not "fair." The petition seeks amendment of the HDCA to afford parties to a complaint a right to appeal from adverse HDC decisions, so that it can better fulfill this statutory mandate.

6. The Human Cost — Two Cases

These two complaints illustrate in striking terms the injustice caused by the lack of an appeal right from adverse HDC decisions:

Case 1 – A Commissioner No Further Action decision (NFA): Vicky Gibson's complaint about the treatment of her 8-year-old son, Kaya Miller[2]

In November 2013 Vicky Gibson took her eight year-old son, Kaya Miller, to a specialist opthalmologist for the second time in 10 weeks. By this time she knew was something was seriously wrong. He was nearly blind and suffered from other troubling symptoms (withdrawn behaviour, clumsiness and falling down, muddled thinking, inability to read or find rooms in his home). These were all, they would later learn, red flags to a serious underlying pathological condition. After some visual tests, the opthalmologist repeated his view from the first visit; he thought it unlikely that Kaya's symptoms were the result of disease, but were most likely to be "functional". That is, that Kaya was for some reason making his symptoms up. He did, however, write a non-urgent referral letter for Kaya to see a paediatrican to rule out a neurological condition, the appointment for which was received two months later.

Six days after the second appointment, Jimmy, Kaya's father, took him to the public hospital, where he was diagnosed with a rare metabolic brain disease, adreno-leuko-dystrophy or ALD.

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[2] This is a real complaint. I have the complainant, Vicky Gibson's full agreement to share it with the HSC and to identify her.

Six months later Kaya died, but had he been referred and the diagnosis made earlier, say after the first appointment in August, his life might have been saved by a bone marrow transplant.

In February 2016, Vicky made a complaint to the Health and Disability Commissioner, Anthony Hill, about Kaya's care, specifically about the ophthalmologist's failure to arrange an urgent MRI or refer him urgently for paediatric assessment. The paedicatricans who treated Kaya at Auckland's Starship Hospital shared her concerns about his treatment. As part of a preliminary assessment of her complaint, the Commissioner sought expert advice from another opthamologist, who said 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 the second appointment stage]", but who ultimately concluded that Kaya's care was generally consistent with accepted practice. A year after her original complaint, a Deputy Commissioner accepted that advice, concluding that the doctor's care was "adequate and appropriate," and accordingly that no further action, not even referral to advocacy let alone an investigation, would be taken on Vicky's complaint.

Vicky could not appeal the Commissioner's NFA decision to any court or tribunal. She could have asked HDC for an internal review of the NFA decision, but that option was never drawn to her attention by HDC. In any event HDC's policy requires the complainant produce new evidence or show mistakes of fact before it will agree to such a review; and it would be carried out by the HDC (probably the same staff) that made the original NFA decision. She could not bring a civil action for damages because of the bar on such actions in the ACC legislation. She could have made a further complaint to the Ombudsman under the Ombudsman Act 1975, but it will generally only assess the fairness of the complaint's procedure, not the fairness of the outcome or decision, and in any event if such unfairness is found, it will only refer the complaint back to the HDC to determine again after correcting the procedural unfairness. She could have brought prohibitively expensive judicial review proceedings, but these are subject to the same limitation of being largely confined to procedural errors, not the merits or fairness of the HDC's decision. Vicky's complaint had reached the end of the road. Yet she had not been let in the front door to tell her story to the very agency tasked with resolving complaints in health care.

<u>Case 2 – A Commissioner 'no breach" finding – Anna McLean's complaint about baby Harold's still birth</u>[3]

In December 2016, Anna McLean, aged 29 years, engaged a self-employed registered midwife, Registered Midwife (RM) Ms DH, to be her lead maternity carer for her first pregnancy. She was a healthy, well woman, and was considered low risk.

On 26 July 2017, at 7 pm, at 39 weeks and 1 day's gestation, Anna contacted Ms DH via text message:

> "Hi RH, sorry to bother you ... I'm not quite sure what's happening to me/baby I stood up to get my dinner and had really intense pain down one side — the right side where the feet are supposed to be, it kind of felt like the baby was turning around or something as it was so so painful! [A]nd I haven't been

[3] This is also a real complaint. I have the consent of the complainant to share the details of her complaint with the Committee. The names of the complainant, her partner and baby, have, however, been changed to protect their privacy.

> able to stop moving since as it still hurts but has eased off. Do you think that could be a contraction? I'm going to have a warm bath now and relax as it gave me quite a fright!!"

Ms RH replied via text message at 8.48pm when she saw the message.

> "Hey Anna. It probably was a Braxton Hicks (uterine tightenings that a pregnant woman may feel late in pregnancy) or baby moving and pressing on something. I wouldn't be too worried. It's a good thing if you start getting niggles."

Anna did not contact Ms DH again that evening. Although the pain continued intensely for "a couple of hours," she felt reassured Ms DH's response.

The following day, there was a pre-arranged, routine antenatal appointment for 4.30pm. At 8.04am, Anna sent Ms DH the following text message:

> "Hi DH, [the pain] was really intense and felt like more than that. I managed to get some sleep and feel ok now. Am I able to please take the 12.30 or an earlier appointment today instead of 4.30?"

As an earlier appointment was unavailable, Anna and her partner, Andrew, attended the 4.30pm appointment. Anna told Ms RH: "[I]f that was anything like labour, I am so scared, because it was so painful!" Andrew told her that "Anna was in so much pain she was doubled over on the floor and in tears and the pain went on for some time".

Ms RH examined Anna, who told Ms DH that her abdomen was "very sore and tender" on palpation. Ms DM found "slight" tenderness on the right side of her abdomen, where the pain had been the night before, but otherwise the assessments were normal. She was able to detect the fetal heart rate through auscultation and felt that there was good fetal movement. For these reasons, she felt she could rule out the need for cardiotocography (CTG) or an ultrasound scan (USS) (both of which were available in the clinic) to determine the likelihood of an adverse event. Ms DH reassured them both that the pain was "nothing to worry about".

At 6.40am on 31 July 2017, Anna telephoned Ms DH advising that she had not felt the baby move since 3am. She met them at the birthing centre at 7.55am, but could not find a fetal heartbeat. Anna was transferred by ambulance to North Shore Hospital, where fetal demise was confirmed and baby Harold was later delivered stillborn by Caesarean section.

In November 2017 Anna and Andrew attended NSH, where they met with Dr Kumar, a specialist obstetrician & gynaecologist, to discuss William's post-mortem. Dr Kumar wrote a letter dated 3 November 2017 to Anna (later provided to HDC), which stated:

> When Ms McLean had this acute pain, she expected that the midwife would examine her and do the necessary checks to make sure that the baby was well. In my opinion, that with severe pain like what Ms McLean describes one needs to rule out a cause which is damaging to the baby, such as placental abruption as a possible cause. Therefore she needed to be seen by her midwife for a physical examination, a CTG to check for fetal distress and possibly a scan to rule out the possibility of this or another condition. That would be the safe course of action, given the potential for a serious adverse outcome.

Anna made a complaint to the HDC. After a preliminary investigation of a year and two months, HDC notified an investigation. HDC obtained a report from an expert midwife, whose opinion was that RM DH's failure to telephone Anna to undertake a telephone assessment

(and instead texting her), after receiving Anna's first text message constituted "a *significant* departure from the standard of care expected which would be viewed with *significant disapproval* by the expert's peers" and that "if there were a failure to carry out further investigation when there was evidence of on-going abdominal pain [at the ante-natal appointment the next day], this would be a significant departure from the accepted standard of practice, which would be viewed with significant disproval by my peers."[4]

Ms DH accepted that she did not provide the appropriate standard of care by not telephoning Anna on 26 July 2017 to further assess the pain described in her text message, and told HDC that she had implemented changes in her practice since these events, including responding to text messages via telephone call for every client.

Two years and four months after the complaint, a Deputy Commissioner issued a decision finding that the midwife had not breached the Code of Rights. While "critical" that Ms DH did not telephone Ms McLean after receiving her text message and that clinical information was shared by text in this situation, she did not make a breach finding, despite the expert's advice, because Ms DH had reflected on her actions and had made changes to her practice. On the failure to perform further tests at the appointment, she said she was unable to determine the exact nature of what was discussed regarding the severity of Ms McLean's pain at the appointment, and so could not make a factual finding different from the information set out in the clinical notes, which merely described a "random pain."

Because the HDC made a "no breach" decision, Anna was unable to appeal the HDC's finding to the Human Rights Review Tribunal. Perversely and bizarrely, had HDC reached a "breach" decision against Ms DH, section 51 of the HDCA states that Anna would have been able to do so, alleging a breach by Ms DH of the Code (the HDC having already found a breach!).

Anna's reaction to the outcome is best described in her own words. She later wrote to the Commissioner as follows:[5]

"It is illogical, disrespectful and dismissive of my experience as the complainant for HDC to accept a finding of HDC's expert that there was a ***significant*** departure from the standard of care expected which would be viewed with ***significant disapproval*** by the expert's peers, yet at the same time to deny the complainant a finding of breach of Right 4(1) and only to make an adverse comment, because the provider has reflected on the events and because of changes instituted by her ***after*** these events.

Having endured the tragic loss of our son at term, and having established my complaint in this respect, I am surely entitled to the ***vindication of a breach finding***. An adverse comment ought to be reserved for relatively minor departures from the standard of care expected, ***not for significant ones***. To decide not to make a finding of breach of Right 4(1) in such circumstances is a ***dereliction of HDC's mandate to promote and protect consumer's rights and an abdication of its role to set standards of reasonable care and skill for the midwifery profession***.

As to this outcome, I am told that I cannot in any way challenge it. I understand this is now the end of the road for my case and justice for baby [Harold}, notwithstanding that it concerns one of the most significant occurrences in my life.... I simply have to accept the result, notwithstanding my concerns that it represents an unbalanced and unjust finding. This final decision is based on one person's judgment as to what amounts to a

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[4] Deputy Commissioner R Wall, Registered Midwife DM: Case 18HDC01152 (16 October 2020).
[5] Letter Anna McLean to Health and Disability Commissioner 2 December 2020.

"reasonable" standard of care, one that differs from the HDC's own expert advisor. I would also like you to know that if there was an opportunity to appeal my case, I would not hesitate to do so."

7. **Most complaints are dismissed with an NFA decision.** An NFA decision is the form of "resolution" of most complaints made to the HDC. In the 2019/20 year (the latest figs available), over 1,000 complaints of approx. 2,200 complaints closed in the 2019/20 year were dismissed with a No Further Action decision, without the Commissioner referring them to any other form of resolution option, even a lower level one such as to an advocate or mediation to attempt resolution by agreement. Between 2014 and 2017 the HDC decided to take no further action in 55% of complaints received, approximately 1,072 of the approximately 2,000 complaints received per annum.

8. **NFA decisions on "serious" complaints.** HDC's policy is that investigations are appropriate for "potentially serious breaches of ethical and professional boundaries, and major lapses in standards of care that have resulted in death or severe disability". Nevertheless, the concern raised by Vicky Gibson's complaint is that NFA decisions are being made on complaints making serious allegations of substandard treatment, which have had serious outcomes (death or serious injury), and in which preliminary independent expert advice is critical of aspects of the care. I shall refer to such a complaint as a "serious complaint." In addition to the complainant's interests of receiving some kind of hearing and resolution of their grievance, these are the very complaints which may raise public health and safety concerns, which, it is submitted, HDC should be referring for a formal investigation.

8. Because HDC does not publish NFA decisions and their reasoning, we cannot know what proportion of NFA decisions are made on serious complaints. In a few complaints, details have surfaced in the public domain for some reason. The following small selection, in all of which NFA decisions were made, does, however, suggests that an NFA on a serious complaint (such as in Vicky Gibson's) is not an isolated case. (Abbreviated descriptions of these complaints are set out here in the interests of brevity. For fuller descriptions, see the Appendix 2 to these submissions):

(1) An NFA decision on a complaint by parents of a still born baby against providers alleging a failure to perform an ultrasound scan after the mother had suffered an antepartum haemorrhage, instead discharging her after blood tests and a night in hospital. HDC's external clinical advice was conflicting, but one external expert considered that the omission amounted to a moderately severe departure from the standard of care.[6]

(2) An NFA decision on a complaint by a woman, alleging failure to diagnose, and appropriately treat a blood clot, inappropriately transferring from the vascular specialism to the general medicine service, and inappropriately discharging her from Hospital, causing her severe ongoing health consequences. Two experts were critical of the care, one considering the care a "moderate departure from acceptable standards."[7]

(3) An NFA on a complaint by a daughter 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. There were breaches of the inter-hospital transfer protocol and a communication error between medical staff at the receiving hospital. This resulted in a 30

[6] See Chief Ombudsman P Boshier, *Preliminary assessment process and decision to take no further action on complaints* (December 2020).

[7] Ibid.

minute delay in obtaining a CT scan, which, while probably not causative, was described by HDC's in-house GP advisor as "somewhat excessive."[8]

(4) An NFA decision on a complaint by Christchurch man, alleging that a hospital consultant oncologist had failed to warn his partner of the possibility of an interruption in the supply of the drugs that she would be receiving before she was admitted on to a pharmaceutical company's Compassionate Use programme (CUP), under which she could access unregistered, unfunded, potentially life-saving medications for her advanced metastatic melanoma; also that the oncologist did not advise her that she could access the drug in the UK as she was a UK citizen, where it was government-funded, thereby depriving her of considering that option. After taking the drugs for about seven weeks, the supply of the drug was abruptly stopped. Her condition rapidly deteriorated, and about six weeks later she died.[9]

(5) An NFA decision on a complaint from two adult children, alleging that a physician had failed to prescribe antibiotics and high-dose steroids to their 81 year-old mother, when she had presented to North Shore Hospital with an acute deterioration of her severe chronic COPD. She was given oxygen and discharged the next day, but three days later was taken by ambulance back to hospital where she died less than an hour later. HDC's in-house GP advisor was not critical, but the family submitted two reports from a leading respiratory physician which were highly critical of the failure to prescribe antibiotics and considered that the omission to prescribe steroids a "major and serious departure from the standard of care."[10]

(6) An NFA on a complaint by a man, who donated bone marrow for a transplant to French woman with leukemia, during which both his sacro-illiac joints were damaged because the wrong, large-sized needles were used for the extraction, as smaller needles were not available, and 1.5 kg of marrow was harvested, five times the usual amount he had told would be taken. His training for admission to the police had to be discontinued because of his injuries.[11]

(7) The surgical mesh complaints. As the petitioner's submissions indicate in greater detail, of the 68 surgical mesh complaints submitted to the HDC, only two were formally investigated and 74% of the complaints were "resolved" by an NFA decision,[12] notwithstanding the serious injuries caused by surgical mesh to large numbers of people and the vast sums paid out in ACC compensation to its victims.

10. **NFAs risk adding insult to injury.** The author has supported or counselled numbers of complainants on the receiving end of NFA decisions. From my observation, receiving a NFA decision carries the serious risk of turning (usually) good and sincere people with a genuine grievance for which they simply want a hearing (and acknowledgement if something has gone wrong) into bitter, obsessive and potentially vexatious litigants, railing at the unfairness of their treatment by the HDC, and who thereafter embark on further, increasingly desperate quests to seek justice. When the process gives them nowhere else to turn, the damage is exacerbated. Research shows that if people consider that they have been heard and listened

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[8] Ombudsman B Waken, *Complaint about Health and Disability Commissioner assessment process* (October 2013).

[9] J Manning, "'Fair, simple, speedy and effective'? Barriers to access to justice in the Health and Disability Commissioner Complaints Process in New Zealand" [2018] *New Zealand Law Review* 611, pp 632-33.

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

[11] D Chisholm, "New Zealand's Bitter Pill" North & South, July 2019.

[12] Information provided by Deputy Commissioner Rose Wall via email.

to with respect and dignity, they are significantly more likely to accept a decision-maker's decision, even if adverse to them.[13]

11. Recent important Ombudsman decision strongly critical of preliminary assessment process and NFA decisions

The excessive numbers of NFAs and HDC's procedure leading to an NFA decision, especially in serious cases, have been the subject of criticism by other decision-makers.

In April 2020 the Chief Ombudsman released an important decision on three complaints on which the HDC had made NFA decisions. Two complainants and a provider had made further complaint to the Ombudsman.[14] In his report, he took the highly unusual step of criticising the substantive fairness of the decisions on two of the complaints, on grounds that in the Ombudsman's opinion the decision was substantively unreasonable, and recommending that the HDC reconsider its NFA decisions.

The Chief Ombudsman's report suggests that the preliminary assessment process leading to the HDC making NFA decisions on complaints is being greatly over-used. He suggests that the Commissioner has been setting the bar of seriousness to warrant a formal investigation of a complaint far too high:

> HDC appears to consider that initiating an investigation is a detrimental punitive action against a provider that should generally be avoided unless serious malpractice is identified. However, this strict criteria appears to inflate the threshold for initiating an investigation beyond the statutory requirements and results in HDC conducting a disproportionate 'preliminary assessment' instead." **Para 137.**

He indicates that what he calls "middle-range or serious" complaints, not just cases of "serious malpractice" that the Commissioner might consider a referral to the Director of Proceedings to consider further proceedings, should also be being formally investigated, rather than the subject of NFA decisions. A key concern he highlights is that failure to do so unfairly deprives complainants of the opportunity for the Commissioner to hold the provider to account by way of a formal finding of breach of the Code if proven, and of the opportunity to take further proceedings themselves before the Human Rights Review Tribunal if they are dissatisfied.

Preliminary assessment is supposed to be an expeditious process, to enable the Commissioner "make a prompt initial determination about how the complaint should be handled." **Para 97**. But, he concludes that HDC's preliminary assessment processes in these cases stepped outside what Parliament envisaged a "preliminary" assessment should entail. The process has been used as a vehicle for an extensive information-gathering exercise and detailed analysis of the standard of care provided to the consumer, which are the hallmarks of an investigation:

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[13] J Moore & M Mello, "Improving reconciliation following medical injury: A qualitative study of responses to patient safety incidents in New Zealand," (2017) 26 BMJ Qual Saf 788.

[14] Chief Ombudsman P Boshier, *Preliminary assessment process and decision to take no further action on complaints* (December 2020). The facts of the first two complaints are described at para 8(1) and (2). The third complaint was brought by a provider, who complained about the time taken (4 years, 3 months) for HDC to complete it preliminary assessment and to take NDA.

> I do not consider that collecting extensive information from the providers, expert advisors, and complainants and then carrying out a comprehensive analysis should form part of the preliminary assessment. Rather these are the types of steps I would expect to see HDC take in the context of an investigation, once a preliminary assessment as to how the complaint should be handled has been promptly completed. I consider it the purpose of an investigation, not a preliminary assessment to establish the findings of a case (where possible) and to come to appropriate conclusions. (**paras 114-115**).

The Ombudsman recommended that the Commissioner develop a comprehensive complaint-handling policy, which specifies the criteria that she and her Deputies will take into account when deciding when to take no further action, and when to instigate an investigation. The policy should attribute weight to the relevant decision-factors, indicating in general terms which are the more important factors to which greater weight should be attached. A key factor would be the wishes of the complainant. Such transparency in a published policy would be welcome, so that both parties to a complaint can address themselves to the criteria identified as relevant in their submissions to HDC at key decision points.

The emphasis on a complainant's interest in a formal investigation in serious complaints is welcome, and will no doubt prompt the Commissioner to undertake a re-orientation of HDC's activities and resources away from preliminary assessments to carrying out an increased number of investigations of complaints. Nevertheless, a Commissioner's resources with which to undertake investigations will always be constrained. There will remain significant numbers of complainants who receive NFA decisions with which they are dissatisfied, given that over 1,000 complaints per annum are currently dealt with in this way. Complainants will still need some recourse to be able to challenge these. In general, the Ombudsman's decision should encourage the Health Select Committee to take this petition seriously, to see what contribution it too can make to making the HDC complaints process function better in terms of delivering fair and just outcomes.

12. **High Court decision critical of NFA decision-making process**

In *Meek v Health and Disability Commissioner* an unrepresented complainant, Mr Stuart Meek, brought judicial review proceedings of NFA decisions on three complaints to HDC about his mental health care by a Mental Health Team.[15] His argument on review was that the Commissioner's assessment process was unfair, in that he had not been given an opportunity to comment on the DHB's responses before NFA decisions were made, and he considered those responses factually inaccurate. The Commissioner argued that an NFA is highly discretionary, made by him within his area of expertise, and the Court should therefore not subject the decision to "overly intensive review." He said that the "simple, speedy and efficient resolution" purposes pointed against a "procedurally intensive approach", especially at the assessment phase. The Commissioner had limited resources and should be "trusted to properly 'triage complaints.'"

The High Court disagreed. Clifford J stated that while preliminary assessment is an important part of the "simple, speedy and efficient" resolution, ***"the first requirement is that the resolution of complaints be fair."*** Where the challenge was a classic challenge to process", as here, the Court should not be diffident about subjecting the HDC process to close scrutiny.

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[15] [2016] NZHC 1205. Meek is the only judicial review action brought by a complainant to date.

Apparently aware of the lack of any appeal right, the Court developed procedural fairness requirements around NFA decisions, emphasising "fair" as well as "simple, speedy, efficient" resolution e.g., complainant's rights to respond to information collected by HDC, and to have factual disputes determined and key witnesses consulted before an NFA decision can be made.

13. **Fewer investigations in last 20 years**

Over the last two decades the proportion of complaints that proceed to a formal investigation have dramatically declined, even though complaint volumes have almost doubled. In 2000/01 538 investigations of 1,338 complaints closed (or 40 percent) were carried out, whereas in 2019/20 133 investigations (or only 6 percent) of 2,226 complaints proceeded to a full investigation.[16] Where not "resolved" by an NFA decision (47 percent in 2019/20), there has been increased use of referral to the provider to resolve the complaint (approx. 20 percent).

The HDC Office has "performance expectations," which includes a "target" for the number of investigations it will undertake and close in the forthcoming year. There is a close correlation between its "target" and the number of investigations it actually carries out.[17]

Year	Target number of investigations	Actual number of investigations undertaken
2020/21	120-130	-
2019/20	115-125	133
2018/19	120	102
2017/18	100	102

It is pretty clear that the explanation for the increased proportion of NFA decisions and the dramatic decline in formal investigations over that period is a deliberate decision to ration scare resources (staff time and other resources) in response to increased complaint volumes, which have increased by 40 percent over the last twenty years. Priority has also been given to closing files and keeping the backlog of open files to a minimum, rather than undertaking time-consuming investigations.

It is important to note that the Chief Ombudsman clearly indicated in his recent decision that a rationing motivation was an illegitimate reason for avoiding an investigation, when one is warranted:

> Even if it can be demonstrated that an investigation is significantly more resource-intensive, it is difficult to identify a clear basis to suggest that resourcing issues, in and of themselves, would justify an apparent departure from the purpose of the legislation (in relation to what constitutes a "preliminary" assessment) or avoiding a formal investigation where it might otherwise be warranted. **Para 135**

14. **No appeal by either party from Commissioner's decision after a formal investigation**

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[16] Health & Disability Commissioner, Annual Report 2000/01 and 2019/20.

[17] See HDC, Statement of Performance Expectations 2020/2021, p 12, available at: https://www.hdc.org.nz/media/5626/statement-of-performance-expectations-2020-21.pdf See also HDC, Statement of Performance Expectations 2018/19: https://www.hdc.org.nz/media/5211/statement-of-performance-expectations-2019-20.pdf See also HDC, Annual Reports, 2017/18, 2018/19, 2019/20.

A reason put forward for not naming individual providers found in breach of the Code of Rights has been that the HDC investigation process is a relatively low-level one, based largely on documents, without the natural justice protections of oral evidence and cross-examination and the forensic fact-finding methods used in court proceedings, and that the Commissioner's opinion is not subject to appeal.[18] The Commissioner or Deputy is very often faced with an inability to resolve disputes between parties over different factual versions of the events. The outcome of the complaint frequently depends on which version the Commissioner decides to accept. In the absence of corroborating documentary evidence, the benefit of the doubt often is given to the provider (and properly so). Thus, as the Naming Policy implicitly accepts, there is a greater likelihood of error in decisions reached via such a process. The judgment is that this is a price worth paying for a relatively low-level, low blame process. Nevertheless, there must be a limit to this utilitarian calculus. A low-level process should not be the *only* process available to the parties. It is submitted that the trade-off is that there must be a right of appeal to enable parties to correct mistakes and injustices in decisions made in such a process.

15. **Generous appeal rights in analogous complaint processes, ACC claims and disciplinary findings in the health sector**

Where a claimant is dissatisfied with ACC's decision on a claim for compensation, say arising out of the same episode of care giving rise to the complaint to HDC, there is internal and external review, as well as three levels of appeal to the courts.

Should a health practitioner be found in breach of the Code, be referred by the Commissioner to the DP, and be found guilty of professional misconduct by the Health Practitioners Disciplinary Tribunal, s/he has a right of appeal to the High Court and with leave, to the Court of Appeal. Similarly, parties to HRRT proceedings have a general appeal right to the High Court and the Court of Appeal on a question of law.

The problem for the parties is, however, how to get past the HDC. The complainant cannot appeal an NFA decision nor, if lucky enough to have their complaint investigated, a "no breach" finding, and a provider cannot appeal a breach finding.

Of the three complaint processes established in the 1990s (the Health and Disability Commissioner, the Privacy Commissioner and the Human Rights Commission), complainants and those complained about have appeal rights to the Human Rights Review Tribunal in privacy and anti-discrimination complaints, but not complaints about health and disability services. This is even though, I submit, that most people, if asked, would regard their health as their most first and important asset (while not disputing that privacy breaches and discrimination can cause significant harms).

None of this makes any sense. It is seriously unbalanced and unfair. The unfortunate consequence is that a Health and Disability Commissioner has too much unaccountable power under the regime as currently established by the HDCA. S/he is the only decision-maker whose decisions cannot be challenged and if erroneous, corrected on appeal.

16. **Ministry of Health's submissions on petition.**

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[18] See Naming Policy, p 15, para 7.

I wish to address two arguments against a right of appeal made by the Ministry of Health's submissions on the petition to the Health Select Committee, see undated letter S Turner to Chair of HSC.

(1) First, it is said:

> The Ministry believes that the ability to raise concerns with the Office of the Ombudsman about the Health and Disability Commissioner's decisions, along with judicial review, functionally acts as a right of appeal for complainants, and those that are subject to complaints. (P 2)

This is simply incorrect. While the Ombudsman does have wide grounds for investigating complaints in the Ombudsman Act 1975, s 22, it seldom uses them. In virtually every Ombudsman report on complaints received from the HDC process, the following boilerplate appears:

> 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.[19]

The Ombudsman's reason given for its practice of confining itself to reviewing HDC's process for procedural unfairness and its reluctance to intervene in the substantive merits of decisions is that it is considered that it is impracticable and possibly illegitimate for the Ombudsman to substitute its view for that of a specialist decision-maker like the HDC.[20] The Chief Ombudsman's recent decision in which he found two NFA decisions substantively unreasonable is very much a (welcome) aberration, but note that he still did not substitute a decision to notify an investigation for the HDC's NFA decisions, but referred the complaints back to the HDC with a recommendation that it reconsider its decisions, albeit with a strong hint that it commence investigations.

Similarly, for judicial review. Apart from the cost barrier of High Court proceedings for most consumers, who unlike providers are uninsured for their legal costs, it is misleading to suggest that judicial review proceedings are equivalent to an appeal. They too are largely confined to a scrutiny of the fairness of the procedure by which the decision was reached, questions of law, with a judicial refusal to consider the substantive fairness of a public authority's decision unless it meets a high bar of being irrational. In *Stubbs v Health and Disability Commissioner* the applicant doctor tried to attack an HDC "breach" finding against him on the ground that (inter alia) it was substantially unfair to him. The High Court stated:[21]

> The tenor of the legislation suggests that this situation is not one where "hard" look judicial review is appropriate. The Commissioner's opinion is just that, an opinion not directly affecting the legal rights or liabilities of the health care provider; the prescribed process has a high level of "fairness" attached with its insistence on referral of any proposed negative comment by the Commissioner 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.

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[19] Ombudsman B Waken, *Complaint about Health and Disability Commissioner assessment process* (October 2013), p 2.

[20] D McGee, *Review of the reviewers* (unpublished paper, March 2010).

[21] High Court, Wellington, 8/2/2010, CIV-2009-485-2146, Ronald Young J, para 35 (refs omitted).

(2) The Ministry also argued that the issue of a right of appeal should be referred back to the incoming Commissioner herself to be addressed in the context of the next five-yearly review of the Act and Code. This would enable consideration of both operational and legislative options, and the Commissioner could provide advice to the Minister of Health on whether any amendments are necessary or desirable.

We would argue strongly that the Committee should not "pass the buck" to the Commissioner in this way, for the following reasons:

(1) Submissions arguing for a right of appeal have been made in the last three reviews of the Act and Code, but have never been supported by the Commissioner. No decision-maker welcomes being subject to the discipline of appeal nor takes kindly to being overturned on appeal. Asking the HDC to advocate for an appeal right from its decisions is, with respect, like "asking turkeys to vote for Christmas."

(2) We welcome the fact that the new Commissioner is considering introducing reforms designed to address some of the concerns that have given rise to the petition. But the petition raises systemic concerns about the overarching design of the HDC complaints process that are beyond the capacity of any Commissioner to address, no matter how well-motivated. The overarching design of the complaints process is determined by the Health and Disability Commissioner Act 1994. The Commissioner herself must function within its statutory parameters.

(3) This Committee is the most appropriate body to inquire into the petition and report its findings to the Minister and to the House. It has the necessary authority and independence to address the issues raised. If the issue is referred back to the Commissioner, and she agrees after her review of the Act and Code that an appeal right is warranted, she will report with such a recommendation to the Minister. This Committee can make just this recommendation without following that circuitous and time-consuming route back to exactly the same decision-maker.

17. **What might a right to review of appeal look like?**

The most straight-forward option to include a right of appeal from NFA decisions and from adverse decisions after a formal investigation would be to amend the HDCA to enable complainants, consumers and providers to take proceedings in the HRRT. The HRRT already has jurisdiction over health and disability complaints; that jurisdiction would simply be expanded. It would be a simple matter to amend section 51 of the Act, as follows:

> **Aggrieved person may bring proceedings before Tribunal**
>
> Notwithstanding section 50(2) but subject to section 53, the aggrieved person (whether personally or by any person authorised to act on his or her behalf) may bring proceedings before the Tribunal against a person to whom section 50 applies if he or she wishes to do so, and—
>
> (a) The Commissioner has made a decision under section 38(1) to take no action or no further action on a complaint;
>
> (b) The Commissioner has found no breach of the Code on the part of the person to whom that section applies;
>
> (c) the Commissioner, having found a breach of the Code on the part of the person to whom that section applies, has not referred the person to the Director of Proceedings under section 45(2)(f); or
>
> (d) the Director of Proceedings declines or fails to take proceedings.

Proceedings before the HRRT are civil, and hearings are de novo. The procedure before the HRRT is formal and court-like, with legal representation, oral evidence by parties and witnesses subject to cross-examination, and formal, often written submissions. This legalisation, formality and (no doubt) expense of the process is, it is submitted, a significant potential disadvantage and may well create a new barrier to accessing justice.

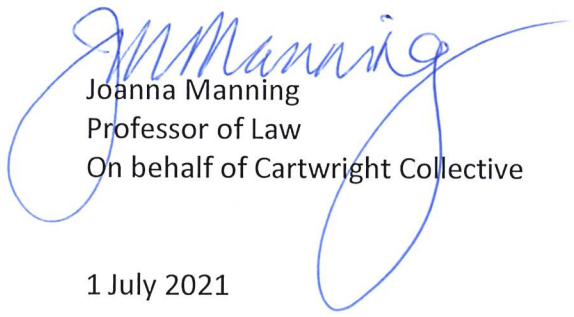
Other less formal, inquisitorial models are well worth considering, such as the ACC review process. It is **not recommended**, however, that the review or appeal body be funded by the HDC, as with the ACC model. Given the potential for compromise to the body's independence and for efficiency measures to be included (as with the ACC model), it is essential that the appellate or review body be completely independent of the HDC and separately funded.

18. **"Throwing the baby out with the bathwater": Balancing low-level resolution with an appeal right.**

There are very valuable aspects of the HDC model worth preserving: it is free, largely lawyer-free and informal, able to resolve more minor complaints by conciliatory means. The Commissioner is independent and has access to excellent clinical advice, circumventing the well-known difficulties for patients and consumers to access medical experts. The vast majority of complaints end after the Commissioner's decision after an investigation.

An often-expressed concern about appeal is that insured and well-resourced providers would appeal every breach finding, while consumers, who are bearing the cost of proceedings themselves, would lack the means to do so ("the inequality of arms argument"). This is a valid concern. It is submitted that this may be a risk worth running. There are over 1,000 NFA decisions and only approx. 100 "breach" findings against providers every year. In purely utilitarian terms, the cost of putting complainants through unmeritorious appeals against "breach" findings brought by providers may be worth it for the benefit of 1,000 complainants having the option of appealing NFA decisions with which they are dissatisfied.

But there are effective, well-tried options for disincentivising unmeritorious appeals by either party, which could be built in. The usual means are cost awards, leave provisions, and subsidising complainant's legal costs (e.g., via levies on providers, as with the disciplinary levy payable by health practitioners under section 131 of the Health Practitioners Competence Assurance Act 2003), not by withholding appeal rights altogether.



Joanna Manning
Professor of Law
On behalf of Cartwright Collective

1 July 2021

Appendix 1

Cartwright Collective

The Cartwright Collective is a group committed to monitoring implementation of the 1988 Cartwright Inquiry Report recommendations. Members also are committed to ensuring policy development is based on sound evidence and to the provision of high quality information to enable consumers to make informed decisions.

Two members were responsible for bringing to light the allegations leading to the Cartwright Inquiry; several were involved in Parties to the Inquiry. Some were actively involved in working with the Ministry of Health in establishing the National Cervical Screening Programme (NCSP) and the Office of the Health and Disability Commissioner (HDC). Others have contributed to the development of the Code of Health Consumers' Rights and ethics committees. Several members are or have been involved in university teaching and research.

Current members of the collective:

Ruth Bonita, ONZM: Emeritus Professor at the University of Auckland and former Director of Surveillance of Non-Communicable Diseases at the World Health Organization in Geneva; member of the Expert Group on the NCSP.

Phillida Bunkle: Co-author of the *Metro* article documenting the 'unfortunate experiment' at National Women's Hospital; co-founder of Fertility Action (now Women's Health Action); initiator and Party to the Ministerial Inquiry into the under-reporting of cervical smear abnormalities in the Gisborne region; a long-standing women's health activist.

Sandra Coney, QSO: Co-author with Phillida Bunkle of the *Metro* article; co-founder of Fertility Action; member of the Ministerial Review Committee on the NCSP; member of the Expert Group that initiated the NCSP and co-author of the programme's first Policy Statement; currently a member of the Waitemata DHB.

Joanna Manning: Professor of Law at the Faculty of Law, University of Auckland; teaches and has published widely both internationally and within NZ in the areas of health law, ethics and policy, as well as tort law, negligence and accident compensation law.

Betsy Marshall, QSO: Extensive NGO sector work in cancer screening policy, including member of the Ministerial Review Committee on the NCSP and Expert Group for the NCSP; Chair of the Advisory Group on NCSP Monitoring and Evaluation; Cancer Society Party representative at the Gisborne Cervical Screening Inquiry.

Auckland Women's Health Council Representation:

Cheryl Hamilton: Former Health Improvement Manager at Auckland Regional Public Health Service, which included oversight of the NCSP Register for the greater Auckland region.

Pauline Proud: Former Project Manager for the Auckland Regional Cervical Screening Coordination Service, working across the three DHBs to improve service delivery and increase access to cervical screening

Appendix 2

Fuller descriptions of complaints processes in para 8 of Submissions

(1) An NFA decision on a complaint by parents of a still born baby against providers alleging a failure to perform an ultrasound scan after the mother had suffered an antepartum haemorrhage, instead discharging her after blood tests and a night in hospital. HDC's external clinical advice was conflicting, but one external expert considered that the omission amounted to substandard care which constituted a moderately severe departure from the standard of care, while another considered it reasonable. The parents then complained about the NFA decision to the Ombudsman, who considered HDC's decision unreasonable and recommended that it reconsider it. The incoming Commissioner apologised for the prolonged (three and a half year) process to reach the NFA decision and decided to open an investigation of the complaint.[22]

(2) An NFA decision on a complaint by a woman, alleging failure to diagnose, and appropriately treat a blood clot, inappropriate transfer from the vascular specialism to the general medicine service and inappropriately discharging her from Hospital, causing her severe ongoing health consequences. Two experts were critical of the care, one considering the care a "moderate departure from acceptable standards." The woman asked HDC how she could take her complaint to the HRRT. The HDC advised her that as her complaint had not been formally investigated and a Code breach found, she could not do so. She complained to the Ombudsman, who found HDC's decision handling and NFA decision unreasonable and recommended that it reconsider it.[23]

(3) An NFA on a complaint by a daughter 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. There were breaches of the inter-hospital transfer protocol and a communication error between medical staff at the receiving hospital. This resulted in a 30 minute delay in obtaining a CT scan, which, while probably not causative, was described by HDC's in-house GP advisor as "somewhat excessive." HDC's reasoning was that the protocol had been largely followed and the GP advisor was not overly critical. The daughter made a further complaint to the Ombudsman, who upheld her complaint that the HDC's decision was unreasonable, on the ground that HDC had advised the Hospital of its provisional decision to take no further action on the complaint before it required further information from it about the deficiencies in the man's care.[24]

(4) An NFA decision on a complaint by Christchurch man, alleging that a hospital consultant oncologist had failed to warn his partner of the possibility of an interruption in the supply of the drugs that she would be receiving before she was admitted on to a pharmaceutical company's Compassionate Use programme (CUP), under which she could access unregistered and otherwise unfunded, potentially life-saving medications for her advanced metastatic melanoma; also that the oncologist did not advise her that she could access the drug in the United Kingdom as she was a UK citizen, where it was government-funded, thereby depriving her of considering that option. After taking the drugs for about seven weeks, the supply of the drug was abruptly stopped. Her condition rapidly deteriorated, and about six weeks later she

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[22] See Chief Ombudsman P Boshier, *Preliminary assessment process and decision to take no further action on complaints* (December 2020).

[23] Ibid.

[24] Ombudsman B Waken, *Complaint about Health and Disability Commissioner assessment process* (October 2013).

died. The doctor acknowledged that he knew of the potential for supply issues, but that the company had assured him that they would be resolved, and so he did not advise the couple. HDC considered that the consent form prior to commencing the programme explained the possibility of an interruption in supply. The complainant vigorously disputed all of the HDC's arguments, but it did not resile from any.[25]

(5) Two adult children complained to the Ombudsman about an NFA decision on their complaint alleging that a physician had failed to prescribe antibiotics and high-dose steroids to their 81 year-old mother, when she had presented to North Shore Hospital with an acute deterioration of her severe chronic COPD. She was given oxygen and discharged the next day, but three days later was taken by ambulance back to hospital where she died less than an hour later. HDC's in-house GP advisor thought that the care met expected standards and the HDC made a NFA decision. It went on to review the decision twice, after submissions from the family, which included two reports from a leading respiratory physician which were highly critical of the failure to prescribe antibiotics and considered that the omission to prescribe steroids was a "major and serious departure from the standard of care." HDC obtained further in-house advice from a second GP, who considered the failure to administer antibiotics "unwise and inconsistent with accepted practice" and the decision relating to steroids "a moderate departure from the standard of care." Nevertheless, HDC confirmed its original NFA decision. The Ombudsman said that although an NFA decision was not for him to second-guess, HDC's discretion not to seek clinical advice from a respiratory physician had been "exercised unreasonably", given the later advice from the experts, which identified a moderate or major departure from professional standards, setting the scene for a breach finding had an investigation been carried out.[26] (When the case went to a coroner's inquest two years after the death, the coroner found that, in light of the divided views of the medical experts, the physician's management was not a significant departure from accepted standards).[27]

(6) An NFA on a complaint by a man, who donated bone marrow for a transplant to French woman with leukemia, which went wrong. Both his sacro-illiac joints were damaged because the wrong, large-sized needles were used for the extraction, as smaller needles were not available, and 1.5 kg of marrow was harvested, five times the usual amount he had told would be taken. His training for admission to the police had to be discontinued. Although the HDC relied on expert advice that the decision to continue with the proceduure with the large size needles was reaonable, given the threat to the recipient's life, and that the procedure was done with reasonable care and skill, the DHB's consent forms were amended to refer to the risk, and the doctor concerned later admitted that he wished he had stopped the procedure.[28]

(7) The surgical mesh complaints. As the petitioner's submissions indicate in greater detail, of the 68 surgical mesh complaints submitted to the HDC, only two were formally investigated and 74% of the complaints were "resolved" by an NFA decision,[29] notwithstanding the serious injuries caused by surgical mesh to large numbers of people and the vast sums paid out in ACC compensation to its victims.

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[25] J Manning, "'Fair, simple, speedy and effective'? Barriers to access to justice in the Health and Disability Commissioner Complaints Process in New Zealand" [2018] *New Zealand Law Review* 611, pp 632-33.

[26] Ombudsman R Paterson, *Complaint: Mrs S* (30 June 2016).

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

[28] D Chisholm, "New Zealand's Bitter Pill" North & South, July 2019.

[29] Information provided by Deputy Commissioner Rose Wall via email.