INQUIRY INTO THE PERFORMANCE OF THE NEW ZEALAND TRANSPORT AGENCY IN RELATION TO DARGAVILLE DIESEL SPECIALISTS

30 JANUARY 2019

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1 OVERVIEW

1.1 Public safety is at the core of the New Zealand Transport Agency's regulatory functions. NZTA's statutory objective is to "undertake its functions in a way that contributes to an effective, efficient, and safe land transport system in the public interest".

1.2 From my review of the Dargaville Diesel Specialists (**DDS**) file I have concluded that NZTA failed to prioritise public safety, with the result that appropriate regulatory action was not taken in a timely or responsive manner. The effect was that DDS and its vehicle inspectors (**VIs**) were permitted to continue issuing Warrants of Fitness (**WoFs**) to New Zealand drivers for considerably longer than was reasonable or safe.

1.3 I have reached the conclusion that the failures I identified are not unique to the DDS case. Rather, they are examples of wider systemic failures within NZTA's regulatory function that have existed for some time and that must be addressed as a priority. I understand that work is under way at NZTA to address failures within its regulatory function. The findings and recommendations I have made in this report should be addressed as part of that wider process.

1.4 NZTA appears to have regarded inspecting organisations (**IOs**) and VIs primarily as its customers and only secondarily as regulated entities.

1.5 Despite having broad regulatory powers over IOs and VIs, NZTA's approach to compliance in this sector has been to inform, educate, and deter and the Agency has focused on working with IOs and VIs to improve performance, to the neglect of appropriate and robust regulatory action when that was necessary.

1.6 While a "customer focus" is a commendable objective generally, the Agency should be clear about how its regulatory function is applied in the interest of public safety. A customer focus should not compromise the wider public interest. To my mind, viewing IOs and VIs solely as the customer and prioritising information and education at the expense of strong regulatory oversight and effective enforcement has led NZTA away from its statutory objective and is not consistent with public safety.

1.7 Information and education are important in promoting competence. Competence is necessary for good performance but does not guarantee it. Poor performers must be regulated in order to protect the public. Education should sit alongside effective regulatory oversight and enforcement, not be a substitute for it. That is all the more so when public safety is at issue.

1.8 NZTA's engagement with IOs and VIs involves a range of interactions and its relationship should differ depending on the transaction involved. Essentially, regulated parties are customers when receiving support and guidance from NZTA, but should not be treated as customers when subject to enforcement action.[1]

1.9 In the DDS case the "inform, educate, deter" approach manifested itself in performance reviews which required compliance staff to pay up to four visits to the certifier before compliance action could be taken – even when noncompliance relating to safety and warranting urgent action was identified.

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[1] Ben Wauchop and Keith Manch "Are Regulated Parties Customers?" (November 2017) *Policy Quarterly*, Vol 13, Issue 4.

1.10 I have also concluded that the processes NZTA's compliance staff are expected to apply when monitoring the performance of IOs and VIs are inadequate. Crucially, there is no meaningful way of elevating urgent or priority files for consideration of robust action. Process failures were exacerbated by insufficient training provided to compliance staff on how to address urgent or priority matters.

1.11 NZTA's culture therefore does not prioritise rigorous regulatory action and does not support staff to take robust enforcement when it is patently needed.

1.12 Together these systemic failures have led to an inadequate response over many years to the compliance issues identified now in relation to DDS, manifested by significant and unacceptable delays in taking enforcement action to address noncompliance in this case.

1.13 From the DDS case, it seems NZTA's approach to appointment of IOs and VIs does not require them to apply formally for reappointment. Thus, once an IO or VI is appointed, there is a presumption that they would remain appointed. I have recommended that NZTA amend this process to require IOs and VIs to seek reappointment formally and to satisfy NZTA that they continue to meet the appointment criteria.

1.14 Any suggestion that NZTA's regulatory shortcomings only arose following vehicle licensing reforms implemented in 2014 is, in my view, wrong. The 2014 reforms – and in particular the introduction of NZTA's customer focus approach to its regulatory function – exacerbated fundamental problems within NZTA's regulatory function. The DDS case itself illustrates this; clearly the certifier was noncompliant in a number of areas identified during compliance visits prior to 2014 and numerous complaints were received, but no meaningful regulatory action was taken.

1.15 My recommendations emphasise:

(a) Refocusing NZTA's regulatory strategy on public safety, ensuring the customer focus model does not compromise robust enforcement when appropriate.

(b) Ensuring NZTA's processes and systems follow its overarching regulatory strategy.

(c) Enabling NZTA to operate as an agile, responsive, and reasonable regulator.

(d) Ensuring that NZTA's compliance staff are appropriately supported in a way that enables them to recommend robust regulatory action where appropriate, and to follow that recommendation through to a decision.

1.16 At the heart of my report is the recommendation that NZTA return to first principles; that is, focus on its core regulatory purpose, namely to undertake its functions in a way that contributes to an effective, efficient, and safe land transport system in the public interest and work to develop a culture that facilitates and encourages rigorous regulatory oversight.

2 RECOMMENDATIONS

In this Report, I have recommended that NZTA:

Section 5

2.1 Sets a standard term of appointment for IOs and VIs. It may be appropriate to consider imposing shorter terms of appointment for IOs or VIs having compliance issues that require close monitoring.

2.2 Requires IOs and VIs to apply formally for reappointment at the expiry of each term of appointment.

2.3 Reviews the standard conditions of appointment for IOs and VIs to ensure they are fit for purpose in relation to its regulatory function.

2.4 Ensures its systems enable the complete compliance history of an IO or VI to be taken into account in the decision making process for their appointment for a further term.

2.5 Reviews its record keeping and information management systems in relation to IOs and VIs in order to:

(a) Ensure the records held for IOs or VIs are complete and readily accessible.

(b) Identify gaps or deficiencies in record keeping and information management.

(c) Ensure any such gaps or deficiencies are remedied.

2.6 Combines the licensing/appointment function and the regulatory/compliance function within NZTA (I understand this has occurred) and ensures a consistent and complementary approach is taken between these functions.

Section 6

2.7 Reviews its regulatory principles and approach. This review should involve, at a minimum:

(a) Refocusing NZTA's regulatory strategy on public safety, ensuring a customer focus model does not compromise robust enforcement action when appropriate.

(b) Ensuring that its processes and systems are consistent with and support its overarching regulatory strategy.

(c) Reviewing NZTA's performance review process, and its risk rating system, to ensure that compliance action is taken based on an assessment of risk to safety, rather than being tied to the number of compliance visits that have taken place.

2.8 Ensures that its policies, procedures, and guidance documents:

(a) Are comprehensive in addressing all key aspects of NZTA's regulatory functions.

(b) Are clear and readily accessible.

2.9 Reviews the Performance Management Reporting System (**PMRS**) and the use of Scheduler (and any other applicable systems) in order to ensure:

(a) There is a file management system which is accessible and which tracks the progress of individual matters, captures key data and locks in follow-up actions and dates in relation to the issues arising.

(b) The forms used by staff as part of the PMRS remain fit for purpose.

2.10 Ensures that adequate and appropriate training and support are given to compliance staff to ensure they understand their regulatory role and exercise it in accordance with NZTA's regulatory strategy and principles as well as its processes and policies.

2.11 Implements the above recommendations nationwide and in a manner which ensures consistency among the different regional groups or teams operated by NZTA.

Section 7

2.12 Provides compliance staff with guidance and procedure documents on how to use NZTA's regulatory tools, including its power of immediate suspension.

2.13 Provides training for its compliance staff on how and when to use these tools, and in particular how to deal with urgent or priority matters.

2.14 Designs and implements a process for review of decisions not to take compliance action following performance reviews which result in findings of serious noncompliance.

2.15 Seeks a change of the Land Transport Rule: Vehicle Standards Compliance 2002 (**Rule**) to enable NZTA to issue a compulsory recall of vehicles inspected by an IO or VI based on an assessment of risk.

Section 8

2.16 Specifies a deadline by which an IO/VI is expected to take required remedial action, or if a deadline is not appropriate, outlines how and when NZTA intends to monitor the required action.

2.17 Drafts a new File Presentation Standard which permits flexibility when necessary, and takes into account NZTA's different regulatory decision types (including urgent decisions).

2.18 Addresses any resourcing issues that may hinder effective decision making. In particular NZTA should:

(a) Ensure it gives responsibility for meeting the applicable File Presentation Standard to staff with the appropriate expertise/experience.

(b) Provide training to compliance staff in meeting the Standard.

2.19 Reviews its line-management responsibilities so it is clear:

(a) Who has oversight over high risk regulatory files and responsibility for regulatory decisions.

(b) Who holds relevant delegations to make these decisions.

2.20 Ensures its document management system enables compliance staff to meet the required Standard and provides training to staff on use of this system to facilitate effective file management.

2.21 Adopts a decision making process which facilitates agile, prompt and responsive decision making. In particular, the process must ensure that recommendations made on a file are followed by a timely decision and any decision is promptly notified and implemented.

2.22 When seeking evidential sufficiency advice for the purpose of regulatory decision making, gives clear instructions to its advisers on the type of regulatory decision that is contemplated (without necessarily limiting the scope of the advice) and indicates whether urgency is required.

Section 9

2.23 Reviews its delegations to ensure it has adequate numbers of staff with delegated power to make regulatory decisions on behalf of NZTA and provides those staff with guidance, training and support.

2.24 If the CIP or an equivalent is to be retained, ensures that:

(a) NZTA's policy documents are clear about which decisions will go before the CIP and which will not. I consider all immediate suspension decisions should be reviewed by the CIP (or a senior manager within NZTA) within 48 hours of any such decision being made.

(b) NZTA's policy documents indicate how urgent decisions should be handled by the CIP.

(c) The CIP has the relevant delegations to enable it, or a member, to make regulatory decisions on behalf of NZTA.

2.25 Ensures that its structure and reporting mechanisms align with its regulatory strategy. Without limiting this recommendation, any mechanisms for measuring performance as well as regulatory targets must be consistent with this strategy.

3 THE INQUIRY

Context

3.1 As at November 2018, there were 3,394,983 passenger cars and vans, and 152,214 motorcycles registered in New Zealand.[2] The 2013 census indicated that over 90% of New Zealand households have access to at least one vehicle, with over 50% of households having access to two or more vehicles.[3]

3.2 NZTA is charged with ensuring vehicle safety on New Zealand's roads. Safety is at the heart of NZTA's statutory functions and objectives[4] and the Agency's stated position is that it is unacceptable for anyone to be killed or seriously injured while travelling or working on the land transport system.[5]

3.3 NZTA has responsibility for regulating approximately 3,200 IOs,[6] and many more individual VIs, who inspect and certify the safety of New Zealand's vehicles. The issuing of WoFs is a critical element of ensuring the safety of New Zealand road users. All road users are entitled to expect that those responsible for certifying their vehicles as safe, are themselves subject to appropriate standards, and rigorous regulatory oversight.

3.4 As I describe in this report, that expectation was not met in the DDS case. NZTA recognised there were serious questions that needed to be addressed about the performance of its regulatory functions in relation to DDS. In October 2018 NZTA instructed me to carry out this Inquiry.

Process

3.5 NZTA gave me authority to make enquiries as I saw fit. In particular:

(a) I was to be given access to any documents held by NZTA that I required.

(b) NZTA agreed to facilitate interviews with staff.

(c) I was instructed to make recommendations not just in relation to the DDS case but on the performance by NZTA of its regulatory functions more generally based on my findings arising out of the DDS case.

3.6 I was given access to NZTA files in relation to DDS and to a substantial volume of additional documents I requested and NZTA answered written questions posed by me in relation to various matters, including questions relating to NZTA's regulatory systems and processes. I wish to acknowledge the support provided by David Pearks, Compliance Programme Advisor within the Transport Access Delivery group at NZTA.

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2 https://www.nzta.govt.nz/resources/new-zealand-motor-vehicle-register-statistics/national-vehicle-fleet-status/ (National Fleet Status as at 30 November 2018).

3 http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-transport-comms/number-motor-vehicles.aspx.

4 NZTA's statutory objective is to "undertake its functions in a way that contributes to an effective, efficient, and safe land transport system in the public interest" (s94, Land Transport Management Act 2003); its functions include to "contribute to an effective, efficient, and safe land transport system in the public interest" (s95(1)(a) of the Land Transport Management Act 2003).

5 https://www.nzta.govt.nz/about-us/about-the-nz-transport-agency/

6 https://www.nzta.govt.nz/vehicles/warrants-and-certificates/warrant-of-fitness/

3.7 Although NZTA cooperated in providing this information (Mr Pearks was assigned to assist my Inquiry and he promptly and diligently attended to meeting my requests), I was surprised at the difficulty encountered in providing certain requested documents, and information in relation to aspects of NZTA's regulatory systems and processes. The process of the Inquiry itself left me with concerns about the lack of accessibility of procedural information and guidance to staff within NZTA in relation to aspects of its regulatory functions. These concerns have been borne out by my substantive findings.

3.8 I conducted interviews with some NZTA staff, including senior managers, who had involvement in the DDS case. These interviews were helpful in progressing my Inquiry. However, I note that before those interviews I was told on behalf of some of those to be interviewed, that some of the information I had been given by NZTA in answer to my requests was wrong. I have taken this into account in arriving at my conclusions and recommendations. The fact that this was asserted by senior staff members of NZTA in relation to information provided to me by NZTA, itself raises questions about the lack of clarity on aspects of NZTA's regulatory systems and processes.

Terms of reference and report

3.9 I am required by the terms of reference to:

(a) Identify what information NZTA obtained about DDS and its vehicle inspectors, Mr Rodney Wilson and Mr Brent Nurse, and when it obtained that information.

(b) Identify what NZTA did in response to the information it obtained.

(c) Identify what NZTA should have done differently, if anything, based on the information it obtained, in the light of NZTA's regulatory functions and responsibilities.

(d) Make recommendations as I see fit on the steps NZTA should take:

(i) In relation to this case.

(ii) In relation to the performance of its regulatory functions generally to ensure that any failures identified in the performance by NZTA of its regulatory functions in this case are not repeated in the future.

3.10 I address these topics and make further recommendations with reference to three periods of activity by NZTA in relation to DDS:

(a) August 2010 to December 2017 – during which time DDS accumulated a substantial record of noncompliance, which was known to NZTA.

(b) December 2017 performance review of DDS by NZTA – which resulted in findings of serious noncompliance by DDS, but following which no regulatory action was proposed other than a follow-up visit in March 2018.

(c) January 2018 to August 2018 – the period following an accident involving a vehicle that had been inspected by DDS, which ultimately resulted in the suspension of DDS as an IO in August 2018.

3.11 Before addressing these three periods of activity, I provide a brief description of DDS as an IO and of relevant events relating to DDS from its appointment as an IO by NZTA in 2010 through to the revocation of its appointment on 23 January 2019.

3.12 In making recommendations in this report, I have taken into account that from mid-October 2018 NZTA has embarked on a process of change in relation to how it carries out its regulatory functions. I have not made recommendations where it would be moot to do so in light of changes already made by NZTA.[7] Generally speaking, however, I have made recommendations based on the facts presented by the DDS case because the process of change under way at NZTA is necessarily a continuing one. In specific areas addressed in this report where changes are already under way, I expect my recommendations to be relevant to the further development and implementation of those changes.[8]

[7] For example, while I have addressed the role of NZTA Adjudicators as a necessary part of making findings on what happened in the DDS case, I have not made any recommendations concerning the role of Adjudicators because that role has now been disestablished.

[8] I am aware, for example, that starting in October 2018, changes have already been made to NZTA's regulatory decision making processes to facilitate quicker decision making, particularly in serious or urgent cases. Nevertheless, I consider it necessary to make the general recommendations in relation to regulatory decision making contained in sections 8 and 9 in this report to ensure that the mistakes that occurred in the DDS case are not repeated in the future.

4 DARGAVILLE DIESEL SPECIALISTS

4.1 DDS is a vehicle repairs and service business which operates in Dargaville. DDS is not an incorporated company but rather Dargaville Diesel Specialists is the trading name for the business operated by Rodney Wilson.

4.2 DDS was appointed by NZTA as an IO in August 2010 and was authorised by NZTA to issue WoFs to light motor vehicles, light trailers, and motorcycles from August 2010.[9]

4.3 DDS's employees include Rodney Wilson (also its owner) and Brent Nurse. Mr Wilson was first appointed as a VI in November 2013. It is not known when Mr Nurse was first appointed as a VI, but I understand this to have occurred prior to Mr Wilson's appointment.

4.4 Following the appointment of DDS in 2010, NZTA officers undertook a substantial number of compliance visits to DDS to inspect DDS and the work of its VIs. Based on the records available, 14 compliance visits were made between 2010 and 2017 (excluding a performance review visit in December 2017).[10]

4.5 Noncompliance was identified on 11 of those visits. While on some occasions the noncompliance related only to record-keeping issues, on five occasions issues were identified with inspections conducted by the VIs relating to matters of safety, including the following:

(a) A failure to check steering thoroughly (including while loaded) was noted at the compliance visits in December 2010, June 2012, August 2015 (and again in December 2017 and March 2018).

(b) Failure to use a beam setter to check lights (or to do so properly) was identified in December 2010, August 2015, May 2017 (and again in December 2017 and March 2018).

(c) Failure to check brakes thoroughly was identified in December 2010, June 2012, August 2015, (and again in December 2017 and March 2018).

(d) On two occasions (in 2011 and 2012) issues with a vehicle's seatbelt were not picked up (and again in December 2017).

4.6 In five instances when areas of noncompliance were identified, infraction letters were issued to DDS, and in one instance (in 2011) a serious safety infraction letter was issued.

4.7 NZTA allowed DDS's appointment as an IO to roll over year-on-year, as well as the appointments of Mr Wilson and Mr Nurse as VIs, with no regulatory action taken beyond issuing the infraction letters.

4.8 On 15 December 2017, DDS (Mr Wilson) issued a WoF to a 1991 Nissan Sentra. As Mr Wilson acknowledged subsequently, his inspection of the vehicle prior to issuing the WoF was not adequate.[11]

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9 Warrant of Fitness Authority Agreement between NZTA and DDS, undated, but believed to have been signed in 2010.

10 A full list of compliance visits, and the relevant action taken by NZTA following each one, is set out in Appendix 3.

11 "Complaint Aide Memoire" dated 22 January 2018, recording notes of an interview between NZTA staff member and Rodney Wilson. It should be noted that Mr Wilson subsequently submitted to NZTA that he was bullied into making this acknowledgment and alleges that the seatbelt must have been changed after his inspection. This allegation appears unlikely and in any event does not explain corrosion that was missed in the inspection.

4.9 An *ad hoc* monitoring review of DDS was carried out by NZTA three days later, on 18 December 2017. In the course of that review:[12]

(a) The NZTA Certification Officer (**CO**) who carried out the review witnessed Rodney Wilson failing to check a vehicle fully before issuing a WoF, including failing to inspect the vehicle's seatbelt webbing properly.

(b) The review found Rodney Wilson, Brent Nurse and DDS in general to be noncompliant in areas related to safety.

(c) The CO spoke to a customer at DDS whose vehicle had just been issued a WoF by Mr Nurse. From that conversation it appeared to the CO that Mr Nurse had not properly checked the vehicle's seat belts. Mr Nurse admitted he had not fully inspected the vehicle before issuing a WoF, and said that, occasionally, when he was "familiar" with a vehicle, he would issue a WoF without fully inspecting it.

4.10 Despite this, no action was proposed by NZTA in relation to DDS beyond scheduling a follow-up visit for March 2018.

4.11 On 6 January 2018, the Nissan Sentra that had received a WoF from DDS on 15 December 2017 was involved in an accident in which it crashed into a drainage ditch.[13] Vehicle failure was not the cause of the accident. However, in the course of the accident, the front passenger's seatbelt snapped and the passenger, William Ball, hit his head on the windscreen. Mr Ball subsequently died of his head injuries on 1 February 2018.

4.12 An inspection undertaken by a VI for Vehicle Testing New Zealand following the crash identified that at the time of the accident the passenger seatbelt was fraying. Corrosion was also found on both front A pillars.[14]

4.13 Because of the failure of the seatbelt in the Sentra during the accident, the circumstances surrounding the accident were referred by the Police to NZTA on 7 January 2018.[15]

4.14 The NZTA CO responsible for investigating the matter identified faults with the vehicle and concluded that it was "highly likely" that these faults would have been present at the time the vehicle was inspected by Mr Wilson on 15 December 2017. The report contained photographs demonstrating the frayed seatbelts as well as corrosion damage including on the right hand A pillar.

4.15 The CO interviewed Mr Wilson on 22 January 2018, when Mr Wilson acknowledged "obviously [aspects of the vehicle] were not checked properly" and the WoF for the vehicle should not have been issued.[16] A Complaints Advisor for NZTA subsequently issued a Complaint Outcome Letter to Mr Wilson, confirming the identified faults were "highly likely" to have been present during Mr Wilson's inspection of the vehicle in December 2017, and requiring Mr Wilson to undertake specified remedial action.[17]

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12 Performance Review Rating Report for DDS; Performance Review Rating Report for Mr Nurse and Mr Wilson; Improvement Form; all with job number 98860, dated 18 December 2017. See also Complaint Aide Memoire for visit to DDS on 18 December 2017.

13 Police Traffic Crash Report dated 6 January 2018.

14 Pillars are the vertical (or near vertical) supports in a car's window area. The A pillars are the front supports adjacent to the front windscreen.

15 Email from NZ Police to NZTA CO, 7 January 2018.

16 Complaint Aide Memoire, dated 22 January 2018.

17 Complaint Outcome Letter, dated 24 January 2018.

4.16 There then followed a long delay (between December 2017 and August 2018) before regulatory action was taken by NZTA in relation to DDS. On 27 August 2018 the appointment of DDS as an IO, and the appointments of Mr Wilson and Mr Nurse as VIs, were finally suspended.

4.17 Shortly thereafter, NZTA instituted what was essentially a voluntary recall of vehicles that had current WoFs issued by DDS, by writing to vehicle owners and advising them to get their vehicle re-checked and providing owners with a voucher permitting them to do so free of charge. A compulsory recall of vehicles was not an available option for NZTA in the circumstances.

4.18 The appointment of DDS as an IO, and the appointments of Mr Wilson and Mr Nurse as VIs, remained suspended until their appointments were revoked in January 2019.

5 APPOINTMENT OF DDS AND COMPLIANCE ACTION TO DECEMBER 2017

Appointment of DDS

5.1 As noted above DDS was first appointed as an IO in August 2010. Mr Wilson was first appointed as a VI in November 2013. It is not known when Mr Nurse was first appointed, but I understand this to have occurred prior to Mr Wilson's appointment. From the information available, it appears that Mr Wilson sought appointment as a VI in 2013 during a period when Mr Nurse was not available or was not employed by DDS.

5.2 NZTA's records are not clear about when Mr Nurse was appointed and Mr Wilson's role with DDS before November 2013.

5.3 It is clear that DDS's appointment as an IO, as well as the appointments of Mr Wilson and Mr Nurse as VIs, were allowed to roll over from the time of their initial appointment.

5.4 This is consistent with NZTA's general practice. The process for appointment of IOs and VIs under the applicable legislation and rules is addressed in Appendix 2 of this report, as is the period of any such appointment. It is sufficient to note here that NZTA may specify the period of appointment for VIs and IOs, and that, based on NZTA's current documentation, VIs are appointed for a three-year term (there is no period specified for IOs).

5.5 The information I have received is that the three-year term has no significant practical application. In practice, VI appointments simply roll over continuously without there being any requirement to re-apply unless:

(a) The VI has not carried out a minimum of 25 vehicle inspections in a 12 month period, including at least one in each of the categories for which they were appointed (I was told the quality of the inspections is not relevant – the key requirement is the number completed).

(b) The appointment has been suspended or revoked.

(c) There are pending criminal charges against the VI that may relate to his or her fitness and propriety.

(d) The VI has left the country indefinitely.

5.6 I also understand that, in practice, IO appointments roll over indefinitely as long as there is an active VI associated with the site and the IO's appointment is not suspended or revoked.

5.7 The effect of this is a presumption that an appointment, once granted, will continue. IOs and VIs only have to meet a very low threshold to continue. NZTA has not undertaken periodic assessments based on information available to it in order to determine whether IOs and VIs continue to be fit and proper, meet other requirements for appointment, and therefore remain competent.

5.8 In the case of DDS, the full range of available information included DDS's significant history of noncompliance between 2010 and December 2017. The DDS file demonstrates that an IO or VI may have a significant history of noncompliance, but unless this has reached the stage when NZTA has suspended or revoked the appointment, their appointment will continue as a matter of course.

5.9 A periodic appointment process would place the onus on the IO/VI to prove to NZTA's satisfaction that they continue to meet the requirements for appointment and would allow NZTA to consider periodically an applicant's history of noncompliance, if any, outside the performance review process and whether that history suggests an applicant is not suitable to be appointed for a further term. This did not occur in the case of DDS and does not occur generally.

5.10 If NZTA had processes and systems in place to ensure the complete compliance history of an IO or VI was available, it could be taken into account in the decision making process for appointment for a further term. This would assist NZTA to "weed out" noncompliant IOs or VIs without necessarily needing to suspend or revoke. Competent and compliant IOs and VIs should not find the application process unduly burdensome.

5.11 Until recently, NZTA's licensing and appointment functions (held by the NZTA's Customer Design and Delivery Group) sat separately from the compliance and enforcement functions (held by the Transport Access and Delivery Group). Given that licensing and appointment of IOs and VIs, and compliance and enforcement of their conduct are all part of NZTA's regulatory function, and the exercise of those functions impact on each other, combining these functions within a single operational group within NZTA would obviously be beneficial and I understand this has already occurred.

Key Findings

- **The effect of NZTA's appointment process is a presumption that an appointment, once granted, will continue, except in limited specified circumstances.**
- **As a result, there is no meaningful process to ensure IOs and VIs continue to meet appropriate minimum standards for reappointment. In effect, the three-year term for VI appointments that has been specified by NZTA has limited, or no, practical application.**
- **NZTA has not undertaken periodic assessments based on information available to it in order to determine whether IOs and VIs continue to be fit and proper, meet other requirements for appointment, and therefore remain competent.**
- **No standard term of appointment has been specified by NZTA for IOs.**
- **Consistent with this practice, DDS's appointment as an IO, as well as the appointments of Mr Wilson and Mr Nurse as VIs, continued after their initial appointment. The process adopted by NZTA did not take into account DDS's considerable history of noncompliance. In the case of Mr Nurse, NZTA does not hold adequate records about his appointment as a VI.**
- **NZTA does not have adequate processes and systems in place to ensure the complete compliance history of an IO or VI is readily available so it could be taken into account in the decision making process for appointment for a further term This would assist NZTA to "weed out" noncompliant IOs or VIs without necessarily needing to suspend or revoke.**

I recommend that NZTA:

1. Sets a standard term of appointment for IOs and VIs. It may be appropriate to consider imposing shorter terms of appointment for IOs or VIs having compliance issues that require close monitoring.

2. Requires IOs and VIs to apply formally for reappointment at the expiry of each term of appointment.

3. Reviews the standard conditions of appointment for IOs and VIs to ensure they are fit for purpose in relation to its regulatory function.

4. Ensures its systems enable the complete compliance history of an IO or VI to be taken into account in the decision making process for their appointment for a further term.

5. Reviews its record keeping and information management systems in relation to IOs and VIs in order to:

   - Ensure the records held for IOs or VIs are complete and readily accessible.

   - Identify gaps or deficiencies in record keeping and information management.

   - Ensure any such gaps or deficiencies are remedied.

6. Combines the licensing/appointment function and the regulatory/compliance function within NZTA (I understand this has occurred) and ensures a consistent and complementary approach is taken between these functions.

Compliance activity

Compliance visits to DDS

5.12 Following the appointment of DDS in 2010, NZTA officers undertook a substantial number of compliance visits to DDS to inspect DDS and the work of its VIs. Based on the records available, 14 compliance visits were made to DDS between 2010 and December 2017 (prior to the inspection on 18 December 2017 which is discussed in detail below). A full list of compliance visits, and the relevant action taken by NZTA following each one, is set out in Appendix 3.

5.13 On 11 of those visits a number of instances of noncompliance were identified. While on some occasions the areas of noncompliance appear to have related to record-keeping deficiencies, as set out at paragraph 4.5 above, on five occasions deficiencies were identified with inspections of vehicles conducted by the VIs, including matters of safety. Infraction letters were issued to DDS, and in one instance (in 2011) a serious safety infraction letter.

5.14 On almost every occasion when an area of noncompliance was identified, a follow-up review visit was scheduled.[18] The information I have been provided indicates these follow-up visits

[18] This appears to have occurred on each occasion, apart from one (a visit in June 2012 where record-keeping and technical issues were identified, and appear not to have been followed up).

were typically carried out within a month or so of the initial visit (sometimes within a shorter period). I understand that provided the specific area of noncompliance had been sufficiently addressed, no further action would be taken. If the area of noncompliance had not been adequately remedied, a further follow-up was scheduled, and so on until the issue was resolved.[19]

5.15 Consistent with the appointment process described above, none of the follow-up visits made by NZTA staff to DDS since 2010 were directed towards considering whether DDS (or its VIs) should continue to be appointed.

5.16 While the process of scheduling follow-up reviews ensured that any immediate areas of noncompliance were monitored and addressed, there seems to have been no linking of prior or repeated areas of noncompliance across several review visits.

5.17 Certain specific areas of noncompliance were recurrently identified in relation to DDS; for example, a failure to check the lights properly was identified on five separate compliance visits in December 2010, August 2015, May 2017, December 2017 and March 2018. However, the fact that this issue was identified in 2010 and 2015 (albeit resolved on each of those occasions), does not appear to have been acknowledged as an issue in 2017. NZTA did not link together past performance reviews, or look holistically at recurring problems (other than in the context of the immediate review). Nor did it elevate such recurring issues for consideration of more robust action. As will be seen from the discussion below, I consider this failure to be attributable to systemic issues within the Agency.

Complaints received about DDS

5.18 After 2010, seven complaints were received about DDS and/or Mr Wilson or Mr Nurse, albeit mostly prior to June 2013 (a full list of complaints received is set out in Appendix 3). All complaints alleged inadequate WoF inspection practices by DDS. A warning notice was issued on one occasion, but on all other occasions no further action was taken in relation to the complaint received.

5.19 The most recent complaint (received in March 2017) was anonymous, but alleged that a WoF had been issued without the vehicle being inspected. This complaint could not be followed up with the complainant because it was anonymous and it was not followed up with DDS. The notes provided to me indicate the intention was to wait until the VIs were next reviewed, presumably to discuss the complaint with the VIs themselves.

5.20 Reviews took place on two occasions in June 2017 but it does not appear that NZTA staff specifically followed up the particular allegations made in the March 2017 anonymous complaint. It also appears that the complaint was not considered following the December 2017 performance review where Mr Nurse was specifically observed not fully inspecting a vehicle before issuing a WoF. This is precisely the type of circumstance when it would be expected that relevant past compliance history (including, in this case, the March 2017 complaint which was clearly pertinent) might have been considered.

[19] By way of illustration, on 13 April 2017, NZTA conducted an unannounced review of DDS. An infraction letter was issued due to record-keeping deficiencies that were identified. Less than a month later, on 3 May 2017, a further review of DDS and of Mr Wilson was undertaken when it was identified that some of the record-keeping issues had not been resolved and there were deficiencies in the inspection carried out under observation by Mr Wilson. A second follow-up review of DDS was undertaken a month later on 8 June 2017 when Mr Wilson's technical issues appear to have been resolved, but the record-keeping issues were still present. A third follow-up review of DDS was undertaken a couple of weeks later on 22 June 2017 at which no issues were identified and the IO's records were found to be up to date. The Performance Review Rating Report (**PRRR**) for the 22 June 2017 visit shows the IO as "compliant".

Analysis of NZTA's compliance activity up to December 2017

5.21 It is clear that:

(a) NZTA failed over an extended period to follow-up identified issues of poor practice and noncompliance by DDS adequately.

(b) Over the period during which the issues of poor practice and noncompliance persisted, NZTA failed to consider taking stronger compliance action against DDS such as revocation or suspension.

5.22 The question of inadequate resourcing was raised by some of those I interviewed.[20] I accept that increased resourcing by NZTA of its regulatory functions will be beneficial (I understand this has already been approved by the NZTA Board). I was told by NZTA staff that some IOs/VIs in their region had not received any performance reviews since vehicle licensing reforms were introduced in 2014 due to a lack of resource. In contrast, DDS received a high number of reviews, inspections and visits in the period 2010 to 2017. It is striking that considerable regulatory resource was applied to DDS during this period, but that this did not achieve anything meaningful from a regulatory perspective.

5.23 It is well-established regulatory practice that a risk-based approach is appropriate, involving the application of a variety of different regulatory tools depending on an assessment of the nature and seriousness of the risk in question.[21] Monitoring, education and assistance are essential elements of any good regulator's compliance model but not at the expense of strong regulatory oversight and effective enforcement.

5.24 Repeated poor practice or noncompliance, particularly in the face of prior efforts to educate and assist, should generally result in stronger compliance action (in the case of DDS, non-reappointment, revocation, or suspension). This is necessary in order to protect the public and also to maintain proper industry standards – to ensure that industry members as a whole understand that they must operate in a competent and compliant manner in order to maintain the privileges of participation in the industry. Had this approach been followed in the case of DDS, I believe it is more likely than not that DDS's appointment would have been revoked by December 2017. Certainly, serious consideration would have been given to doing so. The question is why there was a relatively high amount of regulatory activity in relation to DDS during the period 2010 to 2017 without this having occurred. I address this below.

[20] I was told that, at the time, there were four COs in the Upper North Island who had responsibility for monitoring the performance of approximately 2,250 VIs and 1,150 IOs.

[21] *Regulatory institutions and practices* New Zealand Productivity Commission, June 2014.

Key Findings

- **During the period 2010 to December 2017, NZTA failed adequately to follow-up identified poor practice and noncompliance by DDS.**
- **NZTA should have considered taking stronger compliance action against DDS during that period, such as suspension and/or revocation, and failed to do so.**
- **This failure cannot be attributed to a lack of resource as NZTA staff paid a number of review visits to DDS in the period. However, these visits did not achieve anything meaningful from a regulatory perspective.**
- **NZTA's approach to DDS in the period 2010 to December 2017 did not reflect an appropriate, risk-based approach to regulation focused on public safety.**

6 NZTA'S REGULATORY APPROACH AND SYSTEMS

6.1 I now turn to consider whether the failures identified above on the DDS file between 2010 and 2017 reflect an isolated case of poor regulatory practice or wider systemic failure within NZTA. In doing so I will address NZTA's:

(a) approach to its regulatory functions; and

(b) file management and risk rating systems.

NZTA's approach to its regulatory functions

6.2 I interviewed NZTA staff who told me that reforms to the vehicle licensing sector that occurred in 2014 brought about a change in NZTA's regulatory approach. I was told that since those reforms:

(a) IOs and VIs have been regarded by NZTA as its "customers" which has led to a focus on educating IOs and VIs, with the goal of working with them to foster and encourage improved performance. One NZTA staff member I spoke to talked about "putting the customer [i.e. the IO/VI] at the heart of everything we do".

(b) Consistent with this approach, NZTA's COs are required to conduct up to four reviews of an IO/VI before any enforcement action can or will be taken. This approach has been applied no matter what type of noncompliance was identified, or how urgent the matter was. I was told that, for a period of time, staff were actively discouraged from bringing files forward for decisions.

6.3 This approach is reflected in:

(a) The Model Quality Management System (**QMS**), which is a public document released by NZTA in December 2014 and which explains NZTA's performance monitoring and review process and emphasises cooperation with the IO/VI.

(b) NZTA's Standard Operating Procedures (**SOPs**) for monitoring of IOs/VIs in this sector, namely:

(i) SOP VLR10 (performance reviews of IOs).

(ii) SOP VLR10b (performance reviews for VIs).[22]

[22] This document is broadly similar to VLR10, albeit not an exact duplicate. Other SOPs that are in use by NZTA for enforcement purposes are discussed below.

6.4 My review of these documents confirms:[23]

(a) NZTA's approach to compliance in this sector is to inform, educate, and deter.[24] Consistent with this, NZTA regards the first two performance visits as "routine" (and non-chargeable). If a third visit is required, the process enters the "deter" phase (meaning that IOs will be charged for the visit).

(b) The categories of "noncompliance" include "non-compliant – admin" (paperwork/record keeping), "non-compliant – technical" (a component of the assessment that is not safety-related) and "non-compliant – safety" (having the potential to cause harm to the vehicle occupants, pedestrians or other road users, or when failure of the component is imminent and could cause an inability to operate the vehicle safely).[25]

(c) If an area of noncompliance is identified, NZTA will work with the IO and its VIs to "inform and educate you about how to meet our requirements"[26] and to establish an action plan including a timeframe for a follow-up visit.

(d) If the IO is not fully compliant at the follow-up visit, a further action plan would be agreed. A third visit would "reduce […] our confidence in you as an IO or VI and will mean more visits so that we can monitor your performance more closely…".[27]

(e) Only if an IO or VI fails to rectify areas of noncompliance or when there is "clear evidence of persistently unacceptable performance" will NZTA then move to the next stage of the performance monitoring and review process. The QMS specifies that:

> IOs or VIs will be reviewed and disciplinary action taken if required. If IOs or VIs fail to respond to warnings or suspension actions, evidence gained during performance assessments will be used to support the case for withdrawal of their [Notice of Appointment].
>
> Road safety and the maintenance of a fair vehicle certification system demand our firm and decisive action when required. When IOs or VIs fail to carry out their responsibilities we will act to remove them from the certification system. This will be done in a fair and reasonable manner and decisions will be open to appeal.

(f) The clear message is that, even in the case of persistent or ongoing noncompliance, more than one review visit (and likely several) would be required to resolve any issues. There is no acknowledgement in these documents that, in serious cases, there may be a need for urgent regulatory action to be taken. No guidance is given as to how to manage such a situation.

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23 The analysis contained here and in section 7 below is of the SOPs provided to me by NZTA in response to my request for guidance available to COs for carrying out monitoring/performance reviews for IOs/VIs and for referring complaints/issues to NZTA's Adjudicators who, as will be seen later in this Report, acted as decision makers for NZTA on regulatory actions at the relevant time. I was advised that there are other SOPs but the ones discussed in this section and in section 7 below are the ones that are relevant to "the end of the process i.e. where compliance has not been achieved through education". If, contrary to my understanding, there are other SOPs/guidance documents that are relevant to the compliance issues addressed in this Report, then the fact that these were not specifically provided to me in response to my request further emphasises my concern that these documents are not readily accessible to NZTA staff.

24 SOP VLR10.

25 SOP VLR10.

26 Model QMS.

27 Model QMS.

(g) The SOPs seem to have been designed to guide compliance staff to progress and resolve the review process immediately under consideration; there is no guidance in the SOPs for addressing (or taking appropriate action in relation to) recurring issues that have arisen in past performance reviews.

(h) SOP VLR10 states that "Coaching must be carried out immediately for any NC Technical or Safety issues" and that "the CO must decide if this is sufficient to allow the IO to continue operating until their corrective action process ensures complete corrective action is taken".[28] There is no guidance in SOP VLR10 as to what the CO should do if they decide the IO cannot continue operating during this period.[29]

(i) Consistent with a focus on working with the IO/VI, compliance staff are encouraged to hold an "exit meeting" to "summarise the review, engage the IO/VI in discussion and gain agreement on the next steps". Specifically, at the meeting, COs are encouraged to "assist the IO to identify [gaps in the performance], to take ownership" and to "point out any corrective actions that should be taken if applicable", to "explain where to from here" and that "following subsequent 'Educate' follow-up visits, where performance isn't lifting to the extent needed, advise we will be charging for any required 'Deter' visits". COs are encouraged to leave a copy of the PRRR and to "thank [the IO/VI] for their cooperation."

6.5 In my view NZTA's approach to DDS during the period considered above (2010 to December 2017) was consistent with the general regulatory approach just outlined.

6.6 I consider that NZTA's general regulatory approach was flawed. The Agency should be clear about how its regulatory function is applied in the interest of public safety. A customer focus should not compromise the wider public interest. To my mind, viewing IOs as the customer and prioritising informing and educating these certifiers at the expense of strong regulatory oversight and effective enforcement has led NZTA away from its statutory objective and is not consistent with public safety.

6.7 Information and education are important in promoting competence. Competence is necessary for good performance but does not guarantee it. Poor performers must be regulated in order to protect the public. Education should sit alongside effective regulatory oversight and enforcement, not be a substitute for it. That is all the more so when public safety is at issue.

6.8 I consider that NZTA needs to return to first principles; that is, focus on its core regulatory purpose, namely to undertake its functions in a way that contributes to an effective, efficient, and safe land transport system in the public interest and work to develop a culture that facilitates and encourages rigorous regulatory oversight.

6.9 In reaching these conclusions I have not overlooked that the QMS contemplates the possibility of NZTA acting to remove IOs or VIs from the certification system. However, there is an absence of adequate guidance to COs in the QMS, the SOPs, or elsewhere on how removing IOs or VIs from the certification system is to be achieved. I will return to this in more detail below when addressing NZTA's response following its December 2017 performance review of DDS.

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[28] Similar wording is used specifically for VIs in VLR10b.

[29] The powers held by NZTA to take regulatory action in the event of noncompliance, and the guidance in the SOPs that relates to those powers, are discussed further below.

Key Findings

- **NZTA's general regulatory approach in this sector is paraphrased as "Inform, Educate, Deter". This approach:**
    - **Focuses on IOs and VIs as NZTA's "customers" and mandates multiple review visits to IOs and VIs before regulatory action can be taken, even in the face of serious noncompliance.**
    - **Places undue emphasis on education at the expense of taking stronger regulatory action if required having regard to public safety.**
- **NZTA's approach to DDS during the period considered above (2010 to December 2017) was consistent with this general regulatory approach.**
- **NZTA's engagement with IOs and VIs involves a range of interactions and its relationship with these certifiers should differ depending on the nature of the interaction involved. Essentially, regulated parties are customers when receiving support and guidance from NZTA, but should not be treated as customers when enforcement action may be, or is, required.**

File management and risk rating systems

6.10 NZTA adopts a Performance Management Reporting System. A key tool, Scheduler, is used by NZTA to keep track of the jobs allocated to COs. When a VI or IO is due to be reviewed, a job is raised in Scheduler and a CO will pick up that job and actions to be undertaken and, when completed, will note the actions in Scheduler. Performance reviews are conducted by COs using a PRRR, and Improvement Form or Action Plan. These forms were last reviewed in 2015 and should be reviewed again.

6.11 As I have noted in section 5, there was no, or inadequate, linking of recurring issues that arose in more than one performance review of DDS. It is not clear to me whether this failure can be attributed to Scheduler as a management system to enable proper tracking and follow-up of ongoing or repeated areas of concern, a failure adequately to guide and train staff in the use and operation of Scheduler, or to both. My recommendations below cover all possibilities.

6.12 I asked NZTA whether there was a process for "red-flagging" particular VIs or IOs or particular issues or concerns. I was told that staff can:

(a) Record particular issues in the notes section of NZTA's PMRS.

(b) Allocate a risk rating to VIs and IOs via Scheduler.

6.13 In my view, simply making a note in the PMRS is not a satisfactory way of highlighting urgent matters or ensuring appropriate follow-up on files. This does not elevate the matter in any practical way for review of the appropriateness of any action taken. As I understand it, the note is only visible to those who proactively view that part of the file.

6.14 The risk rating system is also unsatisfactory. The risk rating system in relation to VIs and IOs is reflected in NZTA's SOP VLR10. That SOP states that:

(a) An initial risk rating is the first step in the performance review process as it determines where the IO sits in terms of priority as compared with other IOs.

(b) The criteria for the risk review are high inspection volumes, low inspection fail rates and upheld complaints.

(c) Some IOs/VIs will automatically be deemed "high risk", namely new certifiers that have not been an IO before, a new sole VI, or a limited customer (i.e. low-turnover) IO.

6.15 Although the SOP states the risk rating occurs before the review visits commence, the information I was given from staff indicated that, in practice, a risk rating would often not be applied until after any follow-up visits were completed. There is also confusion about whether a certifier who has required a third visit in order to demonstrate compliance should be ranked as low risk (as they are now compliant) or medium or high risk (as they required three visits to demonstrate compliance).

6.16 Risk ratings are applied by the COs that operate in a specific region of the country. They are not peer-reviewed and there does not appear to have been dedicated nationally consistent training on how to apply risk ratings. As a result, I understand that different approaches to assigning risk ratings were taken in different parts of the country. One staff member suggested that NZTA's regulatory group has been much more fractured since responsibilities were divided up on a regional basis.

6.17 Finally, it appears that applying a high risk rating would not necessarily elevate a file in a meaningful way. The staff I spoke with indicated that, at certain times, there could be many "high risk" sites on their books. In practice, I gather that giving an IO or VI a high risk rating may do nothing more than ensure that the certifier would be reviewed more promptly and kept under more regular scrutiny compared to other, lower risk IOs/VIs. It did not mean that the IO/VI was taken out of the standard process (review, follow-up review) or that concerns about the IO/VI were elevated to more senior staff for consideration of whether stronger regulatory action was required.

Key Findings

- **The Scheduler system is either not fit for purpose as a file management tool or its use and operation is not well understood by all compliance staff.**
- **NZTA's risk rating system does not support compliance staff to elevate urgent or priority files for consideration by management:**
    - **The allocation of a high risk rating generally did nothing more than mean an IO/VI would be reviewed more promptly and kept under more regular scrutiny.**
    - **The risk rating system was applied on an *ad hoc* basis and use of this system by NZTA staff in different regions appears to have been inconsistent.**
    - **There was no or insufficient dedicated training on how to apply this system or on identification of risk generally.**

I recommend that NZTA:

7. Reviews its regulatory principles and approach. This review should involve, at a minimum:

    - Refocusing NZTA's regulatory strategy on public safety, ensuring a customer focus model does not compromise robust enforcement action when appropriate.

    - Ensuring that its processes and systems are consistent with and support its overarching regulatory strategy.

    - Reviewing NZTA's performance review process, and its risk rating system, to ensure that compliance action is taken based on an assessment of risk to safety, rather than being tied to the number of compliance visits that have taken place.

8. Ensures that its policies, procedures, and guidance documents:

    - Are comprehensive in addressing all key aspects of NZTA's regulatory functions.

    - Are clear and readily accessible.

9. Reviews the PMRS and the use of Scheduler (and any other applicable systems) in order to ensure:

    - There is a file management system which is accessible and which tracks the progress of individual matters, captures key data and locks in follow-up actions and dates in relation to the issues arising.

    - The forms used by staff as part of the PMRS remain fit for purpose.

10. Ensures that adequate and appropriate training and support are given to compliance staff to ensure they understand their regulatory role and exercise it in accordance with NZTA's regulatory strategy and principles as well as its processes and policies.

11. Implements the above recommendations nationwide and in a manner which ensures consistency among the different regional groups or teams operated by NZTA.

7 18 DECEMBER 2017 PERFORMANCE REVIEW

7.1 On 18 December 2017 NZTA officers conducted an unannounced performance review of DDS. In terms of NZTA's compliance approach, this was considered to be a "first review" for the IO. As it happened, this review took place just three days after Mr Wilson had inspected and issued a WoF to the Nissan Sentra that would be involved in the fatal vehicle accident less than four weeks later.

NZTA's findings at the 18 December 2017 review

7.2 The PRRR produced by the NZTA CO who conducted the review (together with his manager) on 18 December 2017 identified a number of areas of noncompliance in relation to inspections carried out by VIs Mr Nurse and Mr Wilson, notably:[30]

(a) Neither Mr Nurse nor Mr Wilson used the beam setter to check the vehicle's lights.

(b) Neither checked the brakes of the vehicle under inspection adequately, and Mr Wilson did not check them at all.

(c) Mr Wilson did not check the webbing of the seatbelt properly.

(d) Mr Nurse did not identify corrosion on the structure of the vehicle.

(e) Neither checked the vehicle's suspension adequately.

(f) Neither checked the vehicle's tyres adequately.

(g) Neither did a smoke check on the exhaust.

7.3 It was also observed that there was a high volume of inspections carried out by the IO. The PRRR notes that the "time allocated for inspection [was] unreasonable."

7.4 Notes taken during the visit indicate that Mr Wilson was uncooperative when NZTA officers attempted to explain areas of noncompliance, which resulted in the termination of the conversation with him. This is itself a significant concern.

7.5 In addition to these areas of noncompliance, on arrival the CO spoke to a customer who had just received a WoF from Mr Nurse. The CO confirmed that the WoF had been issued without a proper inspection of the vehicle. The CO took a statement from Mr Nurse about the process he followed for inspecting vehicles and issuing WoFs, during which Mr Nurse confirmed he had not fully inspected the vehicle[31] and he occasionally issued a WoF without fully inspecting the vehicle when he "knew the car".

7.6 In effect, Mr Nurse admitted he sometimes issued WoFs to vehicles when he could not be sure they were safe. This is clearly a significant safety issue and was acknowledged as such by the NZTA staff who attended the review and whom I interviewed.

7.7 Following the review DDS was deemed to be "non-compliant – safety" as well as noncompliant in terms of its training records, induction records, technical information

[30] Strikingly, these serious errors were made with NZTA compliance staff present and observing the inspections – when Mr Wilson and Mr Nurse might be expected to demonstrate their best work.

[31] Although the CO subsequently inspected the vehicle himself and confirmed it was safe and it was not therefore appropriate to revoke the WoF.

records, check sheets, and VI certificates. In accordance with SOP VLR10, the CO duly completed an "Improvement Form" which noted, among other things, that "ALL vehicles are to be fully inspected at all times" and that a follow-up visit to DDS would be scheduled in 2018.

7.8 In my view, this proposed follow-up action was plainly insufficient given the particular issues of poor practice and noncompliance observed on 18 December 2017, against the background of DDS's history of noncompliance. The use of stronger regulatory tools was required by this time. However, for the reasons explained below, I consider this has to be seen in the context of the systemic failure within NZTA's regulatory function.

7.9 I have already addressed NZTA's overarching regulatory approach and have concluded that it placed undue emphasis on education at the expense of taking stronger regulatory action if required having regard to public safety. In doing so I noted that the QMS refers to the possibility of removing IOs or VIs from the certification system, but that there is an absence of guidance to COs on how that is to be achieved. I address this point in more detail now in the context of the lack of urgent compliance action immediately following the 18 December 2017 review.

Guidance to staff on the use of NZTA's regulatory tools

7.10 The law in relation to relevant regulatory tools available to NZTA is summarised in Appendix 4 to this report. Regulatory tools available to NZTA included one or both of:

(a) Issuing a notice of investigation to DDS preliminary to revocation of their appointment (subject to the outcome of any further inquiries and submissions made by DDS, and any applicable right of appeal).

(b) Immediately suspending DDS (which is also subject to any further inquiries or submissions made by DDS which may lead to the lifting of the suspension, and DDS's right of appeal).

7.11 NZTA's internal process documents only provide limited guidance on the use of these regulatory tools, and what guidance is available appears to be restricted to the power to investigate IOs and VIs.

7.12 SOPs VLR10 and 10a guide compliance staff in their monitoring of IOs (SOP VLR10b applies to VIs). The SOP indicates the CO must escalate "serious safety risks" to his or her Certification and Licensing Manager (**CLM**) and that the CLM is "responsible for resolving serious safety risks escalated to them by the CO".[32] However, there is no guidance provided as to how this will occur.

7.13 NZTA referred me to RCCP1 – Regional Certification Investigation Process. This document is a "mechanism" for NZTA to "investigate [IOs and VIs] … that may have failed to meet the requirements of the [Rule] as identified by a member of [NZTA] staff or a member of the public". It specifies that "where an investigation against a VI/IO is upheld, [NZTA] has the mandate to apply appropriate remedial action or, in serious cases suspend or revoke the VI/IO authority."[33]

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[32] It is not clear whether the CLM job title remains current. I understand, however, that in the DDS case in December 2017, the CLM was effectively the manager responsible for the COs located in the Upper North Island.

[33] The document also notes that investigations are initially instigated by the CLM in the applicable region; it may well be that where SOP VLR10 states that the CLM is responsible for resolving serious safety risks, it is intended that this "resolution" will follow the process set out in RCCP1.

7.14 RCCP1 provides guidance where NZTA is considering taking action to investigate IOs and VIs.[34] RCCP1 notes the power to suspend immediately exists when there is a significant risk to land transport safety but it does not (nor does it seem intended to) provide any other guidance as to how this power should be exercised.

7.15 When asked, NZTA did not specifically refer me to any other documents that provide guidance to COs in relation to elevating issues to a decision maker. I was also told that COs received no dedicated training on how to deal with urgent or priority matters. On the information provided to me, therefore, there is no adequate internal guidance for NZTA staff on the application of the power to suspend an IO or VI immediately.

7.16 I also note there was no process in place for elevating or reviewing a decision *not* to take compliance action in response to a performance review where poor practice or noncompliance is found. As this case shows, a decision not to take compliance action may be a significant one in terms of public safety. An oversight or review process for such decisions provides quality assurance as well as valuable guidance to compliance staff.

7.17 I am satisfied the lack of action taken immediately following the 18 December 2017 performance review must be seen in the context of NZTA's inadequate guidance to staff on the application of regulatory interventions involving suspension or revocation, as part of NZTA's undue emphasis on an educative customer focussed approach. I have also reached the conclusion that the failure to take robust regulatory action in relation to DDS was attributable to a lack of a compliance culture, which was largely manifested in a failure by NZTA to support compliance staff in using the regulatory tools available to the Agency.

7.18 Even if the DDS case had been elevated immediately following the 18 December 2017 review, in my opinion urgent action is unlikely to have been taken by NZTA. I have reached this conclusion taking into account:

(a) My findings in the previous section, relating to NZTA's regulatory approach and systems; and

(b) My findings in the following section in relation to the events that occurred after this file was elevated following the fatal accident that occurred on 6 January 2018.

7.19 Finally, even if an urgent decision to suspend DDS had been taken immediately following the 18 December 2017 review, it does not follow from this that Mr Ball's death would have been prevented. This is because NZTA had no power compulsorily to recall all vehicles inspected by DDS. It follows from this that while immediate suspension offers important protection for the public against the risk of unsafe inspections in the future, it does not guarantee protection in relation to prior unsafe inspections. A law change is needed in this area.

[34] For completeness, I also note VCCP2 – Vehicle Certification Complaints Process Guidelines – Regional Assistance. This document governs investigations of VIs and IOs where a complaint is received from someone outside the NZTA.

Key Findings

- **Immediate suspension of DDS was justified given the serious findings of the 18 December 2017 performance review against the background of DDS's long history of poor practice and noncompliance.**
- **NZTA failed to consider taking such action. Instead, a further review was scheduled for 2018.**
- **This failure can be attributed to:**
    - **NZTA's flawed regulatory approach and systems addressed in section 6 above.**
    - **Inadequate guidance and procedure documents for NZTA compliance staff on how to use NZTA's regulatory tools, including its power of immediate suspension.**
    - **Inadequate training for staff on how and when to use these tools.**
    - **No process for elevating or reviewing a decision <u>not</u> to take compliance action in response to a performance review finding serious noncompliance.**
- **Urgent regulatory action is unlikely to have been taken by NZTA even if the compliance staff who carried out the review had elevated the file immediately following the review.**
- **If an urgent decision to suspend DDS had been taken immediately following the review, it does not follow that Mr Ball's death would have been prevented. NZTA has no power compulsorily to recall all vehicles inspected by DDS.**

I recommend that NZTA:

12. Provides compliance staff with guidance and procedure documents on how to use NZTA's regulatory tools, including its power of immediate suspension.
13. Provides training for its compliance staff on how and when to use these tools, and in particular how to deal with urgent or priority matters.
14. Designs and implements a process for review of decisions not to take compliance action following performance reviews which result in findings of serious noncompliance.
15. Seeks a change of the Land Transport Rule: Vehicle Standards Compliance 2002 to enable NZTA to issue a compulsory recall of vehicles inspected by an IO or VI based on an assessment of risk.

8 RESPONSE FOLLOWING JANUARY 2018 ACCIDENT

8.1 On 6 January 2018, the 1991 Nissan Sentra issued a WoF by DDS on 15 December 2017 was involved in an accident. The front passenger of the vehicle, Mr Ball, subsequently died as a result of the accident.

Police notification and initial NZTA response

8.2 NZTA was notified about the accident by the Police the day after it occurred. This notification was treated as a complaint by NZTA. The CO who had attended the 18 December 2017 review of DDS investigated the accident and prepared a complaint report for his manager (who had also attended the 18 December 2017 review).

8.3 The CO's investigation included interviewing Mr Wilson. Mr Wilson acknowledged in the interview that he did not inspect the Nissan Sentra properly and that he should not have issued a WoF for the vehicle.[35]

8.4 Shortly after the CO completed his investigation, on 24 January 2018 a Complaints Advisor for NZTA sent a Complaint Outcome Letter to Mr Wilson at DDS. This letter confirmed that the Police "complaint" against DDS had been upheld and that it, along with other cases involving inspections carried out at DDS, would be referred to "an adjudicator, who will consider your fitness and propriety to provide WoF inspection services".

8.5 The letter also required Mr Wilson and DDS to undertake specified action, including:

(a) Taking "immediate remedial action to ensure that there is no repetition of the actions that led to the inappropriate issue of the WoF".

(b) "Review the reasons for rejection relating to the above items [this appears to refer to the specific faults in the vehicle that should have been identified during the vehicle's WOF inspection], as detailed in [NZTA's Vehicle Inspection Requirements Manual (**VIRM**)]".

(c) "Complete an improvement record … describing the corrective action that has been taken to prevent a recurrence" and "File the completed improvement record in …[DDS's] performance review/quality management system."

8.6 The letter did not set any specific timeframe for completing this remedial action, nor did it require Mr Wilson to report back on progress made against the remedial actions requested, either on a periodic basis or when the action was complete.

8.7 Although NZTA staff undertook further compliance action on this file, as I describe below, that action was largely unconnected with the directions set out in the letter sent on 24 January 2018. Correctly in my view, although far too slowly as will be seen, staff were focused on a decision making process directed towards the possibility of taking stronger compliance action. To a significant degree the 24 January 2018 letter represented a continuation of an essentially educative and remedial approach, which had long since ceased to be sufficient or appropriate in the case of DDS.

[35] Again noting Mr Wilson's subsequent submission that he was bullied into making this statement.

Key Findings

- **NZTA's initial investigation following the Police notification about the accident occurred reasonably promptly and resulted in NZTA requiring DDS to carry out specified remedial action. However, no timeframe was specified for this action, nor was the IO required to report back on progress.**

- **In effect, the Complaint Outcome Letter continued the educative approach that was typical of NZTA's regulatory approach which had long ceased to be sufficient in the case of DDS.**

I recommend that NZTA:

16. Specifies a deadline by which an IO/VI is expected to take required remedial action, or if a deadline is not appropriate, outlines how and when NZTA intends to monitor the required action.

Decision making on a more rigorous regulatory response following the accident

8.8 On 5 February 2018 the CO's Manager discussed the possibility of immediate suspension of DDS with an NZTA Adjudicator.

Discussion with Adjudicator

8.9 Adjudicators were senior NZTA staff who held the key decision making function and delegations on regulatory matters, including on whether to suspend or revoke the appointment of an IO or VI.

8.10 The Adjudicator's note of that conversation records the following information:

> 07.30 Meeting with [Manager] at my desk to discuss the Dargaville Diesel matter as a possible immediate suspension:
>
> - Fatal accident.
> - Seat belt broke in the accident that resulted in a fatality.
> - Police expecting action from the Agency.
> - Seat belt said to be contaminated – with what?
> - A suggestion that the VI/IO missed the fault with the seat belt.
> - I asked what evidence was available?
> - Where did the seat belt break? Was it at a point that would have been visible during the WoF inspection, for example?
> - It seems that investigations were continuing (ESR?)

- I advised that I would need to see clear evidence that the VI/IO were at fault and that that there was an immediate risk to land transport safety.

8.11 Clearly there must be a proper evidential foundation to justify immediate suspension of an IO's appointment. However, in the context of a decision of this kind – which may be temporary while further urgent enquiries are carried out, and which turns on an assessment of risk – the fact that the vehicle's seat belt failed completely in an accident within four weeks of the WoF check by DDS, is itself strong evidence in support of a decision to suspend. Of course, the evidence went much further than that, including Mr Wilson's admissions to the CO following the accident, the findings of the 18 December 2017 review, and the long history of noncompliance by DDS (although it seems from the file note of the discussion that this wider evidence did not form part of the discussion on 5 February 2018).

8.12 The result of the discussion between the Manager and the Adjudicator appears to have been that the Manager understood that significant further work was required before the file could be formally referred to an Adjudicator for a decision on suspension.

8.13 It is relevant in this regard that not long before, in August 2017, NZTA's Adjudicators had created and disseminated a process document described as a "File Presentation Standard". This document states it contains "the requirements of the Adjudicators… in the presentation of ALL files requiring an adjudications review of any endorsement holder, licence holder, or person or entity holding a land transport document." It went on to set out the expectations of the Adjudicators for the presentation of files to their team. The list of items required is extensive. The document confirms that the Standards are "mandatory" and that if a file does not meet the specified standard, it would be returned to the relevant team.

8.14 Good regulatory decision making requires the presentation of good investigative files. It is appropriate that NZTA has a file presentation standard for regulatory decision making. However, the Adjudicators' August 2017 File Presentation Standard reflects a "one size fits all" approach that does not take proper account of the range and different nature of NZTA's regulatory decision types.

8.15 In particular, there is no allowance for urgent decision making necessary to protect against immediate and significant risk to the public. There will be times when urgent decision making is required when the strict requirements of the August 2017 document will not be able to be met before a decision must be made. I do not think the File Presentation Standard is fit for purpose in its current form. It should be amended to reflect the possibility that decisions may be required in urgent or high risk circumstances when the quality and/or quantity of the information available does not (and likely cannot) meet the required standard. In its current form, it may impede NZTA's ability to exercise fully its power to immediately suspend IOs and VIs.

8.16 Additionally, any file presentation standard must be backed up by a workable and user-friendly document management system which enables staff to identify and locate relevant information quickly. The information available to me indicates that the document management system in use at NZTA at the relevant time did not meet these requirements and effectively stymied efforts by NZTA staff to meet the standards required by the Adjudicators.

Follow-up visit to DDS

8.17 A follow-up review visit to DDS took place on 1 March 2018. While this visit was for the purpose of following up the 18 December 2017 review, it was consistent with the outcome of the 5 February 2018 discussion with the Adjudicator that more evidence was necessary. The PRRR for this visit indicates that next to no progress had been made by DDS or Mr Nurse to

address the significant issues that had been identified in the 18 December 2017 review.[36] Significant areas of noncompliance were identified during 1 March 2018 review, many of which concerned safety issues which had featured during the 18 December 2017 review (and in some cases during reviews conducted prior to this).

8.18 The Improvement Form for the visit notes that another follow-up visit would take place in mid-March 2018. However, I understand that after the 1 March 2018 visit, NZTA was advised by NZ Police not to visit the site due to safety concerns relating to Mr Wilson's conduct.

8.19 Following the 5 February 2018 discussion with the Adjudicator, work on the investigation file and report continued in an effort to get the file into a state that would meet the standards required by the Adjudicators for referral. The Manager struggled with this task. He candidly told me that in nearly 18 years with NZTA, including eight of those as manager of a team of COs for the Upper North Island, the DDS file was his first experience of referring a file to an Adjudicator for a decision. While the Adjudicator role was not in existence for all of those 18 years, nevertheless I find this extraordinary for a manager of such experience. I return to this below.

8.20 In any event, a file report was completed by the Manager in early March 2018 but it was not referred to an Adjudicator, largely due to the Adjudicators' workload at the time. Instead, it was referred to the Compliance Intervention Panel (**CIP**) comprised of senior NZTA regulatory managers.

Referral to the CIP

8.21 The DDS file was considered at the CIP's meeting on 9 April 2018, some three months after the crash involving the Nissan Sentra and almost four months after the 18 December 2017 review. Following its consideration of the file, the CIP resolved to "support … the recommendation that the file be referred to a decision maker for consideration as to whether an immediate suspension is appropriate *as a priority*" (emphasis added).

8.22 The minutes of the meeting also record that work would need to be done to determine who held the delegation to make such a decision. I am concerned that a panel of senior regulatory managers established specifically to support effective and efficient regulation by NZTA, in considering a file which they determined required a decision on immediate suspension of the IO as a priority and which had already been subject to significant delay, did not know who held the delegation to make this decision.

8.23 The question of who held the relevant delegation was resolved by 20 April 2018 and it was determined that the file would be sent to an external law firm for an evidential sufficiency review. I understand this decision not to have been based on any particular internal process or policy, but it was made to ensure "the file along with a number of others of similar urgency will move much quicker than before".[37] In other words, it was considered there was a need to advance the file more quickly than would be possible by referring it to an Adjudicator, given the Adjudicators' workload.

8.24 While not recorded in the CIP minutes, it seems the CIP had concerns that the investigation file was still not in good order (a view supported in due course by the external law firm ultimately instructed to provide an evidential sufficiency review). The CIP's view appears to have been conveyed to the Manager responsible for the file. Two days after the CIP meeting,

[36] The Improvement Form noted that "Nothing done since 18 December 2018 [sic]" and that "ALL vehicles are to be fully inspected at all times". Mr Wilson was uncooperative and his performance could not be reviewed.

[37] Internal NZTA email dated 20 April 2018.

on 11 April 2018, the Manager emailed an Adjudicator for advice about what would be needed for the file to be referred to a decision maker. The Adjudicator responded that the Manager should approach the standard as if he were attempting to satisfy a Judge and provided a copy of the August 2017 File Presentation Standard.

8.25 Recognising the Manager was struggling with the task, additional assistance was provided in the form of an Investigation Advisor. However, the Manager told me he was essentially required to start the process of producing a report on the file from scratch in order to meet the File Presentation Standard that the Adjudicators required. This seems to have been extremely time consuming, partly because of the high standards the Adjudicators required, and partly because of the lack of experience or expertise of the Manager in doing this type of work.

8.26 The process also seems to have been impeded by the significant limitations of NZTA's document management system which made searching for specific documents time consuming. I understand that several document management systems have been used by NZTA since its inception. I also appreciate that the functionality within document management systems may not be static and can change (and improve) over time. In any event, I was told by compliance staff that, when they came to put the DDS file together, there was no internal file structure that grouped all documents relating to the IO together. Instead the staff had to search on the IO's name or other identifying details to obtain documents about the certifier. This was time consuming and cumbersome. I was told by one staff member that, despite the number of hours logged on putting together the DDS file for a decision, he still couldn't be sure they found everything relevant. This is clearly unacceptable.

8.27 Although the CIP had recommended that the file be "… referred to a decision maker for consideration as to whether an immediate suspension is appropriate as a priority", it was deemed necessary to take the following additional investigative steps first:

(a) Further interview of Mr Wilson. This occurred in the second half of May 2018. During this interview, Mr Wilson discussed his process for conducting vehicle inspections. When asked how long it took him to complete a WoF inspection, he confirmed that if he went "really fast", he could complete one in half an hour, sometimes slightly less with someone helping. He also confirmed he would typically complete around 10 WoF inspections per day. Notes taken by the Manager either during or after this visit identify several deficiencies in the process adopted by Mr Wilson, including:

(i) Mr Wilson confirmed he had not been using the approved brake meter prior to the December 2017 performance review.

(ii) "Multiple check sheets from November 2017 were not completed fully and accurately by VI Wilson as required by the [VIRM]".

(iii) Mr Wilson's description of his WoF inspection process identified some gaps.

(iv) Additionally, the NZTA manager concluded that, in light of the time taken by Mr Wilson to complete a WoF inspection, together with the number of inspections recorded as having been completed, "would clearly indicate that not all vehicles inspected by VI Wilson would have had a complete and thorough inspection carried out."

(b) Testing of the seatbelts that had been taken out of the Nissan Sentra. I gather that the decision was taken to do this because Police had not tested the belts themselves. The report from the seatbelt test was not received until mid-June 2018.

8.28 While this further evidence was relevant, in the meantime the decision making process on immediate suspension had stalled. In effect, the continued focus on achieving the evidentiary standard that it was understood the Adjudicators required put paid to any prospect of seeking an "immediate" suspension following the CIP recommendation; the process simply took too long. The result is that the file was not sent to external legal advisers for evidential sufficiency review until the end of July 2018, an unacceptable further delay of nearly four months after the CIP's recommendation that the file be referred for consideration of immediate suspension as a priority.

Key Findings

- **The Adjudicators' File Presentation Standard is overly rigid and lacks flexibility to deal with urgent or priority matters.**
- **Adherence to this Standard in an urgent matter, as in the DDS case, led to unacceptable delay and ultimately hindered NZTA from carrying out its regulatory functions in a responsive manner, including using its power to suspend the IO and VI immediately when the circumstances warranted it.**
- **A follow-up review in March 2018 indicated DDS had made no tangible progress towards improving its compliance in key areas.**
- **While the CIP recommendation was for the file to be referred to a decision maker for a decision as a priority, this did not occur.**
- **The delays between the Complaint Outcome Letter (24 January 2018) and the CIP meeting in April 2018, and again between the CIP meeting and the referral of the file to external advisors (late July 2018) were unacceptable. These delays can be attributed to:**
    - **The Adjudicators' workload.**
    - **The rigid requirements of the File Presentation Standard.**
    - **The lack of relevant experience and training of the staff who were tasked with meeting these requirements.**
    - **NZTA's document management system which did not support staff to meet the requirements.**

I recommend that NZTA:

17. Drafts a new File Presentation Standard which permits flexibility when necessary, and takes into account NZTA's different regulatory decision types (including urgent decisions).

18. Addresses any resourcing issues that may hinder effective decision making. In particular NZTA should:

    - Ensure it gives responsibility for meeting the applicable File Presentation Standard to staff with the appropriate expertise/experience.

    - Provide training to compliance staff in meeting the Standard.

19. Reviews its line-management responsibilities so it is clear:

    - Who has oversight over high risk regulatory files and responsibility for regulatory decisions.

    - Who holds relevant delegations to make these decisions.

20. Ensures its document management system enables compliance staff to meet the required Standard and provides training to staff on use of this system to facilitate effective file management.

21 Adopts a decision making process which facilitates agile, prompt and responsive decision making. In particular, the process must ensure that recommendations made on a file are followed by a timely decision and any decision is promptly notified and implemented.

Events through to the suspension of DDS

8.29 In completing the narrative there are two events I will refer to which are not directly relevant to the suspension of DDS, but which reinforce recommendations that I have made earlier in this report.

(a) In June 2018, it was identified that the notice of appointment issued to DDS had not been issued in the correct legal name of the entity. To correct this, NZTA asked DDS to complete a fresh application for appointment as an IO. As it happens, DDS had not done so by the time its appointment was suspended, but three months after the CIP had decided that priority consideration needed to be given to suspending DDS's appointment, another group within NZTA was inviting DDS to apply for a new appointment. This further highlights the need for improved coordination between those at NZTA who exercise licensing and appointment functions and those who exercise compliance and enforcement functions.

(b) In October 2018, after DDS had been suspended, NZTA issued DDS with a warning notice specifically in relation to Mr Nurse's admission during the 18 December 2017 visit that he had not fully inspected a vehicle, and occasionally did not do so when he "knew" the vehicle from previous work or an inspection. I was told the warning

notice was issued "as a follow-up action in response to the noncompliance issued identified [sic] on an earlier visit". I understand the "earlier visit" to be the 18 December 2017 performance review. This point was of course part of the evidence taken into account by NZTA in taking the much more significant step of suspending Mr Nurse in August 2018. Leaving aside the long delay involved, in the circumstances the warning was an unnecessary step, reflecting an apparent throw-back to the educative approach which had been prevalent for so long but which had ceased to be relevant to DDS, and, once again, a lack of coordination between limbs of NZTA's regulatory function.

8.30 Returning to the suspension of DDS, the file was referred to external legal advisors for NZTA at the end of July 2018. The file was not marked urgent, nor were the external advisors informed of its particular urgency in an email or covering letter, with reference to the CIP's recommendation of 9 April 2018 or otherwise.

8.31 I was also told it was necessary for the external legal advisers to make further enquiries to supplement the information on the file before being in a position to give advice on evidential sufficiency.

8.32 NZTA's external advisers provided evidential sufficiency advice to NZTA on 24 August 2018, advising that there was sufficient evidence to suspend DDS, Mr Wilson and Mr Nurse immediately and recommending NZTA take immediate steps to notify those who may have received WoFs from DDS of the need to have their vehicles re-checked.

8.33 The decision to suspend was taken promptly by a manager within NZTA with the appropriate delegation (not an Adjudicator) and the notice of suspension was served on 27 August 2018.

8.34 Following the suspension of DDS, NZTA wrote to all owners of vehicles which had been issued a current WoF by DDS advising them to get their vehicles re-checked and providing a voucher for them to do so in order for the re-check to be free of cost. Not all vehicle owners have elected to get their vehicles re-checked, and as noted above, as the law presently stands the fact that an IO or VI has been suspended does not by itself permit a compulsory recall of all inspected vehicles by that IO or VI for a re-check.

8.35 The appointments of DDS as an IO and of Messrs Wilson and Nurse as VIs were revoked on 23 January 2019. No issues arise in relation to the revocation process for the purpose of this Inquiry.

Key Findings

- **There is a lack of coordination between NZTA's licensing and compliance functions. There also appears to be a lack of coordination between the regulatory function and the complaints processing area.**
- **When the file was referred to NZTA's legal advisors, it was not identified as urgent, despite the CIP's recommendations in April 2018.**

I recommend that NZTA:

22. When seeking evidential sufficiency advice for the purpose of regulatory decision making, gives clear instructions to its advisers on the type of regulatory decision that is contemplated (without necessarily limiting the scope of the advice) and indicates whether urgency is required.

9 REGULATORY DECISION MAKING BY NZTA

9.1 NZTA's regulatory decision making processes failed in the DDS case:

(a) During the period 2010 to early 2018, insufficient consideration was given to making a decision to suspend or revoke DDS's appointment.

(b) Afterwards, following the accident that resulted in the death of Mr Ball, there was a further unacceptable delay of nearly eight months in 2018 before a decision to suspend DDS was finally made.

Lack of decision making prior to 2018

9.2 I have already addressed the systemic failure of NZTA's regulatory function which led to the lack of consideration to suspend or revoke DDS's appointment between 2010 to early 2018 in sections 5 to 7 above. The delay in decision making that occurred in 2018 (addressed in section 8) further illustrates this failure.

9.3 As noted in section 8, the Manager of a team of COs for the Upper North Island told me that in nearly 18 years with NZTA, including eight as manager for the Upper North Island, the DDS file was his first experience of referring a file to an Adjudicator. Another staff member told me that, prior to DDS, he had never seen a file which required immediate action. There may be different explanations for this but one is that the expected small percentage of noncompliant certifiers are not being detected.

9.4 It is revealing of a lack of a compliance culture predating the 2014 vehicle licensing reforms referred to above, that a compliance manager could be appointed and operate in such a significant role for NZTA, and have acquired such limited experience of the key compliance task of preparation of a file for decision. I do not believe that the 2014 reforms caused NZTA's regulatory shortcomings. Instead, it seems to me that the introduction of NZTA's customer focus approach to its regulatory function in 2014 exacerbated fundamental problems already existing within NZTA's regulatory function. The DDS case itself illustrates this; DDS was noncompliant in a number of areas identified during compliance visits prior to 2014, but its appointment was allowed to continue and there was no regulatory action taken beyond issuing infraction letters.

9.5 The lack of any effective guidance or support to ensure the Manager was able to prepare the DDS file for a decision more quickly, even after the file had been elevated to the CIP, also reflects the lack of a compliance culture within NZTA. Even after the fatal accident in January 2018, which followed so soon after the 18 December 2017 review, NZTA was simply unable to progress the file to a prompt decision.

9.6 My conclusion that there were systemic failures within NZTA's regulatory function, which resulted in the lack of any consideration being given to suspending or revoking DDS's appointment prior to 2018, is, of course, based on my Inquiry into the DDS case. The regulatory failures of NZTA are likely to affect other cases. There have been publicly acknowledged failures by NZTA to follow-up issues of poor performance or noncompliance by regulated entities going back a number of years in a much wider set of cases. Considerable media attention was given to this in the latter part of 2018.[38]

[38] This includes the following media reports, https://www.newsroom.co.nz/2018/10/15/277771/transport-chiefs-admit-failures-over-wofs-and-drivers-licences; https://www.radionz.co.nz/news/national/377609/nzta-allowed-dodgy-brake-tests-to-go-on-for-years-documents; https://www.stuff.co.nz/business/103339722/nzta-orders-800-heavy-vehicle-owners-to-

Delayed decision making in 2018

9.7 It is necessary to consider the role of Adjudicators and the CIP in further detail to minimise the risk of future decision failures such as that which occurred in 2018 in this case.

Adjudicators

9.8 I was told the Adjudicator role was created in 2005 (albeit with a different name), largely to ensure that decision making on regulatory matters could be kept separate and independent from the NZTA staff who were "on the ground", such as the COs.[39]

9.9 By early 2018 the Adjudicators were a small team of four staff within NZTA with responsibility for regulatory decision making across the whole of NZTA's regulatory functions. I was told the role of the Adjudicators is to "make significant regulatory decisions including the suspension and revocation of land transport documents – particularly the licences required to operate and drive in commercial services". Consistent with this, I was told that more than 90% of the team's work was in the commercial licensing sector i.e. not relating to IOs and VIs.

9.10 The Adjudicators were delegated numerous decision making powers on behalf of NZTA, including powers to suspend or revoke the appointment of an IO or VI. I understand there were other staff within NZTA who also held these delegated powers but that, at least by the latter part of 2017 and the early part of 2018 the general practice was that only the Adjudicators would make any decisions to investigate a IO/VI, to revoke an appointment or require remedial action to be undertaken following an investigation, or to suspend a IO/VI's appointment immediately.

9.11 The effect was that compliance staff, including the CO and his Manager who conducted the 18 December 2017 review and investigated the fatal accident in January 2018, had no responsibility for making regulatory decisions of any significance. In order for a regulatory decision to be made, compliance staff would have to refer a file to an Adjudicator, who would review the file and make a decision about what action should be taken.

9.12 The Adjudicators were given a great deal of autonomy – while they sat, for a period, within the legal team, and then more recently within NZTA's Transport Access Delivery Group, there appears to have been limited supervision of their work. I was told by NZTA that they were not required to comply with any specific guidance documents or internal processes.[40]

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stop-using-towbars-immediately; https://www.stuff.co.nz/business/104871153/second-tow-bar-engineer-suspended-by-nzta-spotlight-on-another; https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12180456

[39] In 2005, a report released by the Officer of the Auditor-General on the taxi industry included the following comment:

> 'Sometimes, there is no separation in a regional office between the investigation of a case and the decision whether to prosecute, which can lead to a breach of the principles of natural justice. For example, compliance staff who make decisions can also take part in auditing or investigation. **It is important that there is separation of the roles so the decision to prosecute can be made independently, based on the facts obtained during the audit or investigation.** The Authority has recognised this problem, and has attempted to address it in its proposed reorganisation of the Compliance Section's functions (see Part 7) by separating the auditing or investigation roles from the decision-making role." [emphasis added]

[40] I was subsequently told that a Compliance Intervention Model was developed between September 2017 and February 2018 which was intended to guide decision makers and to enhance consistency and certainty. I understand this Model was being used by other decision makers within the Agency, and by the CIP (discussed further below) although the Adjudicators had not been directed to use it. The Adjudicator I spoke with told me there were no operating manuals in use by his team.

Instead, it seems the Adjudicators were permitted to establish their own processes for reviewing regulatory files and to set expectations of other staff who wished to refer such files to them. One way in which this manifested itself was the August 2017 File Presentation Standard addressed above.

9.13 The effect of this structure and approach appears to have been to create a sense of disempowerment for front line staff in relation to decision making, and therefore outcomes, on their files. The focus of Adjudicator decision making seems to have been on ensuring that their decisions were "Judge-proof" i.e. that decisions would survive any appeal or judicial review application. The unintended result was an overly conservative approach to decision making which led to some front line staff taking the view that there was little point in referring a file to an Adjudicator given the amount of work required and the competing demands on their time. This was exacerbated by the delays experienced in obtaining a decision from some of the Adjudicators.[41]

9.14 It is appropriate, where possible, to have a degree of separation between investigative functions and decision making functions on any particular file. This may be achieved in a variety of ways, including vesting responsibility for decision making with a manager or a panel of managers, and including an evidential sufficiency review by legal advisors (internal or external) as part of the decision making process. However, this may not always be possible where an urgent decision in the interests of public safety is required.

9.15 Care must be taken in equating operational separation with independence. Ultimately, whatever role the decision maker has within a regulatory organisation, they must make decisions in accordance with the organisation's purposes and objectives. In the case of NZTA, a decision maker is as accountable for achieving regulatory outcomes in accordance with NZTA's land transport safety purposes and objectives as a front line investigator.

CIP (Compliance Intervention Panel)

9.16 The CIP was an innovation within NZTA, established in October 2017, and comprising senior regulatory managers.

9.17 The Terms of Reference for the CIP state that its purpose is to:

> …support the [NZTA's] Transport Access Delivery (TAD) Group to regulate effectively and efficiently. The CIP supports a robust, consistent and principled decision-making process. In doing so, the CIP will bring in external advisors and engage with staff at all levels with a focus on a broad consideration of alternatives, high quality advice and the capture of learnings for those involved and for the wider agency.

9.18 The Terms of Reference also state that the "key test for 'what should be considered by the CIP?' is that of significance", and that "all decisions in relation to the possible suspension, revocation and/or prosecution of organisations [IOs] will be considered significant and will be referred to the CIP for consideration", although decisions about individuals (VIs) would be considered out of scope unless the "significance assessment prompts referral to the CIP."

9.19 The Terms of Reference also reflect the fact that the CIP, as established, does not have a decision making function or hold required decision making delegations:

> This means that compliance decisions will continue to be made via the current delegation policy and schedule in relation to the relevant legislation. In effect this means that the lowest level of delegation for decisions made based on CIP views sits

[41] As noted above, it was the concern about the backlog of files with Adjudicators which meant this file was not sent to an Adjudicator.

with the Senior Adjudicators, the Manager Rail Safety – Compliance and Intervention, or Manager Licensing and Assessments.

9.20 The effect of this was, while the Terms of Reference refer to CIP "decision-making", in reality the CIP did not make regulatory decisions on behalf of NZTA, but instead occupied an advisory or recommendatory role. The intention was not that the CIP recommendation would substitute for the decision of the Adjudicators although I understand the CIP could recommend that a specific file be considered by the Adjudicators urgently.

9.21 Decision making panels are common within regulatory bodies and I consider the establishment of a decision making panel for significant regulatory decisions by NZTA to be a positive development. However, the way in which the CIP was established in October 2017, adding to, rather than replacing Adjudicator functions, was likely to create delay and further administrative burden for front line staff. That is precisely what occurred in the DDS case.

9.22 The CIP should have the required delegations to make decisions on any cases that are elevated to it for consideration. It is unacceptable that in the DDS case the CIP did not have the delegation to make a decision when it considered the file on 9 April 2018. This would have avoided a further four months of delay.

Avoiding delay and associated failures in the future

9.23 NZTA is a large institution, with responsibility for a wide range of regulatory functions and a very large number of licence holders, service providers and other land transport related operators. While decision making by a suitably comprised panel is commonplace with a wide range of regulatory institutions, I doubt that all regulatory decisions can efficiently be made by the CIP, and indeed this is not necessary. Distinctions can be made in NZTA's policy documents between types of cases that should go to the CIP (or its equivalent) and types of cases that should not.

9.24 While the CIP typically meets fortnightly, I understand it is possible for the CIP to meet urgently. Even so, for those cases not required to go to the CIP, it may be permissible for decisions to be made by the manager of a CO who is responsible for a file. In urgent cases at least, where immediate suspension must be considered in light of significant safety risks, this is likely to be preferable to referral to the CIP.

9.25 To enable responsive decision making it is essential that a range of staff of an appropriate level, expertise, and experience hold appropriate delegations to make regulatory decisions on behalf of NZTA and are supported to make such decisions. Leaving all regulatory decisions to one small group of individuals led to resourcing issues for NZTA which also inhibited prompt and responsive decision making.

9.26 Quality assurance is essential. I consider that all immediate suspension decisions should be reviewed by the CIP, or alternatively a suitably senior manager within NZTA, within 48 hours of any such decision being made.

9.27 Beyond these observations and findings, and my recommendations set out below, I do not consider it is appropriate for me to be prescriptive about the particular form of decision making model to be used by NZTA in the future. Whatever model is used, steps must be taken to address the issues that have arisen in this case, where compliance staff felt disempowered and disconnected from regulatory decision making, and as a result appear not to have felt accountable for outcomes. Compliance staff must be given training on regulatory principles and decision making and I have made recommendations above accordingly.

9.28 It is also essential that NZTA's regulatory model is properly supported by its organisational structure, its resourcing and appropriate performance standards and reporting.

9.29 A number of those I spoke to raised concerns about a shift in focus away from enforcement to an over emphasis on education. I have dealt with that issue in other parts of this report.

9.30 In addition, I heard that, in the past, the performance reporting model has, in some respects, provided perverse incentives by setting targets and identifying measures which discourage accurate and transparent identification of risks and organisational failure.

9.31 I am not in a position to address that issue in the context of this Inquiry, however I note that the structure of any organisation needs to be aligned to its strategy. In my view NZTA's strategy and focus needs to be sharply focussed on safety.

9.32 Mechanisms for measuring NZTA's regulatory performance must be meaningful and designed to capture key tracking measures. Performance measure should capture the right information and be designed to discourage under reporting or misreporting.

9.33 Any regulatory measures should reflect NZTA's overarching regulatory strategy of improving safety. I suggest that regulatory targets should focus on reducing risk and improving compliance. Organisational systems must be adopted that support appropriate and transparent performance reporting.

Key Findings

- **The model of giving Adjudicators all decision making power contributed to a sense of disempowerment in front line compliance staff.**
- **The Adjudicators adopted an overly conservative approach not only to their own decision making but also to the evidential standard that was required before a file would be accepted for consideration. This, combined with the Adjudicators' heavy workload, led to delays as well as an attitude among front line staff that there was little point in referring files to adjudication.**
- **The fact that the CIP did not have the delegated power to make relevant regulatory decisions led to unacceptable delay in the DDS case.**

I recommend that NZTA:[42]

23. Reviews its delegations to ensure it has adequate numbers of staff with delegated power to make regulatory decisions on behalf of NZTA and provides those staff with guidance, training and support.

24 If the CIP or an equivalent is to be retained, ensures that:

- NZTA's policy documents are clear about which decisions will go before the CIP and which will not. I consider all immediate suspension decisions should be reviewed by the CIP (or a senior manager within NZTA) within 48 hours of any such decision being made.

- NZTA's policy documents indicate how urgent decisions should be handled by the CIP.

- The CIP has the relevant delegations to enable it, or a member, to make regulatory decisions on behalf of NZTA.

25. Ensures that its structure and reporting mechanisms align with its regulatory strategy. Without limiting this recommendation, any mechanisms for measuring performance as well as regulatory targets must be consistent with this strategy.

[42] Shortly prior to the completion of my Inquiry I was advised that the Adjudicator roles within NZTA have been disestablished. It is therefore not necessary for me to make recommendations about the Adjudicator role.

APPENDIX 1 - GLOSSARY

Term	Meaning
CIP	Compliance Intervention Panel
CLM	Certification and Licensing Manager
CO	Certification Officer
DDS	Dargaville Diesel Specialists
IO	Inspecting Organisation
NOA	Notice of Appointment
NZTA	New Zealand Transport Agency
PRRR	Performance Review Rating Report
QMS	Quality Management System
Rule	Land Transport Rule: Vehicle Standards Compliance 2002
SOP	Standard Operating Procedure
VI	Vehicle Inspector
VIRM	Vehicle Inspection Requirements Manual for In-Service Certification
WoF	Warrant of Fitness

APPENDIX 2 – PROCESS FOR APPOINTMENT OF IOs AND VIs

IOs and VIs are appointed by NZTA under the Rule, which is made under section 152 of the Land Transport Act 1998. The Rule applies to "all persons and organisations appointed by [NZTA] as certifiers to carry out inspection and certification activities for all motor vehicles."[43]

The power to appoint VIs and IOs vests with NZTA.[44] Only VIs and IOs appointed by NZTA under the Rule may perform the inspection and certification activities specified in the Rule,[45] and IOs and VIs may only carry out the inspection and certification activities for which they are specifically appointed.[46] VIs and IOs must carry out inspection and certification activities "competently and diligently and in accordance with the conditions of their appointment and with [the Rule]".[47]

Under the Rule, when considering an application for appointment, NZTA must be satisfied that the applicant is a "fit and proper person in relation to any of the criteria set out in [s2.6] that NZTA considers appropriate to the application" and must give appropriate weight to a range of other matters including the applicant's "ability and competence to undertake inspection and certification activities", "the arrangements considered necessary by [NZTA] to monitor and review the applicant's performance under [the Rule]", and "the applicant's quality assurance arrangements and performance management systems."[48]

VIs and IOs must carry out their vehicle inspection and certification in accordance with specified conditions.[49]

VIs and IOs must continue to be a fit and proper person in accordance with specific criteria,[50] which include the applicant's criminal history, any transport-related offences, any complaints made against the applicant in relation to transport services provided or operated by the applicant, and any other matter NZTA considers is appropriate in the public interest.

VIs and IOs must keep all records and associated documents relating to vehicle inspection and certification activities. [51]

VIs and IOs must advise NZTA "as soon as practicable if there is a reason to believe that the inspection and certification of a vehicle has been carried out incorrectly."[52]

In addition, NZTA may specify further requirements and conditions on VIs and IOs.[53] I understand that, in practice, these conditions and requirements are imposed via the VIRM as well as a Notice of Appointment (**NOA**) issued for each specific IO and other guidance issued by NZTA from time to time, such as Technical Bulletins or Safety Alerts.

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43 Rule, s1.2.
44 Rule, s2.2.
45 Rule, s2.1(2).
46 Rule, s2.2(2).
47 Rule, s2.1(2).
48 Rule, s2.5.
49 Rule, s2.3.
50 Set out in s2.6 of the Rule.
51 Rule, s2.3(4)(a).
52 Rule, s2.3(4)(b).
53 Rule, s2.3(1).

VIs are also required to sign NZTA's Vehicle Inspector Code of Conduct, under which they agree to, among other things:

> "[U]ndertake vehicle inspection services objectively and consistently and to the standards specified in the [VIRM] and other instructions issued by [NZTA]".
>
> "[F]ully comply with all laws … that are relevant to the vehicle inspection industry in New Zealand".
>
> "[C]omply with all relevant [NZTA] policies and procedures".
>
> "[C]onduct our business and act in a manner that enhances the reputation of the industry in the community and with the public".

The Rule does not specify how long a VI or IO will be appointed for. As noted above at paragraph 5.4 of this Report, it provides that NZTA can specify the period of appointment for VIs and IOs.[54] Consequently, the NZTA's VIRM for In-Service Certification states that VIs are appointed for a three-year term. It also specifies that to maintain appointment a VI must carry out a minimum total of 25 vehicle inspections in a 12 month period, including at least one in each of the categories for which they are appointed (WoF, CoF (light vehicles) and/or CoF (heavy vehicles)).[55] (I was told that the quality of the inspections is not relevant, the key requirement is the number completed.)

The VIRM does not address the appointment period for IOs and I do not believe that NZTA has stipulated such a period. As I have noted at paragraph 5.6 of this Report, I was told that IO appointments are permitted to continue provided there is an active VI associated with the organisation and the IO's appointment is not suspended or revoked.

54 Rule, s2.3(1).

55 VIRM – In-service certification (WoF and CoF), Introduction, section 6.1.4.

APPENDIX 3 - COMPLIANCE AND COMPLAINT HISTORY FOR DDS PRIOR TO 18 DECEMBER 2017 VISIT

Compliance visits

Date	Compliance activity	Issues noted	Action taken
13-10-2010	PRS and WoF records re-inspection	Record-keeping issues	Infraction letter issued to DDS
13-12-2010	First review of DDS, and technical review of Mr Nurse	Record-keeping issues Technical deficiencies	Electronic scoring sheet issued for each part. VI score of 2.5 out of 3
15-6-2011	PRS and WoF Records re-inspection of DDS, and vehicle re-inspection by Mr Nurse	Record-keeping issues Technical deficiencies	Infraction letter issued relating to PRS and WoF records Serious safety infraction letter issued relating to vehicle inspection
3-11-2011	PRS and WoF Records re-inspection of DDS	Record-keeping issues	Infraction letter issued
8-6-2012	Review of DDS, and technical review of Mr Nurse	Record-keeping issues Technical deficiencies	Electronic scoring sheet issued for each part. VI score of 2.4 out of 3
21-1-2014	Review of DDS, and technical review of Mr Wilson	Record-keeping issues	Electronic scoring sheet issued for each part. VI score of 2.9 out of 3
24-8-2015	Unannounced QMS review of DDS and VI review of Mr Wilson	Record-keeping issues Technical deficiencies	PRRR issued for each part
30-9-2015	QMS follow-up for DDS	All issues addressed	PRRR issued – considered to be low risk
5-3-2016	Education visit to DDS	Record-keeping issues	Infraction letter issued
13-4-2017	Unannounced QMS inspection of DDS	Record-keeping issues	Infraction letter issued
3-5-2017	Unannounced QMS review of DDS and VI review of Mr Wilson	Record-keeping issues Technical deficiencies	PRRR issued for each part – rated “non-compliant admin”
8-6-2017	Unannounced follow-up review of DDS	Record-keeping issues (VI not inspected)	PRRR issued for each part – rated “non-compliant admin”
22-6-2017	Unannounced follow-up review of DDS	No issues found	PRRR issued – rated “compliant”

Complaints

Date	Complaint	Action taken
31-10-2011	Complaint about whether vehicle should have passed inspection	No further action due to length of time since inspection
22-12-2011	Wheel bearing collapsed 70kms after WoF issued by DDS	NFA as unable to prove vehicle was not inspected correctly Mr Wilson warned about language and behaviour
17-2-2012	Non-compliant modified vehicle issued WoF by DDS	Warning notice
28-3-2012	Police identified non-compliant seats in a vehicle with a WoF from DDS	NFA as seats fitted after WoF inspection
23-5-2012	Newly purchased vehicle failed WoF on structural corrosion; complainant claims corrosion must have been there when previous WoF issued by DDS	NFA due to length of time since previous inspection
18-6-2013	Newly purchased vehicle failed WoF; complainant claims faults must have been there when previous WoF issued by DDS	NFA due to length of time since previous inspection.[56]
23-3-2017	Anonymous complaint regarding WoF issued without inspection	Did not follow-up. Decision to wait to review the VIs.

[56] In addition it appears that at the time DDS was not authorised to issue WoFs. This was because its sole appointed VI (Mr Nurse) was not currently employed there. Mr Nurse subsequently returned to the IO. In the meantime, Mr Wilson was also successfully appointed as a VI.

APPENDIX 4 - LAW RELEVANT TO AVAILABLE COMPLIANCE ACTION BY NZTA

This appendix summarises the law relevant to compliance action that could have been taken against DDS immediately following the 18 December 2017 review, if not before. It is not intended to be exhaustive but rather to briefly summarise the types of action applicable to safety concerns of the kind that were apparent with DDS.

Monitoring powers

NZTA may require a VI or IO to undergo monitoring and review as required by NZTA, and to provide such information as NZTA reasonably considers relevant.[57]

Under an IO's NOA, it must permit NZTA to monitor or review its performance and must give "all reasonable assistance" to ensure there is reasonable access to the IO's site, regardless of whether NZTA has given the IO prior notice of its intention to conduct monitoring or review.

The NOA provides that NZTA may, without prior notice, conduct a re-inspection of any vehicle that has been inspected or certified by the IO, or may conduct a "mystery shopper" review (where an NZTA staff member attends the IO's site in the guise of a potential customer seeking WoF or CoF services).[58]

On top of this, NZTA is able to set the requirements and conditions of appointment for IOs and VIs.[59] I have recommended above a review of NZTA's standard terms of appointment to ensure they are fit for purpose in relation to the exercise by NZTA of its regulatory function.

Noncompliance with conditions of appointment

Under the Rule, there are two options available for NZTA to take action if it believes that an IO or VI has failed to comply with any of the conditions of their appointment, or has failed to comply with the Rule.[60]

If the failure to comply presents a significant risk to land transport safety, NZTA can exercise its powers under s3.3 of the Rule to suspend immediately the VI or IO or to impose conditions on an appointment. The Rule specifies the information that NZTA must provide to the IO or VI if it takes either action, including the grounds for the action, the fact that the VI or IO may make submissions to

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57 Rule, s3.1.

58 The NOA also provides that:
(a) In conducting monitoring and review of an IO, NZTA will "have reference to the requirements and conditions specified in this [NOA], the VIRM, and if required, the Quality Management Systems [for the IO, as agreed with NZTA]".
(b) The provisions relating to performance monitoring in the NOA and in the Rule do not limit section 198 of the Act (which permits NZTA to require a person authorised to provide a service in the land transport system to undergo inspections or audits) or any other powers of audit, inspection or monitoring conferred on NZTA by any legislation.
(c) If NZTA believes that the IO or a VI working for the IO "is not maintaining acceptable standards in respect of any of the [activities the IO is appointed to undertake]", NZTA may notify the IO of the "deficiency" and require the IO to "rectify the deficiency within a reasonable time".

59 Rule, s2.1(1).

60 In addition to the clauses in the Rule, clauses 56 and 57 of the NOA address non-compliance by an IO. These clauses essentially refer to and repeat what is contained in s3.2 of the Rule (that is, NZTA's power to investigate any alleged failure to comply). There is no mention in the NOA of the powers to immediately suspend or impose conditions on an appointment under s3.3 of the Rule.

NZTA and that it has the right to appeal the decision under section 106 of the Act.[61] The suspension or imposition of conditions will remain in force until such time as NZTA has determined the action to be taken and that action has been taken, or until NZTA withdraws the suspension or condition.[62]

If NZTA is satisfied that a VI or IO has failed to comply with a condition of their appointment or with the Rule, but not that this presents a significant risk to land transport safety, an alternative option under s3.2 of the Rule is to require the VI or IO to undergo an investigation and to provide such information as NZTA reasonably considers appropriate. Following such an investigation, if NZTA is satisfied that the VI or IO has failed to comply with a condition or with the Rule, NZTA may:[63]

- Require the VI or IO to undertake remedial action.
- Suspend the appointment (or a part thereof) of the VI or IO.
- Revoke the appointment (or a part thereof) of the VI or IO.

Before taking any of these three actions following issue of a notice of investigation, NZTA must notify the VI or IO of the proposed action, the reasons for it, the date by which the VI or IO may make submissions, and the date that the proposed action will take effect.[64] NZTA must consider any submissions made and must then decide whether to take the proposed action and provide written notice of its decision.[65]

61 Rule, s3.3(2).
62 Rule, ss3.3(4) and 3.3(5).
63 Rule, s3.2(2).
64 Rule, s3.2(3).
65 Rule, s3.2(6).