14 January 2025

Independent Review of the Medical Council's Notifications Policies and Processes

Medical Council

Te Kaunihera Rata o Aotearoa | Medical Council of New Zealand

RDC Group Ltd

Contents

1. Summary

This report provides an independent review and assurance advice of the Medical Council of New Zealand's | Te Kaunihera Rata o Aotearoa (the Council) notifications policies and procedures relating to notifications concerning a doctor's conduct.

The main messages are that the Council takes notifications seriously and has comprehensive policies in place. While the Council's current processes are generally robust and fit for purpose, there are improvements which could strengthen public protection and enhance the experience of notifiers in several key areas.

While current processes are more robust than in the past, several key issues need addressing:

- The complaints system can be complicated for people to navigate
- The process takes too long to resolve
- There's an imbalance in information sharing (doctors see everything complainants provide, but complainants don't see doctors' responses)
- Delegations could enable faster action to be taken by staff
- Support for people making complaints can be improved
- There's no systematic way to collect and learn from feedback
- Consideration ought to be given to specialised training for staff handling sexual misconduct cases and specialised investigation staff for complex cases.

A central theme of the report is the need to better support notifiers through the process, particularly in cases involving sexual misconduct or abuse. The report suggests developing a hybrid model combining in-house support staff with external specialists for complex cases. This acknowledges both resource constraints and the need for specialised expertise in sensitive cases.

The review identifies timeliness as a challenge, with notifications often taking longer to resolve than ideal. This creates stress for both notifiers and practitioners. The report recommends streamlining processes, including reviewing delegations to staff for certain decisions, though it notes that this may require legislative change.

Another key finding is the opportunity to strengthen feedback mechanisms and continuous improvement. Currently, there's no systematic way to collect and analyse feedback from people who have been through the notification process. Implementing this could help identify systemic issues and drive improvements.

The report also highlights information sharing as an area for development. There's a perceived imbalance where doctors see all information notifiers provide, but notifiers often can't see doctors' responses. The report suggests considering greater transparency, including potentially publishing more disciplinary history on the public register.

From a regulatory perspective, the report recommends exploring alternative dispute resolution mechanisms for appropriate cases. These could include mediation or restorative justice approaches, which would provide more flexible options while maintaining the Council's core regulatory function.

The recommendations align with contemporary regulatory best practices, emphasising the need for an accessible, fair, and effective system while maintaining appropriate procedural safeguards. They also reflect growing expectations around cultural safety, health equity, and support for vulnerable people engaging with regulatory systems.

These findings are particularly relevant given Aotearoa | New Zealand's current focus on health system reform and increasing emphasis on patient voice and experience. The recommendations provide a pathway for the Council to evolve its practices while maintaining its fundamental role in protecting public safety.

2. Background and Context

This report provides Te Kaunihera Rata o Aotearoa | The Medical Council of New Zealand (the Council) with our advice following our assurance review of the Council's policies and procedures relating to notifications concerning the conduct of doctors. This Review was carried out in accordance with the Terms of Reference approved by the Council (see Appendix 1).

The Council established a Temporary Committee (the Temporary Committee), and subsequently, this Review was made to consider and recommend to the Council any actions related to the Royal Commission of Inquiry into Abuse in State Care (the Royal Commission). The Royal Commission reported to the Governor-General in June 2024 and its findings were made public on 24 July 2024.

As part of its inquiry, the Royal Commission looked into the abuse of children, young persons, and vulnerable people in state psychiatric care in New Zealand between 1950 and 1999. Included in this is consideration of Dr Selwyn Leeks' abuse of children under the guise of treatment at the Lake Alice Child and Adolescent Unit from 1972 to 1980.

On 18 April 2024, excerpts of the Royal Commission's final report were provided to Council for comment as part of its natural justice process. In part the the Royal Commission commented that:

- The Council did not always act to ensure people in care were safe from doctors who should not have been practising.
- The Council was unable to locate documents and did not have a reasonable explanation of why they could not be recovered.
- Council was at fault for not acting when it should have done to protect the public, such as;
    - Allowing Dr Leeks to continue to practise.
    - Making decisions concerning complaints of abuse by Dr Leeks that could not be explained due to the incompleteness of records.
    - Prioritising fairness to Dr Leeks over the safety and wellbeing of patients.
    - Accepting Dr Leeks' response to allegations without question.

In this context, the Council commissioned an external, independent review of the processes and actions it takes in response to concerns being raised about a doctor's conduct. This Review extended to the general guidance and advice to its Professional Conduct Committees (PCCs). We were asked to review conduct notifications involving allegations of a doctor abusing a patient to identify whether the issues arising from the Royal Commission's report would be effectively addressed under the Council's current processes, including consideration of the relevant provisions of the Health Practitioners Competence Assurance Act 2003 (HPCAA).

The Temporary Committee would consider the findings of the Review and present these to the Council, along with any recommendations. The Review specifically relates to conduct notifications involving allegations of a doctor abusing a patient, in order to identify whether issues arising from the Royal Commission's inquiry would be effectively addressed under the Council's current processes and can be prevented in the future so that the protection of the public is assured

The Review was to be carried out in a manner consistent with the Council's values which include;

- Whakapono – We act with integrity.
- Whakamārama – We will listen to understand.
- Manaakitanga – We will support each other.
- Kaitiakitanga – We protect the public.
- Kotahitanga – We will work together.

3. Scope and Approach

3.1. Scope

As noted above, the primary objective of this Review was to assess Council's processes and the actions that Council takes in response to concerns being raised about a doctor's conduct. This extends to the establishment of, and general guidance and advice provided to, its PCCs. The Review specifically relates to conduct notifications involving allegations of a doctor abusing a patient to identify whether issues arising from the Royal Commission would be effectively addressed under the Council's current processes.

A secondary objective was to identify improvements to current policies and processes that would enhance the Council's response to notifications of misconduct.

The specific matters we were asked to report on were:

> *4. In particular, the review should assess in respect of these types of notifications:*
>
> *a. whether notifications are robustly handled, and that Council has a well-defined, consistent, and effective process for handling notifications alleging abuse.*
>
> *b. how Council communicates and engages with notifiers and/or patients during the notification process, including whether Council accommodates the patient's needs, health literacy, health equity and cultural safety in its communications and engagement with them.*
>
> *c. whether Council sufficiently considers the patient's voice during the notification process. This may include meeting with the Council's Whakawaha (Consumer Advisory Group).*
>
> *d. whether Council's decision-making adequately protects the health and safety of the public.*
>
> *5. As part of the assessment outlined in paragraph 4 above, the reviewer should assess the work that Council staff carry out in advising and facilitating PCC investigations.*
>
> *6. The review should also review information-sharing of the above types of notifications, including at an inter-agency level, with the notifier, and with the public more generally.*

3.2. Out of scope

The following matters were outside the scope of this Review:

a. Council matters solely relating to performance and/or fitness to practise issues.

b. Commentary on individual cases, Council members, and staff members.

c. Decisions made by PCCs, including the way individual PCCs have undertaken their processes (to not impinge on s 72(1) of the Health Practitioners Competence Assurance Act 2003 'HPCAA'). However, this does not exclude the overarching principles PCCs consider when communicating and engaging with notifiers.

3.3. Approach

In carrying out this Review, we:

- Interviewed the organisations and people listed in Appendix 3, including liaising with Council staff on a regular basis
- Reviewed a broad range of material, including the material listed in Appendix 2
- Analysed comparative information relating to other regulators with similarities to the Medical Council, including
- Drew from Ombudsman's guidance for complaints management by public sector organisations
- Incorporated international regulatory practices, especially the Australian Health Practitioner Regulation Agency
- Assessed current state against best practice criteria

4. Limitations and acknowledgements

This review is limited to the scope and matters set out in our terms of reference and is also limited to the current statutory framework and role of the Council. This review does however identify possible alternatives to the current settings.

The review does not assess the outcomes of any notification or investigation undertaken by the Council.

We would like to acknowledge the thoughtful, open, and constructive input from the individuals and organisations who contributed to the review. People were universally generous with their time and thoughts. Council staff, senior management and Council Member we spoke with are all clearly passionate about and committed to a well-functioning regulatory model which contributes to a high performing and safe health system in New Zealand. In particular, we are grateful for the assistance and information provided by the Council's staff including the legal and registrar teams.

5. Good Practice Guidance for Complaints Systems

The New Zealand Ombudsman has published guidance on what he considers is good practice in relation to complaints systems.[1] While the Ombudsman's focus is generally on the conduct of public service agencies, there are elements of the guidance that may be useful in considering and assessing the systems and processes the Council has in place to manage and respond to notifications.

The Ombudsman identified the following as the key aspects of a complaints system;

Designing an effective complaints process

The 3 steps in an effective complaints process

Step 1: Enabling complaints

The complaints process is client focused, visible, accessible, and valued and supported by management.

[1] https://www.ombudsman.parliament.nz/resources/effective-complaint-handling

Step 2: Responding to complaints

Complaints are responded to promptly and handled objectively, fairly and in confidence. Remedies are provided where appropriate.

Step 3: Accountability and learning

There are clear accountabilities for complaint handling and complaints are used to stimulate agency improvements.

The Ombudsman's guidance sets out the following as reflecting good process;

Process

There must be an effective process for handling complaints. The following key stages in complaint handling should be described in internal procedures:

1. A complaint should be acknowledged promptly;
2. The complaint should be assessed and assigned priority, with a decision made as to who will deal with the complaint and when it should be completed;
3. If the matter cannot be resolved immediately and a review is required, it should be planned, with consideration of what action needs to be taken to consider the complaint and who needs to be consulted;
4. The Review should resolve factual issues and consider options for complaint resolution;
5. The response to the complainant should be clear and informative, as far as possible, explaining the outcome of the complaint and providing reasons for any decisions made or remedies offered;
6. The response should include information about other possible remedies, in the event that the complainant is not satisfied;
7. Any systemic issues that arise as a result of the complaint should be considered and acted on; and
8. Action should be taken to record the complaint and its outcome, and to report to management as appropriate.

The Ombudsman's guidance goes on to identify what they consider to be the elements of effective complaints handling.

Elements of effective complaint handling

A complaints process must be supported by the following elements in order to be effective.

Culture | Principles | People | Process | Analysis

Culture

The agency must value complaints and recognise that effective complaint handling will benefit its reputation and administration.

Principles

An effective complaints process must be modelled on the principles of:

Fairness;

Accessibility;

Responsiveness; and

Efficiency.

Complaint handling must also be integrated with the core business of the agency.

People

The staff who handle complaints must be skilled in their role and have a positive attitude when dealing with complainants.

They should be chosen for that function and be fully trained in the work of the agency and in exemplary complaint handling practices.

They should receive effective supervision and regular feedback about their work.

Process

There must be an effective process for handling complaints. The following key stages in complaint handling should be described in internal procedures:

Analysis

Information about complaints can provide an insight into an agency's policies, procedures and services that are not working as well as they might. It can be used to improve customer service by:

We also examined guidance from the the West Australian Ombudsman which identified a similar framework;

Effective complaint handling systems

An effective complaint handling system provides three key benefits to an organisation:

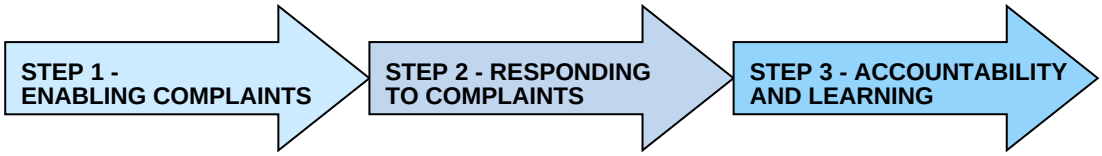
- It resolves issues raised by a person who is dissatisfied in a timely and cost-effective way;
- It provides information that can lead to improvements in service delivery; and
- Where complaints are handled properly, a good system can improve the reputation of an organisation and strengthen public confidence in an organisation's administrative processes.

The public wants:

- a user friendly complaint handling system
- to be heard and understood
- to be respected
- an explanation
- an apology
- action as soon as possible

The organisation needs;

- a user friendly system for accepting feedback
- clear delegations & procedures for staff to deal with complaints and provide remedies
- a recording system to capture complaint data
- to use complaint data to identify problems and trends
- to improve service delivery in identified area



• Arrangements for enabling people to make complaints are customer focused, visible, accessible and valued and supported by management.	• Complaints are responded to promptly and handled objectively, fairly and confidentially. Remedies are provided where complaints are upheld and there is a system for review.	• There are clear accountabilities for complaint handling and complaints are used to stimulate organisational improvements.

6. Current Notification Process

The process for making a notification about a doctor in New Zealand typically involves the following steps:

The person first needs to decide whether to make a notification to:

- The Council (for serious concerns about a doctor's conduct or competence), and
- The Health and Disability Commissioner (HDC) (for concerns about healthcare services).

If making a notification to the Council, the person can:

- Write to the Council directly,
- Fill out a notification form, or
- Contact the Council by phone to discuss their concerns.

After receiving a notification, the Council:

- Acknowledges receipt,
- Completes a rapid assessment,
- May ask the doctor for a response,
- Assesses the seriousness of the concerns, then
- Convenes internally to decide what action to take.

The Council can then:

- Refer the matter to the Health and Disability Commissioner,
- Order a competence review,
- Refer to a Professional Conduct Committee,
- Take immediate action if there are serious concerns, and
- Take no further action if the concerns don't warrant it

If the Council decides to refer the notification to the Professional Conduct Committee (PCC), it is important to state that this is a formal investigation mechanism under the Health Practitioners Competence Assurance Act 2003.

It's triggered when there are serious concerns about a doctor's conduct or when a doctor has been convicted of certain criminal offences.

Each PCC consists of three members - two doctors and one layperson - who are appointed by the Council but operate independently.

The investigation is a legal one: it prioritises natural justice principles, meaning it must be fair and transparent to all parties.

The PCC can gather evidence through various means, including in-person meetings and written statements from relevant parties such as the complainant, the doctor, the employer, and colleagues. They can also seek advice from legal and medical experts. The Council's Legal Team supports this process and provides advice as necessary, including supporting the briefing of external counsel as required.

Key aspects for complainants to understand is that:

- They will be believed.
- They will be invited to provide comments and attend a meeting with the PCC.
- They can bring a support person to any meetings.
- The Council will cover reasonable travel costs for attending meetings.
- The process typically takes 8-12 months to complete.
- Progress updates will be provided between every 6-8 weeks.
- The final decision will be provided within 14 working days of completion.

The PCC has several options available after their investigation:

- Recommend actions to the Council (such as reviewing the doctor's competence or scope of practice),
- Refer the matter to the police,
- Bring charges before the Health Practitioners Disciplinary Tribunal,
- Refer the complaint to conciliation, and/or
- Take no further action.

We understand that in most instances Doctors will have engaged legal representation and while the Council legal team and staff do their best to support and inform notifiers about the process, complainants are not provided with direct independent/advocacy support. From a

procedural fairness perspective, it's important to note that PCC decisions cannot be appealed by the complainant.

Additionally, while complainants can't appeal Health Practitioners Disciplinary Tribunal decisions, the PCC will consult with complainants if they're considering an appeal.

This process reflects a balance between protecting public safety, ensuring procedural fairness for doctors, and providing a structured pathway for addressing serious concerns about medical practice.

Again, it is important to note that this process is part of a broader regulatory framework that aims to maintain professional standards in healthcare while providing appropriate mechanisms for accountability.

7. Reflections on the Current Approach Against the Ombudsman's Guidance

In examining the Council's current approach to responding to notifications of abuse we have used the Ombudsman's three step framework to evaluate the Council's approach.

The Council has been very proactive and engaged in supporting this review, providing a significant amount of information and access to staff and providing the opportunity to review files to get a first-hand view of how a sample of complaints have been handled.

Council advises that with respect to PCC investigation/complaints these are handled in a manner that reflects the principles the Council operates under;

- Whakapono – We act with integrity.
- Whakamārama – We will listen to understand.
- Manaakitanga – We will support each other.
- Kaitiakitanga – We protect the public.
- Kotahitanga – We will work together.

Principles the Medical Council's legal team follows for PCC investigations/prosecutions are as follows:

- Ensure notifiers are kept informed about the progress of a notification (including the progress of an investigation if applicable) by providing regular updates within specified timeframes.
- Ensure all communications relating to the notifications process are made in accordance with the rules of natural justice. This includes ensuring that those affected by decisions are provided the right to be heard, and that the process is conducted in a procedurally fair manner.
- Ensure continuity of communications – have one point of contact from the Council.
- Prioritise sensitive notifications and investigations.
- Tailor the investigative approach or process to fit the circumstances. This may include adapting communications to the needs of the individual(s) involved.
- Meet with the notifier/complainant in person, if possible.
- Encourage witnesses to have a support person. Offer funded counselling to a notifier/complainant where appropriate.
- Identify personal bias and common myths and misconceptions around sexual assault/harassment.
- Being open and transparent with notifiers/witnesses about how their information may be used and/or disclosed to the doctor concerned and why this is necessary.
- Carefully consider people's privacy in determining what information is required and/or is disclosed.
- Apply for notifiers (and other vulnerable witnesses) to give evidence in the HPDT in a special way to decrease re-traumatisation.

Strong inter-agency relationships enable coordinated responses to serious concerns and prevent people from falling through gaps between different regulators. Good relationships also help agencies share best practices and learn from each other. We also note that the Council has in place and maintains active management of a number of Memorandum of Understandings including Memoranda with;

- The Health and Disability Commissioner (HDC)
- NZ Police
- Te Whatu Ora/Health New Zealand

The Council has comprehensive policies and procedures which guide staff and Council members in the response to and management of notifications regarding the conduct of health practitioners covered by the Act.

We were also provided with a small sample of redacted advice provided internally and to PCCs in relation to as sensitive notification. The risk framework and internal advice seemed objective and appropriate. The only suggestion we would make is to consider the extent to which a notifier support service and/or use of restorative/ADR options might enhance the options available to resolve a notification, especially sensitive notifications. This might particularly be useful where the notifier has particular needs, or where the presenting issue might be about clinical understanding/literacy on the part of the notifier and a PCC process may not be the best way to resolve this for the notifier, nor be in the best interest and fairness for the doctor.

7.1. Enabling Complaints

As the Ombudsman of New Zealand has identified, an agency's internal complaints process should be easy for members of the public to access and understand. Otherwise, it is unlikely that people will use it. The guidance notes;

> *All staff members should be aware of the complaints process and be able to either deal with complaints if they can be resolved quickly and easily, or else refer complaints to the relevant person or team within the agency responsible for the complaints process.*
>
> *Complaints should be accepted in a number of ways, such as in person, over the phone, by letter, fax or email.*
>
> *Assistance should be provided to people who are having difficulty formulating their complaint, or who need to communicate with the agency in a particular way due to a disability or a language barrier. It can be helpful to ask people if they have any special requirements for access or communications.*

A report to the Australian Health Practitioner Regulation Agency (Ahpra) noted;[2]

> *"A broader issue for the community is the challenge of improving health literacy. At a time when members of the community appear to have better antennae for inappropriate sexual behaviour in professional settings, there is a surprising lack of knowledge and understanding of basic health information, including why health practitioners may need to undertake physical examinations."*

[2] Better communication with notifiers and practitioners is identified as a key area for improvement in S Biggar, L Lobigs, M Fletcher, How can we make health regulation more humane? A quality improvement approach to understanding complainant and practitioner experiences. Journal of Medical Regulation 2020, 106(1), 7-15.

7.2. Responding to Complaints

Ahpra's Complaints Policy includes the following guidance;

- We publish information about our complaints policy and how to make a complaint and it is easy to find.
- We provide people with a range of contact options to make a complaint.
- We assist people to make a complaint when assistance is needed.
- We recognise that some people have particular needs or vulnerabilities and provide a complaint service that accommodates the requirements of all people.
- We communicate with people in a way that suits the person.
- We encourage people to give us their feedback about our decisions, policies, procedures and service.

Currently, the Council does not systematically gather feedback about the notification process in order to understand the notifier's, or the doctor's experience of the process, including whether communication throughout the process met the needs of the parties. In the absence of the systematic collection of such feedback, the Council misses the opportunity to understand what has gone well and what can be improved on. This includes better understanding whether communication has met the needs of notifiers, or whether there are better ways of communication with them through the process.

7.3. Accountability and learning

Guidance from the Ombudsman and a review of other literature concerning complaint management suggests continuous improvement and the effective gathering and use of feedback are important aspects of an effective complaints system.

Ombudsman guidance includes;

- *Organisations should analyse complaints data and feedback to identify recurrent themes that might identify systemic issues and use the information gathered through their complaint handling systems to identify service, process and information issues that need to be addressed.*
- *Where appropriate, analysis of feedback and complaint information should be used to identify and implement improved practices for particular customer groups including people with disabilities, people living in regional and remote areas, Indigenous people, children and young people, and people from linguistically and culturally diverse backgrounds.*

We would add to this list people who identify as gender and neuro diverse.

Again, Ahpra's complaints policy specifically covers improvement and accountability.

Improvement

- We have well established procedures to identify and report issues about our service delivery, policies and procedures during the management of a complaint.
- We regularly review data captured from the complaints process to identify thematic issues.
- We ensure that any identified problems with our systems or service delivery are followed up and required changes are implemented.
- We encourage learning from complaints to improve our services.

Accountability

- We appropriately resource our complaints management framework and staff are given training and support to effectively manage complaints.
- We identify, measure and report on Key Performance Indicators (KPI's) to ensure that we are providing a quality service.
- We report publicly on our complaints handling performance in our annual report and other documents as appropriate.
- We undertake a review of our complaints management data at least every 12 months so that we can evaluate our performance.
- We review our complete Complaints Management Framework every two (2) years to ensure that it is still fit for purpose.

More systematic analysis of information about notifications would provide the Council with greater insights into how policies, procedures and services are or are not working as designed. This information could then be used to improve how notifications are handled by identifying trends and themes and instances where things have not met the intended standards, or outcomes.

As importantly, the gathering of feedback and the analysis and reporting on this would provide the Council and the profession with important information and assurance that the regulatory system is performing at an appropriate level, or if not this is reported on and responded to appropriately.

The New Zealand Ombudsman recommends;

> *All agencies should set both qualitative and quantitative measures for assessing their complaint handling. There should be regular reporting to senior management about the subject matter of complaints, how the complaints have been dealt with, and the steps taken to resolve systemic problems.*

8. Best Practice Framework

This report relies on several emerging best practices for handling notifications about doctors' conduct, drawing on New Zealand and international examples.

In assessing Council processes, we had regard to the Ombudsman's guidance and regulatory practice of other regulators in New Zealand and overseas. We identified that effective notification systems evidenced some common attributes including:

- Client-focused, visible, and accessible.
- Supported by transparent procedures and management commitment.
- Responsive and timely in handling concerns.
- Fair and objective in approach.
- Focused on continuous improvement through feedback.

The Ahpra model offers additional best practices worth considering:

- Specialised training for staff handling sexual misconduct cases.
- A dedicated notifier support service.
- Specialised investigation teams for complex cases.
- Clear communication protocols with notifiers, and
- Regular review and improvement of processes.

Other regulators highlighted these practical approaches:

- Flexible systems that can be tailored to individual circumstances.
- Clear delegation frameworks to enable timely decision-making.
- Alternative Dispute Resolution options where appropriate.
- Strong focus on supporting vulnerable notifiers, and
- Systems for capturing and analysing feedback.

The best notification systems also incorporate:

- Multiple channels for making notifications.
- Support for people with different needs (language, disability, cultural, etc).
- Clear timeframes and regular communication.
- Transparent processes and outcomes, and
- Protection for both notifiers and practitioners.

It is important to note, however, that this is a statutory process, which means the notification system also needs to balance:

- Public safety and protection
- Natural justice and procedural fairness
- Timeliness and thoroughness
- Support for notifiers while maintaining objectivity and avoiding any perceptions of bias or greater support for notifiers over the medical profession
- Transparency and accountability with appropriate privacy protections/settings

9. Feedback from Stakeholders and other Regulators

The Reviewer was able to discuss the Review and its Terms of Reference with a number of stakeholders including the Council's Whakawaha Reference Group. We also had access to a number of other reviews, some of which canvassed in detail the views of 'users' of complaints systems here and in Australia.

The expectations of the Whakawaha Group largely reflected the Ombudsman guidance we have seen. The Group were positive about the Council's initiation of the review and their comments to us included;

- *We need to create a support system, educate and make information available. Most often, they will be going through the process of educating and training people in the community on our process for the first time.*
- *Timeliness - communicate if you can't meet the timeframe – communication is key; don't want to be ghosted. Be clear about what information is needed from the complainant.*
- *Are there too many internal steps?*
- *It was reflected that certain groups within the population will feel powerless.*
- *It might have happened a long time ago, but it has affected their whole lives.*
- *It's a super complex issue.*

We note that the Group mentioned that they would like to be involved in the review journey and have the opportunity to see and input into the review report and/or the Council's response, if possible.

Interviews with other regulators have consistently highlighted their agreement that taking more of a focus on supporting notifiers is timely. They agreed their own processes could be similarly looked at.

Interviews with other regulators (see Appendix 3) highlighted a number of themes including;

- Taking more of a focus on supporting notifiers is timely. All agreed that their own processes could be similarly looked at and that this needed to be a constant process. None of the regulators we spoke to thought they had a system that fully met the needs of complainants and practitioners, noting there was a tension and a balance that needed to be struck.
- The need to ensure that policies, systems and processes of regulators are flexible enough to give confidence that notifiers are handled with care and in a manner that is appropriate to;
    - The nature of their complaint.
    - Their characteristics including; age, gender, ethnicity/culture, and other personal characteristics and ability to navigate the notification processes and engagement and interaction with the Council.
    - Any other relevant circumstances.

- Timeliness was an issue for all regulators and all agreed that currently notifications generally take too long to resolve, which is not in the best interests of all parties and the regulator. There are a range of factors contributing to this including;

    - Resources available to regulators to triage, manage and resolve notifications.
    - The time involved in consulting other agencies, in particular the need to engage with the HDC to resolve the 'pathway' a notification should best take.

- Some advised they had seen/used Alternative Dispute Resolution (ADR) processes be successfully used in certain circumstances; for instance in helping a health practitioner hear the patient's voice first hand to better understand the impact their approach to practice had on the patient. This might occur in the context of a mediation, restorative justice, or other facilitated engagement between the complainant and practitioner. This could be looked at by the Council as being deployed as part of how it responds to some notifications.

- Some of them identified that their Council structures and delegations had been helpful in speeding up decision making without compromising the quality of decision making. For instance, the Pharmacy Council has delegated to the Registrar significant decision rights to determine the 'pathway' of a complaint at the triage stage. However, it was stressed that the differences between the types of health services being practised, and the context and operating environment were important factors when considering the design of notification/complaints processes and the decision-making points and authorities within the notifications system.

In relation to timeliness – all the regulators we spoke to acknowledged this was an issue. Some believed it would be helpful to Investigate if there are more ways to streamline the processes, including the necessary engagement with HDC and with internal committee structures and delegations.

> *"The involvement of, or requirement to notify the HDC adds time and complexity to bringing complaints to a resolution."*

As already noted, Ahpra has introduced specialised training for Board members and Ahpra staff, committed to better communication with notifiers, introduced a notifications support service and looked to improve timeliness and better support for staff and Board members.

In this report we make similar recommendations, however these are tailored to what we consider to be New Zealand's and the Council's context.

10. Opportunities to make further improvements

Our initial reflections and ongoing thinking on areas that present as improvement opportunities for the Council to give consideration to, include;

1. Improved support of notifiers, noting this doesn't need to be a one size fits all.
2. Look at ADR options as a potential response for some notifications.
3. Streamline triage by potentially delegating some greater levels of triage decision making to staff, e.g. expanding delegations to Council staff (Registrar and/or Deputy Registrar) to allow interim actions to be taken more promptly.
4. Review training for staff and Council members who have direct engagement with notifiers of sexual misconduct and consider the use and deployment of specialist interviewers in certain circumstances, as part of a 'differentiated response' approach to the management of notifications and notifier support.
5. Timeliness - Investigate if there are more ways to streamline the processes, including engagement with HDC and internal committee structures and delegations.
6. More systematically collect and analyse feedback and report on this as part of ongoing reporting to Council and the profession as part of a continuous learning approach.
7. Investigate how greater information sharing mechanisms with notifiers can be enabled so they have greater visibility over how their notification is being managed and how it is resolved by Council.
8. Allowing for information about a doctor's disciplinary history to be published on the public register, to ensure greater transparency and accountability with the public.

10.1. Providing greater support for notifiers could enhance the notification system

Support services acknowledge the emotional and practical challenges of making a notification about a doctor. Good support helps prevent re-traumatisation and encourages people to come forward with legitimate concerns.

The Council provides supports to notifiers. It enables support persons to attend. It also adapts processes for vulnerable notifiers. The reviewers also noted the remote evidence options.

Good regulatory models will have sufficient capability and capacity of suitably trained staff to help support and guide notifiers through the process.

Having access to staff with appropriate training and experience is essential for handling sensitive cases appropriately and gathering information effectively. Well-trained staff can better support notifiers while maintaining procedural fairness and natural justice principles.

We believe there is an opportunity for improvement in this regard. While the Council has experienced staff and these staff do the best they are able to within the current operating model, more specialised capability and capacity, particularly for sexual misconduct cases, would undoubtedly improve the experience for many notifiers.

Feedback from Council staff and the Whakawaha stakeholder group identified that there may be opportunities to help strengthen how notifiers were supported to engage with the Council's notification system.

> *"There are limited protections for notifiers. We try to protect notifiers as much as we can, but the process inevitably re-traumatises them to some extent. We try to minimise*

this by offering counselling, ensuring they have a support network in place, adapting the investigation process, and applying for them to give evidence remotely in the HPDT (which is not always granted). However, some notifiers understandably find the process demanding on them, especially if the doctor is defending the allegations."

Opportunities included:

- Strengthening awareness of the ability of people and communities to make notifications. The Council's website is not as 'user friendly' perhaps for notifiers as it could be. By contrast for instance the HDC website makes the complaint button very clear on the front page of their website and it is clearly signposted in a Google search response. The Council's Google search response and website is not as clear and the language of 'notification' whilst technically correct, may not meet the 'everyday English' test.
- Providing pre-notification support advice and information. Feedback identified that some notifiers will not have the necessary capabilities and supports to make a notification, and additional support might be needed to 'enable' some people to meaningfully engage with the system. Further Whakawaha feedback identified that some communities are less aware of and less capable of supporting their people to access systems like the notifications process, so it may be worthwhile engaging Whakawaha further to explore this issue.
- Investigate a notifier support system similar to that operated by Ahpra in Australia.

A Notifier Support Service similar to that which Ahpra operates could be investigated and adapted to the needs of notifiers.

We discussed the Notifier Support Service operated by Ahpra in Australia with staff from Ahpra. They advised that as part of its commitment to develop highly specialised staff and investigators for handling sexual misconduct cases, Ahpra offers a three-day 'Sexual Boundaries Investigations Training' course. The intention is that all staff involved in handling sexual boundary matters undertake the training. They noted that Ahpra's internal practice does not go as far as some regulators. For instance, in the USA, state law requires the Washington Medical Commission, to ensure that all victim interviews undertakken as part of an alleged sexual misconduct investigation, be 'conducted by a person who has successfully completed a training program on interviewing victims of sexual misconduct in a manner that minimises the negative impacts on the victims'.

Ahpra staff advised that they had implemented a number of changes aimed at improving how they responded to and managed complaints, including the establishment of the Notifications Service and the establishment of specialised investigation teams within Ahpra.

In addition, ongoing training provided to Board members and Ahpra staff responsible for managing complaints was prioritised and to a greater extent systematised.

There are however pros and cons with Ahpra's current arrangements which the staff were generous in sharing with me.

Pros

- A dedicated and funded service that is nationally led and co-ordinated.
- Staff recruited with the specific skill set and experience to provide the level of support needed.
- A separation from the part of the organisation managing and determining the pathway and decisions in relation to the complaint, leading to the impression by complainants that the service is 'there for them'. It is notable that this is not an intended design feature and all staff are Ahpra staff and trained to be clear that they are not 'complainant advocates' and all communication material makes this clear.

Nevertheless, it was acknowledged that this was how this service was perceived by many complainants.

Cons

- The service is relatively small in scale and cannot therefore meet the demand. Consequently timeliness remains an issue, as much for other drivers for poor timeliness.
- Recruiting the right people with the right experience is challenging and can limit the success of the model.
- Within the cost and capability profile of the model, there is less flexibility than is possible if an outsourced model, or hybrid model was operating.
- The geographical size and spread in Australia and their federal model adds complexity, although online channels can mitigate this. However, culturally in the New Zealand context, the ability for face to face interactions to be available is relevant.

In this instance we believe there is scope to investigate a mixed model with some additional in house 'navigator' trained resource with the ability to add to this with external expertise as required.

10.2. The use of alternative dispute resolution mechanisms

As noted, Alternative Dispute Resolution (ADR) processes are opportunities that could be successfully integrated into the Council response to certain notifications in certain circumstances; for instance, in helping a medical practitioner hear the patient's voice first hand to better understand the impact their approach to practice had on the patient. This might occur in the context of a mediation, restorative justice, or other facilitated engagement between the notifier and practitioner.

ADR responses have evolved in New Zealand over time and are seen as responding to the need for:

- more flexibility and less formality
- privacy and confidentiality
- more specialised and innovative solutions
- greater participant involvement and empowerment
- early resolution
- greater timeliness

They can often achieve faster outcomes at a lower cost. Parties are also more likely to be satisfied with the result and it has been suggested that compliance rates after resolution are higher, leading to less greater practice improvements with less costly interventions. They are not a replacement for appropriate regulatory responses, such as a PCC, or Tribunal hearing where these are appropriate. ADR adds to the Council's options without taking anything away from its potential responses as a regulator of the profession.

The types of resolution used can be tailored to the circumstances of the complaint. MBIE provides significant guidance on dispute resolution mechanisms including this table:

Consensual dispute resolution approaches:

Process	Description	When usually appropriate
Conciliation	Relatively informal discussion facilitated by a third party, possibly with an active advisory role.	Where a subject matter expert is required in a less structured or discrete way than mediation.

Facilitation	Less defined, informal group discussion and problem solving facilitated by a third party.	For early intervention and groups.
Mediation	Parties seek to address a dispute with the assistance of a third party. A number of different models.	Most common form of alternative dispute resolution and generally appropriate when a consensual process is required.
Restorative Practices	Focuses on addressing harm. Includes restorative justice.	Restorative justice is only appropriate where one party has acknowledged wrongdoing or admitted fault.

10.3. Reviewing delegations to speed up initial triage decision making

Clear delegation frameworks allow for quick action when patient safety is at risk. Without appropriate delegations, decision-making bottlenecks can delay responses to serious concerns.

The current process does allow for delegated decision making by staff at the triage stage. However, the current legislative framework limits delegation possibilities because some decisions cannot be delegated to staff. This results in slower decision-making, and action(s) by the Council than might otherwise be the case.

Some other regulators identified that staff holding delegations from their Board/Governance level which allowed staff to make decisions without first engaging their Board[3]. It may be possible for the Council to delegate to the Registrar/Deputy Registrar some decisions in response to the triage stage, particularly where there is a recognised ongoing risk to patient safety, either in consultation with designated Board members, or using internal review/decision making processes and/or with an overriding 'no surprises' obligation to alert/advise/consult with the Board as required. We note that legislative change to the HPCAA Act in to expand delegations to Council staff (Registrar and/or Deputy Registrar) will be needed to allow interim actions to be taken more promptly. We would encourage the Council to use the opportunity of the legislative review to consider this possibility in more detail. For instance, in what circumstances, for how long, using what engagement mechanisms with the Chair/Board might delegations be used to respond to certain situations where more timely action on the part of Council would lead to greater levels of patient and public safety.

We do note that the current use of voluntary undertakings works well in many situations and that PCCs are in many cases stood up in short order. So, we would see this as an additional line of response that strengthens the current model rather than fixing a problem with the current approach.

10.4. Strengthening patient/consumer and stakeholder voice

Council has a range of mechanisms for understanding proactively 'customer voice' and using this knowledge in how it designs and operates the notifications system. Council facilitated our engagement with the Whakawaha Group as part of this review, which we found useful in informing our understanding of the system from the diverse perspectives the members of Whakawaha bring.

Continuous improvement is an important aspect of well-functioning regulatory systems. Systematic learning from past cases helps prevent repeat issues and improves the handling

[3] For instance, see the delegations given to the Registrar of the Pharmacy Council.

of future notifications. Without good feedback loops, problems may persist, and opportunities for system improvement may be missed.

While the establishment and engagement with the Whakawaha Group is an excellent initiative and allows for the voices of a range of stakeholders to be proactively 'heard', there is currently no systematic feedback collection mechanism in place to hear directly from participants in the notification process.

There is some collection of feedback through the engagement with notifiers, there is currently no deliberate process for collecting, analysing and reporting on feedback from all individuals participating in notification processes including PCC members and doctors. So, the analysis of patterns and trends is limited by the lack of a systemic approach and the Council is missing opportunities to better learn from past cases. We do note however that the culture within Council, as we experienced it, is one of open communication, learning, accountability and a willingness to understand and improve.

Relatedly there is no ability to provide regular external reporting on system performance; for example, the extent to which notifiers and doctors were 'satisfied' with the process and this cannot be on reported to the public. Providing statistical level reporting to the profession and public on notifications would enhance transparency and accountability

There is an opportunity to make greater use of feedback information to inform Council and staff about opportunities to make continuous improvements. It would also provide the opportunity to provide assurance to Council that the system was operating appropriately.

Findings and Recommendations

Findings

We make the following findings which respond to the Terms of Reference:

Whether notifications are robustly handled, and that Council has a well-defined, consistent, and effective process for handling notifications alleging abuse.

1. The Council takes notifications seriously and is committed to making its complaints processes and practice as fit for purpose as it can be within the statutory framework the Council is required to operate. However, Council's website (which for many notifiers will be their first touchpoint) is not the easiest to navigate and is less clear about which part of the site a notifier needs to get to in order to make a notification. There is some good collateral, such as the animated videos, but we think the experience for notifiers can be improved on. A review would provide Council with the opportunity to make improvements and enhance the usability/experience, having regard to the wide range of patient attributes.

2. The Council's Complaints Policies and Processes are underpinned by its values and our interviews with Council staff and Board members evidenced a genuine commitment to ensure the Council 'owns and operates' a complaints system with policies and processes that are fit for purpose and balance the need to protect the public and drive high standards of professional conduct and competence.

3. Council has a comprehensive set of policies, procedures and guidelines, including flowcharts and staff training material. We found that this is fit for purpose and reflects the Council's statutory framework and appropriate administrative procedures.

4. A review of material related to a sample of notification processes indicates notifications are robustly handled in accordance with Council's underpinning values and the principles which we were told guided how investigations were handled.

5. Staff and Council members we spoke with all appeared experienced, trained and evidenced a professional focus on ensuring notifications were handled in accordance with the legal framework, taking a people centric approach.

How Council communicates and engages with notifiers and/or patients during the notification process, including whether Council accommodates the patient's needs, health literacy, health equity and cultural safety in its communications and engagement with them.

6. Staff and Council members we spoke with all appeared experienced, trained and evidenced a desire to ensure the process was fair and that a fair and just outcome resulted from the process.

7. However, feedback consistently identified that the time to complete notifications through a substantive process was longer than ideal, for both notifiers and the doctors concerned and that this was an area Council should actively explore, including identifying any changes to the statutory framework Council operates within.

8. Generally, Council's communications we reviewed were fit for purpose, however the Whakawaha Reference Group had some helpful suggestions on how this could take on a wider cultural perspective. These included engaging different community, population and patient groups to discuss how to best communicate with and support

their communities to engage with Council, including making a notification, where appropriate.

9. There are limited protections for notifiers. While Council staff and Council members do their best to support notifiers as much as they can, the process is inevitably difficult for some notifiers to experience with some staff suggesting this 're-traumatises' them to some extent. It is to be noted that Council does offer counselling, takes steps to ensure notifiers have a support network in place, adapts and flexes the investigation process, and allows for evidence to be provided remotely in some circumstances. Nevertheless, some notifiers understandably still find the process demanding on them, especially if a doctor is defending the allegations.

Whether Council sufficiently considers the patient's voice during the notification process. This may include meeting with the Council's Whakawaha (Consumer Advisory Group).

10. Council has a range of mechanisms for understanding proactively 'customer voice' and using this knowledge in how it designs and operates the notifications system. Council facilitated our engagement with the Whakawaha Group as part of this review, which we found useful in informing our understanding of the system from the diverse perspectives the members of Whakawaha bring.

11. There is an opportunity for Council to bring the voice of notifiers into its processes more systemically. Currently there is no clear system of capturing feedback from participants at the conclusion of whichever pathway notifications proceed down. While some information is collected, there is currently no deliberate process for collecting, analysing and reporting on feedback from individual notification processes. This also means there is a missed opportunity to use this information to inform Council and staff about opportunities to make continuous improvements. It would also provide the opportunity to provide assurance to Council that the system was operating appropriately. It would also allow for statistical level reporting to the profession and public on notifications which would enhance transparency and accountability.

Whether Council's decision-making adequately protects the health and safety of the public.

12. We note the context, expectations, workplace environments and supervisory models are different from when the complaints about Dr Leeks' practices at Lake Alice were made. However, a fit for purpose medical practice conduct complaints system will continue to need to reflect and adapt to the society and practice models of the time.

13. Future challenges will need to be anticipated and planned for in order to stay ahead of advances in medicine and the law. This includes advancements in technology (the use of AI for e.g.), where and how medical practice is conducted (e.g. online and remote service delivery models) and changes to underpinning legislation.

14. As noted above however, we are satisfied that current arrangements are largely fit for purpose and provide for adequate health and safety protections for the public.

As part of the assessment outlined in paragraph 4 above, the reviewer should assess the work that Council staff carry out in advising and facilitating PCC investigations.

15. Based on the information we have reviewed and interviews we have conducted we consider that the advice and support that Council staff provide in relation to PCC investigations is a real strength. Staff are well-trained, decision-making support tools such as policies, guidance and flow charts are fit for purpose and comprehensive.

16. Delegations are clear and PCC members appear to be well trained, advised and supported to carry out their functions appropriately. PCC material we reviewed appears consistent with the policies and procedures. As noted elsewhere, we observe that there may be opportunities to make greater use of other mechanisms for resolving some notifications, such as through ADR processes.

The Review should also review information-sharing of the above types of notifications, including at an inter-agency level, with the notifier, and with the public more generally

17. Information sharing appeared to follow the currently designed processes and statutory requirements. MOUs appear to cover the right matters and provide a documented basis for effective interagency relationships, particularly with the HDC.

18. Greater information sharing mechanisms with notifiers could help create a greater sense of 'balance' to the notifications process. We were advised that some notifiers can be unhappy that they do not get to see the doctor's response to their complaint, while the doctor gets to see everything that the notifier says or provides to Council and/or the PCC. This does not help with the power imbalance between the doctor and the notifier (who is often the patient). We note that a notifier can request a copy of the doctor's response under the Privacy Act, to the extent the request relates to the notifier's personal information. This relies on the notifier knowing they can make such a request; however we would note this may be something that could be discussed with notifiers if the support for notifiers was enhanced as described earlier in this Report.

19. There is an opportunity to use a more systematic approach in collecting and sharing information with the profession and public about how notifications are managed by the Council. This would enhance transparency and accountability. This could include statistical reporting including numbers of notifications, the stage they are at, days to resolve, types of resolution/outcome, practice context, satisfaction/feedback themes, etc.

20. We recommend giving consideration to allowing for information about a doctor's disciplinary history to be published on a public register, to ensure greater transparency with the public. This would obviously need to be tempered and operated in accordance with appropriate legal and natural justice considerations.

Themes identified in our recommendations

Our recommendations are generally focussed on the following matters:

a. Improved support of notifiers and a support model that is flexible and might better meet the needs of a diverse notifier profile including, age, gender, ethnicity, disability, neuro and sexual diversity, amongst other specific characteristics. This should include reviewing information provided through Council's website to notifiers and members of the public about how to make a notification.

b. Adding to the options for resolving notifications that are consistent with the broad outcomes that the Council is seeking to achieved. There is an opportunity to look at a broader range of options as potential pathways or responses within the overarching complaints model; noting that some of these may require legislative change. For instance:

- the use of alternative dispute resolution approaches (mediation (formal), facilitated engagement (less formal) between the notifier and the practitioner (might include a practice manager/lead),
- restorative justice processes,

- the development of a notifier support model which might reflect aspects of the Ahpra model with some in-house and external functions, providing a greater level of flexibility to better match what's needed within a constrained financial environment.

c. Streamline triage by potentially delegating some greater levels of triage decision making to staff, noting that legislative change may be required to achieve this.

d. Review training of staff and Council members who have direct engagement with notifiers of sexual misconduct and consider the use and deployment of specialist interviewers[4] in certain circumstances, and ensure that Council members, staff, PCC members, and other representing Council are trained and competent with respect to the aspects the Royal Commission identified in its findings; i.e. trauma-informed processes, all forms of discrimination, engaging with vulnerable and/or special needs people, and human rights. Also training on engaging with Māori doctors, notifiers, and witnesses in a culturally appropriate manner.

e. Timeliness - Investigate if there are more ways to streamline the processes, including engagement with HDC and internal committee structures and delegations. The MOU is a good start, but a 'continuous improvement lens' may be able to identify further opportunities to take incremental 'bites' out of the timeline.

f. More systematically collect and analyse feedback and report on this as part of ongoing reporting to Council and the profession as part of a continuous learning approach. This will also support the Council to be transparent in reporting to both Council and the public on how the system is performing and what improvements are being made in response to instances where feedback, or other information identifies that the system is not work as well as it could.

Specific recommendations

There are opportunities to strengthen the support the Council provides to notifiers.

1. We recommend that the Council consider the introduction of a model that provides greater levels of tailored individualised support for some notifiers in order to better support the notifier to come forward and/or to provide levels of support more appropriate to notifiers' needs and circumstances. These needs and circumstances might include such things as;
    a. The cultural circumstances of the person
    b. The physical or mental needs of the person, including people who identify as gender and neuro diverse
    c. The nature of the alleged misconduct

2. We do not recommend the adoption of a fully internal model for the reasons outlined in the relevant section above.

3. We do however recommend that the Council investigate a hybrid approach that might balance internal resources, trained and capable of supporting the bulk of notifiers to 'navigate the process' with an additional outsourced number of 'suppliers' (an approved panel?) to be engaged and deployed to support the more complex and serious complaints. The weight and detail of the model could be informed by an analysis of complaints from, say, the past 5-10 years, and also take account of the Dr Leeks complaints in the model's design.

[4] E.g. https://practice.orangatamariki.govt.nz/our-work/assessment-and-planning/assessments/intake-and-early-assessment/core-assessment-phase/specialist-child-interviewing/

Embedding feedback in a continuous improvement model will strengthen the complaints system.

4. We recommend that the Council formally embed into their processes the collection and analysis of feedback from notifiers and their representatives and support people, as part of a continuous learning approach to the operation of its complaints processes. It should consider using information from this process to inform improvements to its complaints policies and processes and in providing information and education to the profession.

A review of information and privacy settings could strengthen the system and notifier's experience.

5. Greater information sharing mechanisms with notifiers could help create a greater sense of 'balance' to the notifications process. We recommend giving consideration to allowing for information about a doctor's disciplinary history to be published on the public register, to ensure greater transparency with the public.

6. To give effect to this recommendation we recommend that the Council include this in the matters for legislative change to the HPCAA Act in 2025.

Timeliness of notification process

7. Expanding delegations given to Council staff (Registrar and/or Deputy Registrar) to allow interim actions to be taken more promptly could help streamline the front end of the notifications process, noting this will require legislative change to the HPCAA Act in 2025. This delegation could be fettered with a requirement to consult with the Council Chair, or nominated member/subcommittee, where appropriate.

8. We encourage the Council to advocate for legislative change to the HPCAA (and/or the HDC Act) to make the notifications process more efficient. For example, allowing the Council to act on notifications without having to wait on the HDC to first carry out its own processes.

Ongoing Training of staff and Council members will be important in supporting effective management of sexual boundary notifications.

1. Specialised training for staff handling sexual conduct notifications will remain an important aspect of the Council's internal training regime. This includes how Council might identify and manage to unconscious bias or professional capture by its decision makers.

2. Other regulators identified that training of staff and some PCC members was an important aspect of maintaining the capability to be able to be able to respond appropriately to complaints about sexually inappropriate behaviour against a practitioner. It was noted that for the most part, practitioners had a range of supports and advisory channels available to them, however complainants do not generally have the same level of supports available to them, making it all the more important that the Council is able to engage with the notifier and assist and guide them through the notifications process, to the extent this is appropriate.

To give proper effect to relevant Recommendations from the Royal Commission we recommend the Council;[5]

3. Many of the matters traversed in this Review and areas identified for change are directly related to and would help the Council give full effect to the relevant recommendations of the Royal Commission. We note that Council's Legal Team has

[5] Note there is some overlap between these recommendations and those made elsewhere, for the sake of completeness with respect to the relevant recommendations of the Royal Commission, we repeat these here.

identified that the relevant recommendations of the Royal Commission largely include, 66, 67, 133 are given effect to.

4. We understand from Council staff that the relevant recommendations have been scoped and actions identified for Council to give effect to these recommendations. We note, for instance that the Council has issued a public apology to the survivors of Lake Alice Child and Adolescent Unit, and accepted the findings contained in the Royal Commission's report, insofar as they apply to the Council.

5. Recommendations relating to improving the information Council provides to notifiers, its communication approach through the website, delegations changes, increased notifier supports, training and other policy and procedures settings will help Council give effect to Recommendation 65.

6. Recommendation 66 relating to 'people responsible are held to account' is related to the Review's suggested review of what is reported following the commencement and completion of Council's disciplinary processes and what information is shared with other regulatory authorities and medical colleges (New Zealand and international agencies).

7. Ensure that post complaints/investigation reviews identify continuous improvement opportunities and also meet statutory/mandatory and other agreed reporting and notification requirements/obligations.

8. The Council review its data collection, management, security and record keeping information against the Royal Commission's recommendation 52, to satisfy itself that it is compliant with requirements and best practice.

9. We recommend that the Council consider how best to give effect to recommendation 84 in relation to Interagency and International Information sharing provisions. This may well require an analysis of the current privacy and legal framework the Council is required to operate within.

10. To the extent that the Council has not already, the Council consider responding fully to the requirement of the Royal Commission that relevant agencies publish their responses to the Royal Commissions Report and how they are responding to the recommendations of the Royal Commission, as relevant (Recommendation 133).

There are other areas where Council could undertake further work which would also help improve how Council receives and responds to notifications. These matters include;

1. How Council can ensure that it takes into account the diverse characteristics of patients when designing policies and systems used in responding to notifications. Consideration of a risk assessment framework relating to notifiers may be helpful in identifying factors that may make a notifier vulnerable to abuse.

2. Making greater use of 'consumer voice' in future review work and in work to continue to improve Council's systems and processes for responding to notifications

3. Council considering how the principles of Te Tiriti o Waitangi are embedded in the notifications process. This may include restorative justice processes.

Appendix 1 – Terms of Reference

TERMS OF REFERENCE FOR INDEPENDENT REVIEW

INTRODUCTION

Te Kaunihera Rata o Aotearoa | The Medical Council (Council) has established a Temporary Committee (the Temporary Committee) to consider and recommend to Council any actions related to the Royal Commission of Inquiry into Abuse in State Care (the Commission).

As part of its inquiry, the Commission is looking into the abuse of children, young persons, and vulnerable people in state psychiatric care in New Zealand between 1950 and 1999. Included in this is consideration of Dr Selwyn Leeks' abuse of children under the guise of treatment at the Lake Alice Child and Adolescent Unit from 1972 to 1980.

On 18 April 2024, excerpts of the Commission's final report were provided to Council for comment as part of its natural justice process. In summary, the Commission has commented that:

- Council did not always act to ensure people in care were safe from doctors who should not have been practising.
- Council was unable to locate documents and did not have a reasonable explanation of why they could not be recovered.
- Between 1950 and 1999, Council was at fault for: ○ Not acting when it should have done to protect the public, such as allowing Dr Leeks to continue to practise.
    - Making decisions in relation to complaints of abuse by Dr Leeks that it could not explain due to the incompleteness of records.
    - Prioritising fairness to Dr Leeks over the safety and wellbeing of patients. ○ Accepting Dr Leeks' response to allegations without question.

The Commission's final report is due to be published on or around 26 June 2024.

The Council is seeking an external, independent review of the processes and actions it takes in response to concerns being raised about a doctor's conduct. This extends to the establishment of, and general guidance and advice provided to its Professional Conduct Committees (PCCs). The Review specifically relates to conduct notifications involving allegations of a doctor abusing a patient to identify whether issues arising from the Commission's inquiry would be effectively addressed under the Council's current processes and can be prevented in the future so that the protection of the public is assured. This may involve consideration of the relevant provisions of the Health Practitioners Competence Assurance Act 2003 (HPCAA).

The Temporary Committee will also consider the findings of the external Review and present these to the Council, along with any recommendations.

Council's values

The Council's values will guide the external Review. These are:

- **Whakapono** – We act with integrity.
- **Whakamārama** – We will listen to understand.
- **Manaakitanga** – We will support each other.
- **Kaitiakitanga** – We protect the public.

- **Kotahitanga** – We will work together.

TERMS OF REFERENCE

The Terms of Reference for the independent Review are:

1. The purpose of the independent Review is to assess Council's processes and the actions that Council takes in response to concerns being raised about a doctor's conduct. This extends to the establishment of, and general guidance and advice provided to its PCCs. The Review specifically relates to conduct notifications involving allegations of a doctor abusing a patient to identify whether issues arising from the Commissioner's report would be effectively addressed under the Council's current processes and can be prevented in the future so that the protection of the public is assured.

2. 'Abuse' in this context includes physical, sexual, mental, and/or cultural abuse. For the purposes of this Review, it also includes allegations of a doctor breaching sexual boundaries with a current or former patient.

3. A notification does not need to have been made by the patient alleging abuse for it to be captured by this Review. However, the notification (whoever made it) must involve an allegation that a registered doctor may have abused a patient who is or was under their care.

4. In particular, the Review should assess in respect of these types of notifications:

    a. whether notifications are robustly handled, and that Council has a well-defined, consistent, and effective process for handling notifications alleging abuse.

    b. how Council communicates and engages with notifiers and/or patients during the notification process, including whether Council accommodates the patient's needs, health literacy, health equity and cultural safety in its communications and engagement with them.

    c. whether Council sufficiently considers the patient's voice during the notification process. This may include meeting with the Council's Whakawaha (Consumer Advisory Group).

    d. whether Council's decision-making adequately protects the health and safety of the public.

5. As part of the assessment outlined in paragraph 4 above, the reviewer should assess the work that Council staff carry out in advising and facilitating PCC investigations.

6. The Review should also review information-sharing of the above types of notifications, including at an inter-agency level, with the notifier, and with the public more generally.

7. The reviewer is to provide a written report setting out the outcome of the Review, including:

a. Any improvements to Council's notification processes and/or decision making for the Temporary Committee's consideration.

b. Outlining any options for implementing such improvements.

c. Outlining any other matters that the reviewer considers to be relevant to the Commission's inquiry or the Council's notifications processes.

8. Any recommendations should consider Council's existing regulatory framework and statutory mechanisms. The Review may include recommendations or comments regarding legislative amendments to the HPCAA or other related legislation.

9. The reviewer's report will be provided in draft in the first instance. The following timetable will then be complied with:

a. Within 20 working days, the Council and/or the Temporary Committee will provide the reviewer with its comments and/or questions (if any); and

b. Within 20 working days of the Council and/or Temporary Committee's comments and/or questions (if any), the reviewer will amend his report to the extent necessary and issue a final report.

10. The following matters are outside the scope of this Review:

a. Council matters solely relating to performance and/or fitness to practise issues.

b. Commentary on individual cases, Council members, and staff members.

c. Decisions made by PCCs, including the way individual PCCs have undertaken their processes (to not impinge on s 72(1) of the HPCAA). However, this does not exclude the overarching principles PCCs consider when communicating and engaging with notifiers.

Appendix 2 – List of Information Received and Reviewed (not exhaustive)

Medical Council Policies and Procedures including;

- Principles for assessment and management of complaints and notifications
- Principles Applied to Decisions Made Under Delegation
- Guidance for Council on proposing to impose conditions or suspension
- Guidance for Council on immediate suspension without notice
- Risk Assessment Framework
- PCC Complexity Scale
- Policy - Council members and Professional Conduct Committees - September 2023
- Policy - Retention and Disposal August 2019
- Protocol - Internal management and use of information - March 2015
- Protocol - notices of conviction under section 67A of the HPCAA - August 2020

Sensitive Complaints – Information Sheet - Meeting with a Professional Conduct Committee: Professional Boundaries – June 2020

Memorandum of Understanding between Health and Disability Commissioner - Te Toihau Hauora Hauātanga and Te Kaunihera Rata o Aotearoa- Medical Council of New Zealand.

The Australian Health Practitioner Regulation Agency (Ahpra) - Administrative complaint handling policy and procedures.

PCC Investigation Flow Chart

Template for Performance Council papers

Template for Conduct Council papers

Guidance for drafting Council briefing papers

Risk Assessment Framework (linked in some interim action options)

Example of the referral process between MCNZ and HDC.

Example of a Council briefing paper.

Example of an initial memorandum and how it is usually structured.

Examples of legal advice provided to PCCs

NZ Ombudsman – Effective complaint handling Guidelines.

Western Australian Ombudsman Effective complaint handling Guidelines.

Appendix 3 – List of Interviewees

Dr Rachelle Love	Chair - Medical Council of NZ
Simon Watt	Deputy Chair - Medical Council of NZ
	Temporary Committee Members
Joan Simeon	Chief Executive – Medical Council of NZ
Kiri Rikihana	Deputy Chief Executive - Medical Council of NZ
David Dunbar	Registrar - Medical Council of NZ
Emma Kennedy	Deputy Registrar – Medical Council of NZ
Lizzie Masters	Manager Legal - Medical Council of NZ
Catherine Byrne	Chief Executive/Registrar - Nursing Council of NZ
Nick Davis	Deputy Registrar / Senior Legal Advisor – Nursing Council of NZ
James Dunne	Registrar - Physiotherapy Board of NZ
Michael Pead	Chief Executive - Pharmacy Council of NZ
Christine Anderson	Registrar – Pharmacy Council of NZ
Marie MacKay	Chief Executive - Dental Council of NZ
Martin Fletcher	Chief Executive - Australian Health Practitioner Regulation Agency
Matthew Hardy	National Director of Notifications – Australian Health Practitioner Regulation Agency
Eliza Collier	Manager, National Investigations Support & Delivery- Australian Health Practitioner Regulation Agency
Belinda Lines	Lead Notifier Support Service for Victim-survivors and witnesses - Australian Health Practitioner Regulation Agency
Emily Parfitt	National Manager Notifications – Australian Health Practitioner Regulation Agency
Whakawaha Reference Group	Medical Council Stakeholder Reference Group