Following is my submission regarding the Review of the Health and Disability Commissioner Act 1994 and the Code of Health and Disability Services Consumers' Rights

The complainants should have access to independent medical advice. The HDC gathers the information regarding any complaint, which it reviews and makes a decision regarding the care provided. The complainant is kept fully informed but (in our case) is advised that proceedings are confidential which doesn't allow the complainant the opportunity to seek independent medical advice. The medical professionals under investigation have access to all records and legal advice while the complainant is expected to analyse and comment on complicated medical discussions with no assistance. There is a clear imbalance between the complainant and the medical professionals which should be addressed. An interim report is produced by the HDC but is still confidential. It is only after the final report is issued by the HDC that the complainant has the opportunity to discuss the report with medical professionals and research medical journals. If there are comments in the final report that the complainant would have wished to comment on during the investigation it is too late.

As the complainant does not have to opportunity to seek independent medical advice to allow them to make an informed comment on the report before it is finalised there should be an appeals process to allow for a review of any parts in the final report the complainant regards as contentious. The review should include the original decision maker and an independent investigator. The time frame for this appeal process should allow time for the complainant to research the HDC report and gather the appropriate evidence to support any discussion – I would recommend 12 months.

It is my understanding that there is an agreement with the Coroners office that the HDC will investigate any complaint regarding medical professionals and will accept their findings. Unfortunately, the HDC investigation doesn't have the scope of a Coroners investigation and some issues which may have contributed to the problems with the care provided are not covered. In our case these included

- Overcrowding in the emergency department which included beds and staffing
- The focus on reducing patient time in the emergency department – The SCDHB was the greatest improver of NZ health boards at the time
- The influence of prejudice and bias against some patients

Either the scope of the HDC investigation should be increased or the Coroner be given this additional information to allow for a more informed decision regarding the need for a Coronial inquiry.

NZ is a small country and many of the medical professionals belong to the same professional bodies and attend the same conferences/seminars. In cases of major incidents where major injury or death occurs an international experts opinion should be sought. This should also

happen where there are differing views expressed by the NZ medical professionals involved in the investigation as one of the main objects is to improve the outcomes for NZ patients in the future rather than keeping to the status quo.