Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Act and Code Review consultation questions | Ngā pātai matapakinga

This document contains all the questions we are asking as part of the Act and Code Review consultation. Aside from the required questions, you can answer as many or as few as you'd like. When completed, please either email it to review@hdc.org.nz or post it to us at PO Box 1791, Auckland, 1140.

Please visit https://review.hdc.org.nz to answer these questions online.

Your details (required)

It's important for us to know a bit about you so that we understand whose views are being represented in submissions. It helps us to make sure that any changes we recommend will work well for everyone and have an equitable impact.

1. What is your name? [redacted]

2. What is your email address? [redacted]

3. Are you submitting as an individual, or on behalf of an organisation or group?

☐ I am submitting as an individual
x☐ I am submitting on behalf of an organisation or group

4. How did you hear about this consultation? (please select)

☐ HDC website ☐ News media ☐ Social media ☐ Internet
x Through my job ☐ Word of mouth ☐ Other (please specify below)

_____

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If you are submitting on behalf of an organisation or group:

What is the name of your organisation or group?

We are academics involved in the training of health professionals (primarily doctors). This submission is in our personal capacities rather than on behalf of our affiliate institutions.

What type of organisation/group is it?

☐ Consumer organisation/group (please specify below)
☐ Iwi/ Māori organisation/group (please specify below)
☐ Health and/or disability services provider (please specify below)
☐ Central Government
☐ Local Government
x University/Academic
☐ Other (please specify below)

Please feel free to provide any further detail:

As above, whilst this submission reflects our experiences and views as academics and, for two of us, experiences as health services providers, we are not submitting on behalf of an organisation.

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Share 'one big thing'

This survey contains structured questions that ask for your feedback on each chapter in our consultation document. If you would prefer to give us your feedback as a whole, by telling us 'one big thing' – you can do so below.
If this is all you want to provide by way of your submission, that's fine by us.
We will consider all the submissions we receive.

What is your 'one big thing'?

We commend the HDC on this considered review, which highlights legitimate issues and potential areas for advancement and proposes thoughtful responses. We have highlighted areas for further consideration below and in the attached draft revisions to the Code.

Topic 1: Supporting better and equitable complaint resolution

1.1: Did we cover the main issues about **supporting better and equitable complaints resolution**?

Cultural safety and trust in institutions such as health services and the HDC are key to enabling complaints resolution processes that feel fair, meaningful and mana-enhancing to all. These issues are well recognised in the review.

We support the development of further resources and capacity for healthcare providers to directly resolve complaints. We welcome approaches to increase the proportion of complaints which are directly resolved by consumers and providers, with support from the Advocacy Service where appropriate.

Anecdotal evidence and our reading of HDC judgements suggests that in some cases health provider defensiveness can be an impediment to achieving a sense of resolution for complainants. We are interested in exploring ways to lessen the risks of complaints proceedings becoming oppositional. It is possible that hui ā-whānau and hohou te rongo approaches may lessen these risks: evaluation should be incorporated from the outset to determine whether this is the case. To realise the potential, it will be important that service providers feel secure in their role within the process

and that the drivers of defensive responses from health providers are identified and, insofar as possible, addressed. This will take commitment not only from the HDC, but from health care providers. Health care providers have become accustomed to processes such as in-house reviews of patient harm and errors in practice. There may be ways of adapting elements of those processes in responses to patients' complaints. When reviews are framed as a learning opportunity or opportunity to improve quality of the system, people may be less likely to be defensive.

We endorse the focus on equity, identifying systemic issues, and supporting early resolution where this is possible/appropriate.

1.2: What do you think of our suggestions for **supporting better and equitable complaints resolution**, and what impacts could they have?

a. **Amend the purpose statement of the Act** (to include a focus on outcomes for the people involved)- This is an important change in terms of setting direction, although its impact may be more one of setting direction rather than generating discernible changes in practice.
b. **Clarify cultural responsiveness** (in terms of reach, and situating Māori appropriately rather than as an add-on)- We see this as a very important update that could have significant impact upon how services are delivered and the experiences of consumers.
c. **Clarify the role of whānau** (within complaints processes and within the rights themselves- eg as parties who may consent). We agree this is an important area to clarify through guidelines alongside the changes suggested to wording in the Code. The changes in this regard ought to align with the relevant provisions within the PPPR Act (or any act that replaces the PPPR Act)
d. **Ensure gender-inclusive language** This is an important and timely advancement
e. **Protect against retaliation** We can see how concerns about retaliation could deter people from reporting complaints. The proposal to adopt the approach taken in the Protected Disclosures (Protection of Whistleblowers) Act 2022 makes sense. Some guidance for care providers might be needed to explicate their duties in relation to this right.

f. **Clarify provider complaint processes** We agree that it is not always clear how to lodge a complaint with a health care provider. Some consumers may also feel reluctant to complain directly to providers because it may be seen as confrontational, or they may fear being shut down. The advocacy service has an important role to play here, and it would be useful for health care providers to offer a way of registering a complaint that feels less confrontational. In the case of larger providers (PHOs and hospitals for instance) a complaints officer may be warranted. As mentioned above, in addition to clarifying complaint processes, ensuring that such processes are accessible and appropriate is important. Local processes where concerns can be heard and responded to without early escalation are important. Robust guidance and training for providers will be pivotal to realising the aim of responding to complaints in ways that preserve and restore relationships.

g. **Strengthen the Advocacy Service-** We agree that this is valuable and important.

h. **Improve the language of complaint pathways in the Act-** We can see how terms such as 'no further action' may be experienced by complainants as disempowering and understate the work that health providers may do in response to a complaint. The language is worth looking at further- terms need also to take into account the need for closure. A term like 'investigation concluded' or 'no further investigation' may work.

1.3: What other changes, both legislative and non-legislative, should we consider for **supporting better and equitable complaints resolution**?

We support incorporation of an evaluation into re-visioned advocacy and resolution processes to enable gathering of high-quality evidence to inform future refinements. We support the use of health navigators to assist in guiding complainants through the process and improving flow.

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Topic 2: Making the Act and Code more effective for, and responsive to, the needs of Māori

2.1: Did we cover the main issues about **making the Act and the Code more effective for, and responsive to, the needs of, Māori**?

As tauiwi / tangata te Tiriti, we are not well placed to comment directly upon these issues beyond strongly endorsing the need to anchor patient rights in Te Tiriti o Waitangi and ensure that Mātauranga Māori and tikanga is at play in the health system and reflected in its governance.

2.2: What do you think about our suggestions for **making the Act and the Code more effective for, and responsive to, the needs of Māori**, and what impacts could they have?

a. **Incorporate tikanga into the Code** We support the incorporation of Tikanga into the Code, but note that the Law Commission appears to have resolved against setting out what/how tikanga should be observed in any replacement for the PPPR Act. The contexts within which the PPPR Act will apply are different in some respects, and there is not necessarily a need for uniformity of approach to tikanga. As persons responsible for teaching law, ethics and professional practice to medical students, we strongly welcome moving to an expression of consumers' rights anchored in tikanga.

b. **Give practical effect to te Tiriti o Waitangi | the Treaty of Waitangi in the Act**

We strongly endorse the need for this and agree with the measures suggested. There might be a role for Iwi- Māori Partnership Boards and/or the Iwi Leaders Forum/ Hauora Māori Advisory Committee in advising/acting as bodies to hold the HDC as a crown entity to account.

2.3: What other changes, both legislative and non-legislative, should we consider for **making the Act and the Code more effective for, and responsive to, the needs of Māori**?

Topic 3: Making the Act and the Code work better for tāngata whaikaha | disabled people

3.1: Did we cover the main issues about **making the Act and the Code work better for tāngata whaikaha | disabled people**?

One additional area to consider is the provision of health and disability services to tāngata whaikaha | disabled people where a health provider teaching or training component is involved. We have discussed this below in the context of the 'best interests' test in Right 7(4).

3.2: What do you think of our suggestions for **making the Act and the Code work better for tāngata whaikaha | disabled people**, and what impacts could they have?

We welcome the majority of the suggestions. We have made recommendations and raised concerns about the proposed revision to Right 7 (4) below and in 5.2.

Best interests. We would welcome the test in Right 7(4) being confined to the provision of treatment and services. In our comments on Right 7(4) we have noted that 'best interests' standards have, however, long been criticised as ambiguous and open to problematic interpretation. A simple and accessible approach may be to replace 'best interests' with '**interests**'. This approach would also promote disabled consumers' agency in relation to choosing to participate in research or to allow students to observe or be involved in service provision in such contexts with appropriate safeguards.

Conducting research. In relation to Topic 3(e) we welcome the further consideration of the 2019 draft recommendations relating to unconsented research. We strongly support approaches to enable research to be conducted

with adult participants who are unable to provide consent, where such research is directly responsive to the health needs of such populations and appropriate additional protections are implemented. The importance of inclusive approaches – which prioritise protecting vulnerable populations **within** research, rather than **from** research, have been increasingly emphasised in international research ethics guidance over the past decade. The UNCRPD, recent Law Commission review of the PPPR Act, and proposed revisions to this Code, highlight the importance of supported decision-making and respecting the will, preferences and agency of adults with affected decision-making, which can include wanting to take part in research which is relevant to their health needs.

When clarifying the application of the test in Right 7(4) we **do not** recommend that the HDC seeks to establish a test of 'no more than minimal foreseeable risk and no more than minimal forseeable burden' for research with adults who are unable to consent. Such a test is inappropriately specific, and neither mandatory nor sufficient to ensure that the interests of adults who are unable to consent are appropriately protected in research and that such research is conducted ethically.

We appreciate that the HDC Act and Code were developed in response to exceptionally unethical research conducted at National Women's Hospital from 1966. Over the past 30 years a comprehensive framework of governance, review and oversight of health research has been established within Aotearoa. The current NEAC guidance provides a nuanced discussion of ethical considerations relating to research with adults who cannot provide consent.

We consider that research with adults who cannot provide consent should be permitted where such research is relevant to their health needs and appropriate safeguards can be established. Determining when such research is appropriate, how such research should be designed and conducted, and recruitment strategies, requires careful critical consideration and justification on a case-by-case basis, in conjunction with relevant guidance and independent ethical review. This includes consideration of exceptional circumstances in which research associated with more than minimal risk/burden may be appropriate.

We recognise the importance of ensuring that ethical review and oversight of research with adults unable to consent is very rigorous (as it should be in other circumstances such as when there is heightened vulnerability, risk or uncertainty). We note that in many jurisdictions research with adults unable to

provide consent does not require review by a specialist ethics committee, and in Aotearoa, research with children unable to consent to research is not reviewed by a specialist ethics committee. Ethics committees in Aotearoa have experience of reviewing a broad range of health and disability research involving tāngata whaikaha | disabled people, and research where questions about heighted vulnerabilities arise in populations that don't identify as disabled. As such we recommend the HDC consider whether establishment of a specialist ethics committee is necessary to ensure rigorous review of research with adults unable to consent. A requirement that research involving tāngata whaikaha | disabled people be reviewed by an ethics committee that is approved by the Health Research Council Ethics Committee could offer sufficient assurance of quality review.

We endorse the recommendation that specialist guidance continue to be developed for research with adult participants who are unable to consent, and that mechanisms for independent scientific review of such research be developed (noting that such review should be comprehensive and not restricted to risk assessment).

We appreciate that some consultation with tāngata whaikaha | disabled people highlighted caution about allowing more such research to be conducted. Tāngata whaikaha | disabled people are heterogeneous and potential participants will have differing wills, preferences and interests in being involved in such research. We are interested in exploring approaches to engage and conduct qualitative research with tāngata whaikaha, and whānau of adults unable to consent to research, to better understand the nature of their concerns and views about such research, and how they should inform approaches to the design and review of research.

3.3: What other changes should we consider (legislative and non-legislative) for **making the Act and the Code work better for tāngata whaikaha | disabled people**?

Where possible and appropriate we advocate streamlining and the common use of terms across legislation such as the PPPR Act, Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

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Topic 4: Considering options for a right of appeal of HDC decisions

4.1: Did we cover the main issues about **considering options for a right of appeal of HDC decisions**?

We think so.

4.2: What do you think about our suggestions for **considering options for a right of appeal of HDC decisions**, and what impacts could they have?

We were unsure about whether a right of appeal would extend to health providers involved in a complaint, or consumers/whānau who lodge a complaint, or both. Whilst it is an appeals mechanism is a common feature of systems for administering justice, and we recognise the importance of that, the introduction of an appeals mechanism could be in tension with the desire to move away from an adversarial approach. The inclusion of appeals within the HDC's portfolio could also impair faster resolution of complaints and extend the time that consumers and practitioners are held within what may be a distressing process. It may be useful to consider the core purpose of the complaints system, and whether an appeals mechanism is a natural part or complement of that purpose.

Topic 5: Minor and technical improvements

5.1: What do you think about the issues and suggestions for **minor and technical improvements**, and what impacts could they have?

We have also made comments above and below where these minor and technical improvements have been incorporated into suggestions for revisions to the Code.

Defining research. In the context of health and disability, we note that research is not defined in the NEAC standards, the Pae Ora (Healthy Futures) Act 2022, or the Law Commission Review of PPPR Act. It is challenging to provide a simple comprehensive definition of research which effectively and specifically distinguishes it from other knowledge-generating activities conducted by health providers. Current research and oversight systems in Aotearoa, including HDECs and institutional ethics committees, have criteria for evaluating whether proposed activities qualify as research on a case-by-case basis, and if so, which forms of review are required. This includes proposals to conduct retrospective research with clinical or other health datasets where consent cannot be obtained. Given such systems, it may not be necessary for the HDC to seek to define research.

Defining teaching. "Teaching includes pre and post registration learning in the clinical workplace that could involve observation of practice, discussion and reflection on patient care, supervised participation and direct care."

5.2: What other **minor and technical improvements**, both legislative and non-legislative, should we consider?

Please see our comments below on proposed revisions to the text of the Code, most substantively in relation to Right 7(4).

Right 3 Right to dignity and independence

Every consumer has the right to have services provided in a manner that respects their dignity and ~~**independence**~~ **autonomy** ~~of the individual~~. *Suggested rephrasing in tracked changes for clarity.*

Comment: The move from independence is welcome. However autonomy is also a principle deriving primarily from Western philosophies and often interpreted and applied with inadequate

attention to its relational aspects. In addition, while autonomy is very familiar to lawyers and healthcare providers, we are concerned that consumers without relevant academic or disciplinary backgrounds may find the term both unfamiliar, and not intuitive to understand. 'Self-determination' could be an appropriate alternative.

Right 7 Right to make an informed choice and give informed consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

(2) Every consumer must be presumed **to have decision-making capacity** ~~**competent**~~ to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer **does not have decision-making capacity** ~~**is not competent**~~.

[Proposed changes relate to Topic 3, proposal d. Strengthen and clarify the right to support to make decisions.]

(3) Where a consumer has **affected decision-making capacity** ~~**diminished competence**~~, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to **their** ~~**his or her**~~ level of **decision-making capacity** ~~**competence**~~. **Where necessary, this includes the right to support to make decisions.**

[Proposed changes relate to Topic 3, proposal d. Strengthen and clarify the right to support to make decisions; and Topic 1, proposal d. Ensure gender-inclusive language.]

(4) Where a consumer **does not have decision-making capacity** ~~**is not competent**~~ to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where—

(a) it is in the ~~best~~ interests of the consumer; and

Comment: 'Best interests' standards have long been criticised as ambiguous and open to problematic interpretation. As noted in the Law Commission's review of Adult Decision-Making Capacity Law and by UN Committee on the Rights of Persons with Disabilities, substantive concerns have been raised about tendencies for 'best interests' standards to promulgate paternalistic decision-making in ways which are inconsistent with the rights of disabled people. Within the UNCRPD - the term 'best interests' is only used in conjunction with children with disabilities, and not adults. Various terms which better recognise a plurality of views about what comprise 'best' interests, and the importance of prioritising consumer agency in making such determinations have been proposed. A simple and accessible approach could be to replace 'best interests' with 'interests'. While ensuring that the interests of consumers are respected and protected, this approach recognises both the plurality of perspectives, views and

preferences which may be relevant to determining interests, and also that respecting a consumer's will and preferences may entail respecting their agency to choose amongst service options, rather than just being offered a 'best' option. This approach would also promote disabled consumers' agency in relation to choosing to participate in research or to allow students to observe or be involved in service provision in such context with appropriate safeguards.

(b) reasonable steps have been taken to ascertain the **will and preferences ~~views~~** of the consumer~~;~~ and the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider; and

Rationale: The proposal to bring the text from 7(4)(c)(ii) up to 7(4)(b) is suggested in line with Topic 1, proposal c. Clarify the role of whānau and Topic 3, proposal d. Strengthen and clarify the right to support to make decisions.

(c) either,—

(i) if the consumer's **will and preferences ~~views~~** have been ascertained, and having regard to the~~ir **will and preferences those views**~~se, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if **they ~~he or she~~** ~~were competent~~had decision-making capacity; *Tracked changes revisions: proposal to delete second mention of 'will and preferences' is to minimise repetition and increase clarity. Revision to 'were competent' is proposed to be consistent with the HDC's stated aim of removing outdated language about competence*

*Substantive comment: In the context of increasing recognition of the will and preferences of those without decision-making capacity, we have reservations about the blanket requirement for a reasonable provider belief that the **provision of services is consistent with the informed choice a consumer would make if competent**. In contexts where impacts on decision-making capacity are transitory, e.g. due to febrile illness or injury, this requirement is more coherent. However, tāngata whaikaha | disabled people with a more longstanding lack of decision-making capacity have a range of characteristics and lived experiences are also integral to their identity, some of which also impact their decision-making capacity. In such contexts, reaching a reasonable belief about who the consumer would be if competent, and what choices they would make, requires considerable ideation, and potentially exacerbates epistemic inequities between provider and consumer. It is also unclear why and how the anticipated choices of an imagined competent iteration of a consumer in such circumstances should have a role in decision-making. Given that there is already a requirement to act in the (best) interests of the consumer, this additional requirement for a reasonable belief may be unnecessary.*

or

(ii) if **7(4)(c)(i) does not apply ~~the consumer's views have not been ascertained~~**, the provider takes into account **the will and preferences of the consumer to the extent they are ascertained, and** the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

Substantive comments:

1. The aim of strengthening and clarifying the rights of consumers without legal decision-making capacity into account is laudable. However the proposed revisions to 7(4)(c)(ii) - result in rights 7(4)(c)(i) and (ii) no longer referring to distinct contexts in which consumers' will/preferences either have - or have not been ascertained – they now both refer to contents in which will/preferences can be ascertained to some extent. With the current drafting it is not clear what should happen if 7(4)(c)(i) isn't satisfied because a consumer's ascertained will/preferences are to decline the proposed course of treatment and there are no reasonable grounds to believe they would consent if competent. Would 7(4)(c)(i) be considered not to apply for the purposes of 7(4)(c)(ii) in this case - or does the question of application centre on the extent to which will / preferences can be said to have been ascertained? When 7(4)(c)(i) is considered not to apply, would healthcare providers have a novel duty under the revised 7(4)(c)(ii) to seek the views of other suitable persons and, if these differ from the consumer's ascertained will/preferences, evaluate which should be prioritised in decision-making (i.e. second guess the outcome of 7(4)(c)(i))?

2. At present 7(4) states that care may be provided if to adults without decision-making capacity if conditions (a), (b) and (c) are all satisfied. What should health providers do when 7(4)(c) cannot be satisfied (for example because a consumer is brought into an emergency department unconscious and unaccompanied and requires emergency treatment but family and support people are not available to consult)?

3. It is important to be clear in revisions to Right 7 (4) ***whether this right requires healthcare providers not to provide the proposed services in response to expressed will and preferences to decline treatment****. To take a real-world example, a consumer with a paracetamol overdose is brought into an emergency department, after multiple previous admissions for paracetamol overdoses. Records show that the patient has expressed anger and frustration that treatment was provided during previous admissions, and during the current admission has clearly sought to decline treatment (while having very compromised decision-making capacity). If care* ***is*** *provided, an argument can be made that Right 7 (4) has been breached. If care* ***is not*** *provided, in the absence of a comprehensive*

legislative framework, such as the UK's Mental Capacity Act, it is unclear what grounds healthcare providers have to robustly justify the decision not to provide treatment (including in response to coroner's questions for example).

(5) Every consumer may use an advance directive in accordance with the common law.

(6) Where informed consent to a health care procedure is required, it must be in writing if—

(a) the consumer is to participate in any research; or

(b) the procedure is experimental; or

(c) the consumer will be **given medication designed to alter their level of consciousness, or awareness or recall, for the purpose of undertaking ~~the~~ a procedure ~~under general anaesthetic~~**; or *Tracked change revision proposed for clarity*

[Proposed change relates to Topic 5, proposal g. expand the requirement for written consent for sedation that is equivalent to anaesthetic.]

(d) there is a significant risk of **serious** adverse effects on the consumer or the consumer expresses significant concern about the level of risk.

Rationale: Proposed revision in response to research showing that views about what comprises a 'serious' risk differ amongst and between providers and consumers. To address discrepancies in power to define a risk as serious, if a consumer expresses significant concern about risk this should also be addressed and documented.

(7) Every consumer has the right to refuse services and to withdraw consent to services.

(8) Every consumer has the right to express a preference as to who will provide services and have that preference met where reasonable and practicable.

Rationale: Potential revision to recognise some consumer requests (such as requests not to be treated by doctors of specific ethnicities) may not be reasonable.

Right 9 Rights in respect of teaching or research

The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

(9) A provider may not treat or threaten to treat less favourably than other people in the same or substantially similar circumstances —

~~**(a) any consumer of services that are or may be the subject of a complaint;**~~

Rationale: As phrased this is very broad as any service may potentially be the subject of a complaint. Given (9) has been substantively rewritten, perhaps (a) could be deleted for clarity

(b) any person who makes, has made, intends to make, or encourages someone else to make, a complaint; or

(c) any person who provides information in support of, or relating to, a complaint.

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5.3: What are your main concerns about **advancing technology** in relation to the rights of people accessing health and disability services?

There is significant potential for patient rights to be undermined by advances in technology and their utilisation within the health system without undergoing approval/oversight. Clinicians do not necessarily regard novel application of technology in clinical practice as research that requires ethics approval and health providing organisations may have imperfect oversight over what technology is deployed in their services. Alongside the difficulty of determining where data is to be stored and who will access to it when using some increasingly popular tools (e.g. for clinical note-taking), there are questions about how diagnostic/clinical management aids will affect quality of care and how clinical decision-making (and attribution of responsibility) will be affected by their use. The possibility for bias to be introduced or compounded by the use of unsound/black box algorithms is also a source of potential rights violations. These are major issues and require serious consideration. We consider that they warrant exploration beyond what is possible in this consultation.

5.4: What changes, both legislative and non-legislative, should we consider to respond to **advancing technology**?

Publishing and data protection

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

This section provides important information about the release of your information. **Please read it carefully.**

You can find more information in the Privacy Policy at hdc.org.nz.

Being open about our evidence and insights is important to us. This means there are several ways that we may share the responses we receive through this consultation. These may include:

- **Publishing all, part or a summary of a response** (including the names of respondents and their organisations)
- Releasing information **when we are required to do so by law** (including under the Official Information Act 1982

Publishing permission

May we publish your submission? (Required)

☐ Yes, you may publish any part of my submission

~~☐~~ x Yes, but please remove my name/my organisation/group's name

☐ No, you may not release my submission, unless required to do by law

Please note any parts of your submission you do not want published:

Reasons to withhold parts of your submission

HDC is subject to the Official Information Act 1982 (The OIA). This means that when responding to a request made under the OIA, we may be required to disclose information you have provided to us in this consultation.

Please let us know if you think there are any reasons we should not release information you have provided, including personal health information, and in particular:

- which part(s) you think should be withheld, and

- the reason(s) why you think it should be withheld.

We will use this information when preparing our responses to requests for copies of and information on responses to this document under the OIA.

Please note: When preparing OIA responses, we will consider any reasons you have provided here. However, **this does not guarantee that your submission will be withheld.** Valid reasons for withholding official information are specified in the Official Information Act.

☐ Yes, I would like HDC to consider withholding parts of my submission from responses to OIA requests.

I think these parts of my submission should be withheld, for these reasons:

Follow up contact

If needed, can we contact you to follow up for more detail on your submission? (required)

☒ x Yes, you can contact me

☐ No, do not contact me

Further updates

Would you like to receive updates about the review?

☒ x I'd like to receive updates about the review

☐ I'd like to receive updates from HDC about this and other mahi

Thank you

We really appreciate you taking the time to share your thoughts with us. If you have provided your details, we'll keep you updated on progress. If not, feel free to check our consultation website https://review.hdc.org.nz for updates or to contact us if you have any questions. We can be reached at review@hdc.org.nz.