community law
free legal help throughout aotearoa

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Submission on Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights
Community Law Centres Aotearoa – 31 July 2024

Background to CLCA

1. Community Law Centres Aotearoa (**CLCA**) welcomes this opportunity to submit on this review. The contact for this submission is Karen Hodgson, Law Reform Coordinator (karen@clca.co.nz).

2. CLCA is the national body that coordinates and advocates for the 24 Community Law Centres (**CLCs**) across Aotearoa. Our member CLCs work out of over 140 locations to provide free legal help to those who are unable to pay for a private lawyer and do not have access to legal aid. As well as around 300 staff, CLCs' services are supported by over 1,200 volunteer lawyers who run legal advice clinics and deliver free assistance. Each year, these CLCs provide free legal support to 43,000 clients and free law-related education to 24,000 people. In addition, we provide free legal information via the Community Law Manual (the digital version of which has 3,900 views per day on average) as well as an estimated 200,000 people who contact CLCs directly. Te Ara Ture is the nationwide clearinghouse for pro bono legal services, and it is a division of CLCA.

3. CLCs assisted with 265 medico-legal matters in the 2023/34 financial year. Our CLCs can assist clients with complaints to the Health and Disability Commissioner, reviews of decision, Ombudsman complaints, and taking complaints further, in the Human Rights Review Tribunal (**HRRT**) for example. These submissions mainly relate to topic 1 – supporting better and equitable complaint resolution.

4. Auckland Disability Law is a member CLC, and we support ADL's submissions. ADL is the only CLC in Aotearoa New Zealand which solely provides legal services and activities to Deaf and disabled people around their disability-related legal issues.

Topic 1 — Supporting better and equitable complaint resolution

5. The issues identified in the issues paper resonate with CLCs - in particular in relation to delays with HDC investigations (page 20 of the consultation paper). We know that people sometimes choose to avoid an HDC process, in favour of engaging directly with the provider or through an advocate or CLC, because of the delays involved in an HDC investigation. One CLC has a number of cases that have moved through to prosecution by the Director of Proceedings. However, it has taken 4, 6 and 3 years to get to that point. We can only anticipate that delays and backlogs will increase, given that the HDC's funding has been reduced (even though it was clear that more funding was already needed).[1]

6. The same CLC also reported that they struggle to get the HDC to review decisions, despite the HDC having not looked at the complaint and all the relevant information properly. The

[1] 'Terribly short-sighted': Govt cuts struggling health watchdog's budget | Stuff (24 June 2024).

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HDC was going to close a serious complaint about one clinician in particular, until the CLC sourced evidence from overseas to further support the complaint. We support the suggestion that there be a statutory requirement for HDC to review decisions where requested, so that reviews must be undertaken.

7. In relation to the independent Advocacy Service, CLCs say that it appears there are simply not enough advocates to deal with the number of complaints lodged. CLCs have reported that there are very competent and experienced advocates, but that advocates are too stretched. We think that broadening the principles for complaint resolution in the purpose statement to include a focus on outcomes for people is a good way forward, as suggested on page 21, but it can only go so far. We add that it is important that each case is dealt with on its merits and that we do not support any approach that would incentivise or require advocates to close cases in specified times.

8. We think the HDC could be more effective at delivering its intended outcomes, and in particular that "*Systems, organisations and individuals learn from complaints, and quality, safety and consumer experience is improved*".[2] CLCs' experience is that the HDC rarely refers complaints to the Director of Proceedings. The HDC should be referring more complaints, and thought could be given to reviewing the situations for referral to this end.

9. CLCs regularly hear of poor and negligent practice, delays in diagnosis, administration of wrong medication, lack of access to treatment or screening, inexperienced health professionals failing to recognise basic signs of complication or deterioration, misdiagnoses, and life limiting injuries in rest homes where there are inadequate staff/patient ratios. Some CLCs believe that the likelihood of more of these events is increased by delays in getting complaints through the HDC, the overloaded health system, and that the broader complaints system does not appear to result in adequate disciplinary action for health professionals. There is a perception that health professionals are not being held accountable for serious harm.

10. One CLC recently had a case where a number of doctors and the hospital were negligent and the outcome was essentially that so many practitioners beached the Code, none were held individually liable, only the hospital. The hospital committed to making changes (although the CLC says some seem to have reverted) and an apology was to happen. The whānau were offered a hohou te rongo process, but the HDC has been unable to describe what this will involve and the possible outcomes. The unconscious bias that existed and influenced care in this matter was not adequately addressed. The individuals involved did not appear to face any consequences and there is some confusion about what the available remedies are for whānau.

11. We note that to take a matter further to the HRRT to seek financial redress is another time-consuming and exhausting process to undertake following an HDC investigation. Thought could be given to whether there is a more accessible process to award financial redress to complainants in appropriate and serious cases, without having to go through the HRRT. We

[2] See HDC, statement-of-intent-2023-2027.pdf (hdc.org.nz), page 2-3.

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also consider that it may be reasonable to award compensation in serious cases to people who have incurred significant costs for things like accommodation, transport, and days off work, to mount a bedside vigil for a loved one who has suffered because of the negligence of a health professional.

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

12. We support the suggestions to make the Act and the Code more responsive to Māori and tikanga Māori. We don't have anything further to add to these suggestions.

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

13. We also agree that the language in the Code should be amended to better reflect the Disability Convention, and with the suggestions to better enable decision-making support. We made submissions to the Law Commission on its adult decision-making consultations in favour of decision-making support.

Topic 4 — Considering options for a right to appeal HDC decisions

14. We also agree with the suggestions for improving appeal processes (requiring review by the HDC where requested, and lowering the threshold for access to the HRRT to a level akin to the Human Rights Act and Privacy Act, as suggested on pages 44-45 of the consultation document). These changes would be of great benefit to complaint resolution. It should be clear and certain what the next available steps are for people, rather than relying on the HDC's discretion whether to conduct a review of decision. The HRRT should be a more widely available option in line with the other regimes it makes decisions on.

15. We also add that we agree with the increase of the penalty for offences against the Act (s 73) from fine not exceeding $3,000 to a maximum of $10,000 (referred to under topic 5).