ELDER LAW
IN NEW ZEALAND

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be able to continue living in their own place of residence in their later years. In the event that this is no longer possible, the alternative would be for older people to live in a sheltered and supportive environment, which is as close to their community as possible, in both the social and geographical sense.

3.5 Ageing in place in New Zealand

Within New Zealand, ageing in place is defined as the ability of people to “make choices in later life about where to live, and receive the support to do so”.

Despite this broad categorisation, ageing in place often refers to the ability of older people to remain dwelling in the community; residential care in the form of either rest homes or hospitals is specifically excluded.

3.5.1 Factors that support ageing in place in New Zealand

Ageing in place or supporting an older person to remain living in their own home is invariably dependent on a number of key areas including both formal (health care and social support) as well as informal (carers, family, friends and local communities) support structures. The amount of choice that individuals can have available to them is dependent on personal and environmental factors. Factors such as income levels, housing, safety and security, family support, access to community-based support or social services, mobility and health, and access to appropriate and timely information can influence their perceptions and the range of options available to them and their families.

Despite the availability of support, the decision to remain living in one’s own home or to relocate to residential care involves a complex series of decisions by individuals, their families and their healthcare teams.

3.5.2 Evidence of the benefits of ageing in place

A study of an ageing in place intervention, which involved nurse coordination of a home-based support service, matched 78 community-dwelling older people with 78 rest home residents according to activities of daily living (ADL) performance (such as washing and dressing, bathing, and toileting), cognition and age.

The ageing-in-place group demonstrated statistically significant improvement in all clinical outcomes (cognition, depression, ADL function and incontinence) when compared to the residential care group. Furthermore, all

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44 Organisation for Economic Co-operation and Development Caring for Frail Elderly People New Directions in Care (OECD, Paris, 1994).
46 Many of these issues are discussed in chs 5, 9 and 13 and 14.
outcome scores deteriorated for the residential care group but stabilised or improved for the ageing-in-place group.

Despite the many benefits of ageing in place, a New Zealand study revealed a large number of older people were unnecessarily being referred for entry into residential care. The study investigated referrals requesting rest home or private hospital placement for community-dwelling older people, and was undertaken over a three-month period. Results demonstrated that, of the total 158 patients referred for entry into residential care, 42 per cent were managing in their own home at the six-month follow-up. The authors concluded many older people can manage at home for longer than perceived by the referring doctor.

Further support for this is provided by a longitudinal study across three New Zealand cities that investigated why older people with high levels of disability entered residential care and who were the major decision-makers relating to the entry into care. Significant factors were found that increased the likelihood of residential care entry for older people. These included: high scoring dependency on the instrumental activities of daily living scale; and an adult child living some distance away. The evidence from the study participant groups highlighted contrasting views about who was important in the decision-making about entry to residential care. Older people who had moved into residential care generally thought that doctors had played a key role, whereas family members and professionals tended to consider that the decision to move was made by caregivers. The authors concluded that older people with good levels of knowledge about services and support, and good housing, were more likely to continue to live in the community.

3.5.3 Housing policy developments

Many countries have gone on to encourage and explore specific housing initiatives designed to reduce institutional care entry. For example, the Netherlands developed the “Senior Citizen Label”, which is a quality certificate only awarded to those new housing developments which meet a large number of different requirements, several of which are intended to ensure that the older person should not have to leave their dwelling when disability occurs. A group of researchers studied the accommodation options in later life in New Zealand

49 Diane Jorgensen and others “The providers’ profile of the disability support workforce in New Zealand” (2009) 17 Health and Social Care in the Community 396.
51 Diane Jorgensen and others “Why Do Older People in New Zealand Enter Residential Care Rather than Choosing to Remain at Home, and Who Makes that Decision?” (2009) 34 Ageing Int 15.
within a context of the government policy of reducing residential care places. The resultant report focused heavily upon those for whom ageing in place is likely to be most problematic, namely the poor, those who rent, older people from the Māori and Pacific populations and those with high dependency needs. A key conclusion of the report was that ageing in place is clearly a favoured approach in New Zealand government policy; however, staying in a long-term family home may not be the best option in all circumstances. Nevertheless it is likely that the vast majority of older people in the future will be ageing in place rather than in institutional care. The overall international picture is of a strong emphasis on ageing in place and a growing appreciation of the problematic nature of this for some groups and especially those in poor housing conditions.

The notion of ageing in place is reflected very clearly by the policies of successive governments, who have increasingly focused on primary care development.

3.5.4 Relocation of services

There are a number of key evidence-based concepts that have emerged that aim to support ageing in place, whilst also relocating services to the community. These include: care management, restorative home support, appropriate assessment, intermediate care and appropriate technology as well as a focus on staff competency as opposed to a pre-occupation with disciplines (that is, finding the right person for a job, not the right health professional discipline).

3.6 Other key developments in New Zealand

A number of other key developments have occurred over the last decade to better support older people to age in place. In the main, these include:

- a focus around improving the quality of HCSS;
- better coordination of services, namely through the establishment of care managers; and

52 Judith Davey and others Accommodation Options for Older People in Aotearoa New Zealand (Centre for Housing Research Aotearoa New Zealand, June 2004).
54 Judith Davey and others Accommodation Options for Older People in Aotearoa New Zealand (Centre for Housing Research Aotearoa New Zealand, June 2004).
56 Ministry of Health Better, Sooner, More Convenient Health Care in the Community (Ministry of Health, 2 June 2011).
5.2 Determining decision-making capacity

In theory, persons who have capacity have an absolute right to make decisions about their lives and interests in any realm of activity. In practice, however, there are many constraints, both formal and informal, on people's ability to enjoy and express their autonomy. Capacity is often used as an indication of whether people have sufficient understanding to make a valid decision about particular matters – often in connection with medical treatment.

5.2.1 The presumption of legal competence

The well-settled principle that all adults are presumed to be legally competent unless a court determines otherwise is reflected in Cardozo J's comment in Schloendorff v Society of New York Hospital:

“Every human being of adult years and sound mind has a right to determine what should be done with his own body”. It follows that touching other persons without their consent is unlawful, whether or not it results in harm to them or is intended to be for their benefit. This principle applies as much in a clinical context as any other setting. Being under compulsion does not justify an otherwise unlawful touching or invasion of a person's personal space. While patients and people subject to compulsory care legally have the right to take part in decisions relating to their care, the ability to consent (or refusal to do so) must be demonstrable before it will be recognised and acted upon by caregivers – at least where they are in an institutional setting. This generally requires persons to show that they are aware of the benefits, burdens and risks of any decision they make.

5.2.2 Capacity and informed consent

Capacity often reflects the ability to give informed consent. Whether older people are genuinely able to give informed consent is something of a “moveable feast”. In determining older persons’ capacity to give informed consent, account needs to be taken of a range of personal and social factors (not just psychosocial

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5 Schloendorff v Society of New York Hospital 211 NY 125, 105 NE 92 (1914) at 130, 93. See ch 6 for a discussion of legal competence in the context of end of life decision-making.
6 Ethel L Mitty “Decision-Making and Dementia” Try This: Best Practices in Nursing Care to Older Adults with Dementia (Hartford Institute for Geriatric Nursing, New York, 2012) at 1.
impairments) which can affect their ability to choose and make decisions. Institutional pressure, for example, can affect or inhibit unconstrained decision-making that may have little or nothing to do with capacity. Institutionalised patients may technically have the right to have a say in planning for their discharge but this may be subverted by clinical decisions made without their knowledge that reflect the views of clinical staff about efficient management rather than “rights-based” care.

5.3 The New Zealand Bill of Rights Act 1990

In a climate in which pragmatic, fiscal considerations can prevail in the care and management of the elderly and vulnerable, it is important to avoid infantilising and depersonalising older people. This can occur where their actual decision-making capacity is subordinated to institutional realities and clinical paternalism. Nevertheless there are legislative protections which are aimed at protecting the fundamental rights and freedoms of citizens, including the elderly and those who experience disability based on sickness and physical or mental impairment. Foremost amongst these protections is the NZBORA.

The NZBORA affirms certain rights in the International Covenant on Civil and Political Rights in the domestic setting by establishing a set of standards that must be observed by the New Zealand executive, judiciary and legislature.

While the rights are considered fundamental, they can be limited in certain situations if the restriction is reasonable and able to be justified in a fair and democratic society. Thus even though the NZBORA applies to all adult New Zealanders, age-related incapacities can dictate some diminishment of enjoyment of the rights and freedoms in the NZBORA. For example, while everyone has the right to freedom from arbitrary detention, for many elderly people who are incapacitated, some measure of detention may be inescapable as part of the management of their care. If it is not to be considered arbitrary, it must be linked to a bona fide, demonstrable need (such as assessment and treatment for a mental disorder or safe containment) or a risk factor (such as wandering).

5.3.1 The right not to be arbitrarily detained

While advancing incapacity can mean a need for detention which may, in turn, inhibit the enjoyment of other rights such as freedom of association and freedom of movement, this needs to be considered in the context of everyone’s

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9 New Zealand Bill of Rights Act 1990 (NZBORA), s 5.
10 NZBORA, s 22.
inalienable right – irrespective of whether or not he or she is detained – to be treated with, and accorded, the inherent dignity of the human person. Above all, this right should inform all dealings with incapacitated older people subject to any form of detention. It is not enough that the right is affirmed in principle. It must be given expression in the day-to-day care and management of the individual.

5.3.2 The right to refuse treatment

A further NZBORA right that may directly apply to the situation of many older people is the right set out in s 11, which states that “[e]veryone has the right to refuse to undergo any medical treatment”. As many incapacitated older people are detained by the authority of the state, this provision provides protection against arbitrary treatment when the individual refuses, or lacks the capacity, to consent personally. Treatment can only be imposed on a person in such a situation if it is expressly authorised by law, or where it is necessary to save the person’s life. As noted already, any treatment or medical intervention where the recipient does not consent may amount to an assault and render the actor liable to a civil action for damages or criminal prosecution.

As with other rights and freedoms in the NZBORA, the right to refuse treatment is a qualified right and may be overridden by other statutory authorities such as the MHCATA and the PPPRA. This inevitably raises the issue of how a right to refuse treatment can be treated as meaningful when a person either lacks or has substantially impaired ability to make decisions.

The right to refuse treatment reflects a particular aspect of personal autonomy. Everybody is assumed to be an autonomous agent and to possess the ability to make decisions about his or her life. To challenge or remove that ability therefore represents a fundamental intrusion into an individual’s rights and freedoms, and any power that allows it needs to be exercised sparingly. This proposition applies as much to people who are totally incapacitated as to those whose capacity is merely impaired in some way.

There is no formal means of assessing whether a person is, or is not, competent to consent to treatment, although the courts have attempted to establish principles. For example, in Re MB (Medical Treatment),11 the Court considered that the inability to make a decision (incapacity) exists when a person is unable to comprehend and retain information which is material to a decision, especially the likely consequences of not having the treatment, or where he or she is unable to use the information and weigh it up as part of the balancing process in arriving at the decision.12 Applied to an elderly person suffering, say, from mild dementia, this might mean that while the person may have had the capacity to make a

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decision to refuse a buccal swab, because “I do not like doctors putting things in my mouth”, he or she may have lacked capacity to refuse life-saving surgery to repair an aortic aneurysm. The reason would be that the person lacked the capacity that was commensurate with the gravity of the decision he or she purported to make.

It is also generally accepted that treating or imposing treatment against a person’s wishes can impact negatively on the outcome of the treatment and impede the development of a therapeutic relationship between the patient and the professional. In jurisdictions such as the United Kingdom, mental health legislation permitting the compulsory treatment of people with mental illness has consistently been read down to ensure compatibility with the European Convention on Human Rights.13 This has led the English Court of Appeal to find that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment.14 Elderly persons are also beneficiaries of that right to the extent that they are capable of understanding and retaining information relevant to the decision to be made, and able to actually make a decision based on that information. In this area at least, the law now consistently affirms the idea of patient autonomy and the view that intervention, where consent is lacking, should only be permissible in the case of those who lack capacity.15

The right in s 11 of the NZBORA is not expressed as a right not to be treated without consent but rather as the right to refuse treatment. This seems to imply that people are conscious and have the ability, even if impaired, to appreciate that treatment is being offered to them,16 raising the question of whether the right is available to people who are unconscious or incapable of appreciating the treatment. The authors of one text on the NZBORA consider that a purposive interpretation of s 11 embraces not just the right to refuse but the right not to be medically treated without consent.17

12 For the application of definition by the courts, see the cases listed in Andrew Butler and Petra Butler The New Zealand Bill of Rights Act: A Commentary (LexisNexis, Wellington, 2005) at [11.9.3].
15 See Re B (consent to treatment: capacity) [2002] EWHC 429 (Fam).
16 Paul Rishworth and others The New Zealand Bill of Rights (Oxford University Press, Melbourne, 2003) at 255.
payments and overseas pension or benefit payments made directly into their own bank accounts.

10.6 Extra help for older people

Older people, including those who do not qualify for NZ super, may be able to get extra financial help in the form of: 108

- the accommodation supplement;
- the disability allowance; or
- temporary additional support for essential living costs.

10.6.1 Applying for extra help

In order to apply for extra help, older people will need to complete an Extra Help Application (which includes applications for the accommodation supplement, disability allowance and temporary additional support), 109 attend an interview at a Work and Income service centre and bring identification documents to the interview. 110

The general part of the Extra Help Application requires applicants to supply Work and Income with information about:

- themselves;
- their spouse or partner;
- any income that they have received during the 52 weeks before applying for extra help; and
- their bank account and tax details (because applicants for extra help are subjected to means testing).

The form also requires applicants to supply Work and Income with specific information relevant to the type of extra help for which they wish to apply. What follows is an outline of the eligibility criteria and other requirements that need to be met to successfully apply for each form of extra help.

108 “Extra Help” in its various forms may also be available to help older people with electricity costs if they fall within the definition of vulnerable or medically dependent consumers: see Electricity Authority Guideline on arrangements to assist vulnerable consumers (version 2.1, 24 March 2011) at [34]-[41] and Electricity Authority Guideline on arrangements to assist medically dependent consumers (version 2.1, 24 March 2011) at [27]-[32].

109 The form can be completed online, downloaded from the Work and Income website, or collected from a Work and Income service centre.

110 New Zealand-born applicants must bring identification documents displaying their full legal name and date of birth, and overseas born applicants need to supply identification documents and documents proving their lawful residence in New Zealand. All applicants must also supply two other documents that are at least two years old, supporting their identity, and (where relevant) full birth certificates of their children, proof of any name change, their marriage or civil union certificate, a form or letter from Inland Revenue showing their IRD number, and gross income details for the 52 weeks immediately prior to the application.
10.6.2 Accommodation supplement

(1) The purpose of the accommodation supplement

The purpose of the accommodation supplement is to “provide targeted financial assistance to help certain people with high accommodation costs to meet those costs”.\(^{111}\)

Section 61E(1) of the Social Security Act 1964 defines accommodation costs as the costs:

- of renting premises;\(^{112}\)
- associated with home ownership (including home ownership by joint tenants or owners in common);\(^{113}\) or
- of board or lodging.\(^{115}\)

(2) Eligibility criteria for the accommodation supplement

To be eligible for the accommodation supplement, older people must pass an accommodation costs, an income and an asset test.\(^{116}\) Their accommodation costs must be greater than a specified sum,\(^{117}\) and their income and assets (as well as those of their spouse or partner)\(^{118}\) must be less than a specified sum.\(^{119}\)

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\(^{111}\) Social Security Act 1964, s 61DH.

\(^{112}\) However, service costs (for example, the costs of electricity and gas supply, telephone network or broadband Internet connections), including the rent and any arrears, are excluded from the definition of accommodation costs and do not form part of any accommodation supplement payments made to renters.

\(^{113}\) Those costs include essential repairs and maintenance, local authority rates, water rates, house insurance premiums and mortgage payments. Service costs and any arrears are excluded from the definition of accommodation costs and do not form part of any accommodation supplement payments made to owners of premises. If the applicant for the accommodation supplement is eligible to receive debt insurance payments or health or disability insurance payments, then the applicant may be granted the benefit subject to the condition that it may be required to be repaid if these payments are made to the applicant or some other person on behalf of, or for the benefit of, the applicant or a member of the applicant’s family: Social Security Act 1964, ss 61E(1) and 68A(1) and (5)–(7). The amount of accommodation supplement that applicants who are homeowners receive may also be affected if they receive a rates rebate from their local council: see Work and Income Need extra help with costs? (factsheet JO BS0005 - APR 2014) at 3.

\(^{114}\) There are specific rules for allocating accommodation costs to applicants for the accommodation supplement who are joint tenants or owners in common of premises. These rules are in the proviso to s 61E(1) and in s 61EB of the Social Security Act 1964.

\(^{115}\) Arrears of board or lodging payments are excluded from the definition of accommodation costs and do not form part of any accommodation supplement payments made to renters.

\(^{116}\) See Work and Income Need extra help with costs? (factsheet JO BS0005 - APR 2014) at 4.

\(^{117}\) Social Security Act 1964, s 61EC(5) states that the income and assets of a person who is married or in a civil union or de facto relationship include the income and assets of that person’s spouse or partner.
NZ super recipients and older people who do not receive NZ super (or any other benefit) are eligible to apply for the accommodation supplement if they:

- are ordinarily resident in New Zealand;\(^{120}\) and
- meet the accommodation costs, income and asset tests.

Beneficiaries, including those who receive NZ super, are not entitled to receive the accommodation supplement if:

- they are single and their income is greater than a specified amount;\(^ {121}\)
- they are married or in a de facto relationship or civil union, and the combined income of the couple is greater than a specified amount;\(^ {122}\)
- their accommodation costs include payments made at a concessionary rate under a mortgage to Housing New Zealand or the Crown in right of Te Puni Kōkiri;\(^ {123}\)
- they (or their spouses or partners) pay rent for a property owned or managed by Housing New Zealand or provided by registered community housing providers;\(^ {124}\)
- they are residents assessed as requiring long-term residential care in a hospital or rest home in respect of whom a funder is paying some or all of the cost of contracted care services;\(^ {125}\) or
- they are the spouses or partners of persons who are already receiving the accommodation supplement.\(^ {126}\)

(3) Applying for the accommodation supplement

The Accommodation Supplement Application Form (which is incorporated into the Extra Help Application) must be completed within 20 working days of the date that the applicant first contacted Work and Income.\(^ {127}\) In addition to the general information about themselves and their spouse or partner that they are required to supply in the general part of the Extra Help Application form,
applicants for the accommodation supplement must also provide Work and Income with an itemised list of both their cash\(^{128}\) and their non-cash assets, and (if relevant) those of their spouse or partner.

The Accommodation Supplement Application Form also requires applicants to inform Work and Income (supported by documented proof) of the amount of money that they pay in:

- rent;
- board; or
- home ownership costs.

If the application is successful, the amount of the accommodation supplement granted to applicants is determined by a statutory formula.\(^{129}\)

(4) G rounds for reviewing, refusing, reducing, or terminating the accommodation supplement

Pursuant to s 81(2) of the Social Security Act 1964, the Chief Executive of MSD has the discretion to review any accommodation supplement (among other qualifying benefits). The Chief Executive may then suspend, terminate or vary the supplement depending on the outcome of the exercise of that discretion.

The accommodation supplement may also be refused, paid at a reduced rate or terminated if applicants for, or recipients of, the accommodation supplement or their spouses or partners:

- have not realised any assets available for applicants’ personal use;\(^{130}\)
- have directly or indirectly deprived themselves of income or property with the result that they have qualified for the accommodation supplement or received it at an increased rate;\(^{131}\)
- are not ordinarily resident in New Zealand;\(^{132}\) or
- are unlawfully resident or present in New Zealand.\(^{133}\)

128 Cash assets are defined in Social Security Act 1964, s 61E. Non-cash assets are not defined in the Social Security Act 1964 but the Accommodation Supplement Application Form provides examples of such assets.

129 Social Security Act 1964, ss 61E, 61EC and sch 18, pts 1 and 2.

130 Social Security Act 1964, s 61EC(4).


132 Social Security Act 1964, s 74(1)(a).

133 Social Security Act 1964, s 74A(1)(a).

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13.1 **Introducing a human rights approach**

A fundamental founding principle that “all human beings are born free and equal in dignity and rights” underpins other human rights.\(^1\) Inherent dignity is critical to the relationship between older people and those that care for them in paid employment in New Zealand and elsewhere. In 2012, the New Zealand Human Rights Commission (NZHRC) undertook a major national inquiry (the NZHRC inquiry) into equal employment opportunities in the aged care sector. Central to the inquiry report, *Caring Counts*,\(^2\) was the concept that the value society places on older people is connected to the value we place on those who care for them, and that human rights are universal, indivisible and interdependent.

To effectively examine emerging issues in the aged care workforce, then, the interdependence of several aspects of human rights need to be identified and analysed. First there are the rights of older people to health, to care, to safety and to autonomy of decision-making, and second there are the rights of the workforce to a reasonable standard of living, to equal pay, to access to training, and to decent conditions of work. In addition, the increasing corporatisation of aged care service delivery highlights the relevance of the newer human rights and business agenda to the activities of providers.

13.2 **The rights of older people**

Because human rights are universal by definition, the International Bill of Rights\(^3\) and other international human rights standards and principles apply to older people as much as they do to younger people and to all men and women. Emergent debate suggests, however, that specific human rights features relating to older people have not been adequately addressed by existing human rights instruments, including the newest international human rights convention, the Convention on the Rights of Persons with Disabilities.\(^4\) One of the areas identified by the Office of the High Commissioner for Human Rights as “all but completely overlooked by the human rights system” are the “rights issues arising in the delivery of home, institutional or residential care services”.\(^5\)

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\(^2\) Human Rights Commission *Caring Counts* (May 2012).  
The United Nations General Assembly established, in December 2010, the Open-Ended Working Group on Ageing for the purpose of strengthening the human rights of older people. Its mandate is to consider the existing international framework, its gaps and ways to address these, including by considering, as appropriate, the feasibility of further instruments and measures. To date it has worked to highlight the distinctive experience of older people globally, and in some regions (Africa, the Americas and Europe) regional working groups have developed initiatives and non-binding instruments in a bid to make progress.

The Asia Pacific Forum, a regional coordinating mechanism for national human rights institutions has encouraged the NZHRC to raise support with the government for the work of the Open-Ended Working Group on Ageing. New Zealand’s international leadership, demonstrated in recent years with the development of the disability convention, is not yet apparent in relation to a possible international treaty on older people. Prompting governmental support is a potentially fertile area of activity for civil society groups such as Grey Power and Age Concern and other non-governmental organisations interested in the human rights of older people.

The United Nations Principles for Older Persons are not legally binding but are a guide to how the rights of older people should be respected. The 18 principles are grouped under five themes of independence, participation, care, self-fulfilment and dignity. In relation to care, the principles state that older people should benefit from family and community care as well as having access to health care to help them to maintain or regain their optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness. There is an internationally enshrined right to the highest attainable standard of physical and mental health. This includes a system of health protection with health facilities, goods and services which are available, accessible, acceptable and of good quality. An aspect of quality services will require, among other things, skilled and trained medical personnel. This leads to questions about who cares for older people, which is a focus of this chapter.

10 For further discussion, see ch 8.
of the rebate arrangements should be made to residents when they sign their rest home admission agreement.

14.6 Alternative options and future trends

Traditionally, retirement villages provided for relatively affluent older people. However, in New Zealand there is an increasing interest in developing alternative cheaper housing solutions for older people. This is a response to the dramatic rise in the number of older people, the shortage of affordable housing in New Zealand's larger cities, and councils ceasing to provide or reducing the level of pensioner housing. Numerous housing developments throughout New Zealand use the term “retirement village” but are not registered as retirement villages; consequently, residents of these developments do not enjoy many of the protections offered by the RV Act. These developments will usually be freehold or unit title developments with an age restriction on entry.

Abbeyfield-style accommodation is increasing in popularity. This is shared living, with each resident renting his or her own bedsit room with en suite in a large (often purpose-built) house. A housekeeper, who may reside on-site, cooks at least one main meal daily and tends to the communal areas. Normally the number of residents will be limited to approximately 10. The concept of providing rest home level care to seniors in Abbeyfield-style accommodation has also proved successful in the United States.

In Australia, another option is the granting of a ground lease to a resident who then pays for a relocatable home to be placed on the site. This option is not dissimilar to a long-stay mobile home park and it tends to be more affordable than traditional retirement villages.

14.7 Possible legislative changes for retirement villages

Each state in Australia has its own legislation relating to retirement villages. Most are more prescriptive than the New Zealand regime. Recently the Retirement Villages Amendment (Standard Contract) Regulation 2013 was released in New South Wales. The Regulation introduces mandatory standard forms for retirement villages, being a general inquiry form and a village contract. The Regulation also revises the mandatory standard form of disclosure statement.

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87 New Zealand Aged Care Association and Retirement Villages Association “Subsidy in ORAs: The Agreed Regime as of 1 July 2013” (2013). A copy of this protocol is available at Auckland District Health Board “Subsidy in ORAs” <www.adhb.govt.nz>.
88 See Abbeyfield New Zealand <www.abbeyfield.co.nz>.

See more - www.thomsonreuters.co.nz
previously in use in New South Wales. Use of the standard village contract became mandatory on 1 October 2013. Additional terms may be added to the contract, but they must not be inconsistent with any term in the standard contract.

There has been criticism in New Zealand that the variety of retirement village documentation in the market makes it difficult for intending residents to draw comparisons between villages. When the New Zealand legislation is next reviewed, consideration will no doubt be given to the approach being taken in Australia.

14.8 Key matters for intending residents to consider

Moving into a retirement village or rest home is an important decision with long-term personal and financial consequences. Before making any commitment, intending residents and their advising solicitors should first address whether residents simply want an accommodation and lifestyle option, or if they have further needs (either now or in the future) for support services which may include healthcare. Additional matters for consideration when moving into a retirement village may include the following questions:

• What are the costs associated with entry?
• Are the weekly or monthly fees affordable, and for how long can the intending resident afford to continue paying them?
• What costs aren’t covered by the weekly or monthly fees? These might include compulsory charges (such as utility charges) as well as optional charges for additional or enhanced services.
• What are the resident’s key obligations and responsibilities while living in the village (for example, in respect of maintenance)?
• What services and facilities are available?
• What limitations or rules might affect the intending resident’s lifestyle?
• What will happen if the intending resident wants to transfer from his or her retirement village unit to a different type of unit, or to a rest home?
• What are the costs associated with exit, and (where the resident is paying a capital sum) when will he or she (or his or her family) receive the exit payment?
• When villages are compared, what do residents in each village say about their experiences?

Before deciding on or moving into a care facility, the intending resident should consider:

• obtaining a health assessment from a needs assessment and services coordination agency. This will determine whether he or she is eligible for government funding for care;
• visiting a number of rest homes before making a decision;
Chapter 19

DYING WITH OR WITHOUT A WILL

Professor Nicola Peart*

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19.1 Introduction

For most people, the preparation for eventual death involves deciding what to do with their property. Should they make a will? If so, how, and on what terms? Do they have any obligations to provide for family members or friends? What if their mental capacity is diminishing? What happens if they do not make a will? This chapter will address these questions. It begins by explaining what happens to a person’s assets if they die without leaving a valid will. The chapter then goes on to discuss the mental and formal requirements for making a valid will and what will-makers can do to minimise the risk of their will being challenged after their death. While the discussion applies to all will-makers, the comments on assessing testamentary capacity are of particular relevance to older people where capacity may be compromised or subsequently challenged.

19.2 Dying without a will

If a person dies without making a will or if the will is invalid, he or she is said to die intestate. If there is a valid will, but it fails to dispose of all of the estate, there is a partial intestacy. The Administration Act 1969 sets out how a deceased’s estate is to be distributed on a full or partial intestacy. The Administration Act does not apply to Māori land. The Te Ture Whenua Maori Act 1993 (TTWMA) determines the distribution of any interest in Māori land that forms part of a deceased estate.

19.2.1 Intestate succession under the Administration Act 1969

When people die without leaving a valid will, the distribution of their estates depends on the family members they leave behind. Section 77 of the Administration Act provides three tiers of intestate succession. The first tier is where the deceased leaves a surviving spouse or partner. The second tier is where the deceased has no surviving spouse or partner, but leaves “issue”, which is the term used in the Administration Act to denote children and more remote descendants in the direct line, such as grandchildren or great-grandchildren of the deceased. The third tier is where the deceased leaves neither a surviving spouse or partner nor descendants.

(1) Tier one: Surviving spouse or partner

A surviving spouse, civil union partner or de facto partner inherits all of the estate (other than Māori land) if the deceased spouse or partner leaves no issue and no parents.

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1 Administration Act 1969, ss 77–79.
3 Administration Act 1969, s 77 (1).
20.2 Abuse, neglect and exploitation

It is difficult to find legal definitions of the terms “abuse”, “neglect” or “exploitation”. The World Health Organization (WHO) Toronto Declaration on Elder Abuse described abuse as “a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person”. Therefore, for the purposes of this definition, it is the relationship of trust that takes wrongdoing or omission into the realm of abuse.

Exploitation is defined in cl 4 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996 (the Consumer Code) as “any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence.” Reference to “neglect” in the Crimes Act 1961 is in the context of neglecting a legal duty. There must be a duty to fulfil a need or provide a service. While these terms are not predominantly legal concepts, there are several statutory protections and remedies which, although not developed with exclusive attention to the elderly, have useful application.

20.3 Protections for vulnerable adults

20.3.1 The amendments to the Crimes Act 1961

The Crimes Act contains provisions aimed at the “vulnerable adult”, a term which was introduced to the principal act on 19 March 2012, through s 4(1) of the Crimes Amendment Act (No 3) 2011:

“vulnerable adult, for the purposes of sections 151, 195, and 195A, means a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person.”

Section 6 of the amendment Act also inserted a new s 151 into the Crimes Act, and s 7 of the amendment Act inserted new ss 195 and 195A. These sections all contain the term “vulnerable adult” and their effect will now be discussed.

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1 World Health Organisation The Toronto Declaration on the Global Prevention of Elder Abuse (17 November 2002). This has been adopted by Age Concern “Elder Abuse and Neglect Prevention” <www.ageconcern.org.nz>, and the Madrid indicators arising from it have been used by the Office of the Auditor General “Using the United Nations’ Madrid indicators to better understand our ageing population” (10 October 2013) <www.oag.govt.nz>.

2 Similar language is also found in the equitable principles of undue influence and unconscionable bargains.

3 Prior to amendment by the Crimes Amendment Act (No 3) 2011, s 195 referred to “neglect of a child”, but neglect was not defined.

4 For further commentary on the amendments to the Crimes Act 1961, see ch 6.

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The new s 151 of the Crimes Act 1961

The wording replicates the earlier version of s 151, which imposed a duty to provide the necessaries of life to “any other person” who was constrained by the same factors. The new s 151 reads:

“Every one who has actual care or charge of a person who is a vulnerable adult and who is unable to provide himself or herself with necessaries is under a legal duty—

“(a) to provide that person with necessaries; and

“(b) to take reasonable steps to protect that person from injury.”

No decisions have been made under the revised section. The charges laid prior to the amendment have sat alongside more serious counts of manslaughter or murder, and have largely concerned children rather than adults as victims. However, the 2014 District Court decision of R v Quinn involved the conduct of a woman towards her elderly mother, who was admitted to hospital with severe dehydration and ulcerated, infected and necrotic leg wounds into which the covering blankets had grown and in which maggots could be found. His Honour Judge Down found that she was unable by reason of age, disability and sickness to care for herself or withdraw from her daughter’s care, that the defendant had a legal duty to provide the necessaries of life and that she neglected that legal duty. There was some evidence that the victim had earlier declined some interventions, but his Honour found that there was “no lawful excuse to fail to provide adequate … nourishment and hydration … [and] that the deterioration of the deceased’s health must have been obvious to the defendant for some time.” The medical evidence was that the extent of the infection to the legs and the degree of malnutrition and dehydration was so severe that her life was endangered. His Honour concluded that the victim “was in such a poor state of care and health that any person, reasonable or not, would conclude that she had been very badly neglected” and this was “clearly a major departure from the standard of care expected of a person with this legal duty of care”.

Unlike its predecessor, the new s 151 refers only to “necessaries”, and omits “of life”. Previously, criminal responsibility arose where death was caused, or life endangered or health permanently injured, by the omission to provide the...

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5 The only change is the substitution of “mental impairment” for “insanity”.
6 An exception is R v Hamer [2005] 2 NZLR 81 (CA), a case concerning the failure of a man to obtain medical assistance for his wife, whom he knew had ingested a large dose of methadone.
8 R v Quinn [2014] DCR 225 at [100].
9 R v Quinn [2014] DCR 225 at [106].
necessaries. In R v Lunt, the Court of Appeal had held that the “necessaries of life” referred only to goods and services (food, clothing, housing, medical care) necessary to sustain life.\textsuperscript{10} According to parliamentary debates during the first reading of the 2011 Bill, the revision of s 151 contemplated that a carer who provides a vulnerable adult with the basic necessaries of life, but who ties the person to a bed, may be charged under this section.\textsuperscript{11}

The amendment also marks a change from the common law, which imposed no protective obligation, as articulated by Blanchard J in Lunt:\textsuperscript{12}

“\[21\] The common law has never in general terms imposed upon one person a duty to take steps to prevent harm occurring to another. It may be morally repugnant behaviour if, for example, someone simply stands by and watches another, for instance a child, drown in circumstances in which rescue could easily have been effected, but, speaking again in general terms, it is clear that the bystander is under no legal duty to undertake a rescue, or otherwise to protect the drowning person from harm, and the common law provides no legal sanction for omitting to render aid. A duty to take steps which are reasonable in the circumstances to protect or save another person from physical harm is imposed only where a particular relationship or situation exists”.\textsuperscript{13}

Since March 2012, a positive legal obligation to protect from harm has been enshrined within statute by s 151(b) of the Crimes Act, therefore widening the net to attach criminal liability not only to failure to provide necessaries but also to take reasonable steps to protect from injury. The words “actual care” appear for the first time in this revised provision and in s 195, discussed below. The former s 151 referred only to having “charge” of another, and did not include “actual care”. The addition was not debated in Parliament, but given the broadening of the responsibility to “necessaries”, and the extension of criminal responsibility to protection, it seems that requirement of actual care needed to be specified.\textsuperscript{15} It implies physical proximity, contact and involvement.\textsuperscript{14}

\begin{itemize}
\item \textsuperscript{10} R v Lunt [2004] 1 NZLR 498 (CA) at [20]–[26].
\item \textsuperscript{11} (14 September 2011) 675 NZPD 21325.
\item \textsuperscript{12} R v Lunt [2004] 1 NZLR 498 (CA).
\item \textsuperscript{13} Whereas the previous s 151 carried a penalty of seven years' imprisonment, the new provision is silent as to penalty for an offence under s 151.
\item \textsuperscript{14} As opposed to an individual who has the “care” of a child or vulnerable adult simply by virtue of a parenting order made under the Care of Children Act 2004 where the “day-to-day care” is shared, or a donee of enduring power of attorney for personal care and welfare, or a court-appointed welfare guardian pursuant to the Protection of Personal and Property Rights Act 1988.
\end{itemize}