The Hon Craig Knowles
Minister for Health
Parliament House
Macquarie Street
Sydney NSW 2000

Dear Minister

Report of activities for the year ended 30 June 2001.

I am pleased to present the Annual Report and financial statements of the Health Care Complaints Commission for the financial year ended 30 June 2001, for presentation to the Parliament of NSW.

The Report has been prepared and produced in accordance with the provisions of the Annual Reports (Statutory Bodies) Act 1984, the Public Finance and Audit Act 1983, and the Health Care Complaints Act 1993.

The Report covers the work of the Commission and its committed staff in the maintenance and improvement of health care standards and quality services in NSW.

Yours sincerely

Amanda Adrian
Commissioner

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COMMISSIONER'S FOREWORD

In the reporting year of 2000-2001, the Health Care Complaints Commission managed 13,579 inquiries and complaints relating to services provided in the health system in New South Wales. Of these, 2,888 were written complaints, 6,635 were telephone inquiries and 4,056 concerns were managed by the eight Patient Support Officers. This is 19% higher than 1999-2000.

This increasing demand has challenged the Commission to review the way it does its business to enable more effective and efficient means of resolving complaints for people who are using the health system in New South Wales. The Commission has embarked upon a strategy to develop its capacity to use a variety of complaint resolution mechanisms to ensure that complaints are resolved in a more effective and timely way. No one strategy is inherently better than another. The nature of the complaint itself, the surrounding circumstances and the people involved should dictate the selection of the most appropriate method for resolution. It is clear that investigation by the HCCC is necessary in the public interest for certain types of complaints. However, sometimes individual complainants are not satisfied as the process requires a level of impartiality that can make complainants suspicious because the Commission cannot 'be on their side'; and the investigation takes considerable time to ensure that all parties have the right to comment on relevant information collected during the investigation. Complainants may also be dissatisfied if the action recommended by the Commission falls far short of that expected by them at the end of the investigation. The Commission may decide not to take disciplinary action against an individual practitioner or may consider quality improvement initiatives at a health service or health system more appropriate. The Commission is moving towards a more proactive philosophy of complaint resolution in which investigation is only one of the many dispute resolution techniques available. This is in line with the trend towards the use of alternative dispute resolution techniques in the adversarial legal system in NSW and Australia.

Reflecting upon the complaints received by the Commission in the past year, three dominant themes underpin the staggering majority of complaints that are received:

- Organisations and individuals providing health care and services not giving people adequate *information* about their health, illness or injury, diagnosis, treatment options, risks, alternatives and long-term outcomes. Not being informed fully of all aspects of care can limit people's capacity to make appropriate, relevant or informed decisions about their care and can result in people being angry and suspicious that things are worse than they really are. Power imbalances also occur when knowledge is held by only one of the parties in a relationship.
- The poor *communication* abilities of people who provide health care and services. Complaints are various but often relate to inadequacies concerning the listening (and hearing) skills of the health professionals and their support staff; and their lack of responsiveness, sensitivity, tone and respect in talking to people. Many complaints focus on practitioners not being able to acknowledge error, failure or limitations to their knowledge.
- Lack of comprehensive, accurate *documentation*. This may relate to: clinical assessment; clinical care planning; care and treatment provided; clinical observations and monitoring; the concerns of the person cared for; the information provided; any incidents, complications or adverse events; and all relevant matters that go to ensuring quality ongoing care. In addition to quality care issues for individual patients, documentation is critical for monitoring the quality of health care across a service, for research and for evidence-based resource allocation.

Traditionally, these people-based skills have not been valued in the preparation and on-going education of health professionals. Until recently, education has focussed on the 'science' of health care such as: the specialised knowledge of anatomy, physiology, pharmacology, psychology, biochemistry, disease processes, the technical skills of clinical assessment and problem solving about complex sets of signs and symptoms; and the skill and dexterity in performing surgery or other procedures. Fortunate are those people who came into contact with health care professionals who possessed effective communication skills, who valued informed decisions made by people in their care and who recognised that documentation was not merely 'personal musings' for an individual health professional but essential for appropriate and proper care by them and others in the future.

In the past year, the Commission has been discussing these three critical areas of information sharing, communication and documentation, with the professional colleges and associations for health practitioners. Discussions have focussed on looking at meaningful and effective ways to develop awareness and skills in these three areas.

During the year, the Commission began developing an options paper regarding amendments to the Health Care Complaints Act. The Commission had hoped to have already begun the consultation process with consumer organisations, the Minister's office and the Department of Health and other organisations and individuals with an interest in the business of the Commission and how it is conducted. However, the Parliamentary Joint Committee for the Health Care Complaints Commission has been conducting an inquiry into the conciliation functions within the Act and has recently announced an inquiry into the Commission's investigation and prosecution procedures. It is expected that the outcome and recommendations will be relevant to the issues that will need to be discussed when deciding on amendments to the Act.

I continue to be impressed by the Commission's capacity to learn and improve. As the new Commissioner I have demanded great trust and an enormous effort from Commission staff and the Commission's supporters, so that we can try to overcome some of the impediments to the timely and flexible resolution of complaints. I am heartened by the high level of cooperation with the Commission at large, including the support of the Minister for Health, the Director-General of Health and the health professional registration authorities, health professional organisations and health services across New South Wales as well as individual health providers.

I most particularly want to acknowledge the support given by people in the community, the Commission's Consumer Consultative Committee and the consumer peak bodies. Their input continues to enable the Commission to better understand and represent the issues confronting consumers in the delivery of health services throughout the State, and to provide improved complaint handling mechanisms that are sensitive to the needs of our diverse community.

Amanda Adrian
Commissioner

CORPORATE PLAN 1999 TO 2002

Vision

To protect the people of NSW by ensuring that appropriate standards of health services are provided and to be a leader and effective partner in providing diverse complaint handling services.

To act in the public interest by investigating, monitoring, reviewing and resolving complaints about health care with a view to maintaining, promoting and improving health standards and the quality of health care services in New South Wales.

Guarantee of service

The Commission guarantees it will be:

- sensitive, understanding and accessible to all people of NSW;
- fair and expeditious in the investigation of complaints;
- accountable for all processes and decisions;
- pro-active in ensuring complainants and respondents are notified and updated as to progress, until the complaint is closed; and
- be fair in conducting disciplinary proceedings.

Role and functions of the Commission

The role and functions of the Commission are to:

- receive and deal with complaints concerning professional practice and conduct of health practitioners and health services;
- resolve complaints with the parties;
- provide opportunities for people to resolve their complaints and concerns locally;
- investigate complaints, recommend and take appropriate action;
- prosecute disciplinary cases before appropriate Tribunals and committees;
- publish and distribute helpful information about Commission work and activities;
- advise the Minister and others on trends in complaints; and
- consult with key consumers and other stakeholders.

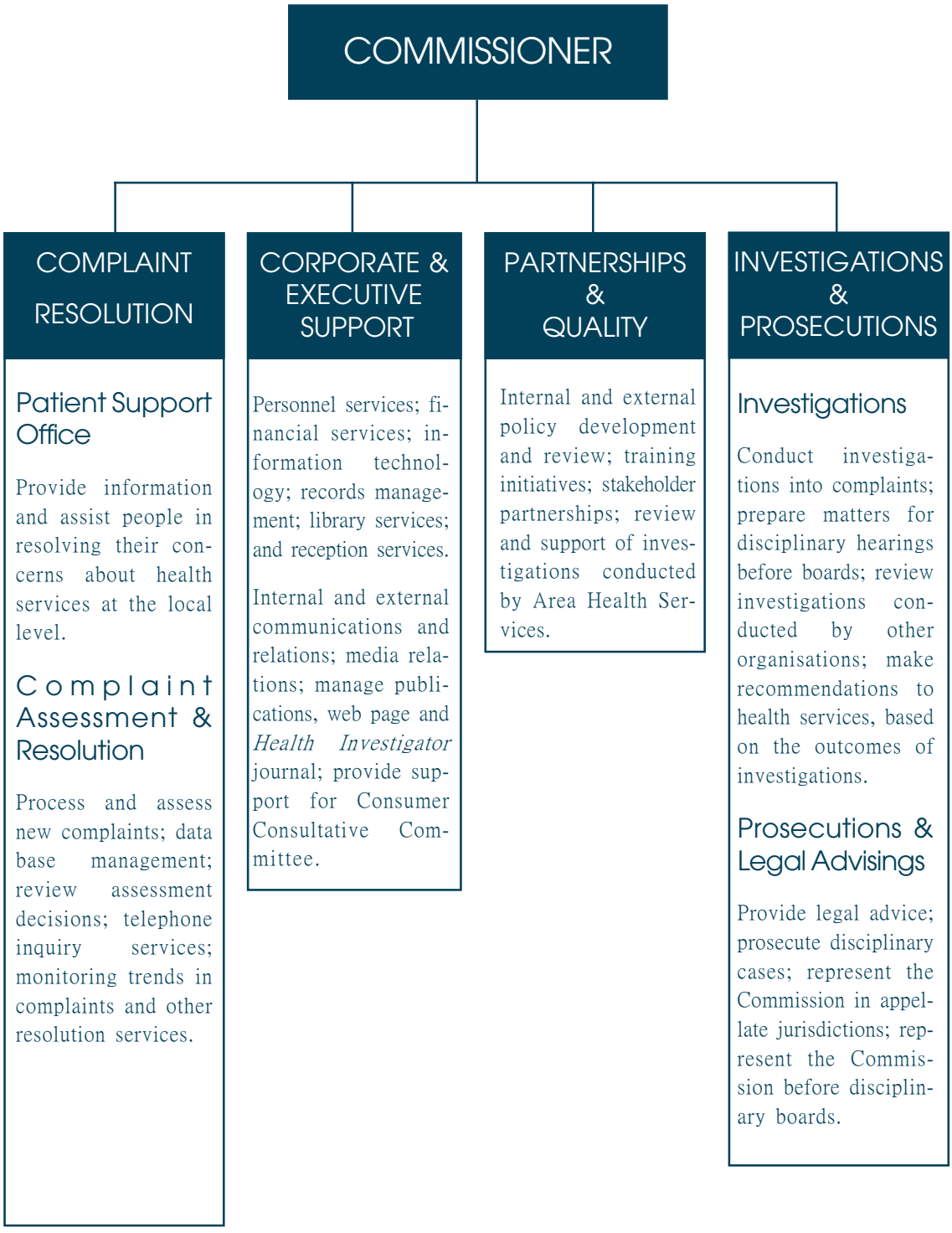
Goals

- facilitate the resolution of complaints;
- provide a timely, thorough and independent investigation of complaints which arise from the delivery of health services in NSW;
- ensure that appropriate action is taken as a result of investigations;
- undertake impartial and fair prosecutions in disciplinary matters;
- manage internal and external liaison, public education, communication and representation; and
- provide staff with a just and safe working environment.

Stakeholders

- The people of NSW
- Minister for Health
- Parliamentary Committee on the Health Care Complaints Commission
- Department of Health
- Area Health Services
- Consumer Consultative Committee
- Health Registration Boards
- Health Practitioners & Facilities
- Health Conciliation Registry
- Health Professional & Educational Organisations
- Other Government Agencies

ORGANISATIONAL CHART AS AT 30 JUNE 2001



PERFORMANCE MEASURES 2000-2001

1. Providing accessible, transparent, independent, fair & timely complaint resolution for health consumers in NSW

- Received 24% more telephone inquiries.
- Received 19% more written complaints.
- Provided a patient support service to 30% more clients.
- Around 80% of complaints were assessed within 7 days of receipt by the Commission.
- 1,000 complaints were closed within 22 days of receipt by the Commission.
- A total of 2,089 complaints were closed within 100 days of receipt by the Commission.
- 82% of concerns in which PSOs were involved, were resolved in the past year.
- 52% of investigations into health providers were substantiated in part or in full.
- 49% of investigations into health services were substantiated in part or in full.
- 65 complaints about health practitioners were referred for prosecution.
- 10 complaints about health practitioners were referred for other disciplinary action.
- 155 complaints were referred to the Health Conciliation Registry.
- 82 cases about health practitioners were decided by disciplinary bodies.
- Accommodated special needs of consumers by making 36 home visits to aged consumers or those with a disability.
- Conducted 153 assessment decision reviews under s28 of the Health Care Complaints Act 1993.
- Conducted 12 investigation outcome reviews.
- Appointed Aboriginal liaison officer to work with Aboriginal and Torres Strait Islander communities.
- Involved Registrar of the Health Conciliation Registry in the assessment of complaints to ensure appropriate matters are assessed for conciliation.
- Commenced the Investigation Improvement Strategy in February 2001 to improve the quality and timeliness of investigations conducted by the Commission.
- Introduced Planning and Review Forum to plan and review investigation strategies at key stages to assist in ensuring consistency and rigour in the investigation process and decision making.
- Continued development and application of consultative resolution within investigation process.
- Commenced review of the HCCC Practice Manual – Investigations and Prosecutions, including current literature and practice.
- Strengthened the peer review system to ensure unbiased opinions are obtained on standards of care.
- Commenced development of a new complaints database – designed to improve complaint management, capture key information for statistical analysis to provide to the Department of Health, professional organisations, registration authorities, Area Health Services, Colleges, consumer groups and the media.

2. Improving the quality of health services & maintaining the professional standards in the health system in NSW

- Provided advice and information to health providers on complaint handling mechanisms and how to avoid complaints.
- Provided feedback service to health providers about what consumers found helpful in the resolution process in an effort to support improved complaints handling in the future.
- Completed education and training on investigations across AHSs and through a number of special initiatives achieving successful outcomes on three primary fronts: improving the capacity of health services to manage complaints at the frontline; better understanding of the role of the HCCC by health services; and better understanding of the challenges facing health services by the Commission.
- Established a Commission advice and liaison service for AHSs to assist in the management of their complaints.
- New round of education and training in complaint resolution and investigation commissioned by NSW Health to begin in the next reporting year.
- Conducted 172 reviews of investigation reports conducted by other bodies under s26 of the Health Care Complaints Act 1993.
- Engaged health services in consultative resolution of complaints.
- Included the topics "How to avoid complaints" and "Lessons learned from complaints" in most presentations and lectures given to health providers and colleges.
- PSO had 48 cases where practice and policy revision was an outcome.

- Completed 47 investigations about health services.
- Commissioner a member of the NSW Quality Council.
- Commission involved in several working parties and seminars to: develop policy foundations; review and comment on draft health system policies; identify case studies for training, education and provide them to working groups to illustrate system weaknesses.
- Commission provided regular reports to Metropolitan Area Health Services annually on PSO activity and the major issues that have arisen in the Area during the year.
- Commissioner meets Minister for Health and Director-General of the Department of Health on a regular basis to discuss current areas of concern.
- Over 40 recommendations arising from investigations into health services provided to the Director-General and health services and are being followed up.

3. Disseminating information & educating the community & health providers on consumer rights & trends in quality & safety in the health system

- Commission staff conducted over 80 presentations for providers and consumers in the reporting year.
- The HCCC brochure *Your rights and responsibilities as a health consumer* provided to health consumers who are planning for a resolution process to help them understand how their rights and responsibilities apply to their particular case. Brochure currently being reviewed for a major re-print and redistribution in the next reporting year.
- Published articles in newsletters, journals and magazines for health consumers and providers over the last year including the Commission's own *Health Investigator, Australian Doctor Weekly,* ASA Newsletter, Midwives Association Newsletter.
- Developed, in conjunction with the ACCC,*air Treatment: Guide to the Trade Practices Act 1974 for the Advertising or Promotion of Medical and Health Services,* to assist health providers understand issues issues related to this topic.
- Commission participated in the Expo 50 Plus.
- Commission's website includes current information about making a complaint, information about the PSO, various complaint handling methods, information for providers and consumers and the Commission's publications including the translated publications.
- Commissioned development of a brochure promoting the Commission's services to the Aboriginal communities.
- Patient support officers continue to give presentations to people whose first language is not English and monitor the uptake of the service from those cultural groups. Approximately 20% of clients who use the service are people from a non-English speaking background.
- People with disabilities have also consistently used the service. Training to improve PSO service to this group was conducted.

4. Managing our organisation for quality

- The Commission and its stakeholders have been reviewing the statement of values in the past year, recognising that these values must underpin the day to day work of the Commission.
- Involved staff and management of the Commission in Planning and Review fora, practice manual review, peer review working group and others.
- Joined the *Joint Initiatives Group* composed of representatives of watchdog agencies formed to develop joint projects or identify ways watchdog agencies may co-operate in service delivery.
- Regular meeting of all staff across the organisation
- Bi-monthly patient support officer training days to increase knowledge and develop the skills needed to provide an optimum service. Topics covered in the past year include disability issues, conciliation, health complaint codes and cultural diversity.
- Learning hub planned for implementation in the next reporting period designed to capture new learning from the various committees and fora within and outside to the Commission.
- Monthly staff development sessions held and staff involved in the monthly lunchtime seminars of the Joint Initiatives Groups.
- Signed the Workplace Agreement introducing more flexible working arrangements for staff and established the Workplace Consultative Committee.
- Occupational health and safety checks were conducted on all Commission offices.

Positioning the Commission for the future – the Moving Forward Project

The *Moving Forward Project* commenced in February 2001. It is a strategic planning initiative designed to review the Health Care Complaints Commission's (HCCC) directions for the future. It examines the current vision, values, strategic statements, corporate plan and structure and ensures that these are appropriate to enable the organisation to continue to meet community expectations, regulatory objectives and the allocated resources.

The outcome of the initiative will be reported upon in the 2001 – 2002 Annual Report. Staff, the Consumer Consultative Committee and a number of other stakeholder groups have reviewed and modified the Statement of Values. The values reflect the diversity of organizational goals from support provided to health consumers by the patient support officers to procedural fairness and impartiality required by investigation officers and legal officers.

Meeting criticism head on - the HCCC investigation improvement strategy

There have been a number of achievements this financial year in the area of investigations with the Commission introducing a more rigorous examination and improvement of investigation processes. The HCCC Investigation Improvement Strategy includes:

- Emphasising active investigation rather than paper based investigations;
- Introducing a formal Planning and Review Forum that concentrates upon planning and formal review at key milestones in an investigation. The Forum meets regularly and is designed to ensure planning and decision-making in the course of investigations is consistent, transparent and appropriate;
- Reviewing and improving the *HCCC Practice Manual - Investigations* to provide staff with clear guidelines on all aspects of contemporary investigation and the requirements of the HCC Act;
- Broadening the Commission base of peer reviewers to ensure that the panel has adequate numbers and the breadth of expertise and to meet the needs of the investigations being undertaken by the Commission;
- Introducing a process to review cases by subject matter, and in some cases using an expert clinical panel to advise the investigation officers. In one example, the Commission was investigating a number of separate and unrelated complaints concerning the competency of nurses. The Commission reviewed the investigations of these matters as a group to identify similarity of issues and to ensure consistency in the investigation process and the outcomes of the investigations. The process also helped to expedite the investigation, as the Commission was able to view the complaints in the broader context of the health system. Other reviews will involve major subject areas of complaints such as obstetrics, paediatrics and emergency medicine. Clinical experts will be invited to participate in the discussions to assist the Commission to achieve an appropriate resolution of the complaints;
- Formally reviewing all matters that have been under investigation for longer than 18 months to examine the reasons for the delay and identify ways to expedite the investigation;
- Keeping parties to investigations better advised of progress and any reasons for delays.

Through the review process, the Commission is improving its focus on quality issues in the health system, including clinical governance. This entails seeing the complaint in a broader context than the individuals involved in a particular incident.

Standardised data collection

Background

Under the Health Care Complaints Act 1993 the Commission is responsible for providing information to the Minister for Health on complaints made about the public health system. To enable the Commission to perform this function the Commissioner and the Director-General of Health reached an agreement that standardised data be collected. The collection of such data is an important step toward health services becoming more transparent and accountable to the public for the services provided. This is consistent with directions being taken world wide and in other parts of Australia. The analysis of data can lead to service improvements. The data collection

project is also contributing to the growing awareness by health services that complaints and local complaint resolution are important components of the quality improvement strategy of an organisation.

Achievement

During the year, the Commission worked closely with the Department of Health and the AHSs to establish a standardised mechanism to collect information about the complaints that consumers made about services provided. The Commission, the Department of Health and the AHSs signed a Memorandum of Understanding in relation to the data collection project and the use of the information.

Data integrity has been a focus of the project for the past 12 months. Coding consistency and data entry have been improved. The data set has been reviewed and it has been agreed that the data set developed by the National Health Complaints Information Project be developed.

- The Commission presently receives quarterly reports from the Department of Health.
- The Commission also received raw data for the first time for analysis.
- The Commission is presently developing its capacity to receive the data electronically and analyse it.
- The Commission and the Department have been meeting to discuss the database requirements in relation to the project.

Improved consumer participation - Consumer Focus Collaboration

Background

The Task Force on Quality of Australian Health Care identified that participation of consumers in the planning and delivery could address problems in the health system and enhance the quality of health services. The Consumer Focus Collaboration (CFC) was formed in 1997 following the *Final Report of the Taskforce in Australian Health Care* (1996) to support and encourage the creation of consumer feedback and participation mechanisms across the country. The Collaboration comprises representatives from Health Complaints Commissions, consumer organisations, professional associations and State and Territory health departments.

The CFC worked with key stakeholders to promote, integrate and disseminate information and promote initiatives which increase consumer involvement in health service planning, delivery and evaluation. The CFC recognises the potential of consumer involvement to improve health service accountability and responsiveness to consumers. The CFC also worked to promote education and training that supports active consumer involvement in health service planning and delivery. Projects resulted in a consumer participation toolkit, a clearing house for consumer feedback methodologies and identification of models for the provision of information to consumers. The CFC promoted these to assist health services implement meaningful programs and informative dialogue with consumers.

Achievement

During the financial year the Health Care Complaints Commission represented the State and Territory Health Complaints Commissions on the CFC. A CD-ROM has been produced containing CFC publications. Final Reports for all Consumer and Provider Partnerships in Health Projects sponsored by the CFC are available on the website for the National Resource Centre for Consumer Partnership in Health: http://nrccph.latrobe.edu.au. The National Resource Centre will be developing a compendium of case studies based on the final reports and the national evaluation of the effectiveness of the projects.

The Department of Health and Aged Care funded the National Resource Centre to undertake a Primary Health Care Project which will target consumer participation in the Department's program areas of general practice, coordinated care trials and shared care for chrinic illness.

The CFC sponsored the Consumer Participation Conference in Sydney during the year. The Commissioner participated in a hypothetical panel and a staff member presented a paper entitled *Improving health services through consumer participation* and chaired a panel.

During the year a CFC project focussed on consumer participation in accreditation review processes. Six other Consumer and Provider Partnerships in Health were substantially completed. A report on these will be released shortly.

The CFC was a time limited strategy and Commonwealth funding for the CFC has concluded. The Commonwealth has agreed to fund a search conference next financial year to provide a forum in which the feasibility of sustaining a national consumer participation agenda can be considered.

Streamlined consultation

During the year, the Commission co-ordinated a number of changes to improve the efficiency of consultation with registration authorities. Inefficiencies, identified at the start and finish of the complaint handling process have been addressed. Duplication of paperwork has been removed by incorporating formal notification of receipt and outcome of complaints into the record of consultation meetings. The Commission has also begun to notify on a monthly basis the registration authorities (except for the Medical Board) of the receipt of complaints about practitioners registered with them to coincide with the monthly board meetings of the registration authorities.

In addition to reducing paperwork, these changes have reduced errors in the processing of complaints by the Commission and decreased the time taken to handle complaints relating to registered health practitioners.

Accurate reporting of complaints

Complaints received by registration authorities must be notified to the Commission. The complaints are then deemed to be complaints under the Health Care Complaints Act 1993. The Commission is required by the Act to include in its annual report the number and types of complaints made to it during the year.

A complaint is any expression of dissatisfaction or concern. Notifications to registration authorities about the possible health problems or impairment of a practitioner are dealt with as complaints if there are no health programs. With the advent of health programs by the Medical Board and the Nurses Board, capture of these complaints by the Commission ceased. This financial year, the Commission recommenced recording these notifications, as they are complaints about practitioners. Last financial year, the Commission reported receiving 38 complaints about impaired practitioners where there was a concern with their physical or mental health or addiction. This year, the Commission received 84 complaints concerning practitioner health. The increase in number is primarily due to the changed reporting procedures.

Outreach and support for Aboriginal communities

During the year the position of Aboriginal Support and Liaison Officer was established and filled in partnership with the Aboriginal Health and Medical Research Council to provide support to Aboriginal people and communities. The Commission found that Aboriginal community knowledge about its services was scant. As a result, one of the first priorities of the outreach and support program was to meet with, learn from and provide information to Aboriginal people, communities and organisations.

A Commission brochure was designed by Streetwize to get the message to the Aboriginal community that they can make complaints at the local level and seek support from the Commission if required. The brochure is due for release next financial year.

Informing Aboriginal communities about the new program and the support officer is difficult because of the geographic spread of Aboriginal communities. Face to face meetings are the best way to build trust and understanding between Aboriginal communities and the Commission. Community visits have commenced and include visiting rural and remote areas.

Aboriginal people and organisations have identified some key barriers to making complaints:

- Many people do not know they can make a complaint. Some people might not report concerns until either their health or relationship with a health service deteriorates. Concerns expressed include fear of being ignored or of making the relationship worse. Aboriginal people, in general do not make complaints easily. For a person to have formally complained about some aspect of care or treatment, a significant situation must have occured. Health services need to respect this and not dismiss the complaint lightly. When dealing with complaints, the service needs to recognise that the person complaining has a significant issue that needs to be examined sensitively and carefully.

- The Commission is seen as being remote. Having a local person to assist with complaints would be helpful. Aboriginal health workers or Aboriginal liaison officers were identified as people who know the health system, are accessible to Aboriginal people and may provide needed support to people who want to convey their concerns about a health service. The Commission is in the early stages of consultation and information gathering to see if a training and support program would assist Aboriginal health workers to provide support for local complaints handling.
- Aboriginal people have stories about bad things that have happened to them or a relative in a hospital. Most stories involve a perceived lack of respect and this acts as a significant barrier to communication.
- Mainstream health services have little or no knowledge about cultural differences and how this may affect services and patient relationship.
- No identifiable forums to look at complaints or communicating concerns exist. Some Aboriginal people would prefer to convey concerns as a group.

The Aboriginal Support and Liaison Officer has provided direct support to people with health concerns using the Patient Support Office framework with cultural modifications. Users of the service have commented positively on the advantage of having an Aboriginal person in that role as the officer has an understanding of the language and culture and has experience with the health system.

Access to an Aboriginal person to provide cultural advice and information has assisted the Commission to better understand how to improve contact with Aboriginal people and how to improve its services.

Value adding - flexible and timely complaint options

Patient Support Office involvement in complaint handling

Background

In addition to assisting consumers with concerns about health services, patient support officers play an active role in assisting complainants who have made formal complaints to the Commission. Once a complaint has been assessed and it has been decided that complaint may be resolved directly between the parties, a patient support officer will assist the parties as required.

When the Commission receives a complaint and forms the opinion that it raises issues which warrant investigation by another agency, the Commission refers the complaint to the identified agency. A patient support officer contacts the complainant and explains the process of referral to the other agency and explains the investigation process. The patient support officer also contacts the agency to monitor the progress and timeliness of the agency' s response to the complainant. When the agency completes its investigation and responds to the complaint, the patient support officer is available to discuss any unresolved concerns and explores ways of resolving them. Meetings between the parties may be facilitated as necessary.

Achievement

During 2000-2001 the Patient Support Office was involved in 1,244 complaints referred to another body by the Commission.

Tailored resolution processes

Background

The Health Care Complaints Act 1993 requires the Commission to assess complaints upon receipt. The purpose of assessment is to decide how a complaint will be handled. The resolution options presently available to the Commission include investigation by the Commission, investigation by another body, or conciliation. The Commission is increasingly realising the necessity to develop resolution strategies tailored to the needs of the health provider, the consumer and the nature of the complaint.

Achievement

During the year the Commission trialed a new approach to improve the handling of complaints assessed as suitable for conciliation. Following assessment, both parties to the complaint were sent a standard letter seeking their written consent to conciliation. A patient support officer then contacted the parties to discuss the issues raised by the complaint, the needs of the parties and the various resolution mechanisms available. The goal was to reach agreement between the parties on which strategy they thought most appropriate to their own circumstances and the nature of the complaint.

For many complaints, conciliation is suitable. For others a more tailored approach is needed. For example, in one case, the complainant was agreeable to either conciliation or resolution with the assistance of the patient support officer. The doctor against whom the complaint had been made refused conciliation stating that he had given all the appropriate explanations to the client already and felt it was a waste of time to give any more.

The patient support officer spent considerable time convincing the doctor that the client, who is from a non-English speaking background, was not clear about the explanations previously given. The patient support officer agreed to work with the client to further specify the issues. The doctor said he would meet with the client only if the patient support officer also attended.

The patient support officer then worked with the client. After obtaining a document from the doctor that explained his condition, the patient support officer suggested that the client take it to another professional whom he trusted. The client chose one who spoke his preferred language. This resolved the matter for the client. There was no need for a further meeting with the doctor about whom the complaint had been made. Both parties were positive about the process used by the Commission and the following comments were made:

- Personalised service: the parties dealt with one staff member instead of multiple contacts with Commission staff and Health Conciliation Registry staff.
- Continuity of service: the staff member was able to continue immediately with the resolution process when the original offer of conciliation was refused by the doctor.
- Streamlined service: the matter was dealt with by one officer instead of referral letters being sent to and fro between the Health Conciliation Registry and the Commission. The resolution occurred without delay.
- Approriate service: the more flexible process resulted in a resolution which may not have been possible otherwise. A patient support officer was able to persuade a reluctant doctor to release a report which provided information central to the complainant's concerns. The report may not have been available at a one-off conciliation conference. The complainant was able to obtain a second opinion from a professional who spoke his language of choice. This process resulted in the client now understanding the information provided by the doctor. This process was critical to the resolution of the complainant's concerns. The time taken for resolution in this case was minimal for both the complainant and the doctor involved.

The Commission will be expanding the use of this approach in the coming year.

Improved customer service in regional areas

The Commission received a complaint from a couple whose infant son died suddenly in a rural area. The couple complained that a general practitioner had not adequately diagnosed their son's condition. A hospital registrar had also failed to seek their consent for treatment and the parents feared he had experimented on the child.

The Commission decided that the complaint raised issues which warranted conciliation. All parties consented to conciliation and the Commission referred the matter to the Health Conciliation Registry. The Health Conciliation Registry presented telephone conciliation but this was refused by the couple as they said they were feeling too emotional to discuss such sensitive issues by phone. They wished to see the doctors, tell their story and show how the incidents had affected them. They also felt that telephone conciliation did not respect the seriousness of their complaint. They wanted a more formal resolution option. The Health Conciliation Registry referred the complaint back to the Commission.

One of the Commission's patient support officers became involved. The couple repeated their

request for a face to face resolution session with an independent person present to facilitate proceedings. None of the eight Commission patient support officers were located in the rural area concerned. While a patient support officer was available to travel to hold the resolution meeting the Commission was aware that the Community Justice Program had a Centre servicing the locality. The Commission arranged for a mediator from the Centre to arrange and conduct the mediation.

Generally Community Justice Centres do not mediate health complaints, but they were interested in participating in the trial. With the assistance of a patient support officer, the Centre obtained the consents of the parties and offered support to the parents in preparation for the sessions. All parties were happy with the involvement of both the Commission and the Community Justice Centre in arranging the mediation session.

Two sessions were conducted in different towns. By the end of the sessions the couple had obtained explanations of what had occurred and an apology. The parents felt that their concerns had been taken seriously by the doctors, who each spent a half day with them.

The PSO and the Community Justice Centre considered the trial successful. It provided an option for assisted resolution of health complaints in rural areas where a patient support officer could not be present. The Commission and the Community Justice Centre will look for opportunities in the coming year to collaborate in the resolution of complaints.

Consultative Resolution Model - A model to facilitate policy and service enhancement

What is consultative resolution?

Consultative resolution (CR) is an informal, facilitative framework developed by the Commission to assist health services to identify and rectify:

- inadequate policies, protocols and procedures;
- substandard service quality and effectiveness;
- barriers to open disclosure and thorough analysis of critical incidents; and
- inadequate investigative processes or outcomes.

The approach is simple, flexible and non-adversarial. CR is different to the advocacy model employed by the Commission's Patient Support Office. Rather than advocating on behalf of the complainant, the Commission representative useing a partnership framework to negotiate improvements, to benefit the complainant, health service and future health consumers. The CR process is directed by the Commission representative, in partnership with the health facility and where applicable, the complainant.

The development of CR has provided the Commission with an effective resolution option that links with quality improvement initiatives in the health system. The process assists health services to critically evaluate service provision, identify service deficiencies and take meaningful action to address the deficiencies. Health services have been responsive to CR and have appreciated the provision of resources and support to assist them to develop awareness of the situation, analytical skills and if required, improved policy and practice.

Objectives of consultative resolution

Whilst the particular objectives of CR vary depending on the issues raised in complaints, overarching objectives include the:

- promotion of quality health services;
- promotion of rigorous review processes linked with quality improvement;
- provision of meaningful information to people who make complaints; and
- facilitation of resolution of health concerns and complaints in a simple, timely and efficient way.

The CR Process

The CR framework is flexible. The amount of information available to the Commission at the time of the decision to utilise CR and the nature of the issues raised in the complaint will determine what particular actions and tasks are required. The general CR approach involves several stages:

- obtaining and analysing information;
- pre-meeting preparation including contacting the relevant parties;

- drafting and circulating the issues paper and any relevant resources;
- individual meetings with participants (if required);
- CR meeting;
- post-meeting actions.

Key Principles underpinning partnerships utilised by CR

The CR process is based on partnerships and this may include uncertainty for the participating managers, clinicians and Commission officers. Uncertainties are addressed to an extent by the provision of information on the CR process and objectives, supporting a culture of learning rather than blame and differentiating the CR approach to that of investigations conducted by the Commission.

The key principles involve:

- Emphasising openness and awareness as an organisational response to the complaint and the CR approach.
- Building health service capacity by involving managers and clinicians in a learning process that may be applied to future situations.
- Focusing on building relationships which use people skills to establish and maintain dialogue based on mutual trust and respect.
- Drawing upon a consumer perspective to provide a deeper understanding of the impact of events under review on the particular consumer and for future health service consumers.
- Acknowledging and using the skills, insights and creativity of participants.
- Focusing on systems and processes rather than blaming the individual.
- Developing strategies to support an appropriate fit between the people, organisational culture, process and issues raised in the complaint.
- Working with mutually understood language and frameworks to enhance the quality of health services.
- Creating an atmosphere where all parties share in the responsibility to achieve a worthwhile outcome.
- Supporting the partnership throughout the process by:
  - orientating participants and providing background information;
  - involve participants in planning;
  - providing adequate notice of meeting and issues to be discussed;
  - setting the scene at the meeting;
  - identifying and working within common goals and values, such as quality improvement, minimising preventable adverse events and patient focused care;
  - re-aligning participants' view of the Commission;
  - linking CR with the quality framework;
  - supporting flexible and informal meetings;
  - supporting joint decision making;
  - supporting open dialogue and empowerment;
  - asking participants how it could have been done better;
  - owning disagreement and solutions as a group.

As a result of the Commission's move away from document-based investigations, the perception of the Commission as a punitive body is changing to the view that the Commission is actively involved in supporting local, Area and State health service quality improvement. CR, as a process, yields positive results and has the potential to shift values and review frameworks at the local level. Due to external involvement in the analysis of an incident and a learning approach that utilises the expertise of participants, the outcomes have been relevant and meaningful. Changes arising from a CR process are more likely to be implemented and sustained as health service management and clinicians share ownership of the identified solutions.

Review of external policy/protocols/ discussion papers

Providing comment on policies, protocols and discussion papers drafted by external bodies is one way the Commission can share the insights gained from people who use health services with other organisations. During the year the Commission has provided comment on material developed by a range of health organisations as the selection below indicates:

- Area Health Services - management of incidents to ensure quality of mental health services - statement of concern/complaints protocol.
- Associated bodies - Professional Standards Council - whistleblowing in the professions.

- NSW Commission for Children and Young People - Inquiry into Children who have no-one to turn to.
- Professional associations - codes of ethics.
- NSW Health - Dying with Dignity: Revised Draft Guidelines for Clinical Decision Making at the End of Life.
- NSW Health - Consumer and community participation draft report – Draft Policy on Effective Discharge Planning
- Other Commissions – discussion paper relating to the review of the Health Services (Conciliation and Review) Act, 1987.
- Anti-Discrimination Board of NSW – Inquiry into discrimination against people with Hepatitis C.

Development of the fair treatment guide

In July 2000, the Commission and the Australian Consumer and Competition Commission (ACCC) jointly launched the *Fair Treatment: Guide to the Trade Practices Act 1974 for the Advertising or Promotion of Medical and Health Services.* The guide was the culmination of a joint policy initiative between the HCCC and the ACCC. A summary to the Guide has since been produced.

The Guide focuses on the need for health practitioners to provide consumers with accurate and honest information in a readily understandable way to help consumers decide on services and procedures and to choose between providers.

Consumers are best protected when they are fully informed and when health practitioners maintain professional and ethical standards.

Review of the Health Care Complaints Act 1993

The Health Care Complaints Act was assented to on 2 December 1993. Section 104 of the Act requires the Minister to review the Act "to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives". During the year the Commission commenced the development of the issues paper to facilitate public discussion.

Investigations training program - partnership initiative

During 1999 the Commission reached an agreement with the Senior Executive Forum of NSW Health[1] to provide a training and advisory service for a period of 12 months, ending November 2000, to AHS staff in relation to the investigation of complaints.

The training program was designed to improve the quality of investigations conducted by Area Health Service (AHS) staff. This was in response to deficiencies noted in AHS investigations regarding methodology, findings, outcomes and documentation.

The program was designed to reflect the values, principles and the six dimensions of quality noted in *The Framework for Managing the Quality of Health Services in NSW Health.*

The Course was provided to each AHS twice during 2000 with 20 participants invited to attend each course. Courses were also provided to staff from NSW Ambulance Service, Corrections Health Service and the NSW Department of Health. From March to November 2000 a total of 37 courses were conducted with an overall number of 578 health service managers attending the training.

The Program covered the following topics:

- the link between complaints and quality management and the value system underpinning complaints management, investigations and service enhancement;
- a working understanding of the principles for appropriate investigation processes;
- the requirements of natural justice;
- investigation planning and monitoring tools;
- information gathering strategies;
- documenting the investigation process and information obtained during interviews;
- identifying service standards;
- appropriate formats for investigation reports;
- making relevant recommendations; and
- who to contact for advice/support to enhance local complaint handling.

Participants provided feedback on the training course assessing the process and content of the training as well as evaluating the Investigation

Workbook. Participants also provided comment on course weaknesses and strengths as well as providing general feedback. The training program was rated very highly. Its relevance to the work of health managers and health providers was considered of great benefit. The feedback identified a lack in the knowledge of many health service providers involved in complaint management but also identified a desire to embrace and adopt the principles and skills presented.

The participants considered the course was relevant, informative and well researched. New insights and tools to assist the conduct of effective and efficient investigations were favourably received. Deficiencies in past investigations were noted and new approaches identified.

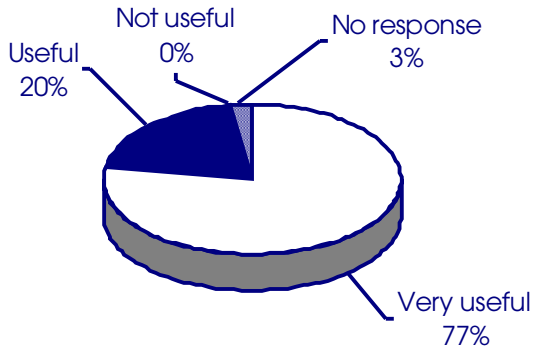
Besides delivery of the training course, the Commission Investigations Adviser provided a consultancy service, offering support and advice for AHS investigators. Attendees supported the availability of the Investigation Advisory Service. Those who used the service found the opportunity to discuss complex issues and identify a way forward worthwhile.

Course participants identified the need for ongoing investigations training to expose front line, middle and upper management to investigation principles, methodology and links to the Quality Framework.

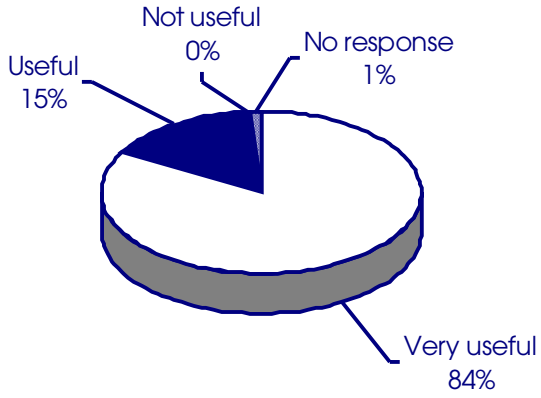
Additional courses that cover complaint resolution and complaints management have been requested by health facilities.

Key program evaluations by course participants are set out in the following graphs.

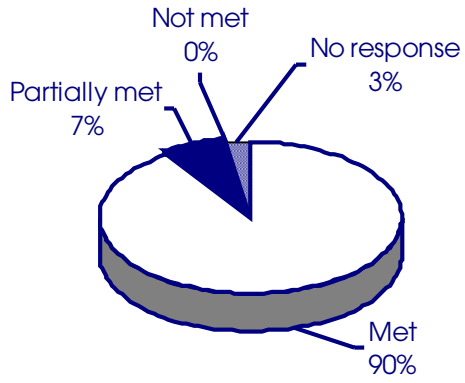
Content of workbook



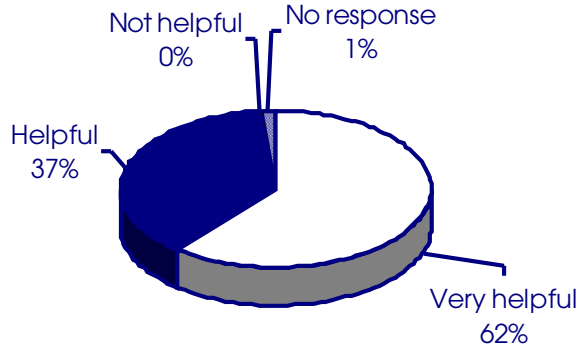
Course content



Objectives of the course



Use of teaching aids



Results of overall training course evaluation

The Program has been assessed by the use of participant surveys which rated the training material, its delivery and the course workbook. Participants were asked to evaluate:

- the relevance of topics covered;
- whether course objectives were met;
- whether teaching aids were helpful;
- the usefulness of the Workbook content;
- whether examples and activities were helpful;
- whether questions were answered; and
- and the usefulness of the course content.

To date Program evaluation has been very positive over all criteria.

Special initiatives training programs

In response to the success of the training program, the Commission was approached by other agencies and Health Complaints Commissions in other States to provide training to their organisations.

In March 2001, the Commission led a 2 day investigation training workshop in Melbourne to representatives of Health Care Complaints Commissions from each state and territory as well as New Zealand.

In March 2001, a one day investigations training course was provided to 30 health service managers from the Northern Sydney Division of Mental Health. Training by Division yielded additional benefits - areas of practice and procedure that could be enhanced were identified and people in local networks with particular investigative skills and experience were also identified.

In June 2001, a two day Investigations Training Course was delivered to various agencies in the Northern Territory, including the Office of the Ombudsman, the Health & Community Services Complaints Commission, Workcover, Department of Housing, the Anti-Discrimination Board, Family & Community Services and the Health Professionals Licensing Authority.

Future initiatives

On review of the success of the initial training program, the Senior Executive Forum of NSW Health has provided further funds to continue and expand the training program by the Commission. In response to the training needs identified by health services, the Commission will be offering a new training program to AHSs, Corrections Health Service, NSW Ambulance and the Children' s Hospital, Westmead. The program has been expanded to include courses on frontline complaint resolution as well as investigation training. Depending on demand, additional courses may be developed to cover investigation of system issues, complaints management, investigation report writing and conducting witness interviews.

The new program will build upon the initial program and continue to link best practice in investigation and complaint resolution to:

- consumer and community participation and partnership with the health system; and
- health service quality improvement, based on an analytical and resolution framework supported by values of openness, transparency and continuous learning.

The training program has afforded the Commission an invaluable opportunity to meet with metropolitan, rural and remote health service mangers. The new program will extend the reach to front line staff. A greater awareness by Commission staff of the challenges experienced by managers in the delivery of quality services has been valuable and influential. Course participants have indicated that they have valued meeting Commission staff as such face to face encounters help to demystifying the Commission, its role and processes. The development of a working relationship between the Commission and the public health system has extended to processes used by the Commission to review and provide feedback on investigations conducted by other bodies. This is reported elsewhere in this document.

Notes:

[1]The Senior Executive Forum is composed of the Director-General of Health, senior officers of the Department of Health and Chief Executive Officers of Area Health Services.

Increased media profile

The Commission has commenced submitting on a two monthly basis articles of relevance to general practitioners to the Australian Doctor weekly journal. Articles have included: the complaints process, the investigation and prosecution functions of the Commission, the issue of prosecuting professionals in a Medical Tribunal after they have been cleared of any wrongdoing in a criminal court; and the importance of good communication between doctors and patients. The Commission will continue to submit articles to Australian Doctor in the future.

The Commission has also been invited to submit articles to other journals such as the Nurses Registration Board Newsletter, the Medical Observer and the NSW Midwifery Newsletter.

Publications

The Commission has commenced a review of all its publications due to several changes in legislation and impending changes in legislation to medical records and privacy issues.

The Commission has placed its translated brochures *The Complaints Process* and *The Patient Support Office* on its website. The *Health Investigator Journal* is also on the website. Hard copies of these publications are available.

Correspondence

The Commission has been working with key stakeholders in the past year to ensure that the information that is provided to consumers and health providers in its information brochures, its website and its correspondence is both informative and appropriately expressed. One of the primary targets has been an extensive review of the correspondence that goes out to people on the receipt of a complaint and at each stage in the Commission's management of the complaint.

So many misconceptions and improper assumptions can be made when receiving a letter because the letter is: unnecessarily bureaucratic or legalistic; lacking in information about processes; terse, curt or seemingly threatening in its language; or dismissive of the importance of a matter. The Consumer Consultative Committee, the health registration boards and other stakeholders were invited to provide the Commission with feedback in relation to its correspondence and to identify where improvements could be made. This feedback has been very useful in assisting the Commission in re-drafting the key letters sent out to all parties to a complaint. In some instances, this has spurred other organisations to review their own correspondence.

Increased community education

The Commission was involved in the Expo-50-Plus for senior citizens which was held at Darling Harbour in March 2001 for two days. Staff met with the public, answered questions and concerns and provided publications.

The Commission placed advertisements in the Seniors Newspaper as well as in the Seniors Card directory, in order to promote the services of the Commission to the older community.

Commission staff gave over 80 presentations to consumer groups and professional groups in NSW. Patient support officers conducted 31 presentations during the year, 20 to consumers and 11 to provider groups.

Topics at presentations included: the role of the Commission, the role of the PSO, patient rights and responsibilities, local resolution of concerns, reducing client dissatisfaction with health services and the investigation and prosecution function osf the Commission

Presentations to professional groups included improvements in the health system, how health professionals can avoid complaints, what steps they could adopt to ensure open and clear communication with patients; keeping clear and concise medical records and what lessons professionals can learn from mistakes. The Commissioner represented the Commission at a number of forums, seminars and conferences including:

- The 3rd National Health Care Complaints Conference in Melbourne;
- NSW Conference on Aboriginal Health in the 63rd Millennium;
- International Nurses Day
- Australasian Association for Quality in Health Care;
- Australian Plaintiff Lawyers Association Ltd;
- KPMG Account Group;
- Corrections Health Service Ethics Group

Consulting with community groups

The Commission held 3 meetings with the Consumer Consultative Committee during the year. The Commission raises issues of significance with the Committee and seeks advice and feedback on major projects and publications. The Committee ensures the Commission remains focussed upon its key goals of independence and serving the public interest. Members of the Consumer Consultative Committee are listed below:

- NSW Council of Social Services
- NSW Council for Intellectual Disability
- Council on the Ageing NSW
- Australian Association for Welfare of Child Health Inc
- Aboriginal Health & Medical Research Council
- Women's Health Resource & Crisis Centres Association
- People Living with HIV/Aids NSW
- Mental Health Co-ordinating Council
- Combined Pensioners & Superannuants Association
- Ethnic Communities Council
- Health Consumers Network (NSW) Inc (Coordinator, NSW Mental Health Consumer Advisory Committee)
- Rural and Remote Health Consumers of Australia

Implemented MYOB accounts software.

This has allowed HCCC to process its own invoices, saving the Commission almost $1,300 each month in fees, which it used to pay to the Department of Transport to process accounts. The Commission's account payment performance has improved significantly now that it is processing its own accounts. The Commission is now able to lodge monthly Business Activity Statements to the Australian Tax Office electronically.

Workplace agreement signed

This Agreement provides for the establishment of a Workplace Consultative Committee as a forum for consultation between management and union representatives on issues affecting the Commission. The Agreement introduced more flexible working arrangements for staff. These arrangements have been introduced in recognition of the long hours worked by Commission staff and to facilitate staff's ability to meet their work and community responsibilities.

WRAPP review completed

The Waste Reduction and Purchasing Plan is monitored by the Director, Corporate Support to ensure that potential environmental effects of Commission activities are taken into consideration in management decisions, relating to the daily functions of the Commission.

As a result of decisions made by management, the Commission achieved a 19% reduction in paper usage during the previous 12 months.

CHALLENGES

Demand and service tensions

The Commission has been managing the increased number of complaints during the past financial year. Any further increase will seriously challenge the organisation's capacity to maintain a high level service.

Improved service to rural and remote communities continues to present a challenge to the Commission.

Improving records management

As the number of complaints received by the Commission rises, records management becomes an increasing challenge for staff. A disposal schedule will be developed to ensure that files are stored, retained and, where appropriate, disposed of, in accord with the State Records Act 1999.

In the coming year, the Commission will be improving its electronic file tracking system. Systems for managing administrative files will also be improved.

Participating in the Treasury on-line entry system pilot

The Commission has been selected to be one of the agencies to pilot NSW Treasury's electronic on-line reporting system. This system will reduce the time and cost of monthly financial reports.

Implementing equity strategies

The challenges facing the Commission in the Ethnic Affairs Priority Statement, Equal Employment Opportunity Management Plan and Disability Strategic Plan are detailed under these sections in this Annual Report.

HCCC investigations - timeframes and volume

The Commission continues to be challenged by the increasing complexity of complaints referred for investigations, particularly as the broader systems issues widen the scope of the investigations. The Commission's new initiatives place it in a better position to deal with these more complex matters. However, complainants and health providers whose matters are assessed for investigation by the Commission continue to be critical of the time that the investigations take as does the Commission itself. The challenges include:

- Improving the assessment of matters for investigation. The volume of matters for investigation will be reduced by assessing for investigation only those matters that specifically require investigation and recognising that other resolution strategies may enable much more appropriate and timely resolution of complaints.
- Equipping and assisting health services to conduct competent investigations of complaints and adverse events themselves so that the need for improvement is recognised and change occurs without requiring referral to the Commission.
- Targeting older investigations to try and finalise them as quickly as possible. Whilst the HCCC Investigation Improvement Strategy implemented in February 2001 has had some success, the Commission continues to be challenged by the length of time taken to finalise its investigations. Focusing on older investigations runs the risk of neglecting the more recent investigations so that they become the delayed investigations of the future.
- Excessive caseloads can overwhelm an investigation officer and reduce productivity further.

The Commission is engaged in a process of continuous improvement. Whilst changes have already been made to improve decision-making and the process of investigation planning and review, there is still considerable room for further development.

Attitudes hampering change and improvement

Although over the years, the Commission has introduced more diverse conflict resolution techniques and emhasised the philosophy of quality improvement, there remains a view in some sections of the health community that the Commission is adversarial, vindictive and ruthless. The Commission's strength lies in its independence and its capacity to be a 'watch-dog' of the health system. This role is unashamedly in the interests of the community. However, to be able to affect change in the health system and on the cultures of the health professionals working in the system, the Commission relies on being able to work closely with health services and health professional organisations. Maintaining the independence and clear focus on the public interest while

brokering change and respect for the Commission's role in the health system is a delicate balancing challenge. It is hoped that some of the negative attitudes of the past will be dispelled by improving the transparency of Commission processes and by using more flexible and responsive complaint resolution mechanisms to enhance health services.

Unregistered health practitioners

As in past years, several investigations involving unregistered health practitioners have raised serious issues of conduct. The Commission's incapacity to take effective action to protect the public from such people in the future remains disturbing. The Commission will be pursuing the implementation of the recommendations from the Parliamentary Committee on the Health Care Complaints Commission's Inquiry into Unregistered Health Practitioners in its consultations around amendments to the Health Care Complaints Act.

Information - the key to quality improvement

The data base project

Developing the new database for the Commission has been a critical yet slow process. The Community and Health Service Complaints Commissioner in the Australian Capital Territory, the Health Complaints Commissioner in Tasmania and the Health Care Complaints Commission in New South Wales are collaborating in the development of an improved database. This will enable flexible and comprehensive case management of complaints and provide the community, government agencies, professional organisations and other stakeholders with information that will provide the basis for system wide safety and quality improvement in health care, public administration and possibly other areas. It is hoped that this joint initiative will have benefits at a national as well as State/Territory and local level.

Information management

The Commission's processes and knowledge base evolves over time and is influenced by changes to legislation, case law, feedback from stakeholders, developments in the health system and procedural fairness and administrative decision making and investigation best practice.

A key challenge for the Commission is to ensure new learning and contextual changes are identified, captured, acted upon and made accessible to Commission staff. A system is earmarked for development to:

- ensure new learning is recorded;
- create an avenue for all people working at the Commission to contribute new ideas, information, solutions and learning; and
- ensure suggestions, ideas and new learning are reviewed and appropriate action taken.

Information technology strategic plan

The Commission aims to significantly increase its Information Technology Management capability in the coming year. Achievement of this goal will depend on its success bidding for project funding. Funding has already been approved for development of a new Complaints Database in partnership with the ACT Ombudsman's Office and the Tasmanian Health Complaints Commission.

Obtaining statutory declarations

During the year, the Commission was unable to obtain statutory declarations in 22 complaints (9%) where the Commission had formed the opinion that there were serious issues which warranted investigation by the Commission. Section 23(3) of the Health Care Complaints Act 1993 prevents the Commission from commencing investigations before the complainant verifies the complaint by statutory declaration. In the past year, the reasons for the Commission not obtaining a statutory declaration included: victims of sexual misconduct who decided not to pursue a complaint, complainants who expressed fear of harassment or intimidation if they continued with the complaint, and health practitioner whistleblowers who were subsequently advised by their employer or insurer not to proceed.

In previous years, the Commission was not able to obtain statutory declarations in some cases because health practitioner whistleblowers decided to withdraw their complaints when they learnt they were unable to remain anonymous. The health practitioner complainants were afraid of retribution by the employer, even though they were aware, for example, that aged residents were being ill-treated by other practitioners.

In one complaint received last year a health practitioner notified the Commission of serious adverse event resulting in the death of a patient. Upon consultation, the Nurses Registration Board expressed the view that the complaint was a serious one which provided grounds for disciplinary action. The Commission was unable to proceed with its investigation as the health practitioner, on the advice of the facility concerned would not provide a statutory declaration. This complaint not only raised possible grounds for disciplinary action, it raised a significant issue of public health and safety, that is, a preventable death. The Commission was prevented from examining the issues raised by the complaint and is considering procedural changes that might prevent further deaths.

Another complaint concerned an unqualified person performing basic medical duties in the absence of medical practitioners in a rapid drug detoxification clinic. The unqualified person was also left with the keys to the drugs cupboard. A medical practitioner was the complainant in this case, but was unable to provide the Commission with a statutory declaration, preferring to remain anonymous. The inability of the Commission to investigate this serious complaint, because of the absence of a statutory declaration, leaves the public at significant risk.

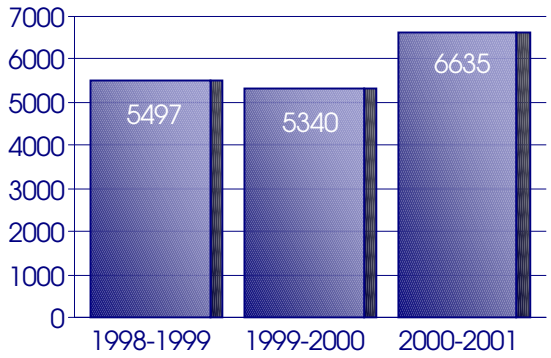
A related issue is the lack of inquiry powers available to the Commission in the investigation of health service complaints. Unlike health practitioner complaints where the Commission refers complaints with substance to a disciplinary body for inquiry and determination, the Commission itself determines complaints about health services. Presently the Commission is required to primarily adjudicate health service complaints on the basis of information provided voluntarily by the service. Other equivalent bodies have powers to undertake inquiries, summons people and interview them.

Telephone inquiries

The Commission provides direct assistance to people via a telephone inquiry officer (TIO). Callers may be advised of the role of the Commission, whether or not their issues fall within the jurisdiction of the Commission, and options available to them to resolve or deal with their concerns.

The Commission received 6,635 telephone inquiries in 2000-2001, 24% more calls than the previous year (5,340). This number includes calls handled by the TIO. It does not include calls of an administrative nature such as requests for Commission publications and complaint statistic inquiries, or calls made to the Patient Support Office.

Number of telephone inquiries received 1999-2001



Inquiries made in person

The primary means of contact with the Commission is by telephone or in writing. From time to time, people attend the Commission to make inquiries in person. Commission staff are available to provide information and/or assist with the preparation of a written complaint as required.

During 2000-2001, an average of six interviews were conducted each month. This is the same number as last financial year.

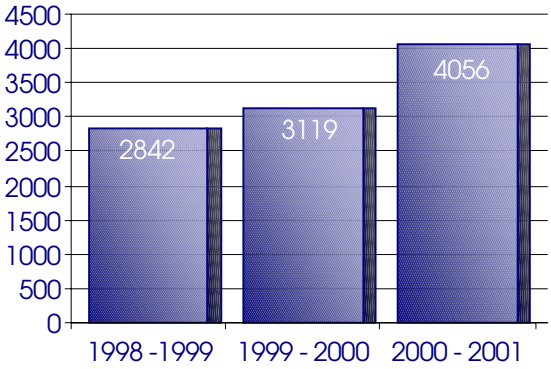
Patient Support Office

The Patient Support Office (PSO) assists consumers to resolve their concerns with private and public health services at the local level. The PSO aims to:

- promote and protect the rights of health consumers;
- assist in the timely, efficient and effective resolution of health concerns;
- empower people to have a positive and active role in their health care and to resolve concerns in the future;
- facilitate access to appropriate health care; and
- assist consumers and health providers to understand approaches to local resolution of health concerns.

In 2000-2001, the PSO provided a service to 4,056 people with health concerns, a 30% increase over the previous year. The following chart shows the numbers of clients provided with a service by the PSO in the past three financial years.

Number of PSO clients



Clients obtained information about the PSO from a variety of sources. Table 1 details how clients found out about the PSO.

Telephone Inquiry Officers (TIOs) or the Assessment Committee at the HCCC refer the majority of clients (67.2%) to the PSO. TIOs refer clients who telephone the Commission but have not lodged a formal complaint. These clients may request an advocate to assist in the local resolution of their concerns with a health provider. TIOs may also refer people with communication difficulties who need further assistance to clarify concerns or write a letter of complaint.

The Assessment Committee refers clients who have lodged written complaints with the Commission. The complaints have been assessed either for investigation by another body, or for direct resolution between the parties. The PSO assists such clients to resolve their concerns.

Table 1 - How clients found out about the PSO

	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
HCCC	1,594	56.1	1,963	62.9	2,727	67.2
PSO Promotion/Word of Mouth	511	18.0	513	16.5	557	13.7
Other/Not stated	365	12.8	316	10.1	446	11.0
Health Provider/Facility	141	5.0	114	3.7	129	3.2
Government Body	44	1.6	69	2.2	70	1.7
Directories	51	1.8	62	2.0	60	1.5
Consumer Organisation	104	3.7	62	2.0	50	1.2
Member of Parliament	32	1.1	20	0.6	17	0.4
Total	**2,842**	**100.0**	**3,119**	**100.0**	**4,056**	**100.0**

During the year PSO clients raised a wide range of health concerns or complaints. A summary of the categories of concerns are detailed in the Table 2.

Table 2 - Type of concerns raised by PSO clients 1999-2001

	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Clinical Standards	1,739	38.7	1,866	38.3	2,049	38.9
Communication	751	16.7	841	17.3	856	16.2
Quality of Care	926	20.6	854	17.5	804	15.3
Miscellaneous	342	7.6	438	9.0	519	9.8
Business Practices	208	4.6	258	5.3	341	6.5
Patient Rights	229	5.1	278	5.7	266	5.1
Prescribing Drugs	66	1.5	69	1.4	108	2.1
Complaints Management	61	1.4	78	1.6	102	1.9
Provider Consumer Relationship	66	1.5	92	1.9	98	1.9
Waiting List	44	1.0	33	0.7	36	0.7
Other Ethical/Improper Conduct	26	0.6	22	0.5	34	0.6
Fraud	4	0.1	14	0.3	22	0.4
Illness Related	0	0.0	13	0.3	20	0.4
Impairment	5	0.1	9	0.2	9	0.2
Character	0	0.0	0	0.0	5	0.1
Resources	29	0.7	8	0.2	3	0.1
Total*	**4,496**	**100.0**	**4,873**	**100.0**	**5,272**	**100.0**

* This total differs from the total number of clients because some clients raised more than one concern.

As with written complaints, a large proportion of consumer concerns relate to clinical standards. It has remained the major category of concern of PSO clients for the past three years, with the percentage (38-39%) remaining constant. This category of complaint includes issues such as inadequate or incorrect diagnosis, inadequate or incorrect treatment, infection control or the quality of medical records.

Communication issues comprise the second largest category of concern. This category includes rude/insensitive communication, incorrect/misleading communication and the failure to provide information. Clients regularly complain that health professionals do not explain issues clearly enough or are dismissive when more information is sought.

Another significant category of concern was quality of care. Inadequate nursing care in hospitals and nursing homes was the primary issue raised in this category during the year. Lack of coordinated care, when several professionals are involved in treatment, and problems with community care are also significant issues. It is noteworthy that there has been a 5.4% drop in these types of concerns over three years. It is the only category that has shown a significant decrease.

The services provided and recorded by the PSO are the provision of information and assisted advocacy. In reality, the PSO works with both the consumer and provider to tailor a resolution strategy which will work for both parties. The flexibility of the model is critical to its acceptance and its success. Table 3 shows the type of service provided to clients for the past three years.

The majority of clients (70.9%) were provided with either support or assisted advocacy services. 'Support' means listening, clarifying issues and assisting people to identify the most appropriate option for resolution. Patient support officers aim to empower clients to take action themselves.

'Assisted advocacy' may include arranging and/or attending resolution meetings between the consumer and the health service, assistance with writing a letter, locating health services that address the client's needs and other means of facilitating local resolution. When resolution meetings are organised, the patient support officer works with both parties to clarify issues and desired outcomes. In complex cases, an issues paper is prepared and sent to the provider or health organization prior to the meeting. Often more than one meeting is required to reach resolution.

A minority of clients (29%) were provided with information to assist them to obtain health or community services, exercise their health rights, find out how to contact consumer support groups or the appropriate person with whom to discuss their health issue. For the patient support officer the provision of information may be a simple matter of looking up a community directory or it may involve research involving other organiasations.

The past financial year saw a decrease in 'Information Only' service and a rise in 'Support and Assisted Advocacy'. This was achieved through better referral of clients to the patient support officers from the telephone inquiry service located in the Commission. TIOs were trained to provide a wider range of information that lessened the need for referrals to patient support officers.

Data collected show that 19% of clients had one or two contacts with the PSO, with 50% having three to five contacts and 22% had more than five contacts. Nine percent of respondents did not indicate the number of times they contacted the PSO.

Table 3 - Type of service provided by PSO

	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Support & Assisted Advocacy (AA)	1,719	60.5	1,876	57.9	3,006	70.9
Information Only (IO)	1,123	39.5	1,365	42.1	1,235	29.1
Total	**2,842**	**100.0**	**3,241**	**100.0**	**4,241**	**100.0**

*this total differs from the total number of clients because some clients raised concerns about more than one provider

Table 4 - PSO service outcomes

	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Resolved	1,180	42.5	1,547	40.2	1,699	33.4
Client pursued with another body/person	776	27.9	1,110	28.9	1,400	27.5
Incomplete resolution	247	8.9	398	10.4	775	15.2
No contact or person declined involvement	332	12.0	504	13.1	658	12.9
Not resolved	170	6.1	170	4.4	389	7.6
Unable to be resolved	74	2.7	117	3.0	168	3.3
Total*	**2,779**	**100.0**	**3,846**	**100.0**	**5,089**	**100.0**

* This total reflects the number of outcomes recorded. Clients may achieve more than 1 outcome eg an apology and a change in procedure. The number of outcomes therefore does not match the total number of clients or concerns.

The various outcomes of the PSO service are noted in Table 4. Outcomes of complaints for consumers are known where patient support officers have been involved in the resolution of the concerns. These known outcomes are recorded under 'resolved', 'partially resolved', 'not resolved'. Where patient support officers were involved in the resolution of complaints, 86% of matters were resolved or partially resolved.

A relatively small percentage (8%) of concerns were recorded as 'not resolved' due to a range of reasons, including the refusal of the health provider to engage in local resolution, client expectations were unable to be met, disagreement on facts, or options for resolution were not acceptable to the client or provider. Other instances where local resolution was not successful were due to: lost medical records or reports; the age of the event presenting difficulties in locating health providers; the client being unwilling to pursue the matter after the resolution process commenced; or information relating to a third party not being able to be obtained.

In other matters, the patient support officer may have assisted the consumer develop a resolution strategy which is carried out by the consumer. In these matters the patient support officer does not know the outcome for the consumer. Where this occurs, the patient support officer involvement is categorised as 'client pursued with another body/person'. The outcomes were recorded in this way in 27.5% of outcomes. It is reasonable to assume that a substantial proportion of these concerns were likely to be resolved as no further contact was made with the patient support officer.

In a small number of cases (13%), the client cannot be located by the patient support officer or the client decided against using the services of the PSO. Similarly, in a small number of cases (3%), the client's concerns were unable to be resolved for another reason, for example, the refusal of the provider to participate in a resolution strategy. The uptake of the PSO service is 87%.

The percentage of cases where there was total resolution of the concerns dropped in the past year, while the percentage rose for incomplete resolution. This may have occurred because patient support officers were encouraged to more actively canvass the clients' opinions about the outcomes. While it may seem to a patient support officer that all that was possible in resolution was achieved, clients remain dissatisfied. Sometimes there are clearly grief-related issues preventing finalisation.

PSO concerns by location and service sector

Table 5 breaks down the concerns raised with the PSO by health service location and type of service (public, private, non-government or other).

Table 5 - Breakdown of concerns by location & service sector 1999-2001

AHS	1998-1999 Total No	1999-2000 Total No	2000-2001 Public[1]	Private[2]	Other[3]	Total No
Central Coast	92	83	61	83	9	**153**
Central Sydney	273	316	162	190	8	**360**
Corrections	47	94	56	1	0	**57**
Far West	10	26	14	12	1	**27**
Greater Murray	39	56	42	37	4	**83**
Hunter	202	274	159	133	21	**313**
Illawarra	71	86	66	60	6	**132**
Interstate/Out of State	5	9	1	6	4	**11**
Macquarie	24	28	24	8	0	**32**
Mid North Coast	61	76	40	36	2	**78**
Mid Western	24	34	37	16	1	**54**
New England	34	52	29	27	2	**58**
Northern Rivers	47	53	50	58	0	**108**
Northern Sydney	416	385	216	309	22	**547**
Not known	243	333	64	123	144	**331**
South Eastern Sydney	411	486	272	391	30	**693**
South Western	352	338	203	218	11	**432**
Southern	50	63	46	22	1	**69**
Wentworth	101	96	66	71	6	**143**
Western Sydney	340	353	259	214	37	**510**
Total*	**2,842**	**3,241**	**1,867**	**2,015**	**309**	**4,191**

[1] Public: all public health services including public hospitals, public nursing homes and community health services

[2] Private: all private health services including private hospitals and nursing homes, private practitioners eg GPs, specialists, dentists etc.

[3] Other: all Non Government Organisations (NGOs) health services, concerns about system-wide issues, access to services that involves all sectors.

* This total differs from the total number of clients because some clients raised concerns about more than one health provider

Note that the Private and NGO health services are located within the geographical boundaries of an Area Health Service but are not under its control.

PSO clients' concerns increased in all Area Health Service regions except the Corrections Health Service in the past year. South Eastern Sydney and Northern Sydney had the greatest increases.

WRITTEN COMPLAINTS

Complaints received

In 2000-2001 the Commission received 2,888 complaints. The bar graph on the right shows the number of complaints received by the Commission have increased each year. The Commission received 19% more complaints in 2000-2001 than it did in 1999-2000.

When the Commission receives and assesses complaints, it categorises them. Each complaint is presently allocated a primary category, which reflects the main issue raised by the complaint. Most complaints raise multiple issues. Table 6 reports on how the Commission categorised the primary issue raised by complaints received in the last three financial years.

Total number of complaints received 1996 - 2001

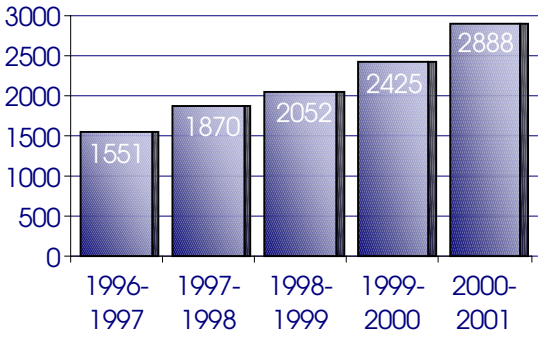


Table 6 - Summary of complaints received by category 1999-2001

Category	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Clinical Standards	1168	56.9	1264	52.1	1463	50.7
Quality of Care	312	15.2	332	13.7	465	16.1
Business Practices	140	6.8	228	9.4	261	9.0
Prescribing Drugs	97	4.7	171	7.1	157	5.4
Provider-Consumer Relationship	129	6.3	123	5.1	134	4.6
Patient Rights	79	3.9	101	4.2	114	3.9
Impairment	24	1.2	38	1.6	84	2.9
Fraud	47	2.3	52	2.1	58	2.0
Other Ethical/Improper Conduct	39	1.9	52	2.1	50	1.7
Miscellaneous	7	0.3	32	1.3	26	0.9
Character	6	0.3	15	0.6	23	0.8
Operative Complication	0	0.0	4	0.2	19	0.7
Waiting Lists	2	0.1	8	0.3	17	0.6
Complaints Management	0	0.0	4	0.2	16	0.6
Resources	2	0.1	1	0.0	1	0.0
Total	**2,052**	**100.0**	**2,425**	**100.0**	**2,888**	**100.0**

Each category of complaint is comprised by various types of complaint. Table 7 provides a further breakdown of each category of complaint by type for those complaints received in 2000-2001. The table shows that the types of complaints received by the Commission remain relatively stable from year to year.

Table 7 - Breakdown of category of complaints received 2000-2001

Category	No.	Category	No
Clinical Standards	**1463**	**Business Practices**	**261**
Treatment - Inadequate	221	Fees	69
Adverse Treatment Outcomes	193	Medico-legal Reports	59
Communication: Insensitive/Rude	160	Inappropriate Commercial Activities	34
Diagnosis - Incorrect	160	Medico-legal Report- Inadequate/Incorrect	24
Diagnosis - Inadequate/Incomplete	143	Medical Certificates	18
Treatment - Incorrect/Inadequate	94	Refusal to hand over medical records	17
Clinical Practice: Diagnosis-Nil/Incorrect	88	Medico-legal Report - Rough/Inadequate	16
Refusal to Treat	69	Commercial Advertising	9
Consent	55	Death Certificate	9
Infection Control	44	Medico-legal Report - nil communication	3
Communication - Nil	44	Medico-legal Report - fraud	2
Communication: Incorrect/ Misleading/Nil	42	Statutory Breaches	1
Prosthetic Services	42	**Prescribing Drugs**	**157**
Competence	40	Wrong/Incorrect Prescribing	54
Refusal to Attend	16	Dispensing	47
Delay in Attending	11	Over Prescribing	14
Failure to follow-up results	9	Illegal Prescribing	14
Experimental Treatments	9	Administration	14
Innovative Treatment	5	Diversion	11
Use of Interpreter	5	Inducement/Favour to Prescribe	3
Medical Records - nil	4	**Provider-Consumer Relationship**	**134**
Medical Records - quality	4	Sexual Assault	36
Language	3	Inappropriate Examination/Treatment	24
Treatment - Gross Mismanagement	1	Sexual Relationship	22
Medical Records - Incomplete	1	Physical Assault	21
Quality of Care	**465**	Sexual Harassment	16
Standards of Care: Facilities	174	Inappropriate Relationship	12
Inappropriate Care	59	Sex for Favour	2
Institutions/Hospital Practice	56	Coercion	1
Administrative Practice	37	**Patient Rights**	**114**
Inappropriate Discharge	32	Breach of Confidentiality	78
Discrimination	19	Access to Records/Reports	26
Premature Discharge	16	Privacy	6
Inappropriate Admission (Mental Health)	16	Records: Accuracy	4
Refusal to Admit	14	**Impairment**	**84**
Inadequate/Unqualified Personnel	11	Drugs	44
Inappropriate Transport	8	Mental/Physical Capacity	31
Standards of Care: Hygiene	8	Age	8
Refusal to Discharge	4	Breach of Conditions	1
Delay in Admission	4	**Fraud**	**58**
Inappropriate Admission	3	Holding Out/Misrepresentation	20
Statutory Compliance	1	Overservicing	14
Multiple Complaints	1	Falsification/Fabrication/Plagiarism	11
Delayed Transfer	1	Financial Inducement/Advantage	9
Delayed Transport	1	Extraordinary Claims	4

Table continued over page...

Table 7 (continued)

Category	No.	Category	No.
Other Ethical Improper Conduct	**50**	**Operative Complication**	**19**
Acts of Dishonesty	24	Operative Complication	19
Inappropriate Professional Conduct	24	**Waiting List**	**17**
Use of Deleterious Drugs	1	Waiting List	17
Other	1	**Complaints Management**	**16**
Miscellaneous	**26**	Dissatisfaction with Process/ Outcome	11
Awaiting More Information	16	Delay/no Response	4
Provide Information	7	Retaliation/Staff Attitude	1
Notification	2	**Resources**	**1**
Various 'Other' Categories	1	Resources	1
Character	**23**	**Total**	**2888**
Conviction/Offence Under Legislation	16		
Breach of Conditions	7		

Table 8 shows a breakdown of complaints received about health services.

Table 8 - Complaints received about health services 1999-2001

Facility	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Public Hospital	336	52.3	406	54.7	503	56.0
Other*	46	7.9	33	4.4	70	7.8
Private Hospital	45	7.0	52	7.0	67	7.5
Nursing Home	38	5.9	30	4.0	48	5.3
Medical Centre	36	5.6	36	4.9	44	4.9
Psychiatric Hospital	44	6.9	24	3.2	23	2.6
Community Health Service	18	2.8	39	5.3	22	2.4
Corrections Health Service	16	2.5	26	3.5	20	2.2
Pathology Centre or Laboratory	8	1.2	7	0.9	19	2.1
Radiology Centre	6	0.9	12	1.6	17	1.9
Area Health Service	6	0.9	17	2.3	13	1.4
Pharmacy	1	0.2	5	0.7	11	1.2
Public Dental Unit	6	0.9	2	0.3	10	1.1
Ambulance Service	10	1.6	16	2.2	7	0.8
Health Funds	0	0.0	2	0.3	7	0.8
Private Medical Practice	6	0.9	12	1.6	6	0.7
Hostel, Aged	5	0.8	2	0.3	5	0.6
Day Procedures Centre	3	0.5	3	0.4	3	0.3
Department of Health	0	0.0	2	0.3	3	0.3
Drug & Alcohol Service	3	0.5	5	0.7	1	0.1
Alternative Health Service	2	0.3	8	1.1	0	0.0
Group Home	4	0.6	2	0.3	0	0.0
Women's Health Centre	3	0.5	1	0.1	0	0.0
Total	**642**	**100.0**	**742**	**100.0**	**899**	**100.0**

Other: 1999-2000 Dental Surgery - Private 3; Other, no code available, 30

Other: 2000-2001 Dental Surgery - Private 2; Physiotherapy Clinic - Private 2; Private Developmental Disability Hospital 1; Nursing Agency - District / Community 1; Hostel - Other 1; Family Planning Clinic 1; Registration Boards 1; Men's Health Clinic 2; Methadone Clinic 1; Sports Medicine 1; Other, no code available 57.

The number of complaints received about health services has increased by 157 or 21% and complaints about public hospitals have increased by 97 (24%) in 2000-2001. While the percentage increases may appear to be significant, the numerical increases are not indicative of any particular trend in relation to health services or public hospitals, particularly in the context of the volume of individual services provided in the health sector.

The Commission receives an increasing number of complaints about private health insurance, public health insurance, pharmaceutical companies, restaurants and government departments and a range of other agencies which are not health services for the purposes of the Health Care Complaints Act 1993. Complaints which are coded "other" are generally not health services.

Complaints received about public hospitals are reported by Area Health Service in Table 9. Comparative data on the number of admissions, non-admitted patient services, emergency department attendances are included to provide some context for the statistics.

Table 9 - Complaints about public hospitals by Area Health Service 1999-2001

Region	1998-1999		1999-2000		2000-2001		2000-2001		
	No	%	No	%	No	%	Admissions	Non-Admitted Patient Services	Emergency Dep't Attendance
Central Coast AHS	14	4.2	21	5.2	20	4.0	66,539	923,160	81,819
Central Sydney AHS	29	8.6	43	10.6	45	8.9	130,306	1,741,554	96,728
Far West AHS	0	0.0	6	1.5	3	0.6	12,328	267,978	45,995
Greater Murray AHS	5	1.5	10	2.5	24	4.8	53,278	743,085	145,569
Hunter AHS	24	7.1	35	8.6	38	7.6	108,575	1,297,644	179,509
Illawarra AHS	17	5.1	20	4.9	34	6.8	71,950	1,006,120	108,483
Macquarie AHS	6	1.8	8	2.0	13	2.6	28,223	323,561	36,060
Mid North Coast AHS	17	5.1	15	3.7	15	3.0	49,003	645,627	105,449
Mid Western AHS	17	5.1	6	1.5	14	2.8	43,854	613,653	103,092
New England AHS	10	3.0	10	2.5	11	2.2	45,126	486,629	100,290
Northern Rivers AHS	7	2.1	11	2.7	19	3.8	59,351	819,879	166,350
Northern Sydney AHS	34	10.1	37	9.1	44	8.7	105,922	1,874,010	1,972,268
Other*	1	0.3	11	2.7	4	0.8	N/A	N/A	N/A
South Eastern Sydney AHS	42	12.5	61	15.0	85	16.9	165,967	2,744,659	214,261
South Western AHS	40	11.9	47	11.6	43	8.5	133,258	1,832,210	163,391
Southern AHS	14	4.2	9	2.2	7	1.4	32,414	565,597	87,437
Wentworth AHS	8	2.4	13	3.2	16	3.2	51,068	559,165	55,747
Western Sydney AHS	51	15.2	43	10.6	68	13.5	130,237	1,785,803	64,891
Total	**336**	**100.0**	**406**	**100.0**	**503**	**100.0**	**1,287,399**	**18,230,334**	**3,727,339**

* Includes The Children's Hospital, Westmead, Port Macquarie Base Hospital and Hawkesbury Health Service

Complaints about public and private hospitals are reported by service area in Table 10.

Table 10 - Complaints received about public and private hospitals analysed by service area 2000-2001

Service Area	Public Hospitals No	Public Hospitals %	Private Hospitals No	Private Hospitals %
Accident and Emergency	120	23.9	7	10.4
Mental Health	55	10.9	1	1.5
Surgery - General	40	8.0	13	19.4
Obstetrics	35	7.0	6	9.0
Administration - General	17	3.4	5	7.5
Gerontology	16	3.2	0	0.0
Psychiatry	16	3.2	2	3.0
Surgery - Orthopaedic	16	3.2	5	7.5
Gynaecology	15	3.0	3	4.5
Cardiology	14	2.8	1	1.5
Neurology	10	2.0	0	0.0
Anaesthesia	9	1.8	0	0.0
Intensive Care	9	1.8	0	0.0
Rehabilitation Medicine	9	1.8	5	7.5
Respiratory	9	1.8	1	1.5
Gastroenterology	8	1.6	1	1.5
Paediatric Medicine	8	1.6	0	0.0
Palliative Care	7	1.4	0	0.0
Surgery - Urology	7	1.4	0	0.0
General Medicine	5	1.0	1	1.5
Oncology - Medical	5	1.0	2	3.0
Pathology	5	1.0	0	0.0
Surgery - Plastic and Reconstructive	5	1.0	3	4.5
Renal Medicine	4	0.8	0	0.0
Administration - Medical Records	3	0.6	0	0.0
Dentistry	3	0.6	0	0.0
Radiography	3	0.6	1	1.5
Radiology	3	0.6	1	1.5
Speech Therapy	3	0.6	0	0.0
Surgery - Cardiothoracic	3	0.6	1	1.5
Surgery - Neuro	3	0.6	0	0.0
Surgery - Paediatric	3	0.6	0	0.0
Other*	35	7.0	8	11.9
Total	**503**	**100.0**	**67**	**100.0**

Other:

Public Hospital: Code not available 6; Drug & Alcohol Services 2; Opthalmology 2; Personal Care 2; Surgery - Ear, Nose & Throat 2; Urology 2; Autopsy 1; Developmental Disability 1; Haematology 1; Immunology 1; Infectious Diseases 1; Neonatology 1; Nuclear Medicine 1; Oncology - Radiation 1; Optometry 1; Pharmacy 1; Physiotherapy 1; Podiatry 1; Psychogeriatrics 1; Psychology 1; Public Health 1; Social & Welfare Work 1; Surgery - Vascular 1; Waiting Lists 1; Drugs - Prescribing 1.

Private Hospitals: Drug & Alcohol Services 1; Opthalmology 1; Surgery - Ear, Nose & Throat 1; Physiotherapy 1; Public Health 1; Endocrinology 1; Surgery - Oncology 2.

Table 11 records the number of complaints received in the reporting year about health practitioners analysed by profession. Comparative data on previous years is also provided.

Table 11 - Complaints received about health practitioners 1999-2001

Profession	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Medical Practitioner	1,065	78.3	1,122	66.9	1,396	70.2
Nurse	114	8.4	179	10.7	212	10.7
Dentist	24	1.8	165	9.8	144	7.2
Pharmacist	9	0.7	74	4.4	67	3.4
Psychologist	34	2.5	39	2.3	58	2.9
Other*	33	2.4	13	0.8	21	1.1
Physiotherapist	12	0.9	17	1.0	15	0.8
Dental Technician & Prosthetist	20	1.5	16	1.0	15	0.8
Optometrist	12	0.9	6	0.4	14	0.7
Chiropractor & Osteopath	11	0.8	22	1.3	11	0.6
Social Worker	5	0.4	4	0.2	11	0.6
Counsellor/Therapist	4	0.3	1	0.1	8	0.4
Alternative Health Provider	11	0.8	7	0.4	6	0.3
Administrative or Clerical Staff	0	0.0	2	0.1	6	0.3
Podiatrist	6	0.4	11	0.7	3	0.2
Optical Dispenser	0	0.0	0	0.0	2	0.1
Total	**1,360**	**100.0**	**1,678**	**100.0**	**1,989**	**100.0**

Other, 2000-2001: Orthotist 1; Deregistered Health Practitioners 1; Traditional Medicine 1; Speech Pathologist 1; Mental Health Worker 1; No code available 16.

In relation to the registered professions, there was an increase in the number of complaints received about medical practitioners, nurses, psychologists, optometrists, and optical dispensers.

Table 12 reports on the categories of complaint received against the registered professions.

As commented on in the section headed Achievements, there has been a large increase in the number of complaints received concerning the possible impairment of a health practitioner. This reflects a change in the recording of complaints by the Commission during the year.

Table 13 highlights who has made or referred a complaint to the Commission. This year, there has been a significant increase in the number of complaints made by health consumers themselves. Complaints made on behalf of consumers by consumer organisations also increased. The increase in complaints made by the Departments of Health (State and Commonwealth) may reflect the recent practice of the Commonwealth writing to the Commission in relation to certain nursing homes visited during the accreditation process. In these cases, the Commonwealth has notified the Commission about concerns or incidents which may attract the Commission's jurisdiction.

Last year, the Commission reported a change to the counting of complaints received by registration authorities. This is reflected in the increase in the proportion of complaints received by the registration authorities in 1999-2000. In 2000-2001, the numbers of complaints received by registration authorities remained static while the proportion dropped. This suggests that the increase in complaints made during 2000-2001 were complaints which were made directly to the Commission and not via the registration authorities. This may support the view that the Commission performed well in disseminating information about the complaint handling system.

Table 12 - Complaints received about registered professions by category 2000-2001

Category	Medical Practitioners	Nurses	Dentists	Pharmacists	Psychologists	Physiotherapists	Dental Technicians/ Prosthetists	Optometrists	Chiropractors & Osteopaths	Podiatrists	Optical Dispensers
Business Practices	178	2	17	6	17	3	0	0	1	0	0
Character	9	10	1	0	1	0	0	0	0	0	0
Clinical Standards	849	45	115	8	11	7	15	10	7	3	1
Complaints Management	3	0	0	0	0	0	0	0	0	0	0
Fraud	22	9	4	2	3	1	0	3	2	0	0
Impairment	33	49	0	0	1	0	0	0	0	0	0
Operative Complication	12	0	2	0	0	0	0	0	0	0	0
Other Ethical/Improper Conduct	15	22	0	1	5	2	0	0	0	0	0
Patient Rights	64	5	0	2	10	0	0	0	0	0	0
Prescribing Drugs	63	22	1	47	0	0	0	0	0	0	0
Provider-Consumer Relationship	78	28	2	0	8	0	0	0	1	0	0
Quality of Care	67	20	2	1	2	2	0	1	0	0	1
Waiting List	3	0	0	0	0	0	0	0	0	0	0
Total	**1,396**	**212**	**144**	**67**	**58**	**15**	**15**	**14**	**11**	**3**	**2**
Total Practitioners registered in NSW as at 30.6.2001	**24,991**	**92,177**	**4,051**	**7,031**	**6,689**	**5,654**	**1,041**	**1,440**	**1,464**	**693**	**1,337**

Table 13 - Source of complaints 1999-2001

Source	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %	2000-2001 No	2000-2001 %
Consumer	921	44.9	978	40.3	1,443	50.0
Registration Board	399	19.4	585	24.1	595	20.6
Family/Friend	354	17.3	449	18.5	363	12.6
Department of Health (State & Commonwealth)	131	6.4	125	5.2	143	5.0
Parliament/Minister	81	3.9	113	4.7	110	3.8
Legal Representative	51	2.5	78	3.2	81	2.8
Consumer Organisation	25	1.2	15	0.6	65	2.3
Other	19	0.9	12	0.5	23	0.8
Health Professional	26	1.3	16	0.7	20	0.7
Government Department	36	1.8	36	1.5	19	0.7
Courts	1	0.0	12	0.5	15	0.5
Professional Association	6	0.3	6	0.2	9	0.3
Non Government Agency	2	0.1	0	0.0	2	0.1
Total	**2,052**	**100.0**	**2,425**	**100.0**	**2,888**	**100.0**

ASSESSMENT OF COMPLAINTS

Background

The Commission assesses all complaints about health services, unregistered health practitioners and registered health practitioners made under either the Health Care Complaints Act 1993 or the professional registration acts. One of the Commission's primary functions is to assess all complaints received by the Commission or registration authorities against registered practitioners. The object of this function is to ensure that the assessment of complaints is objective, consistent, fair, free from bias and made by a body independent of the professions.

The Commission's assessment committee assesses complaints on receipt. Assessment may not occur immediately on receipt where the material provided is voluminous or where further information is required. The assessment committee is usually comprised of the Commissioner and the Director of Complaint Resolution. Staff are invited to attend to ensure that they have a clear understanding of the process and there are usually at least two other members of staff attending each Assessment Committee. Other staff attend from time to time. When assessing complaints about registered practitioners, the Commission is required to consult with the relevant registration authority before it makes a decision. When assessing a complaint about a medical practitioner, the Assessment Committee includes a representative of the Medical Board. All other registration authorities meet monthly so the assessment of a complaint for other registered health practitioners cannot take place until the Commission attends this monthly meeting.

The purpose of complaint assessment is to decide how a complaint will be handled. The Act sets out how the Commission may handle a complaint. The options available to the Commission are to refer the complaint for conciliation, investigate it, refer it to another body for investigation or to decide not to deal with the complaint. The Commission also refers complaints to the Patient Support Office for it to facilitate a resolution between the parties.

During 2000-2001, the Commission received 2,888 written complaints, 463 more complaints than the previous year. This amounts to a 19% increase in the number of complaints dealt with by the Commission, following the 18% rise reported in the 1999-2000 Annual Report.

Table 14 shows how the Commission assessed complaints received in the year, taking into account any changes to the assessment decision after review or reassessment.

Table 14 - Outcome of assessment of complaints received 1999-2001

Assessment	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %	2000-2001 No	2000-2001 %
Refer to another body or person	584	29.4	1,052	43.4	1,444	50.0
Direct resolution	385	19.4	379	15.6	523	18.1
Decline	413	20.8	469	19.3	419	14.5
Investigation by the Commission	459	23.1	384	15.8	335	11.6
Conciliation consented to or awaiting consent*	146	7.3	98	4.0	155	5.4
Awaiting Assessment as at 30 June of the financial year	65	3.3	43	1.8	12	0.4
Total	**2,052**	**100.0**	**2,425**	**100.0**	**2,888**	**100.0**

*As at 30.6.2001, 49 were awaiting consents. As at 30.6.2000, 31 complaints were awaiting consents. As at 30.6.1999, 100 complaints were awaiting consents

Assessment Decisions

REFER TO ANOTHER BODY FOR INVESTIGATION

The Health Care Complaints Act 1993 enables the Commission to refer complaints to another agency if it forms the opinion that the complaint raises issues which warrant investigation by that agency. In 2000-2001 the Commission referred 50% of complaints to another agency for investigation.

The referred complaints are reported on by category in Table 15.

The number of complaints referred to other agencies has increased in line with the increase in complaints generally. The Commission most commonly refers complaints to either the AHSs or one of the registration authorities. The percentage of referrals to AHSs has ranged from 32% to 46% in the past three years. In 2000-2001, it was 41% (Table 16).

Referrals to the registration authorities reflects the largest increase in referrals in the past three years. It is well recognised that registration authorities can play a role in monitoring and maintaining professional standards. Health professionals will often reflect upon and improve their practice when the contact is made by their professional registration authority. These referrals are reported in more detail under the heading of Investigations.

Last year, the Commission reported that one of its strategic aims was to improve local complaint handling. As part of this approach, the Commission has been referring increasing numbers of complaints to the AHSs for them to handle. The Commission has supported local complaint handling by providing training and a consultancy service. These complaints may have been assessed in earlier years as warranting investigation by the Commission. However, there is growing recognition that improvement in the quality of health services is more likely to take place if the investigation is local and the issues are identified and managed locally. The Commission monitors selected complaints and a full report on this work is provided under the heading of Investigations in this Report (page 46).

Table 15 - Category of complaints referred to another body or person for action 1999-2001

Category	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Clinical Standards	311	53.3	536	51.0	693	48.0
Quality of Care	161	27.6	187	17.8	328	22.7
Prescribing Drugs	32	5.5	104	9.9	87	6.0
Business Practices	34	5.8	78	7.4	78	5.4
Impairment	5	0.9	19	1.8	68	4.7
Patient Rights	7	1.2	38	3.6	48	3.3
Provider-Consumer Relationship	11	1.9	25	2.4	41	2.8
Fraud	16	2.7	35	3.3	35	2.4
Other ethical/improper conduct	5	0.9	14	1.3	21	1.5
Character	0	0.0	3	0.3	10	0.7
Complaints Management	0	0.0	0	0.0	10	0.7
Waiting List	1	0.2	5	0.5	10	0.7
Miscellaneous	0	0.0	7	0.7	8	0.6
Illness Related	0	0.0	1	0.1	6	0.4
Resources	1	0.2	0	0.0	1	0.1
Total	**584**	**100.0**	**1,052**	**100.0**	**1,444**	**100.0**

Table 16 - Complaints referred to another body by the body referred to 1999-2001

Body referred to	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Registration Board	57	9.8	485	46.1	625	43.3
AHS	268	45.9	336	31.9	595	41.2
Director-General	63	10.8	67	6.4	80	5.5
Other Body	93	15.9	35	3.3	46	3.2
Other Government Department	0	0.0	15	1.4	31	2.1
Other Commonwealth Government Body	3	0.5	7	0.7	20	1.4
Health Insurance Commission	5	0.9	3	0.3	9	0.6
Private Health Facility	12	2.1	10	1.0	4	0.3
PHICC*	0	0.0	1	0.1	1	0.1
Direct Resolution	0	0.0	1	0.1	0	0.0
Terminated on Complainant Request	0	0.0	4	0.4	0	0.0
Awaiting Processing as at 30 June	83	14.2	88	8.4	33	2.3
Total	**584**	**100.0**	**1,052**	**100.0**	**1,444**	**100.0**

*Private Health Insurance Complaints Commission

Refer for conciliation

Conciliation is a process in which a trained conciliator facilitates the resolution of disputes. Once the Commission decides a complaint should be handled through conciliation, the Commission must refer the complaint to the Health Conciliation Registry (HCR), which is a separate body established under the Health Care Complaints Act 1993 (the Act). Before referring the complaint to the Registry, the Commission must obtain the consent of the parties to do so. Participation in the conciliation process is voluntary.

The Act provides that the conciliation process is confidential. Evidence of anything said or of any admission made during the conciliation process is not admissible in any proceedings before a court, tribunal or body. A document prepared for the purposes of, or in the course of, the conciliation process is also not admissible in any proceedings before a court, tribunal or body. Because of this statutory protection, the Commission will assess complaints for conciliation (if the complaint does not fall into a class of complaint the Commission must investigate) where:

- the complaint lends itself to this model of resolution;
- the complainant has indicated they are considering or have commenced legal action;
- the complainant is seeking monetary compensation as an outcome to the complaint; or
- one of the parties has requested conciliation.

A complaint may also be suitable for conciliation where there has been a breakdown in communication between the parties, where insufficient information was provided, where inadequate explanation was given for an adverse outcome, or where there was an inadequate service.

During 2000-2001, 330 complaints were initially assessed for conciliation. This number is higher than the previous year's initial count of 240. The percentage of complaints assessed for conciliation has remained at around 10% of the total number of complaints received for the past three years. In the past year, the Health Conciliation Registrar has participated in the assessment of all complaints received by the Commission. The number and category of complaints initially assessed for conciliation appears in Table 17.

Of the 330 complaints assessed for conciliation in the financial year, the Commission obtained the relevant consents and referred 106 complaints to the Health Conciliation Registry compared with 67 in 1999-2000 and 46 in 1998-1999. At 30 June 2001 the Commission held 49 files awaiting consent.

Table 17 - Category of complaints received and originally assessed for conciliation 1999-2001

Category	1998-1999*		1999-2000		2000-2001	
	No	%	No	%	No	%
Clinical Standards	121	58.2	177	73.8	248	75.2
Business Practices	4	1.9	11	4.6	28	8.5
Quality of Care	9	4.3	27	11.3	26	7.9
Illness Related	0	0.0	0	0.0	9	2.7
Patient Rights	5	2.4	13	5.4	6	1.8
Prescribing Drugs	2	1.0	5	2.1	6	1.8
Complaints Management	0	0.0	0	0.0	4	1.2
Other ethical/improper conduct	0	0.0	2	0.8	2	0.6
Provider-Consumer Relationship	5	2.4	2	0.8	1	0.3
Fraud	0	0.0	2	0.8	0	0.0
Miscellaneous	0	0.0	1	0.4	0	0.0
Other	62	29.8	0	0.0	0	0.0
Total	**208**	**100.0**	**240**	**100.0**	**330**	**100.0**

* These complaints were not reported on by category in 1998-1999.

During the year, the Commission was unable to obtain the requisite consent in 175 complaints. As reported under *Achievements* the Commission has begun to pilot different ways of engaging all parties to tailor resolution processes to the wishes of the parties.

Complaints where parties failed to consent were re-assessed by the Commission. Table 18 sets out the outcomes of re-assessment for complaints which were initially assessed for conciliation but will not be able to proceed to conciliation.

Conciliation remains an important resolution mechanism and the Commission is keen to reduce the impediments for both complainants and health providers to consenting to participate.

While the HCR is independent of the Commission, the Health Care Complaints Act 1993 requires the Commission to report in its Annual Report on the results of conciliations completed during the year. The report on conciliation outcomes provided to the Commission by the HCR specifies whether or not an agreement was reached, if the parties withdrew from the conciliation process and whether or not there are any public health and safety issues which may require investigation by the Commission.

During the year, the HCR provided the Commission with 81 reports compared with 82 reports last year (Table 19). This includes reports received from the Registry on complaints that may have been received by the Commission and/or referred to the Registry in the previous financial year.

The report of the HCR indicates that 83% of conciliations conducted in 2000-2001 resulted in agreement being reached, compared with 77% in 1999-2000 and 89% in 1998-1999.

Table 18 - Reassessment of complaints not proceeding to conciliation 1999-2001

Assessment Level	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Direct resolution between the parties	23	37.1	61	43.0	123	70.3
Discontinue dealing with	28	45.2	44	31.0	27	15.4
Refer to another body or person	6	9.7	33	23.2	22	12.6
Investigation by the Commission	5	8.1	4	2.8	3	1.7
Total	**62**	**100.0**	**142**	**100.0**	**175**	**100.0**

Table 19 - Outcome of complaints closed by HCR in 1999-2001

Outcome	1998-1999*		1999-2000		2000-2001	
	No	%	No	%	No	%
Agreement reached	41	89.1	63	76.8	67	82.7
No Agreement reached	2	4.3	15	18.3	13	16.0
Referred Back: Conciliation cancelled	3	6.5	3	3.7	1	1.2
Referred Back: Conciliator recommended investigation	0	0.0	1	1.2	0	0.0
Total	**46**	**100.0**	**82**	**100.0**	**81**	**100.0**

* Reporting for 1998-1999 differs from the following years. In 1998-1999, the Commission reported on outcomes of complaints referred and conciliated during the financial year. In 1999-2000 and 2000-2001, the Commission reported on all complaints finalised by the Health Conciliation Registry in the financial year. These totals include complaints referred in previous years.

Direct resolution

Section 3 of the Health Care Complaints Act 1993 sets out an objective for the Commission to provide clear mechanisms to resolve complaints. Complaints received by the Commission invariably contain issues important for the parties involved. Some of these complaints do not fall into the class of complaints that the Commission must investigate. Complaints about access to medical records, failure to listen to family concerns, rude or insensitive communication, unresponsive staff, failure to inform consumers of possible complications, and failure to explain what went wrong and why would not generally fall into this category.

One positive way of dealing with such complaints is by direct or assisted resolution.

These matters usually do not require the formal structured approach of conciliation. Matters, where it would be unreasonable to expect either the complainant or the respondent to set aside half a day or more and attend the premises of the Registry for a conciliation conference, are also not suitable. Complaints of this nature are usually referred to the Commission's PSO.

Table 20 - Category of complaints assessed for direct resolution 1999-2001

Category	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Clinical Standards	259	67.3	235	62.0	307	58.7
Quality of Care	47	12.2	46	12.1	75	14.3
Business Practices	26	6.8	45	11.9	66	12.6
Patient Rights	31	8.1	23	6.1	37	7.1
Prescribing Drugs	13	3.4	13	3.4	15	2.9
Provider-Consumer Relationship	5	1.3	5	1.3	9	1.7
Waiting List	0	0.0	1	0.3	4	0.8
Other ethical/improper conduct	3	0.8	2	0.5	3	0.6
Illness Related	0	0.0	1	0.3	3	0.6
Miscellaneous	0	0.0	4	1.1	2	0.4
Fraud	1	0.3	3	0.8	1	0.2
Complaints Management	0	0.0	0	0.0	1	0.2
Character	0	0.0	1	0.3	0	0.0
Total	**385**	**100.0**	**379**	**100.0**	**523**	**100.0**

In complaints assessed for direct resolution the Commission writes to both parties and attempts to encourage the parties to resolve the issues directly between themselves. In complaints assessed for assisted resolution, the Commission arranges for a patient support officer to contact both parties to assist them in resolving the issues. The Commission's involvement in these complaints provides an important avenue for educating consumers about their health rights. It is also an opportunity to educate health practitioners about the importance of consumer participation in the provision of services. The Commission thereby models resolution techniques for both parties, with the aim of equipping them with skills to deal with similar situations and/or to prevent further complaints. Table 20 shows the type of complaints assessed for direct resolution.

HCCC INVESTIGATION

In 2000-2001, the Commission assessed 335 complaints as suitable for investigation by the Commission. This is 49 complaints fewer than the previous financial year. Table 21 shows a breakdown of the type of complaints assessed for investigation.

The number of complaints assessed for investigation has dropped. This may be due to the greater emphasis placed on the strategies of preliminary inquiry prior to assessment. It may also be due to the Commission's greater reliance on the clinical governance of facilities and their increasing capacity to investigate and resolve complaints locally as part of their quality improvement strategies.

The registration boards have assisted the Commission by obtaining responses from practitioners about a complaint. A key element of complaint handling is procedural fairness. This requires providers to know about a complaint and be given the opportunity to respond to it. Currently the Act requires complaints to be assessed on receipt. This has the disadvantage that it does not give the provider an opportunity to respond to the complaint before the decision is made to investigate. In a number of cases, complaints can be discontinued on the basis of information provided in response to a complaint. The registration authorities have been obtaining a response and then assessing it in consultation with the Commission. This gives the registration authority and the Commission much better information upon which to decide whether or not there may be grounds for disciplinary action against a practitioner. This process allows fewer complaints to be initially assessed for investigation by the Commission. The success of this initiative suggests that there may be some benefits in providing the Commission with a preliminary inquiry power to gather information to assist in the assessment of complaints.

A more detailed report on investigations and their outcomes is provided under the heading of Investigations (page 46).

Table 21 - Category of complaints assessed for investigation 1999-2001

Category	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Clinical Standards	220	47.9	165	43.0	129	38.5
Provider-Consumer Relationship	88	19.2	75	19.5	78	23.3
Prescribing Drugs	40	8.7	46	12.0	39	11.6
Quality of Care	41	8.9	37	9.6	21	6.3
Fraud	15	3.3	6	1.6	13	3.9
Business Practices	6	1.3	10	2.6	13	3.9
Other Ethical/Improper Conduct	16	3.5	15	3.9	11	3.3
Impairment	19	4.1	17	4.4	11	3.3
Character	6	1.3	4	1.0	10	3.0
Patient Rights	5	1.1	7	1.8	8	2.4
Complaints Management	0	0.0	0	0.0	2	0.6
Miscellaneous	1	0.2	0	0.0	0	0.0
Illness Related	0	0.0	2	0.5	0	0.0
Re-registration	2	0.4	0	0.0	0	0.0
Total	**459**	**100.0**	**384**	**100.0**	**335**	**100.0**

Decline to deal with a complaint

The Commission may discontinue dealing with a complaint for a range of reasons including:

- the subject matter is under investigation by another body;
- it is subject to legal proceedings;
- there is, or was, a satisfactory alternative means of dealing with the matter by the complainant;
- the events complained about are more than five years old; or
- the subject matter does not require investigation or conciliation or resolution by other means.

During 2000-2001, the Commission declined to deal with 419 complaints. The proportion of complaints declined this year is nearly 5% lower than last year. Many complaints which may have been declined otherwise were referred to the PSO so that the patient support officers could assist the parties (as appropriate) to recognise that the issues raised in the complaint require resolution. This may be reflected in the increased proportion of matters assessed for referral to the PSO. Half of complaints received by the Commission were referred to another agency for handling.

Table 22 shows the category of complaints assessed and declined.

Review of assessment decisions

Section 28(6) of the Health Care Complaints Act 1993 entitles complainants to a review of the Commission's assessment decision. All complainants are informed of their right to a review when they are notified of the decision. The great majority of requests for a review result from a belief by the complainant that the Commission should investigate their complaint.

In 2000-2001, the Commission reviewed 153 assessment decisions. This is an increase of 20% over the number of assessment reviews conducted last year. This percentage increase reflects the overall increase in the number of complaints received. The outcomes of the assessment reviews undertaken are provided in Table 23.

Table 22 - Category of complaints assessed and declined 1999-2001

Category	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Clinical Standards	212	51.3	238	50.7	212	50.6
Business Practices	69	16.7	90	19.2	93	22.2
Quality of Care	49	11.9	48	10.2	34	8.1
Patient Rights	24	5.8	22	4.7	19	4.5
Other Ethical/Improper Conduct	15	3.6	20	4.3	14	3.3
Prescribing Drugs	8	1.9	5	1.1	14	3.3
Fraud	14	3.4	7	1.5	9	2.1
Provider-Consumer Relationship	20	4.8	14	3.0	7	1.7
Impairment	0	0.0	2	0.4	6	1.4
Waiting List	0	0.0	2	0.4	3	0.7
Character	0	0.0	5	1.1	3	0.7
Complaints Management	0	0.0	4	0.9	2	0.5
Illness Related	0	0.0	0	0.0	2	0.5
Miscellaneous	1	0.2	11	2.3	1	0.2
Resources	1	0.2	1	0.2	0	0.0
Total	**413**	**100.0**	**469**	**100.0**	**419**	**100.0**

Table 23 - Outcome of assessment reviews 1999-2001

Review result	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %	2000-2001 No	2000-2001 %
Assessment decision confirmed	82	64.6	99	77.3	128	83.7
Refer to another body	14	11.0	14	10.9	9	5.9
Conciliation	12	9.4	2	1.6	8	5.2
Direct resolution	16	12.6	7	5.5	4	2.6
Reopen for investigation	3	2.4	6	4.7	4	2.6
Total	**127**	**100.0**	**128**	**100.0**	**153**	**100.0**

Case study

Mr and Mrs H complained regarding the death of their infant son from Group B Streptococcal (GBS) disease, ten hours after his birth on 1 January 2000, at a metropolitan hospital. Perinatal GBS disease is contracted by a newborn from his or her mother, during labour.

The complaint focussed on the failure of the hospital to detect Mrs H's GBS carrier status, and hence to provide effective antibiotic cover during labour. The Commission assessed the complaint and referred the matter to the appropriate AHS for investigation. The AHS subsequently confirmed the events as described in the complaint and advised the Commission that, while some hospitals in NSW universally screen for GBS, the respondent hospital does not universally screen for maternal GBS carrier status ante-natally.

The Commission has received other similar complaints where the events complained about regarded the immediate postnatal death from GBS disease, of otherwise healthy babies. Responding to Mr and Mrs H's request for assessment review, the Commission formed the view that there may be a need for the development of statewide guidelines governing the detection of pregnant women who are carriers of Group B Streptococcus, and the prophylaxis of transmission during delivery.

Foremost in the Commission's mind was that Group B Streptococcus has emerged as a major cause of neonatal morbidity and mortality and the fact that 15% of pregnant women proceeding to labour in NSW have been shown to be carriers of Group B streptococcus. GBS is the leading bacterial cause of neonatal sepsis and 2 in 1000 babies in NSW die following childbirth from complications of GBS infection during 'low-risk' parturition. Universal antenatal GBS screening apparently reduces this incidence to 1:3000. In addition, it appeared that detection was relatively straightforward (antenatal screening) and that simple measures were effective in stopping GBS transmission during delivery (administration of antibiotics during childbirth).

The Commission wrote to the Director-General of Health conveying its concern that a woman accessing public obstetric and antenatal services in NSW may, or may not, have her GBS carrier status disclosed, depending on which hospital is available to her (or is available to her obstetrician). The Commission considered it as unacceptable that preventable infant deaths occur in NSW because of inadequate guidelines and noted that there does not currently exist even a requirement for NSW hospitals or obstetricians to inform expectant mothers of the existence of GBS and GBS neonatal disease, nor that a simple screening test is available.

The Commission requested the Director-General of Health to consider its view that statewide universal screening may be warranted. The Department of Health has subsequently advised the Commission that it currently collating data from all NSW AHSs in this regard, and that its anticipation is that a statewide policy on group B streptococcal disease will be developed.

Independent Complaints Review Committee

The Independent Complaints Review Committee (ICRC) was established by the Commission to provide a second tier of review when a complainant remains dissatisfied with the Commission's decision after the statutory review process. The ICRC reviews assessment decisions and the Commission's decision made at the end of an investigation, once the statutory review rights have been exhausted. Complainants are advised about the ICRC in the Complaints Process brochure, which is sent to all complainants after a complaint has been lodged.

In 2000-2001, the Commission received 11 requests for a review by the ICRC. One of these requests was withdrawn. One complaint was unable to be reviewed by ICRC as the Dental Board was unable to make available a board representative to assist the Commission. This complaint will be reviewed next financial year as the Commission has identified a suitable dentist to sit on the Committee. The ICRC reviewed nine complaints compared with eight complaints in the previous year.

Of these nine complaints, eight involved the Commission's assessment decision and one involved the Commission's decision at the end of an investigation. The Committee recommended no further action in relation to the complaints it reviewed. However, in relation to the investigation review, the complainant was offered the opportunity to discuss the issues raised by the complaint with the Commission's internal medical advisor. The complaint remained closed with the issues resolved satisfactorily.

Complainant profile

Each complainant receives a survey form seeking demographic information. This is analysed by the Commission. Information about individuals is provided voluntarily and remains confidential. The information is used to improve the Commission's accessibility.

In 2000-2001, 567 forms were returned by complainants. Not all questions in the form were answered by the complainants. Table 24 provides the results obtained from the survey. For information about the complainants' ethnic background, please refer to page 97.

Table 24 - Complainant profile 2000-2001

Age Group	No	%
0-15	1	0.2
16-24	25	5.5
25-34	62	13.6
35-44	86	18.8
45-59	157	34.4
60+	126	27.6
Total	**457**	**100.0**
Aboriginal and Torres Strait Islander	**No**	**%**
No	551	98.4
Yes	9	1.6
Total	**560**	**100.0**
Disability	**No**	**%**
No	417	73.7
Yes	149	26.3
Total	**566**	**100.0**
Interpreter Required	**No**	**%**
No	551	97.2
Yes	16	2.8
Total	**567**	**100.0**
Sex	**No**	**%**
Female	1,528	58.2
Male	1,048	39.9
Joint complainants	48	1.8
Total	**2,624**	**100.0**

Table 25 - Complaints open as at 30.6.2001 (including complaints received in past financial years)

Assessment	30.6.2001	%
Commission investigation underway	863	75.8
Referred to another body or person for investigation	73	6.4
Conciliation	72	6.3
Awaiting assessment	56	4.9
Decline to deal with	47	4.1
Direct resolution	27	2.4
Total	**1,138**	**100.0**

Investigations

The Commission undertakes three types of investigation: special investigations, investigations about health services, and investigations about health practitioners. It also refers complaints to other agencies for investigation and action under section 26 of the Health Care Complaints Act 1993. The Commission maintains an active monitoring and consultation role in relation to complaints being followed up by other agencies.

SPECIAL INVESTIGATIONS

Section 59 of the Health Care Complaints Act 1993 permits the Commission to investigate the delivery of health services by a health service provider where concerns may arise out of a complaint or more than one complaint if it:

- raises a significant issue of public health or safety;
- raises a significant question as to the appropriate care or treatment of clients; or
- provides grounds for disciplinary action against a health practitioner.

The Commission may not carry out such an investigation unless it has notified the Director-General of its intention and requests the Director-General to provide it with a report on the matter and the Director-General fails to provide such a report or provides an unsatisfactory report.

Upon reviewing 12 complaint files about a particular health service, the Commission identified a number of issues which may have been significantly affecting the outcomes for clients of that service and decided to carry out a special investigation in 1999-2000. Last year's annual report outlined the special investigation into a health service conducting independent health assessments. It also reported that the Commission was not satisfied with the Director-General's report on the matter.

In deciding to commence a special investigation, the Commission considered the following issues raised by complaints it had received:

- the inadequate information on the powers and conduct of the health service and related appeals mechanisms, including the purpose of any interview and the reasons for any decision;
- apparent weight being given by the person carrying out the medical assessment to any untested allegations contained in the information provided to the health service by the referring agency;
- its potential to have a significant impact on the clinical outcome for the person undergoing the assessment, particularly if they were a whistleblower;
- inadequate assessment, documentation and use of psychiatric diagnoses; and
- lack of transparency and fairness in the processes used by the health service and its appeal mechanism. This included but was not limited to the lack of a clear framework.

The Department of Health engaged a consultant to review the health service in light of the Commission's referral. The Commission received a copy of the consultant's report on 14 April 2000.

The report confirmed the concerns raised by complainants. However, the recommendations of the report failed to deal with all of the concerns raised by the Commission and it did not provide a detailed action plan.

The Commission worked with the Department of Health on these areas during the past year and is now satisfied with the action taken to date.

A number of findings were made by the consultant:

- The extent of initial and ongoing employer-employee consultation during the assessment process is variable.
- Employer referral reports vary in quality and were sometimes deficient.
- In some instances, employees were not provided with a copy of the employer's referral report.
- An insufficient emphasis was placed on ensuring that employees have a good understanding of the policy and procedural requirements of the employer, the assessment body's role, the procedures involved in the process of health assessment, who makes decisions, what information is taken into account, right of access to personal information, confidentiality and the right of appeal.
- Employees referred for assessment should be given an opportunity to make written responses

to the information provided by the employer, prior to the outcome of the assessment being finalised.

- The assessing body needs to ensure that the record of assessment contains sufficient detail to justify all findings and recommendations;
- Procedures for informing employees of the outcome of assessments are in need of significant improvement.
- Special care should be taken in the case of referrals of 'whistleblowers' and employees identified as 'difficult' to ensure a high standard of communication, so that employees are fully aware of assessment and decision-making procedures.
- Procedures on access to personal information need to be streamlined and improved.
- A culture which recognises the opportunities for learning which arise through complaint handling is required.
- Quality assurance measures need to be developed and extended with some form of independent, external quality assurance.
- Accountability needs to be enhanced.
- Information on the right of appeal should be made available at the time of referral.
- The right of appeal could be broadened to encompass administrative and procedural issues.
- Structural reform of the appeal process should be considered.

A range of recommendations were made by the consultant and subsequently approved and acted on by the Department of Health. Some actions have yet to be finalised, including guidelines to assist employers to make appropriate referrals, broadening the appeal mechanism to include administrative process and medical assessment, and determining whether there are situations where employers or the assessing body should meet the cost of a referral to a private practitioner to assist in making a diagnosis.

As a result of the referral, the Department of Health has implemented significant changes designed to increase community confidence in the processes and resultant decisions of the assessment body. The Commission will be monitoring the outcomes of the outstanding actions.

Pressure Ulcer Improvement Group

The origins of the Pressure Ulcer Improvement Group (PUIG) were noted in the Commission's 1998-1999 annual report. The Commission, over a number of years, has received complaints about the development of pressure ulcers in vulnerable people. These complaints, when viewed over time, raised significant questions as to the appropriate care and treatment of people with reduced mobility in a care environment. The Commission considered a system-wide approach was required to reduce the incidence of pressure ulcers, which on the whole are preventable.

The Director-General of Health supported the Commission's recommendation and established the PUIG with a Commission representative. Completed actions to date include:

- review of research-based data on preventing pressure ulcers;
- drafting and issuing of expressions of interest for the development of a training and education package and an implementation and dissemination strategy;
- a survey of AHSs to identify pressure ulcer risk assessment tools in use, extent of pressure ulcer surveillance and whether or not guidelines for the prevention of pressure ulcers were in place; and
- pressure ulcer incidence and management survey.

Significant progress has been made in drafting a policy for pressure ulcer prevention, a consumer information brochure, clinical practice guidelines and an implementation plan. A framework for monitoring the incidence of pressure ulcers in the public health system will also be developed.

The Commission anticipates a significant reduction in the incidence of pressure ulcers in the health system, once the initiatives developed by the PUIG have been implemented.

Investigation and action by other agencies

Referrals to Area Health Services

Section 26 of the Health Care Complaints Act 1993 empowers the Commission to refer complaints to other agencies where it appears the complaint raises issues which require investigation by the other person or body[1].

On referring a complaint to another body for investigation, the Commission may request a report on the investigation, findings and outcomes. Historically, a paper-based review of these reports has occurred. The quality of the investigation from AHSs and other bodies responsible for health services was variable[2]. The investigation may have been viewed as inadequate or the action arising from the investigation's findings not sufficient to minimise the recurrence of a preventable adverse event.

To assist AHSs improve their handling of complaints, the Commission conducted a series of investigation training workshops across the public health system. A key component of the course was the link between performance feedback[3], investigation methodology and quality improvement. The Investigation Training Program was, in large part, developed to address the quality of AHS investigations which the Commission had referred to the health services for investigation, under s26 of the Health Care Complaints Act.

Commission officers had face-to-face contact with over 550 health service managers and program directors, who were eager to take appropriate action on complaints, including system enhancements. Some did not feel confident in the process and others expressed difficulty with the health system's cultural inhibitors to open disclosure, rigorous analysis and initiating change. Also, it is not always easy to identify system problems when one is immersed in it day to day, had a hand in designing the system, or is responsible for system maintenance, review and enhancement.

The investigation training program evolved into a partnership process with Commission officers sharing investigation knowledge and experience and the health managers providing insights into the health system and expressing a willingness to engage with the Commission on a co-operative basis.

Partnership is used to infer the coming together of two parties to work towards a common goal. In this case, the parties are the Commission and health services and the common goal is enhancing service quality in the health system. In an attempt to circumvent unproductive paper exchanges, a new model of managing s26 investigations by the Commission has been developed and trialed. In addition to training support, the Commission now provides an investigation consultancy service to AHSs, in relation to matters the Commission has referred to external bodies. The investigations advisor is also responsible fo reviewing s26 reports and a new approach has been trialed. Rather than a paper based approach to review investigations undertaken by another agency, the investigations advisor provides advice during the course of an investigation and also feedback on conclusion. Emphasis is placed on active engagement through phone contact and meetings rather than through correspondence. Emphasis has also been placed on meaningful changes in the health system to reduce errors and improve quality. As a result of the changes, productive communication has increased between the Commission and staff investigating or responsible for the investigation of s26 referrals.

The program has resulted in:

- improved quality of investigations conducted by AHSs;
- increased effectiveness of AHS investigators;
- increased confidence of complainants in investigations conducted by AHS officers;
- improved identification of system deficiencies and actions to enhance system safety.

In 2000-2001, the Commission referred 1,444 complaints to other bodies for investigation. Of the complaints referred, 252 were identified as appropriate for review by the Commission to determine whether further action was warranted and whether the issues raised in the complaint had been appropriately addressed.

Since July 2000, the Commission has finalised the review of 172 investigations conducted by AHSs. Under the new program, since January 2001, 109 investigations were reviewed and finalised. As at the end of June 2001, 134 matters were awaiting further information and action by the investigating body, after being reviewed by the Commission. Sixty-nine complaints were awaiting investigation reports from the AHSs.

As part of the Commission's program to support the quality of investigations conducted by the AHSs, additional data have been collected on 99 complaints finalised since January 2001 and will be collected for all finalised reviews of s26 investigations during the next financial year.

Of the 99 finalised reviews the Commission is continuing to monitor implementation of recommendations and policy outcomes in 11 cases. Table 26 sets out the outcomes of the investigations conducted by AHSs, including the outcome of investigations that required additional action after the initial review of the investigation report.

Table 26 - Outcomes of investigations conducted by AHSs in 2000-2001

Action Arising	No
Apology or other redress offered	37
Staff education provided	31
Policy/protocol change	25
Information provided	24
Staff member counselled	18
Resolution meeting	18
No Action	13
Systems review	13
Referred to appropriate authority (eg HCCC, DoH, Police)	6
Trend to be monitored	4
Revise duty statements, selection & induction processes	4
Equipment reviewed/repaired/ replaced	3
Service to be provided	3
Refer to quality improvement com.	2
Supervision	2
Resource allocation	2
Community education	1
Conduct clinical audit	1
After negotiating with insurer - a settlement	1
Total	**208**

* As an investigation may have more than one outcome, the total exceeds the number of investigations conducted and included in the sample.

The outcomes noted in the table demonstrate the range of positive outcomes arising from the investigation of complaints by AHSs.

The Commission has noted a marked improvement in the investigative methodology adopted by the AHSs investigating these complaints, as well as an improvement in the comprehensive corrective strategies identified to address the issues arising from the complaints. The Commission noted that AHSs such as Wentworth and Illawarra AHSs have adopted HCCC investigation processes along with their own innovative complaint management strategies. This has resulted in the provision of reports of exceptional quality.

NOTES:

[1] Complaints are not referred for investigation by another person or body if they meet the criteria outlined in s23 of the Act for complaints that must be investigated by the Commission.

[2] The Commission refers complaints, pursuant to s26 of the Act, to a range of bodies including registration boards and organisations responsible for the provision of private sector health services. Reference to AHS investigations does not imply that investigations conducted by other bodies do not show similar variance but rather reflects the larger number of investigations conducted by AHSs.

[3] The Commission views complaints as a very important form of performance feedback; internal feedback processes include critical incidents, outcome measures and preventable adverse event rates.

Notifications to the Director-General

Following assessment, the Commission must notify the Director-General of the NSW Department of Health if it appears to the Commission that a complaint involves a possible breach of Acts administered by the Department. The Director-General is required to notify the Commission if he proposes to deal with the complaint, and if so, the outcome of the complaint. During 2000-2001 the Commission reviewed six reports on the outcome of the Department's investigation. Four of the complaints raised issues relating to admission and treatment provided under the Mental Health Act.

Referrals to health registration authorities

The Commission referred 595 complaints to the eleven registration authorities for investigation under s26 of the Act during 2000-2001. With the exception of the Pharmacy Board, the purpose of the referral enables the gathering of information from health practitioners before a decision is made how a complaint will be handled.

The Health Care Complaints Act 1993 does not enable the Commission to undertake such inquiries, whereas the registration authorities have statutory power to obtain information or responses.

After receiving the complaint, the Board writes to the identified practitioner(s), provides a copy of the complaint and seeks a formal response. As part of the response, the Board also requests that the practitioner provide copies of any relevant health records for review.

Once the requested information is received, the Board's complaint screening committees and the Commission review the complaint, the response and the records. A decision is then made about how the complaint will be handled. This process can lead to a number of different outcomes. The following actions or further resolution steps may result:

- a letter to the practitioner expressing the Board's concerns about an aspect of care or other aspect of professional practice;
- no further action where no issues of concern were identified;
- the practitioner may be requested to attend an interview with two nominees of the Board if there are unresolved concerns. Further action may arise after the interview if concerns remain;
- the complaint may be referred back to the Commission with a recommendation that the complaint be investigated by the Commission, referred for conciliation, or resolution involving a patient support officer;
- the Board may recommend that the practitioner provide the complainant with an apology; or
- the complaint may be referred to the Health or Performance Committees of the Board where the complaint and/or the response highlight that there may be an issue of impairment or performance.

The response from the practitioner is provided to the complainant, as well as an outline of the process involved. This process often provides sufficient information to the complainant to resolve their concerns. Many practitioners appreciate the opportunity to make a response to the complaint before the Commission decides how it will be handled. This approach has successfully reduced the number of matters where a Commission investigation would otherwise commence.

HCCC INVESTIGATIONS INTO HEALTH SERVICES

Under s23 of the Health Care Complaints Act 1993, the Commission is required to investigate a complaint about a health service if it appears to the Commission that the complaint raises a significant issue of public health or safety; or raises a significant question as to the appropriate care or treatment of a client by a health service provider.

At the end of an investigation into a health service, the Commission must decide to:

- terminate the matter;
- make recommendations or comments to the health service on the matter, which is the subject of the complaint;
- or refer the matter, which is the subject of the complaint, to the Director of Public Prosecutions.

If the Commission makes recommendations or comments, it must prepare a report on the matter for the Director-General. The report must include the reasons for the Commission's conclusions and the reasons for any action recommended to be taken.

Where the Commission proposes to make recommendations or comments, the Commission must first inform the health service of the substance of the grounds for its proposed action and give the health service an opportunity to make submissions.

The Commission may request the Director General to notify it of any action taken or proposed, as a consequence of its report. If the Commission is not satisfied that sufficient steps have been taken within a reasonable time, the Commission may make a report to the Minister. If the Commission is not satisfied that sufficient steps have been taken within a reasonable time as a consequence of its report to the Minister, it may make a special report on the matter to the Presiding Officer of each House of Parliament.

In 2000-2001, the Commission completed 47 investigations about health services. Table 27 shows the category of finalised complaints by health services.

Table 28 shows the outcome of these investigations. Out of 47 finalised investigations about

health services, 23 were substantiated or partially substantiated. As an outcome to these 23 investigations the Commission made over 40 recommendations relating to changes in policy, guidelines, procedures and training. Where the Commission made a recommendation, it provided a report to the Director-General, as required by the Health Care Complaints Act 1993.

Twelve health services accepted the Commission's recommendations in full. One AHS accepted the Commission's recommendations in part, and initiated its own solutions in addition to the Commission's recommended action. It decided to employ specialist paediatric registrars and to cease providing intensive care for children under 12 years of age. Six health services initiated their own solutions as a result of Commission recommendations. The Commission reviewed the proposed solutions and found them all acceptable.

Comments without recommendations were made to three health services. Another health service ceased to operate and the Commission made no comment or recommendation. In one of the 47 finalised investigations, the Commission made no recommendations as the primary issues related to the nature of the available facilities and staffing. However, the issues were drawn to the AHS's attention.

Table 27 - Investigations finalised about health services 1999-2001

Description	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Public Hospital - Inpatients	29	49.2	35	46.7	13	27.7
Private Hospital	11	18.6	7	9.3	8	17.0
Public Hospital - Outpatients	5	8.5	10	13.3	7	14.9
Private Nursing Home	0	0.0	5	6.7	3	6.4
Other	6	10.2	3	4.0	3	6.4
Ambulance Service	0	0.0	0	0.0	3	6.4
Medical Centre - Private	4	6.8	3	4.0	2	4.3
Public Psychiatric Hospital	0	0.0	3	4.0	2	4.3
Drug & Alcohol Service	0	0.0	1	1.3	2	4.3
Men's Health Clinic	2	3.4	4	5.3	1	2.1
Boarding House	0	0.0	0	0.0	1	2.1
Department of Health	0	0.0	0	0.0	1	2.1
Community Health Service	0	0.0	0	0.0	1	2.1
Area Health Service	1	1.7	2	2.7	0	0.0
Radiology Practice	0	0.0	1	1.3	0	0
Public Nursing Home	1	1.7	1	1.3	0	0
Total	**59**	**100.0**	**75**	**100.0**	**47**	**100.0**

Table 28 - Outcome of investigations finalised about health services 1999-2001

Investigation result	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Substantiated	19	32.2	33	44.0	12	25.5
Partially Substantiated	10	16.9	14	18.7	11	23.4
Not Substantiated	24	40.7	23	30.7	15	31.9
Terminated by Commission	6	10.2	1	1.3	9	19.1
Referred to another body	0	0.0	4	5.3	0	0
Total	**59**	**100.0**	**75**	**100.0**	**47**	**100.0**

The Commission is precluded by s91 of the Health Care Complaints Act 1993 from making recommendations, which may be beyond the resources appropriated by Parliament for the delivery of health services and which may be inconsistent with the way in which those resources have been allocated by the Minister and the Director-General in accordance with government policy.

During the year, the Commission made no reports to the Minister because recommendations made by the Commission were accepted in full or solutions acceptable to the Commission were identified.

Of the investigations finalised, 49% were substantiated or partially substantiated. It is not unusual that the substantiation rate of health service complaints is lower than the rate for health practitioners. A possible reason for this is the Commission's complaint assessment practice, which at the outset names the employer in addition to the individual practitioner so that systems issues are considered. The Commission may name the employer as a respondent where systems issues may have contributed to an incident leading to the complaint.

A feature of complaints made about health providers is the difficulty complainants have in pinpointing and accurately labelling the problem and possible causes and contributors to the problem. This is directly related to the complexity of the health system and the specialised knowledge bases involved. By identifying the health service at the assessment stage, the Commission focusses on possible systems and procedural issues which may have contributed to the complaint being made about the individual. This practice, while it assists in focussing on the quality improvement possibilities, may capture health services in investigations where finally it is determined that there are no systems issues requiring a response.

Complainants have no statutory right of review of the Commission's decision at the end of an investigation about a health service. Complainants have such a right in relation to decisions made at the end of an investigation about a health practitioner. This would appear to be an anomaly in the Health Care Complaints Act 1993. The absence of such a statutory provision does not preclude the Commission from administratively reviewing its decision on the request of the complainant. It is good administrative practice to do so. The Commission does not keep statistics on the reviews requested about the Commission's decision at the end of a health service investigation.

Systemic changes arising from adverse events at Dubbo and Canterbury Hospitals

The Commission reported in its last annual report on incidents at Dubbo and Canterbury Hospitals, the Commission's investigation and resultant recommendations. Both incidents involved operating theatres, substances used in procedures, failure to detect the introduction of inappropriate substances and inadequate safeguards in the ordering and supply of substances, oversight by pharmacists in theatres, inadequate or incorrect information entered into medical records and failure to adhere to the requirements of several Departmental circulars.

Identified system failures raised concerns with the ongoing safety of surgical and diagnostic services provided by theatres. Recommendations were identified to address system weaknesses and reduce the possibility of human error leading to patient harm.

The two AHSs responsible for the hospitals and the Department of Health supported the recommendations. Significant progress has been made by the Department on the implementation of the recommendations across the State. Actions to date include:

- Requirements for an electronic prescribing decision support system, which incorporates adverse event reporting, have been completed.
- The NSW Therapeutic Assessment Group (TAG) considered the scope of pharmacy services which should be provided by hospital pharmacy departments to operating theatres in hospitals, and the need to identify appropriate mechanisms by which the suitability of products used in theatres could be assessed. TAG reported to the Department of Health in June 2000 and made 44 recommendations. Responsibility for acting on the recommendations has been allocated to AHSs, the Department and the Medicines Coding Council of Australia. Area Health Services have reviewed current practice against recommended practice and where gaps have been identified, action plans have been developed. The recommendations included:

  - increased involvement of pharmacists in the oversight of therapeutic substances introduced into theatres;
  - development of standard protocols to cover usual procedures carried out in operating theatres. The protocols are to include all pharmaceuticals, irrigation fluids, contrast media and other therapeutic substances and are to be reviewed;
  - development of guidelines for the preparation and management of standard protocols;
  - improved safety and checking of therapeutic substance ordering and supply;
  - pharmacy supervision of storage areas for pharmaceuticals;
  - an explicit note in relevant hospital policy and procedure documents that end users are responsible for the final checking of a product prior to its administration;
  - development of processes that encourage reporting incidents associated with drugs to an appropriate evaluation committee for review, evaluation and action;
  - educational interventions.
- Revision of Department of Health Circular 95/37, Guidelines for the Handling of Medication in NSW Public Hospitals, to incorporate the TAG recommendations.
- The Department has initiated a project to address the issue of an ongoing audit process in facilities to ensure the quality of records is maintained.

Although the events that led to the Commission's investigation were regrettable, the actions taken as a result of open analysis and reporting go a long way towards filling the gaps in the safety nets that are required in all complex service delivery situations, especially those that impact on the health and safety of the people of NSW.

INVESTIGATIONS ABOUT HEALTH PRACTITIONERS

Section 23 of the Health Care Complaints Act 1993 (the Act) requires the Commission to investigate complaints about registered and unregistered health practitioners where the complaint: raises a significant issue of public health or safety, or raises a significant question as to the appropriate care or treatment of a client, or provides grounds for disciplinary action against a health practitioner or where the complaint involves gross negligence.

The Commission is required to consult with any relevant registration authority in relation to complaints made about registered practitioners before it makes its decision about how a complaint will be handled. Registration authorities provide the Commission with invaluable assistance in relation to applicable standards of practice and whether or not a complaint may provide grounds for disciplinary action.

In addition to those complaints the Commission decides to investigate, the Health Care Complaints Act 1993 requires the Commission to investigate a complaint against a registered health practitioner when the registration authority asks it to do so. The Commission must also investigate complaints in certain circumstances when registration authorities impose interim orders on health practitioners.

The Commission may investigate a complaint despite any agreement reached between the parties.

At the end of an investigation about a health practitioner, the Commission must decide under s39 of the Act to:

- prosecute the complaint as a complainant before a disciplinary body;
- intervene in any proceedings that may be taken before a disciplinary body;
- refer the complaint to the appropriate registration authority (if any) with a recommendation as to any disciplinary action the Commission considers appropriate in respect of the complaint;
- make comments to the health practitioner on the matter the subject of the complaint;
- terminate the matter; or
- refer the matter, the subject of the complaint, to the Director of Public Prosecutions.

At the end of an investigation into an unregistered health practitioner, the actions the Commission may take are limited to: making comments to the health practitioner, terminating the matters or referring the matter to the Director of Public Prosecutions. The Commission also has discretion to inform an appropriate professional association.

During 2000-2001, the Commission finalised 237 investigations about registered and unregistered health practitioners. The finalised investigations are reported on by profession in Table 29.

Fewer investigations were completed during the year. The drop in finalisations reflects a number of factors including a change in the way the Commis-

sion records its finalised investigations. Last year, the Commission counted as finalised those complaints which were awaiting consultation with the relevant registration authority. This year, only those complaints which had completed the consultation process were counted for the purposes of annual reporting.

Table 30 details the time taken to finalise investigations in 2000-2001. These time frames reflect the present processes and will be reviewed closely.

The better planning of investigations and a more thorough approach to the gathering of information has led to a more rigorous investigation process. Planning and review fora have been established as a strategy to improve the quality of investigations and the consistency of decision-making. While these fora are resource intensive, they are an essential strategy designed to build on the competence of investigators and the consistency of the quality of investigations.

It is anticipated that more active information gathering during an investigation and the systematic review of complaints at identified stages of the investigation may shorten the investigation

Table 29 - Investigations finalised about health practitioners 1999-2001

Description	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Medical Practitioner	277	77.4	255	69.7	161	67.9
Nurse	34	9.5	56	15.3	49	20.7
Psychologist	12	3.4	15	4.1	9	3.8
Podiatrist	0	0.0	3	0.8	4	1.7
Chiropractor	4	1.1	6	1.6	3	1.3
Natural Therapist	5	1.4	5	1.4	2	0.8
Pharmacist	3	0.8	2	0.5	2	0.8
Physiotherapist	3	0.8	5	1.4	1	0.4
Other	12	3.4	3	0.8	1	0.4
Dental Technician/Prosthetist	4	1.1	2	0.5	1	0.4
Social Worker	0	0.0	2	0.5	1	0.4
Osteopath	3	0.8	1	0.3	1	0.4
Acupuncturist	0	0.0	0	0.0	1	0.4
Ambulance Personnel	0	0.0	0	0.0	1	0.4
Unregistered (Counsellor/Therapist)	0	0.0	6	1.6	0	0.0
Dentist	1	0.3	3	0.8	0	0.0
Optometrist	0	0.0	2	0.5	0	0.0
Total	**358**	**100.0**	**366**	**100.0**	**237**	**100.0**

Table 30 - Length of time taken to complete investigations in 2000-2001

Month	Health Service		Health Practitioner	
	No	%	No	%
<6 months	0	0	10	4.2
7-12 months	3	6.4	28	11.8
13-18 months	3	6.4	31	13.1
19-24 months	9	19.1	37	15.6
25-30 months	7	14.9	49	20.7
31-36 months	10	21.3	34	14.3
>37 months	8	17.0	25	10.5
Unable to receive statutory declaration	7	14.9	23	9.7
Total	**47**	**100.0**	**237**	**100.0**

time frame as complaints, that can be terminated, will be identified at an earlier stage.

Table 31 reports on the percentage of finalised investigations which were substantiated or not.

Of the 237 investigations finalised, 124 (52.3%) were either substantiated or partially substantiated. This compares with substantiated rates of 61.5% in 1999-2000 and 45.8% in 1998-1999. It is difficult to draw any conclusions from the substantiation rate and its variance from year to year. There are many factors which contribute to the substantiation or otherwise of a complaint.

Six finalised investigations (2.5%) concerned unregistered health practitioners. While the Commission receives many more complaints about registered practitioners than unregistered practitioners, it would appear that an equivalent number are being investigated about unregistered practitioners by the Commission.

One investigation was terminated as it was unsubstantiated. Of the five substantiated/partially substantiated investigations, the Commission referred one of those complaints to both the Coroner and Director of Public Prosecutions and made comment to the other four unregistered practitioners.

Of the 124 substantiated/partially substantiated complaints, 119 involved registered health practitioners. The Commission made comments to 40 health practitioners at the end of its investigations.

In six substantiated cases, the Commission decided not to refer the matter for disciplinary action. The reasons varied for each. In one matter, the Commission accepted an underlying temporary health condition as the cause of the conduct. Two complaints were not prosecuted before a Tribunal, as the 69 year old practitioner involved in both cases retired from practice and signed an undertaking that he would not seek to practice in NSW or any other jurisdiction in the future. The Commission intended to prosecute a sexual misconduct case before a Tribunal, but the complainant withdrew as a voluntary witness. In one case, the Commission took no action because, among other reasons, the health practitioner had made extraordinary efforts to remedy the situation. In another matter the facts were substantiated and would have ordinarily provided grounds for disciplinary action, but because of the circumstances of the case, the Commission decided to terminate the complaint.

Table 32 reports on the registered health practitioners referred for disciplinary action following an investigation.

In these cases, the Commission made a decision at the end of its investigation to either prosecute a complaint as a complainant before a disciplinary body or to refer the complaint to the appropriate registration authority (if any) with a recommendation as to any disciplinary action the Commission considered appropriate in respect of the complaint.

During the year, the Commission decided to prosecute 65 complaints about registered practitioners and to refer 10 complaints to the relevant registration authority for other disciplinary action.

A smaller proportion of complaints (16%) were referred to the registration authorities for recommended disciplinary action than in previous years: 28% in 1999-2000; and 25% in 1998-1999.

The Health Care Complaints Act 1993 provides limited options for action by the Commission at the end of its investigations about health practitioners. The Act anticipates possible referrals to the Director of Public Prosecutions at the end of

Table 31 - Outcome of investigations finalised about health practitioners 1999-2001

Investigation result	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Substantiated	136	38.0	213	58.2	102	43.0
Partially substantiated	28	7.8	12	3.3	22	9.3
Not substantiated	93	26.0	96	26.2	85	35.9
Terminated by Commission	70	19.6	42	11.5	28	11.8
Referred to another body	31	8.7	3	0.8	0	0.0
Total	**358**	**100.0**	**366**	**100.0**	**237**	**100.0**

an investigation about a health practitioner, but it does not anticipate other possibilities, such as the referral of a complaint to the Coroner, the Director-General of Health or health services for review of procedures as appropriate. The following case study is an illustration.

Table 32 - Complaints about health practitioners referred for disciplinary action at the end of an investigation 1999-2001

Disciplinary body referred to	1998-1999 No	1998-1999 %	1999-2000 No	1999-2000 %	2000-2001 No	2000-2001 %
Medical PSC	29	25.7	46	27.2	24	32.0
Nurses Tribunal	2	1.8	12	7.1	17	22.7
Medical Tribunal	36	31.9	39	23.1	15	20.0
Medical Board	27	23.9	35	20.7	9	12.0
Psychologists PSC	7	6.2	3	1.8	3	4.0
Chiropractors & Osteopaths Tribunal	2	1.8	1	0.6	2	2.7
Nurses Board	2	1.8	9	5.3	1	1.3
Nurses PSC	7	6.2	13	7.7	1	1.3
Pharmacy Board	0	0.0	2	1.2	1	1.3
Physiotherapists Board	0	0.0	3	1.8	1	1.3
Podiatrists PSC	0	0.0	1	0.6	1	1.3
Dental Technicians Board	1	0.9	1	0.6	0	0.0
Psychologists Board	0	0.0	4	2.4	0	0.0
Total	**113**	**100.0**	**169**	**100.0**	**75**	**100.0**

Case Study

In 2000-2001, the Commission finalised complaints about an obstetrician and a midwife. While the Commission terminated the complaints about the individual practitioners, the investigation identified issues which warranted attention by a health service and other issues which warranted attention by the Director-General of Health.

The complaint concerned the care and treatment by the obstetrician prior to and during the birth the complainant's son who was diagnosed with cerebral palsy. From the medical records, the paediatrician was notified at 8.20pm and the obstetrician was paged at 8.25pm. At 8.30pm there was no head on view and no bulging perineum. The midwife did not have experience in performing an episiotomy on an unextended perineum. The midwife decided to hold the foetal head off the perineum for four minutes. The obstetrician arrived at 8.34pm and a forceps delivery took place at 8.39pm. The midwife attempted to hold the head back in an attempt to relieve what was, she presumed, the umbilical cord compression.

During its investigation the Commission established that the midwife had recently attended a seminar entitled "Electronic Fetal Monitoring" in which it was suggested that variable decelerations may be caused by a short cord, which effectively strangled the foetus as it descended though the pelvis. It was further suggested that in an extreme emergency, this situation might be appropriately treated by elevating the presenting part.

The Commission was informed by the peer reviewer that holding the baby back was considered a dubious practice, even twenty years ago. An episiostomy would have meant rapid delivery of the baby, albeit oxygen deprived, and more measures would have been possible if the baby had not been held back.

The Commission outlined to the Director-General of Health its concerns about the practice of holding babies back and asked whether or

not the practice was still being taught. Appropriately, the Commission has no power to determine or recommend general standards of clinical practice.

The Department of Health reviewed the issue in conjunction with a member of a Faculty of Nursing, with the NSW Maternal and Perinatal Committee and Midwives Association. It was agreed that the practice of "holding the baby back" was outdated. The Department was advised that although the practice had not been taught for 20 years or more, there were cases of obstetric emergencies involving a prolapsed cord where the presenting part may be held off the cord while preparing for an emergency operative delivery. The Department of Health issued a circular on Maternity Emergencies which requires all maternity facilities to have protocols in place for the immediate management of obstetric emergencies, including umbilical cord prolapse. Hospitals are also required to have in place mechanisms for continuing staff education for maternity emergencies.

The Health Care Complaints Act 1993 requires the Commission to provide a report to the Director-General of Health in relation to recommendations made at the end of investigations about health services. The Act does not reflect the need for the Commission to refer particular clinical issues to the Department when they are identified during the course of an investigation into a health practitioner, whether or not the investigation is substantiated.

IMPAIRED PRACTITIONER COMPLAINTS

The Medical Practice Act 1992 and the Nurses Act 1991 include an alternative to disciplinary action when a complaint relates to the practitioner's impairment. The Acts provide for Impaired Registrant's Program which assesses and monitors a practitioner's impairment and its impact on performance.

An impairment is any physical or mental impairment, disability, condition or disorder which detrimentally affects or is likely to detrimentally affect a person's physical or mental capacity to practise. Habitual drunkenness or addiction to a deleterious drug is considered to be a physical or mental disorder.

The majority of notifications about impaired practitioners made to the registration boards are self notifications or referrals by concerned employers, family, or colleagues. While initially treated as complaints, they are generally referred to the registration boards for action. Complaints made to the Commission usually relate to practitioners who have refused to comply with directions of their registration board to attend a medical examination, or where the practitioner has failed to comply with undertakings or conditions of registration as part of the Registration Board Impaired (Registrant) Program.

The Commission assigned an experienced senior investigation officer the responsibility of investigating and, if warranted, prosecuting formal complaints involving impairment before Professional Standards Committees. The purpose in prosecuting a matter is to seek the imposition of conditions of registration. Undertakings made in the Impaired (Registrant) Program are voluntary, to affect a better compliance. In special cases, where a practitioner is considered unfit to practice due to an impairment, a Professional Standards Committee may make recommendations to a Tribunal for suspension or deregistration.

The challenge for the Commission in 2001-2002 was to complete investigations relating to impaired practitioners involving a mental or physical condition within four months, and for complex matters within six to eight months. However, matters that relate to impaired practitioners due to drug addiction and substance abuse, often involve: a long history of breaches of the *Poisons and Therapeutic Goods Act, 1966* and *Regulations, 1994*, and/or the *Drug Misuse and Trafficking Act, 1985*; relapses; other misconduct and additional incidents, and can take in excess of 12 months to finalise.

Investigation Reviews

Section 41(3) of the Health Care Complaints Act 1993 requires the Commission to review its decision at the end of an investigation about a health practitioner upon the request of the complainant. During the year the Commission completed 12 reviews. Table 33 reports on the outcome of those reviews. Two investigations were reopened after review, while in ten investigations, the decision remained the same.

Table 33 - Outcome of health practitioner investigation reviews 1999-2001

Outcome	1998-1999		1999-2000		2000-2001	
	No	%	No	%	No	%
Remain closed after further analysis	39	90.7	7	87.5	10	83.3
Reopen for investigation	4	9.3	1	12.5	2	16.7
Total	**43**	**100.0**	**8**	**100.0**	**12**	**100.0**

At the end of the financial year there were 863 open investigation files. Table 34 gives a breakdown of these files by category.

Table 34 - Category of open investigations 2000-2001

Category	1999-2000		2000-2001	
	No	%	No	%
Clinical Standards	378	48.6	373	43.2
Fraud	17	2.2	168	19.5
Other ethical/improper conduct	29	3.7	101	11.7
Miscellaneous	7	0.9	83	9.6
Complaints Management	0	0.0	35	4.1
Provider-Consumer Relationship	131	16.9	24	2.8
Patient Rights	15	1.9	21	2.4
Quality of Care	73	9.4	17	2.0
Prescribing Drugs	85	10.9	15	1.7
Illness Related	2	0.3	11	1.3
Business Practices	19	2.5	11	1.3
Impairment	15	1.9	2	0.2
Character	5	0.6	2	0.2
Reregistration	1	0.1	0	0
Total	**777**	**100.0**	**863**	**100.0**

Prosecutions

As at the end of the financial year, 82 cases had been decided before the various disciplinary bodies including 9 review or re-registration applications and 5 appeals. As at 30 June 2001, 56 cases were awaiting hearings and a further 32 cases had been heard and were awaiting judgments.

These are similar figures to last year and reflect a continuing high level of cases being prepared and conducted by the Prosecutions and Advisings Team. The figures suggest that there will be a continuation of a significant level of activity over the next year with a concomitant high level of expenditure on prosecutions. Details of the finalised cases are in Table 35.

Table 35 - Outcomes of disciplinary cases completed 2000-2001

Unsatisfactory Professional Conduct	
Medical Professional Standards Committee	
Proved	
Reprimand and conditions	5
Conditions and fine	1
Reprimand	3
Caution and Conditions	1
Caution	1
Partially Proved	
Reprimand and conditions	2
Reprimand	1
No Orders	1
Caution	2
Not Proved	
Dismissed	4
Referred to Medical Tribunal	1
Nurses Professional Standards Committee	
Proved	
Reprimand	1
Reprimand and Conditions	6
Partially Proved	
Reprimand and Conditions	1
Not Proved	
Dismissed	4
Total	**34**

Professional Misconduct	
Medical Tribunal	
Proved	
De-registered (Dr Bernard; Dr Motom; Dr Bar-Mordecai; Dr Matter; Dr Dent; Dr Dallas; Dr Sabag; Dr Sinha; Dr Gluskie; Dr McEvoy; Dr Annetts; Dr Danforth; Dr Pollard; Dr Ferguson; Dr Mcleay)	15
Reprimand and conditions (Dr Balakrishnan)	1
Suspended and conditions (Dr Burchett)	1
Fine (Dr Angus)	1
Partially Proved	
Conditions (Dr Yong)	1
Not Proved	
Withdrawn and Dismissed (Dr N)	1
Nurses Tribunal	
Proved	
Reprimand (Mr Franks)	1
De-registered (Mr Tootle; Mr Green)	2
Suspended and conditions (Mr Robson, Ms Nicholls)	2
Not Proved	
Dismissed (Mr Eagle; Mrs McLeod)	2
Chiropractors & Osteopaths Tribunal	
Proved	
Suspended	1
Dental Technicians Board	
Not Proved	
Dismissed	1
Pharmacy Board	
Proved	
Reprimand and Conditions	1
Physiotherapists Registration Board	
Proved	
De-Registered	1
Psychologists Board	
Proved	
Reprimand & Conditions	2
Conditions	1
Total	**34**

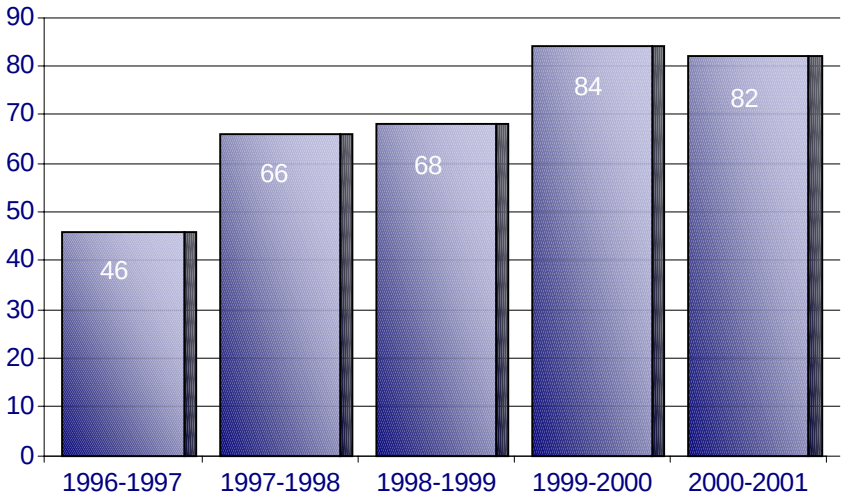
Table continued next page...

Table 35 (continued)

Appeals	
Court of Appeal	
Appeal by Doctor against de-registration (Mr Wanigaratne): Dismissed	1
Appeal by HCCC against Medical Tribunal Decision (Dr Clarke): Upheld	1
Supreme Court	
Summons against Medical Board referring complaint (Dr Gorman): Dismissed	1
Summons to stay proceedings (Dr Gorman) Dismissed	1
District Court	
Appeal against Physiotherapist Board Decision by practitioner (Mr Bombell) Upheld	1
Total	**5**

Re-Registration Applications	
Medical Tribunal	
Dismissed (Mr Pratt–Erwin; Mr Rahman)	2
Re-registered with conditions (Mr Corbett; Mr Wanigaratne; Mr Gayed; Mr Pham; Mr Barich)	5
Medical Board Inquiry	
Dismissed (Mr Gamaliel)	1
Re-registered (Mr Kohout)	1
Total	**9**

Disciplinary Cases Completed 1997-2001



Social Invisibility: consequences for people with mental illness

One in five adult Australians experience some form of mental illness each year. While this figure is a cause for concern, what is more disturbing, according to the research conducted by the Australian Bureau of Statistics in 1997, is that over 60% of those affected do not seek any treatment for their condition.

To understand why most people with mental illness choose to remain invisible to the health system, we need look no further than the number one factor that impacts on the lives of those affected. According to recent research conducted by the mental health charity SANE Australia, twenty percent of those consulted said that stigma was their major concern. They said that misunderstanding and discrimination affected them across all aspects of their lives, including their treatment in mental health services.

During the past year many people with mental illness raised the issue of stigma with the Commission. It was explicit when people said they feared calling mental health services because they thought they would be involuntarily detained without good reason. Explicit as well is the denial of health rights. It was implicit in many of the communication difficulties raised by consumers and in the lack of adequate treatment options in some cases.

The other primary concerns for people with mental illness revealed by the SANE study were: the level of clinical care and access to treatments, difficulty getting mental health services to take action and provide help before a crisis occurs, and better support for families.

The complaints and concerns raised with the Commission have covered all these areas. Of particular concern have been the lack of appropriate facilities for adolescents who threatened suicide, the premature discharge of patients, the lack of adequate community support and monitoring and the lack of appropriate information and support to family members. Tragic consequences have resulted in too many cases.

Improvements in the health system, however, are being made and the Commission is collaborating with health staff to address the major concerns as can be seen in the following case studies.

I JUST WANT TO GO HOME

Ms L, a young woman with a history of mental illness lives within the community, and receives some support from a Community Mental Health Team.

Ms L was contacted by the Mental Health Team and told to admit herself to the psychiatric ward at the local public hospital. She was threatened that if she did not do this she would be taken there as an involuntary patient. After two days Ms L had not been assessed, nor appeared before a magistrate, and staff were telling her that she had to remain in hospital for at least two more weeks. Ms L rang the PSO because she wanted to go home, but said she was 'not allowed' to leave.

The PSO contacted the hospital to establish why Ms L was in hospital and whether she was a voluntary of involuntary patient. The Mental Health Support Unit had insisted that the woman be admitted to hospital because she had experienced difficulty with the Department of Housing regarding her accommodation and was at risk of losing her unit. It was considered that by placing Ms L in hospital an opportunity would be available to smooth things over with the Department of Housing. It was also confirmed that Ms L was admitted as a voluntary patient, and as such was able to leave the hospital whenever she wanted to.

The PSO explained to the doctor that Ms L was not aware that the Mental Health Unit was attempting to address her housing crisis, nor was she aware that she was able to discharge herself from hospital. The doctor assured the PSO that the client would be informed of the reason for her admission, and also of her right to leave.

Ms L was discharged from hospital later that day.

IS GAOL AN APPROPRIATE OPTION?

Mr K, a young man with mental illness had difficulties in dealing with community based mental health support and in complying with medication routines. The young man was admitted to a psychiatric hospital after a breakdown.

Mr K had a diagnosis of schizophrenia and required a lot of support. On many occasions whilst in hospital Mr K asked the nurse on duty for

medication as he was feeling quite anxious. Mr K was upset that his requests were denied and kicked a door as a demonstration of his frustration. As a result he was placed in an isolation room.

The hospital did not follow procedures associated with the removal of a patient to an isolation room and Mr K was left with a cigarette lighter. Mr K then set fire to the bed inside the isolation room. Staff of the hospital called the police and Mr K was charged with maliciously destroying property. He later received a notice to attend court.

Mr K was terribly distressed about his impending court appearance. He had experienced prison in another state, and was aware of, and frightened by, the thought of another gaol experience. Mr K's mother made various contacts with the hospital to try to establish why charges were laid, and to encourage them to drop the charges. She was told that they would not be dropped, as it was believed that her son needed to learn about 'action and consequence'. She then sought assistance from the PSO.

The PSO advocated with the Director of Mental Health Services for a review of the decisions that had been made, especially within a context of why the incident occurred, what the hospital was trying to achieve, and what the likely outcomes for Mr K would be (ie immediate gaol, or placement in gaol when he broke parole as it was considered impossible for him to comply with parole conditions). The Director agreed that the case would be reviewed.

After the review, all charges were dropped and a different set of strategies was developed in relation to Mr K. These strategies included a treatment order being sought under the Mental Health Act, a plan regarding his transfer to a locked rehabilitation ward when he became more 'settled', subsequent transfer to the cottage program at the hospital and eventually community placement.

Mr K and his family were very satisfied with the outcome.

Mother's mental illness is blamed for baby's feeding problems

Ms D was a first-time mother of a baby with gastro-oesophageal reflux and low weight gain. She experienced difficulty feeding her baby. Ms D experienced problems in trying to seek real solutions to the medical condition of her child. She complained in writing to the CEO of the hospital against the doctors who provided treatment to her daughter.

Ms D also has a history of mental illness. She felt doubly hindered by the fact that the doctors cited her history of mental illness as the cause of her lactation problems. She was also given conflicting advice - the child's paediatrician prescribed medication for the baby's reflux and the doctor at the hospital advised her to discontinue the use of the drug.

Ms D sought a second opinion at another hospital as she doubted the diagnosis and proposed treatment. In that hospital a different treatment plan including the tube feeding of the child was implemented. The mother continued to express her milk to show she did not have the milk supply problem. The baby continued to vomit in spite of the alternate treatment plan.

Ms D received a response to her original complaint from the Director of Women's and Children's Health but was not satisfied with it. At the PSO's suggestion she had a successful meeting with the Principal Director of Nursing. She said her concerns were listened to and were seriously considered. She reported that the Director was very understanding about her situation. Ms D rejected the reasons given by the doctors as to why her daughter finally showed signs of improving.

As an outcome to the meeting, Ms D requested that a statement be written by the service stating that the baby's problem was related to the reflux and not lactation problems due to her mental illness. She asked that this statement be placed in her child's file.

At the last follow up Ms D reported the receipt of a very positive letter from the CEO. Ms D was pleased the CEO understood "the importance of educating health workers." A copy of this letter and a statement from the doctor had also been kept in her child's file.

ALLEGED INDECENT ASSAULT IN A MENTAL HEALTH FACILITY

Ms S complained to the Commission that another patient indecently assaulted her in an Acute Observation Area of a major metropolitan mental health unit. Ms S was an 'involuntary' patient having been admitted under the Mental Health Act, 1990, following a drug overdose, and was being detained prior to a Magistrate's inquiry. The alleged perpetrator was male and also an involuntary patient. Ms S complained that the alleged perpetrator forced her against a wall in a common area, whilst he simultaneously handled her breasts and masturbated in front of her.

Ms S said that she encountered a predominantly dismissive response from staff when she reported the incident. In addition, she stated that she later absconded from the secured ward, but re-presented in the early hours of the following morning as she felt increasingly unwell.

Ms S's primary concerns regarded her vulnerability to such assault whilst in an Acute Observation Area, and the adequacy of staff supervision of the common area. She was also concerned that staff responded to her report of the incident in an uncaring and inadequate manner.

Upon assessment of the complaint, the Commission considered the matter to warrant investigation by the Area Health Service responsible for the mental health unit and referred the complaint for investigation under s26 of the Health Care Complaints Act, 1993. The Area Health Service was requested to report to the Commission, at the completion of their investigation, the nature and outcome of the investigation.

As part of their investigation, the AHS reviewed Ms S's file notes, interviewed staff who were on duty on the day in question, and examined the current relevant policy documents. The AHS investigation disclosed that Ms S had not reported the incident to staff until two days after the incident and that, whilst prompt action was taken in line with the AHS's 'Sexual Safety Policy', there was a breach of the policy when senior members of staff at the Unit failed to report the incident to the senior management of the AHS. The Commission was advised that the AHS subsequently issued a formal reminder to all relevant staff concerning the need to report all such allegations/ incidents to senior management at the AHS.

The AHS contended that, in response to her reporting of the incident, Ms S was given supportive counseling, an offer was made to contact the Police, and an appointment was made for assessment by the Sexual Assault Service, which took place the day following her report of the assault. However, in view of the complaint that staff were uncaring, the AHS commenced education programs for staff about supporting people who are indecently or sexually assaulted.

The alleged perpetrator had already been transferred to a different secured ward on the evening of the assault due to his continuing sexually disinhibited behaviour. As a result of their investigation, the AHS conceded that it was likely the assault occurred as described by Ms S and stated that they had formally acknowledged this to her.

The AHS also provided information to the Commission regarding the supervision and gender segregation of patients in the Acute Observation Area, and advised as to what structures were in place to reduce the future likelihood of unsupervised interaction between male and female patients. Upon review of the AHS's investigation, the Commission formed the view that some issues had not been satisfactorily addressed, particularly regarding the means by which Ms S had absconded (a faulty window latch), and the adequacy of policy governing night supervision on the ward.

The AHS subsequently provided further information showing the changes made to patient supervision and facility security since the incident. This satisfied the Commission.

The Commission arranged for the AHS to respond to Ms S directly about the outcome of their investigation. The Commission advised Ms S of its satisfaction that the matter had been adequately addressed and provided Ms S with the service of the Commission's Patient Support Office in her future dealings with the AHS.

Communication

Communication issues arise in nearly all complaints received by the Commission. The fact that it occurs across the diverse range of matters suggests that there is a fundamental lesson that is yet to be fully integrated as a key aspect of the delivery of health services. The lack of adequate communication arises in complaints that range from the simple questions that were not answered, rudeness and unsensitivity, to a denial of important information that can affect a major decision relating to the health care of a health consumer.

What is apparent from these complaints is that the health consumer is developing higher expectations about the quality of information s/he expects from health practitioners. With the development of internet access to health related information, and television and media coverage on health and medical matters, consumers are generally much more knowledgeable about health issues. We have recently seen the consequences of technological advances such as IVF (which has always required ethical and legal standards) as the children born from these procedures are now of an age where their genetic heritage can be vitally important to their developing future. The standards that consumers expect have increased dramatically as a result.

Having said that, it is also apparent that the simplest of things are also still required. Misunderstandings are part and parcel of the human condition. A wrong assumption or the failure to explain a simple procedure can lead a person to carry an unnecessary burden of anxiety for many years. The case study of a young woman, examined by a paediatrician for Attention Deficit Hyperactivity Disorder (ADHD) when she was twelve years old is a telling example. The paediatrician did not explain to the woman his reason for asking the patient to remove her blouse, or seeming to look at her breasts. The paediatrician was in fact looking for secondary sexual characteristics and other conditions commonly associated with ADHD. The woman interpreted the request to be improper, and held that belief for seven years until she lodged her complaint. How many other people in the health system may be similarly carrying such a weight resulting from incomplete communication?

The Commission' s objects are clearly stated in s3 of the Act. A fundamental element of each of the objects is the quality of communication between the consumer, the health provider and the health system as a whole. Free exchange of information and knowledge allows each of the participants in the health environment to articulate their needs, their opinions and their intentions or desired outcomes. We have much work ahead of us as we continue to strive for true and effective partnership in the provision of health services.

Another critical element of this broad issue of communication relates to comprehensive, accurate and objective documentation in health care records. The Commission receives many complaints where the adequacy and quality of information in health care records is minimal and illegible.

Failure to keep records of sperm and egg donors

The Commission received complaints from four women against Dr X, a Gynaecologist. The four women all conceived children between 1987 and 1992 as a result of fertility treatment by Dr X using donor sperm or donor eggs. The main issue in all four complaints was that Dr X did not make and preserve adequate records in relation to the donors. Consequently Dr X was not able to provide information about the donors to the women and their children.

The investigation of these complaints was particularly challenging because the acceptable standards of practice governing fertility treatments have changed and evolved considerably over the last 20 years. The Commission is always careful to apply the prevailing standard of practice as it was at the time of the treatment when analysing a complaint.

As well as obtaining the opinion of an independent gynaecologist on the minimum acceptable standard of practice, the Commission also researched published guidelines and codes of conduct from reputable sources, taking careful note of the date of publication.

The Commission prosecuted Dr X at a Professional Standards Committee convened by the Medical Board. Interestingly, in his defence Dr X pointed out that he had complied with the only legislation that refers to sperm donor records, the Human Tissue Act 1983. However, the Committee in its decision agreed with the Commission that compliance with the Human Tissue Act was not enough. Dr X had failed to comply with the minimum acceptable standards for maintaining records that prevailed at the time.

The Commission identified a strong public interest in investigating and prosecuting these four complaints because there has been a steady shift in community standards towards recognition of the rights of donor offspring to obtain information about their genetic heritage and New South Wales does not have legislation governing fertility treatments. If donor records are inadequate or are destroyed then donor offspring lose the chance of ever obtaining that information.

Dr X was found guilty of unsatisfactory professional conduct, he was reprimanded, fined $3,300 and required to attend an education course on doctor-patient communication within one year.

JMOs need supervision and assistance

Mr N was a man from a non-English speaking background. He had been constipated for a period of time and attended a consultation with his general practitioner. An examination by the general practitioner indicated that there was a foreign body which was obstructing his anus and Mr N was directed to attend the emergency (A&E) department of a public hospital to have the obstruction removed.

Upon presentation at the A&E Department Mr N was examined by a doctor who confirmed that there was a foreign body in his anus and indicated that an X-ray would be required, but this did not occur. Another doctor became involved and he spoke to Mr N in a manner that showed a lack of respect. Mr N believed that from the way in which questions were asked and statements made, that assumptions were being made regarding his sexual orientation. The object was removed from the anus without pain relief and in a manner that caused serious damage to Mr N.

Since the removal of the object Mr N had undergone surgery on four occasions to repair damage caused by the extraction methods used. In addition, the client will experience life long limitations to the quality of his daily life with significant daily adjustments to accommodate his reduced health status.

Mr N had two separate meetings at the hospital to have his concerns addressed but neither was satisfactory. Mr N then placed a formal complaint with HCCC, and this was referred to the AHS to investigate and report to the client.

Mr N found the response, received from the Area Health Service inadequate. The PSO sought a meeting between Mr N, assisted by an interpreter, a Director from the Area Health Service and the PSO. The resolution meeting occurred and produced positive results including:

- A written apology for the way in which Mr N was spoken to and treated, for the pain and damage caused, for the delay in dealing properly with his concerns and for the inconvenience and expense he had incurred.
- Developing a system to ensure junior doctors are aware of exactly what they can and cannot do and know to seek help when they are in an unfamiliar situation (to be implemented by the end of 2001).
- Educating junior doctors on how to communicate respectfully and well with people.
- Reimbursing Mr N's expnses for ongoing health maintenance since the incident.

Mr N was pleased with the outcome of the resolution meeting. He felt that he had been treated with respect and his concerns validated. Mr N had been considering legal avenues to address his concerns, but with the positive outcome to the resolution meeting felt that it was no longer necessary.

People who are transgender

Ms P was a transgender person who made contact with the PSO identifying concerns regarding her treatment in public hospitals. It became apparent that Ms P's concerns were broader than the particular incident being addressed. Ms P's concerns were underscored by issues around perceptions of value, stereotyping, myths and prejudices that exist in relation to people who are transgender.

Ms P wanted to ensure that the experiences she had to endure were brought to an end for all people who are transgender. In order to better understand the systemic issues the PSO conducted research including:

- Related policies: NSW Health Services Policy Gender Equity in Health and the NSW Health Circular 2000/8 *Managing Workplace Issues for Transgender People*;
- Legislation: The Industrial Relation Act, 1996. Section 5.4.3 covers the use of facilities;
- Relevant contacts: The name of the CEO of another health service that had commenced some work in the area of transgender issues;
- Contact with an advocate from the Gender Centre: Sought information regarding appropriate language, health related issues and previous work on transgender issues within other health services. The PSO also sought the Gender Centre's willingness to participate in an ongoing training process with the Area.

The PSO provided the AHS representative an outline of the issues and the information that had been obtained to assist in preparing for the meeting and in reaching a positive outcome.

The resolution meeting was held with a senior Area clinical manager, Ms P, an advocate from The Gender Centre and the PSO. A commitment to initiate change across the Area, with possible implications for change in other areas was achieved. The change will be implemented through a three-tiered approach:

- development of appropriate policies and protocols to ensure that people who are transgender receive quality health services;
- development of a database of information that will provide information to health practitioners to assist when addressing specific medical issues for people who are transgender (eg information about hormones). This database of information will be available to all employees on the intranet; and
- values based training for employees. Practitioners working in emergency department, urology and gynaecology will be targeted as the first to receive training.

Follow-up mechanisms (including telephone contact and meetings) were identified as part of the change process to ensure that the initiatives committed to are developed and followed through.

Meeting individual needs

Mr V was an elderly gentleman who experienced limitations as a result of four strokes. The limitations have resulted in diminished capacity in terms of mobility, speech and comprehension, although he remained an intelligent and knowledgeable person.

Following a fall Mr V sustained an injury to his ankle and was transferred to a private hospital. He was concerned about the treatment he received and how that treatment related to the specialist who was responsible for his care. He believed that he had spent a week in hospital when it was not necessary, that his sore ankle received no real attention, that he was subjected to tests without his consent, and that following his hospitalisation the doctors breached confidentiality by contacting his son and discussing financial matters with him. Mr V is responsible for his own decisions and financial matters in all areas of his life and he contacted the PSO for support.

Mr V sought assistance to prepare a formal complaint to be placed with the HCCC. An offer of conciliation was made but due to his limitations following the strokes Mr V indicated that he wanted the PSO to assist him in resolving his complaint with the doctor.

The PSO contacted Dr D at the request of Mr V and sought a meeting to resolve the issues. The considerations influencing this meeting included:

Location: The meeting was held at Mr V's home due to the transport complications resulting from mobility and Mr V's use of a motorised scooter.

Timing: A morning meeting was sought as the PSO sensed that Mr V seemed to function better in the mornings when he was not tired.

Preparation: The issues of concern were discussed with Dr D at some length so as to ensure that he understood Mr V's perspective in relation to each of them.

At the meeting Mr V clearly articulated his anger in relation to what he believed had occurred to him. Dr D explained what tests were undertaken and why they had been considered to be necessary. Dr D apologised for the distress that had been caused to Mr V. Dr D conceded that they

should have taken more care in ensuring that Mr V had clearly understood what was required and that they had his informed consent. Dr D also apologised for contacting Mr V's son. At the end of the meeting Mr V indicated that he was now ready to put "an end to it", and they finished with a handshake.

No one's responsibility

In February 1997, Ms A was diagnosed with breast cancer. In March 1997, she had surgery and the pathology was taken and sent to Dr X of Company B.

In September 1998, Ms A discovered that there was a new chemotherapy drug, which may have assisted her with her breast cancer. To ascertain whether the drug would be appropriate for her, a test was required to be done on the pathology tissue taken in March 1997.

Ms A requested that her doctor, Dr P, contact Dr X and have him test her pathology samples.

On 30 November 1998, Dr P advised Ms A that Company B had gone into liquidation. Ms A stated that she had made numerous calls to Dr X and the liquidators in an attempt to retrieve her slides. The liquidator was allegedly willing to hand over the slides if Dr X would identify them. Dr X, according to Ms A, was not helpful.

On 8 December 1998, Ms A sought legal advice from her solicitors. With the help of her solicitor Ms A received her slides.

The slides were allegedly being stored in a warehouse that was being partly demolished. As a result of Ms A's solicitors' actions, the slides were moved to another facility. Ms A subsequently died in July 2000.

The Commission investigated this complaint to determine whether the assistance given by Dr X to Ms A was appropriate in the circumstances.

The Commission found that it took Ms A six weeks to obtain her pathology slides from Company B. It appears that the standard time to retrieve slides is generally 48 hours. This matter was complicated by the fact that Company B had gone into liquidation and the assets were under the control of a liquidator. Although it appears that Dr X did not have a legal obligation to assist Ms A in retrieving her slides in a timely manner, he did have an ethical obligation to assist her. The peer reviewer was severely critical of all the parties involved.

Dr X conceded that in hindsight he should have overcome the difficulties and ensured that the material was given to Ms A. Dr X also reinforced his opinion that he felt that it was the liquidators' responsibility to assist Ms A.

Dr X accepted some responsibility for the delays caused to Ms A and has advised that if presented with a similar occurrence he would assist the patient.

The Commission made comments to Dr X for his failure to provide timely and adequate assistance to Ms A in her attempt to locate her slides.

Sensitivity and sympathy required

Ms T complained that Dr N (Obstetrician and Gynaecologist) provided inadequate care to her during her pregnancy with her fifth child. She considered that Dr N should not have discharged her from Hospital at term because of her baby's unstable lie (changing position). She also considered that Dr N had been rude, arrogant, intimidating and uncaring in the face of her concerns during his conversation with her on prior to her discharge. Ms T's baby was delivered stillborn on 9 days later.

The Commission investigated the matter. Statements were obtained from two nurses who described the conversation between Ms S and Dr N on the day she was discharged. Following this conversation between Dr N and Ms T, the nurses stated that they further discussed Ms T's and their concerns with Dr N, but Dr N remained of the view that Ms T should be discharged on that day. The nurses wrote in the medical record that they were concerned about Ms T's discharge.

The matter was sent out to an obstetrician reviewer for an opinion. The Commission concluded that although Dr N had provided adequate obstetric management of Ms T, Dr N did not adequately allay Ms T's concerns about her baby's well-being but reacted to her concerns with irritation and annoyance. Following consultation with the NSW Medical Board, the Commission made comments to Dr N about his poor communication with Ms T.

COMMUNICATION BREAKDOWN IN THE OPERATING THEATRE

This complaint was received from Mrs R who had an abdominal hysterectomy in a private hospital. The hysterectomy was performed by Dr T, specialist obstetrician and gynaecologist. Dr T invited her colleague Dr E, a gynaecological oncologist to assist in the operation.

At the conclusion of the operation there was a misunderstanding between Dr T and Dr E about ordering post operative anticoagulant medication. They agreed that the drug Fragmin was required to help prevent blood clots, but each of them thought that the other had ordered it on the medication chart. As a result neither Dr T nor Dr E ordered the Fragmin on the medication chart but Dr T wrote in the post operative instructions, "Fragmin as ordered".

The Fragmin was then ordered by Dr M, a junior resident medical officer (RMO), but he ordered double the maximum dose. In the days following Mrs R's hysterectomy either Dr T or Dr E saw Mrs R daily. Neither of them noticed the high dose of Fragmin prescribed until someone else noticed it on the 5th day after the surgery when Mrs R started to bleed into the surgical wound.

Mrs R recovered and was discharged from hospital 14th days after surgery.

The Commission investigated complaints in relation to the three doctors, Dr T, Dr E and Dr M.

The Private Health Care Branch of the Department of Health conducted an investigation of this incident in relation to the hospital. The hospital expressed the view that the responsibility for drug prescribing lies with the admitting specialist.

The Commission obtained an expert review of the RMO's conduct. The reviewer considered that the responsibility lay with the admitting consultant(s) and was not critical of Dr M. The Commission finalised the complaint against Dr M without taking any disciplinary action. In so doing the Commission pointed out to Dr M that a junior medical practitioner must accept personal responsibility for his/her own prescribing.

The Commission obtained a peer review of the conduct of Dr T and Dr E. The reviewer was mildly critical of them for the communication breakdown that resulted in a failure to ensure that the correct dose of Fragmin was ordered on Mrs R's medication chart.

The reviewer was also mildly critical of Dr E for his failure to check Mrs R's medication chart 4 days after surgery when he documented in the notes "wound bruised".

Dr T and Dr E acknowledged the seriousness of their mistake. The Commission made comments to Dr T and Dr E based on the peer reviewer's criticisms.

LACK OF COMMUNICATION AFTER SURGERY

Mrs R had a pre-existing medical condition and needed to have gynaecological surgery. The gynaecologist suggested an epidural anaesthetic and her neurologist agreed. The anaesthetist was of the opinion that an epidural was not appropriate because of her pre-existing medical condition. He assured the complainant that she would have no problems with a general anaesthetic.

Mrs R proceeded with the day surgery and complained to the Commission about her experience. Her major concerns were that the anaesthetist did not provide written post-operative orders for nursing staff and did not attend her post-operatively and allowed her to be discharged five hours after the procedure. Mrs R reported that she had been extremely distressed post-operatively and could not breathe properly. The nursing staff had not been properly briefed about her pre-existing medical condition and subsequently she did not receive the medication she required in a timely manner. After she was discharged Mrs R passed out and fell at home, sustaining a fractured nose.

Mrs R had attempted to resolve the matter with the anaesthetist and the hospital. She felt she had made some headway with the hospital but was very dissatisfied with the response from the anaesthetist.

The matter was assessed for conciliation. Both the doctor and the hospital consented to conciliation, however Mrs R was concerned that the doctor would not properly hear her during the conciliation. Mrs R also wanted her husband to attend the conciliation with her. In view of her concerns Mrs R requested the Commission to review the assessment decision under s26 (6) of the Act. The assessment decision to refer the

matter to the Health Conciliation Registry was reviewed and found to be appropriate.

Mrs R then agreed to conciliate the matter. Her husband was recognised as a party to the complaint and his consent to conciliate was also sought by the Commission. The matter was referred to the Health Conciliation Registry.

Erring on the Side of Caution (Review of Assessment)

Mr H complained to the Commission in relation to his consultation with Dr S, dermatologist, during which Dr S diagnosed Mr H as having an acute staphylococcal infection involving the left thumbnail. Dr S prescribed Flucloxacillin for Mr H's infected nail. Mr H had given Dr S a vague history of having previously had some sort of adverse reaction to penicillin. However, Mr H had also reported that his mother and grandmother had both experienced allergic reactions to penicillin. Flucloxacillin in a form of penicillin.

According to Mr H, after three days of Flucloxacillin administration he experienced an extreme adverse reaction that was subsequently diagnosed as being Stevens-Johnson Syndrome (SJS). SJS is a rare but dangerous hypersensitivity cutaneous reaction which, associated with some drugs including penicillin, can be fatal. Mr H described his reaction as being severe in that he shed a large amount of skin. Mr H stated the impact of his two-month convalescence on his employment and primary relationship was also severe. The Commission originally assessed the complaint for conciliation. Both Mr H and Dr S declined conciliation and Mr H requested the Commission review the assessment decision.

The Commission re-examined the matter, researched the literature and sought medical advice. The Commission subsequently formed the view that, while it would be generally appropriate to treat suspected or proven staphylococcal infections with Flucloxacillin, it would prudent to avoid any form of penicillin where there is a history of penicillin allergy and to use an alternative antibiotic agent instead. The Commission considered that, while it is open for a physician to test the reliability of a history such as given by Mr H, the doctor must err on the side of safety where there is any doubt about this question, as there appeared to be in this case. The Commission concluded that it appeared unwise and inappropriate for Dr S to have prescribed Flucloxacillin for Mr H regardless of whether he developed "SJS" or not.

There remained a question regarding the adequacy of Dr S's knowledge and/or judgement in prescribing Flucloxacillin where there existed a personal and family history of allergy to penicillin and where there existed an alternative effective pharmacological therapy (eg Cephalexin, Clindamycin). The Commission reassessed the complaint and referred the matter to the NSW Medical Board for the Board to satisfy itself in relation to the adequacy of Dr S's knowledge and/or judgement regarding the uses of penicillin and its alternatives.

Consultative Resolution Model

Ms T, a teenage girl had been distressed and developed a negative view of herself. Her parents became aware, in the early evening of a Saturday, that their daughter intended to suicide, and they confirmed this with her. Ms T's parents contacted the local crisis mental health team for support and direction as her private psychiatrist was not available. The parents were advised to take Ms T to the emergency department (ED) of their local hospital where someone from the team would meet them.

Mrs T drove her to the ED but a member of the crisis team did not meet them. There was no support provided for Ms T and her mother as they waited hours for an assessment to be conducted. There was no separate area for Mrs T to wait with Ms T, and this added to the distress of both. No other support was offered to them during this time.

After the lengthy wait, Ms T was first assessed by a psychiatric nurse from the crisis team who believed Ms T did not require admission. Mrs T insisted that a psychiatric registrar be called to also provide an assessment. The registrar also advised that Mrs T should take her daughter home. The registrar told Mrs T that there were no beds available at the hospital. Mrs T was not told of any other units/ hospitals (public or private) where they might have been able to arrange admission to a safe environment. Mrs T was instructed to monitor her daughter 24 hours a day, and she

was told that the crisis team would call the next morning to provide assistance. This did not occur. Despite seeing private practitioners Ms T committed suicide twelve days after her initial presentation to hospital.

The parents of Ms T placed a formal complaint with the HCCC. They sought the support of the PSO in attending a meeting with the director of mental health services at the hospital. The issues of concern identified by Mr and Mrs T were discussed with the director, and they were satisfied that the issues they presented would be adequately addressed. However, they were later dissatisfied when letters they received from the Area director of mental health did not meet their expectations. Mr and Mrs T placed a request for a review of assessment decision with the HCCC.

The Commission decided to conduct a consultative resolution process with the AHS to discuss the issues raised by Mr and Mrs T. An initial resolution meeting was held between the parents and the director of mental health services at the hospital. This was followed by a consultative resolution meeting held between Commission staff and the AHS. The outcomes of these two meetings were as follows:

- to create a dedicated room for mental health assessment and use as a possible waiting area for distressed families at the hospital;
- to employ two extra child and adolescent psychiatrists;
- to develop an on-call roster of a child and adolescent psychiatrist across the area;
- to develop a formal procedure whereby the triage nurse should be able to advise families of the expected waiting time to see a member of the acute team;
- to write new guidelines and educate staff to ensure that the acute team follow up with families where it has been indicated to families that this is what will occur;
- to develop a policy which clarifies the acute team and other mental health services' responsibilities to provide the same care to people with a private psychiatrist as for those being cared for by a psychiatrist in the public sector;
- to amend policies in respect to follow-up of patients and contact with private practitioners treating patients who present to hospital;
- to develop a procedure for following up consumers and relatives who are requesting admission to hospital but who are being managed in the community;
- to simplify information provision between the ED and the crisis team;
- to develop a protocol to assist in the assessment of a family's ability to provide care and monitoring of a potentially suicidal family member.

Accountability, responsibility and supervision

A challenge for health services is ensuring that they achieve a balance of competent health professionals to provide the services to the community they serve while also enabling more inexperienced health professional employees to gain experience and learn in an environment that is both supportive and safe without being oppressive. The results for people relying on these services when this balance is not right can be traumatic, disabling and sometimes disastrous. The responsibility of less experienced health professionals is to ensure that they know the limitations of their knowledge and skill and that they do not compromise the care being provided to a person. The responsibility of the supervising, more experienced professional is to ensure that they understand the limitations of the person they are supervising and are available to provide advice and support in a timely and safe way while allowing the more junior person to learn. Another responsible agent in this is the organisation and the governing body who have a responsibility to ensure that the appropriate protocols for 'on call' arrangements are in place; that staff know how to seek appropriate advice and assistance if they are unable to contact their primary supervisor; that there is a culture of prioritising the protection of the safety of people over the learning needs of the individual health professional; that the consumer and the health care team all have a voice that is respected and valued in clinical decision making; and the health professionals are adequately supported with physical and human resources to aid quality decision making and care to be provided without short cuts being taken.

There is evidence in the complaints received by the Commission that these pre-requisites are not always there as some of the following case studies illustrate.

RESPONSIBILITY FOR MANAGEMENT OF A SICK BABY AND DOCUMENTATION IN HEALTH CARE RECORDS

Baby A was six months old and had suffered for a few days with a cough and irritability. One night her parents, Mr and Mrs B, noticed that she appeared to be in a lot of pain, had a temperature and was disturbed by sudden noises and light. In the morning she was pale, lethargic and limp. Mr and Mrs B took Baby A to the emergency department at the local hospital. On the way she developed a rash on her chest. Later that day she was diagnosed with meningococcal septicaemia and transferred to a specialist_children's hospital. She subsequently underwent amputations on all four limbs. Mr and Mrs B complained to the Commission about the adequacy of the care and treatment provided by the first hospital and the consultant paediatrician in attendance, Dr M.

The most important causes of bacterial meningitis in young children are Haemophilus influenzae and Neisseria meningitidis (meningococcus). Immunisation against Haemophilus meningitis is now routine (the Hib vaccine). In meningicoccal meningitis the symptoms appear suddenly and the bacteria can cause widespread meningococcal infection culminating in meningococcal septicaemia, with its characteristic haemorrhagic rash anywhere on the body. Unless rapidly diagnosed and treated, death can occur within a week.

Mr and Mrs B arrived with Baby A at the Emergency Department at just after 9.00 am. On assessment it was noted that Baby A had several small and very faint spots on her chest, and she was pale, had a high temperature and an increased heart rate. The duty medical officer saw her immediately. He obtained blood samples including blood cultures and contacted the paediatrician on duty, Dr M.

Dr M saw Baby A at about 11.00 am. He told the Commission that she had a non-purpuric morbilliform rash over her trunk and body (a skin rash resembling that of measles). A morbilliform rash is non-specific but can be a preliminary sign of meningococcal septicaemia. A purpuric rash, which results from bleeding into the skin from small blood vessels, is highly suggestive of meningococcal septicaemia. Given Baby A's history of illness over the past few days, Dr M made an initial working diagnosis of viral respiratory illness.

At about 1.00 pm Baby A was admitted to the children's ward for close observation. At 2.00 pm she was still very pale and peripherally pink. During the next hour a nurse expressed concerns about Baby A to the resident medical officer (RMO) and asked him to review her. The nurse in charge of the evening shift noted at about 4.15pm that a rash had appeared which was getting darker and more evident and was beginning to cover Baby A's body. The RMO contacted Dr M, who gave orders to insert an intravenous (IV) cannula. The nurse unit manager, who was a clinical nurse specialist in paediatrics, noted that the rash was persisting but a purpuric discolouration had appeared below one of Baby A's nipples. He immediately realised the significance of the rash and contacted Dr M, who gave telephone orders for treatment pending his arrival on the ward. It was clear at this point that Baby A had widespread sepsis and the blood supply to her arms and legs was seriously reduced. Baby A was transferred to the intensive care unit and later taken to a specialist children's hospital by the NETS team (Neonatal Emergency Transport Service).

The peer reviewer was not critical of Baby A's management by hospital staff throughout this event. However, the reviewer considered that the recording in the hospital notes was not adequate, particularly with regard to a formal admission history, physical examination and management plan by a medical officer, and continuing notes by nursing staff. The AHS later advised the Commission about initiatives and improvements undertaken as a result of Baby A's admission. The Commission was satisfied with the hospital's actions.

The peer reviewer was critical of three aspects of Dr M's management of Baby A, in particular that he did not re-assess her sufficiently promptly after he saw her initially in the Emergency Department, allowing about five hours to elapse. The reviewer stated that the consultant should take the responsibility for this re-assessment in a situation where the level of paediatric experience of the staff might be limited.

The Commission recommended that Dr M be counselled by the Medical Board on the following matters arising from the reviewer's opinion on his management of Baby A:

- the need to start prophylactic antibiotic therapy, if on the initial assessment of a patient a diagnosis of meningococcal meningitis is considered, even if discounted at that point;
- the need to re-assess the patient within at least one hour, and continue such regular assessment until the correct diagnosis is confirmed and/or a decision is made to start antibiotic therapy;
- the need to fully record clinical findings in a patient's medical notes at each visit, including at initial assessment, and to include in the record directions for observation and orders for treatment.

Dr M left with the clear understanding that meningococcal disease must always be considered in a child with fever and a rash, and that there should be a low threshold for the commencement of antibiotics in such a case. Dr M acknowledged that adequate medical records must be maintained and these are the responsibility of the doctor in charge of the patient.

Registrar Leaves It Up To Others

A complaint referred to the Commission by the State Coroner concerned Ms S who was admitted to a public hospital for an endoscopic retrograde cholangio pancreatography (ERCP) operation by a gastroenterologist In this procedure X-ray contrast liquid is inserted into the bile duct through an endoscope passed down the throat in order to obtain X-ray pictures of the bile duct. Ms S subsequently died as a result of the procedure.

A statement from Ms S's husband and Ms S's health care records identified issues for investigation in relation to four doctors and two health services. The operation was performed in the early morning and was planned as a day-only admission. However, Ms S was not discharged that day because of ongoing pain. A resident doctor ordered blood tests and an abdominal X-ray that afternoon and discussed the case with Dr L, a medical registrar.

The resident doctor believed that Dr L would be on duty that evening to review the results of Ms S's tests and X-rays, but that was not the case. It appears that the blood test results and X-ray were reviewed that evening by an intern of limited experience who apparently considered them to be normal.

The following afternoon Dr L reviewed the X-ray with a radiologist and diagnosed a posterior perforation of the duodenum. Dr L then entered an urgent plan of management including ordering three different intravenous antibiotics.

Despite Dr L's urgent orders, Ms S did not receive the first intravenous antibiotic for five hours. At some point Dr L cancelled his order for one of the antibiotics by crossing a line through it in the medication chart, however Dr L did not sign and date the cancellation or make any entry in the notes to explain his cancellation. Ms S's management was then taken over by a consultant surgeon.

Later that day Dr L amended the resident doctor's entry in the patient notes from the previous evening. He crossed out "Dr L (Med Reg) contacted & will review patient" and inserted an entry saying "evening RMO (Dr M) will review". Dr L did not sign or date his amendment. Ms S died from the effects of the perforation five days later.

The Commission obtained reports from two expert reviewers with experience in ERCP procedures. The first reviewer made the following criticisms of Dr L:

- "The perforation is difficult to detect on an X-Ray. It is a complication of ERCP which Dr L should not have expected a junior doctor to identify."
- "Dr L's unsigned retrospective entry in the notes is of serious concern."

The second peer reviewer was also critical of Dr L for:

- "failure to ensure that the first dose of intravenous antibiotics were administered promptly when he ordered them."

At the end of the investigation, s40 of the Health Care Complaints Act 1993 ensures that respondents have the opportunity to comment on the Commission's grounds for disciplinary action. At this point Dr L showed considerable insight into his conduct and accepted the criticisms of the expert reviewers. The Commission and the Medical Board took the view that Dr L's insight indicated that consumers would be protected from similar conduct in future and it was agreed to make written comments to Dr L based on the

criticisms of the expert reviewers.

The Commission has also completed the investigation of the other health providers identified in this complaint and taken action where issues were identified.

Inadequate supervision of RMO by Registrar during procedure of insertion of central line

Ms P was sent to hospital by her GP for treatment with intravenous antibiotics following an injury to her leg and the development of cellulitis. After a few days and after a number of problems with the cannula, it was decided that Ms P should have a long line inserted in the intensive care unit (ICU) for ongoing antibiotic treatment. The peripherally inserted central venous catheter (PICC) is a fine plastic catheter that is inserted until the tip is in one of the great veins leading to the heart. As the catheter is quite small in diameter it has a flexible guide wire in the lumen to assist in the insertion and passage along the veins. The guide wire should be removed after insertion.

Dr D (a resident medical officer) who performed the procedure, had not seen the type of catheter before, nor had he ever before inserted one. Dr C, the ICU Registrar was guiding him through the procedure. At the end of the procedure an X-ray was done to check the position of the line. Ms P was sent home and the IV treatment was continued twice daily. Ms P experienced some chest pain after a few days and at the check up appointment another X-ray was ordered. Ms P was then told that everything was where it should be and returned home. Yet she continued to have a very sore leg and an ultrasound was done to check that a blood clot was not developing. After 2 weeks the long line was removed.

At about this time Ms P noticed a cyst like lump appearing on her right knee. It was lanced but no pus came out. The next day a second ultrasound was done. The technician asked Ms P if he could call in a specialist as something was worrying him. Ms P heard him saying to the specialist, "what is this line? It should not be there." There was no mention of this in the report.

Another few weeks passed with Ms P having a lot of pain and having trouble walking or bending the knee. She saw her GP on Friday to report the jabbing pains and a further X-Ray and ultrasound were ordered for the Monday. But on the weekend the cyst like lump appeared again. After a few hours she was feeling the area and felt something hard. Ms P pulled at it and to her horror a fine wire started to pull out of her knee. She called for help from her son and together they pulled and removed the 57cm wire. It was then that she remembered the line the technician saw but could not explain.

The hospital was contacted and after arranging an Electrocardiograph (ECG) and another X-ray for Ms P, the hospital undertook a number of actions, including:

- A full investigation of the incident
- In-service education sessions
- Notification to the product manufacturers of the PICC line
- Meeting between hospital staff and representatives of the manufacturer to review the incident, product and its use
- Meeting with the patient, hospital staff and the manufacturer to determine the sequence of events
- The manufacturer has notified the Therapeutic Goods Administration
- Hospital protocols and guidelines for the insertion of central lines have been modified.

Ms P complained to the Commission and the AHS was asked for a report on their investigation.

In response to the complaint Dr C stated that he was supervising Dr D as an ICU registrar and that he had been called away to review an unstable patient leaving the insertion unsupervised. He acknowledged that he should, in hindsight, have asked Dr D to cease the procedure until he returned. He said that he had learnt a valuable lesson that he hoped would lead to better practice and that he should have paid more attention.

During the last contact by the PSO, Ms P said that she felt that the complaints process has run its course and she was now leaving it to the legal process as she has ongoing health concerns. She was thrilled that the PSO had taken so much interest and appreciated the follow up.

The discussions regarding supervision of more junior medical officers arecontinuing with the Director-General and the Post graduate Medical Council.

In two places at once

Mr K, an older man was admitted by Dr I his vascular surgeon, to the ICU of a small private hospital to undergo a urokinase infusion, an intravenous infusion to dissolve venous thrombi and pulmonary emboli. Having commenced the infusion, Dr I then left the hospital to attend another hospital where he had a surgical list. Mr K was monitored throughout the day under the care of Dr B, the resident medical officer in ICU. Dr Y, the director of ICU, was working at a nearby public hospital that day.

Mr K's condition deteriorated throughout the day, with the onset of cardiac and renal failure. Dr B consulted with Dr Y who gave treatment instructions by phone, then later telephoned Dr I, who decided that Mr L's leg would have to be amputated. Dr I arrived several hours later to perform the surgery. Mr K's leg was amputated below the knee and a second amputation was performed when his wound became infected. Mr K died within a few days.

The HCCC investigation considered the appropriateness of care and after seeking both peer and expert opinion, found that the standard of care and the treatment were appropriate. Mr K was a man whose medical condition was complex and the treatment was a last try to rescue his failing health. The amputation was an unfortunate consequence but was done as a life saving measure.

Also arising from the investigation were questions about the appropriateness of admitting Mr K with his complex and serious medical history to that type of hospital without the adequate medical back-up should it be needed. It was also a concern that Dr I, with his expertise, left for the day and was not available should he be needed as he was in an operating theatre at least an hour and half's drive away. The HCCC investigation had to consider whether Dr B had sufficient training and experience to be able to effectively monitor Mr K.

The other question that arose was the appropriateness of the staffing arrangements. The person responsible for rostering and ensuring that there was sufficient specialist cover was Dr B, who was also the hospital's medical services director and a part owner of the hospital. He also acted as surgical assistant in the evening when Dr I returned to perform the surgery. The expert who reviewed this matter remarked upon the potential for a conflict of interest in these arrangements. The expert was critical of Dr I for his absence from the hospital, or for not arranging another specialist to attend, when he was aware of the deterioration and knew he would not be able to attend himself for several hours.

Although the complaint relating to the care was not substantiated, the issues relating to supervision and staffing were brought to the attention of the Director-General for Health. The recommendations were that: area health services and the licensing body for private hospitals, the Private Health Care Branch of the NSW Health Department, should be aware of the potential for compromise when a practitioner is on duty at one hospital and on call at another; and that when reviewing staffing arrangements, both the public and private hospitals must be satisfied that arrangements for specialist availability are adequate for the level of care being provided to people.

Supervision of junior medical officers

Ms B complained about the care provided to her late father, Mr B, by a rural hospital emergency department (ED). Ms B was particularly concerned about the rude behaviour and clinical judgement of Dr H, a first year resident medical officer.

Ms B explained that her 69 year old father suffered a shoulder injury from a boating accident. He saw his local GP who organised an appointment for him with an orthopaedic specialist, scheduled for several weeks later. Only days prior to consulting the specialist, on a weekend, Mr B complained of severe shoulder pain and presented to the local hospital ED on three occasions. He was seen by Dr S (first year resident medical officer) on two separate presentations on the Saturday and by Dr A (third year resident medical officer) on the Sunday. He also attended a GP for shoulder pain at the local after hours medical service on the Sunday. Each time, Mr B was treated for the pain and then sent home with medication for the pain.

In the early morning of Monday, Mr B began to act abnormally - he became agitated and confused, threatened his wife, and had a motor vehicle accident. He was taken by ambulance to the hospital where he was seen by Dr H in the ED. De-

spite Mr B's obvious confusion, slurring of words and odd behaviour, Dr H was reluctant to admit Mr B. This was also despite the fact that Ms B and Mr B's GP were highly concerned about Mr B's condition. Mr B was subsequently seen by an orthopaedic specialist, who admitted Mr B. Mr B was admitted to ICU but died the following day of overwhelming infection and organ failure.

The Commission investigated the matter and obtained an independent review from a specialist in emergency medicine. The Commission concluded that:

- Dr S treated Mr B appropriately on his first presentation. However, as Mr B returned to hospital on a second occasion that day, Dr S should have arranged further investigation and consultation about Mr B's condition and ongoing pain.
- Dr A should have performed further investigations and kept better health care records.
- Dr H should have communicated much better with Ms B. Dr H should have considered Mr B's overall condition before contemplating sending him home. Dr H should have recognised the significance of Mr B's abnormal observations, and treated him without delay. He also should have performed further investigations to ensure that some of Mr B's symptoms did not relate to Mr B's motor vehicle accident earlier that day.
- The hospital provided inadequate care to Mr B on the 3 days in question. However, the Commission recognised that since that time, the hospital had changed its processes in an attempt to improve the care. The Commission recommended that the hospital continue to monitor the situation in the ED to ensure that there were no further recurrences of these sorts of deficiencies.

Following consultation with the NSW Medical Board about the medical practitioners, the Commission made comments to Dr S, Dr A, Dr H and the hospital about their departures from the acceptable standard of care in their provision of service to Mr B. Ms B was informed of the outcome.

Comment: As can be illustrated in the case studies above and following, in the course of resolving a complaint about an individual health service or health professional the HCCC often comes across issues that are clearly common to other services and professional activities. In identifying regional or system wide areas for improvement in the quality of health services, the Commission is more and more actively working with the services and professionals to achieve sustainable clinical service improvements and raising the standards of care provided by individuals. The HCCC investigation, resolution, education and training strategies are an important vehicle for this, as is the newly developing formal advice and liaison role that is designed to assist health services and health professionals resolve complaints at a local level so that they do not escalate to a point where the person has to come to the Commission. There are clearly many system wide lessons to learn as the following case studies illustrate.

Rural Public Hospital Policy Changes and Recommendations Implemented

Ms D made a complaint to the HCCC about the treatment her mother, Ms T, received in a rural hospital. The matter was referred to the AHS for investigation and the Commission requested a report under s.26 (1) of the Health Care Complaints Act. Ms D complained about a number of issues including:

- The rude and abrupt attitude of particular staff members towards her mother, commenting on numerous occasions that the Ms T was "putting on a turn" or that she was "making herself sick".
- Incidences when Ms T was left sitting up in a chair for hours at a time with no access to a buzzer to call for assistance.
- A fall Ms T had whilst in the hospital. A medical officer did not examine her and her family were not notified.
- Injuries received while Ms T was in the lifting machine. Her skin was torn and her little finger was jammed on one occasion.

The matter was investigated and the client received a response from the AHS providing explanations and recommendations to address the is-

sues of inadequacy. Ms D was not satisfied that the recommendations would be implemented. The investigation process had suffered significant delays and the client had lost confidence in the hospital to implement the recommendations. With assistance from the PSO Ms D identified what information and documentation she required from the hospital to assure herself that her concerns had been taken seriously and that action had been taken.

The PSO contacted the AHS to discuss Ms D's outstanding concerns and to request further information about action taken by the hospital. Ms D was provided with the following:

- Dates and content of in-service educational programs scheduled for the hospital to address the issues of attitudes towards consumers. Several staff were required to attend an Area training program on providing a quality service.
- Particular staff members had been counselled by the Acting Health Services Manager about their attitude and the matter was to be referred to the new health services manager when an appointment was made. Staff appraisals were due to be conducted and the opportunity would be taken to highlight professional behaviour and attitudes towards patients.
- Further training for staff about how to handle patients safely
- A copy of the revised policy regarding patient incidents which required that a medical officer be notified of any patient incidents within 24 hours of occurrence and the patient's next of kin to be notified at the earliest opportunity.

Ms D was generally satisfied with the information and documentation provided. However, she was still concerned about the process of counselling for the nurses she had identified as having attitude problems. Ms D decided to write to the HCCC for the attention of the officer who would be reviewing the report from the AHS, so that the officer would be aware of her outstanding concern.

SYSTEMS IMPROVEMENT FOR THE AMBULANCE SERVICE

The Commission received a complaint from the Ambulance Service about the response by the Ambulance Service to a call for assistance to Address A. The Ambulance Service was therefore both the complainant and the health service provider respondent to the complaint.

The statutory declaration requests investigation of the management of the call taking and the dispatch process to Address A. In particular, the Commission investigated the issue of whether the on-call resources should have been used to respond to the emergency request at Address A.

The complaint also sought a review of the action initiated by the Service to transfer the primary call taking and dispatch responsibilities for the area from the one operations centre to the another operation centre.

The incident in question concerned a call for an emergency response to Ms A, an older person living in Town V in a unit at Address A. Ms A was discovered to be ill and vomiting. A call was made on her behalf to the Ambulance Service, which dispatched a vehicle from Town W. The vehicle took over 40 minutes to respond to Ms A's emergency call. The main complaints centred on the delay in response time and the appropriateness of the allocation of a vehicle from Town W to Town V, when the nearest vehicle was at Town X. The local Member of Parliament, raised the complaint in State Parliament in April 2000. A member of Ms A's family and her local doctor were also reported in the print media.

This incident followed in the shadow of a similar incident at Town V in February 2000 in which a person died before the ambulance from Town W arrived. There was a great deal of community concern in the region about the adequacy and quality of service by the Ambulance Service.

The Commission conducted an investigation of the call taking, despatching and resource allocation processes. Individual members of the service were interviewed and the Ambulance Service's policies and guidelines were reviewed. Whilst the Commission was not able to come to a conclusion about the individuals involved in the particu-

lar case, systemic issues were identified which had contributed to the incorrect allocation of a vehicle from a neighbouring area.

In summary, the Commission made the following recommendations. That the Ambulance Service:

- review call taking procedures to ensure consistent practice that emergency calls are in fact taken rather than referred to another number;
- log the initial call and then pass it on to the appropriate centre rather than have clients make another call;
- continue developing a triage based call system involving staff with appropriate skills, knowledge and experience to make judgements of a clinical nature and assess risks and priorities;
- provide staff with appropriate ongoing training and support.
- review the implementation of directives, in particular the leeway given to officers where there is a direct conflict with instructions to be frugal with resources and the rostering of overtime. The Commission found it undesirable to allow the needs and safety of the community to be compromised by an interpretation of directives that placed an emphasis on keeping expenditure down.
- review its dispatching policy for consistency of implementation and provide officers with clearer support to override directions, overtly or impliedly given, that use of on-call vehicles is a last resort; and
- develop a separate monitoring or formal bench marking of response times to monitor estimated time on arrivals (ETAs), and actual arrival times, with a built in mechanism to alert dispatchers when ETAs are not met;
- review its complaint handling process, in particular the dissemination of information about the outcomes of complaints. The outcomes of complaints should be viewed in the broader context of impact on service delivery, public health and safety, and for quality improvement purposes, not merely that individuals are dealt with according to disciplinary or conduct principles.

Breach of confidentiality

Dr S (general practitioner) wrote to Mrs L in 2000 informing her that a representative from organisation M, would ring her and arrange an assessment in her home. He informed her in the letter that Medicare would pay for her assessment and a report would be supplied to Dr S.

A representative from the organisation later rang Mrs L and Mrs L told her daughter, Ms D, that the representative tried to pressure-sell her on a number of services provided by the organisation. Ms D complained to the Commission that Dr S had breached her mother's confidentiality by giving her personal details to the organisation, without her mother's consent.

The Commission investigated the matter. Dr S stated that he employed the organisation to collect the information component of the health assessment for patients over 75 years old, an item available under Medicare. A registered nurse collected the information. Up until spring 2000, he had given out the names, addresses and dates of birth of 42 patients, including those of Mrs L. He ceased doing so, once he was notified that there was a complaint against him in relation to this matter. He noted that organisation M had assisted at least 80 practitioners to assess over 2000 patients since the organisation was established. He added that the registered nurse who contacted Mrs L by telephone stated that the conversation only lasted 5 minutes and denied that she pressured Mrs L during the conversation.

The Health Insurance Commission (HIC) informed the Commission that a new Medicare item was introduced in November 1999. This related to the health assessment of patients over 75 years old. It included a proviso that a third party could gather the information for this type of assessment under the supervision of a medical practitioner.

Following review of the matter by a medical advisor employed by the Commission, the Commission concluded that Dr S breached patient confidentiality because he released personal details of Mrs L and 41 other patients to the M organisation, without obtaining patient consent prior to releasing the information.

The matter was referred to the NSW Medical Board to take further action.

CONTINUITY OF CARE ACROSS HEALTH SERVICES

Mrs A lodged a complaint concerning the death of her husband whilst he was on the waiting list for an organ transplant. The complaint involved two major metropolitan hospitals in different AHSs and alleged that neither hospital provided adequate support in terms of social work follow up and other necessary support, prior to her husband's death.

Mr and Mrs A lived in a remote rural town. Mr A required urgent hospitalisation and was transferred by air ambulance to Sydney, accompanied by his wife. He was admitted in critical condition to Hospital B. During his admission he was assessed by the transplant team at Hospital C and was accepted on the waiting list for an organ transplant. He was told the wait could be 6 to 18 months. During his admission at Hospital B he caught a virus and had a persistent cough.

A month after his original admission Mr A's physician advised that Mr A was to be discharged, but that he should remain in the city until a donor organ became available. The Commission was informed by the Hospital B physician that discharge planning involved the social work department. Ms D, the Hospital B social worker had one interview with Mr A, in the absence of his wife, but there was no evidence of any other action being taken on her part. No resources or services such as transport were arranged and no report was forwarded to the transplant team social worker as was usual practice. Mrs A contacted the transplant team social worker who found them some accommodation in premises owned by Hospital B. Mr and Mrs A had no relatives or friends in Sydney to whom they could turn for support. Mr A was discharged but was to return daily to Hospital B for tests. Without transport assistance they were reliant mainly on public transport, although Mr A was very ill and weak. Mrs A was not able to obtain a repeat prescription for a crucial medication for Mr A from Hospital C but was told to find a local GP.

Ten days later Mrs A returned to their hostel room after a short absence to find her husband dead. Mrs A claimed that she received no support or follow up from the Hospital B Social Worker or the Hospital C transplant team after her husband's death.

The Commission's physician peer reviewer considered that the day-to-day medical care and pathology services provided for Mr A by both Hospital B and Hospital C were sub-optimal for a rural patient isolated in a major city. The reviewer also considered that Hospital B's discharge policies were inadequate in relation to rural patients required to take up long term accommodation in the city to await transplants.

The social work peer reviewer was severely critical of the Hospital B's social worker who failed in nearly every aspect of her obligations towards Mr and Mrs A. In addition, the reviewer considered that the discharge policies of Hospital B had not been adequately implemented, in particular in relation to the lack of early planning, the lack of proper liaison between both hospitals and the failure to organise and co-ordinate appropriate resources prior to discharge, so that everything would be in place when the patient left the hospital. The social work reviewer noted that it was unclear as to which hospital bore the responsibility for managing Mr A's needs after discharge. A system should have been in place to allow this to be negotiated between the two social work departments to ensure that Mr and Mrs A's needs were met. The reviewer noted that Mr and Mrs A were dealing with two complex hospital systems and a range of people from different disciplines. The reviewer stated that their needs would have been better met had there been greater communication and liaison between these professionals across both hospitals.

The Commission made adverse comments to Ms D, the social worker for Hospital B, in the strongest of terms. Ms D informed the Commission that she acknowledged the social work reviewer's criticisms and asked that her sincere apologies be passed on to Mrs A.

The Commission also made adverse comments to Hospital B and Hospital C, in relation to the inadequate care provided to Mr A and to Mrs A after her husband's death. The Commission made detailed policy recommendations after considering submissions from each AHS. A significant aspect of the Commission's recommendations involved the need for the development of a protocol for patients referred for organ transplant and greater co-operation and liaison between hospitals. The Commission also recommended that the operation of the protocol should be periodi-

cally reviewed and evaluated, along with the effectiveness of the discharge planning processes.

The Commission was concerned that although the events involving Mr A happened some five years previously, there remained some unresolved communication and liaison issues concerning patients who are referred between hospitals or who receive treatment from a number of practitioners at different hospitals at the same time. The AHSs for Hospital B and Hospital C expressed inconsistent views as to the types of services that transplant waiting list patients could access and which hospital provided the primary contact point for the patient.

The Commission is required under section 42 of the Health Care Complaints Act 1993 to make a report to the Director-General of Health concerning the outcome of any investigation into a public health organisation. For the reasons outlined above the Commission has recommended that the Department review its policies related to the provision of service to rural patients required to remain in Sydney to receive care and that the Department develop guidelines for the provision of coordinated care to patients referred between AHSs.

Failure to interpret distress of a baby during induction

Part 1: Registrar

Ms Q was 21 years of age and attended a hospital between November 1995 and May 1996 for her first pregnancy. She was seen at the antenatal clinic by an obstetrician and visiting medical officer (VMO) when she was 12 weeks pregnant and no abnormality was detected. On 20 December 1995 she was noted to have some proteinuria and she commenced weekly antenatal visits. On 24 April 1996 a Cardiotocography (CTG) was again performed. As she was 39 weeks pregnant it was suggested she be reviewed in early May for a possible induction. In May 1996 she was reviewed by Dr B and was estimated to be 40 weeks and 5 days pregnant.

Ms Q was admitted to the labour ward where Prostin gel was inserted to induce labour. The CTG trace was abnormal showing a decrease in variability and decelerations of the foetal heart rate.

At 5am the patient awoke with painful contractions and a further CTG trace showed variability and decelerations. A midwife that came on duty at 7am was unhappy about the CTG tracing and refused a second dose of Prostin gel, and suggested a Syntocinon Drip would be less stressful to the baby. Dr U, the registrar, reviewed the tracings mid morning and considered the tracings no worse or better than the previous tracings and contacted Dr B, the obstetrician by phone. It was decided to give the second dose of Prostin gel. Dr U went off duty that night and had discussed Ms Q with the resident medical officer (RMO) where he suggested that she should be reassessed in one hour and if there were any problems Dr B should be contacted. The RMO went home and it was understood that the nurse-in-charge would examine Ms Q, check the CTG trace and cervix and give another dose of Prostin gel if there was no change. A third dose of Prostin gel was later administered and the CTG tracings showed no difference to earlier traces. Somewhere between 7 & 8 pm monitoring ceased and Ms Q went to sleep. At 5.55am there were no foetal sounds and later death-in-utero was confirmed. The cause of death was hypoxia.

The complaint referred to a Professional Standards Committee of the Medical Board concerned whether Dr U failed to correctly interpret the CTG tracings, failed to diagnose foetal distress and failed to establish an active management plan following a third dose of Prostin.

The Committee found Dr U guilty of unsatisfactory professional conduct and cautioned him. The members stated that Dr U should have recognized his lack of knowledge and experience and been more assertive in seeking direct assistance from Dr B, however, he had showed remorse and accepted responsibility for his actions.

The Committee was critical of Dr B in that he had made assumptions about Dr U's expertise without confirming them and there was evidence at the time of the management of the patient's pregnancy that the registrar had insufficient training and experience in the interpretation of CTG traces and the diagnosis of foetal distress. The Committee noted the problems not only in the actions of Dr U but in the processes of the hospital and the supervision by Dr B.

Part 2: Obstetrician

Another Professional Standards Committee found Dr B, the VMO not guilty of unsatisfactory professional conduct. The complaint concerned the lack of direct consultant level supervision or assessment for almost thirty six hours while attempts at induction of labour were carried out. The Committee was not satisfied that Dr B was notified of the concerns over the patient's labour. The Committee was concerned that the management of Ms Q was not conducted in accordance with the best practice of obstetrics but the Committee accepted that this was due to systemic problems at the hospital.

The Committee made the following observations and comments concerning improvement of the standard of care at the hospital:

- There is a very wide variation throughout the public hospital system in the way in which hospital classified patients are managed. It would be helpful for a set of guidelines to be published, so that all concerned know what their rights and responsibilities are in this context.
- Hospital patients should not be left to the good offices of the nursing staff when in a fragile obstetric situation. The poor observations of protocols to the point that patient care was affected and a very poor clinical outcome was the result. There did not appear to be a widely observed protocol for the management of hypertensive or other high risk patients in "high risk" clinics.
- There did not seem to be a clear designation of the privileges and responsibilities of a registrar/ senior RMO. There were a set of rules but they did not appear to be widely observed and there was no clear statement of the registrar to inform the consultant when he is off duty and the person coming on duty was of much lower experience and training. In the experience of two of the Committee members it is common practice for the consultant on duty/on call for a labour ward to do rounds to see all patients in labour at least once daily (and possibly twice). The Committee believed it should be expected that a hospital classify patients to expect this level of consultant supervision as a basic minimum.
- Consultants also need to have a very clear understanding of the capacity of the resident staff and give them clarity as to what they expect in patient care and when they expect to be notified and in what circumstances.
- The handover between shifts is most important for the welfare of obstetric patients and in cases where the progress is not clear cut, a written plan of management should be in the notes for the benefit of the patient and those that may have to see the patient later.
- The hospital should review the Department of Health instructions on stillbirth and make certain that all medical and nursing staff in the obstetric unit understand what is required.

The Committee found there was at least one, possibly more episodes of hypoxia took place which caused changes in the CTG and despite the midwives drawing this to the attention of Dr U, the assessment performed and subsequent call to Dr B failed to appreciate or convey the true seriousness of these circumstances.

Crossing the boundaries

Dr Gluskie was a specialist psychiatrist. The Commission made a complaint to the Medical Tribunal against him alleging that he engaged in inappropriate physical contact with a patient during consultations; disclosed personal information about himself and his feelings during consultations; engaged in a personal and sexual relationship with Ms X, a patient, and continued to treat her after engaging in a personal and sexual relationship; inappropriately insisted that Ms X keep their sexual and personal relationship a secret; inappropriately refused to refer Ms X to another psychiatrist; inappropriately referred Ms X to a female therapist whom he knew to have been de-registered as a medical practitioner for sexual misconduct; and inappropriately commenced consulting Ms X's therapist for his own personal therapy.

The practitioner was involved in litigation in relation to a civil claim. The Tribunal noted that the practitioner insisted that Ms X could not trust her lawyers with the truth about their sexual relationship and that she should lie to her lawyers and in the witness box in order to protect him. Ms X felt tormented by this. Ms X felt that she did not want to betray him in putting him at risk but she knew that she could not lie under oath. Both the practitioner and the therapist suggested often that she should not proceed with her case in order to ensure the protection of the practitioner.

The Tribunal found that there was a clear and continual exploitation of Ms X and an abuse of the practitioner's power throughout the therapeutic relationship where there was a high degree of dependency between Ms X and the practitioner. Of particular concern to the Tribunal was the aspect of secrecy which was injected into the relationship by the practitioner even before any sexual contact or any inappropriate personal relationship developed. The effect of the secrecy was to isolate Ms X from other professional, family or personal contacts who might have been able to assist her.

The Tribunal found Dr Gluskie guilty of professional misconduct and ordered that he be de-registered. The Tribunal declined to fix any period pursuant to s.64(3) of the Medical Practice Act before he can apply for re-registration because he had removed himself from the Register and had no intention of seeking to return to practice. It would be many years before the practitioner could be in a position to demonstrate that he was a fit and proper person to be re-registered due to the serious nature of the misconduct and his apparent lack of insight.

Exploitation

The complaint to the Medical Tribunal against Dr M J Bar-Mordecai alleged that he was guilty of unsatisfactory professional conduct and professional misconduct towards two patients. The first concerned a relationship with and treatment of an elderly patient and the second concerned disclosure of confidential information to the second patient's husband.

In relation to Ms Y, the elderly patient, the Commission alleged that the practitioner engaged in a personal and sexual relationship with her, obtained financial advantages from her, obtained financial benefits from her estate upon her death, administered 30mg of morphine to her just prior to her death and inappropriately signed her medical certificate for death and failed to keep a drug register for drugs of addiction.

The practitioner argued in his defence that he was Ms Y's defacto spouse. He took civil action in the Supreme Court to become the administrator of her estate and the sole beneficiary. The practitioner claimed Ms Y had died interstate and as he had been her defacto spouse he was entitled to her estate.

The Tribunal stated that it was comfortably satisfied on the balance of probabilities that the practitioner embarked upon a course of conduct calculated to obtain the entire estate. The Tribunal found that during the lifetime of Ms Y he continued to accept gifts of a financial nature from her and that shortly after her death his greed got the better of him and he set out destroying the evidence of her will so that he could found a claim for the total of her estate. In the course of maintaining this claim he lied under oath in written and oral evidence to the Supreme Court.

In relation to the injection of 30mg of morphine to Ms Y the Tribunal was comfortably satisfied that it amounted to professional misconduct. The Tribunal also found it: inappropriate for the practitioner to sign the medical certificate for cause

of death in circumstances where the practitioner was treating Ms Y; had considered himself to be a potential beneficiary from the estate of Ms Y; and was at the time engaged in a relationship with Ms Y.

The second complaint alleged that whilst treating a patient, the practitioner disclosed to her husband, in consultations, confidential information about the patient. The complaint also alleged that the practitioner gave inappropriate advice to the patient's husband concerning his relationship with the patient. The practitioner asserted that in NSW there is little or no patient confidentiality between medical practitioners and the patient. The Tribunal stated that this was incorrect and that there was a primary duty of the medical practitioner not to disclose what has been revealed by the patient to any other person. The Tribunal stated that the evidence of the practitioner made it clear that he used what he had learned from the patient to give advice to the husband without the permission of the patient. The evidence of the practitioner also made it clear that he intermingled information given to him by the patient with that given to him by the husband to form an opinion as to the relative merits of the parties and that this was not a function of a medical practitioner. In addition, the practitioner offered to the husband the means to perpetrate a deceit in the event of any subsequent Family Court proceedings, a course of conduct which is not only improper and unethical but also illegal.

When it came to protective orders the Tribunal was concerned that on almost every aspect on which the practitioner's conduct was criticised, he fully maintained that he was correct and that everyone else was wrong. The Tribunal also stated that the practitioner's conduct with two other female patients after the death of Ms Y demonstrated that he still acted without understanding of the proper rules of conduct governing medical practise. The Tribunal found that his attitude to the use of morphine and his previous use was not in accordance with any current evidence available and was severely criticised by many of the clinical experts. The practitioner was also quite blind to the obligations he faced by signing the medical certificate as to the cause of Ms Y's death, he was not prepared to accept that as a registered medical practitioner he was required to abide by the law and he failed to keep a drug register.

Of particular concern to the Tribunal was the serious defects in the practitioner's character and his lack of integrity, demonstrated by his inability to distinguish the boundaries of the professional doctor/patient relationship which resulted in his repeated acts of sexual relationships with patients, and the claims about the destruction of Ms Y's will so that he could found a claim for the total estate.

Dr Bar-Mordecai was de-registered and cannot apply for a review for 7 years from 6 September, 2000. Dr Bar-Mordecai has appealed against the Tribunal's decision.

Duality and Deception

The Commission made a complaint to the Medical Tribunal that Dr Dent engaged in sexual relations with two patients in 1989 and 1990. Dr Dent was a psychiatrist and had reported his conduct in relation to Ms G in 1989 to the Royal Australian and New Zealand College of Psychiatrists in 1996 where he admitted that the physical intimacy was initiated by himself and expressed feelings of guilt and shame. He provided references to the College and to the Tribunal. The opinions expressed by the authors of the references were all based on the fact that there was only one incidence of sexual misconduct.

The Tribunal found the practitioner guilty of professional misconduct and that he engaged in reprehensible acts involving improper sexual relationships with two vulnerable women. His misconduct with each patient constituted a grossly serious departure from the standards of behaviour required of a medical practitioner.

The Tribunal found that the practitioner was well aware of the reports of his referees being placed before the College and that he intended the College to take their reports into account and he allowed his referees to believe that his conduct with Ms G was an isolated act. He clearly represented to the College that he was guilty of one instance of sexual misconduct with a patient. The Tribunal was of the view that the practitioner engaged in a calculated deception and that this deceit, together with his denial of misconduct with the other patient to his treating psychiatrist, demonstrated a serious lack of insight on his part.

The Professional Conduct Committee of the College determined that it would issue Dr Dent with

a confidential warning regarding his conduct and professional practise and counsel him. Members of the Tribunal stated that it was not the function of the Tribunal to examine the proceedings of the College, however, they found it extraordinary that in the full knowledge of the practitioner's sexual misconduct with a patient over a period of some 6 months, the only sanction imposed was the confidential warning and counselling. The Tribunal ordered he be de-registered and that he not make an application for review for a period of four years from 15 November 2000.

The use of character evidence

The Commission made a complaint against the practitioner which was heard before the Medical Tribunal alleging that the practitioner was guilty of unsatisfactory professional conduct and professional misconduct in prescribing an excessive dosage of Kapanol, a form of morphine, to an elderly patient who subsequently died. The Tribunal dismissed the complaint and the Commission appealed against the decision.

The challenge before the Court of Appeal was limited to the manner in which the Tribunal dealt with the admitted mistake by the practitioner in his prescription of Kapanol for the patient. The practitioner intended a dosage of 10mg but in error he wrote a prescription for 100mg. The Tribunal held that the only criticism that can be made of the practitioner's conduct is one careless act of prescribing an excessive dose of Kapanol and that in the opinion of the Tribunal it does not constitute professional misconduct. It also held that whilst mere negligence, such as a prescribing error, may constitute unsatisfactory professional conduct in certain circumstances, in the particular circumstances in which the practitioner made his error it does not demonstrate that he exhibited a lack of adequate knowledge, skill, judgement or care in the practice of medicine.

The Tribunal stated that it had taken the practitioner's good character into account in both assessing the likelihood that he would be negligent and wanting in adequate knowledge, skill, judgement or care and in considering his credibility on matters in issue.

The Court of Appeal upheld the appeal. In its judgment on 1 June 2001 the Court held that the Tribunal did not give adequate reasons for its decision to dismiss the complaint against the practitioner. There was no examination of the quality of the prescribing error and when such is undertaken it is clear that the practitioner demonstrated a lack of adequate care in the practice of medicine in relation to the patient. It also held that the Tribunal was not entitled to take character into account when considering whether a practitioner is guilty of unsatisfactory professional conduct. Character evidence may be relevant to credit and penalty but the practitioner's credit was not an issue. It had no relevance to the consequences which might flow from the inadvertent error. The mistake made by the practitioner involved no issue of credibility.

The Court found the practitioner was guilty of unsatisfactory professional conduct. The court made no protective orders having regard to the merits, the public welfare, his good character and the passage of time since 1996 when the conduct occurred.

Putting patients at risk

The Commission referred complaints against Dr R Dallas, a GP, to the Medical Tribunal. The complaints alleged that he had been convicted under the Medical Practice Act 1992 of eight counts of aiding and abetting his brother, who was not a registered medical practitioner, to hold himself out to be willing to perform a medical service. Further complaints alleged that Dr Dallas had been guilty of professional misconduct and/or unsatisfactory professional conduct in relation to that conduct which lead to his convictions.

There was also an additional complaint in relation to a patient who was not involved in the criminal prosecution against Dr Dallas. This complaint alleged that Dr Dallas had by his presence, countenance, advice, assistance or co-operation, knowingly enabled his brother to engage in professional practise as if he were a registered medical practitioner. In relation to this patient the complaint alleged that Dr Dallas' brother had attended and treated the patient, including performing an internal vaginal examination on her.

In finding each of the complaints proven, the Tribunal said there was no doubt that there had been an erosion of confidence in the medical profession in the eyes of former patients and by mem-

bers of the public who were aware that for some six years "a completely unqualified, untrained layman was able to pass himself off as a doctor with the collusion and connivance of the practitioner".

The Tribunal's judgment makes it clear that the public has a rightful expectation that medical practitioners will not only possess diagnostic skills and a capacity to treat and advise, but will also possess traits of character which attract trust and confidence and that they act honestly and honourably in their special relationship with trusting patients.

The Tribunal de-registered Dr Dallas and ordered that he not re-apply for registration for a period of 4 years.

Dr Dallas' brother was convicted of criminal charges under the Medical Practice Act 1992.

Responsibility of clinical team members

The Nurses Tribunal conducted an inquiry into a complaint against Ms Nicholls, a registered nurse, concerning her involvement in certain medical procedures performed at Canterbury Hospital in Sydney between March and June 1999. The procedures in question involved the pancreas and bile duct and are known as endoscopic retrograde cholangio pancreatography (ERCP). The procedure is carried out using an endoscope in which a contrast agent is injected into the pancreas via the bile duct for the purpose of obtaining an image of that organ. The complaint concerning the performance of these procedures was the subject of a major investigation by the Commission following the discovery that patients had been injected with the substance known as Phenol in 60% Conray 280 instead of Conray 280. Conray 280 is an inert contrast medium used for the purposes of obtaining x-ray films whilst Phenol is a caustic agent, which can damage, kill or destroy tissue. A number of patients suffered adverse outcomes attributable to the use of the Phenol substance after undergoing their procedures.

Ms Nicholls a registered nurse of some 23 years standing was employed by Canterbury Hospital at the time as the instrument nurse, the nurse assisting the medical practitioner. The procedures, the subject of the complaint, were conducted by a gastroenterologist. During the relevant period Ms Nicholls was the instrument nurse on all but three occasions. The complaint against Ms Nicholls alleged that she was guilty of professional misconduct in relation to a breach of professional nursing standards in failing to check the contrast medium with the medical practitioner; failing to check with the medical practitioner that the substance used was appropriate for use, failing to recognise that the substance used as a contrast medium which was labelled "use under strict medical supervision – caustic substance" was different to Conray 280; failing to recognise the significance of the warning on the label and failure to appropriately check the solution with another accredited nurse and a medical practitioner before it was injected. Three other matters related to breaches of standards on specific occasions including drawing up contrast medium in advance of all procedures and failing to check the accuracy of details recorded in operating suite nurses reports.

Ms Nicholls did not attend the Tribunal inquiry, however, the Tribunal had access to documents prepared by Ms Nicholls or her solicitors during the investigation of the complaint against her and the preparation of the matter for disciplinary inquiry.

The Tribunal in its decision reviewed the factual background of the matter. The Tribunal found that there had clearly been a breach of standards in relation to the procedures performed at Canterbury Hospital. The standard requires that before a substance is injected into the body cavity of the patient the substance being injected and its nature should be checked by the circulating nurse in the operating theatre with the instrument nurse and the medical practitioner carrying out the procedure. It was accepted by all concerned with the procedures in question that there was no adequate checking for suitability of the substance being injected. The Tribunal concluded that:

> *Lax standards prevailed among the nurses, the medical practitioner··· and also reached as far as the hospital pharmacy. That is important in assisting us to identify the precise role and extent of Ms Nicholls' responsibility. That does not, however, excuse Ms Nicholls from her responsibility as an individual nurse in these events. We take the view that her responsibility is at two levels. One was as an individual practitioner, in other words as a nurse in the operating theatre.*

However she also had responsibilities in a supervisory sense as a result of her being the instrument nurse in the operating theatre on those occasions between 22nd March and 7th June 1999.

The judgment includes a detailed examination of the facts of the matter including consideration of how the wrong substance came to be ordered by Canterbury Hospital, how it was used during the procedures in question and eventually drawn to the attention of the medical practitioner by an agency nurse at which time the mistake was discovered. The Tribunal heard from two expert perioperative nurses and it noted that the gist of their evidence could be described as "check, check and check again". It noted that:

In relation to Ms Nicholl's actions, it is clear that her responses to the change of contrast medium were entirely inadequate. Her actions themselves played a part in this institutional culture. Responsibility for this blunder is multi-disciplinary and spread across the spectrum including medical practitioner, nursing staff and pharmacy staff.

The Tribunal found the particulars of complaint proved and that the nurse's conduct constituted professional misconduct. It ordered that Ms Nicholls be suspended from practicing as an accredited nurse for a period of 12 months commencing 26 June 2000 and ordered her to attend a course at Sydney University concerning pharmacology or a similar course approved by the Nurses Registration Board.

Criminal activity and professional integrity

The Medical Tribunal heard a complaint relating to Dr Motum a specialist psychiatrist alleging that he was not of good character, that he had been convicted of offences in NSW, and that he suffered from an impairment.

The allegation of impairment related to a longstanding history of anxiety and depression and possible personality disorder.

Dr Motum's legal representatives argued that the actions of which Dr Motum had been found guilty and admitted were not sufficient to establish lack of good character. In its decision the Tribunal reviewed the relevant facts which can be briefly summarised as follows:

Dr Motum approached a male prostitute and took him to his home on the night in question. An agreement had been made in relation to sexual services to be provided by the prostitute and a price. In the area of the victim's home a dispute arose as to the amount of money to be paid, there was a short but heated argument. The victim left the motor vehicle and walked across the road, the practitioner drove a short distance and then stopped, the practitioner fired a revolver out of the window of the motor vehicle in the direction of the victim and the bullet struck the victim in the chest. The victim was taken by ambulance from the scene and was discharged from hospital the following day. He was not seriously injured. Dr Motum's representatives argued that Dr Motum simply intended to shoot in the direction of the victim but not at him whilst the Commission asserted that Dr Motum had intended to shoot the victim. The Tribunal concluded that the wounding of the victim was reckless rather than intentional. The Tribunal noted that after the shooting Dr Motum took certain action intending to cover up his involvement in the shooting and that he gave the police a deliberately false alibi in an attempt to avoid being held responsible for the shooting.

In relation to the other matter of harassing a female witness involved in the proceedings the Tribunal found that this occurred on three occasions and that the harassment consisted of telephone calls to the witness and conversations with the witness that were designed to intimidate and humiliate her.

The Tribunal noted that a further telephone call to the witness by Dr Motum had occurred shortly before the criminal matter was heard in the District Court and that it was conveyed to the sentencing judge that the intimidation of the witness had not been repeated since 1998. That representation was wrong and the Tribunal found that Dr Motum had made no efforts to ensure that the Court was not misled.

The Tribunal reviewed the relevant case law as to what constitutes lack of good character and concluded that Dr Motum was not of good character. It noted:

The Tribunal considers that for a person to be of good character for the purposes of the practice of medicine as a registered medical

practitioner it is imperative that his or her character be such that he or she will not deliberately do any harm to another person at least without reasonable excuse and that he or she will not commit major serious offences against the criminal law. After all, the practice of medicine is designed to prevent or alleviate suffering not to inflict it.

In the present case Dr Motum deliberately embarked on a campaign where by over a protracted period he intimidated and humiliated the female witness without reasonable excuse. In addition he committed major offences against the criminal law in relation to possession and use of a firearms over a period of years.

The Tribunal went on to note that:

The conduct of Dr Motum was so grossly contrary to the norms of all right thinking members of our society that shows that not only is he not of good character generally but that he is not of good character for the purpose of the practice of medicine as a registered practitioner.

The Tribunal found the complaint of impairment to be proved and that Dr Motum suffered from anxiety and depression and paranoid personality traits and that those conditions were likely to affect his capacity to practice medicine. The Tribunal, however, was not satisfied that Dr Motum's impairment was such as to render him not competent to practice medicine subject to certain conditions on his practice being met. The Tribunal found two of the three complaints relating to good character and convictions proved and ordered that Dr Motum's name be removed from the register and that no application for review of the order for removal of his name be made until three years from the date of the orders.

Dr Motum was convicted in the District Court in Sydney on 17 January 2000 of malicious wounding and firing a firearm in a manner likely to injure a person in relation to the incident and had been sentenced to a period of periodic detention at the time of the Tribunal inquiry.

Failure to investigate

Mr P, a registered nurse, was employed as a nurse manager in a psychiatric hospital. A member of the nursing staff reported to Mr P they had observed a patient being assaulted by another member of the nursing staff. The Commission became aware of the complaint through the Official Visitors Scheme.

The Commission made a complaint to a Professional Standards Committee that Mr P failed to investigate the allegations of the assault; report the assault to more senior staff members in a timely manner and consult with senior staff as to the most appropriate action to be taken; adequately document the incident and take any action to ensure the continuing safety of the patient.

In a letter to the Commission Mr P admitted he had failed to adequately investigate and document the complaint. Mr P failed to appear before the Professional Standards Committee, as such the inquiry was held in his absence.

The Committee accepted RN P's admission of the complaint. He was reprimanded, ordered to attend education and had conditions placed on his practice.

Inappropriate surgery in GP's Rooms

Ms H presented to Dr V's rooms in November 1994 and again in December 1994 with a lump in her breast. Dr V was convinced that the lump was benign and correctly ordered an ultrasound and mammogram. Both were reported as normal. Dr V saw Ms H again about a month later and ordered a further test. Although Dr V was convinced that the lump was benign she agreed to remove it in her rooms. When Ms H questioned Dr V about the need to refer her to a specialist she was reassured that the lump was benign and the operation was a minor one. An extensive lumpectomy was attempted but, due to a lot of bleeding from a severed artery, was not completed. Dr V stitched up the wound because of the bleeding and without removing the lump. Ms H was concerned and had a discussion about what might happen if the wound bled overnight and whether or not she should go to the hospital to see a specialist immediately. She was told by Dr V that she would "lose face" if she went to a specialist with an unhealed wound. She asked Ms H to trust

her and she would refer her to a specialist when the wound was healed.

Two months after the surgical intervention Ms H was referred to a specialist and was the subject of further surgery where the lump proved to be malignant. Ms H subsequently died of metastatic breast cancer.

The Professional Standards Committee found that Dr V was guilty of unsatisfactory professional conduct and reprimanded her. The Committee stated that Ms H should have been referred to a specialist, as Dr V should have reasonably considered this course of action. The Committee also found that Dr V inappropriately performed surgery on Ms H's breast in her general practice rooms. Ms H had returned for follow up visits and complained of swelling, discolouration, redness and pain at the operation site. The Committee found this to be wound infection and believed that whilst the practitioner managed this appropriately, it would not have been necessary if Ms H had been referred to a specialist after the surgery.

Addicted to drugs - case 1

Dr D came to the attention of the Medical Board following an investigation by the NSW Department of Health Pharmaceutical Services Branch inspectors (PSB) for self-prescribing as well as prescribing for his wife and daughter large quantities of 'prescribed restricted substances' (Schedule 4, Appendix D drugs). In 1998, Dr D was admitted to the Impaired Registrant Program (IRP) and undertook to comply with voluntary conditions of registration. Conditions related to monitoring Dr D's progress in rehabilitation from codeine and benzodiazepines by urinalysis and regular reviews by his GP and treating psychiatrist of choice and the Board-nominated psychiatrist and Impaired Registrant Panel (IRP). However, for a period of seven months, Dr D failed to comply with conditions of registration, claiming that he misunderstood directions in relation to urinalyses and procrastinated about attending a General Practitioner. When reviewed by the IRP, the Panel formed the view that Dr D had demonstrated a disregard for the IRP by failing to comply with conditions of his registration. The Medical Board referred the matter as a complaint to the Commission for investigation.

Action taken by the Commission included a review of documents relating to Dr D's involvement in the IRP, consultations with PSB and review of prescriptions issued by Dr D which precipitated his referral to the Medical Board in 1998. The investigation resulted in information being obtained which substantiated the allegations. In addition, Dr D had prescribed benzodiazepines in the names of patients and continued to prescribe for his family, presenting prescriptions at pharmacists himself over a wide area. This conduct was considered to be consistent with drug seeking and self-administration. After consultation with the Medical Board, the Commission decided to prosecute a complaint of unsatisfactory professional conduct for failing to comply with conditions of registration and for improper or unethical conduct in the practice of medicine.

The Committee recommended that the practitioner be de-registered after considering all the evidence and information that came to its attention during the inquiry.

Addicted to drugs - case 2

As a university student, Dr G experimented with a number of what he later called 'recreation drugs' and worked in a pharmacy where he obtained narcotics by falsifying pharmacy records and altering prescriptions. After graduation, when applying for registration as a medical practitioner, Dr G made false statements on his application in that he stated that he had not been addicted to a deleterious substance. After Dr G commenced in general practice, he came to the attention of the NSW Health Department's Pharmaceutical Services Branch (PSB) in relation to a large number of prescriptions for Schedule 8 drugs of addiction (S8 drugs): Physeptone, Morphine and Pethidine, which Dr G had written in the names of various people, and were presented and collected at various pharmacies by Dr G. His prescribing practices were investigated by PSB inspectors.

On being confronted with overwhelming evidence of breaches of the Poisons and Therapeutic Goods Act, 1966 and Regulations 1994, Dr G admitted he had been self-administering narcotics he had obtained from prescriptions he had issued in the names of patients and his family members. He made admissions on the basis that charges would not be made against him if he made full admis-

sions, relinquished his s8 prescribing authority and entered the Medical Board Impaired Registrants Programme (IRP). Dr G agreed to this course of action and indicated that he was committed to rehabilitation from drug use.

Dr G was assessed by the Medical Board and became a participant in the IRP. After several years, Dr G again came to the notice of the PSB inspectors for issuing a very large number of prescriptions for a restricted substance Panadeine Forte in the names of patients and family members, that had been presented and collected by Dr G. When interviewed by PSB, Dr G had no satisfactory explanation. PSB notified the Medical Board and around the same time the IRP received a urinalysis drug screen report for Dr G that was positive for narcotic. Dr G stated that he had been prescribed the drug by his dentist for pain relief from a tooth abscess.

The Medical Board referred the matter to the Commission for investigation. The Commission interviewed staff at the medical centre where Dr G was employed, interviewed PSB officers, interviewed the dentist involved, reviewed patient notes and pharmacy printouts, reviewed all prescriptions located by PSB that had been issued by Dr G, and obtained information from the Medical Board in relation to Dr G's level of compliance with conditions of registration.

The Commission found evidence of fraudulent and misleading documentation by Dr G dating from his days working in a pharmacy and a subsequent false statement on his application to be entered onto the Register of Medical Practitioners. Evidence obtained by the Commission indicated that Dr G had a very long history of drug abuse, and there was no extended period where Dr G had complied with conditions of registration. Statements provided to the Commission suggested that Dr G substituted urine samples, dissolved and centrifuged large numbers of Panadeine Forte tablets in order to separate out the Codeine for injection, collected unused s8 drugs from patients and self-administered them.

The Commission prosecuted a complaint before a Professional Standards Committee with a view to recommending that Dr G be suspended or deregistered on the basis of his impairment and evidence that he was unable to comply with conditions to remain registered.

On the basis that Dr G had received treatment with Naltrexone which was being closely supervised by his wife, a health practitioner, and had complied with all requirements of his treating psychiatrist, in the ten-months between referral to the Commission by the Medical Board and the date of the hearing, the Committee decided that Dr G was fit to practice medicine subject to stringent conditions of registration and to be monitored by the Medical Board.

Unregistered health practitioners & providers of complementary therapies

POOR ADVICE LEAD TO TRAGIC OUTCOME

J, a young boy was born with aortic stenosis, diagnosed by his paediatrician in hospital within a few days of his birth. The paediatrician arranged for J's parents to take him to a cardiologist for a specialist assessment. The cardiologist told the parents that J's condition was serious and that he would require urgent surgery to correct the problem.

J's father had been seeing a natural therapist for many years. He decided to obtain a second opinion from the natural therapist after he had seen the cardiologist. The natural therapist did a saliva test and attached the baby to a machine to read the baby's electrical currents. He diagnosed a number of conditions and reassured J's parents that by the simple application of the machine to reverse the negative or harmful currents, together with homeopathic drops, he could cure J's condition. With one application of the machine, the therapist claimed to have partially cured the condition.

J's parents were heartened by this news, as it meant J could avoid an anaesthetic and invasive surgery at his early age. They went to see the cardiologist again and told him their decision to cancel the surgery and said that the natural treatment was working. On re-testing J's heart function, the cardiologist found that J's condition was, if anything, worse and advised them to proceed with the surgery. He explained it was a problem only correctible by surgery. The cardiologist was so concerned, he discussed the matter with the paediatrician, with the surgeon who was to perform the surgery, with the community nurse, and

with DOCS with a view to obtaining a court order. He also contacted the therapist and discussed J's welfare. J's parents were convinced that the natural treatment would work. But as J grew sicker, his mother became distressed, and eventually made another appointment for a consultation with the surgeon. J died that night.

Investigation by the HCCC of an unregistered practitioner in the natural therapies is hampered by the absence of regulatory and protective mechanisms. In this case the HCCC had to rely on the advice of a range of professional associations to give advice on the appropriate use of homeopathic treatment, application of the principles of acupuncture and appropriate use of the machine. Another issue was the therapists' responsibilities in providing advice to the parents which differed from the advice of other practitioners including the specialist opinion of a cardiologist and a paediatrician.

The outcomes available to the HCCC were to make comments to the therapist and to write to his professional association. The Commission referred the matter to the DPP as an outcome to the investigation. The Commission also referred the case to the Coroner. At the Inquest, the Coroner terminated the hearing, and referred the matter to the DPP for further consideration as to whether to lay criminal charges.

Deceptive conduct

Over the period 1997-2000 the Commission received nine complaints concerning Mr N a Naturopath.

Concerns raised by complainants in regard to Mr N included excessive fees, practices, advertising claims and his use of the title Dr which led some to believe he was medical doctor. Mr N has a PhD degree.

Mr N posted advertisements in the local press offering live blood, urine and saliva analysis to detect many diseases including cancer.

One complainant, Mr C, attended Mr N's rooms for consultation regarding his digestive problems. Mr N performed 'live blood cell analysis' and informed Mr C that the test showed he had a cancer causing micro organism at a comparatively advanced stage of development. Mr N suggested he provide treatment in the form of vitamins and other supplements at a total cost of $257.

Another complainant, Mrs D, consulted with Mr N complaining of feeling unwell. After carrying out live blood cell analysis Mr N gave a diagnosis of probable early liver cancer, chronic fatigue syndrome, lupus and liver parasites. He offered a treatment plan of liver tonic, dietary advice and urinalysis which totalled nearly $1000.

Mr N was offered the opportunity to provide a rationale in support of his use of live blood cell analysis or any evidence as to its effectiveness, but did not respond.

Following investigation the Commission concluded that live blood cell analysis is not recognised within conventional medical practice, having no scientific validity. The Commission also found that the treatment offered by Mr N was excessively expensive and ineffective.

The Commission was critical of Mr N's use of the technique and his assertion to clients that it can diagnose serious illness. The Commission was also critical of Mr N's offers of treatment and his assertion that these would be effective.

Further, the Commission was of the view that Mr N's inappropriately diagnosing and offering to treat serious illnesses such as cancer, as well as his use of the title Dr, may have involved breaches of the Medical Practice Act, 1992, and the complaints were referred to the NSW Medical Board for investigation.

The Commission also referred the complaints to the Therapeutic Goods Administration for investigation in regard to the issue of live blood analysis and to the Department of Fair Trading in regard to advertising claims.

The Commission advised the Australian Traditional Medicine Society (ATMS) of its findings and as a result Mr N's name was removed from the ATMS Register.

INQUIRIES

Report on mandatory reporting of medical negligence

The Joint Parliamentary Committee on the Health Care Complaints Commission launched an inquiry into section 80(1)(j) of the Health Care Complaints Act, 1993 which was first reported on in the 1999-2000 Annual Report (p71). In November 2000 the Committee released its *Report on Mandatory Reporting of Medical Negligence.* The report made 12 recommendations which are listed below:

Summary of Key Issues

The Health Care Complaints Commission is currently required under Section 80 (1) (j) of the Health Care Complaints Act 1993 (NSW) *to investigate the frequency, type and nature of allegations made in legal proceedings of malpractice by health care practitioners.* The Commission is presently unable to perform this function because there are no legal obligations on individuals and organisations that hold such information to report it to the Commission.

Summary of Recommendations

1. That, in the public interest, mandatory reporting of medical negligence litigation be introduced into New South Wales.
2. That the NSW District Court consider establishing a Professional Negligence List (Health and Legal) in line with that established by the NSW Supreme Court.
3. That the Health Care Complaints Act 1993 be amended to require that de-identified data on claims filed, cases settled and cases adjudicated be made available to the Health Care Complaints Commission by indemnifiers and insurers covering medical practitioners, practising in the NSW health system, for the purpose of investigating the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners, as set out at section 80 (1)(j) objectives.
4. That a working party be established of relevant stakeholders including representatives of major medical negligence litigation insurers and indemnifiers, relevant registration boards, health providers and the Health Care Complaints Commission
5. That the Health Care Complaints Commission establishes a combined database of complaints and medical malpractice information for the purposes of providing information for risk assessment and quality assurance purposes to the NSW health system.
6. That the Health Care Complaints Act 1993 be amended to require that the Health Care Complaints Commission be required to publish in its annual report summary data on the frequency, type and nature of allegations made in legal proceedings of malpractice by health practitioners.
7. That insurers be required to provide identified data on medical negligence litigation claims filed, cases settled and cases adjudicated, to the Medical Board of NSW for the purpose of identifying matters of gross negligence, professional misconduct, unsatisfactory professional conduct and consistent sub-conduct performance.
8. That a two year pilot project be undertaken by the NSW Medical board to access the utility of data received, regarding medical negligence litigation actions, from insurers for identifying matters of gross negligence, professional misconduct, unsatisfactory professional conduct and consistent sub-standard performance.
9. That a two year pilot project by the NSW Medical Board be jointly funded by the NSW Medical Board and NSW Health.
10. That the NSW Medical Board confer with the Health Care Complaints Commission, in accordance with Section 49 of the Medical Practice Act, where it is of the opinion that a medical negligence litigation claim or case should be investigated, in accordance with Section 23 of the Health Care Complaints Act 1993.
11. That after initial assessment of a medical negligence litigation claim or case, if the NSW Medical Board has concerns about the performance of a medical practitioner, but which are not serious enough to warrant investigation under Section 23 of the Health Care Complaints Act 1993, that the NSW Medical Board deals with the matter in accordance with Section 50 of the Medical Practice Act.

12. That at the conclusion of the pilot project; the NSW Medical Board provides findings to the Minister for Health and the Joint Committee on the Health Care Complaints Commission. This Report provides findings on the costs and benefits of mandatory reporting of medical negligence, whether the scheme should be extended to other health practitioners and providers and, where relevant, propose a model for reporting and analysis of identified medical negligence litigation data.

Conclusion: Inquiry has been underway awaiting a report.

Inquiry into conciliation processes

During the year the Parliamentary Committee on the Health Care Complaints Commission continued with its public inquiry into conciliation processes. The Commission made a written submission to the Committee in 1999-2000. The Commission appeared before the Inquiry on two occasions during 2000-2001.

Inquiry into the procedures followed during investigations & prosecutions undertaken by the HCCC

In June 2001 the Committee commenced an inquiry into the procedures followed during investigations and prosecutions undertaken by the Commission. The Terms of Reference for the inquiry are listed below. The closing dates for the submissions has been set for 28 July 2001.

Terms of Reference

The Committee is to inquire into and report on:

(a) the procedures followed by the Health Care Complaints Commission during the investigation process;

(b) the amount of evidence currently considered sufficient by the Health Care Complaints Commission and the NSW Medical Board to prosecute a case before the NSW Medical Tribunal;

(c) the treatment of cases referred by other government agencies such as the Health Insurance Commission;

(d) possible ways in which the investigation and prosecution process can be improved;

(e) the investigation and prosecution process in comparative jurisdictions;

(f) other relevant matters.

SATSIFACTION WITH THE HCCC

Results of the PSO satisfaction survey

The Patient Support Office seeks client feedback after service provision. This year surveys were posted to each client at quarterly intervals, together with a self stamped envelope, for the return of the survey. Of a total of 1,450 surveys sent to clients, 238 completed surveys were returned. This represents a 19.5% response rate, significantly down on last financial year when 31.4% of surveys were returned. There is no known explanation for the difference in the return rate.

Key results include:

- 92% thought PSOs were sensitive to their concerns;
- 89% found PSOs were prompt in returning their calls;
- 85% were satisfied with the service they received;
- 70% of concerns were partially or totally resolved; and
- 90% would use the PSO service again.

About 10% of respondents expressed dissatisfaction with the service they received. Some of them indicated that they were dissatisfied with the outcome rather than the service. In some instances the client's desired outcome could not be achieved through advocacy.

Ten percent of the people had problems contacting a patient support officer. Generally they did not like leaving messages on voicemail despite most people noting their calls were promptly returned. The results obtained for this financial year were similar to those for 1999-2000.

CLIENTS' FEEDBACK FROM THE SATISFACTION SURVEY

- The PSO was most helpful. He was very persistent in obtaining information and documentation that I was unable to get.
- I found the PSO to be a compassionate listener with constructive views and information and a positive person to call on at any time.
- I found the PSO agreeable, willing, most helpful and straight-forward. She gave advice clearly with due consideration for my age etc.
- Very supportive person. Not bureaucratic. Listened well. I will use them again.
- A valuable service which gave me the encouragement (on more than one occasion) to pursue my complaint with the provider.
- I have no hesitation in getting in contact with the PSO. It is about time we found out we have someone to help us in Broken Hill.
- I was never aware of this department during all the years I attended hospital. I think the public should be made more aware.
- The PSO was absolutely wonderful. She arranged everything and then followed up to make sure things were okay.
- Thank you very much for the information and the concern you have shown. I really would like to inform the Polynesian community about your services.
- I was advised to write a letter of dissatisfaction to the practitioner involved but I didn' t carry it through due to fear of consequences.
- It was not the PSO' s fault that the system as it now stands gives very little room for negotiation or compromise.
- The PSO is based in a hospital. I feel the workplace should be more impartial.
- It is helpful knowing the patient support service is available so we can speak to someone independent.
- The PSO was always helpful and encouraging and her follow up of the matter concerned saw it resolved. I would have probably given up.

Results of the investigations satisfaction surveys

All individual complainants involved in completed investigations were sent a Consumer Satisfaction Survey by post and asked to complete the questionnaire and return it in the reply paid envelope provided. Forty five surveys were returned in 2000-2001. The Commission is currently revising its feedback mechanisms in order to try to increase consumer responses. Feedback from consumers is valuable to the Commission and criticisms are considered when reviewing policies and procedures.

The results of the 45 satisfaction surveys are:

- 90.2% of the consumers found the initial telephone information received from the Commission helpful;
- 90.5% of consumers found the Commission brochures informative and helpful;
- 73% of consumers said that the investigation staff returned their calls within 24 hours;
- 66.7% of consumers said that they received the authority forms and statutory declarations within 2 weeks;
- 97.3% of consumers found the investigation staff were sensitive, responsive to their inquiries and easy to contact;
- 71.1% of consumers said that they were satisfied with the way their complaint was handled by the HCCC;
- 76.8% of consumers said that the HCCC resolved the issues raised in their complaint.

Some of the criticisms raised in the satisfaction surveys included:

- Consumers had to ring the investigation officer to find out what was happening to their case. Some found it difficult to contact the officer concerned, others complained that the officers in charge of their case kept changing.
- Many consumers responded that the investigation of their complaint took too long to conclude. This is an issue the Commission is aware of and has put measures in place to speed up investigations.

Following are some quotes from some of the satisfaction surveys received:

- "They were very efficient in their work and sensitive to my moods during various stages of the investigation. Their code of ethics made it very easy to trust them"
- "I never felt dumb when not understanding terms (medical or legal). Everything was made quite clear. The time was a bit frustrating, but with anything legal it takes time. I have spoken to other people who have had problems with medical staff and have suggested to go to the HCCC. Thank you".
- "As a Senior Police Prosecutor I originally assessed information to determine whether criminal prosecution was warranted. In this event the public interest was well served by the outcome achieved by the HCCC. Ms ... was the epitome of the committed, consummate professional."
- "I do think that regular contact between the case officer and myself would have been helpful as I often thought, after not hearing from staff for a long time, that my case had been forgotten."
- "The time it took to come to a hearing was way too long. Otherwise, handled professionally"

Complaints about the Commission

In 2000-2001, the Commission received 13 complaints from complainants and respondents about the Commission. The complaints were about delays in the investigation process; failure to respond to their complaint, failure to keep them updated on the progress of their complaint; dissatisfaction with an investigation outcome, even after a review process had been carried out; dissatisfaction with the Commission's assessment decision.

The Commission has responded to all the people making the complaints and has addressed many of the issues raised by the complaints. The Commission has also implemented a review of its investigations process and put measures in place to speed up the investigations of complaints as it recognises the level of stress it imposes on complainants and respondents.

The Commission is reviewing its complaints handling process in relation to complaints it receives about its services. All complaints and their outcomes will be recorded in a database and analysed to track of performance.

Dissatisfaction with Commission

Mr Wortley commenced proceedings in the Supreme Court seeking damages against the Health Care Complaints Commission in relation to action taken by the Commission in assessing his complaint concerning health services he had received. The question of whether the facts pleaded by Mr Wortley in his Statement of Claim lodged with the Court disclosed a good cause of action was referred to Mr Justice Sully for determination.

Justice Sully handed down his decision on 13 March 2001 in which he determined that the Statement of Claim did not disclose a good cause of action. Justice Sully reviewed the case law with respect to circumstances in which statutory bodies and officers employed by statutory bodies were liable in common law for damages allegedly incurred by individuals. His Honour referred to the leading English case of *X (Minors) V Bedfordshire County Council [1995] 2 AC633*. The Court in that case referred to the established principle that in the ordinary course a breach of statutory duty does not by itself give rise to any private law cause of action. A private cause of action will arise if it can be shown that the statutory duty was imposed for the protection of a limited class of the public and that Parliament intended to confer on members of that class a private cause of action. In such cases it is necessary to examine the legislation under which the statutory body acts. The established principle is that regulatory or welfare legislation affecting a particular area of activity whilst providing protection to individuals particularly affected by that activity is not to be treated as being passed for the benefit of those individuals but for the benefit for society in general.

His Honour reviewed the statutory scheme established by the Health Care Complaints Commission Act 1993 and concluded:

"In my opinion, a fair reading of the entirety of the statutory scheme for which the Act makes provision indicates that the Act falls precisely within the category of 'regulatory or welfare legislation affecting a particular area of activity'.

His Honour formed the view that the legislation should be treated as being passed for the benefit of society in general. His Honour also considered whether allegations made by Mr Wortley in a statement of claim that certain employees of the Commission performed their statutory duties in such a way as to establish a cause of action in negligence personally and individually, and personally and individually as servants of the Commission. His Honour concluded that the relationship between Mr Wortley and the employees or servants of the Commission was not sufficiently proximate to establish a cause of action. His Honour referred to another English case *Elguzouli-Daf V Commissioner of Police of the Metropolis and another [1995] QB 355*. In that case a plaintiff sought to pursue a claim of negligence against the Crown Prosecution Service in relation to its performance of its statutory duty in relation to the plaintiff. The Appeals Court held that without any voluntary assumption of responsibility to a particular defendant in criminal proceedings there was no duty of care heard by the Crown Prosecution Service in its conduct of its prosecution of a defendant. The Appeals Court considered the policy factors supporting its decision noting that if the Service were liable in negligence to defendants that would impact adversely on its ability to concentrate on its prime function of prosecuting offenders. The existence of such a duty and the steps that would be required to protect officers of the Crown Prosecution Service against negligence claims would adversely affect the efficiency of the Service and the quality of the criminal justice system. Justice Sully noted that the analysis adopted by the Court was applicable to the position in the public health system of the Health Care Complaints Commission.

Disability action plan

The priorities set in the Commission's Disability Action Plan are reflected in its current Corporate Plan. The Commission has made progress in implementing the Disability Action Plan:

Physical access

The Commission rents office space to house its head office staff. The building owners have commenced upgrading the common areas of the building and it is anticipated that the identified barriers to physical access will be removed by the Plan target of December 2002.

A speaker located at the entrance to the building car park is connected directly to the Commission's reception desk. This allows people with disabilities arriving by car to request assistance if necessary.

A sign with high colour contrast is located opposite the lifts on Level 4 of the building, clearly indicating the direction of the Commission's reception area. The reception area is accessible by people in wheelchairs. An interview table is located in this area so that officers can meet with clients face to face. In the coming reporting period, an interview room will be constructed to ensure greater privacy and to reduce background noise for these meetings.

The Commission's office areas are accessible by people in wheelchairs and the Conference Rooms have double doors, to facilitate greater access where necessary.

Promoting positive community attitudes

Commission staff promote its services to people with a disability and the Commission is currently drawing up a promotions plan targetting various disability groups in NSW.

Training of staff

Budget constraints resulted in the planned staff training being deferred. It is anticipated that a full training program will be implemented in the next reporting period.

Information about services

The Commission has a policy on access to information that includes commitments to providing information in plain English and in a range of formats to accommodate the needs of people with disabilities. The Commission's communication strategies include distributing information about the HCCC to disability-specific community groups and media outlets.

Employment at the Health Care Complaints Commission

Reasonable accommodation was made for staff with disabilities during the year. These included provision of equipment and approval of leave as required. The Workplace Agreement, which commenced during the reporting period, provides for flexible hours of work for all staff. Special arrangements regarding working hours and location can be made for staff with disabilities, or with carer responsibilities, on either a short or long term basis.

Complaints procedures

The Commission is currently reviewing a written policy dealing with complaints from staff and consumers about the Health Care Complaints Commission.

The Commission encourages staff and consumers who have a complaint about the HCCC to attempt to resolve the matter with the action officer, contact person or supervisor.

The Commission will promote its complaints mechanism to all consumers by including relevant information in publications, the Commission's Web page and correspondece.

Privacy management plan

The Commission has prepared and implemented a Privacy Management Plan, as required under the Privacy and Personal Information Protection Act 1998, to ensure compliance with the requirements of the Act.

The plan may be accessed from the Commission's website and is available on request.

Key features of the plan include:

- policies and practices to ensure the Commission complies with the requirements of the Act;
- how these policies and practices will be communicated within the Commission; and
- internal review arrangements.

Staff information and education sessions have been held to ensure staff are aware of the requirements of the Act and the Commission's Privacy Management Plan.

People may request information on whether the Commission holds personal information and may request access to that information. During the financial year no requests of this nature were received. There have been no requests for a review of the conduct of the Commission pursuant to Part 5 of the Act.

Electronic service delivery

The Health Care Complaints Commission is committed to providing electronic service delivery according to the NSW State Government guidelines. The Commission supports the Government's aim of ensuring that, where appropriate, government publications and services are accessible through the internet. This facilityalso increases access to information and services to consumers across NSW.

The framework implemented by the Commission to date has involved the establishment and development of an internet and an intranet site including Commission publications such as:

- Annual Report
- FOI information
- press releases
- brochures
- bulletins

Projects implemented include:

- Voicemail - introduction of this facility has improved the efficiency of the Commission's main switchboard; and
- Complaint Handling System - stages 1 and 2 of the development phase of this program have been commenced. Once implemented, this program will allow for identification of health care complaint trends through more detailed analysis of complaint data.

Most Patient Support Offices were connected to the internet during the past year. This has been carried out in collaboration with the Area Health Services in which the individual patient support officers are located.

The internet has proved to be a valuable research tool for patient support officers, enabling them to provide better quality information to their clients. It has also provided quicker access to information about appropriate referral organisations.

Ethnic affairs priorities statement

The Commission made good progress implementing the 2000 - 2001 Ethnic Affairs Priority Statement. The statement comprised four initiatives:

1. Promote consumer input into decision making.
2. Provide access to information for people from culturally diverse backgrounds.
3. Ensure cultural diversity is addressed in all areas of service delivery.
4. Staff management and recruitment practices incorporate cultural diversity issues.

Mr Sam Choucaire, the Director of the MultiCultural Health Unit, South Eastern Sydney Area Health Service, continued to sit on the Commission's Consumer Consultative Committee. With his assistance, a training course in Cultural Awareness for HCCC staff was developed and presented during the reporting period.

Table 36 gives information about the ethnic diversity of people who access the Commission's services.

Table 36 - Commission's consumer demographic survey

Total responses	567	
Complainants born in a Non-English speaking country (NESC)	99	17.4%
Top 5 NESCs		
Greece	8	
Germany	8	
China	8	
Lebanon	7	
Egypt	6	
Complainants who speak a language other than English at home (LOTE)	29	5.1%
Top 2 LOTEs spoken at home		
Arabic	6	
Mandarin	4	
Complainants requiring an interpreter	16	2.8%

The Commission worked to facilitate communication with Sydney's Spanish speaking community regarding the deregistration of a doctor who had served them. The Medical Tribunal decision was translated into Spanish and made available to the community and an interview on SBS radio with the Commissioner was also translated into Spanish.

All brochures in community languages are now on the Commission's web site. This material will be updated and reprinted in the coming year.

The Commission is working with the South Sydney Area Health Service and the Joint Initiatives Group to pilot a community education strategy on the rights of health care consumers.

Freedom of information

This year saw a significant drop in the number of FOI requests received. Requests fell to the lowest level since 1993, however, there is no clear reason for this variation. The Commission will continue to keep staff available to process requests, anticipating that an average of 43 requests will continue to be received each year.

During the reporting year the Administrative Decisions Tribunal of NSW considered an appeal from an applicant [NSW ADT 47] contesting a FOI decision made by the Commission. The Commission had decided to deny the applicant access to documents on the basis that they related to the personal affairs of another individual. The applicant contested this decision in the belief that disclosure of the documents was in the public interest. The Tribunal upheld the Commission's decision to deny access.

Section A - Number of new FOI requests

	FOI requests	Personal*	Other#	Total
A1	New	33	-	33
A2	Brought forward	-	-	-
A3	Total to be processed	33	-	33
A4	Completed	32	-	32
A5	Transferred out	-	-	-
A6	Withdrawn	-	-	-
A7	Total processed	32	-	32
A8	Unfinished (carried forward)	1	-	1

*Personal requests are those made by individuals

Other requests are those made by organisations

Section B -What happened to completed requests?

B1	Granted in Full	10	-
B2	Granted in Part	16	-
B3	Refused	6	-
B4	Deferred	-	-
B5	Completed	32	-

Section C - Ministerial certificates - none issued during the period.

Section D - Formal consultations - no requests required formal consultation.

Section E - Amendment of personal records - no such requests were made during the period.

Section F - Notation of personal records - no requests for notation were made during period.

Section G - FOI requests granted in part or refused.

	Basis of disallowing or restricting access	Personal	Other
G1	Section 19 (application incomplete, wrongly directed)	-	-
G2	Section 22 (deposit not paid)	-	-
G3	Section 25 (1)(a1) (diversion of resources)	-	-
G4	Section 25 (1)(a) (exempt)	16	-
G5	Section 25 (1)(b), (c), (d) (otherwise available)	-	-
G6	Section 28 (1)(b) (documents not held)	-	-
G7	Section 24 (2) (deemed refused, over 21 days)	-	-
G8	Section 31 (4) (released to Medical Practitioner)	-	-
	Schedule 2 (complaint being processed by the HCCC)	6	-
G9	**Totals**	**24**	-

Section H - Costs and fees of requests processed during period

		Assessed Costs	FOI Fees Received
H1	H1 All completed requests	$15,000	$585

Section I - Discounts allowed

	Type of Discount Allowed	Personal	Other
I1	Public Interest	-	-
I2	Financial hardship - Pensioner/Child	16	-
I3	Financial hardship - non-profit organisation	-	-
I4	**Totals**	**16**	-
I5	Significant correction of personal records	-	-

Section J - Days to process

J1	0 - 21 days	30	-
J2	22 - 35 days	2	-
J3	Over 35 days	-	-
J4	**Totals**	**32**	**-**

Section K - Processing time

K1	0 - 10 hours	29	1
K2	11 - 20 hours	3	-
K3	21 - 40 hours	-	-
K4	Over 40 hours	-	-
K5	**Totals**	**32**	**1**

Section L - Reviews and Appeals

L1	Number of internal reviews finalised	1
L2	Number of Ombudsman reviews finalised	-
L3	Number of District Court appeals finalised	-
	Number of ADT appeals finalised	1

Bases of Internal Review		Personal		Other	
Grounds on which internal review requested		Upheld	Varied	Upheld	Varied
L4	Access refused	1	-	-	-
L5	Deferred	-	-	-	-
L6	Exempt matter	-	-	-	-
L7	Unreasonable charges	-	-	-	-
L8	Charge unreasonably incurred	-	-	-	-
L9	Amendment refused	-	-	-	-
L10	**Totals**	**-**	**-**	**-**	**-**

HUMAN RESOURCES

Management & structure

The names of the members of the statutory body:

The Commission consists of a Commissioner appointed by the Governor.

The Commissioner is Amanda Adrian, BA, LLB, RN, FRCNA, FNSWCN. The Commissioner's position is at Level 5 of the Senior Executive Service with a remuneration package of $158,840. She was appointed to the position on 26 June 2000.

SENIOR OFFICERS WITHIN THE STAFF ESTABLISHMENT OF THE BODY

Director, Complaint Assessment & Resolution: Julie Kinross, MSW, PG Dip Soc Planning, BA (Psych), PG Dip Ad Finance & Investment

Director, Investigations & Prosecutions: Tom Galloway, LLM - *Left HCCC 9/3/01*

Director, Strategic Partnerships & Quality Improvement: Bruce Greetham, MM

Director, Corporate Support: Tom McKnight, *(Left HCCC 27/4/01)*; Trevor Covell, PAC *(Acting)*

Manager, Prosecutions & Legal Advisings: David Swain, B LegS, LLM, DipCrim

Manager, Investigations Team: Elizabeth Wing, LLB

Manager, Investigations Team: Ian Crosbie, Grad Cert Man, MNIA, JP *(Temp appt)*

Manager, Patient Support Office: Brian McMahon, BA Theology, Dip Human Development (Peru) *(Temp appt)*

Manager, Complaint Assessment & Resolution: Sharlene Wiebenga, B App Sc (Health)

Manager, Public Affairs: Maida Talhami, BBA (USA)

Manager, Information Technology & Systems: Simone Cable, CNA (Certified Netware Administrator)

Commissioner's Executive Assistant: Virginia Westerson

Code of conduct

No changes were made to the Commission's Code of Conduct for staff.

Exceptional movements in employee wages, salaries or allowances

The Crown Employees (Public Sector Salaries January 2000) Award provided for a 2% pay rise for staff from 1 January 2001. This increased the Commission's salaries, wages and allowances liability by around $33,200 in the reporting period. This was partially offset by a reduction of around $28,300 in the salary package of the new Commissioner compared to that of the outgoing Commissioner.

Personnel policies & practices

The leave and other entitlements of Commission staff are covered by the Public Sector Management Act 1988 and its General Regulation. These entitlements are managed according to the guidelines set by the Premier's Department in the NSW Personnel Handbook and other publications. Staff entitlements include: flexible working hours; the option of full or part time work; maternity, parental and adoption leave; leave for family and community service obligations; and time off for study. The Commission supports the use of these entitlements by staff to balance their work and family commitments. The Workplace Agreement which was entered into during the reporting period has also increased the flexibility options available to staff.

Industrial relations policies & practices

The Commission adopts a participative management approach to industrial relations. General meetings of staff are held each month at which matters affecting staff are discussed. The Workplace Consultative Committee, comprising the Commissioner, senior managers and representatives of the Public Service Association of NSW, meets every two months. This Committee was established by the Workplace Agreement and is the formal mechanism for:

1. strengthening consultation, information sharing, communication and negotiation between employees, management and the Association in the workplace;
2. facilitating fair and co-operative relations within the Commission; and
3. strengthening participation in implementing productive reform in the Commission.

Table 36 - The number of employees, by category, with comparison to each of not less than 3 years before the reporting year.

Number of staff at 30 June (effective full time)					
Category		2001	2000	1999	1998
Executive	Senior Executive Officer	1	1	1	1
	Senior Officer	1	2	2	0
Clerk	Grade 11/12	1	2	2	2
	Grade 10	4	4	4	4
	Grade 7/8	32.53	29.3	26.4	22.2
	Grade 5/6	4	2.6	6	5
	Clerk 3/4	7	5	5	4
	Clerk 2	0	1	1	1
	Clerk 1	1	1	1	1
Clerical Officer	Grade 3/4	8	8	10.77	10.77
	Grade 1	2	1	1	1
Trainee		1	1	0	0
Legal Officer	Grade VI	1	1	1	1
	Grade III-IV	4	4	4	4
	Grade II	2	0	1	0
Medical advisers		0.2	0	1.03	1.03
Total*		**69.73**	**62.9**	**67.2**	**58**

*Note: the totals for previous reporting years may not match those published in previous annual reports as those were counts of positions, whereas these figures are counts of people based their Effective Full Time pattern of work: Full time staff = 1, part time staff =<1.

Equal employment opportunity

During the year, the Commission entered into a Workplace Agreement with its staff to foster improved and more flexible work practices and working conditions for the benefit of employees and the achievement of the Commission's aims and objectives. The Agreement promotes the principles and practice of Equal Employment Opportunity by:

- providing a forum, the Workplace Consultative Committee, in which EEO concerns can be discussed;
- reasserting a commitment to EEO principles in recruitment;
- formalising the Commission's commitment to developing staff, not only for their current positions, but also for career progression;
- varying the Award conditions for Hours of Duty as a tangible expression of the Commission's commitment to implementing flexible work practices and to assist staff to achieve a balance between their personal and work responsibilities:
  - up to 2 days of Flex Leave may be taken each settlement period;
  - Flex Leave may be taken in multiples of a quarter of a day;
  - other forms of leave may be taken by the hour (min 15 minutes);
  - up to 5 days of Flex Leave may be banked in any 6 month period, subject to certain conditions;
  - Bandwidth has been extended to commence at 7 am;
  - an unpaid break of up to 3 hours is permitted between the hours of 11:30 am and 2:30 pm.

Anecdotal evidence suggests that these, more flexible, arrangements are proving beneficial for staff and are assisting them to pursue study and to meet family commitments. A more structured survey will be conducted in the next reporting period to properly evaluate the impact of the Agreement.

Table 38 - Percent of total staff by level

Level	Total Staff #	Respondents %	Men %	Women %	A %	B %	C %	D %
< $26,802	1	100		100				
$26,802 - $35,202	2	100	50	50				
$35,202 - $39,354	12	100	8	92		33	42	
$39,355 - $49,799	5	100	60	40				
$49,800 - $64,400	38	100	29	71	2.60	16	8	11
$64,401 - $80,499	9	100	33	67		11	11	50
> $80,499 (non-SES)	4	100	50	50				
> $80,499 (SES)	1	100		100				
Total %			**29**	**71**	**1.40**	**15**	**13**	**8**
Subgroup Totals #	**72**		**21**	**51**	**1**	**11**	**9**	**6**

A: Aboriginal people & Torres Strait Islanders
B: People from racial, ethnic & ethno-religious minority groups
C: People whose language first spoken as a child was not English
D: People with a disability

Table 39 - Percent of total staff by employment basis

Level	Total Staff #	Respondents %	Men %	Women %	A %	B %	C %	D %
Permanent								
Full time	47	100	26	74	2.10	15	17	9
Part time	4	100	50	50				
Temporary								
Full time	15	100	40	60		20	7	
Part time	4	100	25	75		25		50
Contract								
SES	1	100		100				
Non SES								
Training positions	1	100		100				
Retained staff								
Casual								
Total %			**29**	**71**	**1.40**	**15**	**13**	**8**
Subgroup Totals #	**72**		**21**	**51**	**1**	**11**	**9**	**6**

Overseas travel and international liaison

Julie Kinross, Director, Complaint Assessment & Resolution, accepted an invitation to attend the 24th Annual Congress of the Kuring-gai District Medical Association in Johannesburg, South Africa in July 2000. She presented a paper on the functions of the NSW Health Care Complaints Commission and the disciplinary system in relation to medical practitioners. Travel and accommodation costs were met by the conference organisers.

Out of 47 speakers, Ms Kinross' s presentation was unanimously rated by registrants as the best and most relevant presentation. The conference provided an excellent opportunity to promote the Commission' s activities.

The Commission received a delegation in March 2001 from the Hong Kong Department of Health who were looking at setting up a similar complaints handling body in Hong Kong. The delegation spent two days with the Commission, learning about the objectives and function of the Commission under the Health Care Complaints Act, 1993 as well as how the Commission conducted its business.

The Commission also received the Deputy Commissioner from the New Zealand Health Complaints Commission who also came to learn about how the HCCC conducted its business.

The Commission also received visitors from the Ministry of Health, Singapore, who were researching the Australian complaints systems for implementation in Singapore.

The Health Complaints Deputy Ombudsman from the United Kingdom also visited the Commission.

FINANCE

Table 40 - Outline budget for 2001-2002 financial year Operating statement

	Budget 2001-2002 $000	$000	Actual 2000-2001 $000	$000
Expenses				
Operating expenses				
Employee related	4,518		4,323	
Other	1,618		2,321	
Maintenance	10		0	
Depreciation and amortisation	30		30	
		6,176		6,674
Retained revenue				
Sales of goods and services	15		10	
Investment income	15		25	
Other	200		188	
Gain on disposal of non current assets	**0**	**230**	**11**	**234**
Expenses-Revenue = net cost of services		**5,946**		**6,440**

Account payment performance

The Commission's Accounts Complaints Officer is the Director, Corporate Support. In accordance with the provisions of the Public Finance & Audit Regulation 2000 (cl 18), the Commission's purchase orders include the contact number for the Accounts Complaints Officer and the following advice: "Except where otherwise provided by a contract or supplier's terms, invoices are payable 30 days from receipt of goods or services and receipt of a complying invoice."

There have not been any instances where interest has been paid by the Commission for late payment of accounts.

During the March quarter, the Commission assumed control of payment of its accounts. This function had been performed by the Department of Transport on the Commission's behalf. This change has resulted in a significant improvement in the Commission's account payment performance.

Table 41 - Account payment performance

	Sept 2000	Dec 2000	Mar 2001	Jun 2001
Accounts payable at the end of each quarter				
Current (within due date)	$1,891	$17,706	$547	$0
Less than 30 days overdue	$0	$0	$0	$0
Accounts paid within each quarter				
Accounts paid on time				
Target(%)	100	100	100	100
Actual(%)	100	100	100	100
($)	$548,750	$549,759	$718,375	$570,759

Report on risk management, insurance activities and occupational health & safety

The Commission's workers' compensation, motor vehicle, public liability, property and miscellaneous items insurance is provided by the NSW Treasury Managed Fund through GIO Australia. The statistics provided by the GIO show that the number of claims made is low, however, the cost for each claim is high.

The Commission continues to work with staff and their treating doctors to facilitate effective rehabilitation and an early return to work by injured staff members wherever possible.

The functions of the Commission's Occupational Health & Safety Committee are being reviewed in light of the proposed changes to OH&S legislation. Regular workplace inspections are conducted and action is taken to minimise identified risks.

The insurance statistics show that body stressing, ie. manual handling and repetitive strain injury, is the subject of the majority of workers' compensation claims. Accordingly, the Commission will be aiming to minimise this risk in the coming year through provision of appropriate equipment and training to staff.

Table 42 - Workers compensation

	Accident year		
	1998-1999 as at 31/3/00	1999-2000 as at 31/3/01	2000-2001 as at 31/3/01
Total number of claims	6	9	4
Total number of employees	64	64	65
Number of claims per employee	0.094	0.141	0.062
Average claim cost per claim	$2,022	$871	$1,180
Average cost per employee	$190	$122	$73
Top 3 types of claim	Body stressing (4) Fall/trip/slip (2)	Other/unspecified (2) Body stressing (4) Fall/trip/slip (1)	Body stressing (2) Hit by objects (1) Fall/trip/slip (1)

Table 43 - Motor vehicle

	Accident year		
	1998-1999 as at 31/3/00	1999-2000 as at 31/3/01	2000-2001 as at 31/3/01
Total number of claims	2	0	4
Fleet size	3	3	3
Number of claims per vehicle	0.667	0	1.33
Average claim cost per claim	$2,362	$0	$2,166
Average cost per vehicle	$1,574	$0	$2,888
Top 3 types of claims	Collision w/ vehicle (1) Collision w/ property (1)		Accumulated damage (1) Damage whilst parked (1) Collision with property (1)

Energy Management

The Health Care Complaints Commission is committed to the NSW Government Energy Management Policy as part of the National Greenhouse Strategy. The Commission joins with all government agencies in seeking to achieve and sustain reduced greenhouse gas emissions and increased energy savings.

The Director, Corporate Support is the Commission's designated Energy Manager. The Commission's Energy Management Plan was reviewed during the reporting year and will be incorporated in the next Corporate Plan, which will commence in July 2002.

Staff are aware of their responsibility to save energy and actively ensure that all lights, airconditioning and equipment are switched off at the end of each day. Photocopiers revert to powersave mode during periods of inactivity during the day. Some rooms have manually controlled air conditioning systems, allowing the systems to be switched off when not needed.

Using these simple measures, the Commission has achieved a slight reduction in its electricity usage compared to the past two financial years. Figures provided by the Ministry for Energy and Utilities show that the Commission's energy usage in the 1999-2000 financial year was a third less than the state average.

Table 44 - Energy data for the Commission's Foveaux Street offices 2000-2001 financial year

	Office building - tenant services vehicles	Transport - passenger	CO_2 emissions (tonnes)
Energy Use			
Electricity (kWh)	143,555		137
Petrol (L)		4,052	9
Normalisation factors			
Occupancy (number of people)	61		
Area (m^2)	1,516		
Distance travelled (km)		44,558	
Energy Utilisation Index			
MJ/person/annum	8,475		
MJ/m^2/annum	341		
MJ/km		3	

Consultants

Total number of engagements: 1
Total cost: $5,658
Assignment: Records management review.

The following is a list of some of the legislation, including registration Acts, relevant to the work of the Commission:

- Chiropractors and Osteopaths Act 1991
- Dental Technicians Registration Act 1975
- Dentists Act 1989
- Health Services Act 1997
- Health Care Complaints Act 1993
- Health Administration Act 1982
- Medical Practice Act 1992
- Mental Health Act 1990
- Nurses Act 1991
- Nursing Homes Act 1988
- Optical Dispensers Licencing Act 1963
- Optometrists Act 1930
- Pharmacy Act 1964
- Physiotherapy Registration Act 1945
- Podiatrists Act 1989
- Poisons and Therapeutic Goods Act 1966
- Private Hospitals and Day Procedures Centres Act 1988
- Psychologists Act 1989
- Public Hospitals Act 1929
- Public Health Act 1991

Legal Changes:

The following significant legal changes occurred in the last year:

- Amendments to the Medical Practice Act, 1992 (commenced 10/2000).
- Decision of *Wortley -v- HCCC* where the Supreme Court held that the Health Care Complaints Act 1993 is welfare legislation for the benefit of the whole of society.

APPENDIX B: COMMITTEES & TASKFORCES

The Commission has representation on significant statutory bodies and interdepartmental committees including:

Ad Hoc Committee – Commissioner

Australian Council for Safety & Quality in Healthcare - Commissioner

Chief Executives Committee - Commissioner

Chiropractors and Osteopaths Registration Board Complaints Screening Committee – Manager, Prosecutions & Advisings

Consumer Focus Collaboration - Director, Complaint Resolution

Dental Board Complaints Screening Committee - Director, Strategic Partnerships & Quality Improvement

Dental Technicians Registration Complaints Screening Committee – Manager, Investigation Team 2

Joint Initiatives Group – Director, Strategic Partnerships & Quality Improvement

Medical Board Conduct Committee - Commissioner

Medical Board Medico-Legal sub-committee - Commissioner

Methadone Liaison Group - Manager, Patient Support Office

Ministerial Advisory Committee on Privacy & Health Information - Commissioner

National Council of Health Care Commissioners - Commissioner

National Health Complaints Information System Project Steering Committee – Commissioner

New South Wales Health Consumer & Community Participation Group - Commissioner

Nurses Registration Board Conduct Committee - Commissioner

Optical Dispensers Registration Board Complaints Screening Committee – Manager, Investigation Team 2

Optometrists Registration Board Complaints Screening Committee – Manager, Investigation Team 2

Pharmacy Board Complaints Screening Committee – Manager, Investigation Team 1

Physiotherapists Registration Board Complaints Screening Committee – Manager, Prosecutions & Advisings

Podiatrists Registration Board Complaints Screening Committee – Director, Strategic Partnerships & Quality Improvement

Professional Standards Council - Commissioner

Psychologists Registration Board Complaints Screening Committee - Commissioner

Skin Care Improvement and Pressure Ulcer Prevention Group - Director, Strategic Partnerships & Quality Improvement

Statewide Complaints Data Project Management Committee – Manager, Complaints & Resolution

Watchdog Agencies - Commissioner

APPENDIX C: PROFESSIONAL REVIEW & ADVISORY PANEL

The following is a list of health practitioners who review and advise the Commission on health care standards

Acupuncturist
Ms C Rogers

Chiropractor
Mr P Cowie
Mr LJ Whitman
Mr GK Wynn

Dental Surgeon
Dr A H Anker
Dr J Pearman
Dr G Smith
Dr J Spark
Dr EJ Wilkinson
Mr W Cearns

Medical Practitioner
Dr RJ Abbott
Dr RG Adler
Dr IS Alexander
Dr HO Allen
Dr WB Andrews
Dr NC Bacon
Dr RA Barnett
Dr BH Barraclough
Dr EJ Beckenham
Dr PS Bekhor
Dr JR Bell
Dr M Bellamy
Dr WJ Benson
Dr ST Bernard
Dr P Berton
Dr J Bertouch
Dr M Besser
Dr KF Bleasel
Dr E Bokey
Dr B Bourke
Dr D Bowers
Dr DH Brazier
Prof H Brodaty
Dr GS Brodie
Dr AJ Brooks
Dr A Brown
Prof N Buchanan
Dr JM Bunker
Dr DE Cam
Dr A Child
Dr CIV Childs
Dr IM Chung
Dr R Chung
A/Prof GF Cleghorn
Dr PB Colditz
Dr RL Coles
Dr PC Collett
Dr CA Commens
Dr C Cupitt
Dr PW Curtis
Dr RJ Day
Dr HG Dickson
Dr IS Dunlop
Dr F Ehrlich
Dr DR Eisinger
Dr BS Elison
Dr KJ Ellard
Dr J Ellard
Dr JF England
Professor L Evans
Dr G Falk
Dr AE Farnsworth
Dr A Farnsworth
Dr B Fasher
Dr AJ Ferrier
Dr E Fisher
Dr C Fisher
Dr JJ Flachs
Dr GW Fulde
Dr J Gambin
Dr BJ Gatus
Dr ME Gibbons
Dr M Giblin
Prof WP Gibson
Dr DJ Gillett
Dr J Gillis
Dr I Goldberg
Dr KJ Goulston
Dr J Greenwood
Dr DJ Handelsman
Dr M Harding
Dr BC Harris
Prof Harris
Dr KG Hartman
Dr P Hazell
Dr PN Hendel
Dr RA Higgins
Dr IA Hill
Dr MM Hoekstra
Dr PR Holman
Dr TB Hugh
Dr KF Hume
Dr WK Hunter
Dr B Hutson
Dr RS Hyslop
Dr G Isaacs
Dr J Isbister
Dr A James
Dr ER Jane
Professor RPS Jansen
Dr DM Jensen
Dr SM Jurd
Dr A Kelly
Dr JP Keneally
Dr I Kern
Dr S Khatri
Dr D Kitching
Dr B Kotze
Dr EP Kremer
Dr HCS Ku
Professor J Kurtzberg
Dr AE Ledner
Dr V Lele
Dr JR Lenehan
Dr GI Leslie
Dr E Loughman
Dr P Lye
Dr RC Lyneham
Dr KW Mackay
Dr AR MacQueen
Dr L Mann
Dr Linda Mann
Prof J May
Prof W McCarthy
Dr T McDonagh
Dr MG Mcgee-Collett
Dr R T McGuinness
Dr R McMurdo
Dr J E Mowbray
Dr Y Mudaliar
Dr G Nelson
Prof C O' Brien
Dr T O' Donnell
Dr M O' Meara
Dr J Parmegiani
Dr T Parry
Dr DG Pennington
Prof RJ Pepperell
Dr JP Percy
Dr KW Perkins
Dr J Phillips

Dr PC Pigott
Dr J Pitkin
Dr CD Pond
Dr SB Porges
Prof S Posen
Dr J Proietto
Dr DS Pryor
Dr C Quadrio
Prof TS Reeve
Dr S Richards
Dr HR Rikard-Bell
Dr CM Rogers
Dr M Rowley
Professor JP Royle
Dr RG Rushworth
Prof J Saunders
Prof D Saunders
Dr RC Seidler
Dr J Sippe
Dr JC Slaughter
Dr IR Smee
Dr KS Steinbeck
Dr WA Stening
Dr IJ Stewart
Dr DW Storey
Dr MG Suranyi
Dr E Taft
Dr RF Taylor
Prof CC Tennant
Prof GD Tracy
Prof RF Uren
Dr CR Vickers
Dr J Vinen
Dr D Wakefield
Dr J Warden
Dr RE Ware
Dr PS Warren
Dr A White
Dr AJ Wilson
Dr A Wodak
Dr JM Wright
Prof S Zwi

Nurse

Ms S Banks
Ms J Barr
Sr S Berenger
Ms RM Billings
Ms B Bradley
Ms Pat Brodie
Ms A Brown
Mrs J Caldwell
Ms J Capizzi
Ms T Clarke
Ms H Cooke
Ms D Dempsey
Mr GM Dulhunty
Ms A Grieve
Sr S Keats
Mrs N Kirby
Mr B McNair
Ms HC Mill
Ms J Mountford
Ms R Oates
Ms R O' Donnell
Ms L Osborn
Ms JB Richardson
Ms J Robinson
Ms F Russell
Ms K Spence
Prof IL Stein
Ms D Tully
Ms A Upton
Mr C Waite
Ms RA White

Occupational Therapist

Ms P Knudson

Optometrist

Mr C Henderson
Mr P Moore

Osteopath

Mr RC Partington

Pharmacist

Mr D North

Physiotherapist

Mr A Coleiro
Ms JM Hanley
Mr A Lucas
Ms T Powell

Podiatrist

Ms JA Burgess
Mr M Kinchington

Psychologist

Mr S Borenstein
Mr R Bryant
Ms G Goldberg
Ms A Gordon
Mr TS Keogh
Prof KM McConkey
Dr WA Roberts

Social Worker

Ms J Alexander

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Fax: (02) 9281 4585

TTY service for hearing and speech impaired: (02) 9219 7555

Toll Free in NSW: 1800 043 159

Website

www.hccc.nsw.gov.au

E-mail

hccc@hccc.nsw.gov.au

Interpreters

Interpreters can be arranged to discuss a complaint.

Publications

All Commission publications including Annual Reports can be downloaded from the Commission's website. Hardcopies are also available.

Patient Support Office

It is best to contact patient support officers by telephone:

Penrith/BlueMountains	(02) 4734 3870
Western Sydney	(02) 9881 1506
South Eastern Sydney	(02) 9382 8129
South Western Sydney	(02) 9828 5710
Central Sydney	(02) 9395 2028
Northern Sydney	(02) 9926 8184
Newcastle/Hunter	(02) 4985 3143

Patient support officers' phone numbers change from time to time. If you are having difficulty getting in touch with any of them, please ring the Commission.

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HCCC
HEALTH CARE COMPLAINTS COMMISSION