EMBARGOED FROM RELEASE OTHER THAN TO PARTIES AND EMPLOYEES AND COUNSEL FOR 3 HOURS AFTER DELIVERY BY REGISTRAR

IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

CIV 2006-404-4724

BETWEEN	DIAGNOSTIC MEDLAB LTD Plaintiff
AND	AUCKLAND DISTRICT HEALTH BOARD, WAITEMATA DISTRICT HEALTH BOARD, COUNTIES-MANUKAU DISTRICT HEALTH BOARD First Defendants
AND	LAB TESTS AUCKLAND LTD Second Defendant
AND	HARBOUR PRIMARY HEALTH ORGANISATION Intervener

Hearing: 12, 13, 14, 15, 16, 19, 20, 21, 22 and 23 February 2007

Appearances: J Hodder, A Ross, K Anderson and M Wisker for Plaintiff
G Illingworth QC, C Browne and A Holmes for First Defendants
P Davison QC, M Gavin and S Cook for Second Defendant
B Gray QC and H Janes for Intervener

Judgment: 20 March 2007 at 11:00 am

JUDGMENT OF ASHER J

This judgment was delivered by me on 20 March 2007 at 11:00 am pursuant to Rule 540(4) of the High Court Rules

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Registrar/Deputy Registrar

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Date

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Introduction

[1] Between December 2005 and June 2006 the three District Health Boards in the Auckland region, the Auckland District Health Board, the Waitemata District Health Board and the Counties-Manukau District Health Board (the Auckland Regional District Health Boards or "ARDHBs") conducted a Request for Proposal process to choose a contracting party to provide community pathology services in the Auckland region from 1 July 2007. The contract was awarded to Lab Tests Auckland Ltd ("Lab Tests").

[2] The other contender had been Diagnostic Medlab Ltd ("DML"). DML had been the primary provider of community pathology testing services to the DHBs in the Auckland region for some years. The contract for those services comes to an end on 30 June 2007.

[3] In these proceedings DML challenges the decision to enter into the Lab Tests contract and the contract itself. Orders are sought that the decision and contract are invalid and of no effect.

[4] The plaintiff's submissions involve four broad heads of claim. The first is based on Dr Tony Bierre's involvement with the ARDHBs and the implications of his involvement and knowledge. The second relates to DML's right to be consulted during the process and its legitimate expectation as to what was involved in the RFP process. The third alleges that the ARDHBs failed to consult with the Auckland public and general practitioners. The intervener has presented the argument and evidence in support of this head of claim. The fourth alleges the ARDHBs' decision was unreasonable or irrational, and relies particularly on mistakes allegedly made during the decision-making process.

[5] Extensive evidence and submissions have been filed. There are 68 affidavits and 11,905 pages of documents in 14 volumes. In excess of 700 pages of submissions have been presented. I am not critical of the quantity of material that has been put before the Court (although many of the affidavits have not been referred to). The factual background covers the actions of a number of bodies and persons

engaged in an important public process over a considerable period of time. The legal issues are not straightforward. From the perspective of both the plaintiff and the second defendant there are substantial investments and many jobs at stake. The allegations concern the good administration of a service that is vital to the health of Aucklanders. All these factors have also resulted in this judgment being of unusual length.

[6] The plaintiff is supported in its endeavour by the Harbour Primary Health Organisation ("Harbour PHO"), which was granted permission to intervene in a judgment of Lang J of 18 October 2006: *Diagnostic Medlab Limited v Auckland District Health Board & Ors* HC AK CIV-2006-404-472 18 October 2006. Harbour PHO was permitted to file affidavits, cross-examine and make submissions at trial in relation to the issues of consultation, the potential effect on it of the new contract, the likely consequence if the ARDHBs' process is found to have been flawed, the issue of potential shift in volumes, costs and finally the issue of relief. The right to intervene was granted on the basis that the interests of Harbour PHO did not differ from the interests of the other Auckland PHOs representing the other general practitioners in the larger Auckland area. Leave was granted on the assumption that Harbour PHO would be able to adequately represent the other PHO interests in the region. Further, the grant of leave contemplated that the interests of individual general practitioners could be raised through the plaintiff or Harbour PHO.

Is the ARDHBs' decision to enter into the Lab Tests contract reviewable?

[7] The defendants have accepted that the ARDHBs' decision to grant the contract to Lab Tests is amenable to judicial review. It is desirable, however, to put the Court's role in this case in context.

[8] The Court's power of review evolved as an attempt to ensure that decisions made by a public body are made according to law even if the decision does not otherwise involve an actionable wrong: *Mercury Energy Ltd v Electricity Corporation of New Zealand Ltd* [1994] 2 NZLR 385 (PC) at 388. The focus of judicial review is not on the quality of the decision made but rather the process that led to that decision, although the line between the two is becoming less distinct.

Thus judicial review involves the Court sitting in judgment on the decision-making process, whereas an appeal involves sitting in judgment on the decision itself: *Chief Constable of the North Wales Police v Evans* [1982] 1 WLR 1155 (HL) at 1174.

[9] The Judicature Amendment Act 1972 supplements but does not derogate from the power of the Court to grant judicial review at common law pursuant to its inherent supervisory jurisdiction: *Mercury Energy Ltd v ECNZ* at 388. Thus the definition of "statutory power", the phrase in s 4 of the Judicature Amendment Act 1972, is not controlling in a determination whether a body is subject to judicial review. Whether a body is subject to judicial review necessitates a consideration of the source of the power exercised by decision-makers and, increasingly, the consequences of the power exercised. It has recently been observed that the Courts are now less concerned with the source of power exercised by decision-makers and are more willing to review the exercise of any power having public consequences: *Wilson v White* [2005] 1 NZLR 189 (CA) at [21].

[10] The power at issue in this case is a power to enter a contract. The power of District Health Boards ("DHBs") to enter into service contracts is expressly provided for in s 25(2) of the New Zealand Public Health and Disability Act 2000 ("the PHD Act"), which states that:

> **25 Service agreements**
>
> …
>
> (2) A DHB may, if permitted to do so by its annual plan and in accordance with that plan,—
>
> (a) negotiate and enter into service agreements containing any terms and conditions that may be agreed; and
>
> …

[11] It has been clear since *Webster v Auckland Harbour Board* [1983] NZLR 646 (CA) that the exercise of contractual powers by public authorities is open to review on public law grounds in an appropriate case. This approach has since been confirmed in *Royal Australasian College of Surgeons v Phipps* [1999] 3 NZLR 1 (CA).

[12] Whether a contractual power exercised by a Crown Health Enterprise (the commercially oriented predecessor to DHBs) was susceptible to judicial review was considered in *Southern Community Laboratories Limited & Ors v Healthcare Otago Ltd & Ors* HC DUN CP30/96 19 December 1996. Eichelbaum CJ concluded at 17 that the statement of claim was an attempt to incorporate administrative law concepts into a commercial decision-making process, and that the issues were not justiciable. He struck out the statement of claim.

[13] The defendants have not sought to rely on *Southern Community Laboratories v Healthcare Otago* to argue that the decision in these proceedings is not susceptible to judicial review. The *Southern Community Laboratories v Healthcare Otago* decision was made in the context of the Health and Disability Services Act 1993, which expressly brought a commercial edge to public health. Section 11(2)(d) of that Act provided that Crown Health Enterprises should be as successful and efficient as comparable businesses that are not owned by the Crown. That legislation, and with it the emphasis on efficiency and profitability, was swept away by the PHD Act. There is no reference in the new Act to the new DHBs being comparable to businesses. The primary focus for DHBs under the PHD Act is now the improvement of the health of the New Zealand public.

[14] The commercial context present in *Southern Community Laboratories* has gone, and the DHBs' power to enter into contracts with service providers should be subject to judicial review. DHBs are clearly public bodies. DHBs' ability to enter into contracts with major service providers goes to the heart of their statutory duty to protect and improve public health. The Lab Tests contract relates to the provision of all laboratory-testing services for the Auckland region and, as will be discussed later in this judgment, has significant public consequences. I therefore conclude that the decision to enter into the contract with Lab Tests is reviewable.

[15] Before considering the plaintiff's various claims, it is necessary to first set out a brief history of the events leading up to the Lab Tests contract. To assist in the reading of this judgment I have set out at Appendix A a list of some of the organisations and persons referred to, and at Appendix B a list of acronyms and abbreviations commonly used.

Brief history

[16] The PHD Act provided a new legislative framework for the management of public and personal health services. It reorganised the public health and disability sector by creating 21 DHBs, each of which was responsible for the efficient and effective delivery of health services to the population within its specified geographic region.

[17] The Act makes it clear that the DHBs are statutory entities rather than companies: s 5(3). The purposes of the Act include achieving for New Zealanders the improvement, promotion and protection of their health and providing a community voice in matters relating to personal health services: s 3(1). These objectives are to be pursued to the extent that they are reasonably achievable within the funding provided: s 3(2).

[18] Under the PHD Act DHBs each receive funding through a Crown funding agreement, by which they fund the purchase of health services in its region. The DHBs nationally have a budget of around $8 billion and fund approximately 80% of New Zealand's public health services. They also provide health services through public hospitals.

[19] Prior to the enactment of the PHD Act in 2000, funding and provider roles in the health industry were kept separate. Funding had been the responsibility of a separate entity, the Health Funding Authority, which purchased health services.

[20] When the PHD Act was enacted the funding role of the Health Funding Authority devolved to the relevant DHBs in particular regions. The DHBs took over the existing contracts, and as those contracts ended the DHBs assumed responsibility for purchasing and funding the health services that had previously been the responsibility of the Health Funding Authority.

[21] One of the services that must be provided within a health region is the collection and testing of laboratory test samples. In 2000 the Health Funding Authority had entered into contracts for such services in the Auckland region,

including a contract for community laboratory services with DML. That involved the three DHBs in the Auckland region: the Auckland District Health Board ("ADHB"), the Counties-Manukau District Health Board ("CMDHB") and the Waitemata District Health Board ("WDHB").

[22] At the time the DHBs were established there were two types of laboratories: commercial laboratories that undertook specimen collection and testing in the community, generally at the request of general practitioners, and hospital laboratories that serviced a particular hospital. DML had around 91% of the market share; a competitor, Southern Community Laboratories ("SCL") had about 6.7%, and the combined hospital laboratories had about 2.3%. When the Health Funding Authority was disestablished in 2001, the DML regional contract devolved to the ADHB, which held that contract on behalf of itself, CMDHB and WDHB. All of the pre-2001 Health Funding Authority contracts nationwide concluded by 30 December 2005. The DML and SCL contracts expired on 30 September 2005.

[23] It is part of the function of DHBs to ensure the delivery of efficient and effective health services to their communities. With only limited funding available, it is necessary for them to make decisions as to priorities. It is an essential part of their task to ensure that they get value for money by obtaining services of an acceptable quality at the best possible price.

[24] From at least 2002 the DHBs had had concerns about the provision of laboratory services. In 2002 a report had been prepared for all DHBs by a Dr Reinhard Pauls on options for reform of diagnostic laboratory services markets. Another paper had been prepared by France and Lawrence on the "Costs of New Zealand Pathology". Various further papers canvassed options for a reform of New Zealand laboratory services, including a paper by Dr Bierre prepared prior to his becoming an ADHB member.

[25] In 2004 the ARDHBs initiated a project to review the options for laboratory services in the Auckland region. It was led by Dr Bjorn Pilstrom. The purpose was to evaluate any potential benefits from reorganising the region's laboratory services from the perspective of a supplier. Parallel to this the three ARDHBs laboratories

had started work to identify opportunities for a closer collaboration between them. The preparation of the report reflected the general concern felt by the ARDHBs, in particular the ADHB, about laboratory services in the region.

[26] The final report was produced in January 2005. It stated that, while providing a very good service, Auckland had an unusually large number of collection sites for its population. The study evaluated options for their cost-saving potential and strategic fit. These were:

a) consolidation of DHB laboratories;

b) a DHB absorption of community laboratory testing; and

c) a consolidated public-private joint entity service for a competitive tender of all the similar functions.

The report concluded that there was a lack of transparency in the costs of testing, and deficiencies in demand management. The report recommended that a public-private joint entity would give the best combination of financial and strategic benefits. This was not, of course, what actually eventuated.

[27] Following the Pilstrom Report, the regional chief executive officers of the Boards decided to consolidate Auckland pathology services into one entity. They commissioned a Dr Bruce Gollop to lead an Auckland Metro Laboratory Project, which was to implement the consolidation plan. The ARDHBs were mindful of the fact that both the DML and the SCL contracts expired during 2005. Dr Gollop described his task as being to evaluate critically the Pilstrom Report, to review and, if necessary, to renegotiate existing contracts, to consult with various parties, and to recommend an appropriate way forward. He was to be the project manager for this task.

[28] Dr Gollop was an experienced independent consultant. He had both engineering and medical qualifications and described himself as a "health management consultant". His experience included periods as the chief executive of

Northland Health Ltd, as general manager of Auckland Hospital, and as the inaugural chief executive of District Health Boards NZ.

[29] One of the matters Dr Gollop had to consider was the expiry of the community laboratory service contracts with DML and SCL later in 2005. Ultimately he recommended that the DML contract be extended for two years to 30 June 2007 but that the SCL contract be allowed to terminate. The ARDHBs ultimately accepted his recommendation and renewed the DML contract when it expired for two years and did not renew the SCL contract. There was now an opportunity for a full and considered Request for Proposal ("RFP") process to take place over the next year to decide on the appropriate long-term contracting party to take over in July 2007.

[30] As part of the ARDHBs' attempt to decide on the contents of and strategy behind the RFP, Dr Gollop set up a workshop in October 2005 to consider the RFP and an RFP working group was developed. The work of that group led to a discussion document being prepared. An evaluation panel for the RFP process was set up, consisting of various persons with expertise. Its members were not members of the particular ARDHBs. Dr Gollop was on that panel.

[31] On 30 November 2005 the discussion document was circulated in the Auckland region. Expressions of interest from proposers were sought. These were duly received, and in early February 2006 the ARDHBs' Request for Proposal, known as RFP 577 ("the RFP"), was distributed to those parties who had registered expressions of interest. On 10 April 2006 proposals were received from DML and the Auckland Pathology Consortium Ltd ("the Consortium").

[32] DML is a New Zealand private company. Its origins lie in various local laboratory companies, but these were bought out in December 1999 by Sonic Healthcare Pty Ltd ("Sonic"), which now owns all its shares. Sonic is a significant Australian public company with interests in hospitals and laboratories in Australia. It has four subsidiary community laboratory testing companies in New Zealand, including DML.

[33] The other proposer, the Consortium, comprised four shareholding groups. The first was Gribbles Pathology NZ Ltd ("Gribbles"), which at the time of the proposal had a 75% shareholding. That company was part of the diagnostic division of Healthscope Ltd ("Healthscope"), another significant Australian public company listed on the Australian Stock Exchange in 1994. Healthscope's core business was private hospitals and diagnostic pathology. Gribbles Group Pty Ltd, the Australian subsidiary of Healthscope, is the third largest provider of pathology services in Australia, while Healthscope Hospitals are the second largest provider in the private hospital sector. Gribbles had until that point included a veterinary division with operations in both Australia and New Zealand, and Northland Pathology Laboratory Ltd, which provided private pathology services to the Northland DHB.

[34] The second shareholder was LabTests Auckland Limited, a company owned by Dr Bierre and his family interests. At the time of the proposal it held 15%. The third shareholder was a company LabTest Support Limited, that included the interests of an experienced private and public health sector nurse and administrator, Lee Mathias, who at the time of the proposal held 5%. The fourth shareholding of 5% was reserved for pathologists and senior management to be appointed.

[35] Evaluation panel meetings and discussions with the proposers took place throughout April and May 2006. DML submitted amended proposals as a consequence of those discussions. In May 2006 the evaluation panel recommended that the Consortium be selected as first preferred provider, and in early June 2006 the ARDHBs met and approved that recommendation. The proposers were notified.

[36] There were then further negotiations between the ARDHBs and the Consortium. A new company was formed by the Consortium to be the contracting party, Lab Tests Auckland Ltd ("Lab Tests"), which is the second defendant in these proceedings. Lab Tests is a different entity from Dr Bierre's company of the same name, which was changed to Taupehi Holdings Ltd. On 14 July 2006 a contract was signed by the ARDHBs and Lab Tests. DML filed these proceedings on 8 August 2006.

[37] DML at present receives specimens from approximately 10,000 patients a day. Each patient's request involves between three and four tests so that approximately 35,000 tests are carried out each day. DML employs 750 staff to do this, with 300 laboratory staff, including scientists and technologists, and 35 pathologists, being 23.5 full-time equivalents ("FTEs"), doing the relevant pathology work. Samples are collected from DML's 83 collection rooms, or through house calls or collection at the general practitioner's surgery. At present 6.9% of all blood samples are collected by general practitioners. DML pays general practitioners $4.50 for each blood sample taken.

[38] The new service to be operated by Lab Tests will involve approximately 47 collection rooms (the number has increased from 43 since the contract was signed), all of which will be at different premises from those leased by DML. Instead of 23.5 FTE pathologists being employed, Lab Tests will employ 17, resulting in a salary saving of approximately $2 million per annum. Instead of employing 236 FTE nurses and couriers, Lab Tests will employ 172, resulting in a saving of approximately $2.6 million per annum. The exact numbers of FTEs actually employed by Lab Tests has been something of a moveable feast through the hearing.

[39] There is some debate about the exact amount of savings between the Lab Tests and DML contracts. The initial difference per annum was approximately $16 million. The Consortium's proposal was based on a cost of $333.533 million over five years, and DML's was based on $427.357 million. Although the Consortium's proposal has now extended to eight years, the Consortium's final offer of 12 May 2006 over a five-year period of $334.869 million and DML's offer of $403.439 million leaves a difference of approximately $68.57 million.

[40] It is now appropriate to begin by considering the most serious of the plaintiff's claims, the allegation that the decision-making process was unfair and unlawful because of the involvement of Dr Bierre, who was an ADHB member, in the successful bid. This head of claim involves an extensive review of ARDHB activities since the PHD Act came into force in January 2001.

First head of claim: Dr Bierre's wrongful involvement

The nature of this head of claim

[41] The essence of DML's complaint under this head is not complex. Dr Bierre was a pathologist and ADHB member who wished to secure a contract with the ARDHBs for laboratory testing work. Dr Bierre later became an instrumental part of the Consortium's ultimately successful proposal. DML submits that Dr Bierre did not properly declare his conflict of interest and obtained an improper "insider" advantage in the RFP process by virtue of his position as an ADHB member. The issue arises as to whether Dr Bierre's involvement and, more crucially, the ARDHBs' failure to address it, tainted the decision-making process.

[42] DML makes a number of specific claims. DML alleges that as an ADHB member Dr Bierre was an insider to the ARDHB deliberations and policy development that led to the decision to seek proposals, and to the distribution of the discussion document at the end of November 2005. DML claims that Dr Bierre was instrumental in formulating the thinking behind the RFP and was privy to the wishes and concerns of the evaluation panel (those who eventually considered the bids). It alleges that Dr Bierre's position enabled him to access information useful to formulating a bid in line with the ARDHBs' thinking. DML claims that it had none of these advantages and as a consequence, unlike the Consortium, was unable to present a bid attuned to the ARDHBs' thinking. Thus DML submits that the Consortium bid, formulated as it was by Dr Bierre, was given an unfair advantage, to the detriment of DML and the public, both of whom were entitled to a bid process where no party had an insider advantage.

[43] Mr Ross, who presented this part of the argument for the plaintiff, immediately acknowledged that DML's complaint about Dr Bierre's involvement did not fall neatly under one of the usual administrative law headings. He readily agreed that there was no allegation of actual bias against the ARDHBs, into which category a conflict of interest would traditionally fall. Mr Ross did call in aid four administrative law concepts in pursuing his argument, namely:

a) want of good faith (although not implying dishonesty);

b) breach of statute;

c) breach of a legitimate expectation of fair treatment; and

d) apparent bias.

[44] The plaintiff correctly did not strain to find an administrative law label that might apply to the sort of conduct complained of. Judicial review does not depend on a particular set of facts satisfying a particular precedent or falling under a particular sub-heading. The fact that the conduct complained of in these proceedings does not appear to fall into any established sub-categories of procedural impropriety is not determinative. There is now a presumption that administrative law imposes a general requirement of procedural fairness on public decision-making, and I intend to approach the plaintiff's submissions on Dr Bierre's involvement from that point of view.

[45] Indeed, Mr Illingworth for the ARDHBs had no quarrel with the proposition that there must be procedural fairness on the part of DHBs in exercising a function susceptible to judicial review, such as a decision to enter into a significant commercial contract for services. As he acknowledged, s 27 of the New Zealand Bill of Rights Act 1990 requires public authorities to observe the principles of natural justice.

[46] Mr Illingworth did not accept, however, that the conduct complained was remotely suggestive of procedural unfairness. He submitted that inequities of the sort alleged in the present case are inevitable in commercial proposal situations. He argued that the incumbent DML itself enjoyed a significant advantage over any other potential provider because of its intimate knowledge of the commercial realities of the market. Therefore, to endeavour to paraphrase his submission, as inequities are inevitable in commercial proposal situations, the Court cannot censure them under the heading of procedural unfairness.

[47] I do not accept Mr Illingworth's proposition. DML's advantage over other potential providers was simply part and parcel of having an incumbent provider tender to continue to provide a service. It was inescapable. The advantage naturally enjoyed by an incumbent does not affect in any way the need to apply ordinary principles of procedural fairness. The commercial context may be relevant to the standard of procedural fairness to be imposed, but it does not mean that the rules of natural justice should not apply with appropriate force to the decision-making process.

[48] I consider that DML's complaint about Dr Bierre's involvement is essentially a complaint about the probity of the decision-making processes adopted by the ARDHBs. As it is not in dispute that the decision-making processes of a public body are very much subject to the requirement that they be procedurally fair, I therefore consider it appropriate to consider Dr Bierre's involvement and the ARDHBs' response to it under the heading of procedural fairness.

[49] Mr Illingworth argued that a low standard of scrutiny should be applied to this decision-making process when assessing procedural fairness.

[50] The Courts are able to determine appropriate standards of procedural fairness in a judicial review exercise once the context of the exercise of the power is fully understood. The Courts have traditionally, directly and fully, exercised such a power: *Discount Brands Ltd v Westfield (New Zealand) Limited* [2005] 2 NZLR 597 (SC) at [54]. Deference to the administrative body is not required in matters of procedure, as it is, in contrast, in respect of the quality of a decision. While Courts are not necessarily well qualified to assess the merits of an administrative decision, Courts are well equipped to assess the adequacy of an administrative procedure.

[51] I accept that the standards of natural justice required by the Court will vary with the nature of the power exercised. Cooke J noted as much in *CREEDNZ Inc v Governor General* [1981] 1 NZLR 172 (CA) at 186-187. What is required of a Court or quasi-judicial body in terms of procedural fairness will clearly be more onerous than what is required of a government minister making a decision that has a strong policy element.

[52] Two matters support Mr Illingworth's argument for a low standard of procedural fairness. First, the public elects seven of a DHB's 11 members, while the remaining four members are Government-appointed. Appointees can be expected to have existing connections with DHB activities, or policies and philosophies that they will actively pursue, which would not be appropriate for someone acting in a judicial or quasi-judicial capacity. This is recognised in cl 36 of Schedule 3 of the PHD Act. Second, this was a commercial decision. DHBs must be able to act in a commercial and robust manner when deciding to award commercial contracts. They will necessarily have to deal with the usual puffery encountered in commercial contract negotiation and respond in a commercially appropriate way, or risk paying far too much for services.

[53] However, the subject of the decision-making in this case was the award of a monopoly contract for community laboratories in the Auckland area. All laboratory services in Auckland would depend on the outcome of the ARDHBs' decision. This is a subject extremely important to the Auckland public. It is the people of Auckland, most of whom are likely to require laboratory testing at some point in their lives, who have the biggest interest in a fair decision-making process. Insofar as a fair decision-making process helps to ensure that the best decision is reached, the Auckland public was entitled to that.

[54] A failure to adopt fair procedures means that the process of making a merits-based decision is disrupted. An unfair process may allow decision-makers to be swayed by matters that should not have swayed them. It may encourage decision-makers to view parties in a light in which they would not otherwise have viewed them. It may prevent decision-makers from adequately assessing information presented to them. It may cause decision-makers to place emphasis on, or disregard, matters that would not ordinarily have deserved that treatment. An unfair process can mean that a party who knows the decision-maker's thinking and expectations can unfairly use that knowledge to its advantage and to the disadvantage of other worthy candidates.

[55] The need for good procedures is recognised in the statutory imperatives against conflicts of interest and the misuse of the ARDHBs' information that exist in

the PHD Act (cl 6 of Schedule 2 and cl 36 of Schedule 3) dealing with disclosure of interest and in ss 62 to 72 of the Crown Entities Act 2004. Further statutory provisions of the Crown Entities Act set out duties on the DHB members and on the DHBs themselves as to the way in which they should act (ss 49-52), including acting with honesty and integrity, in good faith and not at the expense of the entity's interest, and with reasonable diligence and skill and not to disclose information: (ss 53-57).

[56] These provisions, coupled with the importance of the ARDHBs' tasks, all indicate that the legislature expects more than minimal or cursory standards of procedural fairness, although obviously the standard expected of judicial or quasi-judicial decision-makers is not required.

Relevant facts: The involvement of Dr Bierre in the lead up to the Request for Proposal

[57] Dr Bierre is an experienced pathologist. He is a member of the Royal College of Pathologists of Australasia, has had overseas experience, and was a shareholder in Diagnostic Laboratory Ltd from 1990 to 1999.

[58] When Sonic purchased all the shares in DML in December 1999, Dr Bierre sold his shares to Sonic. He remained employed at DML until 31 January 2001, by which time he was the clinical director of cytopathology and chairman of the DML board of management. He had not had any involvement up to that point in the negotiation of laboratory service contracts with funding authorities.

[59] Employment Court proceedings took place following Dr Bierre's departure from DML. These were subsequently resolved in a confidential settlement. Prior to leaving DML Dr Bierre had commenced an executive MBA course run by the University of Otago. He continued his studies after leaving DML and prepared a finance paper on the diagnostics laboratory industry in New Zealand. Later, as part of the MBA program, he co-wrote a project report entitled "The Laboratory Services Industry in New Zealand: Methods of Diagnostic Test Purchasing." The paper was completed around August 2004.

[60] In the meantime, after having left DML, Dr Bierre had had some difficulties in obtaining a satisfactory job as a pathologist. Through his research projects he had had some contact with Andrew Coe, a project manager with the Northern DHB Support Agency Ltd ("NDSA"). The NDSA is a company set up by the ARDHBs to co-ordinate their activities and provide support.

[61] Dr Bierre then formed two companies. The affidavit documents disclose some confusion as to their exact history, but it is not material. It appears that on 26 November 2003 Dr Bierre incorporated Labtests Auckland Ltd, a company which would later become a 15% shareholder in the Consortium, which was ultimately the successful proposer. Labtests Auckland Ltd later changed its name to Taupehi Holdings Ltd, and the Labtests name was used to form a new company, Lab Tests Auckland Ltd, which signed the contract with the ARDHBs in July 2006. Dr Bierre also formed LabTests New Zealand Ltd on 4 December 2003. He and his family interests owned the shares in both companies. At first the companies did not trade.

[62] On 10 December 2003 Dr Bierre met with Brian Watson, the managing director of Gribbles. He also met the laboratory manager and clinical director of LabPlus Ltd, the hospital laboratory company owned by the ADHB. The purpose of the meetings was to see whether a boutique laboratory business that Dr Bierre was proposing relating to the national breast cancer screening programme could work with the laboratory support of Gribbles or LabPlus.

[63] In 2004 Dr Bierre and a research partner, Mr Halls, devised a pilot project for the establishment of a histopathology and cytopathology laboratory in Auckland. A written paper was prepared dated 29 July 2004, arguing that there was an under-capacity in the histology and cytology areas and proposing open-book accounting and an agreed cost of capital return to providers. They put the project, seeking ADHB funding, to Mr Dennis Jury, the general manager of funding for the ADHB. He stated that he would pass the proposal on to Mr Coe at the NDSA. Some follow-up emails and meetings took place but the proposal for funding for a pilot project was eventually rejected.

[64] Dr Bierre did some temporary work, including pathology work in Sydney, in the latter half of 2004. He also met with Dr Pilstrom in July 2004, who was a Swedish medical practitioner and researcher who was working in the area of laboratory services in New Zealand and Sydney. Dr Bierre also did part-time work from July 2004 as a lecturer in anatomical pathology for the Department of Molecular Medicine and Pathology at the University of Auckland School of Medicine. Also, late in the year, he did some consultancy work for a laboratory provider in relation to Otago and Southland RFPs.

[65] In July 2004 Dr Bierre was approached about standing for election to the ADHB. In his affidavit Dr Bierre stated that he was at this point concerned about a conflict of interest, as his employment was likely to be reliant on DHB funding in the future. It was explained to him that many people who worked or could potentially work for DHBs were nevertheless Board members, and that conflicts could be managed appropriately. He was selected to stand on the Citizens and Ratepayers ticket.

[66] Candidates were required to make a statement to the electoral officer of any conflicts. On 7 August 2004 Dr Bierre submitted a conflict of interest statement, which is set out later in this judgment (para [143]). He advised of his work as a pathologist and said he was not employed by or in a contractual relationship with the ADHB, but that there was a possibility that this might change. Voting took place in mid-September/early October 2004 and Dr Bierre was elected.

[67] In his affidavit Dr Bierre stated that he revived the possibility of opening a boutique laboratory in Auckland at the end of 2004. He decided this time to establish the laboratory first and then seek funding from the ADHB. He saw the expiry of DML's contract in September 2005 as an opportunity for his laboratory. In November 2004 he made a note in his diary to commit his boutique laboratory to an entry in the telephone book. On about 13 December 2004 he went on a fact-finding trip to the USA to look at boutique laboratories there and examine equipment and systems that they were using. After the Christmas/New Year break he placed orders for some equipment from the USA using his company LabTests Auckland Ltd. He decided that he would personally fund the laboratory in the short term and

continue to look for alternative sources for funding. He employed a laboratory technician, and opened his laboratory on 21 March 2005. It stayed open until some time in June 2005.

[68] At the first ADHB meeting attended by Dr Bierre in December 2004 the chairman, Mr Wayne Brown, asked each Board member to make a brief statement. Dr Bierre referred to his conflict of interest in what he describes as "similar terms" to his written statement. He did not mention the pilot project, his developing interest in opening a boutique laboratory or the possibility that he might seek funds from the ADHB.

[69] Dr Bierre stated in his affidavit that Mr Brown expressed his general opinion on conflicts of interest at that meeting. Mr Brown said that practically all persons on New Zealand DHBs, particularly doctors, faced conflicts of interest, given the fact that all medical services were funded through DHBs. Valuable experience should not be lost for that reason. He had noted that conflicts of interest related to particular transactions, and that if ADHB members were interested in particular transactions then they had to exclude themselves.

[70] These observations have been reiterated by Mr Brown in his affidavit. Mr Brown's policy was to manage conflicts. The elected members of DHBs tend generally to rely directly or indirectly for at least part of their income on expenditure of public funds under the control of a DHB. Mr Brown has given evidence that of the ADHB elected in 2004, two were employees of the ADHB and another was a director of two companies who bid against the ADHB for Government contracts. All members either directly or indirectly earned at least part of their income from the expenditure of public funds under the control of the ADHB. The ADHB openly contemplated that members would have conflicts of interest, and provided an interest register in which ADHB members could register any such conflict.

[71] At the time Dr Bierre was standing for the Board, Dr Pilstrom was preparing his report for the ARDHBs on laboratory services in the Auckland region. The Pilstrom Report was presented in January 2005 approximately one month after Dr Bierre had attended his first ADHB meeting on 6 December 2004.

[72] On 7 March 2005, on behalf of his company LabTests, Dr Bierre applied to Dr Jury, the chief funding and planning officer for the ADHB, for a contract to provide histopathology and cytopathology services in the Auckland region. In a theme that Dr Bierre was to pursue in the year to follow, he stated that he and his partner believed in an open-book accounting approach within an agreed cost of capital return. The same theme had been put forward on 29 July 2004 when Dr Bierre had sought funding for the establishment of a private project in the area. Dr Bierre also emphasised the necessity to decrease the "information asymmetry", in other words, a perceived lack of financial information provided by DML and other community laboratory service providers. It was a term he would continue to use. On 30 March 2005 Dr Jury advised Dr Bierre that the ADHB had no policy on the provision of histopathology and sited pathology services consistent with his application, but that his letter would be considered by those undertaking the review of services.

[73] As the only pathologist on the ADHB, which was leading the way in considering reconstructing the provision of laboratory services in the Auckland region, Dr Bierre became increasingly involved in the suggestions for reform and the work of Dr Gollop through 2005. On 3 February 2005 he was appointed to the ADHB audit committee, an influential committee that met in private and was concerned with financial issues. There was some urgency in finalising a position on laboratory services as the contracts with both DML and SCL were due to expire in September 2005.

[74] At an audit committee meeting on 4 May 2005 Dr Bierre successfully moved a motion that the ADHB purchasing policy be amended to require the use of a competitive tender process when services or supplies were being purchased, or if this were not possible due to market conditions, to require that "open-book accounting" be established with a supplier. Dr Bierre, although he had referred to a conflict of interest, did not advise the committee that he was seeking a contract for laboratory services for himself. The audit committee recommendation was adopted in this form by the ADHB meeting that followed on 5 May 2005.

[75] Through May 2005 there were discussions and emails between Dr Bierre in his capacity as an ADHB member and Dr Jury and Dr Gollop, who both in due course became members of the evaluation panel. In the course of these exchanges Dr Bierre set out his assessment of laboratory services in Auckland, using language critical of the incumbent providers of laboratory services.

[76] He met with Dr Gollop on 17 May 2005. Following that meeting, in his email of 18 May 2005 to Dr Gollop, he said:

> [DML's] culture, past behaviour and critical requirement to continue to return *super profits* to their shareholders leaves me very cynical that by you agreeing *to kill off the very people who can help you* make changes and cementing in place once again the monopoly status that when the time comes to make the changes you talk about – *they will be holding all the cards*.
>
> [emphasis added]

Dr Gollop responded to Dr Bierre's email stating that he did not share the view that DML would be holding all the cards when the issue of renewal arose. He appears to have accepted that any prospective bidder should provide an open-book proposal.

[77] Dr Bierre sent a handwritten fax to Dr Gollop on 20 May 2005 forwarding a letter from International Accreditation New Zealand praising Dr Bierre's laboratory. Dr Bierre's action was consistent with his earlier proposal to establish a small specialist laboratory, although he made no specific reference to it. Among the matters he raised in the fax was whether it was right to "kill off" organisations that were innovative, "willing to contract on an open book basis" and able to increase capacity where it was clearly deficient.

[78] On 23 May 2005 Dr Bierre prepared a detailed confidential memorandum for members of the ADHB about his vision for community laboratory services. He referred to his "declared conflict of interest" but again was not specific as to its nature. He supported Dr Gollop's recommendation that all ARDHB hospital testing services be amalgamated into one alliance, which in time would enter into a long-term alliance or partnership arrangement with a third party.

[79] In 2004 DML did not have a monopoly on all the Auckland community collections. SCL, through a historical anomaly that it is not necessary to traverse was funded by the Otago Health Board and had 6.7 % of community testing in the Auckland region. DML had the balance. In addition, certain ADHB hospitals had their own particular laboratories, which carried out testing to meet the testing requirements within the hospitals.

[80] Dr Bierre was critical of a proposal of Dr Gollop's that SCL exit the market, stating "this would further reinforce DML's virtual monopoly situation in Auckland." He argued that such a proposal did not address structural issues and would cement DML's monopoly and secure its increased profitability. Dr Bierre criticised the $3.8 million in savings resulting from the proposal as "short term". He again used the phrase "information asymmetry" in commenting on the existing situation.

[81] At the same time, Dr Bierre advised an ADHB member, Mr Burkhardt, that Sonic, DML's Australian parent, owned approximately 70% of New Zealand laboratories. He questioned whether corporate investors actually added any value to the New Zealand health care scene.

[82] On 31 May 2005, Dr Bierre emailed all ADHB members advising that there was "obvious waste" in the laboratory sector. He said that certain organisations were making "super profits" and would not agree to an "open-book" approach, but those making a reasonable commercial return on invested capital would "readily do so".

[83] In these exchanges Dr Bierre put forward the idea that DML was making excessive profits, was obstructive and unwilling to work with the DHBs, and was seeking a monopoly, and repeated that open-book disclosure was desirable. At the ADHB meeting of 2 June 2005, Dr Bierre reiterated the same concerns after having declared a general conflict of interest. He opposed the extension of the DML contract for a further two years and opposed the exit of SCL, and spoke of South Island laboratories making savings of 15%-17% by having competitive tenders.

[84] On 2 June 2004 the chief executive officer of CMDHB, Mr Stephen McKernan, clearly concerned about a conflict of interest, wrote to persons to be involved in a pending regional meeting of the ARDHBs suggesting that they "tread very carefully" in respect of Dr Bierre. He did not know that Dr Bierre had an operating laboratory or that he was planning to have a specific interest in supplying laboratory services. His caution derived rather from Dr Bierre's position as a pathologist and previous interest in laboratory services. He said:

> I would have thought he has an interest in this and is as such conflicted. There is a consultation process about to commence with this project so should he not feed his views into that process?

He questioned whether he was being overly sensitive, but observed that there was a need to ensure that the process was "squeaky clean" as it would inevitably be subject to review.

[85] The deputy chair of the ARDHBs in 2005 was Mr Ross Keenan. As part of his role as deputy chair he chaired a monthly meeting with chairs and chief executive officers of the ARDHBs. His role was to foster a regional approach to health issues.

[86] Mr Keenan's response to Mr McKernan's concern was that Dr Bierre had fully declared his interests in both the ADHB situation and "the wider business interests", and that:

> His presence as Board member of A+ (and agreed by many) is to support a management view that might consider dealing more aggressively with the DML situation than is currently proposed.

"A+" referred to the ADHB hospital laboratory. Mr Keenan stated that he could muzzle Dr Bierre if that was the wish, but that as a closed forum the chief executives and chairs of the ARDHBs should at least hear his views. Mr Keenan was unaware when he made these observations that Dr Bierre was actively seeking funding for his own boutique laboratory and had been seeking ADHB funding. On the basis of Mr Keenan's explanation, Mr McKernan took no further action.

[87] On 9 June 2005, at Mr Keenan's invitation, Dr Bierre attended the Northern Regional DHB collaboration meeting to outline his views on Dr Gollop's current

proposal to extend the DML contract and allow the SCL contract to terminate pending an RFP.

[88] At this time, Mr Brown's view was that there was not a conflict problem as long as it was declared, and that he did not want to make a decision in the absence of all the information. However, it is clear from both Mr McKernan's and Mr Brown's affidavits that they considered the conflict, being Dr Bierre's role as a practising pathologist and thus his being likely to have a degree of personal interest in changes to pathology services, and as an ADHB member. They did not realise that Dr Bierre was himself an interested bidder for a portion of the service. Dr Bierre's conflict of interest was accepted by Mr Brown and Mr McKernan on that basis, and he attended the meeting.

[89] In a memo of 28 June 2005 to the chief executive officers and chairs of the ARDHBs, Dr Gollop discussed various recommendations, including an agreement to reduce the current DML collection centres by 20 to approximately 70, while still maintaining acceptable geographical coverage. This would be in addition to the loss of approximately 20 to 25 collection rooms that were being provided by SCL.

[90] At the audit committee meeting of 6 July 2005 Dr Bierre unsuccessfully opposed Dr Gollop's revised proposal to enter into a further two-year contract with DML and to allow the contract with SCL to lapse.

[91] Dr Bierre was still actively pursuing his idea for what he described as a boutique histology and cytology laboratory. On Friday 24 June 2005 he wrote to a member of Parliament, Dr Paul Hutchison, asserting that there was a monopoly on histology and cytology services in Auckland, and claiming that his company LabTests could provide a "valuable alternative". He asked for a letter of support. Dr Hutchison in response wrote a short and careful letter on 27 June 2005 to Mr Brown, attaching Dr Bierre's letter and suggesting that it be considered. He stated: "Clearly he has a conflict of interest being a member of the ADHB."

[92] Dr Hutchison's letter alerted Mr Brown for the first time to the fact that Dr Bierre's company was involved in negotiations with ADHB. On 8 July 2005

Mr Brown wrote a stern letter to Dr Bierre, stating that while he had known of his directorship of LabTests, he wished to record his disappointment that he had not been made aware that Dr Bierre's company was involved in negotiations with the ADHB. He noted that the ADHB may therefore have been compromised in the interim, and that the ADHB had put "considerable stock on your advice in regard to current regional laboratory testing process, and your advice has been central to decisions the Board has taken". He noted that there appeared to be a clear conflict of interest, and stated that Dr Bierre's personal position should have been made clear to have allowed the ADHB to consider the conflict and his ongoing involvement. He observed that Dr Bierre's failure to do so "may have compromised the Board's process". He stated that Dr Bierre should "now be excluded from considerations on lab testing and the current regional process".

[93] Dr Bierre responded shortly afterwards on 11 July 2005. Over a number of pages he set out his involvement in laboratory issues since early 2004. He stated that he believed that ADHB members were aware of his company. He stated that he had attempted to keep his personal practice of medicine "as divorced as possible" from ADHB business, and that he had endeavoured to introduce concepts and ideas of "significant benefit" to the ADHB with particular emphasis in obtaining "value for money spent on health in our region". While justifying his position, he also said he was now "mothballing" his practice.

[94] Mr Brown did not reply to Dr Bierre's letter, and he does not state in his affidavit what he thought about it. Dr Bierre remained fully involved in the ARDHBs' considerations and continued to advocate his views. Mr Brown in his affidavit said that Dr Bierre did not participate further in discussions about laboratory matters at the meetings of 3 and 4 August 2005, having stood down from the laboratory services "item" in view of his conflict. However, the minutes show Dr Bierre was present at both the audit committee meeting on 3 August 2005 and the ADHB meeting on 4 August 2005. Dr Bierre states that at the 4 August 2005 meeting he made little comment and abstained from voting on the community laboratory proposal item. However, in other respects he remained fully involved.

[95] On 12 July 2005, a day after sending his letter to Mr Brown, Dr Bierre emailed Mr Brown suggesting a break-up of the laboratory service into components to give the ARDHBs "levers of control". The next day Dr Bierre received a note from Mr Keenan that had also been sent to the chief executive officers and chairs of the ARDHBs. This memorandum amounted to a frank disclosure to the chairs and chief executive officers of Mr Keenan's thinking. Mr Keenan in his affidavit described the letter as a "check list" of some of his concerns and suggestions about the future provision of laboratory services.

[96] In his affidavit Mr Keenan noted that he was aware from Dr Bierre's emails, ARDHBs' discussions and presentations that Dr Bierre's views on laboratory services accorded with many of his own. Mr Keenan made it clear in his affidavit that he was aware of Mr McKernan's earlier concern about Dr Bierre's having a conflict of interest but, like Mr McKernan, he knew only of a general conflict arising from Dr Bierre's being a pathologist. He stated that he was unaware that Dr Bierre was interested in putting in a bid to provide laboratory services. He also stated that he was not aware that Mr Brown had specifically raised a conflict of interest issue with Dr Bierre a few days earlier. He stated that if he had been aware of this he would not have sent his 13 July memorandum setting out his detailed personal views to Dr Bierre.

[97] Mr Keenan's memorandum of 13 July uses the term "super profits", also used by Dr Bierre, and states that DML's "non-response" when asked to be transparent about current costs and margins was an attempt to retain these super profits. He commented in the memorandum that he understood that DML had been recently sold to an Australian owner. The memorandum stated that no doubt DML's purchase price was constructed on "forward estimates of super profits". He stated the sorts of things he would be looking for, emphasising transparency, and continued:

> I would advise the players that *we seek a minimum saving on current spend of $20M in the first year* (whatever that year may be given we may need to seek a temporary extension to the current timing). The $20M would be against the total spend with both lab services currently and therefore a pro-rata discussion would need to be held.

[emphasis added]

He then goes on to discuss the possibility of a joint venture involving the PHOs and a provider.

[98] Dr Bierre responded by an email of 20 July 2005, in which he stated:

> Dear Ross,
>
> Thank goodness for your common and business sense! I am glad you are on *the right track*. *Any help behind the scenes* I can give to ensure a good outcome for the region – *given the conflict of interest issue* – please don't hesitate to ask.
>
> [emphasis added]

[99] At the 14 July 2005 meeting Mr Brown told the Northern Regional District Health Board representatives about Dr Bierre's conflict of interest, referring specifically to the boutique laboratory and Dr Bierre's attempt to gain a contract from the ADHB. There was no formal consideration of his position. It was resolved to proceed in accordance with Dr Gollop's recommendation and Dr Bierre's view that a monopoly extension to DML be refused was rejected. In the weeks that followed, the DML extension of contract to 30 June 2007 was formally confirmed.

[100] Dr Bierre attended the ADHB meeting on 4 August 2005 when the extension of the DML contract was confirmed. He attended the audit committee meeting of 31 August 2005 when procurement policies were discussed. A resolution was passed that the audit committee recommend that the ADHB adopt a more "aggressive commercial orientated procurement and payment policy with details to be finalised by the Audit Committee". It is likely Dr Bierre would have received Dr Gollop's pathology project report of August 2005 that considered the options for laboratory testing in draft. Dr Bierre was not heavily involved in the ARDHBs' laboratory matters during September and October 2005.

[101] Meanwhile, on 2 August 2005 he applied for a position as a histopathologist and cytopathologist for Gribbles. The position sought related to a Gribbles response to an RFP for the Northland district. On 23 September 2005 he was employed by Gribbles as a consultant in relation to the Northern RFP.

[102] On 11 October 2005 Dr Bierre sent an email to Mr Keenan commenting on a press release from the New Zealand Association of Pathology Practices concerning a Commerce Commission decision to decline an application for clearance for the funding and delivery of pathology services in Otago and Southland. He stated that he would not wish to make any comment "which would be copied to others", but the tone of his email is hostile to the comments of Dr Paul Ockelford of DML in the press release. He commented that there was very little substance to Dr Ockelford's comments, and that his "rhetoric" was nothing but "scare tactics" and should probably be challenged. Dr Bierre's email portrayed DML as an entity that was playing games with the ARDHBs.

[103] On 1 November 2005 the ARDHBs held a strategy workshop concerning the upcoming RFP. The workshop was intended to allow the ARDHBs to discuss privately what they wanted from the RFP process and to begin work on a discussion document. Dr Bierre attended this important meeting. Dr Gollop had explained Dr Bierre's presence at the meeting as being due to his "expertise and independence from the current providers". The notes of the meeting show that Dr Bierre pursued a line of argument hostile to DML. For instance, he advised the ARDHBs that "now we have an inefficient delivery model with high unit costs". The notes taken at the meeting show that it was a detailed and open discussion about the ARDHBs' objectives. Following the meeting a revised draft discussion document was circulated to various ADHB members including Dr Bierre.

[104] A Northern Regional District Health Board collaboration meeting took place on 17 November 2005, but there is nothing to indicate that Dr Bierre attended that meeting.

[105] On 26 November 2005 Dr Bierre signed a "casual contract of employment" with Gribbles Analytical Laboratories NZ as a pathology consultant based at Penrose and other locations. On 28 November 2005 Dr Liz Walker, the general manager of Gribbles Veterinary, sent an email to Dr Bierre stating "as we discussed earlier in November" Gribbles would like to discuss "further opportunities" in various districts in New Zealand "as well as Auckland DHBs". Clearly Gribbles had discussed with Dr Bierre prior to 26 November 2005 a possible Gribbles presence in Auckland.

[106] Dr Bierre continued to act as an ADHB member after 26 November 2005. He exchanged a series of emails with Mr Brown in early December in which Dr Bierre summarised the Commerce Commission decision. Dr Bierre's analysis of the Commerce Commission decision was circulated to Board members. Mr Brown's email of 2 December 2005 concluded by thanking Dr Bierre for his "insights into the arcane world of pathology".

[107] On 7 December 2005 Dr Bierre emailed personnel at the Auckland Hospital Laboratory stating that he was interested in putting together a consortium of players to respond to the RFP and seeking their possible involvement. One of the persons contacted, Ms Fiona Ritsma, immediately responded expressing her concern about a perception of conflict of interest on Dr Bierre's part. She noted that Dr Bierre was an elected ADHB member who would ultimately be making a decision and signing off on the proposals. Dr Bierre did not appear to consider that there was a problem. He responded by an email of 9 December 2005 stating:

> I have declared my conflict of interest in this area to the Board as I am required to do and if I am involved in responses to the RFP as I intend to be as a practising pathologist, I will be excused from any decision-making at Board level. This has already occurred in some of the preliminary discussions.

He expressed the view that New Zealand was a small country and that persons with ability and expertise should not be excluded on the basis of conflicts and in any event, that there was a process for dealing with conflicts of interest.

[108] Ms Ritsma was not convinced. She responded immediately stating that she had passed on his email to others despite its being sent to her "in confidence". She stated that she felt the need to ensure that there was no perception of conflict of interest which could be used to argue against the overall process.

[109] On 20 December 2005 Dr Bierre met with Ms Ritsma and others from the hospital laboratories to discuss the prospect of merger with community laboratories. Mr Hewitt from Healthscope of Australia was present. It was clear that the Consortium proposal was developing. Dr Bierre appears to have continued to regard himself still as a fully functioning ADHB member at this meeting.

[110] Mr Gary Smith, the chief executive officer of the ADHB, met with Dr Bierre on 21 December 2005. Mr Smith had been given a copy of the email exchange of 7 to 9 December with Ms Ritsma which he noted he considered "inappropriate". He stated in his affidavit that he was concerned about Dr Bierre's conflict of interest and spoke to Mr Brown on the topic. Mr Smith and Mr Brown agreed that Mr Smith would speak to Dr Bierre about his conflict of interest, which he did. His file note, which indicates that he raised the topic of conflict of interest with Dr Bierre, supports this. He says that Dr Bierre agreed to stand down after Mr Smith had raised the topic with him. Dr Bierre, on the other hand, stated that it was he who raised the matter of conflict of interest on 21 December 2005, and that he reached the decision to take a leave of absence independently from Mr Smith. He refers to his own file note which is dated 14 January 2005, which he says is not the date when the note was made.

[111] Neither Dr Bierre nor Mr Smith has responded in any direct way to the other's version of what happened. It is not a critical issue, but I prefer Mr Smith's account, which is more consistent with Mr Smith's undoubtedly contemporaneous file note. It is also consistent with Dr Bierre's limited concern about conflict of interest that he demonstrated throughout, evinced in his 11 July 2005 letter to Mr Brown and in his December exchange with Ms Ritsma.

[112] On 22 December 2005 Dr Bierre wrote to Mr Brown applying for a leave of absence from the ADHB from 14 January 2006 to 30 June 2006. He gave as a reason the fact that he wished to respond as a provider to the RFP. He stated in his letter:

> Such leave of absence will in my opinion manage any conflict of interest issues that could arise concerning the RFP process and my position as a Board member.

Mr Brown agreed to this stand-down, and in the meeting of 22 December 2005 it was noted by the ADHB. There is no evidence that there were any evaluation panel or ADHB discussions in which Dr Bierre was involved between 22 December 2005 and 14 January 2006.

[113] I am satisfied that all parties involved in the process honoured the substance of Dr Bierre's stand-down, and that Dr Bierre did not seek to obtain information or influence his ADHB and evaluation panel contacts during that stand-down period. His state of knowledge of confidential information or, as it may be called, any state of advantage, must therefore be judged as at 23 December 2005. This does not mean that the events that followed are less important. It is the plaintiff's claim that the information that Dr Bierre had acquired up to that point gave him a material advantage, and that this is clearly seen in the events of 2006. It is the defendants' assertion that that is not so, and that any knowledge that he had was also ultimately enjoyed by DML.

[114] On 6 January 2006, Dr Bierre in response to the discussion document registered his interest as a proposer to provide community laboratory services on behalf of the Consortium. At this point in time Dr Bierre's stand-down had not at least technically commenced, the stated commencement date being 14 January 2006.

[115] On 30 November 2005 a draft discussion document had been circulated to all stakeholders. This document will be discussed later in the judgment in relation to consultation. The RFP itself was issued on approximately 8 February 2006.

[116] As could be expected, through February and March 2006 both DML and Lab Tests were very busy preparing their respective proposals. Dr Bierre reserved the company name "Auckland Pathology Consortium Limited", and he secured the involvement of Gribbles and Ms Mathias. The parties met with PHOs and with the hospital laboratories. It became clear that the suggestion to amalgamate with the hospital laboratories would not work because there was little spare useable capacity in those laboratories. This position was confirmed at a meeting of the DHB laboratories strategic leadership group on 14 March 2006, and by letters on 17 March 2006 to those who had expressed an interest in responding to the RFP.

[117] On 10 April 2006 the Consortium submitted a response to the RFP, a document of some 136 pages. On the same date DML lodged its proposal. Both proposals were in two parts. The first part of the proposal related to the mandatory and non-financial criteria. The second part of the proposal related to financial

matters and was presented in a separate sealed envelope. The idea behind the separation of the proposal into two parts was so the evaluation panel's consideration of the non-financial criteria would not be coloured by the proposal's economic aspects.

[118] As leader of the Consortium proposal, Dr Bierre then had to field questions and liaise with the evaluation panel, which he did through April and May. Dr Bierre's dealings with the evaluation panel were premised on his being the leader of the Consortium bid, and there is no suggestion that this was not clearly understood by all involved.

[119] In December 2005 the ARDHBs had engaged Audit New Zealand to provide independent "probity assurance" in respect of the tendering process for the community laboratory services contract. Its objectives were to ensure that the proposal process conformed to good practice, that the subsequent evaluation process was robust and in keeping with recognised good practice, that the risks of litigation through a failure to adopt good processes were minimised, and that adverse risks arising from complaints by disaffected parties, process failure, or improper practices were minimised. An experienced auditor, Mr William Inglis, became involved in late December 2005. He reviewed documents and attended evaluation panel meetings and some meetings with DML and the Consortium. He prepared a report which was presented by Audit New Zealand on 24 May 2006. The report stated that the processes were conducted in keeping with recognised good practice. It further stated: "We are not aware of any departures from good practice or outstanding probity issues up to this point of time".

[120] On 12 July 2006, after the evaluation panel's recommendation of early June had been accepted by the ARDHBs, and two days before the Lab Tests contract was signed, Mr Keenan circulated an email directed to Dr Jury on the evaluation panel, setting out a number of questions that he had been specifically asked by the chairs at the various meetings of the ARDHBs. The first question was "Qualify Tony Bierre position – no influence/no insider info and probity clearance". This question and the others were responded to in a memorandum of 13 July 2006 from the general

counsel to the ADHB. In respect of the query raised about Dr Bierre's position, he responded:

> ADHB and Tony Bierre have addressed any conflicts by an approach that exceeds all statutory or ethical obligations.
>
> All participants in the community laboratory sector – DML and SCL in particular – were involved on the extended strategic assessment that occurred prior to the release of the RFP. Significant information was shared in this process, including the final report. Via this process and the direct involvement in the sector the other respondents would have had access to more specific information and understanding as to ARDHBs' strategies and Tony Bierre.

[121] It is now necessary to consider these facts against the allegations of procedural impropriety. It is convenient to do so under the separate headings of conflict of interest and use of confidential information as these concepts best capture what was allegedly improper about Dr Bierre's involvement.

Conflict of interest

Conflicts of interest in administrative law

[122] A conflict of interest arises when a person carries out a particular function with two or more interests in conflict. In administrative law, a conflict of interest exists when a person has a private interest in a decision where that person also has a public role. In such a case the person's public role and private interest are in conflict. The result can be a poor decision because private concerns that have nothing to do with the public duty have influenced the decision.

[123] The concept of a conflict of interest is well known in the common law. It has developed particularly in the context of professional and fiduciary duties, the classic example being a solicitor's duty not to be in a conflict of interest with a client. It is also well understood in public law where its usual expression is under the heading of bias or apparent bias.

[124] The public law rule against conflicts of interest is not, as it is in private law, based on a relationship of trust and the need to protect a particular client or person to whom the trust is owed. Rather, the rule exists to protect members of the public

affected by the decision from poor decision-making. Conflicts of interest can be seen as an aspect of the administrative law requirement of procedural propriety in decision-making. The corollary is that insisting on procedural propriety helps to uphold public confidence in public decision-making.

[125] It must be recognised immediately that persons elected to public office will often be elected on the basis of express philosophies and policies. They will inevitably make decisions influenced by those stated policies and principles. It is well accepted that, providing the task of decision-making is approached with an open mind, such conflicts are acceptable: *Turner v Allison* [1971] NZLR 833 (CA), *R v Amber Valley District Council ex parte Jackson* [1985] 1 WLR 298. There is a distinction, however, between a conflict arising from the personal views held by a decision-maker, and a conflict arising from a personal financial interest in the outcome of a decision.

[126] A conflict of interest can be benign where the person who is conflicted does not participate in making the actual decision and the decision-makers know about and understand the conflict. If the conflict is declared, the decision-makers can stand the conflicted person down in respect of certain matters, or consider input from the conflicted person while making appropriate allowances for the conflict. The ability to compensate for the conflict cannot extend to voting, however, where the conflicted person could directly influence the outcome or decision. The undesirability of a conflicted person taking part in decision-making is reflected in cl 36 of Schedule 3 to the PHD Act. Clause 36(4) states that a conflicted member who discloses a conflict may, if the Board permits the member to do so, take part in deliberations but may not take part in any decision.

[127] The difference between a conflict of interest and misuse of information is clearly reflected in the provisions of the Crown Entities Act, where different sections set out duties under each heading. Sections 62 to 72 relate to conflicts of interest and s 57 relates to the misuse of information. A conflict of interest will not necessarily give rise to misuse of the DHB information, but a misuse of the DHB information will generally arise from a conflict of interest. Conflicts of interest can be managed, and this is contemplated by the relevant section. In contrast, managing or permitting

the use of confidential information is much more slippery territory. The fact that any such misuse of information is disclosed may not prevent damage to the ARDHBs' fair process.

[128] It is clear that Dr Bierre participated to one degree or another in the ARDHBs' deliberations leading up to the selection of the first preferred provider. It is equally clear that, although participating in the DHBs' deliberations, Dr Bierre did not take part in final decision-making. There is no allegation that the decision-makers were biased. Thus, while counsel accepted that Dr Bierre had a conflict of interest as an ADHB member interesting in securing a contract with the ARDHBs, it was submitted for both the ARDHBs and Lab Tests that his disclosure of the conflict was adequate to excuse his involvement in deliberations. Thus, it was submitted that the ARDHBs had not made any procedural error in allowing Dr Bierre's continued involvement.

Conflicts of interest in the relevant statutes

[129] The two statutes that relate specifically to DHBs are the PHD Act 2000 and the Crown Entitles Act 2004. Clause 36 of the Schedule 3 of the PHD Act provides as follows:

> **36 Disclosure of interests**
>
> (1) A member of a board of a DHB who is interested in a transaction of the DHB must, as soon as practicable after the relevant facts have come to the member's knowledge, disclose the nature of the interest to the board.
>
> (2) A member of a board who makes a disclosure under this clause must not (unless subclause (4) applies, or the Minister, by a waiver or modification of the application of this sub-clause under clause 37, permits) –
>
> (a) take part, after the disclosure in any deliberation or decision of the board relating to the transaction; or
>
> (b) be included in the quorum required by clause 25 for any such deliberation or decision; or
>
> (c) sign any document relating to the entry into a transaction or the initiation of the transaction.

(3) A disclosure under this clause must be recorded in the minutes of the next meeting of the board concerned and entered in a separate interests register maintained for the purpose.

(4) However, a member of the board who makes a disclosure under this clause may take part in any deliberation (but not any decision) of the board relating to the transaction concerned if a majority of the other board members of the board permits the member to do so.

…

[130] "Conflict of interest" is defined in s 6 of the PHD Act as "having an interest in a transaction" (the word used throughout cl 36 of Schedule 3). Section 6 defines "transaction" as follows:

> **transaction**, in relation to a DHB, means—
>
> (a) the exercise or performance of a function, duty, or power of the DHB; or
>
> (b) an arrangement, agreement, or contract to which the DHB is a party; or
>
> (c) a proposal that the DHB enter into an arrangement, agreement, or contract.

Section 6 goes on to define being "interested in a transaction":

> (2) For the purposes of this Act, a person who is a member of a board of a DHB or a member of a committee of such board or a delegate of such board is interested in a transaction of a DHB if, and only if, the board member or member of the committee or the delegate—
>
> (a) is a party to, or will derive a financial benefit from, the transaction; or
>
> (b) has a financial interest in another party to the transaction; or
>
> (c) is a director, member, official, partner, or trustee of another party to, or person who will or may derive a financial benefit from, the transaction, not being a party that is—
>
> (i) the Crown; or
>
> (ii) a publicly-owned health and disability organisation; or
>
> (iii) a body that is wholly owned by 1 or more publicly-owned health and disability organisations; or

> (d) is the parent, child, spouse or partner, or spouse of another party to, or person who will or may derive a financial benefit from, the transaction; or
>
> (e) is otherwise directly or indirectly interested in the transaction.
>
> (3) A person is not interested in a transaction for the purposes of subsection (2)—
>
> (a) if his or her interest is so remote or insignificant that it cannot reasonably be regarded as likely to influence him or her in carrying out his or her responsibilities under this Act or another Act; or
>
> (b) because he or she receives remuneration or other benefits authorised under this Act or another Act.

[131] The PHD Act states at cl 6 Schedule 2 that a DHB candidate must provide the electoral officer with a good faith statement disclosing conflicts. Sections 62 to 72 of the Crown Entities Act create a more extensive regime for disclosure of interests. They are more rigorous in that they do not allow a conflicted person to even participate in a discussion (s 66(a)) but by virtue of s 21(3) of the PHD Act they do not apply to DHBs. The less rigorous requirements for DHBs is a legislative recognition of the fact that DHB members tend mainly to come from the health professions and will therefore have connections with DHBs.

[132] It can be seen that the PHD Act defines "transaction" extremely broadly to include any exercise or performance of a function, duty or power of a DHB. Clearly, funding community laboratory services in Auckland is a function, duty and power of a DHB. A part of performing that duty is considering requests for funding. Further, the reviews carried out by Dr Pilstrom and then by Dr Gollop were part of the exercise and performance of that statutory function.

[133] I am satisfied that the deliberations and steps taken through 2005 towards renewing the DML contract, preparing the discussion documents, and issuing the RFP, were a function, duty and power of the ADHB as defined by (a) and (c) in the first part of s 6. Thus, because the process of selecting a community laboratory services provider is a "transaction", the requirement in 36(4) to disclose conflicts of interest applied to all DHB members involved.

[134] The concept of a conflict of interest in administrative law, while coinciding generally with the "interest in a transaction" concept in the PHD Act, is not constrained by the wording of cl 36. A conflict of interest remains a conflict of interest even if disclosed, or approved, pursuant to cl 36. In other words, even if a conflict of interest has been dealt with in terms of cl 36 it can still, for administrative law purposes, be impermissible if it amounts to procedural unfairness or impropriety. This proposition is developed in the misuse of information section in this judgment.

Did Dr Bierre have any conflicts of interest and, if so, when did they arise?

[135] At the time Dr Bierre was elected to the ADHB in October 2004, he held a part-time lecturing position at the University of Auckland School of Medicine, which was partially funded by the ADHB. He was the managing director of LabTests Auckland Ltd, which was the company he used for his consultancy work. He was the director of LabTests New Zealand Ltd, a shelf company that had been created so it could be used to provide laboratory-testing services in the future. These matters, which actually or potentially involved the Boards' funding, were clearly in conflict with his role as an ADHB member.

[136] In addition, as previously noted, Dr Bierre attempted throughout 2004 and 2005 to secure ADHB funding for his boutique laboratory, which he started to set up in December 2004. Even after being informed by Dr Jury on 30 March 2005 that ADHB had no policy for the provision of services consistent with his boutique laboratory proposal, Dr Bierre continued to communicate with Dr Jury and Mr Coe of the NDSA about a possible future for his boutique laboratory.

[137] On learning that Dr Bierre was involved in negotiations to secure ADHB funding, Mr Brown's letter of 8 July 2005 informed Dr Bierre that he should be excluded from the regional process considering laboratory testing. While there is no evidence that Dr Bierre took any active steps to obtain a share of the Auckland community laboratory work during the period between mid-July 2005 and mid-November 2005, he was certainly not excluded from the ARDHBs' deliberative process in relation to laboratory testing as Mr Brown had indicated in his letter of 8 July 2005, save for being asked not to participate in some matters in meetings of 3

and 4 August, which he still attended. Dr Bierre's continued involvement in the process did not, it seems, meet with any protest from Mr Brown, although Mr Brown did inform the Northern Regional District Health Board collaboration meeting on 14 July 2005 of the specific nature of Dr Bierre's conflict of interest.

[138] Dr Bierre's position at ADHB meetings throughout this period remained consistent with his desire to secure funding for his boutique laboratory. He opposed the termination of the SCL contract, which would have given DML a monopoly in the provision of community laboratory services. His position at ADHB meetings throughout this period was not consistent, however, with his having any interest and involvement in a general Consortium bid for all of the Auckland community laboratory services, as that would surely have required the termination of the SCL contract.

[139] Indeed, Dr Bierre's evidence as to the limited nature of his communications with Gribbles in August 2005 when he applied for the job of general manager has not been contested. At that stage there was no suggestion that Gribbles would be involved in a Consortium bid for the Auckland laboratory work. Gribbles was pursuing work in the Northland district and was involved in veterinary laboratory testing. Although on about 23 September 2005 Dr Bierre signed a casual contract of employment with Gribbles on very wide terms, which was wrongly dated 26 November 2003, it did not, he maintains, contemplate a bid in the Auckland market.

[140] In November 2005, however, Dr Bierre began to liase with Gribbles and Healthscope regarding what would later become the Consortium proposal to provide community laboratory services in Auckland. Dr Bierre in his affidavit indicates that he started to develop the idea of a Consortium bid in early December 2005. However, it is clear from Dr Liz Walker's email of 28 November 2005 that discussions had taken place between Dr Walker and Dr Bierre earlier in November about opportunities for Gribbles in New Zealand, including in Auckland. Neither Dr Bierre nor Dr Walker has detailed the nature of those November discussions.

[141] This was a new and significant development. Given Dr Bierre's position as an ADHB member, as soon as Gribbles raised the issue of the ARDHBs with him, he was in an acute conflict of interest position. As an ADHB member Dr Bierre was obliged to consider the improvement, promotion and protection of the health of the people of Auckland in accordance with the PHD Act. As a consultant with Gribbles and a person with an interest in a consortium that was considering making a proposal, he was obliged to attempt to secure a contract for that Consortium. The two goals were clearly incompatible.

[142] Thus, Dr Bierre's attempt to secure ADHB funding for his boutique laboratory throughout 2004 and 2005 clearly amounted to an attempt to "derive a financial benefit" from the ARDHBs' transaction in terms of s 6(2)(a) of the PHD Act. Dr Bierre's attempt to secure a contract for his Consortium proposal, beginning at some point in November 2005, also clearly amounted to an attempt to "derive a financial benefit" from the ARDHBs' transaction. In addition, Dr Bierre's role with the Consortium plainly made him a director of a party who would derive a financial benefit from the transaction in terms of s 6(2)(c). There can therefore be no doubt that Dr Bierre had a conflict of interest in the sense of being interested in the "transaction" for the purposes of 36(1) when he was pursuing a contract for his boutique laboratory throughout 2004 and 2005 and when he was pursing a contract for his Consortium proposal from November 2005.

Did Dr Bierre adequately disclose his conflicts of interest?

[143] Dr Bierre's disclosure of interest to electors in August 2004 provided under cl 6 of Schedule 2 of the PHD Act read as follows:

> I hereby disclose the following conflict of interest with the Auckland District Health Board that may arise in the future. I am currently employed as a part-time Senior Lecturer at the University of Auckland School of Medicine. The Auckland District Health Board (ADHB) is the major funder of pathology services in the Auckland region. All pathologists working in the region served by the ADHB are either employed by the ADHB or have a contractual relationship with the ADHB. At present I am not employed by ADHB nor have a contractual relationship with the ADHB. However, there is a possibility that this may change in the future and may represent a conflict of interest.

While certain matters were disclosed, the statement did not inform electors of any intention on Dr Bierre's part to seek ADHB funding for his own embryonic laboratory services company.

[144] Nor was such an intention stated in the specific statement completed by Dr Bierre on 8 December 2004 to be registered on the ADHB interests register. The practice of ADHB members appears to have been to simply list the member's role in any companies with which a member was involved. The statement in response from Dr Bierre read as follows:

1. Senior Lecturer (Part-time), Department of Molecular Medicine and Pathology, University of Auckland
2. Owner/Director, ZKTHB Ltd
3. Managing Director LABTESTS Auckland Ltd
4. Director LABTESTS New Zealand Ltd
5. Member, Medical Advisory Committee, New Zealand Breast Cancer Foundation

[145] Any specific disclosure of Dr Bierre's intention to provide laboratory services would have been recorded in the minutes of the ADHB meeting and entered in the interests register pursuant to 36(3). It was not, and it can be concluded that Dr Bierre did not disclose any such intention.

[146] To be meaningful, a disclosure statement should disclose the *nature* of any conflict of interest that might arise so that other DHB members can properly assess it. Indeed, cl 36(1) of the PHD Act stipulates that the "nature" of the interest must be disclosed. Disclosing the "nature" of a conflict involves more than simply providing the name of a company in which the DHB member has an interest. The name of a company might not give any indication of the kind of work the company carries out. The name "LabTests" did give an indication of the type of work that might be carried out by that company, but it gave no indication as to whether the company was actually carrying out that sort of work, or wished to carry out laboratory tests in the future, and if so whether ADHB funding would be sought.

[147] Dr Bierre's intention to open a laboratory and seek funding from December 2004, the fact that his company LabTests was operating as a boutique laboratory between March and June 2005, and the fact that he sought ADHB funding for it, should have been formally disclosed. Only that sort of disclosure statement would have adequately informed a person examining the interests register of the true nature of Dr Bierre's interests.

[148] Mr Davison QC for Lab Tests submitted that the obligation to disclose did not arise until the proposal had reached the level of advancement or progress that it was a "real prospect". The point at which disclosure should take place is not so easily encapsulated. In any event I am satisfied that from Dr Bierre's point of view he saw himself as having a real prospect for funding from December 2004.

[149] Dr Bierre thus clearly remained in default of his obligation under cl 36 of Schedule 3 to disclose the nature of his conflict of interest during his attempts to secure funding for his boutique laboratory throughout 2005. The extent of his default is demonstrated by Mr Brown's reaction on learning that Dr Bierre was actively negotiating for ADHB funding. In his letter of 8 July 2005 he noted that Dr Bierre had failed to "expressly declare" his conflict of interest. Mr Brown revealed the seriousness of the nature of Dr Bierre's conflict by saying in his letter that the ADHB had placed "considerable stock" on Dr Bierre's advice and that it had been "central" to decisions that the ADHB had taken.

[150] Dr Bierre responded to Mr Brown's reprimand by refusing to accept that there had been any failure on his part to address his potential conflict of interest. His response was consistent with a continued indifference to the conflict inherent in his role as both an ADHB member and a potential provider. He did indicate that he had decided to close down ("mothball") his laboratory.

[151] Further, Dr Bierre does not appear to have considered there to be any conflict of interest even after he was, by his own acknowledgement in early December 2005, actively developing the idea of a Consortium bid. In his exchange of emails with Ms Ritsma between 7 and 9 December 2005, it was Ms Ritsma who pointed out the conflict of interest to Dr Bierre. The ARDHBs' employees and members became

aware of his intentions only through Ms Ritsma's circulation of the email exchange with Dr Bierre. It was the exchange with Dr Smith on 21 December 2005 that led to his standing down from the Board. Dr Bierre did not, therefore, properly disclose the true nature of his conflict of interest until it was disclosed by Ms Ritsma in December 2005. Thereafter, he stood down from the Board after meeting with Mr Smith on 21 December 2005.

Did the ARDHBs adequately deal with Dr Bierre's conflicts of interest?

[152] The ARDHBs' failure to act on Dr Bierre's conflict of interest had unfortunate consequences. Dr Bierre was able to endeavour to influence and mould the Boards' thinking to be consistent with his commercial goals. His role should have been formally considered by the ARDHBs under the procedure in cl 36(4) of Schedule 3 of the PHD Act. If it had been, Dr Bierre, given his strong desire for ADHB laboratory funding, would have been stood down as Mr Brown on 8 July 2005 indicated he should be, from considerations involving laboratory testing and the regional process that was underway.

[153] Dr Jury and Mr Coe were aware of Dr Bierre's boutique laboratory and desire for funding for his boutique laboratory because Dr Bierre spoke to them in support of his requests. Further, Dr Bierre says that he spoke to at least one ADHB member a Dr Di Nash, in mid-2005 where he informed her of his boutique laboratory and sought her support. Dr Nash has not filed an affidavit. It was not until ADHB chair Mr Brown received the letter from Dr Hutchison in July 2005, that the ADHB became fully aware of the true nature of Dr Bierre's conflict of interest.

[154] At the time Mr Brown became aware of the conflict, the Board should have considered Dr Bierre's conflict of interest pursuant to cl 36 of Schedule 3 of the PHD Act, given his position at the heart of policy-making for the pending RFP. The position of Dr Bierre was very different from the common conflict that can arise in DHBs, where members commonly have working or professional relationships with DHBs or their associated organisations. As a potential proposer who stood to directly gain from the outcome of the process he should have been stood down

entirely from any involvement in the ARDHBs' considerations of community laboratories from that point.

[155] Indeed, this was Mr Brown's initial reaction, expressed in his letter of 8 July 2005. It is possible that Mr Brown took no further action because Dr Bierre's letter of 11 July 2005 had stated that he was "mothballing" his laboratory. This may have been interpreted by Mr Brown as a promise that Dr Bierre would no longer have any involvement in seeking funding for his own laboratory interests. However, given the significance of the issue, that should have been clarified. If Mr Brown had checked he would have found that Dr Bierre had not abandoned his attempts to secure funding for his own laboratory but had rather put them temporarily on hold. His conflict of interest continued, and the ARDHBs' failure to prohibit further involvement amounted to a serious procedural error.

Conclusion on conflicts of interest

[156] Dr Bierre was in a conflict of interest from the time he started sitting on the ADHB in December 2004. Throughout his time as an ADHB member he was interested in securing ADHB funding for his own laboratory, which amounted to an attempt to further his own private financial interests. Dr Bierre had an even more serious conflict of interest once he began discussions with Gribbles and others in November 2005 about a general proposal to provide laboratory services in Auckland in response to the pending RFP.

[157] Dr Bierre's initial concern about his conflict of interest in July 2004, Mr McKernan's reaction on 2 June 2004, Dr Hutchison's comment on 27 June 2005, Mr Brown's reaction on 8 July 2005, Ms Ritsma's reaction on 7 December 2005 and Mr Smith's position later in December 2005, were all correct. Dr Bierre's conflicts of interest were a serious threat to the integrity of the ARDHBs' process.

[158] From the time Mr Brown became aware of Dr Bierre's serious conflict of interest, the ADHB was obliged to address it. The action taken by the ARDHBs was entirely inadequate. Indeed, apart from Dr Bierre's abstention from voting in the 4 August resolution, there was no action. The ADHB could have recorded the

disclosure in the Minutes and entered it into a separate interests register pursuant to clause 36. It could then have voted on whether Dr Bierre could take part in any deliberations. For the reasons I will set out in the next part of this judgment, it would then have had to conclude that Dr Bierre should cease to have any involvement in deliberations relating to laboratory services and the RFP. In allowing Dr Bierre to continue to be involved in discussions about laboratory services, while he wished to bid for them himself, the ARDHBs permitted this process to be damaged. They were being influenced by a person who was driven by his own interests, rather than the interests set out in the PHD Act.

[159] Unfortunately, no action was taken until 21 December 2005 when, after the email exchange with Ms Ritsma and being spoken to by Mr Smith, Dr Bierre agreed to stand down. By this time, however, Dr Bierre had a detailed knowledge of the thinking of the panel and the ARDHBs' members. The ARDHBs missed another chance to address the conflict of interest by failing to reiterate in February and March 2006, when it was clear that Dr Bierre was planning to submit a proposal, that his involvement in entering a proposal was inappropriate and impermissible. Finally, the ARDHBs' receipt of the Consortium proposal, despite being aware of the conflict of interest, amounted to another missed opportunity.

[160] The ARDHBs had a duty to ensure that they conducted their affairs fairly and properly. This duty arose not only from cl 36 of Schedule 3 of the PHD Act but also from a public law duty to conduct public affairs with probity. The ARDHBs' failure to prevent Dr Bierre's involvement in the ARDHBs' attempt to reform the provision of community laboratory services, meant that the only pathologist involved was seeking outcomes that suited his commercial goals rather than the ARDHBs' statutory objectives of improving and protecting public health. The ARDHBs' failure to prevent Dr Bierre's involvement damaged the integrity of the ARDHBs' considerations and undermined public confidence in Board processes. The ARDHBs' failure to respond adequately to Dr Bierre's conflict of interest created the platform for Dr Bierre to use knowledge and information acquired from his ADHB position to make a proposal with the opportunity arose.

Use of the ARDHBs' information for private purposes

The concept of misuse of the ARDHBs' information

[161] The plaintiff submits that Dr Bierre used, or appeared to use, his unique knowledge, influence and relationship derived from his position as an ADHB member to procure a material advantage both for himself and for the other participants in his consortium. I now consider this allegation and what it means for the ARDHBs' decision-making.

[162] The concept of misuse of confidential information is well known in our civil law. The action for breach of confidence is a right of action based on equitable principles, sometimes overlapping with, although never dependent on, a fiduciary duty: *AB Consolidated Limited v Europe Strength Food Co Pty Ltd* [1978] 2 NZLR 515 (CA). It has even been expressed as a property right with remedies sounding in tort on occasions, as discussed in Todd *The Law of Torts in New Zealand* (4 ed 2005) para 15.5.01. However, this is a different concept to misuse of information in the public arena. In private law misuse of information turns on the abuse of a relationship of confidentiality causing loss to the person whose confidence has been abused. In public law, the misuse of information turns on damage to the public process, where, in the words of s 57(2)(b) of the Crown Entities Act, the public process is "prejudiced".

[163] While the PHD Act provides a mechanism for dealing with conflicts of interest in cl 36 of Schedule 3, it is silent on the misuse of information. The Crown Entities Act, however, deals with both conflicts of interest (in ss 62 to 72) and the misuse of information in s 57. Section 57 reads:

> **57 Duty not to disclose information**
>
> (1) A member of a statutory entity who has information in his or her capacity as a member that would not otherwise be available to him or her must not disclose that information to any person, or make use of, or act on, that information, except—
>
> (a) in the performance of the entity's functions; or
>
> (b) as required or permitted by law; or

> (c) in accordance with subsection (2); or
>
> (d) in complying with the requirements for members to disclose interests.
>
> (2) A member may disclose, make use of, or act on the information if—
>
> (a) the member is first authorised to do so by the board or, in the case of a corporation sole, by the responsible Minister; and
>
> (b) the disclosure, use, or act in question will not, or will be unlikely to, prejudice the entity.

[164] Section 21(1) of the PHD Act states that a DHB is a Crown entity. Section 21(2) states that the Crown Entities Act applies to each DHB, except to the extent that the PHD Act expressly provides otherwise. The PHD Act does expressly provide otherwise in respect of the disclosure of interest provision in cl 36 of Schedule 3. This is why s 21(3) lists the conflict of interest sections in ss 62-72 of the Crown Entities Act as provisions of the Crown Entities Act that do not apply to DHBs. However, s 57 of the Crown Entities Act is not listed in s 21(3) of the Crown Entities Act as a provision that does not apply to DHBs. The duty not to disclose information in the Crown Entities Act pertaining to a Crown entity must therefore be intended to apply in respect of DHBs.

[165] Section 57(1) sets out the circumstances in which information can be disclosed or used or acted upon. Unsurprisingly, the circumstances in which information can be legitimately disclosed or used or acted upon, are circumstances where the information is used is in the performance of the entities' functions, or as required by or permitted by law. DHB members are allowed to make use of or act on the information for other purposes if they have first obtained express authorisation from the DHB, and second, the use of or disclosure of the information will not prejudice the entity. Thus, it will be a breach of s 57 of the Crown Entities Act for a DHB member to use DHB information other than for permitted purposes unless, first, the member has obtained the DHBs' authorisation and, second, no prejudice will be suffered by the entity. Under the section, DHB authorisation of the disclosure alone will not be sufficient.

[166] The terms "information" and "prejudice" are not defined in the Crown Entities Act. Information will have its ordinary meaning of "something told;

knowledge": *New Zealand Oxford Dictionary*, (2005). "Prejudice", in the context, has the meaning of damaging or impairing the DHB's function. Prejudice to the entity would include prejudice to the integrity of the entity's decision-making process. If the entity is making poor decisions because of a breach of the duty on a Board member not to disclose information, it can be said to have been prejudiced.

[167] Section 57 does no more than state in legislative form what must in any event be what is properly and fairly required in terms of DHB procedure. It would be procedurally improper for a DHB to allow its private information to be used for other than DHB purposes, in such a way as to prejudice the functioning of the DHB. A competitive proposal situation is only one example of a situation in which misuse of DHB information could be damaging.

[168] Generally, there can be no way to fix a misuse of confidential information, as the party using that information will have secured an advantage over other parties who do not have it. The user's improper advantage relative to others in the decision-making process will jeopardise the chances of the decision-maker reaching the best decision. The integrity of the decision-making process can be damaged regardless of whether or not other DHB members knew about the use of the DHB information. The public will suffer if procedures are not set in place in an attempt to ensure that the best outcome is reached.

[169] None of the usual administrative law categorisations easily apply to misuse of confidential information. The rationale behind the rule against bias, namely the need to maintain public confidence in public bodies, is relevant. However, bias relates to the decision-maker. Were this situation one of bias, the danger would be that the ARDHBs and evaluation panel members might unfairly lean one way or another because of particular sympathies. This case is different. Here the process was open to manipulation by one of the proposers because of that proposer's unique and privileged knowledge arising from connections with the decision-maker. If there is a principle here, it is that a DHB should not allow insiders to an administrative process to use significant information gained as a consequence of their position, for their personal advantage.

[170] There does not appear to be any case law that directly grapples with the use of information issues that arise in this case. I have, however, been assisted by the decision of *LGS Group Inc v Canada (Attorney-General)* (T.D.) [1995] 3 FC 474. That was an application for judicial review of a decision of a Minister to rescind a contract between the Minister and the applicant. The contract in question was the result of an RFP process where the successful applicant had been assisted by an independent contractor who had been extensively involved in preparing the RFP document. A clause in the contract prohibited a former public office-holder from deriving any direct benefit from the contract. It was concluded that it would have been impossible for the consultant to have divorced himself from his knowledge of the philosophy and methodology behind the RFP.

[171] That case was different from the present situation, in that the subject of the review application was the Minister's decision to rescind the contract because of a breach of the clause not to derive benefit, and not the wrongful use of information. However, the Court referred at [41] to the insider's ability to advise the proposer on the "expectations and mindset" of those who would review the proposal. The Court emphasised the object of enhancing public confidence in the integrity of public office holders, and the "principle" of ensuring that "former public office holders do not take improper advantage of their previous office": [48].

[172] The assumption by that Court that information as to the "expectations and mindset" of the decision-makers had been used wrongfully, gives rise to the question of whether the wrongful use of such information can be assumed in certain situations, without specific proof being required. Mr Illingworth suggested in oral submissions that a person in Dr Bierre's situation could have an "onus of persuasion" to show that no wrongful advantage had been obtained.

[173] As a matter of common sense, questions must be asked when a person who has been on a decision-making body involved in the lead-up to a request for proposals or tenders, then participates in a proposal to that same body. It can be expected that the proposer will have knowledge of the decision-maker's expectations and mindset beyond that of any other proposer in the absence of an explanation to the contrary. I will return to this issue after examining the evidence.

[174] Mr Illingworth rightly accepted that a DHB should act even-handedly and consistently in relation to valuable confidential inside information. However, he submitted that there would always be information inequities in a commercial competitive tender situation. He pointed out that, as the incumbent, DML had a great deal of information that no other competitor could acquire. Further, he contended that the information available to Dr Bierre was information that would have been available in any event to all parties by the end of the RFP process. In essence he argued that as the information was later available to all interested parties, there was no advantage and no prejudice to the ARDHBs' process.

[175] Thus it is necessary to determine whether Dr Bierre used information that would not have been otherwise available to him or others to the particular advantage of the Consortium proposal. Once the facts of Dr Bierre's knowledge are determined, the issue becomes what the Board should have done.

[176] I have set out earlier in this judgment the history of Dr Bierre's involvement in the ARDHBs' matters between December 2005 and December 2006. I will now proceed to consider certain specific categories of information that he acquired, and examine whether they were used and to what advantage, if any.

What information, if any, was acquired by Dr Bierre as an ADHB member?

[177] Dr Bierre was intimately involved in the development of the ARDHBs' thinking on community laboratory matters for the 12 months between his first ADHB meeting in December 2004 and his stand-down in December 2005. He was the only specialist pathologist on the ADHB. As a former clinical director of cytopathology and chairman of DML's board of management, he was an expert in community laboratory services in Auckland. This expertise had developed further after he left DML. He lectured at Auckland University, carried out research into the laboratory situation in New Zealand, and for his MBA did consultancy work.

[178] His knowledge about how pathology services worked in Auckland did not come from his role as an ADHB member. Indeed, he undoubtedly contributed to the knowledge of laboratory services of the other ADHB members and employees. I

also see no evidence that he developed any sort of emotional hold over any particular ADHB member or employee, although he appeared to have their confidence and his views on pathology matters were treated with great respect. His views were not, however, always followed. He lost a vigorous debate with Dr Gollop, for instance, about the termination of SCL.

[179] What Dr Bierre did do, however, was become privy to the thinking of the ARDHBs' leading members, employees and consultants who were involved in the review of laboratory services and the ensuing RFP process. He was aware of their attitude to DML and its processes. A knowledge of how persons in a decision-making position think can be commercially useful information. It is relevant that cases such as *Black v Taylor* [1993] 3 NZLR 403 (CA) at 406 recognised that a valuable knowledge about a party's thinking and attitudes can be gleaned from a professional relationship (while it is recognised that the standards required of solicitors in a conflict of interest situation are entirely different and much more stringent than apply here). The advantages of knowing a person's characteristics, in that case a client's weakness, fears and reactions, were recognised as being "information", which could indeed be used against the original client. While there were certain specific pieces of information that I have referred to that were used by Dr Bierre, he also had the more general sort of information referred to in *Black v Taylor*, similar to the knowledge of the "expectations and mindset" referred to in the *LGS Group Inc v Canada (Attorney-General)* case. During his time on the ADHB he would have gained an intimate knowledge of what the decision-makers were thinking and how they would react to certain proposals. I turn now to the details of that knowledge.

[180] Dr Bierre became aware of the ARDHBs' desire for an open-book exchange of accounting information from the successful bidder. This was a concept probably favoured by the ARDHBs before Dr Bierre became a member. However, the ARDHBs' view was developed by Dr Bierre's frequent statements of the need for "open-book accounting". For instance, the motion he moved at the audit meeting on 4 May 2005 that there be such "open-book" accounting reflected a similar wording in LabTests' bid in respect of histopathology and cytopathology services earlier that year. Given Dr Bierre's position as the only expert pathologist on the Board, the fact

that he was advocating the idea would have made it assume an even greater significance in the ARDHBs' thinking.

[181] DML was aware of the ARDHBs' desire for an open exchange of accounting information. DML made a policy decision not to comply. Dr Bierre's knowledge that the ARDHBs sought open-book accounting in itself did not necessarily amount to a great information advantage. However, DML did not appear to realise just how uncomfortable the ARDHBs were with its refusal to co-operate on transparency. Dr Bierre was aware of the discomfort. He had helped to create it.

[182] In addition to emphasising the need for "open-book" accounting, when discussing matters with the ADHB and its employees and consultants, Dr Bierre painted a picture of DML as taking exorbitant profits and refusing to co-operate with the ARDHB attempts to change the status quo. Dr Bierre suggested that this was why DML would not disclose their costs. In his email of 18 May 2005 to Mr Smith of the ADHB, Dr Bierre referred to DML's "culture, past behaviour and critical requirement to continue to return super profits" and said that if they were given a monopoly "they will be holding all the cards". He repeated his references to DML's monopoly position, and on 31 May 2005 emailed all ADHB members advising again that organisations were making "super profits". Mr Keenan in his memorandum that followed on 13 July 2005 used Dr Bierre's phrase "super profits" twice. Given that Dr Bierre was a former senior executive of DML, his disparaging statements about DML's profits were undoubtedly given considerable weight.

[183] By the time of the RFP Dr Bierre was aware that the ARDHB perceived DML to be making excessive profits. He had helped to create this perception. While DML was undoubtedly aware that the ARDHBs wanted it to fully disclose its profit margins, it was not aware of the extent of the dissatisfaction of some of the ARDHBs' members and staff consultants with DML. The notes of DML discussions through the lead up to the RFP show an awareness of the ARDHBs' desire for "open-book" accounting but show no recognition of the level of the ARDHBs' concern. Dr Bierre, on the other hand, was well aware of how DML was regarded by the ARDHBs and by members of the evaluation panel.

[184] While on the ADHB, Dr Bierre also obtained information about the thinking of ADHB members and staff as to the level of savings that they wished to achieve.

[185] The public documents that had been issued, such as the Pilstrom Report, disclosed a wish for only relatively modest savings. For instance, the Pilstrom Report referred to potential savings in the order of $2 to $3 million per annum.

[186] Mr Keenan's confidential memorandum circulated to Dr Bierre, on the other hand, referred to minimum savings on the current spend in the first year of $20 million. Dr Bierre himself had informed ADHB members of considerable savings being enjoyed by South Island DHBs. Such savings could only be achieved by a radical reduction in overheads of the sort ultimately reflected in the Lab Tests' bid, which greatly reduced the number of community laboratories and pathologists and phlebotomists employed.

[187] Dr Bierre and the Consortium knew that a saving in the region of $20 million was the sort of saving that influential ADHB personnel involved in the RFP process were looking for. The proposal that Lab Tests ultimately put in offered savings of over $16 million per annum.

[188] Its appeal to the thinking of the evaluation panel members is reflected in the fact that in their initial consideration of the proposal on 18 May 2006, six of the seven members gave Dr Bierre's bid ten out of ten on value for money, and the other nine out of ten. In contrast, three members of the evaluation panel initially marked the DML proposal on a value for money basis at zero, one other at three out of ten and three others at five out of ten. The zero rating of value for money given by three evaluation panel members to the DML bid and its comparison to the near perfect rating for the Consortium bid seems unjustified. A good service was being offered by DML with a low profit return to the provider. DML's profit margin at that point was below 6%. While the perception that the DML price was too high would reduce a value for money score, it is very hard to understand how a zero score could have been considered appropriate by members of the evaluation panel. I attribute this to the fact that the DML bid was completely out of tune with the thinking of the

evaluation panel members, and, as Dr Bierre planned, the Consortium bid in contrast was precisely attuned.

[189] Dr Bierre also understood that some of the ARDHBs' members and employees like Mr Keenan were looking for a complete change in the way in which the laboratory services were set up in Auckland, if it were necessary to reduce costs. This is developed in the next section.

How it was used to the advantage of the Lab Tests proposal?

[190] Dr Bierre's understanding of the thinking of the ARDHBs and evaluation panel members can be seen in his strategy paper of 21 March 2006, which he prepared for the Consortium. He stated:

> [The Consortium] will win this RFP if we are able to: …
>
> - change the business model or paradigm sufficiently so the incumbent finds it difficult to adapt and is seen to be trying to maintain the status quo.

[191] While the Consortium through Dr Bierre knew that this would create a winning proposal round, DML did not. When DML prepared its proposal it was not thinking in terms of changing the business model or paradigm. Its offer rather offered adaptions to the status quo.

[192] In his paper of 21 March 2006 Dr Bierre noted that the proposal to be put forward would reduce the collection centres to between 40 and 42. He proposed that approximately 50% of collection would be through the collection room network and 50% at the time of GP consultation. He was able to propose such radical changes knowing they would appeal to the evaluation panel and the ARDHBs members.

[193] The Consortium proposal stated in no fewer than four different places that a move to collection by general practitioners was a core aspect of the bid. A typical phrase was "[The Consortium] believes collection is a core primary health organisation (PHO) activity". It was stated in the proposal that the key driver was to change the "current service paradigm". Phrases that Dr Bierre had used in his earlier communications to Consortium members were used in the final proposal that he

drafted, as were others that he had used in his time on the ADHB. For instance the phrase "decreases the information asymmetry" recalls his use of the term "information asymmetry" in his confidential paper to members of the ADHB on 23 May 2005. He had referred in that paper to the need to address the "underlying structural issues", which was a theme of the Consortium bid.

[194] The views of Dr Bierre, expressed in his strategy paper of 21 March 2006 and which featured in the Consortium proposal, pick up on themes expressed by Mr Keenan in his paper of 14 July 2005. Mr Keenan's views as to radical savings and his negative views on DML had been particularly noted and approved by Dr Bierre.

[195] Dr Bierre knew that a proposal for a radical change, drawing on these particular themes, was in tune with the thinking of critical persons involved in the Board processes. He knew what the vice chairman of the ARDHBs thought was a "good outcome". Mr Keenan's views were widely circulated. His paper of 13 July 2005 had been presented the next day at the regional meeting of the DHBs.

[196] Dr Bierre's unique awareness of what the ARDHBs wanted is reflected in the emphasis in his proposal for PHO collections and also referred to by Mr Keenan in his reference to "GPs/Primary Sector relationships". The task of collection would be placed more on general practitioners, alleviating the need for separate collection rooms. The Consortium proposal mentions in no fewer than four places that collection is a "core PHO/GP activity." While there is no evidence that this was an idea developed by Dr Bierre over the preceding year, Dr Bierre knew it would be well received (as it was), because of his understanding of the way that the ARDHBs and evaluation panel members thought.

[197] An indication of the extent of this advantage can be seen in the assessment made of Dr Bierre's position by Healthscope when it considered what percentage Dr Bierre should have of the Consortium in May 2006. In the paper addressing the proposal for the Healthscope board of May 2006, a justification was put forward for giving Dr Bierre a substantial shareholding in the new company that would hold the contract. It was stated:

> The key attributes Dr Bierre brings to [The Consortium] are:
>
> - expertise and knowledge of pathology service provisions in the Auckland region;
> - a sound network of supporters within the healthcare/DHB system;
> - a position on the Auckland DHB providing *excellent lines of communication by information*; and
> - being *a major influence in the restructuring model* for pathology services provision.
>
> [emphasis added]

[198] The first two bullet points are unexceptional. However, the next two indicate the extent of the advantage that Dr Bierre gave to the Consortium bid. His position on the ADHB was seen to provide excellent "lines of information." It was stated that he had been a "major influence" in the restructuring of the model. These statements show that those in Gribbles and Heathscope who had worked with Dr Bierre on the proposal had seen him as having used information he obtained as an ADHB member for the advantage of the Consortium proposal. He was seen as having influenced the restructuring model for pathology services. This matter would not have been worthy of comment if the information had been generally available. The value of having influenced the restructuring model was that it enabled the Consortium proposal to exactly respond to the ARDHBs' wishes.

[199] Mr Ross submitted that the unique advantage that Dr Bierre's knowledge of this information gave is confirmed by the value placed on his involvement by Healthscope Limited. He had 15% of the Consortium shares at the time of the proposal. He has not had to contribute any working capital, and it seems that the Consortium has now spent in excess of $17 million in setting up the new service. The only financial contribution that Dr Bierre made was to acquire shares in the new Lab Tests company for the payment of $83,000.

[200] If the initial expectation of Healthscope and Dr Bierre that the contract will return 12.6% earnings before tax is realised, Dr Bierre will earn close to $1 million per year for his $83,000 investment. While this does not take into account the repayment of advances by Healthscope, those repayments will add to the value of

Dr Bierre's equity. In addition, Dr Bierre will receive a salary as the chief executive officer of Lab Tests.

[201] Dr Bierre's position can be contrasted to that of Ms Mathias. Dr Bierre is the CEO of Lab Tests, and she is the manager in charge of establishing collection centres in the transportation network. She is a very experienced Auckland professional in the health area, who has held very senior positions. However, she is not a former ADHB member, nor a prime organiser of the RFP. The shareholding that her family company was allocated was 5%.

[202] It is not possible to draw too much from Dr Bierre's employment package. He is undoubtedly a skilled pathologist and would have had value to Lab Tests without his ADHB experience. However, I infer from the wording of the Healthscope paper to which I have referred that the shareholding given to Dr Bierre was perceived by Healthscope to be in part a recognition of the advantage he brought to the Consortium proposal arising from his former role as an ADHB member.

[203] That advantage was his knowledge of what the ARDHBs wanted, and what would make a winning bid. That was information that he should not have used. The Consortium's use of that information debased the proposal process and made it unsound on an objective basis. It prejudiced the ARDHBs' function to make good decisions about providing good health services for Aucklanders.

[204] It was submitted for the ARDHBs that there was not a level playing field in any event, because of DML's advantages as the incumbent, which included a detailed knowledge of costs, and the practicalities of running community laboratories in Auckland. Those undoubtedly were advantages for DML, but they were unavoidable and were known and understood by the ARDHBs and evaluation panel members. The advantage to Lab Tests, on the other hand, was distinctly avoidable, and if the disclosure process had been properly followed at the outset by Dr Bierre, and he had fully disclosed his interest as a proposer and stood down from all considerations from the beginning, it would have been avoided.

[205] DML wanted to keep its contract and adopted a commercial approach to attempt to do so. I have no doubt that if it knew that savings in the order of $20 million per annum were what the ARDHBs wanted, while perhaps preferring the level of service offered by status quo, it would have tailored its bid to meet that expectation. Indeed, DML's willingness to meet the ARDHBs' standards can be seen throughout negotiations during the bid process. DML was aware that the ARDHBs were not happy with the cost of the DML bid, but was struggling to find out what exactly it was that the ARDHBs wanted. Their file notes show them seeking assurances that the status quo of services was to continue. They were not informed as to the level of savings desired. Lab Tests, on the other hand, did know what level of savings was desired because of Dr Bierre's intimate involvement in the ARDHBs' processes.

[206] The confidential information that Dr Bierre had was not of the traditional type of trade secrets or hard facts. But he knew, after a year's intimate experience with key decision-makers on the ARDHBs, what they wanted. This gave the Consortium proposal a huge advantage. I have already noted how in terms of value for money, the Lab Tests proposal completely carried the day, and was completely in tune with the thinking of members of the evaluation panel.

What the ARDHBs should have done

[207] The ARDHBs, on becoming aware that Dr Bierre might be involved in a proposal in December 2005, should have refused to entertain any bid involving him, given his involvement in deciding on the ARDHBs' strategy and matters preliminary to the RFP. Any such proposal would be tainted by Dr Bierre's knowledge as an insider. The ARDHBs should have made this position clear to Dr Bierre in December 2005, when it became a possibility that he would enter a proposal. Further, as it became clearer through February and March of 2005 that he was leading the Consortium proposal, the ARDHBs should have made it clear that such a proposal involving him would not be accepted. Then, when a proposal was filed by the Consortium showing Dr Bierre with a 15% interest, this should have been rejected pursuant to cl 43 of the RFP, or the whole RFP process suspended or cancelled.

[208] The ARDHBs' failure to take any of these steps was a serious error. A process which permits a particular party to use confidential information about the particular wishes of a decision-maker to its advantage is much less likely to achieve the best result for the public than a proposal process that is procedurally fair.

Was the stand-down by Dr Bierre sufficient?

[209] Mr Illingworth for the ARDHBs argued that Dr Bierre's withdrawal from the decision-making process in December was a vitally important aspect of the case. He relied on the withdrawal of a conflicted judge after the decision of *Re Pinochet* [2000] 1 AC 147 to demonstrate how withdrawal from participation in a decision-making process can be sufficient to remove any suggestion of bias. The second House of Lords decision, made without the judge, was sufficient even though the judge remained a member of the House.

[210] However, I do not think that the analogy between the *Pinochet* case and the present situation is apt. A decision-maker in a judicial or quasi-judicial situation who may have a conflict of interest can stand down, and his or her colleagues can proceed with a fair hearing providing there is no apparent bias. This is not a case about bias of the decision-makers. The difference here is that the stood-down member, Dr Bierre, did not drop out of the process. He was fully involved in the ongoing process of determination, not as a decider but as a proposer. Rather than cease to have anything to do with the ongoing process, he was at the heart of it. Dr Bierre should have stepped out of the process altogether. Standing down in December was not enough.

Did Dr Bierre's information advantage disappear?

[211] It is argued for the ARDHBs and Dr Bierre that the advantage enjoyed by Dr Bierre evaporated in the course of the exchanges during the proposal process.

[212] The minutes of DML's October 2005 think-tank meetings show that DML appreciated that the ARDHBs wanted a "killer" deal in terms of value for money and wished to gain work for the hospital laboratories. The minutes show a clear decision

by DML to avoid an "open-book" or margin based on "return from assets" approach to the RFP. It was noted that DML had various options in relation to the RFP proposals, including offering reduced levels of service, a feature of which could include the reduction of collection rooms. DML's knowledge will be referred to in more detail later in this judgment in relation to the consultation submissions.

[213] However, the minutes and the DML affidavits reveal that DML did not appreciate, as Dr Bierre did, that DML was perceived by persons on the ARDHBs and related entities as a monopolist making super profits and committed to opposing significant change. While the DML minutes show DML knew the ARDHBs were seeking a "killer" deal, there was no appreciation of quite the level of savings being sought.. A reduced service was just one of quite a number of options DML noted and did not pursue. As I have stated, I have no doubt that if DML had appreciated the level of savings desired by the ARDHBs' members, that at least an alternative bid would have been on a greatly reduced basis similar to that proposed by Lab Tests.

[214] I do not consider that the RFP expressly stated a desire for such savings. If it had, DML would have responded, as it did later in attempts to meet the ARDHBs' expectations. The RFP itself did not indicate that profound changes to the structure of the service were expected in order to save costs. It referred on a number of occasions to the requirement of a "high quality" pathology service. There was reference to "maintaining or improving service quality", to a "comprehensive, quality pathology service", to a "quality, cost-effective and sustainable pathology service" and at cl 3.1(k) to "the provision of pathology services as currently provided (seven days per week)". Indeed, at cl 1.1 it was stated that "the service specification is to, at least, maintain the current mix and type of community pathology services provided".

[215] On 19 December 2005 Dr Arthur Morris, chief executive of DML, had written to Dr Gollop commenting on the general and open nature of the draft RFP and asking a number of very detailed questions. He suggested on quite a number of occasions that the RFP should be changed to specify that particular aspects of the service be "as currently provided".

[216] In a meeting that took place on 10 January 2006 attended by Dr Morris, Mr Coe and Dr Gollop, various points raised in the letter were discussed. Dr Morris took notes in the letter. He noted:

> General theme ⟶ status quo + mod =

His other notes are also consistent with expecting no significant changes to the status quo. He said in his affidavit that Dr Gollop confirmed to him that the general theme of the RFP was that the status quo would apply to the level of service to be purchased. He was not cross-examined on this point. While Dr Gollop and Mr Coe demurred somewhat on the reference to the "status quo", I am satisfied given Dr Morris's testimony, the file note and the contents of the RFP, that DML reasonably did not envisage that major changes to structure of the existing service would be acceptable. This is why Dr Bierre's Consortium had such an advantage, understanding as Dr Bierre did the acceptance of the ARDHBs of the possibility of fundamental change.

[217] Following the submission of the proposals on 10 April 2006, the proposals were considered by members of the evaluation panel and discussed at a meeting on 19 April 2006. There was clear disappointment with the DML bid, which was described as "business as usual" and noted for its "lack of imagination," just as Dr Bierre would have anticipated.

[218] Dr Morris and Mr Frank Tuck of DML met with Dr Gollop and others of the evaluation panel on three occasions, the first of which was on 21 April 2006. Dr Gollop expressed his disappointment at the price offered. It was made clear that significant change in the DML offer was required if it was to be entertained. There was some discussion about substantially reducing collection centres to 50 rooms.

[219] There was a further meeting on 26 April 2006 where Dr Gollop made it clear to the DML representatives that they had underestimated the ARDHBs' appetite for change. It was made clear that the overriding issue was the DML price.

[220] This led to a letter from DML on 28 April 2006 where it made a proposal based on a collection network of 50 rooms with longer opening hours. A schedule

was attached setting out proposed closures for some of the existing laboratory rooms. The revised price was $24 million less than the first offer over five years – a reduction of just under $5 million per annum. The amended proposal did not involve any reduction in the number of pathologists or phlebotomists. There was also, for the first time in the DML proposals, a reference to more involvement of the PHOs in laboratory testing, again in response to some indications in the April meetings that this was a matter in which the ARDHBs were interested. The letter concluded:

> We believe this proposal addresses the issues we were asked to address. If, however, you have ideas that would lead to further costs savings please discuss them with us. We will return to you any realised savings from such recommendations.

[221] There was a further meeting following that letter between DML representatives and evaluation panel representatives on 4 May 2006. Dr Gollop advised that the new price was still not good enough and that there was a perception that the price was too high. At this point the return that DML expected after tax on its proposal was only 5.1%, so it can be readily understood that DML found it difficult to understand or respond to the attack on its price. The minutes record questions from Dr Morris as to whether there were other areas in which they could cut costs. Dr Morris in his affidavit states that he asked to be told of any other differences in the level of service that were contemplated. The response from the evaluation panel appears to have been along the lines that DML was the incumbent, and would have to decide on the sort of proposal to make.

[222] Dr Gollop in his affidavit states that DML continued to resist proposals for change in the round of discussions following the lodging of the proposals. However, this is not entirely surprising. DML had lodged its proposal on the basis that it did not anticipate substantial change to the status quo. It was disadvantaged relative to Lab Tests from that point on as it tried to understand exactly what the ARDHBs wanted. It had already committed itself to a position with its April 10 proposal. Naturally, as the incumbent it would have intuitively resisted suggestions that the status quo change. In fact, DML did respond to the request for change after lodging its initial proposal, and its further proposals involved the reduction of collection rooms and a very substantial reduction of its net profitability, at least in the short term.

[223] I do not consider that these communications can be seen as ameliorating the unfair procedural advantage enjoyed by Dr Bierre's Consortium. The evaluation panel members did not give any detail of the Lab Tests proposal, presumably because of confidentiality obligations. They undoubtedly thought that the signals that they were giving to DML were frank and fair, but they did not negate the advantage that Dr Bierre's Consortium had had from the beginning. From the moment that the proposals were lodged on 10 April, DML was disadvantaged. Its proposal was based on the existing business model, Dr Bierre's avowedly was not. DML had lodged a bid very much out of sympathy with the thinking of the evaluation panel members, whereas the Consortium proposal had hit the exact notes of Board concern. The extent to which DML had failed to catch up from this is reflected in its zero and low ratings for value for money on 18 May 2006, even after lodging its amended proposals with profit margins below 4%.

[224] In summary, DML lodged its proposal on 10 April 2006 on the basis that it knew it had to cut costs, but that that there could not be radical reductions because the ARDHBs were not contemplating radical changes to the structure of the existing service. Dr Bierre's Consortium, on the other hand, lodged its application knowing that there was a perception that DML was making super profits and that radical costs savings, in Mr Keenan's view of $20 million a year, were required. Dr Bierre's Consortium also anticipated that calling for increased general practitioner collections would strike a chord with the ARDHBs. From 10 April 2006 when the bids were lodged, DML was out of sympathy with the evaluation panel and ARDHBs' thinking, while the Consortium proposal exactly met the evaluation panel and ARDHBs' thinking, save for initial concerns as to the Consortium's viability. The procedural error in allowing Dr Bierre to participate in the bid despite his conflict of interest and knowledge was not purged by the round of discussions that followed the lodging of the initial proposals.

Conclusion as to the use of information by Dr Bierre

[225] In terms of s 57 of the Crown Entities Act, Dr Bierre was making use of information that he had acquired in his capacity as an ADHB member that would not have otherwise been available to him. He knew, but DML did not, that the ARDHBs

considered that DML was making super profits, and that it wanted a radical new structure plan from which it could extract savings of up to $20 million per annum. He knew they would be receptive to the idea of placing more collections with general practitioners. In terms of s 57(2) he did not use the information in the performance of the ARDHBs' functions, or as required or permitted by law. He used it for his own personal advantage in the Consortium proposal. He did not obtain authorisation to use it from the ADHB. In any event, its use prejudiced the ARDHBs, and could not have been authorised. Its use damaged the integrity of the ARDHBs' processes by giving one party an unfair advantage over another, and thereby jeopardised the chances of reaching the best decision.

[226] This meant that Dr Bierre was in breach of s 57. Further, the ARDHBs' knowledge of his conflict and their consequent inaction made the process procedurally unfair. The Consortium proposal had a significant advantage over the DML proposal. The public were not getting the benefit of a fair RFP process.

[227] Dr Bierre should have appreciated that as an ADHB member involved in the processes leading up to the RFP he could not participate in the bid. It could not be fair for him to do so. The ARDHBs, for their part, should have appreciated that Dr Bierre's involvement in a proposal was unacceptable. The evaluation panel and ARDHBs' knowledge of Dr Bierre's conflict of interest from December 2005 could not purge his information advantage. What was required was that Dr Bierre abstain from participation in any way in the Lab Tests' bid. It was not procedurally fair to allow one party to obtain an improper advantage over another.

[228] I consider that it was impossible for Dr Bierre to divorce himself from his knowledge of the ARDHBs' philosophy and wishes. Even if there were not specific pieces of information that could be isolated and referred to, it can be inferred that the Consortium gleaned a significant and improper advantage from the involvement of Dr Bierre. It is important from the point of view of public confidence in the integrity of public office holders that they are not perceived to have taken advantage of their previous office.

[229] I am satisfied to the civil standard that Dr Bierre had actual knowledge of the ARDHBs' information, which gave the Consortium proposal a significant advantage. Although I have mentioned an onus of persuasion, I do not have to turn to such a concept. I conclude that Dr Bierre's use of that information which he had acquired as an ADHB member in the Consortium proposal, and the ARDHBs' acceptance of that Consortium proposal in the circumstances, constituted a clear procedural impropriety.

General conclusion on Dr Bierre's involvement

[230] Dr Bierre should have declared the conflict of interest arising out of his ADHB membership and his desire to bid for ADHB funding for his own laboratory at the outset of his ADHB membership and certainly from the end of December 2004 when his plans to open his own laboratory had firmed. The necessity to disclose became even stronger when he actually applied for ADHB funding in March 2005, and stronger again in November 2005 when he had discussions with Gribbles about the Auckland pathology situation.

[231] The issue is not so much what Dr Bierre should have done, but how the ARDHBs should have reacted. The immediate reaction of quite a number of persons when first presented with Dr Bierre's situation was correct: he was in a conflict of interest position that needed to be addressed. Unfortunately nothing of substance was done when those views were expressed. Mr Brown's comment in his letter of 8 July confirmed the "central" role of Dr Bierre in relation to laboratory matters and accurately expressed the view that his failure to expressly declare his conflict of interest might have "compromised" the ARDHBs' process.

[232] The compromise that his conflict of interest constituted could have been contained by the ARDHBs providing Dr Bierre had abandoned any interest in bidding for the ARDHBs' funding himself. It is clear from his affidavit that he never did so. Mr Brown did not check whether Dr Bierre had abandoned his plans when he had the exchange with him in July 2005, or act on his perception that the conflict of interest would prejudice the ARDHBs' process. Dr Bierre remained on the ADHB, and then lodged the Consortium proposal.

[233] In summary, the ARDHBs' procedural errors in relation to Dr Bierre were:

a) The ADHB failing to act in July 2005, when it became fully aware of his conflict of interest, to ensure that he would not be a proposer, or to prevent his further participation in laboratory matters.

b) The ARDHBs failing to advise in December 2005, when they became aware of Dr Bierre's possible involvement in the Consortium proposal, that such a proposal would be unacceptable because of his position as an ADHB member.

c) The ARDHBs failing to make it clear from January through to April 2006 as Dr Bierre's involvement became more likely, that a proposal from the Consortium involving him would be unacceptable.

d) The ARDHBs failing to refuse to receive the Consortium proposal in April 2006 when it became clear that Dr Bierre was involved as a shareholder.

Together these errors constituted a serious procedural error. They were a breach of the rules of natural justice and specific breaches of cl 36 of Schedule 3 of the PHD Act and s 57 of the Crown Entities Act. I will consider the consequences of these errors in the last section of this judgment.

Second head of claim: failure to consult with DML/legitimate expectation

[234] It is pleaded in the amended statement of claim that there was a failure to consult with DML. This was not a point developed in submissions by Mr Hodder. It can be dealt with shortly. There is no specific duty on the DHBs in the PHD Act or related documents, of consultation with a proposer.

[235] A party with a particular interest in a particular administrative process that leads to the allocation of a commercial interest may have a legitimate expectation that it will be given a fair opportunity to outline its position. For example, a licence-holder with a reasonable expectation of renewal can expect to be given an

opportunity to express its position: *Fowler & Roderique Ltd v Attorney-General* [1987] 2 NZLR 56 (CA).

[236] DML may well have had a legitimate expectation that it have an opportunity to propose for the new contract. But, as the account of facts relating to Dr Bierre's involvement shows, DML was clearly given an opportunity to make a proposal. Further, the ARDHBs were in close contact with DML, both prior to and during the RFP process. Meetings took place between DML and ARDHB representatives, a discussion document was issued, and a meeting to discuss the discussion document was held. The detailed RFP document was issued and three subsequent meetings took place to discuss it.

[237] I conclude that insofar as the ARDHBs had an obligation to communicate with and provide DML an opportunity to make a proposal, the duty was clearly discharged.

[238] Mr Hodder also submitted that DML had a legitimate expectation that:

a) the ARDHBs were not seeking, and would not contract with a party to provide, a service that did not comply with the quality specifications in the RFP;

b) the quality sought under the RFP would not involve a quality reduction; and

c) the process would be conducted fairly, consistently and rationally.

[239] Legitimate expectation is an aspect of the duty on the part of administrative bodies to act in a way which is administratively fair: *Attorney-General of Hong Kong v Ng Yuen Shiu* [1983] AC 629 (PC) at 637-638. It arises in particular when a public authority promises to follow a certain procedure and then does not do so. In the interests of good administration the public authority should act fairly and implement its promise.

[240] DML's first two argued legitimate expectation claims allegedly arise from detailed representations made by the ARDHBs during the RFP process. I accept that in general terms the first and second claimed expectations could be seen as arising from the RFP. This was not really in contention.

[241] I do not need to consider the third legitimate expectation claim, that the process would be conducted "fairly, consistently and rationally". That claim is something of a catch-all, and does not add anything to the more specific claims of procedural unfairness already considered.

[242] Assuming that DML can properly point to legitimate expectations that the ARDHBs would insist on compliance with RFP quality specifications and would insist that there be no reduction in quality, it has not proven that the ARDHBs failed to meet such expectations.

[243] I am not satisfied that the level of service that the ARDHBs require from Lab Tests pursuant to its contract can be understood as failing to comply with the quality specifications in the RFP. The quality specifications in the contract are expressed in general terms, but clearly do not derogate from what was stipulated in the RFP. The real difference is that a much cheaper service would now be provided within similar quality specifications. Whether or not the significant changes involved in the Lab Tests contract have an effect on the quality of service, it cannot be said that the quality specifications in the Lab Tests contract allow for this.

[244] I am unable to conclude that there will be a change to the quality of service delivery under the Lab Tests contract. The plaintiff asserts that the quality of service under the Lab Tests contract will plummet. For the reasons that will be outlined later in this judgment, a Court is not well equipped to judge whether or not this is so. It may be the case that the significant changes involved in the Lab Tests contract affect the quality of service provided. But what is plain is that the ARDHBs, rightly or wrongly, clearly believe that there will be no reduction in quality under the Lab Tests contract which, after all, contains similar quality specifications as those expressed in the RFP and in the current contract with DML. Insofar as the ARDHBs

have not deliberately accepted a proposal that they knew would result in a reduced quality of service, they have not gone back on any legitimate expectation.

Conclusion on failure to consult with DML/legitimate expectation

[245] I conclude that, assuming that DML could establish that it had legitimate expectations that the ARDHBs would insist on compliance with RFP quality specifications and would insist that there be no reduction in quality, it has not been proven that those legitimate expectations were not met. The quality specifications were stated generally and were very similar to what was stated in the RFP. Further, it has not been proven that the Lab Tests contract will not produce any reduction in quality, and in any event, it is clear that the ARDHBs do not believe that that is what will eventuate.

[246] It is not necessary to determine the pleaded legitimate expectation that the process would be conducted "fairly, consistently and rationally". The issues raised by this pleading are dealt with in other parts of this judgment.

Third head of claim: failure to consult adequately with the PHOs

Introduction

[247] Mr Gray QC for the intervener submitted that there was a duty on the ARDHBs to consult with Harbour PHO and the other PHOs in the Auckland area. PHOs are primary health organisations. The acronym is in common use. They are not referred to in the PHD Act or any other statute, but were established following the enactment of the PHD Act. They are referred to in the main Government health policy documents.

[248] Under the Government Primary Health Care Strategy document the PHOs' "key role" is stated to be that of a local grass-roots organisation that provides and co-ordinates local primary health care services for the particular enrolled population they represent. Each is funded by the local DHB and provides a set of essential

primary health care services to those who are enrolled. They are non-profit bodies, and membership is voluntary. All general practitioners are encouraged to join them.

[249] Under the New Zealand Primary Healthcare Strategy issued by the Minister of Health in February 2001 it is stated to be part of the new vision that people will be part of the local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. It is stated:

> The vision and the new directions will involve moving to a system where services are organised around the needs of a defined group of people. Primary health organisations will be the local structures to achieve this.

PHOs are a critical part of ensuring local community involvement in decision-making.

[250] Harbour PHO is one of six PHOs in the WDHB geographic area. It has a contract with WDHB for the delivery of primary health care services in the Waitemata region. Mr Gray accepted that for the purposes of his consultation argument, the PHO should be treated as representative of local general practitioners. I am satisfied that although not all local general practitioners are members, any duty to consult with local general practitioners would be satisfied by consultation with the relevant PHOs. I have already mentioned that the Harbour PHO can be regarded as a representative of all the PHOs in the Auckland Districts.

[251] Laboratory services are an integral part of the care provided to patients by general practitioners. Laboratory tests are used for diagnostic purposes and for ongoing monitoring. General practitioners are the main referrers of patients to laboratory services in the community. Efficient and prompt laboratory collection and processing of samples, and the ability to discuss results with the relevant pathologists, are very important to the good conduct of a general practice. It was not therefore in dispute that general practitioners are directly affected by the ARDHBs' purchasing decisions.

[252] It is now necessary to consider whether the ARDHBs have a duty to consult with PHOs over possible changes to the provision of community laboratory services and, if so, whether the ARDHBs discharged their duty to do so.

Documents relevant to any duty to consult

[253] The PHD Act imposes a duty on DHBs to foster community participation in significant changes to the provision of services. It states at s 22(1)(h) of that every DHB has as its objective:

> To foster *community participation* in health improvement, and in planning for the provision of services and for *significant changes* to the provision of services.
>
> [Emphasis added]

[254] While the PHD Act makes no reference to PHOs, at s 3(1)(c) it is stated that an objective of the Act is to:

> provide a community voice in matters relating to personal health services, public health services and disability support services –
>
> …
>
> (iii) by providing for consultation on strategic planning.

It is stated specifically in s 5(1) that the PHD Act reorganises the public health and disability sector. Section 8(1) states that the Minister must determine a strategy for health services, called the New Zealand Health Strategy, to provide the framework for the Government's overall direction of the health sector in "improving the health of people and communities".

[255] The Minister released the New Zealand Health Strategy in December 2000. One of its seven fundamental principles is "active involvement of consumers in communities at all levels". It states at 43 that DHBs should consult with those who use services that "could be changed as a result of a decision".

[256] In the funding agreement that WDHB signed with the Crown on 8 August 2005 pursuant to s 10 of the PHD Act, it was provided under B.1.1 that the DHB would deliver its outputs in a manner consistent with the goals and objectives of the New Zealand Health Strategy. The funding agreements with the ADHB and CMDHB had similar clauses. The funding agreements therefore bind the DHBs to adhere to the terms of the New Zealand Health Strategy, and thus to involve

consumers in decision-making and consult with those whose use of the services could be changed by a pending decision.

[257] On 1 July 2005 an operational policy framework issued by the Ministry of Health became effective. It was one of a number of documents setting out the "accountabilities" of DHBs. It is specifically referred to in the Crown funding agreements, where it is stated at A.3.2 to apply to all DHBs from 1 July 2005. The operational policy framework stated at paragraph 4.3.C that the Ministry has developed certain "Consultation Guidelines" and that each DHB is required to comply with its "statutory and legal obligations relating to consultation."

[258] The consultation guidelines issued by the Ministry of Health state at 18: "If the decision involves possible significant change to the way services are delivered or access to services, then the DHB should consult." The guidelines state at 9 that those who could be affected by the outcome, often referred to as "stakeholders", should be consulted. The paper paraphrases the principles as to what constitutes proper consultation that were set out by the Court of Appeal in *Wellington International Airport v Air New Zealand* [1993] 1 NZLR 671 at 675, including:

a) Consultation includes listening to what others have to say and considering the responses.

b) The consultative process must be genuine and not a sham.

c) Sufficient time for consultation must be allowed.

d) The party obliged to consult must provide enough information to enable the person consulted to be adequately informed so as to be able to make intelligent and useful responses.

e) The party obliged to consult must keep an open mind and be ready to change and even start afresh, although it is entitled to have a work plan already in mind.

[259] Thus a reading of the PHD Act and the Government documents created thereafter shows that at the heart of the functions of DHBs is the need to consult with those in the community affected by significant decisions. The community's involvement in significant decision-making goes beyond their powers to elect members of DHBs. Those in the community affected by the decision have a right to be consulted on important matters. I consider that s 22(1)(h) and the documents referred to create a legal duty on the part of DHBs to consult with those sections of the community or their proper representatives who may be affected by a contemplated significant change to health services.

[260] This obligation to consult is confirmed in the DHBs' own laboratory review project documents, which repeatedly refer to an obligation and requirement to consult. When the DHBs commenced their investigation into laboratory testing, the "DHB NZ Laboratories – Project Plan" stated at paragraph 3 that referrers would need to be consulted and that general practitioners were key stakeholders. At paragraph 6 the Plan stated that affected individuals, groups and organisations should be consulted and again reiterated that general practitioners and PHOs were "stakeholders".

[261] Similarly, the discussion document on laboratory services strategy published on 18 June 2002 stated at paragraph 7.2.2 (4) that it was compulsory for DHBs to consult as they would be creating "significant changes to how laboratory services are funded". The NDSA's project considering laboratory demand management of May 2003 stated that the PHOs were "collaborating institutions". Further, the Pilstrom Report referred specifically to the necessity of conducting wide stakeholder consultation, including with the PHOs, and stated:

> Repeated consultations are likely to be required throughout the implementation for different initiatives, such as re-organisation of collection services.

[262] The obligation to consult with the PHOs was thus very clearly recognised by the ARDHBs. The Pilstrom Report and other documents were distributed to general practitioners and PHOs and, against this background, PHOs would have had a legitimate expectation that they would be consulted about significant changes to the way in which laboratory services were delivered.

[263] The contracts between the ADHBs and relevant PHOs are also instructive. They are of a fairly standard form. The contracts include a clause (D.14.1 in the current WDHB and Harbour PHO contract), which provides:

> We both agree to advise the other party promptly in writing of any changes, problems, significant risks, or significant issues (including suspected fraud and/or serious non-compliance with the obligations under this agreement and those issues that could reasonably be considered to have high media or public interest) which materially reduce or effect, or are likely to materially reduce or affect, the ability of either of us to meet our respective obligations under this agreement.

Clause S.9.3 provides that unless otherwise agreed, neither will operate in a way that shifts costs or volumes between services such as to result in additional costs to either party. This clause places a contractual obligation upon the ARDHBs to consult with PHOs on any significant issues that concern them, particularly those that are likely to result in high media or public interest. This case is not pleaded in contract, PHOs do not sue on the contracts. However, the contracts are relevant because they do show that the PHOs could legitimately expect to be consulted on significant changes.

Conclusion as to duty to consult

[264] The PHD Act, the New Zealand health strategy, the funding agreement, the operational framework and the consultation guidelines placed an obligation to consult with those affected by significant decisions. The ARDHB documents and contracts gave the PHOs a legitimate expectation that this would happen.

Did the RFP process and subsequent Lab Tests agreement amount to a change significant enough to require consultation?

[265] I am satisfied from the extensive affidavit evidence filed on behalf of Harbour PHO that laboratory services are an integral part of the first contact care provided to patients by general practitioners. The services are used for diagnostic purposes and the ongoing monitoring of patients. General practitioners are the main referrers and users of the services. They are directly affected by the ARDHBs' purchasing decisions concerning community diagnostic testing. Such testing underpins thousands of diagnoses carried out every day, and provides ongoing

information about patients who require frequent monitoring for their particular conditions or drug programmes.

[266] Thus efficient and prompt laboratory collection together with efficient and prompt processing of the samples that are taken, and an accessibility by general practitioners to the relevant pathologists who have been involved in the testing, are all very important aspects of Auckland health services, and the good conduct of a general practice. It was not an exaggeration for Ms Susan Turner, the chief executive of the Harbour PHO, to say that community-referred diagnostic testing is "at the very heart of primary medicine."

[267] A review of the ARDHBs' actions up until they entered into the contract with Lab Tests shows that they were prepared to accept the following changes:

a) A long-term contract with an entity other than DML.

b) An exclusive long-term contract to a single monopoly provider.

c) The achievement of very significant cost savings by the following devices:

    i) Pursuing the prospect of possible amalgamation of the ARDHBs hospital laboratories with the business of the new provider.

    ii) Reducing collection centres down from 84 to 43 (ultimately 47).

    iii) Reducing pathologist FTEs down from 23.5 to 16, (increased later to 17).

    iv) Reducing FTE nurses and couriers down from 236 to 172 .

d) Moving towards general practitioners assuming much greater responsibility for collecting samples.

[268] I will deal with the extent to which these changes were communicated in the next section of this judgment. I record at this point that the overall effect of these contemplated changes was significant. It is not possible for the reasons that I give later, to express a final view on how much those changes will affect the every day practice of general practitioners. I am, however, satisfied that they will be affected, and that the changes contemplated by the ARDHBs were sufficiently significant to require consultation.

[269] An indication as to the significance of the changes can be seen in the contentions of the PHOs. They claim:

a) That the reduction in collection centres will substantially reduce access for patients, particularly high-need patients who already often do not present for testing unless it is a simple and quick process that can be carried out close to home.

b) That the turnaround times for regional biochemistry and haematology testing will blow out beyond the existing normal 12 to 48 hours.

c) That general practitioners require immediate access to consultant pathologists to discuss results and to discuss treatment or other investigative options so that patients can be managed efficiently in the community rather than admitted to hospital. They fear that general practitioners' access to pathologist will be dramatically reduced because pathologists will have to work much harder to carry out their testing load. They also consider that there is a danger that the error rate (which is at present 1% for DML collections) will increase, to the subsequent detriment of patients.

d) That general practitioners' specimen collection skills have rapidly diminished over the years. While it used to be common for general practitioners to collect specimens, most have not done so now for quite some time. It is said that general practitioners simply do not have the skills for a move to general practitioner collections.

e) That there are substantial transition risks involved in the proposed changeover. Harbour PHO does not think that it can be done adequately in the time available. It does not think that the expected savings will be achieved. It believes that in fact the new service will prove to be grossly inadequate and that substantial public funds will have to be spent in upgrading it back to close to something that DML was already offering. It questions whether savings of anything like $15 million per annum will be achieved.

[270] It is not necessary, and indeed for reasons that I will be elaborating on later in this judgment, possible, to comment on the merits of these various assertions. They may or may not be correct. That is not the point. The point is that the proposed changes are of significance to general practitioners who should have been fully consulted. That process should have been approached by the ARDHBs providing full information, and without undue haste.

Steps actually taken by the ARDHBs to consult with the PHOs

[271] The formal step taken by the ARDHBs to consult with the PHOs was the distribution of the discussion document of 30 November 2005.

[272] It is first necessary to deal briefly with a suggestion that this discussion document was not sent to all the PHOs. Witnesses for the ARDHBs have deposed that the document was sent out to the PHOs. Only one PHO responded to it; the others did not. In the end Mr Gray for the intervener did not seek a specific finding that the 30 November letter was not sent to the PHOs. I conclude that it was sent. The timing of its delivery, and its contents, to which I will refer, can explain the fact that it was not recalled by some of the persons to whom it was apparently sent.

[273] The letter of 30 November 2005 that accompanied the discussion document stated that the ARDHBs intended to select a laboratory provider as a strategic partner to work closely with the three ARDHBs. It read:

Dear Stakeholder

Future contracting for community laboratory services: Auckland Region

The Auckland Region's District Health Boards (DHBs) intend to select a laboratory provider as a strategic partner to work closely with the three DHBs in order to provide high quality pathology services in a timely, effective and efficient manner across the complete spectrum of community and hospital care.

Attached is a discussion document that has been developed to identify the key issues from the DHB perspective to which we would seek your comments and feedback by 14 January 2006, via an e-mail …

Additional information will be available on our website www.ndsa.co.nz on the Laboratory Project page in early December. The additional information will include a copy of the Current Service Specifications and a Working Draft of the Proposed Service Specifications.

Following a review of feedback received, it is our intention to finalise the Request for proposals (RFP) documentation for issue in February 2006.

If you wish to be considered as a potential provider and to receive the finalised RFP documentation, please register your interest by 14 January 2006.

Selection of a long term strategic partner for the provision of community laboratory services will be completed by 30 June 2006 with provision to be required by 1st July 2007.

[274] The letter attached a discussion document. Despite suggestions to the contrary in some of the affidavits filed by Harbour PHO, the letter clearly signals the prospect of a change of provider. Those general practitioners who read it cannot blame the ARDHBs for their assumption that DML would secure the contract. However, the letter itself contains no indications that any major changes to the way in which services were organised and supported were anticipated. What was sought was a long-term strategic partner with whom the ARDHBs could work to achieve their consistent vision of a high quality, cost-effective service.

[275] The attached discussion document contained more information. It stated that the vision was to provide high quality pathology services in a timely, effective and efficient manner across the complete spectrum of community and health care. It also stated that the vision was for a "high performing system that is at the "lowest possible cost", and a preliminary belief that "a significantly lower overall cost base" was realisable.

[276] The same sort of language is set out in the "Regional Pathology Vision" section, which expressly seeks a high quality pathology service and places priority on a high performing system that is at the lowest possible cost consistent with the desired quality of service provision.

[277] In the section under the heading "Financial" there is reference to "new service configurations". There is then reference by way of example to community tests being processed in DHB hospitals, and some hospital tests being carried out in community laboratories. The discussion document also refers to providing a "suite of proposals", "more innovative solutions" and "new service configurations".

[278] While a careful reading might alert a reader to the ARDHBs' willingness to receive proposals outside the conventional square, the example given of rationalisation with the hospital laboratories was an idea that had been around for some time and was not new or different. As might have been expected, it came to nothing. I do not consider that these references to possible change, somewhat buried as they were under the heading "Financial", can be regarded as notice of any significant proposed change to pathology and phlebotomist resources. The overall message is rather to maintaining quality at the lowest cost.

[279] While there is a reference to "Demand Management" and of weight being given to proposals that outline a strategy that will "optimise demand", and while it was also stated that close collaboration with primary care practitioners and their PHOs was expected, this is not an indication that a concerted move to greatly increase GP collections is a realistic prospect. Nor do I consider that the reference to additional information on the NDSA website would have served to put PHOs on notice.

[280] Only six organisations responded to the discussion document. Only one PHO responded, being the Mangere Community Health Trust PHO. The actual feedback provided on the discussion document focused on minor matters, and the responses indicated no appreciation that any major change was pending. I do not put this down simply to busy practitioners receiving lengthy documents at a busy time of year. Ms Turner, the chief executive of Harbour PHO, who has considerable

experience in the field, saw nothing in the discussion document to indicate that the RFP would have any significant impact on general practitioners or the structure or quality of the laboratory testing. She observed in her affidavit, in my view fairly, that it was not possible to discern that changes of the scale involved in the Lab Tests contract were in fact contemplated.

[281] DML has presented a Colmar Brunton survey response that shows that 72% of general practitioners believed that there had been no consultation at all. There has been considerable argument about the admissibility and reliability of the survey response. I have found the survey to be of no assistance. I consider that the facts relating to the consultation are clear. There was a degree of consultation, but it was limited to the discussion document. If it had clearly telegraphed the changes proposed, it may have been sufficient, although there is also the issue of insufficient time. Certainly ARDHBs did nothing wrong in sending the discussion document to PHOs rather than to each individual general practitioner. The real issue is whether the discussion document constituted fair consultation with the PHOs, in the sense that it meaningfully notified the PHOs of the possibility of the changes that in fact eventuated and gave an opportunity for feedback and discussion.

[282] The possible changes to a new provider, with a single long term monopoly contract were clearly telegraphed, as they were explicit from a cursory consideration of the discussion document. The whole concept of an RFP process logically opens up the possibility that there will be a new provider. It was also clear from the discussion document that the provider would be the sole provider for the Auckland area.

[283] The other changes to the collection sites, numbers of phlebotomists and pathologists and the move towards general practitioner collections, were not, however, fairly and clearly forecast in any of the discussion material. Nor were they raised by the ARDHBs with the PHOs after the proposals had been received when they knew exactly the sort of changes Lab Tests was proposing. Indeed, if the ARDHBs had simply said that they would be seeking a saving on the current spend of $16 million per annum, that in itself would have alerted PHOs to the fact that major changes to the services would be pending. They did not. There was no doubt

that the announcement of Lab Tests as the successful party and the changes it involved came as a great shock to the majority of general practitioners.

[284] There are grave fears that the new system will be inefficient and that patients' healthcare generally will suffer. These fears may or may not be correct. What is clear is that the proposed changes are significant and that general practitioners through their PHOs should have been given an opportunity to make the comments that they have now made very strongly and in considerable detail in the numerous affidavits that have been filed on behalf of the Harbour PHO.

[285] A cautious approach must be taken, of course, to strong claims of protest in a context like this. There is a natural conservative resistance to change. Busy professional people will tend not to examine discussion documents in depth and will subconsciously tend to make the comfortable assumption that no great change is pending, then react indignantly if it does come. However, this case is not one which involves protest to previously slept on rights. The discussion document, even if it had been read carefully, is bland and does not indicate that significant change is contemplated. While the long-term strategic partner might not be DML, it would be envisaged that the service that would be provided would not be radically different from that presently provided. It is not a document that, adopting the approach of McGechan J quoted in *Wellington International Airport v Air New Zealand* at 675, "adequately informed" the party to be consulted so that the party was able to make intelligent and useful responses.

[286] I record also that I do not regard the RFP document as a consultation document. It was not designed with consultation in mind and it was not circulated to the PHOs. It had contractual force from the moment it was issued and so could not be altered. It was not treated as a consultation document by either the DHBs or the PHOs. It was a document directed to those who were interested in making a proposal.

[287] The consultation guidelines binding on the ARDHBs also required there to be "sufficient time" for consultation. Even if a proper consultation document had been

sent out, it should not have gone out in early December with responses due on 14 January. The three busiest working weeks of the year were not "sufficient time".

[288] The Harbour PHO has provided examples of what it submits amounts to appropriate consultation, in the form of other DHBs' approaches to consultation in considering strategic options for laboratory services. These were the Wairarapa DHB Strategic Options document and the 2005 Canterbury DHB Consultation document. Those documents were very detailed statements of strategic options that were sent out under cover of individual letters to particular stakeholders. The response timeframe was at least six working weeks, and was not over the Christmas period. The potential options for the future provision of laboratory services were set out in detail over many pages. A specific submission booklet with particular questions for response set out was given to interested persons on at least one occasion.

[289] I conclude that the ARDHBs should have sent documentation along these lines out to the Harbour PHO and other PHOs. In particular, they should have provided an informative and explicit outline of the proposed changes. They did not do so.

[290] It is not open to the ARDHBs to assert that by the end of 2005 they were the victims of a difficult timeframe and had to get on with the proposal process. They had created that timeframe. The ARDHBs could have given DML an extension longer than two years, or issued the discussion document some months earlier than the beginning of December 2005. It was up to the ARDHBs to decide. They are not able to present self-imposed time problems as an excuse for a compromised consultation process. Their obligation to provide for adequate consultation was absolute.

No requirement to move to general practitioner collections

[291] It has been argued by the defendants that there was no need to discuss general practitioner collections because such collections were not a contractual requirement. However, it is clear that while the ARDHBs have dropped the idea of the short-term

amalgamation of hospital laboratories and community laboratories, the ARDHBs are still very interested in increasing the number of general practitioner collections. This is evident from the evaluation panel reaction to the Consortium proposal, which particularly emphasised general practitioner collections, and from the contract with Lab Tests where there is specific reference to general practitioner collections as a "service improvement strategy". The contractual obligation to collect still rests with Lab Tests, but as Lab Tests has indicated it will encourage general practitioners to carry out collections. It is possible that in so doing Lab Tests may be able to secure enough general practitioner support to put pressure on general practitioners generally to move to such a collection system. Whether this happens or not, it is now a possibility, and general practitioners through their PHOs should have been given an opportunity to discuss it.

Claim that it was too late to consult on significant changes

[292] Mr Illingworth suggested that when the significant changes that were a feature of the Consortium bid were communicated to the ARDHBs in the Consortium proposal of April 2006, it was then too late for further consultation. He compared the process to being on a ferris wheel. It was not possible to stop and consult Proposals were confidential, and information supplied by proposers could not be released without the proposer's consent pursuant to clauses 56–58 of the RFP.

[293] I do not accept that these clauses necessarily precluded the ARDHBs from discussing the changes that were proposed by the Consortium with the PHOs. They could have sought a waiver of the confidentiality requirement from the Consortium. If significant change was now to be considered following the Consortium proposal, they could have suspended or indeed cancelled the proposal process and started again with proper consultation pursuant to clauses 1 and 12.

[294] In any event, I not consider that such contractual constraints can excuse the ARDHBs from their duty to consult in this instance. It was absolute. They cannot now raise confidentiality and the restrictions of contractual terms that they drafted and imposed as a basis to avoid performance of their duty. Indeed, in the

circumstances, the inclusion of those clauses can be seen as an aspect of their breach of the consultation obligation.

[295] The Court is wary of imposing a standard of perfection on the ARDHBs and so making their already difficult job impossible. Consultation is time-consuming and expensive. However, the duty to consult is at the forefront of the legislation and other operative government documents. It is unavoidable. Practices have to be devised by ARDHBs that accommodate that requirement. I have no doubt that such practices can be devised and followed. Indeed, I have referred to instances where DHBs appear to have observed the requirement to consult in a timely and meaningful manner.

The ability to consult further before change

[296] Mr Illingworth submitted that there is still time for consultation on major changes. Clause D14A of the Lab Tests contract provides for a procedure to change services. He observed that turnaround times could continue to be negotiated as they are amongst the "key performance indicators", which are targets that can be set and adjusted under the contract. He further pointed out that the contract still required a high quality of services and made no specific provision for the reduction of pathologists of phlebotomists. Schedule 6 of the contract refers to demand management activities, which states that the parties will create a partnership approach with the PHOs and ARDHBs that will ensure that members of the laboratory "value chain" work together to address issues, such as demand for laboratory tests, and that the parties would "work with PHOs" to create guidelines for patient management including best practice guidance. It does not contractually require a move to general practitioner collections, and this may not happen.

[297] While it is correct that there are quite a number of terms in the contract to enable the ARDHBs to insist on standards and negotiate on certain issues, these do not provide any realistic answer to the ARDHBs' failure to consult. The consequence of the contract is that the service will receive $16 million less in funding per annum than that which was previously paid. The new services to be set up will have reduced numbers of collection rooms, phlebotomists and pathologists,

pursuant to the contract. These changes will occur, and there has been no opportunity for input from the PHOs. While there may still be some room for negotiation as to standards, and more discussion about a move to encourage increased general practitioner collection, general practitioners will be in a very different laboratory testing environment from the time the contract comes into force.

[298] The way the contractual environment has changed can be seen from paragraph 4.2 of Schedule 1 of the contract with Lab Tests, which reads:

> The collection of specimens must meet the requirements of referring practitioners along with the following:
>
> (a) collection of specimens at the time of visit to a primary care provider within the PHO setting is seen as a service improvement strategy that we would encourage.

[299] This clause was not in the earlier contract with DML. Increased general practitioner collection is now a specific objective under the Lab Tests contract. As with the DML contract, it remained the provider's, now Lab Tests', obligation under the new contract to provide the laboratory services. However, the new strategy of general practitioner collection, while not a contractual obligation, was given contractual recognition, and that vitally affects the PHOs. They had not been consulted about it. While there will be some further room for negotiation, it will be in a different contractual environment than that which existed previously. This has happened without the PHOs' having had any opportunity to provide their views.

Conclusion on obligation to consult with PHOs

[300] I have found that there was an obligation on the ARDHBs to have meaningful and timely consultation with the PHOs about the changes that were ultimately implemented by signing the Lab Tests contract. That obligation was derived from the statutory framework, including the various plans and contracts that had statutory force. Also, a legitimate expectation of consultation was created by the ARDHB response, and the specific contracts between the PHOs and the ARDHBs. I have found that the ARDHBs did not discharge their duty to consult. The effect of the failure to consult was that the decision that resulted was *ultra vires.* The consequences of this will be considered later in the judgment.

Fourth head of claim: Unreasonableness/Irrationality

[301] The plaintiff's case claiming unreasonableness on the part of the DHBs contained a number of different pleaded allegations. Specifically it was alleged that in making their decision the ARDHBs acted irrationally and/or arbitrarily, relied on material mistakes of fact, failed to take into account relevant considerations, took into account irrelevant considerations and/or failed to act reasonably and in the public interest. Mr Hodder for DML emphasised the range of levels of scrutiny that could be adopted in assessing the reasonableness of a decision, and submitted that this particular case warranted a "hard look". He relied in particular on Lord Diplock's statement in *Secretary of State for Education and Science v Metropolitan Borough of Tameside* [1977] AC 1014 at 1065:

> Put more compendiously, the question for the court is, did the Secretary of State ask himself the right question and take reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly?

[302] I have already outlined briefly the key differences between the facilities and employees that are being offered by DML and those that will be offered by Lab Tests. I will summarise the key changes relied on by Mr Hodder to support his claim of irrationality and unreasonableness:

a) Change from 83 to 47 collection rooms;

b) Change from 25 to 16 FTE pathologists;

c) Change from 236 to 172 FTE nurses and couriers.

d) Lab Tests'ability to terminate contract on 18 months' notice.

He also submitted, relying on affidavit evidence, that Lab Tests could not properly set up a satisfactory network of laboratories in the 12 month time-frame.

[303] Mr Hodder submitted, relying on extensive affidavit evidence, that these changes will have disastrous consequences. He argued that the reduction in staffing will logically mean that the same amount of work will have to be done by about half

the number of people who currently do it. He submits that the reduction in staffing will increase turn-around times and mean that pathologists are not accessible to general practitioners who need to discuss laboratory results. Further, it will mean patients have to drive greater distances and endure longer queues. Mr Hodder submits that the net consequence of all this will be that many patients who would otherwise get laboratory tests done will not, and that the quality of laboratory services will decline generally because the pathologists and phlebotomists will be overworked. Mr Hodder relies extensively on the affidavits of a Canadian laboratory expert, Ms Bailey, who has given evidence that there will be an inevitable drop in levels of service. She has queried the ability of any company to staff a new laboratory service within the one-year timeframe stipulated in the contract.

[304] Mr Hodder further submits that the Lab Tests contract is financially unviable, and that in due course the ARDHBs will be forced to pay Lab Tests more, or Lab Tests may invoke the 18 month notice provision and abandon the contract. Mr Hodder notes that DML's final offer involved DML achieving earnings after tax of approximately 4.45% or 6.64% EBTA, while the Consortium proposal involved a higher profit margin of 12.6% UBT. He submits that Lab Tests' profit margin, which is higher than DML's on significantly tighter price restraints, is unrealistic and impossible. He submits that it is the people of Auckland that will suffer as a consequence of Lab Tests' unrealistic costings.

[305] Mr Hodder particularly emphasises the 18 month termination period, and suggests that if Lab Tests cannot extract from the ARDHBs the money that it will inevitably later seek, it may cut its losses and walk away from the contract. He suggests that the guarantee cannot provide a certainty of continuing service but only a basis for a damages claim.

[306] These allegations are all firmly denied by the ARDHBs and Lab Tests. They point to the experience of the evaluation panel. The panel included a Dr Albert White, a distinguished independent pathologist from New Plymouth, who filed an affidavit expressing his confidence that all the risks are manageable. It was submitted for Lab Tests that the reduction in collection centres must be seen against a background of over-service in certain areas, for example, Howick, which has three

collection centres. Lab Tests submits that the new centres will be better positioned and so just as convenient as the present, much greater, number, while opening for longer hours will be able to compensate for the fewer staff. The actual numbers of people that can be processed through the collection centres will not, it is submitted, materially change, and indeed may be slightly greater under Lab Tests.

[307] Further, it is pointed out that Lab Tests has already invested more than $17 million of set-up in Auckland. The work required to open in the 12 months period is proceeding on schedule. Gribbles through its related companies has considerable experience in running laboratories, and it is submitted that Gribbles and its principal, Healthscope, would not have made this investment unless they were confident that they could make the project work. It is suggested that it is hardly likely that they will walk away from such an investment.

[308] This brief summary indicates that the plaintiff's submission that the Lab Tests contract will not work for the people of Auckland is factually controversial.

Is a "hard look" warranted?

[309] The classic formulation of unreasonableness is that known as unreasonableness in the "*Wednesbury* sense", as expressed by Lord Greene MR in *Associated Provincial Picture Houses Limited v Wednesbury Corporation* [1948] 1 KB 223 (CA) at 299, and reiterated many times in Commonwealth Courts. Lord Diplock in *Council of Civil Service Unions v Minister of the Civil Services* [1985] AC 374 (HL) at 410 said that unreasonableness, or "irrationality" as he preferred to call it:

> [A]pplies to a decision which is so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided to have arrived at it.

[310] It may seem anomalous to apply the name of a briefly considered 1949 English case which, as Lord Cooke pointed out in *R v Chief Constable of Sussex, ex parte International Trader's Ferry Limited* [1999] 2 AC 418 (HL) has become an incantation of the Courts of the United Kingdom and beyond. However, the concept has developed along with administrative law generally over the last 55 years and in

its modern form it has a widely recognised meaning, not easily encapsulated by any other short descriptive phrase.

[311] In *Wellington City Council v Woolworths New Zealand Limited (No. 2)* [1996] 2 NZLR 537 (CA) Richardson P drew on the *Wednesbury* case to state the principle thus at 545:

> [I]f the outcome of the exercise of discretion is irrational or such that no reasonable body of persons could have arrived at the decision, the only proper inference is that the power itself has been misused.

This statement, which avoids the tautology inherent in the original *Wednesbury* expression, encapsulates the *Wednesbury* doctrine in its traditional form as it is understood in this country.

[312] It has been said frequently by counsel in this case, quoting Lord Steyne in *R v Secretary of State for the Home Department, ex parte Daly* [2001] 2 AC 532 (HL) at [28], that "in law context is everything". A number of New Zealand cases have stated that a Court's scrutiny of the reasonableness of the decision can vary according to the subject matter of the decision: *Progressive Enterprises Limited v North Shore City Council* [2006] NZRMA 72 (HC), *Wolf v Minister of Immigration* [2004] NZAR 414 and *Pharmaceutical Management Agency Limited v Roussel Uclaf Australia Pty Ltd* [1998] NZAR 58 (CA).

[313] I do not consider that this case requires the anxious scrutiny or "hard look" that may be appropriate when a fundamental human right is at stake. The decision in this case, while of importance to the people of Auckland, was driven by the ARDHBs' desire to maintain a quality service, while cutting costs. As such, it involved a high degree of policy. While that might also be the case for a hospital or rest home, this case did not involve a significant intrusion into the life of a particular individual as in, for instance, *R v North and Eastern Health Authority, ex parte Coughlan* [2001] QB 213 (CA), where a closer scrutiny was held to be warranted. It was stated by Sir Thomas Bingham MR in *R v Ministry of Defence, ex parte Smith* [1996] QB 517 (CA) at 556:

> The greater the policy content of a decision, and the more remote the subject matter of a decision from ordinary judicial experience, the more hesitant the Court must necessarily be in holding the decision to be irrational …

[314] It is inappropriate for a Court to enquire too closely into the reasonableness of a decision in a context where the Court can have no level of comfort as to its ability to understand and assess the medical and economic subtleties that arise. There is no benchmark or set of standards as to what constitutes a reasonable laboratory service facility like Auckland. It would be arbitrary in the course of a judicial review hearing, where the evidence quite rightly has not been tested by cross-examination, to choose between conflicting sets of opinions presented by the parties. Indeed, a high requirement of unreasonableness is appropriate to the process of judicial review, where evidence generally takes the form of untested affidavits. Grave irrationality of the true *Wednesbury* type described will normally be apparent on the papers and does not require detailed factual analysis. I propose to approach the unreasonableness submission on the basis summarised by Richardson J in *Wellington City Council v Woolworths.*

Was this decision unreasonable in a Wednesbury sense?

[315] Mr Hodder submitted that even if a "hard look" approach were not adopted, the decision was nevertheless unreasonable in an orthodox *Wednesbury* sense.

[316] Before turning to the decision itself, it is necessary to consider briefly the context in which the decision was made. DHBs face significant financial hurdles. ADHB, for example, runs at a substantial deficit, which it is required to reduce over time while still maintaining services. DHBs, as ADHB chair Wayne Brown pointed out, are easily seen by suppliers as a "soft touch". The limited funding out of which DHBs must provide a wide range of service means that sensible reductions in one area can lead to significant advances in treatment in another. It has been necessary for DHBs to take a hard-nosed and focused approach to achieve costs savings. Against this backdrop, the ARDHBs' desire to find a way to reduce community laboratory service costs can be seen to be entirely reasonable.

[317] The plaintiff's first criticism is that the quality of service can be provided under the Lab Tests contract will be so poor as to make the decision to award the contract unreasonable.

[318] I do not think that the decision to reduce the number of collection points to 47 can be seen as patently unreasonable. If, for instance, the ARDHBs had agreed to have one collection point for the whole of Auckland, that might be seen as unreasonable in a *Wednesbury* sense. 47 collection rooms may well be sufficient; possibly it will be insufficient, but it cannot be said that it is a patently unreasonable decision.

[319] Similarly, I do not think that the decision to reduce the number of pathologists and phlebotomists is patently unreasonable. While it involves a tangible reduction in processing capability, it is possible that existing staff were not being used efficiently, and it may be the case that by adjusting opening hours and testing methods new levels of efficiency can be achieved. I appreciate that this is strongly disputed by the plaintiff's witnesses, but the first defendants' equally experienced witnesses say the contrary. The same disagreement occurs regarding the suggestion that there may be more general practitioner collections. Many of the intervener's deponents are strongly opposed to increased general practitioners collections. However, some general practitioners embrace the idea. The move thus cannot be described as patently absurd.

[320] The plaintiff's second criticism is that the start date and the costings in the Lab Tests contract are so unrealistic as to make the decision to award the contract unreasonable.

[321] I do not consider that the contract is patently unreasonable in this respect either. If, for instance, the contract had been awarded to an under-capitalised company, lacking in resources, experience or a guarantee, it could perhaps be said that the decision to do so was patently unreasonable. But that is not the case here. In this case experienced persons on the evaluation panel and the ARDHBs have judged that the Consortium can start up on time and meet its commitments. The experienced and independent Dr White is satisfied that Lab Tests will perform, and

affidavit evidence from Lab Tests affirms that the work to achieve start-up by 1 July 2007 is on timetable. Further, Lab Tests firmly maintains that the savings provided in its contract are achievable, and the panel and ARDHB members are clearly persuaded that this is so. It is not, then, possible for this Court to conclude that Lab Tests will fail.

[322] I conclude that the plaintiff has not established that the decision to award the contract to Lab Tests was one which no reasonable authority could have reached.

Mistake of fact

[323] Mr Hodder also submitted that the ARDHBs made a mistake of fact in assuming that Lab Tests was capable of providing the requisite level of service described by the RFP. He relied in particular on *Secretary of State for Education and Science v Metropolitan Borough of Tameside*, in which Lord Wilberforce at 1047 held that the Secretary of State for Education could not act upon an "incorrect basis of fact" and Lord Diplock held at 1065 that the Secretary had to ask "the right question" and be adequately informed so as to be able to answer the question correctly.

[324] In *Daganayasi v Minister of Immigration* [1980] 2 NZLR 130 (CA) the Judges expressed different views as to the existence of a mistake of fact doctrine, and a cautious approach to its existence was taken in *New Zealand Fisheries Industry Association Inc. v Minister of Agriculture and Fisheries* [1988] 1 NZLR 544 (CA) and *Southern Ocean Trawlers Limited v Director-General of Agriculture and Fisheries* [1993] 2 NZLR 53 (CA). It is easiest to see a mistake of fact as an example of traditional *Wednesbury* unreasonableness, or an error of law, or a consideration of a relevant matter or failure to consider an irrelevant matter. In *Lewis v Wilson & Horton Limited* [2000] 3 NZLR 546 (CA) Elias CJ stated at [63]:

> Where the facts cannot support a decision, judicial review is available on the partially overlapping grounds of error of law (on the basis that it must be inferred that the decision maker has misconceived the law) or unreasonableness.

Thus, I conclude that the mistake of fact submission will be available if it falls into one of the orthodox grounds of judicial review.

[325] The particular focus of the plaintiff's submission in this case was that the RFP effectively required the same quality of service, namely the DML mix and type of community pathology services conducted to a high standard. It seems that the material mistake of fact alleged is the assumption that Lab Tests was capable of providing the requisite quality of service described by the RFP. The mistakes alleged by Mr Hodder were not mistakes about incontrovertible facts about which there could be no other reasonably held view. Rather, the Court is being invited to examine closely the merits of particular aspects of the decision which, for the reasons already given, I am not prepared to do.

A surprising aspect of the decision-making process

[326] While I have found that it was open for reasonable DHBs to reach the decision that they did, I accept that one aspect of the decision is surprising. This is the very low "value for money" grading given by members of the evaluation panel to the DML proposal. There was certainly a basis for the members of the panel to grade DML below the Consortium given that the Consortium was claiming to offer service to a similar quality at a much lower price. However, DML had greatly reduced its profit margin down to below 6% and its overall charge was considerably less than its price in 2005. It was always accepted that the quality of the DML service was excellent. In that context, the gradings of zero to three out of ten for value for money seem irrational.

[327] However, there is a danger under the head of *Wednesbury* unreasonableness of focusing on a particular aspect of the decision-making process which is capable of criticism, and elevating that to an attack on the decision as a whole. There was, for instance, some modification of these ratings later. I have concluded that this very low rating can best be seen as a reflection on how well tuned the Lab Tests offer was to the ARDHBs' thinking as a result of the problems that arose in the procedure adopted by the ARDHBs. It does not constitute a basis for finding that the decision as a whole was unreasonable.

[328] Inevitably, errors in the decision-making process may result in a decision that is unsound. However, the Court is far better equipped to approach the problem from the perspective of errors in that process, which it is qualified to evaluate, rather than by examining the overall quality of a complex commercial and policy decision, which it is not.

Conclusion as to unreasonableness/irrationality

[329] While the decision was of great importance to Aucklanders, that factor alone does not give the Court the licence or the ability to lift the decision-making lid and endeavour to unravel and examine the morass of intertwined factors that led to the award of the contract. The decision itself was made by experienced DHBs acting on the recommendation of an evaluation panel. While there are some surprising aspects to it, on an overview it cannot be rejected as a decision that no reasonable Board or DHB could make. This set of claims does not succeed.

Consequences

Was the ARDHBs' decision ultra vires?

[330] I have found that there were breaches of the PHD Act and the Crown Entities Act by Dr Bierre. I have also found that by going through a preparation process for the RFP with Dr Bierre being involved, and accepting a bid from a party in which he had a financial interest, the ARDHBs made serious procedural errors. I have found that there was a failure by the ARDHBs to consult the PHOs pursuant to their obligation under the PHD Act and its attendant documents and pursuant to the PHOs' legitimate expectation that they would be consulted.

[331] It is stated in Wade *Administrative Law* (9 ed 2004) at 38 that "every administrative act is either *intra vires* or *ultra vires*; and the Court can condemn it only if it is *ultra vires*." The concept of *ultra vires* has been broadened to reflect the fact that Parliament grants a decision-maker a power to decide on the basis that the power is to be exercised lawfully, fairly and within the bounds of reason. If there is a failure to meet that obligation, the decision is assumed to have been made *ultra*

vires, or outside the decision-maker's jurisdiction. Thus it was stated by Tipping J in *O'Regan v Lousich* [1995] 2 NZLR 620 (HC) at 626, following the approach taken by the House of Lords in *Page v Hull University Visitor* [1993] 1 All ER 97:

> If the decision-maker goes wrong in law, acts unfairly or makes an unreasonable decision, the decision is regarded as having been made *ultra vires* and thereby the decision-maker exceeds his or her jurisdiction

[332] Therefore, if a body fails to observe a duty imposed by a legislative framework requiring it to consult, it is acting outside its jurisdiction. Parliament does not give a person or body the power to decide by way of an unfair process. If a body fails to act according to the rules of natural justice, it is acting in a way not authorised by Parliament and that is therefore *ultra vires*. This position was confirmed in New Zealand by the Court of Appeal in *Peters v Davison* [1999] 2 NZLR 164 (CA) at 205.

[333] I conclude therefore that the decision by the ARDHBs to enter into the contract with Lab Tests was *ultra vires*.

What is the effect on the ARDHBs' decision of its being ultra vires?

[334] The theory behind the invalidity of *ultra vires* administrative law actions is complex and has been the subject of considerable debate, ranging from the distinction between void and voidable acts to the concept of degrees of nullity. The issues were summarised by Professor Taggart in his often cited article "Rival Theories in Administrative Law: Some Practical and Theoretical Consequences" in Taggart (ed) *Judicial Review of Administrative Action in the 1980s* (1986). Counsel in their submissions did not enter into that debate.

[335] I propose approaching the issue of invalidity on the basis set out by the Court of Appeal in *AJ Burr Ltd v Blenheim Borough Council* [1980] 2 NZLR 1 (CA); Fisher J in *Martin v Ryan* [1990] 2 NZLR 209 (HC) and *Wihapi v Hamilton Law Society* [1992] 3 NZLR 367 at 372. In *Martin v Ryan* Fisher J held, following *Reid v Rowley* [1977] 2 NZLR 472 and *AJ Burr Limited v Blenheim Borough Council* than an *ultra vires* decision is potentially a nullity, but it will be operative until set aside retrospectively by a Court. The invalidity is latent until it is impugned

retrospectively by a Court of competent jurisdiction. The principles were set out in *Murray v Whakatane District Council* [1999] 3 NZLR 276 (HC) where Elias J held at 320:

> It is settled law that every unlawful administrative act, except perhaps in extreme cases of clear usurpation of power, is operative until set aside by a Court. … The validity of a decision is therefore a concept which is "relative, depending upon the court's willingness to grant relief in any particular situation": Wade and Forsythe, *Administrative Law* (7th ed, 1994) at p 341.

The theory of retrospective invalidation has since been followed in a number of High Court decisions: see *Evans v New Zealand Parole Board* [2005] NZAR 328 at [34]-[38] and *Adlam v Stratford Racing Club* HC NP CIV 2006-443-000238 1 February 2007.

[336] Therefore, I will not assume that the ARDHBs' defective decision was a nullity in the sense that it was invalid at the time it was made. Rather I will approach it from the perspective that it is operative unless set aside.

[337] Whether the decision and the subsequent contract can or should be declared invalid needs to be considered first in relation to the express statutory provisions dealing with the consequences of actions that are in breach of the duties of DHBs or Board members and second, under the common law.

The effect of s 87 of the PHD Act

[338] Section 87 of the PHD Act prevents the invalidation of certain contracts following from a decision that does not comply with certain listed provisions. It states:

> **87. Saving of certain transactions**
>
> The validity or enforceability of any deed, agreement, right, or obligation entered into, or incurred by, the Crown or a publicly-owned health and disability organisation is not affected by a failure by the Crown or the organisation to comply with –
>
> (a) any provision in sections 3, 4, or 8, or Parts 3 and 4; or
>
> (b) any regulations made under section 92(1)(e); or

(c) any provision of Schedules 3 to 6; or

(d) any provision in any statement of intent or district strategic plan or annual plan; or

(e) any direction or requirement given under this Act or any other Act.

[339] On its plain words, s 87(c) precludes a declaration that the contract with Lab Tests is invalid solely because of the failure to comply with the requirement to disclose interests pursuant to cl 36 of Schedule 3. Section 87 preserves the validity of certain transactions following a specific listed event, namely a failure of a publicly-owned health and disability organisation to comply with the specified provisions of the Act, or a failure to comply with any direction or requirement given under the PHD Act, or any other Act. Section 87 does not on its face purport to deny access to judicial review. Nor does it purport to deny a Court's ability to declare an *ultra vires* act invalid. It focuses rather on the consequences of administrative acts, namely the deeds, agreements, rights or obligations that may follow.

[340] Section 87(c) refers specifically to Schedule 3 and thus encompasses cl 36, which requires the disclosure of interests. It is argued for the defendants that s 87 prevents invalidation of the Lab Tests contract, even if there has been a failure to comply with the requirement to disclose interests in cl 36 of Schedule 3. It is necessary, therefore, to consider the scope and ambit of s 87.

[341] Section 87 does not purport to prevent a Court from declaring an *ultra vires* act invalid. It does not purport to prevent access to judicial review at all. If it did so, s 87 would be a privative clause. However, I do not interpret s 87 as being a privative clause. The Courts will presume that Parliament does not intend to immunise a decision-maker from review, although it is perfectly possible for it to do so: *Anisminic Ltd v Foreign Compensation Commission* [1969] 2 AC 147 per Lord Wilberforce, *O'Regan v Lousich* [1995] 2 NZLR 620 at 627. A Court is obliged by s 6 of the New Zealand Bill of Rights Act 1990 to construe s 87 of the PHD Act in a manner consistent with s 27(1) of the Bill of Rights Act. This section gives every person the right to "the observance of the principles of natural justice". Section 27(2) preserves the right to apply in accordance with law for judicial review. An interpretation of s 87 that ousted judicial review would be contrary to s 27. If

that had been the intention, it could have been expected that Parliament would have said so explicitly.

[342] I consider, rather, that the ambit of s 87 was to protect the rights of parties contracting with DHBs in the event of the sort of DHB failure defined in s 87. Its intention was to prevent DHBs or other parties complicit in a failure to comply with statutory requirements from effectively taking advantage of that wrongdoing by seeking to invalidate a deed, agreement, right or obligation to the detriment of third parties.

[343] This has been the view of academic commentators considering s 21 of the State Owned Enterprises Act 1987, which was similar in its wording to s 87 of the PHD Act. In his article "*State Owned Enterprises and Social Responsibility: A contradiction in terms?"* [1993] NZ Recent Law Rev 343 at 353, Professor Taggart stated that:

> In the State-Owned Enterprises Bill 1986, clause 20 (as s 21 then was) was not restricted to Part 1 and purported to immunise "acts and omissions" from challenge. This privative clause was criticised before the Select Committee and it was modified to its present form. As s 21 now stands it relates to contractual transactions and not to judicial review. This shows that Parliament did not intend to exclude the Court's review powers in relation to compliance with Part 1. On the contrary, the possibility of Court review was recognised and deliberately left open.

The same view was expressed in Taylor *Judicial Review: A New Zealand Perspective* (1991) para 1.12 where he stated that s 21 related to the law of contracts and does not affect judicial review.

[344] The defendants relied on this statement of Williams J in *Vector Ltd v Transpower Ltd* HC AK CL 1/98 17 August 2000 at [46]:

> Finally, another statutory indication against the reviewability of Transpower's pricing decision is the State-Owned Enterprises Act 1986 s 21, earlier cited. If Parliament has thought it fit to provide that failure on the part of an SOE to comply with its statement of corporate intent is not to affect the validity of agreements, rights and obligations into which that SOE enters, that, too suggests that Parliament intended that failures by SOEs to comply with their statement of corporate intent should be accountable only in terms of the State-Owned Enterprises Act 1986 itself and not through the Courts at the suit of a customer seeking judicial review.

That statement was made in the context of a strike-out application relating to a very different type of decision and a different statutory context. I do not interpret s 87 as requiring, as the second defendant relying on this statement submitted, matters of accountability to be dealt with only within the framework of the PHD Act.

[345] I conclude that s 87 cannot be called in aid by the ARDHBs to preclude invalidation of a contract following a successful judicial review application by a third party of the decision to award the contract.

[346] DML submitted that s 87 of the PHD Act had been impliedly repealed by ss 19 and 20 of the Crown Entities Act, which protect certain *ultra vires* acts by Crown entities. However, this cannot be so, as s 21 of the PHD Act which was enacted after the Crown Entities Act, specifically lists those sections of the Crown Entities Act that do not apply to DHBs. This would have been the place for the Legislature to have stated if certain sections in the PHD Act were repealed or subject to the Crown Entities Act. In the absence of any such provision I assume that s 87 of the PHD Act should not be put to one side and remains in force. For the reasons that I set out in the next section of the judgment, it is clear that the protection afforded by s 20 of the Crown Entities Act is limited to the contractual claims of innocent third parties.

The effect of ss 19–21 of the Crown Entities Act 2004

[347] Section 19 affirms the common law position that *ultra vires* acts will be invalid. Section 20 purports to protect transactions entered into in certain circumstances by statutory entities from the doctrine of *ultra vires*. The sections read as follows:

> **19 Acts in breach of statute are invalid**
>
> (1) An act of a statutory entity is invalid, unless section 20 applies, if it is—
>
> (a) an act that is contrary to, or outside the authority of, an Act; or
>
> (b) an act that is done otherwise than for the purpose of performing its functions.

(2) Subsection (1) does not limit any discretion of a court to grant relief in respect of a minor or technical breach.

20 Some natural person acts protected

(1) Section 19, or any rule of law to similar effect, does not prevent a person dealing with a statutory entity from enforcing a transaction that is a natural person act unless the person dealing with the entity had, or ought reasonably to have had, knowledge—

(a) of an express restriction in an Act that makes the act contrary to, or outside the authority of, the Act; or

(b) that the act is done otherwise than for the purpose of performing the entity's functions.

(2) A person who relies on subsection (1) has the onus of proving that that person did not have, and ought not reasonably to have had, the knowledge referred to in that subsection.

(3) A statutory entity must report, in its annual report, each transaction that the entity has performed in the year to which the report relates that was invalid under section 19 but enforced in reliance on this section.

(4) For the avoidance of doubt, this section does not affect any person's other remedies (for example, remedies in contract) under the general law.

[348] The Crown Entities Act originated in the Public Finance (State Sector Management) Bill. Clauses 60 and 61 of that Bill later became ss 19 and 20 of the Crown Entities Act. The explanatory notes to the Public Finance (State Sector Management) Bill are of assistance in interpreting sections 19 and 20.

[349] The explanatory notes state that clause 60 (s 19) continues the "existing law". It is stated that s 20, however

> *[M]odifies the 'ultra vires' doctrine (as regards third parties)* for acts of a statutory entity that are acts that a natural person could have done. An example is --- a statutory entity, A employs an employee, Mr B. An Act of Parliament says that A must not employ an employee until A has consulted with the State Services Commissioner about that employee's terms and conditions of employment. A does not so consult. Mr B does not know this omission.
>
> Under the existing law, the contract of employment with Mr B is of no effect. Under clause *61*, the contract of employment with Mr B can be enforced by Mr B, because the powers of appointing an employee is a power that an actual person has. It does not matter that A has acted in breach of its Act of Parliament.

[Emphasis added]

[350] The explanatory notes go on to state that the reasons for modifying the doctrine of *ultra vires* in such a way are the uncertainty for parties when entering into transactions not provided for in the statute, the high transaction costs involved in seeking legal advice about proposed actions and the possibility that "the doctrine can be used as an excuse for walking away from legal obligations". It is also noted that other mechanisms are better designed to ensure the accountability of statutory entities.

[351] It is then stated further:

> The modification of the doctrine applies only if there is an *innocent third party involved*. If the person dealing with the entity *knew, or ought reasonably to have known, that the act was outside an Act*, then the protection does not apply, and the act is still illegal.
>
> [Emphasis added]

[352] Section 20 clearly prevents a statutory entity from raising its own error against third parties. For instance, it would prevent a DHB from refusing to perform a contractual obligation on the basis that the DHB had made an error as to its power to enter into the contract. Thus s 20 is not of relevance in this case. The ARDHBs are not trying to take advantage of their own wrongs by raising their own errors as a defence to a contract. On the contrary, the ARDHBs seek to uphold the contract. Rather, the error is being raised by third parties themselves, namely DML and the intervener.

[353] Moreover, I do not think that Dr Bierre or Lab Tests can avail themselves of any protection under s 20. In this case the act that was contrary to or outside the authority of the Crown Entities Act was the use of the ARDHBs' information by Dr Bierre. Dr Bierre and the Consortium were aware of the background and state of knowledge. Indeed, I have already referred to the Healthscope Minutes, which expressly acknowledged his use of information. In the words of s 20(1)(b), they "had or ought reasonably to have had knowledge" that the decision was *ultra vires.*

[354] I also note that s 21 expressly states that s 20 does not limit an application in accordance with law for judicial review. Clearly s 20 is not intended to operate in any general way as a privative clause. Consistently with s 27 of the New Zealand Bill of Rights Act 1990 it leaves unaffected the right of a party to challenge the decision of a public authority for a failure to observe the principles of natural justice by judicial review. Its limited purpose is that referred to in the explanatory notes.

[355] I conclude that neither s 87 of the PHD Act nor ss 19-26 of the Crown Entities Act affect the decision that must be made as to what remedies, if any, should be ordered as a consequence of the above findings. The validity of the decision and of the contract itself fall to be determined on traditional common law principles.

Can the contract be declared invalid?

[356] I have concluded that the decision to enter into the Lab Tests contract was *ultra vires* and that s 87 of the PHD Act and s 20 of the Crown Entities Act do not apply. It could be expected that it would follow that the contract itself, having been entered into by a party that was acting *ultra vires*, would also be invalid. Mr Illingworth for the first defendant submits, however, that this should not be so. He refers to *Crédit Suisse v Allerdale Borough Council* [1997] QB 306 (CA). In that decision Hobhouse LJ held that the issue of the validity of a contract was to be decided in private law terms unless there was a lack of capacity to enter into the contract at all. He stated at 356 that "the existence of private law rights must be determined as a private law issue."

[357] The first defendant submitted that the ARDHBs clearly had capacity to enter into the contract and so a flawed process adopted by the decision-maker gave rise only to private law issues. Therefore, it was submitted, there was no power at common law to interfere with the Lab Tests contract.

[358] This submission, however, overlooks the rationale of public protection that lies behind administrative law. As Lord Templeman said of local bodies in *Hazell v Hammersmith & Fulham London Borough Council* [1992] 2 AC 1 (HL) at cl 36 "the object of the doctrine of ultra vires is the protection of the public." There is a public

interest in good decision-making. Decisions that are made in breach of the rules of natural justice or contrary to statutory powers do not constitute good decision-making.

[359] I respectfully agree with the observation of Neill LJ in the *Crédit Suisse v Allerdale Borough Council* case, who disagreed with Hobhouse LJ. Neill LJ stated that he knew of no authority proposition that the *ultra vires* decisions of local authorities can be classified into categories of invalidity, and stated at 343:

> Where a public authority acts outside of its jurisdiction in any of the ways indicated by Lord Reid in *Anisminic v Foreign Compensation Commission* [1969] 2 AC 147, 171 the decision is void. In the case of a decision to enter into a contract of guarantee the consequences in private law are those which flow where one of the parties to a contract lacks capacity. I see no escape from this conclusion.

[360] DHBs' objects and powers are solely those that Parliament set out in the PHD Act, and beyond those powers they are legally incapable of doing anything: *Re Westminster City Council* [1986] AC 668. The wider powers open to private persons are not available to them, and the statutory protection available to third parties when dealing with private companies is also not available, subject to s 87 of the PHD Act and s 20 of the Crown Entities Act as discussed. A contract made by a DHB outside its powers is therefore wholly void, subject to the presumption that it is operative until specifically declared invalid.

[361] The question that must now be addressed is whether the Court in its discretion should set aside the ARDHBs' decision and so retrospectively invalidate the decision and the contract.

Application of discretion

[362] The position on the Court's discretion as to remedies was recently restated by the Court of Appeal in *Unison Networks Limited v Commerce Commission* CA 284/05 19 December 2006 at [82], quoting Professor Feldman *English Public Law* (2004) at paragraph 18.52:

> Although it is unusual to do so, the Court may decide to refuse remedies … possibly allowing invalid public action to stand, because countervailing public considerations justify withholding the relief.

The Court in *Unison Networks Limited v Commerce Commission* referred to some of the reasons for refusing relief, including the implications on third parties and on public administration. It also referred to situations where relief would serve no purpose, such as where the applicant has achieved the substantial result sought, or where an error has been substantially cured: at [83].

[363] It was submitted for the ARDHBs that to grant relief would cause great administrative inconvenience to the ARDHBs, who would be forced to undertake a costly and time-consuming second proposal process for no apparent purpose. It was possible that the ARDHBs could enter into a second contract, thereby exposing themselves to a damages claim. It was also suggested that DML does not have 'clean hands' and had brought the situation on itself by its failure to open its books to the DHBs and its combative approach to the proposal process. It was said that to grant relief to DML would embolden disappointed incumbents to challenge adverse commercial decisions and make DHBs unduly apprehensive with regard to reform and change.

[364] Lab Tests, for its part, submits that it will suffer great prejudice if the contract is set aside. It will be forced to participate in another RFP process. It has invested in excess of $17 million already on the assumption that it had a valid contract. It points out that if the Court intervenes, the ARDHBs will no longer have a contract for pathology services on 1 July 2007, as the contract with DML expires on 30 June 2007. Finally, it submitted that there is a clear risk to the general Auckland public health in the short term if the proposal process starts again.

[365] I now proceed to consider these various arguments.

DML's "clean hands"

[366] "Clean hands" are relevant in a consideration of equitable relief but are not an established reason for a refusal to grant administrative law remedies. Given the fact that the remedies in question arise from public law, and that the concept behind

administrative law is the protection of the public from bad administrative decisions, there must be a limit to the relevance of an applicant's conduct when considering relief.

[367] In this case the two procedural faults identified, Dr Bierre's conflict of interest and the permitted misuse of information, and the ARDHBs' failure to consult the PHOs, resulted in the community, in whose interests the decision was made, being deprived of a properly made decision. DML's moral position is irrelevant. Even if DML were unscrupulous and had behaved badly, the decision-making process would still be flawed and the public would still be entitled to have it done properly. I do not consider that such circumstances would be a reason to refuse relief.

[368] Mr Davison for Lab Tests emphasised a memorandum dated June 2006 written by Chris Wilkes, the finance director of Sonic, in which it was stated that the decision to award the contract to the Consortium was described as "understandable", and it was noted that DML would probably have "done the same" and often does when it comes to dealing with suppliers. It was stated "they have effectively called our bluff." The memorandum discusses the ways DML might get some leverage, having found itself in the position of second preferred bidder.

[369] There was mention of approaching politicians and issuing proceedings. There was the suggestion of an offer to take representatives of the ARDHBs on a tour of laboratories around the world to show them the efficiency of the DML operation in Auckland. This would be an opportunity for Dr Morris to get to know the ARDHBs' personnel better.

[370] I do not consider any of these comments in the memo to be either surprising or reprehensible, although they certainly prevent DML taking any high moral ground. They demonstrate a search for the right tactical position to be taken in its negotiations now that it was likely to lose the contract. I have considered elsewhere DML's tactical decision not to openly provide its financial information. It is the sort of decision that a large commercial party could be expected to take. Therefore, even

if it were a valid consideration, I do not consider that any action on DML's part should persuade the Court to exercise its discretion not to grant relief.

Prejudice to third parties

[371] Lab Tests submits that it should be regarded as a third party. It has spent in excess of $17 million in setting up new laboratories and implementing its plans. If the contract is held to be void, this will clearly prejudice Lab Tests and its shareholders.

[372] I do not accept that hardship to Lab Tests should be regarded as a reason not to grant the relief sought. Lab Tests is not truly a third party. It is the successor to the Consortium, the two major shareholders of which were involved in the *ultra vires* acts. Lab Tests is not the position of an innocent third party. The Healthscope Board Minute of 27 June 2006 shows that Dr Bierre was given a substantial shareholding in Lab Tests knowing that he had provided the Consortium with relevant information derived from his position on the ADHB, and I have already noted that Lab Tests could not avail itself of the protection in s 20 of the Crown Entities Act even if that section applied.

Position of the defendants

[373] The ARDHBs acted in good faith. Their task is a difficult one. I accept that it will be costly for them to have to go through the proposal process again, and the effect of this will be to reduce the funds available for health in the Auckland region. But these sort of costs often arise when there is relief granted in judicial review to remedy a faulty process. The public have an interest in DHBs adopting fair processes. The ARDHBs' good intentions and the cost of a further process are not reasons that preclude relief.

[374] The prospect of Lab Tests suing the DHBs has been raised. I make no comment on this, except to note the remarks I have already made as to the awareness of Lab Tests' shareholders of the advantage gained through the involvement of Dr

Bierre. At issue here is good decision-making in the interests of the public. I do not consider that the possibility of a claim is a reason to deny relief.

Proportionality and the wider implications of a finding of invalidity

[375] I consider that a relevant factor in considering whether to grant relief is whether the seriousness of the error identified in the successful judicial review application is proportionate to the consequences of relief being granted. Weight should be given to the gravity of the error and all the circumstances of the case: *AJ Burr Ltd v Blenheim Borough Council* [1980] 2 NZLR 1 (CA) at 4, *Hill v Wellington Transport District Licensing Authority* [1984] 2 NZLR 314 (CA) at 324.

[376] There is no doubt that the effect of a decision to invalidate the contract will be wide-ranging. Although I have had no particular submissions made in this regard, such an order will no doubt affect the employment of the persons that Lab Tests have already employed. This is of course a matter of concern, but the employment of the DML staff has also been at stake in these proceedings.

[377] I doubt whether there will be a hiatus of laboratory services from 1 July 2007 if relief is granted. DML has undertaken to continue to provide a service on the 2005 prices. Realistically, there are likely to be options for the provision of interim services in the short term.

[378] I do not consider that the Court is imposing an intolerable "flood-gates" type of burden on DHBs by retrospectively invalidating the decision and contract. A stern response is required to a grave error which has affected the balance of a public process. I also do not accept Lab Tests' submission that it is inevitable that the same result will be reached if relief is granted. That submission was based on the proposition that the Lab Tests contract would remain in force. Once, however, that contract is declared of no effect and the proposal process has to be conducted again, it cannot be said that any conclusion is inevitable.

[379] These errors were not minor. They were major faults in a procedure that was of importance to the people whom the ARDHBs served. Although they did not

involve dishonesty, they were serious, and the effects were far-reaching. The Consortium bid ended up greatly advantaged by Dr Bierre's improper use of knowledge. This skewed the decision-making process significantly. Further, the PHOs were not consulted. That was a serious failure incompatible with the statement of intent issued under the PHD Act and the plans and contracts that followed.

[380] I conclude that the decision to enter into the Lab Tests contract, and the contract itself, should be declared invalid.

The various claims

[381] While I have divided the plaintiff's claims into four heads of claim, DML's amended statement of claim raises a considerable number of overlapping complaints. I will now briefly refer to each specific complaint, with a reference to the decisions in this judgment.

a) Bias or other fault by the ARDHBs, based on the involvement in the Lab Tests' bid of pathologist and ADHB member, Dr Bierre.

   I have found that there was no bias in the orthodox sense, but that Dr Bierre should not have been involved in laboratory matters as a potential proposer, and once he had, should not have participated in a proposal.

b) Actions by the ARDHBs contrary to DML's legitimate expectations as to what was being sought by the ARDHBs as to a service model, the quality and level of service, and the RFP process.

   I have found there here was no breach of any legitimate expectation.

c) The ARDHBs' actions were irrational and/or arbitrary, and involved:

   i) a failure to make proper inquiries;

ii) an error in assessing the mandatory criteria;

iii) reliance on material mistakes of fact; and

iv) a failure to take into account relevant considerations or taking into account irrelevant considerations.

These claims have not succeeded.

d) Failure of the ARDHBs to consult with parties who should have been consulted.

There was no failure of the ARDHBs to consult with DML, but there was a failure to consult with the PHOs.

e) Failure of the ARDHBs to satisfy themselves as to the usability, adequacy and quality of a changed service model, and its ability to meet the health care needs of the wider communities.

This claim had the effect of attacking the merits of the decision and does not succeed.

f) Failure of the ARDHBs to give DML the opportunity to bid on the same basis as other bidders.

I have found that DML was given an adequate opportunity to make a proposal but that it was disadvantaged because of Dr Bierre's ability to use confidential information for the Consortium proposal.

g) Failure of the ARDHBs to act reasonably and in the public interest.

This claim, which is an attack on the reasonableness of the decision, does not succeed.

h) The contract was not permitted by or consistent with the ARDHBs' annual plans and was *ultra vires*.

I have upheld the intervener's submission that there was both a breach of a requirement to consult imposed by the statute and related documents, including plans, and also that there was a breach of a legitimate expectation on the part of the PHOs that they would be consulted.

Particular orders

[382] The orders sought were as follows:

a) a declaration that the decision and the Lab Tests contract are *ultra vires* and of no effect;

b) an order that the decision be set aside;

c) a declaration that the contract entered into between the ARDHBs and Lab Tests is invalid and/or of no effect;

d) an order that the ARDHBs reconsider whether, and if so on what basis, they will contract for primary-preferred pathology testing, having regard to all potentially affected parties including all those persons listed in paragraphs 65.1 and 65.4; and

e) costs

[383] I note that originally the plaintiff sought a further order that no person who had contact or discussions with Dr Bierre concerning the ARDHB strategy for purchasing primary/referred pathology services prior to August 2005 should participate in the design and/or evaluation of any further RFP processes or other processes. At the close of submissions I was advised that that relief is no longer sought. I consider that that is an appropriate position of the plaintiff to take. There is no suggestion that the members of the evaluation panel or ARDHBs were biased.

The evidence shows that all those involved in the ARDHBs and evaluation panel acted in good faith. The advantage that Dr Bierre's knowledge gave to the Consortium has now been effectively neutralised by the very public nature of these proceedings and the very full disclosure that has taken place.

[384] The effect of declaring the decision to enter into the contract invalid will be that the request for proposals process will have to begin again. It was submitted to me by Mr Illingworth that if the only successful cause of action was the claim of failure to consult with the PHOs, a direction could be given that the RFP process could be continued by the evaluation panel after the stage at which it had decided on a first preferred bidder. The premise upon which Mr Illingworth's submission was made has not eventuated. I have, in addition to upholding the claim on the basis of failure to consult with the PHOs, upheld the claim of conflict of procedural unfairness. In order to purge the unfair advantage gained by Lab Tests it will be necessary to start the RFP process again.

[385] I am not clear as to how the relief sought in (d) will advance matters. I did not receive detailed submissions on that prayer for relief. It refers to para 65.1 of the amended statement of claim, and there are persons listed in that paragraph whose interests have not been the subject of submissions. Given the fact that the parties could not have anticipated which causes of action would succeed or fail, and what relief might arise, I will not grant that relief. However, I will reserve leave to enable the parties to seek further directions, if necessary.

Summary

[386] The plaintiff succeeds in its claim based on conflict of interest and misuse of information.

[387] The plaintiff fails in its claim that it was not properly consulted and that the ARDHBs breached DML's legitimate expectations.

[388] The plaintiff succeeds in the claim, presented by the intervener, that the PHOs should have been properly consulted, and that the consultation that took place was inadequate.

[389] The plaintiff fails in its claim based on unreasonableness, irrationality and mistake of fact.

[390] The primary relief sought by the plaintiff will be granted.

Relief granted

[391] An order is made that the decision of the ARDHBs to award a contract for laboratory services for the Auckland region to Lab Tests was *ultra vires* and is invalid and of no effect.

[392] An order is made that the contract entered into between the ARDHBs and Lab Tests for the provision of primary preferred pathology services on 14 July 2006 is invalid and of no effect.

[393] Leave is reserved to the parties to seek further directions.

Costs

[394] I observe, without in any way pre-determining the issue, that costs could be expected to follow the event, but also that a considerable amount of hearing time was spent on the plaintiff's unsuccessful arguments. I would hope that the parties would agree on costs. If they cannot, the plaintiff and intervener should file submissions within 21 days, with the first and second defendants to file submissions within a further 14 days.

[395] If counsel wish to seek to vary these costs directions, they should file memoranda, and if necessary seek a telephone directions conference.

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Asher J

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"A"

[Some personnel referred to]

ADHB

ADHB Board referred to:		**ADHB Management referred to:**	
Chair	Wayne Brown	CEO	Garry Smith
Deputy Chair	Ross Keenan	GM Funding	Dennis Jury
Board members referred to:	Tony Bierre	Inhouse counsel	Bruce Northey
	Harry Burkhardt		
	Di Nash		

ADHB Audit Committee members referred to:		**LABPLUS employees referred to:**	
Chair	Harry Burkhardt	General Manager, Clinical Support Services	Fiona Ritsma
Member	Tony Bierre		

CMDHB

CMDHB Board referred to:		**CMDHB Management referred to:**	
Deputy Chair	Ross Keenan	CEO	Stephen McKernan

WDHB

WDHB Board referred to:	
Deputy Chair	Ross Keenan

RFP 577

RFP Working group members referred to:		**RFP 577 Evaluation Panel referred to:**	
Projector Coordinator	Bruce Gollop	Project Director, NDSA	Bruce Gollop
Laboratory Services Manager	Andrew Coe	GM Funding & Planning ADHB	Dennis Jury

RFP 577

GM Funding & Planning, ADHB	Dennis Jury	Materials Manager, ADHB	Chris Morgan
		Independent Pathologist	Bert White
		Audit NZ	Bill Inglis
		Assistants to Evaluation panel referred to	
		ADHB Inhouse counsel	Bruce Northey

DML

DML personnel referred to:		**Sonic personnel referred to:**	
Chief Executive	Arthur Morris	Finance Director	Chris Wilks

HARBOUR PHO

Harbour PHO personnel referred to:

CEO	Susan Turner

LAB TESTS

APC/Labtests personnel referred to:		**Gribbles/Healthscope personnel referred to:**	
CEO	Tony Bierre	General Manager, Pathology NZ	Liz Walker
Director	Lee Mathias		

"B"

[Acronyms and abbreviations commonly used]

ADHB	Auckland District Health Board
ARDHBs	Auckland Regional District Health Boards
CMDHB	Counties-Manukau District Health Board
DHBs	District Health Boards
DML	Diagnostic Medlab Ltd
FTEs	Full-time Equivalents
Gribbles	Gribbles Pathology NZ Ltd
Healthscope	Healthscope Ltd
Lab Tests	Lab Tests Auckland Ltd
NDSA	Northern DHB Support Agency Ltd
PHOs	Primary Health Organisations
RFP	Request for Proposal process
SCL	Southern Community Laboratories
Sonic	Sonic Healthcare Pty Ltd
the Consortium	Auckland Pathology Consortium Ltd
the PHD Act	New Zealand Health and Disability Act 2000
WDHB	Waitemata District Health Board