The Hon Mr Craig Knowles MP
Minister for Health
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Minister

Report of activities for the year ended 30 June 1999

I am pleased to present the Annual Report and financial statements of the Health Care Complaints Commission for the financial year ended 30 June 1999, for presentation to the Parliament of New South Wales.

The Report has been prepared and produced in accordance with the provisions of the Annual Reports (Departments) Act 1985, 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 New South Wales.

Yours sincerely

Merrilyn Walton
Health Care Complaints Commissioner

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Commissioner’s foreword

I am pleased to report the Commission’s new organisational structure is working well. The structure has enabled the Commission to be more flexible in its approach to complaints. Over the past year the Commission directly helped 10,400 complainants by one of many ways it uses to resolve complaints. The Commission resolves complaints by selecting the most appropriate method, taking into account the seriousness of the complaint and the public interest. This may be by providing assistance to a complainant to meet with a health care provider, referring the parties to conciliation, or investigating a complaint. The success of the Patient Support Office which helped over 2,500 consumers last year has meant fewer people were referred for conciliation this year than last. Facilitating the parties to resolve a complaint themselves is a constructive and simpler method for many complaints that might have in the past been referred to conciliation.

The Commission has identified three main priorities over the next 3 years. These are to improve the profile of the Commission in providing effective and efficient dispute resolution, reduce delays in investigating complaints and create better mechanisms for providing feedback on systemic problems in health service delivery to the health system. The Commission is now well placed to progress these goals.

Another function of the Commission is to monitor, identify and advise the Minister for Health on trends in complaints. The Commission has identified two issues raising systemic concerns for the health system.

The first related to the lack of adequate care and treatment for nursing home patients admitted to hospitals for the treatment of acute medical conditions. The Director General of Health, in response to the Commission's notification of its investigation under part 3 of the Health Care Complaints Act 1993 established a state wide working party to "investigate and report on the prevention and management of pressure sores when elderly patients are admitted to public hospitals from nursing homes." I am a member of the working party and am pleased with the Committee's work to date.

The second issue concerns the trend in complaints identifying deficiencies in the continuity of care for patients in public hospitals. Continuity of care is a growing problem for the health system. How patients are treated and processed through the system requires new and innovative methods. The Director General of Health has agreed to a joint sponsorship of a project to address continuity of care.

Cosmetic surgery was a major focus throughout the year. The Minister in response to concerns raised by health practitioners and consumers established a Ministerial Inquiry into Cosmetic Surgery. As Chairperson of the Inquiry I am aware of the importance of consumers having access to reliable information to assist them in their decisions. A full report can be found on p54.

Not all Commission activities are city based. The Commission receives many complaints concerning health services from rural NSW. This financial year, the Commission initiated a major program of rural consultations throughout NSW. The program included separate

consultations with indigenous communities. Many Aboriginal communities told us about the problems they experienced, including discrimination and access to District hospitals. I will be reporting the results of these consultations to the Minister for Health and the Director General of Health when consultations are complete.

The Commission continues to build relationships with the health system and is pleased with the cooperation it receives from health managers and chief executive officers. There is a growing trend of Area Health Services and health facilities seeking the Commission's assistance in managing complex complaints. The Commission also continues to maintain good relationships with the Consumer Consultative Committee, the registration boards, the professional colleges and associations. This report shows the diverse range of activities involving the Commission and I hope it gives you insight into our work. It covers the work of the Commission, the types of complaints received and how they are managed. It identifies those cases that raised significant public health and safety issues as well as significant questions in relation to the care and treatment of patients in the health system.

My thanks go to the hard working staff of the Commission who demonstrate both commitment and diligence in their work.

Merrilyn Walton
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.

Mission

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;
- 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;
- consult with key consumers and other stakeholders.

Stakeholders

The people of NSW

Minister for Health

Joint Parliamentary Committee

Department of Health

Area Health Services

Consumer Consultative Committee

Health Reference Panel

Health Registration Boards

Health Practitioners & Facilities

Health Conciliation Registry

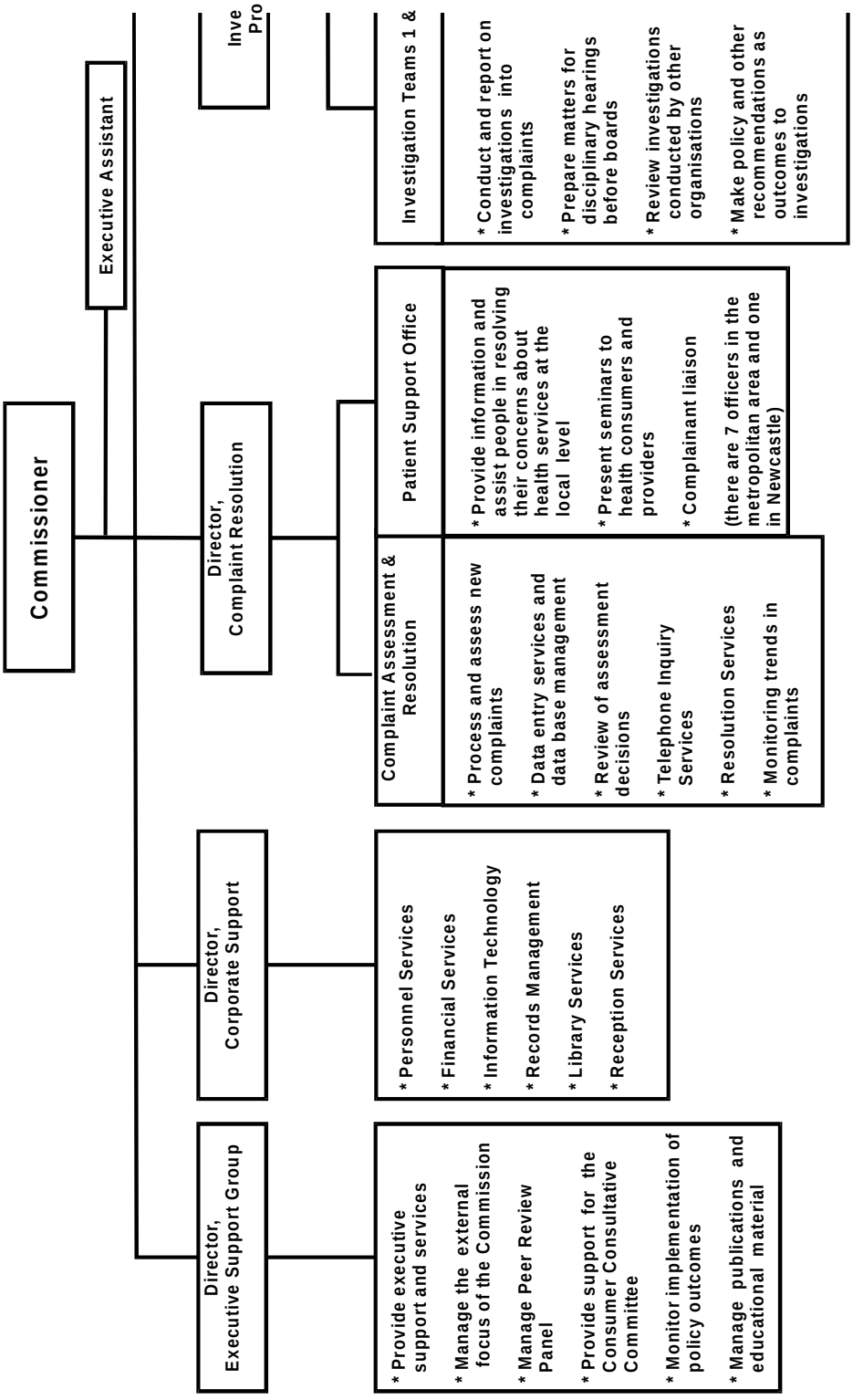
Health Professional & Educational Bodies

Other Government Agencies

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.

Organisation Chart as at 30 June 1999



Performance Measures

Assess complaints in a timely, fair and independent manner

- Received a total of 2052 complaints in 1998-99
- 97% of complaints were assessed within one week of receipt by the Commission
- Assessed all complaints made to registration authorities about health practitioners

Provide a timely, thorough and independent investigation of complaints which arise from the delivery of health services in NSW

- 1000 complaints were completed and closed in less than 61 days
- 1185 complaints were completed and closed in less than 100 days
- Average time taken to finalise complaints was 681 days (reduced from 728 days in 1997-98)
- Closed 417 investigations in 1998-99
- Substantiated in full or in part 193 investigations

Ensure appropriate action is taken as a result of investigations

- Referred 113 cases to Tribunals and Professional Standards Committees for disciplinary action
- Prosecuted 31 health care providers before Professional Standards Committees and 33 practitioners before Tribunals or appellate courts
- Made policy recommendations in 17 cases

Manage internal and external liaison, public education, communication and representation

- Distributed over 35,000 brochures and 1500 posters
- Brochures available in up to 15 languages
- Gave over 470 presentation to consumer and provider groups; estimated number of people attending exceeded 10,100
- Held rural information sessions in 5 country towns
- Participated in many radio, television and newspaper interviews
- Produced articles for journals and conference papers
- Held four meetings with the Consumer Consultative Committee
- Met regularly with registration boards
- Produced four issues of the Commission's journal *Health Investigator*

Highlights of the Year

Ministerial Inquiry into Cosmetic Surgery

An Inquiry into Cosmetic Surgery was announced by the NSW Minister for Health in late 1998. The Inquiry was prompted by complaints from consumers and health professionals made through the NSW Health Department, the NSW Medical Board, the Health Care Complaints Commission and professional bodies. The concerns were about the way in which cosmetic surgery procedures are promoted and the quality and safety of those procedures. It is a comprehensive inquiry into cosmetic surgery and has attracted international interest.

The Health Care Complaints Commissioner, Ms Merrilyn Walton, is chairing the Ministerial Committee. A report into the findings of the inquiry will be released in October 1999.

Launch of *Your Rights and Responsibilities as a Health Consumer* Booklet

The Hon Dr Andrew Refshauge, then Minister for Health, launched the Commission's new brochure titled *Your rights and responsibilities as a health consumer* in August 1998 in Parliament House. The Commission printed 150,000 copies of this brochure for distribution throughout NSW.

Rural Information Sessions

In February 1999, the Commission embarked on an education program throughout rural NSW. The Commissioner and staff visited 5 country towns in 4 months and talked to approximately 500 people. The aim of these tours was to introduce the Commission to communities and health care providers in rural NSW, explain the functions and role of the Commission and, importantly, to hear about issues concerning health care services.

The Commission visited Newcastle, Lismore, Grafton, Wollongong and Queanbeyan, and will continue to visit other rural centres throughout 1999-2000.

Launch of a Poster for Indigenous Communities

In March 1999, the Commission launched a poster promoting the Commission and its services to Aboriginal communities in NSW.

Skin Care Improvement and Pressure Ulcer Prevention Group

The Commission received complaints about elderly nursing home residents, who, following admission to a major metropolitan hospital developed deep pressure ulcerations with significant necrosis and infection. The Commission considered the complaint raised significant questions as to the care and treatment of elderly patients. Recommendations were made to the Department of Health that these issues be addressed by the establishment of a working party operating under the aegis of the Department. Commissioner Walton represents the Commission on this working party.

Continuity of Care Project

The Commission is aware of a disturbing trend in complaints concerning the 'slipping through the system' of patients. These cases involve a number of health care practitioners (from a number of institutions or areas of practice) treating the same person. There have been instances where no single practitioner has assumed responsibility for the overall care of the patient. This has led to some tragic consequences for some patients. The Commission has recommended to the Department of Health that this issue requires a coordinated approach via a working party to address the issues.

Aboriginal Reconciliation

The Aboriginal Reconciliation Committee provided staff with a series of workshops aimed at increasing their awareness about reconciliation and about Aboriginal and Torres Strait Islander communities.

The year ended with a plenary session during which staff were invited to sign a statement in support of Reconciliation and which makes a commitment to making the Commission's service more accessible to Aboriginal and Torres Strait Islander peoples. The signed statement will be forwarded to the Council for Aboriginal Reconciliation.

Inquiry into Unregistered Health Practitioners

The Joint Parliamentary Committee into the Health Care Complaints Commission conducted an inquiry in 1998-99 into the adequacy and appropriateness of current mechanisms for resolving complaints concerning unregistered health practitioners. The inquiry was commenced after repeated concerns from the Commission and consumers about the limited ability of existing mechanisms to protect the public from inappropriate treatment given by unregistered health practitioners.

The Commission made a submission to the inquiry and the results of the inquiry are discussed in more detail in the section titled "Commission's Stakeholders".

The year at a glance

Description	1996-97	1997-98	1998-99
Number of telephone inquiries received	6,381	6,119	5,497
Number of complaints received	1,551	1,870	2,052
Number of complaints closed	1,899	1,900	1,858
Number of complaints against facilities	529	616	642
Number of complaints against doctors	803	989	1,065
Number of complaints against nurses	62	89	114
Number of complaints referred for conciliation	218	264	146
Number of complaints referred for investigation	420	419	459
Number of Patient Support Office clients	-	2,109	2,842

Division of Complaint Resolution

The Commission's restructuring was completed this year with the creation of two new Divisions: The Division of Complaint Resolution and the Division of Investigations and Prosecutions.

The Division of Complaint Resolution includes two sections of the Commission - the Complaint Assessment and Resolution section and the Patient Support Office. A new Director commenced in October 1998. The strategic activities of the Division and the key activities of each section are reported on below.

Strategic Initiatives

Investigations Advisor

During the year the Commission reached an agreement with the Department of Health and the Area Health Services for the Commission to provide a training and advisory service to Area Health staff in relation to complaint handling. The position will be funded for a 12 month period by the Area Health Services. The job evaluation of the position was finalised in mid June and the temporary position was advertised. The Investigations Advisor will develop and conduct a training course for each Area Health Service. The Investigations Advisor will also produce a manual to assist Area Health staff responsible for investigations. The Commission aims to support the health system in its endeavours to provide independent investigations to become more responsive to consumer feedback and to use feedback as a tool to improve services. It is hoped this initiative along with other Area strategies will improve the quality of investigations and reduce formal complaints being lodged with the Commission.

Statewide Complaint Data Collection Project

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 perform its 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 forward in health services becoming more transparent and accountable to the public for the services provided, a move which is consistent with directions being taken world wide and in other parts of Australia. The collection and analysis of data can lead to service improvements. The project is also contributing to the growing awareness by health services of the importance of complaints and local complaint resolution. During the year the Commission worked closely with the Department of Health and the Area Health Services to establish a standardised mechanism to collect information about the complaints consumers made about services provided.

A Memorandum of Understanding between the Commission, Department of Health and the Area Health Services is yet to be signed. The Commission is yet to be satisfied that data will be provided in a form which will allow it to perform its function of reporting to the Minister.

The Commission has led this reform which has its genesis in the annual reporting by the Commission on the complaints made to it about public hospitals.

National Health Complaints Information Project

The National Health Complaints Information Project (NHCIP) is an initiative of the National Council of Health Complaints Commissioners and the Commonwealth Department of Health and Aged Care. The Project aims to collect and analyse complaints information from all States and Territories, initially from Health Complaints Commissions. Other health organisations may contribute complaint data as the Project evolves.

For the first time, complaint trends may be identified on a National level thereby increasing the value of complaints and the information they yield.

The Commission has actively participated in the development of the project which is contemplating use of the Commission's deidentified data set.

Consumer Focus Collaboration

The Task Force on Quality of Australian Health Care identified problems in the health system which could be addressed and the quality of health services enhanced by the participation of consumers of these services in planning and delivery. The Consumer Focus Collaboration (CFC) was formed to support and encourage the creation of consumer feedback and participation mechanisms. The Collaboration comprises representatives from Health Complaints Commissions, consumer organisations, professional associations and State and Territory Governments.

The CFC works with key stakeholders to promote, integrate and disseminate information and initiatives, which increase consumer involvement in health service planning, delivery and evaluation. Through projects such as a consumer participation toolkit, a clearing house for consumer feedback methodologies and identifying models for the provision of information to consumers, the CFC plans to promote models to assist health services to implement meaningful programs and dialogue with consumers.

The Health Care Complaints Commission represented the State and Territory Health Complaints Commissions on the CFC during the financial year.

Referral of complaints to registration authorities for investigation

The Commission and the New South Wales Medical Board established a protocol for the referral of certain types of complaints to the registration authority for its investigation under section 26 of the Health Care Complaints Act 1993. The types of complaints referred include those involving poor communication where there is a history of similar complaints against the practitioner and complaints which give rise to concern about the clinical competence of a practitioner.

In 1998-99 the Commission referred 22 complaints to the Medical Board. The Board substantiated the vast majority of those complaints and counselled practitioners when appropriate.

As a matter of course the Commission has requested the Board to provide it with a report on its investigations and its findings. Regular liaison meetings are held between the Commission and the Board to deal with issues as they arise. This is an important Commission initiative as it provides a timely effective response to complaints which do not warrant formal investigation by the Commission.

The Commission also held discussions with the Psychologist's Registration Board and the Nurse's Registration Board to establish a similar mechanism to refer complaints to the respective registration authority for investigation. Both Boards have agreed and the Commission commenced referring suitable complaints towards the end of the financial year.

Complainant Liaison Officer

During the year the function of the Complainant Liaison Officer (CLO) was reviewed. The CLO was responsible for the support of complainants whose complaint involved allegations of sexual assault or harassment. The CLO remained involved with each complainant from the receipt of a complaint to the finalisation of any disciplinary proceedings. The reporting arrangement of the CLO was changed from the Legal Section to the Division of Complaint Resolution. From 1 July 1999 the function will be performed by the Patient Support Office.

Review of publications and correspondence

The Commission has embarked on a review of its publications and correspondence. The Commission is aiming to provide clearer information to the parties about the complaint process and the role of the Commission.

Review of assessment decisions

Section 28(6) of the Health Care Complaints Act 1993 entitles complainants to a review of the Commission's complaint assessment decision on the request of the complainant. The Commission has reviewed this function and made substantial improvements. Complainants are now provided with a full statement of reasons and a customised response to their concerns. This has resulted in an improvement in customer satisfaction with the Commission's decision making.

Complaint Assessment & Resolution

The Complaint Assessment and Resolution section handles all telephone and in-person inquiries. It provides secretariat assistance to the Complaint Assessment Committee. It is responsible for the statutory function of notifying respondents of the receipt of a complaint and notifying the parties of the Commission's assessment decision. The section undertakes the pre-assessment work on complaints which require further information before an assessment decision can be made. After assessment the section refers complaints to the Health Conciliation Registry, other bodies or to other areas of the Commission such as the Patient Support Office or the Division of Investigations and Prosecutions as appropriate.

Complaints received by Category 1998-99

Breakdown	No.
Clinical Standards	**1168**
Adverse Treatment Outcomes	45
Clinical Practice: Diagnosis-Nil/Incorrect	70
Communication - Nil	23
Communication: Insensitive/Rude	141
Communication: Incorrect/Misleading/Nil	23
Competence	32
Consent	21
Delay in Attending	6
Diagnosis - Incorrect	103
Diagnosis - Nil/Incorrect	4
Diagnosis - Inadequate/Incomplete	38
Experimental Treatments	10
Failure to follow-up results	6
Infection Control	29
Innovative Treatment	1
Medical records - nil	9
Medical records - quality	4
Prosthetic Services	4
Refusal to Attend	17
Refusal to Treat	21
Transmission of Infection	1
Treatment - Incorrect/Inadequate	344
Treatment - Inadequate	212
Unqualified/Non-Qualified	2
Use of Interpreter	0
Provider-Patient/Client Relationship	**129**
Inappropriate Examination/Treatment	44
Inappropriate Relationship	17
Physical Assault	17
Sexual Relationship	16
Sexual Harassment	16
Sexual Assault	19
Sex for Favour	0

Breakdown	No.
Patient Rights	**79**
Access to Records/Reports	34
Breach of Confidentiality	20
Consent	2
Privacy	9
Records: Accuracy	9
Second opinion not provided	1
Discrimination	4
Prescribing Drugs	**98**
Over Prescribing	8
Wrong/Incorrect Prescribing	66
Inducement/Favour to Prescribe	1
Illegal Prescribing	5
Diversion	3
Dispensing	11
Administration	3
Quality Of Care	**312**
Administrative Practice	15
Delay in Admission	3
Delayed transfer	1
Delayed transport	1
Inadequate/Unqualified Personnel	0
Inappropriate Admission	0
Inappropriate Discharge	12
Inappropriate Transport	1
Inappropriate Admission (Mental Health)	21
Inappropriate Care	64
Institutions/Hospital Practice	85
Premature Discharge	5
Refusal to Admit	2
Refusal to Discharge	1
Standards of Care: Hygiene	12
Standards of Care: Facilities	89
Statutory Compliance	0

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Complaints received by Category 1998-99 (cont.)

Breakdown	No.	Breakdown	No.
Business Practices	**140**	**Fraud**	**47**
Clinical Advertising	8	Extraordinary Claims	2
Commercial Advertising	7	Falsification/Fabrication/Plagiarism	8
Death Certificate	2	Financial Inducement/Advantage	19
Debt Collection	1	Holding Out/Misrepresentation	9
Fees	35	Overservicing	9
Health Insurance Commission	1		
Inappropriate Commercial Activities	13	**Other Ethical Improper Conduct**	**39**
Medical Certificates	6	Acts of Dishonesty	9
Medico-legal report-inadequate/incorrect	1	Inappropriate Professional Conduct	28
Medico-legal report - nil communication	2	Use of Deleterious Drugs	2
Medico-legal report - fraud	2	Use of Organs	0
Medico-legal report - rough/inadequate	6		
Medico-Legal Reports	53	**Miscellaneous**	**5**
Refusal to hand over medical records	2	Awaiting more information	3
Statutory Breaches	1	Various ‘other’ categories	2
Impairment	**24**	**Waiting List**	**1**
Age	2	Waiting List	1
Breach of Conditions	6		
Drugs	8	**Re-registration**	**2**
Mental/Physical Capacity	8	Appeal from a re-registration/review	0
		Re-registration	2
Character	**6**	Review of findings and orders	0
Breach of Conditions	0		
Conviction/Offence under legislation	6	**Resources**	**2**
		Resources	2

Summary of complaints received by category 1996-97 - 1998-99

Category	1996-97	%	1997-98	%	1998-99	%
Clinical Standards	883	56.9	1129	60.4	1168	56.9
Provider-Patient/Client Relationship	95	6.1	87	4.7	129	6.3
Patient Rights	54	3.5	61	3.3	79	3.9
Prescribing Drugs	60	3.9	67	3.6	97	4.7
Quality of Care	191	12.3	250	13.4	312	15.2
Business Practices	97	6.3	163	8.7	140	6.8
Impairment	8	0.5	17	0.9	24	1.2
Character	3	0.2	7	0.4	6	0.3
Fraud	23	1.5	23	1.2	47	2.3
Other ethical/improper conduct	4	0.3	30	1.6	39	1.9
Re-Registration	4	0.3	5	0.3	2	0.1
Waiting Lists	3	0.2	0	0.0	2	0.1
Resources	0	0.0	1	0.1	2	0.1
Miscellaneous	104	6.7	30	1.6	5	.2
Other (code deleted after 1996-97)	22	1.4	0	0.0	0	0.0
Total	**1,551**	**100**	**1,870**	**100**	**2,052**	**100**

Complaints received against Facilities 1996-97 - 1998-99

Facility	1996-97	%	1997-98	%	1998-99	%
Public Hospital	299	56.5	323	52.4	336	52.3
Private Hospital	41	7.8	54	8.8	45	7.0
Psychiatric Hospital	13	2.5	22	3.6	44	6.9
Nursing Home	23	4.3	28	4.5	38	5.9
Medical Centre	37	7.0	31	5.0	36	5.6
Area/District Health Service	7	1.3	8	1.3	6	0.9
Ambulance Service	8	1.5	8	1.3	10	1.6
Community Health Service	10	1.9	20	3.2	18	2.8
Corrections Health Service	10	1.9	10	1.6	16	2.5
Health Funds	3	0.6	2	0.3	0	0.0
Department of Health	11	2.1	8	1.3	0	0.0
Drug & Alcohol Service	8	1.5	7	1.1	3	0.5
Public Dental Unit	4	0.8	12	1.9	6	0.9
Pathology Centre or Laboratory	6	1.1	5	0.8	8	1.2
Radiology Centres	4	0.8	5	0.8	6	0.9
Women's Health Centre	2	0.4	2	0.3	3	0.5
Group Homes	2	0.4	2	0.3	4	0.6
Day Procedures Centres			5	0.8	3	0.5
Pharmacies			4	0.6	1	0.2
Other[#]	41	7.8	60	9.7	59	9.2
Total	**529**	**100**	**616**	**100**	**642**	**100**

[#]Other includes: Alternative Health Service (2); Blood Bank (1); Boarding House (1); Chiropractic Practice (1); Dental Laboratory (3); Dental Surgery - Private (3); Early Childhood Clinic (1); Family Planning Clinic (1); Domestic Residence (1); Hostel - Aged (5); Hostel - Other (2); Nursing Agency - District/Community (4); Optometrist Practice (1); Physiotherapy Clinic - Private (1); Private Medical Practice (6); Registration Boards (1); Methadone Clinic (1); Other (no code available) (24)*.

Complaints against public hospitals by Area Health Service 1998-99

Area Health Service	No.	%	Area Health Service	No.	%
Greater Murray HS	5	1.5	Hunter AHS	24	7.1
Macquarie HS	6	1.8	Illawarra AHS	17	5.1
Mid North Coast HS	17	5.1	Northern Sydney AHS	34	10.1
Mid Western HS	17	5.1	South Western AHS	40	11.9
New England HS	10	3.0	Wentworth AHS	8	2.4
Northern Rivers HS	7	2.1	Western Sydney AHS	51	15.2
Southern HS	14	4.2	South Eastern Sydney AHS	42	12.5
Central Coast AHS	14	4.2	Unknown	1	0.3
Central Sydney AHS	29	8.6			
			TOTAL	**336**	**100**

Complaints received against public hospitals by Service Area 1998-99

Description	No.	%		Description	No.	%
Accident and Emergency	88	29.3		Urology	5	1.7
Surgery - General	36	12.0		Intensive Care	5	1.7
Obstetrics	21	7.0		Administration -		
Administration - General	13	4.3		Medical Records	4	1.3
Cardiology	10	3.3		Respiratory	4	1.3
Paediatric Medicine	9	3.0		Gastroenterology	4	1.3
Gynaecology	7	2.3		Gerontology	3	1.0
Mental Health	6	2.0		Opthalmology	3	1.0
Rehabilitation Medicine	6	2.0		Renal Medicine	3	1.0
Psychiatry	6	2.0		Other#	62	20.7
Oncology - Medical	5	1.7				
				Total	**300***	**100**

Other includes: Neonatology, 2; Neurology, 2; General Medicine, 2; Oncology - Radiation, 2; Midwifery, 1; Haematology (Clinical), 1; Public Health, 1; Podiatry, 1; Immunology (Clinical), 1; Sexual Health, 1; Dermatology, 1; Pharmacy, 1; Drugs - Prescribing, 1; Autopsy, 1; Anaesthesia - Other, 1; Sexual Assault Service, 1; Palliative Care, 1; Other (no code available), 41.

* 36 complaints against public hospitals did not have a clear service area identified.

Complaints received by Profession 1996-97 - 1998-99

Profession	1996-97	%	1997-98	%	1998-99	%
Medical Practitioner	803	78.6	989	78.7	1065	78.3
Nurse	62	6.1	89	7.1	114	8.4
Podiatrist	4	0.4	5	0.4	6	0.4
Chiropractor & Osteopath	11	1.1	10	0.8	11	0.8
Dentist	32	3.1	16	1.3	24	1.8
Dental Technician & Prosthetist	12	1.2	16	1.3	20	1.5
Pharmacist	9	0.9	6	0.5	9	0.7
Optometrist	5	0.5	4	0.3	12	0.9
Psychologist	27	2.6	48	3.8	34	2.5
Physiotherapist	8	0.8	9	0.7	12	0.9
Social Worker	7	0.7	7	0.6	5	0.4
Alternative Health Provider	9	0.9	20	1.6	11	0.8
Counsellor/Therapist*	0	0.0	8	0.6	4	0.3
Other#	33	3.2	29	2.3	33	2.4
Total	**1,022**	**100**	**1,256**	**100**	**1,360**	**100**

*coded added 1 July 97

#Other: Administrative or Clerical Staff (6); Occupational Therapist (1); Welfare Officer (1); Speech Pathologist (1); Health Education Officer (1); Psychotherapist (7); Assistant in Nursing (1); Struck off health practitioner (2); Deregistered health practitioner (3); Other (no code available) (10).

Category of complaints received against medical practitioners and nurses in 1998-99

Category	Medical Practitioners		Nurses	
	Number	%	Number	%
Clinical Standards	669	62.8	45	39.5
Miscellaneous	2	0.2	0	0
Business Practices	103	9.7	0	0.0
Provider-Patient/Client Relationship	79	7.4	17	14.9
Prescribing Drugs	64	6.0	14	12.3
Quality Of Care	48	4.5	11	9.6
Patient Rights	40	3.8	4	3.5
Fraud	26	2.4	4	3.5
Other Ethical/Improper Conduct	16	1.5	9	7.9
Impairment	15	1.4	6	5.3
Character	2	0.2	4	3.5
Waiting List	1	0.1	0	0.0
TOTAL	**1,065**	**100**	**114**	**100**

Source of complaints 1996-97 - 1998-99

Source	1996-97	%	1997-98	%	1998-99	%
Parliament/Minister	40	2.6	39	2.1	81	3.9
Department of Health (State & Commonwealth)	98	6.3	108	5.8	131	6.4
Consumer/Patient	761	49.1	881	47.1	921	44.9
Family/Friend	363	23.4	410	21.9	354	17.3
Registration Board	144	9.3	228	12.2	399	19.4
Coroner's Court	4	0.3	5	0.3	1	0.0
Government Department	31	2.0	66	3.5	36	1.8
Health Professional	33	2.1	36	1.9	26	1.3
Legal Representative	56	3.6	61	3.3	51	2.5
Other	21	1.4	36	1.9	52*	2.5
Total	**1,551**	**100**	**1,870**	**100**	**2,052**	**100**

*Other: Consumer Organisation (25); Health Insurance Commission (1); Non-Government Organisation (2); Mental Health Advocacy (2); Royal Australian & NZ College of Psychiatrists (4); Pharmacy Association (2); Other (No code available) (16).

Files open as at 30.6.1999

(including files received in past financial years)

Assessment Level	No.	%
Pre-assessment inquiry	15	1.6
Discontinue dealing with	34	3.7
Referred to Director-General	1	0.1
Referred to another body or person	31	3.4
Referred for conciliation	33	3.6
Commission investigation	789	86.1
Referred for direct resolution	13	1.4
Total	**916**	**100**

Category of complaints for files open as at 30.6.1999

Category	No.	%
Clinical Standards	461	50.3
Pattern of Practice	2	0.2
Fraud	29	3.2
Other Ethical/Improper Conduct	28	3.1
Professional Practice	1	0.1
Miscellaneous	130	14.2
Re-registration	1	0.1
Provider-Patient/Client Relationship	112	12.2
Patient Rights	17	1.9
Prescribing Drugs	43	4.7
Quality Of Care	64	7.0
Business Practices	13	1.4
Impairment	10	1.1
Character	5	0.5
Total	**916**	**100**

Telephone inquiries

The role of the two Telephone Inquiry Officers is to provide information to callers about options available to them to resolve or deal with a complaint. Telephone Inquiry Officers may obtain and provide information to callers to assist them resolve complaints with the practitioner or health facility concerned. If a Telephone Inquiry Officer is unable to resolve a caller's concern, the caller may be referred to a Patient Support Officer or a Resolution Officer, or advised to make a formal complaint to the Commission in writing.

The Commission received 5,497 telephone inquiries in 1998-99, around 600 fewer than last year. This number includes only the calls handled by the telephone inquiry officers and does not include calls of an administrative nature such as requests for Commission publications or complaint statistic inquiries.

This financial year the Patient Support Office became involved for the first time in fielding telephone inquiries about health services in their regional area. Telephone calls are either made

directly to the Patient Support Officer or referred to them through the Commission's switchboard. These calls are reported in the Annual Report under the Patient Support Office. Taking into account the number of calls referred to the Patient Support Officer the number of inquiry calls to the Commission increased in the year.

The Commission reviewed its Complaint Form during the year ready for implementation next financial year. The form will assist complainants to provide sufficient detail for the Commission to make an assessment decision. It will also assist in the accurate identification of respondents and improve the quality of complaint information.

Face to face inquiries

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. The Commission's Resolution Officers are available to provide information and/or assist with the preparation of a written complaint as required.

During 1998-99, 37 inquiry interviews were conducted by Resolution Officers. The availability of Patient Support Officers in local areas has reduced the need for people to attend the Commission in person.

Assessment of complaints

The Commission assesses all complaints 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 assessment are objective, fair, free from bias and made by a body independent of the professions.

The purpose of assessment is to decide how a complaint will be handled. The Commission may decide to handle a complaint by referring it for conciliation, investigating it, referring it to another body for investigation or by deciding not to deal with the complaint. The Commission may refer the complaint to the Patient Support Office for it to facilitate a resolution between the parties themselves.

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 comprised of the Commissioner, the Director of Complaint Resolution and the Director of Investigations and Prosecutions. Other staff attend from time to time. The Commission is required to consult with registration boards about its assessment decision in relation to complaints against registered practitioners.

During 1998-99, the Commission received 2052 written complaints, 182 more complaints than the previous year. This amounts to a 10% increase in the number of complaints dealt with by the Commission.

Outcome of Assessment of all complaints 1996-97 - 1998-99

Assessment of Complaints	**19 96-97**	**%**	**1997-98**	**%**	**1998-99**	**%**
Conciliation offered	218	14.3	264	14.4	146	7.3
Direct Resolution Between Parties	153	10.0	278	15.2	385	19.4
Refer to another body or person	471	30.9	584	31.8	584	29.4
Investigation	420	27.6	419	22.8	459	23.1
Discontinue Dealing With	262	17.2	290	15.8	413	20.8
Awaiting Assessment as at 30 June 1999					65	3.3
Total	**1,524**	**100**	**1,835**	**100**	**2,052**	**100**

Assessment Decisions

Discontinue dealing with the complaint

The Commission may discontinue dealing with a complaint. The reasons include:

- 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 of are more than five years old; or
- the subject matter does not require investigation or conciliation.

During 1998-99, the Commission declined to deal with 413 complaints. The proportion of complaints declined this year is 5% higher than last year. This represents an increasing practice of the Commission to decline the complaint because the Patient Support Office is available to assist parties resolve issues. Most complaints which are declined are referred to the Patient Support Office.

Category of complaints assessed and declined 1998-99

Category	No.	%
Clinical Standards	212	51.3
Fraud	14	3.4
Other ethical/ improper conduct	15	3.6
Miscellaneous	1	0.3
Resources	1	0.3
Provider-Patient/ Client Relationship	20	4.8
Patient Rights	24	5.8
Prescribing Drugs	8	1.9
Quality Of Care	49	11.9
Business Practices	69	16.7
Total	**413**	**100**

Case study - Medico-legal opinion

The Commission received a written complaint from Mrs A who believed her husband had been the subject of a biassed medico-legal report. Mr A had lodged a claim with his insurance company believing his chronic Post-Traumatic Stress Disorder (PTSD) made him permanently disabled under his life insurance policy. Mrs A advised that her husband was a 50-year-old Vietnam veteran and had been regarded by the Commonwealth Department of Veteran Affairs as being “totally and permanently incapacitated” for some years.

The general practitioner who assessed Mr A for the claim concluded Mr A did not suffer PTSD and was fit to work. Mrs A believed that the GP based this opinion on a brief and inappropriate examination of Mr A and that the GP asked inappropriate questions which seemed biassed and in favour of the insurance company.

The Commission assessed the complaint and declined to deal with it on the basis that there were other satisfactory means of dealing with the complaint. Mr A could seek another medical opinion. The contents of the report could be contested by seeking a review of the insurance company’s decision.

The examination conducted by the doctor appeared appropriate to the Commission and there were no grounds for disciplinary action raised by the complaint. The complaint therefore did not warrant investigation by the Commission or conciliation.

Refer to another person or body for investigation including the Director General of Health

Under section 26 of the Health Care Complaints Act 1993, the Commission may refer a complaint to another person or body for investigation if it appears the complaint raises issues which require investigation by the other person or body. During 1998-99, 576 complaints were referred to another body for investigation. These bodies include Area Health Services or the managing body of a private health facility. In 299 cases, the Commission requested a report regarding the

conduct and outcome of the investigation for monitoring purposes. Of the 149 reports received and reviewed during 1998-99, the Commission determined to investigate four complaints due to the seriousness of the issues arising from the other body's investigation.

Following assessment the Commission must notify the Director-General of Health if it appears to the Commission that a complaint involves a possible breach of certain Acts administered by the Department of Health. These breaches usually relate to pharmaceutical services, private health care, or public health. The Director General is required to notify the Commission if the Director General proposes to deal with the complaint and if so, the outcome of the complaint. During 1998-99, 58 complaints were referred to the Director-General of Health.

Complaints referred for action to another body or person by category 1998-99

Category	No.	%
Clinical Standards	311	53.2
Quality Of Care	161	27.5
Business Practices	34	5.8
Prescribing Drugs	32	5.5
Fraud	16	2.7
Provider-Patient/ Client Relationship	11	1.9
Patient Rights	7	1.2
Impairment	5	0.9
Other ethical/ improper conduct	5	0.9
Waiting List	1	0.2
Resources	1	0.2
Total	**584**	**100**

Assessed for referral to another body or person for action 1998-99 and closed by Commission

Area Health Service	268	53.5
Director General	63	12.6
Health Insurance Comm.	5	1.0
Other Body	76	15.2
Comm'th Govt Dept	3	0.6
State Govt Dept	15	2.9
Private Health Facility	12	2.4
Private Health Provider	2	0.4
Registration Board	57	11.4
Total	**501**	**100**

Reports requested for complaints referred to another body or person for action 1998-99

Body report requested from	No.	%
AHS/District	190	63.5
Director General	23	7.7
Other Body	43	14.4
Comm'th Govt Dept	1	0.3
State Govt Dept	8	2.7
Private Health Facility	10	3.3
Private Health Provider	1	0.3
Registration Board	23	7.7
Total	**299**	**100**

Commission action on receipt of investigation reports by another body 1998-99

Action	No.	%
Conciliation	1	0.7
No further action	138	92.6
Refer to another body	3	2.0
Refer for direct resolution	1	0.7
Reopen for investigation	4	2.7
To remain closed	2	1.3
Total	**149**	**100**

Case study - Management of chronic respiratory illness

Ms Y complained about the management of the final stages of her father's chronic respiratory illness by a rural district public hospital. Her father had a long-standing history of worsening respiratory illness including emphysema and tuberculosis and had been recently admitted to the district hospital in severe respiratory distress. The patient's condition did not improve and he was transferred to the nearest base hospital eight days later. Intensive care interventions at the hospital had limited effect and following a degree of symptomatic relief, the patient was transferred back to the district hospital four days later. He remained at the district hospital until his death three months later.

Ms Y raised a number of concerns in relation to her father's initial treatment during his first admission to the district hospital. Ms Y claimed that particular examinations and tests were not performed, acute interventions not executed, and that nursing care was inadequate. Several issues related to the care provided by the admitting medical officer to her father including inappropriate clinical management and insensitive communication.

Following pre-assessment inquiries which included obtaining a detailed report from the admitting doctor and copies of the relevant medical records, the Commission decided there were no issues which warranted investigation by the Commission itself but there were issues appropriate for investigation by the AHS. The Commission referred the complaint to the responsible Area Health Service for investigation and asked it to report back to the Commission on its findings.

The AHS advised the Commission about the treatment decisions made for Ms Y's father and clarified some issues raised by the complainant regarding her father's progress. The report confirmed that the complainant's father was critically ill upon initial admission, that he was aware he was suffering end-stage chronic respiratory disease and that he and his doctor had agreed he would receive palliative care management only. This fact was not previously known by the complainant. The hospital responded to the complaint by meeting with the complainant to resolve the issues directly, to provide an apology for any inappropriate or inadequate communication by hospital staff, and to instigate specific programmes at the district hospital aimed at improved nurse education and overall clinical competency.

The matter was reviewed by one of the Commission's Senior Investigation Officers. The complainant advised the Commission that they were satisfied with the process and the outcome. The Commission decided no further action was warranted.

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. Before referring the complaint to the Registry, the Commission must obtain the consents of the parties to attempt conciliation. Participation in the conciliation process is voluntary.

A complaint may 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 1998-99, 146 complaints were assessed for conciliation. This number is lower than the

previous year. The Commission has identified the types of complaints that may be suitable for conciliation and these will shortly be published in the Commission's brochure on conciliation. This work will be the basis of the conciliation assessment protocol recommended by the Health Care Complaints Act Review Committee in its final report.

The percentage drop in the numbers of complaints assessed for conciliation reflects the size of the percentage increase in the number of complaints assessed for direct resolution between the parties with the assistance of the Patient Support Office. The flexibility and less formal approach taken by the Patient Support Office makes direct resolution a more suitable method of handling a wide range of complaints. Complainants often feel more comfortable having an officer of the Commission involved in the resolution of issues. Fewer complainants seek a review of the direct resolution assessment than they do for complaints assessed for conciliation. Respondents are also more successfully engaged. The effectiveness of the Patient Support Office has lessened the need for the formal, structured, statutorily based approach to dispute resolution offered by the Registry.

Number of complaints received in 1998-99 and assessed for conciliation

Category	No.	%
Business Practices	4	2.7
Clinical Standards	121	82.9
Patient Rights	5	3.4
Prescribing Drugs	2	1.4
Provider-Patient/ Client Relationship	5	3.4
Quality Of Care	9	6.2
Total	**146**	**100**

While the Health Conciliation Registry is independent from the Commission, the Health Care Complaints Act 1993 requires the Commission to report in its Annual Report on the outcome of complaints referred to the Health Conciliation Registry. The report on conciliation outcomes provided to the Commission by the Health Conciliation Registry only 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. The Health Conciliation Registry provided the Commission with 46 reports on the outcome of complaints conciliated during the 1998-99 period: 3 conciliations were cancelled, 41 parties reached agreement, and 2 did not reach agreement.

Outcome of complaints received and referred to HCR in 1998-99

Conciliation Result	No.	%
Conciliation cancelled	3	2.0
Terminated: Agreement reached	41	28.0
Terminated: No Agreement reached	2	1.4
Consents not yet obtained or agreement not yet finalised as at 30.6.99	100	68.5
Total	**146**	**100**

In 1998-99 63 or 43% of complaints originally assessed for conciliation were not referred to the Health Conciliation Registry because one or both the parties failed to consent for the complaint to be referred. The Final Report by the Health Care Complaints Act Review Committee found that parties were refusing consent in 50% of complaints. While the Commission assessed fewer complaints for conciliation, it has referred a greater proportion of those complaints than previous years. The Commission expends considerable resources in trying to persuade the parties to attend conciliation.

Complaints where parties failed to consent were reassessed by the Commission and the outcome of the reassessment is contained in the table below. In these circumstances additional information may be available to the Commission either from the complainant or the respondent.

Complaints not proceeding to conciliation and reassessed to another level

Assessment decision	No.	%
Discontinue dealing with	28	44.4
Refer to another body or person	6	9.5
Refer back to conciliation	1	1.6
Refer for investigation	5	7.9
Refer for direct resolution	23	36.5
Total	**63**	**100**

Complainants refuse to consent to conciliation for a number of reasons. Some have very strong views that their complaints raise serious issues which should be investigated or that the health practitioner will not tell the truth and an investigation by an independent body is the only means by which the facts can be established.

Health practitioners may refuse consent for conciliation because the issues raised have been or are subject to legal proceedings. They may also refuse because they will not get paid for attendance or because they place no importance on obtaining consumer feedback about their service or resolving issues. About equal numbers of complainants and respondents refuse to consent to conciliation.

The Health Conciliation Registry reports on conciliation outcomes indicate that 90% of conciliations conducted in 1998-99 and reported to the Commission resulted in agreement being reached. The high rate of agreement reflects the fact that only parties who want to resolve issues and can see benefit in discussing the issues consent to conciliation and are referred to the Health Conciliation Registry.

Future Plans to improve conciliation

The Commission has redrafted its Complaint Process brochure which sets out in detail how the Commission makes assessment decisions. The Commission has also prepared a detailed brochure on the conciliation process. These brochures are presently being printed. The parties to complaints will be provided with this material next financial year and it is anticipated this may lead to better understanding of the Commission's assessment decisions.

Complainants and respondents continue to lodge complaints with the Commission about the HCR even though the Commission has no administrative responsibility for that body. Despite the legislative provisions which separate the conciliation function from the Commission, parties to a complaint perceive the Commission to be responsible for the function. The separation of the function from the Commission creates confusion for the parties and unnecessary administrative duplication. The Commission has brought these issues to the attention of the Department of Health and has requested the Health Conciliation Registry make its independence from the Commission and its complaint handling procedures more transparent to consumers of its services. The Commission has reviewed its own brochure on conciliation which will include information on how to make a complaint about the HCR.

The Commission made submissions to the Health Care Complaints Act Review Committee about the conciliation function. The Final Report of that Committee recommended the Health Conciliation Registry take on the administrative responsibility of obtaining consents and that attendance by respondents be made mandatory.

The Commission will be involved in training Registry conciliators next financial year on the role of the Commission and the nature of public health and safety issues to ensure appropriate matters are referred back to the Commission.

Case study - Treatment of acute encephalitis

Mr and Mrs B complained to the Commission about various aspects of their son's care. He was admitted to a metropolitan teaching hospital following acute encephalitis associated with an infection and later died. They complained about poor and insensitive communication from the boy's attending practitioners. The parents also raised a number of particular questions in relation to the admitting practitioner's clinical management decisions.

Upon complaint assessment, which included examination of correspondence which had already passed between the parents and hospital

management, it was apparent the parents had not been adequately informed about their son's progress and certain decisions made by his doctors. There was no evidence, based on the information supplied by the complainants, that the standard of care was unacceptable. Clinical advice obtained by the Commission as part of the pre-assessment inquiries confirmed that the infection was an acute and physiologically devastating infection which was difficult to treat effectively. The Commission came to the view that the parents' many questions warranted the concerted attention of the clinicians involved in the boy's care, notwithstanding the hospital's attempts to address the issues raised by the parents.

A conciliation meeting was arranged with the parties including the senior clinicians who attended the boy, the hospital's Director of Clinical Services, and the parents. A conciliator from the Health Conciliation Registry facilitated the meeting which according to the registry resulted in agreement being reached between the parties.

Refer for 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. Many complaints however, if investigated by the Commission, would not assist the Commission to achieve its purpose of maintaining health standards in New South Wales. These complaints typically include complaints about access to medical records, rude or insensitive communication and unresponsive staff.

One positive way of dealing with a complaint that does not warrant investigation by the Commission itself or conciliation through the Health Conciliation Registry, is by direct or assisted resolution. The Commission therefore assists in the resolution of issues where otherwise no service would be provided.

These matters usually do not require the formal structured approach of conciliation. They include 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. Complaints of this nature are referred to the Commission's Patient Support Office.

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 will arrange for a Patient Support Officer to contact both parties and assist them in resolving the issues. The Commission's involvement in these complaints provides an important avenue for educating consumers about their health rights and 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 to deal with similar situations or to prevent further complaints.

Category of complaints assessed for Direct Resolution 1998-99

Category	No.	%
Clinical Standards	259	67.3
Fraud	1	0.3
Other Ethical Improper Conduct	3	0.8
Provider-Patient/ Client Relationship	5	1.3
Patient Rights	31	8.1
Prescribing Drugs	13	3.4
Quality Of Care	47	12.0
Business Practices	26	6.8
Total	**385**	**100**

Case study - Changes to mental health services

A consumer of mental health services in rural NSW complained to the Commission about the changes made to the services in her area. She had general concerns regarding perceived reduced access to services, but particularly regarding specific management decisions made by the mental health practitioners directly involved in her care.

It was apparent upon assessment there were no issues which warranted investigation or

conciliation, and consideration was given to the available appropriate means of resolving the complainant's concerns. It was decided to refer the matter for direct resolution between the complainant and the Area mental health service, primarily because the complainant needed to maintain an effective, ongoing therapeutic relationship with the service. The Commission invited the complainant to utilise the Commission's Patient Support Office to assist her resolve her issues with the service.

Refer a complaint for investigation

In 1998-99, the Commission assessed 459 complaints as suitable for investigation by the Commission. Complaints assessed for investigation are listed below by category:

Category of Complaints assessed for investigation 1998-99

Category	No.	%
Clinical Standards	220	48.0
Fraud	15	3.3
Other Ethical Improper Conduct	16	3.5
Miscellaneous	1	0.2
Re-registration	2	0.4
Provider-Patient/ Client Relationship	88	19.2
Patient Rights	5	1.1
Prescribing Drugs	40	8.7
Quality Of Care	41	8.9
Business Practices	6	1.3
Impairment	19	4.1
Character	6	1.3
Total	**459**	**100**

A more detailed report on investigations and their outcomes is covered in the *Division of Investigations and Prosecutions* report.

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 and take disciplinary or other action against the respondent.

In 1998-99, the Commission reviewed 127 assessment decisions and the outcomes of these reviews are provided in the table below:

Outcome	No.
Conciliation offered	12
Direct resolution	16
Referred to another body	14
Remained closed after further information	74
Remained closed resolved	8
Opened for investigation	3
Total	**127**

Independent Complaints Review Committee

The Independent Complaints Review Committee (ICRC) was set up to review complaints where a complainant remains dissatisfied with the Commission assessment decision after the review process. The ICRC met twice in 1998-99 to review 4 cases in which the complainant requested such a review.

The Committee recommended:

1. two files to remain closed
2. one file to be reopened and the respondent referred to the Medical Board
3. the Commission ensure the recommendations made to the College are implemented. (The Commission has no power to require this).

Complainant Profile

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

In 1998-99, 1600 forms were sent to complainants. 1400 forms were completed and returned. Not all questions in the form were answered by the complainants. Following are the results obtained from the survey.

Sex

Sex	**%**
Female	61%
Male	35%
Multiple complainants	4%

Language spoken at home

Language	**%**
English	97%
Other than English	3%

Country of Birth

Country	**%**
Australia	76.0
England	4.6
Lebanon	1.5
Hungary	1.3
Philippines	1.1
China	1.1
Italy	1.1
Greece	0.9
India	0.7
USA	0.7
South Africa	0.7
Argentina	0.7
Netherlands	0.7
Other	8.8
Total	**100**

Other

Aboriginal & Torres Straight Islander	1.5%
People requiring an interpreter	0.9%
People with a disability	22%

Patient Support Office

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

- promote and protect the rights of health consumers;
- facilitate 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.

The PSO has seven officers located in Sydney metropolitan area health services and the Hunter area. There are officers at Liverpool, Penrith, Mt Druitt, Zetland, St Leonards, Balmain and Newcastle. An additional officer provides a service to rural areas.

Patient Support Officers (PSOs) assist health consumers resolve concerns by facilitating self advocacy or through negotiation and discussion with health service providers. PSOs operate from a model which empowers people to resolve their own concerns with the assistance of a support person who has a detailed knowledge of the health system, access to information on a variety of services and training in assisting people to clarify their concerns and identify means to resolve them.

Most health consumers respond positively to the PSO. Consumers value help that is independent of the health system and encouragement when trying to make a complaint or provide constructive feedback to health services. Some PSO clients want the PSO to ‘fix the problem’ without the client’s involvement or think local resolution is a lesser option than an investigation by the Commission. Once an explanation of the service is provided and they experience a positive response to their concerns, the majority of clients are pleased with the service and the outcomes they achieve.

PSOs have over two years experience in advocating with and on behalf of health consumers. Their experience, flexibility, skills and positive attitude have contributed to the outcomes noted in this report.

Why do health consumers contact the PSO?

People contact the PSO with a variety of concerns such as delays in diagnosis or treatment, inadequate treatment, poor facilities, communication issues, medication, access to medical records, inappropriate discharge, billing practices and privacy. Most people want to find out what they can do to improve their current health services or prevent other patients from experiencing the same problems.

Many people comment on the difficulties they experience when making a complaint to health services. They are unsure about what to expect from a health provider or health facility when they make a complaint. Consumers ask questions about how to complain or when they want to speak with someone about their concerns. Many consumers have already experienced a negative response from health services to their issues before the involvement of the PSO.

Promoting the Service

Public hospitals and community health facilities are prime sites for the display of PSO brochures and posters. Health consumers need to know about the service and how to access it. The Commission has taken many steps to ensure the material is on display, but unfortunately with limited success. Some health services do not support nor promote the existence of complaint mechanisms and external advocacy services.

Divisions of General Practice have been approached to include information on the PSO in newsletters and encourage general practitioners to display PSO promotional material. Again the response has been variable.

Each PSO has developed a promotions plan for their area including targets for distribution of posters and brochures, presentations, networking and attending information days. The plan was designed to ensure different groups in the community had access to information about the service.

Inmate Patient Support Service

The Commission identified the NSW Correctional Centres population as a community group that experience difficulty accessing information on the role of the Commission, lodging complaints or successfully resolving complaints at the local level. As a result, patient support officers have been allocated to three Correctional Centres to promote the service, help health staff to maximise effective local resolution of concerns and to support inmates to resolve their concerns and to take a positive and active role in their health care. PSOs visit other metropolitan Centres in response to requests by inmates or their advocates.

The PSO have has encountered a number of difficulties including accessing inmates and some health service providers at the prison facility. The Corrections Health Service has been supportive of the program and its aims.

Presentations

PSOs conducted 97 presentations during the year, 64 to consumers and 33 to provider groups. Topics at presentations include; the role of the PSO, patient rights and responsibilities, local resolution of concerns and reducing client dissatisfaction with health services.

Approximately 3382 people attended PSO presentations. Most presentations were to small to medium sized groups. PSOs conducted fewer presentations this financial year than last year. Time available for presentations was reduced due to the increase in client numbers and service delivery demands.

Presentations are useful for PSOs to meet with different community groups and learn about their particular needs or experiences of the health system.

Relationship with health facilities/ providers

Patient support officers do not seek to duplicate existing services. Clients are referred to hospital patient representatives, (where they exist). They are advised to recontact the PSO if they are unhappy with the outcome. Clients sometimes decline a referral to hospital patient representatives as they believe a patient representative cannot represent the interests of both the client and hospital.

Once the PSO role is explained, most service providers are comfortable with PSO involvement in the resolution process. Some hospitals invite PSO involvement when they have already attempted resolution. As providers learn about the PSO and experience the resolution process, understanding and confidence increases.

Relationship with Area Health Services

The Commission acknowledges the valuable support of the PSO program by Area Health Services. Areas provide office space and support. They also assist when facilities resist local resolution.

Reports were provided to individual Area Health Services in metropolitan Sydney and the Hunter. They provided information on the concerns raised by PSO clients, relationship with the AHS, issues arising from client concerns, display of PSO material and identified problems.

Evaluation of the Patient Support Office

An evaluation of the PSO was commissioned to examine the service and to identify aspects for improvement. The Evaluation was provided during May 1999.

The Evaluation found:

- Promotional strategies were impressive in reach and diverse in tactics. Some confusion remained about the role of the PSO and some service providers had negative perceptions of PSO posters and brochures.
- Informality and friendliness of the PSO contributed to its accessibility to clients and service providers. Access was usually by telephone. The Report recommended a review of PSO communication systems to ensure they are responsive and reliable.
- The PSO is perceived by service providers and clients as informal, non bureaucratic, locally based and able to facilitate quick resolution of clients' health concerns.

Client feedback to the PSO indicates high levels of client satisfaction.

- The PSO client/services information system requires upgrading and conversion from a manual to an electronic system.
- Location of PSOs in area health service facilities was the most appropriate practical option given most clients access the PSO by telephone, service visibility is determined by promotional activities and the cost of alternative sites.
- The anticipated overlap between the roles of patient representatives in public hospitals and PSOs has not eventuated given the PSOs role as an independent advocate and an independent source of support for clients with concerns about health services. The Report recommended closer liaison and improved working relationships between the two groups.
- PSOs energy and enthusiasm for their work is high.

One of the concerns raised by the Evaluation, the manual collation of activity data, has been partially addressed by the development of a database to record and analyse client services information. Further action is planned to respond to the evaluation.

PSO service provision

PSOs provided a service to 2842 people with health concerns this financial year (this figure also includes clients who have contacted the PSO more than once about different issues). This represents a 34% increase compared with the previous year. About 40% of clients were provided with information to assist them obtain health or community services, exercise their health rights, find out how to contact consumer support groups, or who to talk to about a health issue. The majority of clients (60%) were provided with assisted advocacy services such as assistance with writing a letter, arranging and or attending resolution meetings, locating health services that address the client's needs and other means of facilitating local resolution.

The provision of information may be a simple matter of looking up a community directory or it may involve research involving other organisations. Assisted advocacy may involve a number of meetings or discussions with the client to clarify issues and desired outcomes and work with both parties to prepare for resolution meetings. Should the client decide to write to a provider or health organisation the PSO may be involved in reviewing the response with the client and assist with any required follow up.

Data collected from the satisfaction survey shows that 34% of clients had one or two contacts with the PSO with 45% having three to five contacts and 21% had more than five contacts.

Outcomes

The various outcomes of PSO support are noted in the Table *PSO Service Outcomes*. Of the issues that were the subject of PSO involvement 71% were resolved, 15% partially resolved, 10% not resolved and 4% unable to be resolved.

A relatively small percentage of concerns were not resolved for a range of reasons including the refusal of the health provider to engage in local resolution, client expectations were unrealistic, 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 or disposed of medical records or reports, the age of the event presented difficulties in locating health providers, the client unwilling to pursue after the resolution process commenced or information relating to a third party could not be obtained.

Client satisfaction

The PSO routinely seeks client feedback during and after the service. The following information comes from Satisfaction Surveys and letters from PSO clients.

Results of satisfaction survey

The Commission received 160 completed surveys from a total of 864 surveys issued (18.5% response rate). Key results include:

- 95% thought PSOs were sensitive to their concerns.
- 95% found PSOs were prompt in returning their calls
- 85% were satisfied with the service they received.
- 74% of concerns were partially or totally resolved.

- 91% would use the PSO service again

About 9% of respondents expressed dissatisfaction with the service they received and 9% had problems contacting a PSO. Generally they did not like leaving messages on voicemail despite most people noting their calls were promptly returned. Respondents who noted on the questionnaire that they were dissatisfied with the service said they were dissatisfied with the outcome rather than the service. In some instances the client's desired outcome cannot be achieved through advocacy.

The results obtained for this financial year were similar to those for 1997/98.

Service improvement suggestions

- Better communication between support officers eg when permanent PSO on annual leave.
- Throw away the answering machine - delay in answering calls and providing information.
- Quicker response to complaints is required.
- Provide further information on why it may take time to resolve a problem.
- I did not know about this service, maybe you should somehow let the public know you are there for them.
- PSO must have more power. At the moment the PSO is very limited.
- Follow up from the PSO to see if the issue was resolved.
- More PSOs would benefit families and individuals trying to improve access to services.

Action taken as a result of client feedback

- Continue efforts to ensure PSO promotional material is displayed in health service facilities. Continue presentations next financial year despite increased level of client contact.
- Clients are encouraged to re-contact the PSO if they have not resolved their concerns. Some clients are followed up to see if they require additional assistance.
- Clients are provided with sources of health related information.
- Most PSOs have a second telephone line to improve access to voicemail. Concerns with access to PSOs is monitored through feedback from satisfaction surveys.
- Mechanisms are in place to share peak workloads between team members to reduce time taken to return calls.

Case study - Man needing a knee operation

Mr A contacted the PSO seeking help. He informed the PSO that he had sustained a knee injury and had been on his orthopaedic surgeon's list for nine years. After he was scheduled for operation, it was cancelled twice. When the operation was carried out by the registrar under the supervision of the consultant, it was not successful and he was re-booked for a second operation. Mr A had contacted the PSO after this operation had been cancelled on two occasions.

The PSO sought permission from Mr A to talk to the admissions department of the hospital and the orthopaedic surgeon concerned. The admission's department confirmed his story and advised the PSO that, according to the health department's guidelines, the surgeon could cancel the man's operation for a third time, before they were obliged to re-prioritise him as an emergency. The PSO then rang the surgeon on behalf of Mr A and asked the surgeon why the operation had been delayed. Initially, the surgeon was quite hostile to the PSO's enquiry but later could understand the situation from Mr A's point of view.

The surgeon explained that he only had one day a week operating rights at the hospital, that he was not a knee specialist, and that the type of orthopaedic work he did often warranted him scheduling patients for emergency orthopaedic work which took precedence over his elective surgery. The PSO then asked the surgeon to consider re-prioritising the client, which he refused. The information was relayed back to the client, who, while understanding the surgeon's position, became even more despondent. The PSO discussed other options with Mr A including: waiting until this surgeon could operate; go to another surgeon and face an even longer wait; or consider going private. This the

client could not afford to do. While Mr A considered his options, the PSO rang the medical superintendent, informed him of Mr A's circumstances and sought his help in facilitating the client's operation.

Following the medical superintendent's intervention, the PSO received a call from Mr A two days later to say that he had been called into the hospital and that the consultant had performed his operation.

Case study - Inappropriate examination

A young woman made a formal complaint to the Commission, following, what she perceived to be, an inappropriate examination by a specialist. She had gone to see a doctor at a general practice with a rash on her body. During the consultation, she lifted her shirt to show the doctor the rash. He asked her if she had a rash any where else on her body to which she said no. In the process of examining her the doctor lifted her bra and pulled her trousers and underpants slightly down.

The Commission decided that the complaint did not warrant formal investigation and referred the complaint for direct resolution with the PSO.

On receipt of the referral from the Commission, the PSO rang the client to talk about the Commission's assessment decision, the role of the PSO, and made arrangements to meet.

At the interview, the PSO discussed the contents of the letter the client wanted to write to the doctor, asked her to symbolically demonstrate what the doctor had done. The client demonstrated to the PSO what the doctor had done and was able to identify and explore how she felt. She identified that she had felt extremely unsafe and had been fearful of what the doctor might have done. She was able to discuss with the PSO the issues that this incident raised for her and potentially for other young women seeking medical care.

The PSO discussed her options for resolution and the arrangement was made that the PSO would speak to the doctor on her behalf. The next day the PSO rang the doctor, who by this time had received a copy of the complaint from the Commission. He seemed genuinely upset by the complaint, by the contents of the letter and the feelings it had evoked.

He explained that he had several young patients die of melanoma recently and that he had become extra careful about checking for abnormal lesions. It was clear that the doctor fully understood how the client had felt and commented that he had teenage daughters of his own and that he would not have wanted them to have been in the same position. The doctor advised the PSO he would change his clinical practice, undertaking to have a nurse present during consultations with female patients.

The feedback was given to the client who accepted the explanation, was glad the doctor was going to change his clinical practice and believed the whole exercise had been worthwhile.

Case study - Enhanced services for people with disabilities

Parents of an adult with significant physical and intellectual disabilities complained to the Commission that their son received inadequate care during several hospitalisations. The patient developed complications to an invasive investigation and experienced considerable pain and distress. Nursing and medical staff did not anticipate complications after the procedure and were not able to interpret the patient's signs of distress. The patient's parents agreed to help care for their son whilst he was in hospital. Initially it was expected that he would be in hospital for several days. Due to the complications he was in hospital for several weeks. His parents felt they were expected to keep up the level of support they provided to their son throughout his hospitalisation. They were exhausted and felt used by the hospital.

The patient was fearful of returning to the hospital and his parents could not trust the hospital to care for their son. Consequently, his parents had to drive over 100 kilometres from their home to access alternative health services.

The complaint was referred to the hospital management for investigation with a request to report back to the Commission. The hospital made several inadequate reports to the Commission as they did not identify the issues nor propose adequate remedial action.

The Patient Support Office was requested to assist the hospital and complainant to identify a

way forward. The patient support officer (PSO) and complainant clarified the main issues as inadequate pre-admission assessment, shared care arrangements, staff competency in caring for people with significant disabilities and poor recognition of post operative pain.

Senior hospital managers met with the PSO and accepted there was room for improvement in the identified areas. The hospital agreed to form a working group comprising the complainant, hospital representatives and a person with expertise in the provision of health services to people with disabilities to develop new approaches, policies and procedures. The PSO provided the hospital with preadmission forms and policies used by other facilities. The hospital drafted new policies and assessment forms which supported quality service provision to people with disabilities.

The complainant was pleased that consumer feedback had led to positive action and was looking forward to improving services via membership on the working group. The actions of the hospital have regained the parents' trust and the patient has commenced using local health services once more.

Positive Comment

- For my particular need, it could not have been improved. Excellent help at a most distressing time. The support officer was able to present a very balanced view of the concern discussed.
- Your telephone recording system was the best that I have experienced. I could even contact your office during the night or at any time of the day. I always got a helpful and quick response. No time was wasted.
- The PSO went about his business very quietly and efficiently. The PSO service is very much needed. I would use it again.
- I had the best representation. It couldn't be better. I must add that if your services were not available we would be very down trodden.
- She was helpful and non judgmental. Without her support I may have given up. She went out of her way to help me - a very valued service.
- He mediated very well. I got an outcome that is better than I expected, an explanation and an apology.
- I think this service is vital in saving the health system thousands of dollars in litigation - for some the only other avenue to resolve problems.

PSO Client Survey Results

Client Characteristics	No	%
Child (0-12)	149	5.24
Youth (12-18)	51	1.79
Aged (70+)	520	18.30
Unemployed	14	0.49
NESB	284	9.99
Aboriginal/ Torres Strait Islander	23	0.81
Mental Illness*	320	11.26
Drug/Alcohol*	49	1.72
Methadone*	83	2.92
Physical Disability*	182	6.40
Developmental Disability*	36	1.27
None of the above	1131	39.80
Total	**2,842**	**100**

* clients identified themselves as being in these categories

Type of Service	No	%
Assisted Advocacy (AA)	1719	60.49
Information Only (IO)	1123	39.51
Total:	**2,842**	**100**

Knowledge of Service*	No	%
PSO Promotions	225	7.92
Used PSO service previously/ Word of mouth	286	10.06
HCCC	1594	56.09
Health Provider/Facility	141	4.96
Consumer/Community Organisation	104	3.66
Member of Parliament	32	1.13
Government Body	44	1.55
Directories	51	1.79
Other/Not noted	365	12.84
Total	**2,842**	**100**

* ie where people obtained information on the PSO

PSO Service Details

Type of concern raised by PSO clients	No	%
Clinical Standards	1739	38.68
Communication	751	16.70
Medical Records	45	1.00
Provider-Patient/ Client relationship	66	1.47
Patient Rights	229	5.09
Prescribing/Dispensing drugs	66	1.47
Quality of Care	926	20.60
Business Practices	208	4.63
Impairment	5	0.11
Fraud	4	0.09
Other unethical or improper conduct	26	0.58
Information only	297	6.61
Waiting List	44	0.98
Resources	29	0.65
Complaint Management	61	1.36
Total	**4,496**	**100**

PSO service outcomes	No	%
No contact or patient pursued without PSO involvement	332	11.95
Client pursued matter with another body/person	776	27.92
Resolved	1180	42.46
Incomplete resolution	247	8.89
Not Resolved	170	6.12
Unable to be resolved	74	2.66
Total*	**2,779**	**100**

*This total does not match the total number of concerns as outcome codes are not provided for information only inquiries.

Service concerns by Area Health Service & service sector

AHS	Public	Private	NGO	Other*	Total
Far West	6	3	0	1	10
Greater Murray	17	21	0	1	39
Macquarie	14	9	0	1	24
Mid North Coast	35	20	0	6	61
Mid Western	12	12	0	0	24
New England	14	16	1	3	34
Northern Rivers	21	23	0	3	47
Southern	26	21	0	3	50
Central Coast	45	43	1	3	92
Central Sydney	127	125	1	20	273
Hunter	113	82	1	6	202
Illawarra	35	32	1	3	71
Northern Sydney	180	206	15	15	416
South Western	199	130	7	16	352
Wentworth	53	45	1	2	101
Western Sydney	206	123	1	10	340
South Eastern Sydney	182	192	5	32	411
Interstate/Outer state	0	5	0	0	5
Corrections HS	45	0	0	2	47
Not known	64	71	1	107	243
Totals	**1,394**	**1,179**	**35**	**234**	**2,842**

* The 'other' column includes concerns about system wide issues, access to services that involve all sectors and matters that were not coded.

1. Public: all public health services including public hospitals, community health centres
2. Private: all private health services and non-government organisation's health services
3. NGO: Non Government Organisation

Presentations

Total Presentations given

Group	No
Consumers	64
Providers	33
Total	**97**

Target Groups

Target Group	Count	No Attending
Aged	29	1,404
Aged people with dementia	1	10
People with disability	5	171
General community	42	1,317
People with mental health	3	37
People from NESB	8	275
Women	9	169
Total	**97**	**3,383**

Division of Investigations & Prosecutions

The Commission's restructure established the Investigations and Prosecutions Division this financial year. A new position of Director, Investigations and Prosecutions was created with responsibility for the two areas. This position was filled in November 1998.

Strategic Initiatives

Reduction in Investigation Delays

The Commission has remained focused on producing quality investigations. In relation to timely investigations, the Commission has established target time frames which clearly identify for both staff and the parties to a complaint the Commission's time frame. All investigations are to be completed within 18 months. The investigation process includes identified stages or action steps and each action step has its own time frame. The implementation of target time frames is part of a program to develop an outcome oriented culture.

The Commission is seeking to enhance the current database to be a case management tool in addition to its present functions of record management and management information. Action steps and designated time frames will form the basis of the case management system. During the year the Commission developed a business case for this enhancement.

The Commission's Investigations Committee meets regularly to examine methods to reduce delays. The Committee is comprised of team managers, the Director of Investigations and Prosecutions and individual officers from each team. The Committee is one of the vehicles for continuous improvement. Its recent focus has been simplifying the investigative process and ensuring files are reviewed at key intervals. Matters which will not require further action by the Commission can be terminated promptly. Consideration is also being given to the format of the investigation report.

This year the Commission consolidated the capacity for more on-site investigations. On site investigations are suited to complaints where there are multiple complainants and witnesses to be interviewed about similar issues. As a result Commission officers have spent more time in the field.

This methodology enables the investigator to gain a full and detailed knowledge of the surrounding circumstances. The investigator can evaluate witnesses and evidence in a more effective way. It reduces the delays commonly associated with a postal box approach.

Impairment Officer

A number of the Registration Acts provide for processes which are not disciplinary in nature to deal with practitioners who suffer some form of impairment. The types of impairment vary widely but include addictions to particular drugs and physical and psychiatric disabilities. It is important complaints involving practitioners who may be impaired or complaints involving breaches of impairment conditions are dealt with expeditiously. The quarantining of these complaints and allocation to a specialist investigation officer has improved the efficiency of handling these complaints.

Hearing Officers

A significant number of the matters which proceed to a disciplinary hearing are heard by Professional Standards Committees. These Committees have power to caution or reprimand a practitioner and to impose conditions on future professional practice. They do not have power to suspend or de-register, that power being reserved for Tribunals.

The provisions of the Medical Practice Act and the Nurses Act prevent either the Commission or the respondents being legally represented at Professional Standards Committee hearings. Hearings are held in private. The Commission has two Hearing Officers who conduct matters before such Committees. A Hearing Officer is not an admitted Solicitor or Barrister.

Investigations

The Commission finalised 417 investigations in 1998-99 and decided 459 new complaints warranted investigation. While the Commission completed fewer investigations in 1998-99 than it did last year it improved the timeliness of investigations.

Time taken to investigate complaints closed in 1998-99 (in days)

	Facilities		Professions	
	1997-98	1998-99	1997-98	1998-99
Maximum time taken	1,479	1,380	1,597	1,435
Minimum time taken	85	16	19	16
Median time taken	690	701	686	604
Average time taken	755	732	701	631

The Commission's focus on outcomes and early review has led to an increase in the percentage of investigations terminated by the Commission. It has also increased the percentage of complaints identified as being suitable for referral to a Board or the Health Conciliation Registry as a ground of termination.

Outcome of all investigations completed 1996-1997 - 1998-99

Outcome	1997-98	%	1998-99	%
Substantiated	222	44.8	155	37.2
Partially Substantiated#	25	5.0	38	9.1
Not Substantiated	170	34.3	117	28.1
Referred to Medical Board*	9	1.8	22	5.3
Referred to Nurses Reg. Board	4	0.8	2	0.5
Referred to another body	2	0.4	5	1.2
Transferred to Conciliation Registry	N/A		2	0.5
Terminated on Complainant Request	N/A		1	0.2
Investigation not completed	64	12.9	N/A	
Terminated by Commission	N/A		75	18.0
Total	**496**	**100**	**417**	**100**

* e.g. complaints concerning practitioners who may be impaired, possible breach of Acts administered by the Board and letter conveying criticisms to practitioners. # Introduced the code 1 July 1997

Investigations finalised against facilities - 1998-99

Facility	No.	%
Public hospital - inpatients	29	49.2
Private hospital	11	18.6
Public hospital - outpatients	5	8.5
Medical centre - private	4	6.8
Men's health clinic	2	3.4
Dental surgery - private	1	1.7
Prison medical service	1	1.7
Pathology centres / labs	1	1.7
Day procedure centre	1	1.7
Public nursing home	1	1.7
Area health service	1	1.7
Women's health centre	1	1.7
Hostel - aged	1	1.7
Total	**59**	**100**

Outcome of investigations against facilities 1998-99

Investigation result	No.	%
Substantiated	19	32.2
Partially Substantiated	10	16.9
Not Substantiated	24	40.7
Terminated by Commission	6	10.2
Total	**59**	**100**

Investigations finalised against professions -1998-99

Profession	No.	%
Medical Practitioner	277	77.4
Nurse	34	9.5
Psychologist	12	3.4
Traditional Medicine Provider	4	1.1
Dental Technician/ Prosthetist	4	1.1
Chiropractor	4	1.1
Physiotherapist	3	0.8
Pharmacist	3	0.8
Osteopath	3	0.8
Struck off health practitioner	2	0.6
Dentist	1	0.3
Naturopath	1	0.3
Psychotherapist	1	0.3
Deregistered health practitioner	1	0.3
Other	8	2.2
Total	**358**	**100**

Outcome of investigations against professions

Investigation result	No.	%
Substantiated	136	38.0
Partially Substantiated	28	7.8
Not Substantiated	93	26.0
Referred to Medical Bd	22	6.1
Referred to Nurses Reg Bd	2	0.6
Referred to Other Body	5	1.4
Terminated by Commission	69	19.3
Terminated on Complainant Request	1	0.3
Transferred to Conciliation Registry	2	0.6
Total	**358**	**100**

Review of investigation outcomes

Section 41(3) of the Health Care Complaints Act 1993 entitles complainants to a review of Commission's decision about what action the Commission will take after an investigation. The investigation file is reviewed by an Investigation Team Manager or Legal Team Manager with no prior involvement in the investigation. In 1998-99, 23 reviews were completed by the Legal Team and 20 reviews were completed by the Investigations Teams. The outcomes are as follows:

No further action required	39
Reopened for investigation	4
Total	**43**

Case Study - Family practice not up to standard

Complaint

Dr X, is a GP with a family practice. The patient consulted Dr X at his surgery then sent a letter of complaint concerning Dr X to a Public Health Unit who referred the complaint to the Commission. The patient wished to remain anonymous. In view of the serious public health issues the complaint raised, it was agreed that the Director of the Public Health Unit would lodge a complaint by a statutory declaration with the Commission.

Some of the specific concerns included:

- Dettol stored in a drink container;
- drugs stored beyond their use-by date;
- paper sheets on an examination table not changed between patients;
- waiting patients left unattended in consulting/treatment rooms;
- prescription pad and medical certificate pad left unattended;
- doctor did not wash his hands following an examination; and
- no sinks in consulting/treatment rooms.

Investigation

Commission staff visited Dr X at his surgery and with his consent inspected the premises. During the inspection it was discovered that:

- Dr X did not have:
  - a sink in any of the three rooms where patients were seen
  - any Adrenaline in his surgery to treat heart attack.
- Patients sometimes had unsupervised access to Dr X's:
  - medical bag containing injectable narcotics
  - prescription pads

Outcome

The Commission recommended counselling by the NSW Medical Board in relation to:

(a) infection control and hand washing; and

(b) risks of unsupervised patient access to consulting/treatment rooms.

The Commission also requested an on-site visit by the Public Health Unit to advise Dr X on Department of Health guidelines for infection control and to check that he had taken the appropriate steps to protect public health.

The Medical Board accepted the recommendation and the counselling occurred. A report was provided to the Commission.

Case study - Failure to detect breast lump

Complaint

Ms A visited a general practitioner, Dr B, because she had lumps in her breasts. She had a mammogram the same day at an Imaging Centre. A few days later she was recalled and told that "all the ladies that were taken on that particular day had the same markings on their films". She was asked to return to have another series of mammograms. Ms A had a second series of mammograms. A report was provided by Dr B which did not refer to any abnormalities. Over one year later Ms A saw a general practitioner for a Pap smear test. The general practitioner also asked if her breasts had been checked recently. Ms A told her about the mammograms. On examination the general practitioner felt a lump in the left breast and arranged a follow up appointment at a breast Clinic. Ms A took the mammograms from the previous year with her to the appointment and stated that she was told that there was "quite evident calcification" in the

these films not reported by Dr B. A further series of mammograms and ultrasound were undertaken and Ms A subsequently had a lumpectomy and removal of 24 lymph nodes in that year.

Investigation

The matter was assessed for investigation. Reports were obtained and the matter was sent for external review by an independent radiologist whose expertise is in mammography. The reviewer was mildly critical in relation to the fact that the pathology in the left breast was "missed" as it was not noted in the pathology report. In relation to the performance of the mammographic study on Ms A, the reviewer was moderately critical.

The complaint outcome was referred to the NSW Medical Board for counselling pursuant to s50(1) of the Medical Practice Act 1992. The purpose of counselling was primarily to remind Dr B of the standard for adequate examination of mammographic films. The objectives of counselling for Dr B were:

- to explore his failure to adequately report on the pathology in Ms A's left breast, evident in the mammogram films;
- to explore his failure in relation to the reporting of the mammographic study on Ms A and its "unassessed complete repeat study";
- to state the appropriate methods for mammographic examination;
- to acknowledge that he departed from an adequate standard of care by failing to perform an adequate mammographic examination for Ms A; and
- to identify procedures required to ensure an adequate standard of reporting in casual/locum circumstances.

Case study - Inadequate examination

Complaint

Ms A, aged over 70 years, made a complaint about her treatment by her regular general practitioner when she complained of thirst, dry mouth and increased frequency of urination. Ms A thought she might have diabetes and asked the doctor to assess her for this.

Ms A said that the general practitioner did not examine her or perform any tests and advised her to suck lemon drops for her dry mouth. The general practitioner thought the symptoms of a dry mouth were related to another medical condition.

One week later, Ms A consulted another general practitioner who performed a capillary blood glucose assessment and the blood sugar was found to be exceptionally high at 30. The normal range is below 8.

Ms A was admitted to hospital and commenced on insulin treatment.

Investigation

As part of the investigation by the Commission, the general practitioner provided a report and agreed with Ms A's recollection of the facts. The general practitioner did not have a glucometer at the time to measure capillary blood sugar and agreed she did not recognise the symptoms as arising from diabetes.

The Commission found the complaint substantiated and referred the matter to the NSW Medical Board with a recommendation that counselling occur.

The Doctor was counselled by the NSW Medical Board and the panel noted the poor management of Ms A and the doctor's poor record of care of the patient in general.

Prosecutions

At the conclusion of an investigation of a complaint against a health practitioner, the Commission may decide after consultation with the appropriate registration authority, to prosecute the complaint as a complainant before a disciplinary body. Prior to making this decision the Commission informs the practitioner of the substance of the grounds for its proposed action and gives the practitioner an opportunity to make submissions.

The Commission prosecuted 28 health care providers before Professional Standards Committees and a further 33 practitioners before Tribunals or appellate Courts.

During the course of the year there has been a growing number of matters in which the Commission has been subpoenaed to produce documents from its investigative or prosecution files. The identification and evaluation of material sought by subpoena and subsequent appearances and argument is starting to absorb an increasing about of legal officer time. The extent of information sought has also been growing.

Substantiated Investigations referred for disciplinary action in 1998-99

Body Referred To	**No.**
Chiropractors & Osteopaths Board	2
Dental Technicians Registration Board	1
Medical Board (counselling)	27
Medical PSC	29
Medical Tribunal	36
Nurses PSC	7
Nurses Registration Board	2
Nurses Tribunal	2
Psychologists PSC	7
Total	**113**

PSC = Professional Standards Committee

Once a complaint is referred to a disciplinary body following consultation it often takes a number of months for an inquiry to be held and a decision made. At any one time there are a number of inquiries listed for hearing or part heard.

Orders were made by disciplinary bodies in 59 matters, including re-registration applications. This figure is similar to the 57 complaints finalised by disciplinary bodies last year. The outcomes of these matters are reported in the following table.

In 1998-99, seven appeals in various jurisdictions were finalised. This is consistent with the number of appeals (8) finalised last year.

Outcome of Disciplinary Action Taken 1998-99 DOCTORS

Type of Complaint	Outcome	Orders
Medical Board Inquiry		
Reregistration Application	Reregistered	
Reregistration Application	Inquiry not held	Withdrawn by doctor
Medical Professional Standards Committee		
Unsatisfactory Conduct	Partially proved	De-registered
Unsatisfactory Conduct	Proved	Conditions on registration
Unsatisfactory Conduct	Proved	Caution or reprimand
Unsatisfactory Conduct	Proved	Conditions on registration
Unsatisfactory Conduct	Proved	Caution or reprimand
Unsatisfactory Conduct	Proved	Caution or reprimand
Unsatisfactory Conduct	Proved	De-registered
Unsatisfactory Conduct	Proved	Caution or reprimand
Unsatisfactory Conduct	Proved	Conditions on registration
Unsatisfactory Conduct	Inquiry not held	No orders
Unsatisfactory Conduct	Referred to Tribunal	Referred to Tribunal
Unsatisfactory Conduct	Not proved	Dismissed
Unsatisfactory Conduct	Not proved	Dismissed
Unsatisfactory Conduct	Proved	Caution or reprimand
Unsatisfactory Conduct	Proved	Educational courses ordered
Unsatisfactory Conduct	Not proved	Dismissed
Unsatisfactory Conduct	Not proved	Dismissed
Unsatisfactory Conduct	Proved	Conditions on registration
Unsatisfactory Conduct	Proved	Caution or reprimand
Unsatisfactory Conduct	Proved	Conditions on registration
Unsatisfactory Conduct	Proved	De-registered
Impairment	Proved	De-registered
Impairment	Proved	De-registered
Impairment	Proved	Referred to Tribunal
Professional Misconduct	Proved	Caution or reprimand
Medical Tribunal		
Professional Misconduct (Dr A Barich)	Proved	De-registered
Professional Misconduct (Dr N Pham)	Proved	Suspend registration
Professional Misconduct (Dr A Ivanov)	Proved	De-registered
Professional Misconduct (Dr M Thomas)	Partially proved	Reprimand & fine
Professional Misconduct (Dr K Pillai)	Proved	De-registered
Professional Misconduct (Dr R Richards)	Proved	De-registered
Professional Misconduct (Dr A Zahra-Newman)		Proved Not to be re-registered until conditions complied with
Professional Misconduct (Dr J Salama)	Proved	De-registered
Reregistration Application (Mr R Hampshire)	Restore Name	Re-registered
Professional Misconduct (Dr C Reitberger)	Not proved	Dismissed
Professional Misconduct (Dr M Wanigaratne)	Proved	De-registered
Professional Misconduct (Dr H Harper)	Proved	De-registered
Reregistration Application (Mr C Tsioutis)	Withdrawn	Dismissed
Reregistration Application (Mr W McBride)	Restore name	Re-register with conditions
Reregistration Application (Mr J Bannister)	Dismissed	Dismissed
Reregistration Application (Dr W Haddad)	Restore name	Re-register with conditions
Review Application (Dr R Hare)	Review upheld	Conditions lifted

Outcome of Disciplinary Action Taken 1998-99 NURSES

Type of Complaint		Outcome	Orders
Nurses Professional Standards Committee			
Professional Misconduct		Not proved	Dismissed
Unsatisfactory Conduct		Not proved	Dismissed
Nurses Tribunal			
Professional Misconduct	(Mr P Leckie)	Proved	Suspension & conditions
Professional Misconduct	(Mr S Lyons)	Proved	De-registered
Professional Misconduct	(Ms M Lecky-Thompson)	Proved	De-registered
Professional Misconduct	(Mr J de Leeuw)	Proved	De-registered
Professional Misconduct	(Ms D Cini)	Proved	De-registered
Professional Misconduct	(Mr A Alvandi)	Not proved	Dismissed
Professional Misconduct	(Mr S McKinley)	Proved	Reprimand & conditions
Impairment	(Name suppressed)	Proved	De-registered
Re-registration application	(Mr C Jacobsen)	Restore name	Re-register with conditions

Outcome of Disciplinary Action Taken 1998-99 OTHER

Type of Complaint	Outcome	Orders
Pharmacy Board		
Professional Misconduct	Proved	De-registered
Professional Misconduct	Proved	Reprimand and fine
Pharmacy Professional Standards Committee		
Professional Misconduct	Proved	Suspension, reprimand & conditions
Psychologists Professional Standards Committee		
Professional Misconduct	Proved	Reprimand
Professional Misconduct	Proved	De-registered
Professional Misconduct	Proved	Caution, conditions imposed

Appeals & Other Hearings

Type of Complaint	Outcome	Orders
Court of Appeal		
Appeal by appellant against Medical Tribunal refusing re-registration (Mr M Zaidi)	Dismissed	Dismissed
HCCC appeal against Medical Tribunal decision to suspend doctor (Dr N Pham)	Upheld	De-registered
District Court		
Appeal against de-registration by pharmacist (Mr H Beck)	Upheld	Suspended
Appeal against de-registration by psychologist (Mr S Woods)	Upheld	Reprimand
High Court		
Special leave application against Court of Appeal decision concerning refusal to re-register (Mr M Zaidi)	Refused	Refused
Supreme Court		
Appeal by Medical Practitioner against Medical Tribunal decision on Review Application (Dr R Gorman)	Dismissed	Dismissed
Summons to have PSC Inquiry held by Medical Tribunal or Supreme Court (Dr R Gorman)	Dismissed	Dismissed

Tribunal Cases

W G McBride - Review Application

In 1998 Mr McBride made a second review application seeking re-registration. The first application was dismissed by the Medical Tribunal in 1996.

On 9 November 1998 the Medical Tribunal made an order re-registering Mr McBride and imposed the following conditions on his practice of medicine:

- that he not undertake medical research;
- that he be subject to supervision for a period determined by the Medical Board; and
- that he not undertake surgery until he satisfies the Medical Board that he is competent to perform surgery.

Mr McBride was de-registered by the Medical Tribunal in 1993 when it found him to lack good character in relation to complaints concerning scientific fraud.

The review Tribunal noted that for an applicant to be successful, the determination by the Tribunal must be based upon a finding that the applicant has discharged the onus of proof on the balance of probabilities and that they are now a fit and proper person to practice medicine. Of fundamental significance in dealing with re-registration applications is the consideration of the public interest and protection of the public.

The Tribunal found that Mr McBride frankly admitted that it was his dishonesty that caused his de-registration and he therefore had insight into his misconduct. The Tribunal acknowledged that Mr McBride had been a gifted medical practitioner and because of that had made and could still make a significant contribution to the public of this state. It concluded that there was a public interest in him resuming practice because it was accepted that he now understands the reasons which lead to his de-registration in the first place and that he had come to terms with the fact that his position in the community arising out of the earlier dishonesty had changed from being a highly respected member of the community and a highly respected medical practitioner to something significantly less than that.

The Tribunal rejected the view that Mr McBride should be provided with an unrestricted licence in order to allow him to provide medical services to the American Samoan people. The Tribunal considered conditions should be placed on Mr McBride's practice given the fact he had been away from practice for such a significant period of time.

Dr H K Harper - Sexual Relationship

The Commission made a complaint against Dr Harper that he was guilty of professional misconduct and unsatisfactory professional conduct because he engaged in a personal and sexual relationship with a patient between 1994 and 1996 in circumstances where he was aware that the patient was having marital problems and suffered from a psychiatric illness.

The practitioner admitted the complaint and conceded that it was appropriate in the circumstances that a de-registration order be made. The practitioner did not give sworn evidence before the Tribunal and no explanation was given for not calling witnesses who could support the practitioner's contention that he was suffering from depression at the relevant time.

In making a de-registration order the Tribunal was conscious of the very serious nature of the proven misconduct, that any sexual relationship between a doctor and patient is forbidden, the culpability of the practitioner was aggravated by the facts that the relationship continued over a significant period of time and the practitioner was aware the patient was having marital problems and suffered from a psychiatric illness. The Tribunal noted the guiding principles concerning the duties and responsibilities of practitioners and the public expectation that they will maintain high standards and the need for good character as enunciated in Richter -v- Walton unreported Court of Appeal 15 July 1993 and HCCC -v- Litchfield, 1996 41 NSW LR 630.

Dr N G Pham - Drug Prescribing

Dr Pham was found guilty of professional misconduct by the Medical Tribunal on 21 August 1998 in relation to inappropriate and over-prescribing of drugs including drugs of addiction and androgenic/anabolic steroids. The prescribing occurred in a two year period between 1994 and 1996.

On 21 August 1998 the Tribunal found Dr Pham guilty of professional misconduct and ordered that he be suspended from practising medicine until January 1999. The Tribunal also ordered that he seek and undergo psychiatric treatment and/or counselling and also imposed conditions on his registration at the expiry of the suspension period.

The Commission appealed the Tribunal decision to the Court of Appeal concerning the inadequacy of the protective orders and sought an order removing the name of the practitioner from the medical register and costs.

The Court of Appeal upheld the appeal set aside the orders made by the Tribunal and instead ordered that Dr Pham's name be removed from the register and that he pay the Commission's costs for the proceedings in the Tribunal and of the appeal.

The Court held that the Tribunal's decision contained significant inconsistencies and the conclusion was unavoidable that the Tribunal was excessively influenced by the consequences of de-registration for Dr Pham and insufficiently attentive to the primary subject of its concern, the protection of the community. The Court stated that the seriousness of Dr Pham's misconduct and his gross abuse of his position as a medical practitioner was self-evident. Despite warning, he persisted in extremely unethical and illegal conduct over a considerable period. He was heedless of the consequences to the patients affected and was plainly motivated by greed. His false testimony to the Tribunal tended to suggest lack of remorse and gives no confidence that he will voluntarily behave properly in the future. The Court considered that no order other than de-registration was appropriate and that the orders made by the Tribunal were so unreasonable as to demonstrate error. The Court also held that the Tribunal's discretion plainly miscarried when it did not order Dr Pham to pay the Commission's costs.

M Lecky-Thompson - Homebirth Midwifery Practice

The Commission made six complaints against Ms M Lecky-Thompson concerning her conduct in relation to a number of homebirths. Ms Lecky-Thompson was a registered nurse and midwife with a homebirth practice.

The complaints alleged a number of matters including:

- failing to transfer women to hospital during labour within an appropriate period of time including where foetal heart sounds could not be heard and where there was prolonged post-partum haemorrhage;
- using a ventouse to assist in a delivery when it was inappropriate to do so;
- attempting to resuscitate a still born or a respiratory depressed child in a manner that was inappropriate and inadequate;
- failing to adequately assess the condition of a newly born respiratory depressed infant and failing to transfer the infant to hospital within an appropriate period of time;
- failing to provide adequate resuscitation to a mother suffering post-partum haemorrhage;
- altering records in a dishonest manner;
- lying to an obstetrician in the course of a planned home birth for twins;
- providing inadequate antenatal care in the presence of potential serious complications of pregnancy;
- providing inadequate advice to pregnant women of the risks of attending high risk births in a homebirth setting and failing to advise against a planned homebirth in such circumstances;
- undertaking homebirths in the presence of high risk complications without appropriate clinical assistance.

Evidence was presented in the Tribunal inquiry over a period of nine weeks in 1996 and 1997. Findings were made on 13 November 1998 and a written decision given on 7 December 1998. After evidence was taken in relation to protective orders, the Tribunal finalised the inquiry on 23 December 1998 when it de-registered Ms Lecky-Thompson and fixed a period of three years before she could apply for re-registration.

The Tribunal recognised that the major issues arising out of its findings concerned Ms Lecky-Thompson's professional judgement during crucial parts of her client's labour, her fundamental honesty in the course of carrying out her duties as a midwife and her understanding of her professional role as a practitioner. It was unavoidable to observe that her failure to transfer her clients at crucial moments in labour was a recurrent feature of the complaints.

Ms Lecky-Thompson proposed that she be allowed to remain in practice but be supervised as a homebirth midwife. It was further proposed that she be supervised by a mentor and she report to a panel of supervisors. The Tribunal had a fundamental difficulty with this flowing from her rejection of the Tribunal's findings in a number of important aspects.

The Tribunal stated that the evidence was compelling that Ms Lecky-Thompson will for the foreseeable future fail to advise her clients or prospective clients adequately to ensure their safety and the safety of their babies. The Tribunal was also of the view that given Ms Lecky-Thompson's unethical behaviour there was a real risk that she may lie to colleagues including obstetricians in the course of her professional practice. The Tribunal concluded that at the present time she was not fit to practice and should not do so until she comes to realise that honesty in professional practice is a duty owed to her own clients as well as to her colleagues and both are equivalent.

Professional Standards Committee Cases

Supervision of Pharmacies

Ms B was the co-proprietor of a pharmacy. The Commission's complaint alleged that the pharmacist failed to adequately acquaint herself with and failed to adequately supervise the manner in which the pharmacy was being conducted and operated. Her co-proprietor and an employed pharmacist had been supplying drugs contrary to the provisions of the Poisons Act. The drugs included drugs of addiction some of which were dispensed using forged or altered prescriptions. There were also concerns about the storage and labelling of drugs and record keeping.

The Commission argued that as a part owner of the pharmacy and as the joint employer of all the pharmacists at the pharmacy the practitioner had a responsibility to the public to protect them against the illegal actions of her partner and her employed pharmacists. It was not alleged that the pharmacist had been involved in any of the illegal actions.

The pharmacist was found guilty of professional misconduct and was severely reprimanded. A fine was also imposed.

The Pharmacy Board accepted the recommendations of the Committee mindful that a clear message must be sent to the profession reminding them that professional responsibilities of partner pharmacists should not be delegated to an employee or a partner. The Committee stated:

- the ownership of the pharmacy by a pharmacist is a privileged position. The legislation has accepted that this form of exclusive right is granted to provide the maximum possible protection to the public. The responsibility of ownership extends to ensure that suitable procedures, protocol and validation are in place to eliminate professional misconduct in the pharmacy;
- the responsibility of the owner is in no way limited. Partnership agreements or other external agreements e.g. marriage do not limit this professional responsibility nor does the extent of the shareholding or the

involvement in the pharmacy limit this professional responsibility;

- the responsibility of the owner is to ensure that the pharmacy has qualified staff to enable all procedures to be properly carried out.

The Committee and Board commended the pharmacist for her remedial actions immediately taken on being made aware of the activities of her partner and employed pharmacist. These actions included taking steps to put a stop to the illegal supply of the drugs and introducing new checking procedures.

GP providing intensive prolonged psychotherapy

Ms A was referred to Dr B, a GP psychotherapist, by another GP in early 1993 with a complex range of problems. Ms A had been treated by psychiatrists and psychologists for some years for an acute eating disorder, but had never undergone psychotherapy. Sessions were initially three times a week, but after a time changed to five times a week. She was concerned about the cost and frequency of sessions, but her concerns were dismissed by Dr B. She continued to see Dr B until the end of 1995. During that time her weight dropped substantially, causing her partner concern. No action was taken by Dr B in this regard. During this time, Ms A continued to see other GPs who prescribed medications and Dr B was aware of this. Ms A stated that Dr B had made inappropriate sexual comments about her during sessions and expressed sexual interest in her.

The complaint was investigated by the Commission, and referred to a Professional Standards Committee. Dr B stated that Ms A posed a difficult management problem. Before the Committee Dr B admitted that he failed to properly terminate the therapeutic relationship. He denied that he had made sexual comments to Ms A, that he was inadequately trained to provide psychoanalytical psychotherapy, that he refused her request for a referral and did not refer her to a psychiatrist or for treatment of an eating disorder. Dr B's practice was only about 30% psychoanalytical psychotherapy at the time of hearing, and he was winding down this part of his practice.

The Committee heard from an independent psychiatrist who practised psychoanalytical psychotherapy. His evidence was that there would not be more than a dozen people in NSW who could provide psychoanalytical psychotherapy to a patient for five sessions a week. He did not feel qualified to provide therapy with such frequency.

The Committee determined that while therapy of this duration and intensity might not be inappropriate for a person like Ms A, Dr B did not have sufficient training and experience to properly provide this treatment. He was found guilty of unsatisfactory professional conduct.

The Committee was not convinced that Ms A presented clinical evidence of a frank eating disorder during treatment by Dr B, and found this particular not proved. The Committee was also not convinced that Ms A had requested a referral, considering that her comments were part of the therapeutic process rather than a request. The Committee did not accept Ms A's evidence about the sexualisation of therapy by Dr B.

The Committee cautioned Dr B, and made orders that he should terminate and/or refer all patients currently having psychoanalytical psychotherapy by him to suitably qualified practitioners. He was required to be supervised while still providing psychoanalytical psychotherapy and conditions about appropriate training, supervision and reporting to the Board were imposed should he wish to return to this type of treatment.

After hours care of an insulin dependent diabetic

Mrs A, an insulin dependent diabetic, had been vomiting for about 24 hours. As she felt too unwell to go to the hospital A&E, her husband called the after hours medical service. When Dr B arrived, he took her temperature and blood pressure but did not otherwise physically examine her. Mrs A's husband told Dr B that she was diabetic. Dr B told her that she had a "tummy bug" and gave her a prescription for stemetil tablets and ketostix, and advised her to call if she had further problems. He did not elicit from Mrs A the history of surgery for diverticulitis twelve months previously. Mr A

called the doctor again later in the afternoon. Dr B returned, but again did not perform a physical examination or urinalysis. A few hours later Mr A called 000. Mrs A was taken by ambulance to A&E where an intestinal obstruction was diagnosed.

The Commission investigated the complaint and referred it to a Professional Standards Committee for inquiry. The Committee heard evidence from an independent rural general practitioner about the appropriate standard of practice in respect of a patient like Mrs A. The reviewer stated that prolonged vomiting in an insulin dependent diabetic was dangerous because of the gravity of the possible consequences, and that such a patient needed to be thoroughly examined and a detailed history taken. Such a patient would also need very clear information about how to adequately monitor their condition, including recording blood sugars and urine output. On the second visit, an abdominal x-ray would be required given the persistent vomiting.

The Committee found that Dr B did not take an adequate history or perform an adequate examination on Mrs A on either occasion he attended her and that he failed to provide sufficient instructions for her to monitor her condition, particularly her diabetes, on the second occasion. The Committee also found that Dr B did not review his initial diagnosis when called to see Mrs A a second time. The reviewer's comments that the records made by Dr B did not provide sufficient information to be of any assistance to the patient's usual GP were noted. There was no criticism of Dr B's failure to detect the intestinal obstruction, because that condition is difficult to diagnose in the early stages.

For more than twenty years Dr B practised only on weekends as part of a locum service to a local general practice. He said that his main medical education was talking to other after hours doctors at the change of shifts, and that he did not attend conferences or seminars. The Committee was critical of Dr B's level of clinical knowledge in respect of a number of case study scenarios of common urgent presentations put to him, and formed the view that he did not have an adequate understanding of components of history taking or physical examination and that he had inadequate knowledge about the actions and effects of newer medications.

Dr B was found guilty of unsatisfactory professional conduct. He was required to attend a Board appointed supervisor monthly to review his clinical management of patients and assess the adequacy of his skills. Dr B was also required to attend the RACGP Annual Revision Seminar annually for three years, to maintain a log of other CME activities to be submitted to the Board, and to maintain his medical records in accordance with the requirements of Schedule 2 of the Medical Practice Regulation 1998.

Executive Support Group

The Executive Support Group (ESG) was established in mid 1998 to co-ordinate and manage internal and external liaison, public education, communication and representation activities of the Commission. ESG is responsible for facilitating liaison with stakeholders, coordination of review of legislation, the development and implementation of policy recommendations, maintaining the Commission publications and educational activities as well as its community, parliamentary, media and public relations.

Key Initiatives

Metropolitan and regional community consultation and information sessions

Under the Health Care Complaints Act 1993, the Commission is required to consult with groups with an interest in the provision of health services, including health care providers. The Commission is also required to provide information to health service providers on complaint processes and the trends in complaints. The Commission has expanded its activities to increase the distribution of information about the Commission and the Commission's consultation processes.

During the first half of 1999, the Commission has expanded its consultation program to rural NSW. The Commissioner and senior staff have travelled to 5 regional centres, held information sessions with health care providers, members of the community and meetings with each AHS Chief Executive Officer. The sessions have been well attended, with the additional benefit of allowing the Commission to gather information about local concerns. The Commission also featured in local media.

Over the second half of 1999, the Commissioner and staff will be travelling to a further 10 regional centres, with an additional program of visits to remote and regional Aboriginal communities.

Feedback to Area Health Services

In late 1998, the Commissioner held meetings with the Chief Executive Officer of each metropolitan Area Health Service (AHS). These consultations include providing each AHS with statistics and case discussion relevant to their area; exploring current or proposed developments in the provision of health services; the co-ordination of care and treatment of patients after admission to hospital; and the conduct of investigations by the AHS following referrals of complaints from the Commission.

Legislative review

The unit has co-ordinated the Commission's responses to a number of pieces of legislation which affect the way in which the Commission and the health care system operate. Primary among these has been the continuing development of the Health Care Complaints Amendment Bill 1999, which is being drafted by Parliamentary Counsel to conform with the recommendations of the Health Care Complaints Act Review Committee as endorsed by State Cabinet.

The Commission has also commented on various health registration acts which are undergoing revision to ensure compliance with the Competition Principles Agreement. The Commission has participated in reviews of legislation covering the medical profession, pharmacists, osteopaths and chiropractors, physiotherapists and others, as well as legislation governing child protection matters, information privacy, private hospitals and day procedures centres and nursing homes.

Involvement in Ministerial and joint parliamentary inquiries

ESG assumed the responsibility for the finalisation and production of the 1998 Report of the Ministerial Committee of Inquiry into Impotency Treatment Services, which was described in last year's Annual Report. ESG has also assisted in establishing the Ministerial Committee of Inquiry into Cosmetic Surgery and provides on-going administrative support to the inquiry.

In May 1998, the Joint Committee on the Health Care Complaints Commission resolved to conduct an inquiry into unregistered health practitioners to examine the adequacy and appropriateness of current mechanisms for resolving complaints. ESG co-ordinated the Commission's responses to this inquiry, including details on the Commission's experience with unregistered and alternative health care practitioners, the risks that arise in the provision of quality and responsible care to consumers, and various models which may be introduced to improve consumer protection and maintain professional standards. The Joint Committee published its report in December 1998.

Publications and provision of information to key stakeholders

ESG co-ordinates the development, production and distribution of the Commission's publications, educational activities and information provision to stakeholders. In August 1998, the Minister for Health launched the Commission's brochure *Your Rights and Responsibilities as a Health Consumer*, which was widely distributed to hospitals, Area Health Services, community groups and health care providers. The Commission worked closely with the Breast Cancer Action Group NSW to produce a brochure on *Breast cancer - life after diagnosis*, which was released in October 1998, to coincide with National Breast Cancer Awareness Month.

In March 1999, the then Minister for Health, the Hon Dr Andrew Refshauge and Ms Linda Burney, Deputy Director-General of the NSW Department of Aboriginal Affairs, launched a new poster designed for the Commission by Ms Tracey Bostock from Boomalli Artist's Co-operative. This poster specifically targeted Aboriginal communities throughout New South Wales as a supplement to the planned program of visits to remote and regional communities. These visits aim to raise awareness of the Commission's role in complaints about health services, and to help improve health service delivery to indigenous communities.

Health Investigator

The Commission's quarterly subscription journal continued to target key issues in the provision of health care in the State. Health Investigator builds on the wealth of information collected by the Commission during its complaint handling and investigative functions as well as benefiting greatly from contributions from colleagues throughout the health care systems and consumers. A greater editorial emphasis on layout, design and themes have seen the journal increase its relevance and accessibility to all interested in health care in New South Wales.

Policy Recommendations

Commission investigations of health services may result in the Commission making recommendations for change if a complaint is substantiated. In 1998-99 the Commission made 17 recommendations for policy changes.

Authority to which policy recommendations made 1998-99

Authority	No.
Director General of Health	12
Dental Centre	1
Area Health Service	4
Total	**17**

Policy Recommendations 1998-99

Recommendation	No.
Counselling for patients	1
Care of patients	3
Training	2
Discharge procedures	1
Review hospital protocol	1
Review clinical guidelines	7
Monitor facility/service	2
Total	**17**

Response to policy recommendations 1998-99

Response	No.
Accepted in full	6
Initiated own solution	2
Not known as at 30.6.99	9
Total	**17**

Use of psychotropic medication in nursing homes

In the 1997-1998 Annual report the Commission reported on the Ministerial Taskforce on Psychotropic Medication Use in Nursing Homes.

This year the Commission finalised an investigation which raised similar issues. The Commission substantiated a complaint concerning an elderly resident who was prescribed psychotropic medication without the consent of his next of kin. The Commission noted to the Director-General of Health that the issues were covered in the Taskforce Report.

Perinatal Death Committee of the NSW Department of Health

The Commission made a number of policy recommendations to this Departmental Committee during the year, as an outcome of investigations of the care and treatment provided by hospital staff.

A mother of twins made her complaint subsequent to the neonatal death of her babies in a teaching hospital. The babies suffered from acute twin to twin transfusion syndrome which has a poor outcome. One baby died soon after birth and the other at a later date. The mother was convinced that if her babies had been monitored differently by hospital staff, they would have had a better chance of survival.

The investigation found that an adequate standard of care was delivered by hospital staff in the time leading up to the delivery of the twins. The syndrome that affected the twin babies could not have been predicted by the hospital staff.

However, the mother had received conflicting information about the cause of the perinatal deaths from the hospital registrar and other hospital staff. No senior member of the obstetric staff took responsibility to inform the parents about the possible causes of the perinatal deaths. The investigation found that it was the role of the

Visiting Medical Officer to meet with parents who experience a perinatal death and explain the cause of the death and answer their questions. There was no hospital policy to guide hospital staff about the importance of communication with parents who suffer a perinatal death.

The Commission recommended that the Department refer this issue to the Perinatal Death Committee who supported the Commission's recommendation that this issue be drawn to the attention of VMOs.

Centre for Mental Health

The Commission investigated the death by suicide of a patient admitted to a general hospital for investigation of a self inflicted wound. The patient was recognised as at high risk of self harm and assigned a nurse to provide one to one supervision at all times. However, the patient's widow complained that the nursing staff were not in attendance when the patient jumped through the window of his hospital room to his death.

The Commission found that the complaint was substantiated in that the level of supervision of a suicidal patient was provided by a nurse with inadequate training and experience for the role. The Commission recommended that the Centre for Mental Health review the protocols in place for managing a suicidal patient in the hospital.

The Director-General of Health supported this recommendation and advised that the Centre for Mental Health had made additional policy changes to enhance the safety of patients at risk of self harm. In particular the recommendation was that if a patient at high risk of suicide is provided with one to one care in a general hospital unit, every effort should be made to obtain an appropriately qualified psychiatric nurse.

Inquiries

The Ministerial Committee of Inquiry into Impotency Treatment Services

The initiation and conduct of this Inquiry was detailed in last year's Annual Report.

The Committee's report was released to the public by the Minister for Health in October 1998 and included a number of findings and recommendations covering the terms of reference in order to promote improved professional practice and higher standards of consumer safety. A full copy of the Inquiry report may be obtained from the Commission. The findings and recommendations addressed: the preparation of pharmaceutical products intended for patient self-injection; patient assessment, diagnosis and care; the pricing of supplied appliances and medications, with other related financial aspects of impotency treatment services; and advertising impotency treatment services.

The Commission pursued the implementation of the recommendations of the Inquiry. Recommendations have been fed into the review of legislation, including the review of the Medical Practice Act 1992, in conjunction with recommendations arising from the Inquiry into Cosmetic Surgery, the Commissioner met with the ACCC and the Federal Department of Science, Industry and Tourism regarding the introduction of a code of practice for impotency treatment services. An article regarding the conduct of the Inquiry and its findings and recommendations were published in the NSW Medical Board Newsletter, to reinforce the necessity to maintain professional standards.

The Ministerial Committee of Inquiry into Cosmetic Surgery

In late 1998, the then Minister for Health, appointed a Ministerial Committee to investigate whether there were problems with the provision or availability of cosmetic surgery and to recommend what should be done to fix the problems, including the introduction of consumer safeguards relating to regulatory and professional registration processes. With Commissioner Walton as Chairperson, the Committee of 11 members reviewed a wide range of cosmetic surgery procedures, covering all surgery "performed to reshape normal structures of the body, or to adorn parts of the body, with the aim of improving the consumer's appearance and self esteem".

The Committee received almost 90 written submissions from individuals and organisations around Australia and internationally. Public hearings were held in March and April 1999, during which over 40 individuals and organisations appeared before the Committee.

The Committee commissioned two independent studies. A clinical review was conducted by the Centre for Effective Health Care, University of Sydney, on scientific information and guidelines available on major cosmetic surgery procedures and the efficacy and safety of these procedures. Social research consultants 'Community Solutions' conducted a survey of people who have had cosmetic surgery. The Survey covered the reasons for the procedure, how they chose a particular procedure and provider, whether they were given enough information, whether they were satisfied with the result and whether they considered the cost reasonable.

The Committee is due to report its findings and recommendations to the Minister for Health in October 1999.

The Commission met with the ACCC to discuss developing a guide to compliance with fair trading laws in the promotion of health services.

Skin Care Improvement and Pressure Ulcer Prevention Group

The Commission received complaints about elderly residents of nursing homes who, following admission to major metropolitan hospitals for the conduct of acute medical conditions, developed deep pressure ulcerations with significant necrosis and infection. The patients did not have any pressure breakdown areas prior to their admission to hospital. The Commission considered that these complaints raised significant questions as to the appropriate care or treatment of elderly people in public hospitals and further considered that the most effective approach to addressing the systemic concerns would be the establishment of a working party operating under the aegis of the NSW Department of Health. The Director-General of the Department of Health supported the Commission's recommendation and established a working party as a sub-committee of the Ministerial Advisory Committee on Quality in Health Care.

The working party is the first group to consider pressure ulcer prevention, management and skin care improvement at a State level in Australia. Pressure ulcers are likely to become increasingly problematic as life expectancy increases for a larger number of Australians, who, with increased age, tend to develop chronic health problems requiring hospital treatment. Pressure ulcers affect populations such as the elderly who have limited mobility, reduced cognition and less independent activities of daily living. Prevention of pressure ulcerations is needed to reduce patient morbidity and mortality as well as overall health care costs. This aspect of care may be overlooked when treatment is being provided for more acute or apparent health problems.

Commissioner Merrilyn Walton represents the Commission on the working party, which also includes a consumer representative nominated by the Commission. The group has four main areas of activity:

- the development of consumer information and guidelines for the prevention and management of pressure ulcers
- a review of current hospital practices, clinical systems and accreditation processes
- audit of the cost or 'burden' of pressure ulcer management, and determination and monitoring of the prevalence of pressure ulcers in NSW
- development and review of education and training material for health professionals at all levels

The group is to meet at least quarterly in order to promote an early resolution of its activities, findings and make recommendations.

Continuity of Care project

In recent times, the Commission has become aware of a disturbing trend in complaints concerning the 'slipping through the system' of patients. As a result of the involvement of a number of health care practitioners from a number of institutions or areas of practice, there have been instances where no single practitioner assumed responsibility for the overall care of a patient, including a failure to be aware of all tests conducted or their results. This confusion or lack of continuity had led to some tragic consequences, including a failure to advise a 60 year old man of a possible tumour or granuloma in his chest until inoperable lung cancer was diagnosed 18 months later. Other complaints involved the failure to diagnose a spinal subluxation and failure to recognise the significance of the neurological impairment of a 75 year old man who died as a result of the spinal condition two months after admission.

The Commission compiled some initial information regarding this trend, including the above cases, and sought further information, including copies of policy documents, protocols, case examples or recommendations on how patient care could be better co-ordinated. The Commission sought information from Area Health Services, the Health Department, Colleges, Associations, United Medical Protection and the Australian Medical Association. The Commission held meetings with a number of Colleges and with the Health Department regarding the issues raised in continuity of care, and it was agreed that the issue required a co-ordinated approach. The Director General of Health has agreed to sponsor a project which examines this issue.

The Commission's Stakeholders

The Joint Parliamentary Committee

The Joint Parliamentary Committee into the Health Care Complaints Commission conducted an inquiry in 1998-99 into the adequacy and appropriateness of current mechanisms for resolving complaints concerning unregistered health practitioners. This was in response to repeated comments by the Commission about the limited ability to protect the public from unprofessional treatment given by unregistered health practitioners.

The Commission participated in the inquiry and made a submission. The Inquiry made seven recommendations which are summarised below:

1. That the Commission take a greater role in educating consumers about the Commission's ability to investigate complaints about unregistered health practitioners.
2. That the Department of Health and Colleges support this initiative.
3. That the Minister for Health consider providing the Commission legislative powers to refer matters which concern possible breaches of the Minister's Act to the Director General of Health.
4. That the Health Care Complaints Act 1993 be amended to allow the Commission to require health professional associations to establish uniform complaints handling and disciplinary mechanisms
5. That the Minister for Health examine the feasibility of establishing umbrella legislation to cover unregistered health care practitioners
6. That the Minister for Health consider providing the Commission with a naming power.
7. That the Minister for Health consider establishing or nominating a body with the power to issue court-enforceable orders to allow health consumers obtain refunds.

The Commission will be following up these recommendations in the next financial year.

Consultations with the Health Registration Boards and the Health Conciliation Registry

Under the Act, a complaint to a registration board is also a complaint to the Commission and vice versa. The Commission has a statutory obligation to consult with the relevant board in relation to how a complaint against a registered health care practitioner should be handled as well as in relation to the outcome of each investigation. As most complaints against individuals concern medical practitioners, a representative of the Medical Board of NSW attends an Assessment Committee meeting held at the Commission each week. Consultations occur with the other registration boards on a regular basis, with senior Commission officers attending the Complaints Committees of the Boards.

The Commission holds quarterly meetings with the registration boards and the Health Conciliation Registry through the Ad Hoc Committee - Complaints/Disciplinary Process in order to increase communication about issues arising from complaints and their management (for further details see next section).

Consultations with Health Professional Organisations

The Commission recognises the importance of regular consultations with representatives of health care practitioners to facilitate the level and style of communication regarding the resolution of complaints, disciplinary and educational activities.

The Commission is a member of the Ad Hoc Committee - Complaints/Disciplinary Process which meets quarterly and includes the following membership:

- the Health Care Complaints Commission
- the NSW Medical Board
- the Health Conciliation Registry
- the Health Professionals Registration Boards

- the Australian Medical Association (NSW) and
- United Medical Protection

The Commission holds regular meetings with the NSW Nurses' Association in order to discuss matters of common concern regarding the regulation of the nursing profession. The Commission meets with representatives of the Professional Colleges, Private Health Insurance Agencies and other professional organisations on a needs basis.

Consultations with Consumer Groups

The Commission recognises consumers and key consumer groups as being essential stakeholders in the work conducted by the Commission. The Commission is advised on its activities by its Consumer Consultative Committee, which includes representatives of the following organisations:

- Public Interest Advocacy Centre
- People with Disabilities NSW
- NSW Council of Social Services
- NSW Council for Intellectual Disability Ltd
- NSW Council on the Ageing
- Australian Association for Welfare of Child Health Inc
- Aboriginal Health and 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

The Consumer Consultative Committee has the following functions to assist the Commission in its work:

- mechanism for consumer input
- provision of advice on activities including:
  - consumer complaints
  - standards of health service delivery
  - public interest issues
  - policy development
- dissemination of information to consumer groups

Statewide information and consultation process 1999

Under the Act, the Health Care Complaints Commission has the function to consult with groups with an interest in the provision of health services. The Commission is also required to provide information on complaint processes and the trends in complaints.

The Commission has initiated a program to consolidate an information and consultation process in key areas of rural and regional NSW. The first of these consultations started on February 25 and the will continue throughout 2000.

In each location, the Commission invites Members of Parliament, members of the Commission's Peer Review Panel, public and private health practitioners, representatives of consumer organisations and members of the public. These information and consultation sessions provide a valuable and interesting opportunity for the whole community to learn more about the Commission and its operations, as well as to provide feedback to the Commission on local issues.

The sessions include presentations on the role and functions of the Commission, with discussion concerning how the complaints process can maintain and improve the standards of health services throughout New South Wales.

Session locations and dates: The Commission conducted one session for consumers and a separate session for health workers in each location.

Date	**Location**
February 25	Newcastle
March 1-2	Lismore
March 2-3	Grafton
May 13	Wollongong
May 24	Queanbeyan

Corporate Services

Our People

Establishment and Staff Profile - Snapshot

(EFT* positions as at 30 June each year)

Titles of Positions	1996	1997	1998	1999	at 1/7/98	at 30/6/99
Establishment - Permanent Positions - EFT Staff - EFT						
Director/Commissioner (SES)	1	1	1	1	1	1
Deputy Commissioner (SES)	1	1	0	0	0	0
Directors (Senior Officers)	0	0	2	2	2	2
Directors (Graded Officers)	0	0	2	2	2	2
Heads of Teams/Managers	6	6	5	5	5	5
Legal Officers, various titles	5	5	5	5	5	5
Hearing Officers	0	0	1	2	1	2
Senior Investigation Officers	14	14	14	13	14	13
Preliminary Investigation Officers/ Resolution Officers	4	4	3	3	3	3
Complainant Liaison Officer	0	0	0	1	0	1
Patient Support Officers	0	8	8	8	8	8
Telephone Inquiry Officers	2	2	2	2	2	2
Clerks, various titles	10	8	8	9	8	9
Clerical Officers, various titles	11	11	12	11	12	11
Sub Total	*54*	*60*	*63*	*64*	*63*	*64*
Temporary Positions - EFT						
Medical Advisers (part-time)	1.2	1.2	1.2	1.2	1.2	1.2
Clerks - I&T Manager	1	1	1	0	0	0
Special Projects Officer	0	0	0	1	0	1
Total Positions - EFT	**56.2**	**62.2**	**65.2**	**66.2**	**64.2**	**66.2**

**EFT is an abbreviation for Equivalent Full-Time*

Equal Employment Opportunity

The distribution of staff by level and employment basis as at 30 June 1999 is shown on the following two tables.

Percent of Total Staff by Level

	Subgroup as Percent of Total Staff at each Level				Subgroup as Estimated Percent of Total Staff at each Level				
Level	**Total Staff No.**	**Respon-dents %**	**Men %**	**Women %**	***A*** **%**	***B*** **%**	***C*** **%**	***D*** **%**	***E*** **%**
< $25,761	0								
$25,761 - $33,835	1	100	100	0	0.0	0	0	0	0.0
$33,836 - $37,825	13	46	8	92	0.0	17	67	17	0.0
$37,8*26* - $47,866	11	82	18	82	0.0	0	0	11	0.0
$47,86*7* - $61,899	30	93	27	73	3.6	25	14	14	0.0
$61,*900* - $77,374	10	90	50	50	0.0	33	22	0	0.0
> $77,*374* (non-SES)	6	83	50	50	0.0	0	0	40	0.0
> $77,*374* (SES)	1	100	0	100	0.0	0	0	0	0.0
Total	**72**	**82**	**28**	**72**	**1.5**	**18**	**21**	**14**	**0.0**
Estimate Range (95% confidence level)					1.4-2.3	15.3-23.0	15.2-27.0	11.1-19.1	0.0-0.0

KEY for table above and next page

A: Aboriginal People & Torres Strait Islanders
B: People from Racial, Ethnic, Ethno-Religious Minority Groups
C: People Whose First Language First Spoken as a Child was not English
D: People with a Disability;
E: People with a Disability Requiring Adjustment at Work

Percent of Total Staff by Employment Basis

	Subgroup as Percent of Total Staff at each Level				Subgroup as Estimated Percent of Total Staff at each Level				
Employment Basis	**Total Staff No.**	**Respon-dents %**	**Men %**	**Women %**	***A*** **%**	***B*** **%**	***C*** **%**	***D*** **%**	***E*** **%**
Permanent									
Full-Time	58	86	28	72	2.0	20	20	12	0.0
Part-Time	2	100	0	100	0.0	50	0	0	0.0
Temporary									
Full-Time	5	40	40	60	0.0	0	0	0	0.0
Part-Time	6	67	33	67	0.0	0	0	50	0.0
Contract									
SES	1	100	0	100	0.0	0	0	0	0.0
Non SES	0								
Casual	0								
Total	**72**	**82**	**28**	**72**	**1.6**	**18**	**16**	**14**	**0.0**
Estimate Range (95% confidence level)					1.4-2.8	15.3-20.9	13.9-19.5	11.1-17.8	0.0-0.0
SUBTOTALS									
Permanent	60	87	27	73	1.9	21	19	12	0.0
Temporary	11	55	36	64	0.0	0	0	27	0.0
Contract	1	100	0	100	0.0	0	0	0	0.0
Full-Time	64	83	29	71	1.8	18	18	11	0.0
Part-Time	8	75	25	75	0.0	13	0	38	0.0

During the reporting year 14 opportunities were provided for staff to act/provide relief in higher positions and be paid a higher duties allowance.

Eight of the opportunities resulted from staff being temporarily appointed as a result of either external advertising action and/or expressions of interest being called from Commission staff members. On the other occasions, particular staff members were deemed by management to be the most appropriate and suitable person to act/ provide relief in the position.

In all instances the opportunities occurred when the period of relief was in excess of five consecutive working days, either as a result of staff absences on leave or where temporary and permanent vacancies would provide a development opportunity for a staff member for an extended period of time.

Two members of staff were granted approval to accept temporary appointments with other government departments during the year.

Turnover & Recruitment

Appointments 1998-99

Position Classification	P	T
Director, Investigations & Prosecutions	1	0
Director, Corporate Support	1	0
Director, Complaint Resolution	1	0
Manager, Complaints Assessment & Resolution	1	0
Manager, Team 1	1	0
Director, Executive Support	1	0
Senior Investigation Officer	1	2
Resolution Officers	0	3
Telephone Inquiry Officers	1	2
Legal Officers	2	0
Clerical support Officers	2	2
Data Control Officer	1	0
Executive Assistant	1	0
Publications/Policy Officer	1	0
Hearing Officer	2	0

P = Permanent; T = Temporary

Terminations 1998-99

Position Classification	P	T
Director, Corporate Support	1	0
Manager Complaints Assessment & Resolution	1	0
Manager Team 1	1	0
Senior Investigation Officers	1	2
Resolution Officers	0	2
Telephone Inquiry Officers	1	2
Legal Officers	1	0
Clerical Support Officers	1	2
Data Control Operators	1	0
Special Projects Officer	0	1

P = Permanent; T = Temporary

SES Positions

The number and levels of SES positions over the past 3 years are listed in the Table below.

		1996/97	1997/98 to 30/9/97	1997/98 from 1/10/97			1998/99
Band	**Range**	**Number**		**Level**		**Number**	
Band 1	Lower Upper	- 1	- -	1	Lower Upper	- -	- -
Band 2	Lower Upper	- -	- -	2	Lower Upper	1* -	- -
Band 3	Lower Upper	1 -	1 -	3	Lower Upper	- -	- -
Band 4	Lower Upper	- -	- -	4	Lower Upper	- -	- -
				5	Lower Upper	- 1	- 1
				6	Lower Upper	- -	- -
				7	Lower Upper	- -	- -
				8	Lower Upper	- -	- -
Totals		2	1			2*	1

*a) Four Band structure was replaced by Eight Level structure from 1/10/97. b) All positions were filled by women. * Indicates one of the SES positions was vacant from 28 July to 30 November 1997 and again from 21 April to 31 May 1998, the position was deleted effective from 1 June 1998.*

Enterprise Bargaining

Negotiation of a Workplace Agreement continued during 1998-99. The Commission is optimistic agreement will be reached in the coming year.

Grievances

One formal grievance was lodged during the year and an investigation commenced in accordance with the Commission's Freedom from Harassment and Grievance and Dispute resolution Policy and Procedures. The outcome was not known at the end of this reporting period.

Overseas Travel

During the reporting year, overseas travel was undertaken by staff members as follows.

Name & Position	Destination	Reason
Merrilyn Walton, Commissioner	Cape Town, South Africa	Attend "3rd International Conference on Medical Registration" conducted by the University of Cape Town.
David Harris, Legal Officer	Brussels, Belgium	Attend seminar "Informed Consent:- Who Is It Protecting?" conducted by Royal Academy of Medicine, Belgium.
Merrilyn Walton, Commissioner	United Kingdom and the United States of America	Attend conference held by the Royal Society of Medicine, England on "The Influence of Litigation on Medical Practice". Attend "87th Annual Meeting of Federation of State Medical Boards of the USA". In addition to attending the above conferences, the visits to both the UK and the USA involved the conducting of interviews relating to the Inquiry into Cosmetic Surgery (see details below #).
*****Sarah Crawford, Director, Executive Support	London, England	Attend conference held by the Royal Society of Medicine, England on "The Influence of Litigation on Medical Practice".

***Note**: The Commission only paid for the Conference Registration fee, accommodation expenses plus half the cost of Ms Crawford's train fare from Paris to London.

#Commissioner Merrilyn Walton, as Chair of the Inquiry into Cosmetic Surgery, used the visits to both the United Kingdom and the United States of America to further her inquiries.

Energy Management Plan

The Commission is committed to the Government's Energy Management Policy, *Reducing Greenhouse Emissions*. The Director, Corporate Support has been appointed as the Commission's Energy Manager.

The Commission has prepared an energy management plan which is summarised as follows:

- Building energy savings measures will be further considered if the Commission renews its current lease towards the end of next year or if it relocates.
- The Commission will consider:
  - fuel efficiency when renewing its two fleet vehicles next financial year.
  - energy efficiency ratings when replacing computers, other office machines and equipment.
  - energy efficiency when two photocopy machines are replaced next financial year.

The Commission has not set specific goals in addition to the public sector wide goals. Mechanisms to collect data and monitor energy usage are in place. There are no energy savings outcomes to report at this stage.

Training and Development Awareness

Seminars and Courses Attended

A total of $30,183 was spent for the purpose of allowing various staff to attend various seminars and courses throughout the year. Details are as follows;

Seminar/Course	**Total Staff Attended**
Services for Refugees	1
Central Co-ordinating Committee of Spokeswomen	1
St John's Ambulance Course	1
National Investigation Symposium	13
Victims Rights - Future Directions	1
Shifting Ground Conference	1
NSW Administrative Decisions Tribunal	1
Executive Secretaries Workshop	1
Dealing with Difficult Complainants	3
Open government Conference	2
Minimising the Harm - Health in Prisons	1
Perspectives in Medical Mishaps	3
General Skills Workshop	1
Using Complaints and Incident Reports to Improve Performance	1
Subpoenas and How to Deal With Them	1
Evidence, Excellence, Expectations	1
Annual Conference of Spokeswomen	1
Senior First Aid Course	1
Influence of Litigation on Medical Practice	2
Annual Meeting of Federation of State Medical Boards of U.S.A.	1
National Health Care Complaints Conference	7
Informed Consent Conference - Belgium	1
International Conference on Medical Registration - South Africa	1
Occupational Health and Safety Workshop	1
Conflict Resolution Workshop	2
Investigation Symposium	1
Plastic Surgeons Conference	1
Fringe Benefits Tax Training	3

Reports from Committees

Occupational Health & Safety

The OH&S Committee has conducted workplace inspections regularly in order to ensure a safe environment for staff and visitors.

The Committee has continued to encourage staff to be responsible in their work practices while new staff have been provided with OH&S information as part of their induction at the Commission.

The Employee Assistance Program is still available to staff and their family members for counselling at no cost to themselves.

Aboriginal Reconciliation

The Aboriginal Reconciliation Committee provided staff with a series of workshops aimed at increasing their awareness about reconciliation and about Aboriginal and Torres Strait Islander communities.

The workshops for Investigation and Legal Officers and PSO concentrated on how to approach complaints from Aboriginal and Torres Strait Islander people about health care in remote areas with inadequate health services. A workshop for clerical and administration officers concentrated on communication skills and cultural differences.

The year ended with a plenary session during which staff were invited to sign a statement in support of Reconciliation and which makes a commitment to making the Commission's service more accessible to Aboriginal and Torres Strait Islander peoples. The plenary included two guest speakers: Ms Linda Burney, Chair of the NSW State Reconciliation Committee and Ms Lola McNaughton, Aboriginal Health and Medical Research Council. The signed statement will be forwarded to the Council for Aboriginal Reconciliation.

Risk Management

The Commission's workers' compensation, motor vehicles, public liability, property and miscellaneous items insurance are provided by the NSW Treasury Managed Fund, managed by GIO. There have been no significant changes to risks or risk management arrangements during the year.

Consultants

Three consultancy projects costing $25,000 in total were let during the year. These were an evaluation of the Patient Support Office, modifications to the complaint handling database and preparation of an office accommodation facility plan.

Workers' Compensation Claims

The Commission continued its low level of claims made on the fund. This result reflects both the focus that management has placed on minimising risk and creating a safe workplace as well as the efforts of an active occupational health and safety committee within the Commission.

	1995/ 1996	**1996/ 1997**	**1997/ 1998**	**1998/ 1999**
Number of Claims	7	7	5	5
Claim Payments ($000)	9	19	5	6
Total Cost ($000)	13	25	6	10

Motor Vehicle Claims

In 1998-99 there were less claims against the managed fund for motor vehicle repairs than the previous year with only two claims made.

In respect of the two claims made , one was the fault of the Commission staff member driving the vehicle at the time and the other resulted from another vehicle colliding with a Commission vehicle whilst it was stationary.

	1995/ 1996	**1996/ 1997**	**1997/ 1998**	**1998/ 1999**
Number of Claims	2	1	4	2
Total Cost ($000)	2	1	8	5

The Commission has reduced its fleet of motor vehicles from three to two i.e. one SES and two pool vehicles.

At present the SES vehicle is leased and the two pool vehicles are owned by the Commission. A review of this situation will be made in the near future for the purpose of determining the practicality of replacing the Commission vehicles with leased vehicles.

Account Payment Performance

A total of 1420 invoices were received during the year and were processed as follows.

< 31 days after receipt = 88.5%

< 60 days after receipt = 8%

> 60 days after receipt = 3.5%

Information Technology - Y2K Issues

Concerns by the approaching year 2000 have coincided this year with projects to consolidate and improve the Commission's data handling systems. Implementation of Year 2000 related adaptions are progressing well, in keeping with the time line set by the Department of Information Technology and Management.

The Commission established a Committee which meets weekly to consider planning and implementation issues. The Commission has developed detailed contingency plans to deal with the potential failure of systems on 1 January 2000 and these plans will continue to develop with the Commission's business practices as the end of this calendar year draws closer. A new server for the Commission's network has been purchased, as part of a major revision of the in-house computer systems. The upgrade will be in place shortly. The major outstanding task has been the modification of the Complaint Handling database. Work will commence soon to ensure the database will be Y2K compliant, as a precursor to an upgrade and redesign of information management systems throughout the Commission.

The Commission was allocated $98,000 for year 2000 compliance activities of which about $30,000 has been spent on the purchase of computer equipment. The remaining funds are to ensure that the Commission's complaint handling database system is compliant and to rewrite associated reports.

Financial Reports

1998-99

Appendix A: Equity

Ethnic Affairs Priorities

The Commission developed its Ethnic Affairs Priority Statement and Ongoing Initiatives covering the period 1997-2000 and is the basis of this report.

Goal 1

Promote consumer input into Commission decision making by convening regular Consumer Consultative Committee Meetings and consider inclusion of specific ethnic representation on Consumer Consultative Committee (CCC).

Performance

- Consumer Consultative Committee met quarterly.
- Ethnic Communities Council nominated the Chairman of the Health Sub-Committee to represent them
- Ethnic Media, Telephone Interpreter Service (TIS), Health Care Interpreter Service (HCIS) and Indigenous network part of general distribution list for HCCC information and publications.

Goal 2

Provide access to information for people with language backgrounds other than English, including indigenous people.

Performance

- Complaints Process Brochure available in languages was revised prior to reprint
  - Spanish, Serbian, Portugese, Khmer, Korean, Italian, Greek, Assyrian, Turkish, Macedonian, Laotian, Arabic, Japanese, Russian.
- Information Sheet on the Patient Support Office available in Armenian, Tagalog, Farsi/Dari, for distribution in identified areas.
- Commenced Rural Outreach programme.
- Commenced Prisoner Outreach programme.
- Translated Patients Rights & Responsibilities brochure into plain English and pictures used to convey messages.
- Review of the translated Freecall service (7 languages) to assess level of use and effectiveness suggested the service is not effective and will be discontinued.
- Occasional use of on site interpreters and ongoing use of TIS and HCIS.

Goal 3

Maintain Consumer Satisfaction Survey

Performance

- New code implemented to collect data on complaints where non-use of interpreter by health professional was a factor in complaint.
- Complainant (profile) survey form revised to obtain religious and cultural background information. Data collection commenced on 1 July 1998.

Goal 4

Provide training for staff on use of TIS and HCIS

Performance

- Staff encouraged to obtain CLAS accreditation - one staff member currently receives the allowance.
- Telephone Inquiry, Resolution, Legal and Senior Investigation Officers briefed on use of TIS and HCIS.

Goal 5

Develop data base for consumers with language backgrounds other than English

Performance

- Capturing complainant profile information on language and religion commenced in 1998-99.

Goal 6

Include Cultural Diversity Implementation Plan initiatives in Business Plans and in Staff Performance, Evaluation And Development Scheme (SPEADS), Statements of Duties and vacant position advertisements.

Performance

- Appropriate responsibility included in statements of duty or position descriptions.
- Job advertisements include understanding and commitment to cultural diversity principles and issues.
- Recommended recruitment and selection strategies have been implemented.
- Criteria included in SPEADS agreements.

Goal 7

Maintain EEO data

Performance

See Equal Employment Opportunity information

Disability

Goal 1

To improve access to HCCC services for consumers with disabilities

Performance

- Patients Rights & Responsibilities brochure translated into plain English and pictures used to convey message.
- Stationery revised and information on TTY number and E-mail address included. All reprints of brochures will have this information included.
- Disability Contact Officer identified.
- Staff members trained in use of TTY.

Goal 2

To ensure access to premises and facilities by clients and staff with disabilities

Performance

- A Disability Audit was commissioned to assess standard and suitability of current physical facilities, eg, entrances, signage, toilets, equipment. The report makes extensive recommendations and many relate to the premises occupied by the Commission. These have yet to be considered and incorporated into an action plan which would necessarily involve negotiations with the building owners.

Goal 3

To increase awareness of the services provided by HCCC to consumers with disabilities

Performance

- TTY, Fax, E-mail and Website numbers and addresses included in brochures (ongoing, as revised or reprinted).
- Patient Rights & Responsibilities brochure written in plain English.
- Non-verbal information, eg, pictures used in Patient Rights brochure.
- All new publications comply with Ageing and Disability Department print guidelines.

Goal 4

To report on complaints relating to disability issues, eg, access to services/facilities

Performance

- Data base enhanced to include field so this information can be recorded and reported.

Goal 5

Increase the awareness of and sensitivity to the needs of clients and colleagues with disabilities

Performance

- Home interviews conducted.

Goal 6

To ensure people with disabilities have opportunities for work and career development

Performance

- Grievance and Harassment Policy and Procedures in place.
- No preclusion from career work opportunities.

Goal 7

To ensure the principle of reasonable adjustment is adopted and applied for staff with disabilities (including temporary disability from illness)

Future Strategies

- Continue to review brochures prior to re-print and new brochures to ensure easily understood and appropriate size font used.
- Include brochures/publications on proposed Website.
- Identify alternative means of providing information on services, eg, audio-tape.
- Review existing facilities to expand capacity for employment for people with disabilities.
- Analyse EEO data survey form to identify whether staff have special needs.

Ageing

The Commission is a key agency and has contributed to the development of the NSW Government Healthy Ageing Framework. The Commission's Action Plan follows with a report on progress.

Goal 1

To improve access to HCCC services & information

Performance

- Number of home visits to witnesses and consumers who were unable to travel to the Commission in 1998-99 was 4. Patient Support Officers have conducted a total of 34 home visits to interview consumers unable to travel.
- The Commission conducts seminars on a regular basis to health care providers and consumers on the complaint process, role of the Commission, rights and responsibilities and Patient Support Office. Patient Support Officers have conducted a total of 45 presentations to aged and disability groups in NSW since 1 July 1998. Commission conducted 5 information sessions in rural NSW in 1998-99. Total estimated attendance at consumer sessions is 250.

Goal 2

To provide training to key staff on ageing issues

Future Strategies

- Plan to be discussed by Consumer Consultative Committee.
- Seek input from specific consumer groups on ageing issues.
- Provide training to staff on ageing issues.

Goal 3

To report on complaints relating to ageing issues

Performance

- Each complainant receives a "Complainant Data Form" which asks questions related to sex, cultural background, age, disability and religion. Only 25% of these surveys are returned to the Commission and the two categories normally not completed are religion and age. This survey is purely voluntary, and the Commission cannot insist on the information being provided. Even though the data could be useful to help the Commission target special groups, it does not impact on how the complaint is handled.

Women

The Commission has not been defined as a key agency for the purpose of the Annual Reports (Departments) Amendment (Women's Action Plan) Regulation 1997. However, the following initiatives have been implemented or continued during the reporting period:

- Representation of women's group on the Consumer Consultative Committee
- Representation of associations dealing with specific women's health issues on the Consumer Health Reference Panel, eg, breast implant, older women's network, family planning, transgender and breast cancer.
- Staff have been trained in issues confronting Transgender people in health services

Future Strategies

- The Patient Support Office Inmate Outreach Programme to include women's correctional centres.

Appendix B: Freedom of Information

Section A

Numbers of new FOI requests - Information relating to numbers of new FOI requests received, those processed and those incomplete from the previous period.

	FOI requests	Personal	Other	Total
A1	New	45	1	46
A2	Brought forward	-	-	-
A3	Total to be processed	45	1	46
A4	Completed	38	1	39
A5	Transferred out	-	-	-
A6	Withdrawn	7	-	7
A7	Total processed	45	1	46
A8	Unfinished (carried forward)	-	-	-

Section B

What happened to completed requests

	Results of FOI	Personal	Other
B1	Granted in Full	6	-
B2	Granted in Part	32	-
B3	Refused (Declined)	-	1
B4	Deferred	-	-
B5	Completed	38	1

Section C

Ministerial Certificates - number issued during the period

C1	Ministerial Certificates issued	-

Section D

Formal consultations - number of requests requiring consultations (issued) and total number of FORMAL consultations for the period

		Issued	Total
D1	Number of requests requiring formal consultations	-	-

Section E

Amendment of personal records - number of requests for amendment processed during the period

	Results of requests	Total
E1	Agreed	-
E2	Refused	-
E3	Total	-

Section F

Notation of personal records - number of requests for notation processed during period

F3	Number of requests	-

Section G

FOI requests granted in part or refused. Basis of disallowing access - number of times each reason cited in relation to completed requests which were 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)	**38**	**1**
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)	-	-
G9	Totals	-	-

Section H

Costs and fees of requests processed during period, not including costs and fees for unfinished requests

		Assessed Costs	FOI Fees Received
H1	H1 All completed requests	$8,000	$855

Section I

Discounts allowed - number of FOI requests processed during the period where discounts were allowed

	Type of Discount Allowed	Personal	Other
I1	Public Interest	-	-
I2	Financial hardship - Pensioner/Child	20	-
I3	Financial hardship - non-profit organisation	-	-
I4	Totals	20	-
I5	Significant correction of personal records	-	-

Section J

Days to process - number of completed requests by calendar days (elapsed time) taken to process

	Elapsed Time	Personal	Other
J1	0 - 21 days	33	1
J2	22 - 35 days	5	-
J3	Over 35 days	-	-
J4	Totals	38	1

Section K

Processing time - number of completed requests by hours taken to process

	Processing Hours	Personal	Other
K1	0 - 10 hours	32	1
K2	11 - 20 hours	5	-
K3	21 - 40 hours	1	-
K4	Over 40 hours	-	-
K5	Totals	38	1

Section L

Reviews and Appeals - number finalised during period

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

Appendix C: Legislation

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

Appendix D: Committees & Taskforces

The Commission has representation on significant Statutory Bodies and Interdepartmental committees including:

Chief Executives Committee - Commissioner

Chiropractors and Osteopaths Registration Board Complaints - Director, Complaint Resolution

Committee of Inquiry into Cosmetic Surgery - Commissioner

Consumer Focus Collaboration Committee - Director, Complaint Resolution

Dental Board Complaints Committee - Director, Complaint Resolution

Dental Technicians and Prosthetists Registration Complaints Committee - Director, Complaint Resolution

Department of Health Information Management Committee - Commissioner

Medical Board Conduct Committee - Commissioner

Medical Board Medico-legal sub-committee, Director, Complaint Resolution

Ministerial Advisory Committee, Quality in Health Care - Commissioner

National Council of Health Care Commissioners - Commissioner

National Health Complaints Information System Project Steering Committee - Commissioner

Nurses Registration Board Conduct Committee - Commissioner

Optical Dispensers Registration Complaints Committee - Director, Investigations and Prosections

Optometrists Board Complaints Committee - Director, Investigations and Prosections

Pharmacy Board Complaints Committee - Director, Complaint Resolution

Physiotherapists Registration Complaints Committee - Director, Investigations and Prosections

Processes of Review in Mental Health Services - Manager, Patient Support Office

Psychologists Registration Complaints Committee - Commissioner

Skin Care Improvement and Pressure Ulcer Prevention Group - Commissioner

Statewide Complaints Data Project Management Committee - Director, Complaint Resolution

Transgender Working Party - Publications and Information Officer

Watchdog Agencies - Commissioner

Appendix E: Staff of the Commission

(At 30 June 1999)

Commissioner
Merrilyn Walton, BA, MSW, Adjunct Associate Professor, Department of Psychological Medicine, University of Sydney

Director, Investigations & Prosecutions
Tom Galloway, LLM (Syd)

Director, Complaint Resolutions
Julie Kinross, MSW, BA, PG Dip. Ad.Finance & Investment.

Director, Corporate Support
Tom McKnight

Director, Executive Support
Sarah Crawford, BCom, LLB, GDLP

Manager, Legal Section
David Swain, BLegS, DipCrim., LLM

Manager, Complaints Assessment & Resolution
David Moss (Acting), BN, RN.

Manager, Investigation Team 1
Elizabeth Wing, LLB

Manager, Investigation Team 2
Sally Anne Forsstrom, BA, DNE, RN, FRCNA.

Administrative Officer
Trevor Covell, PAC

Legal Officers
David Harris, BA, LLB
Kanagasabai Vasan, MA Attorney-at-Law
Sarah Connors, BA, LLB.
Lynne Organ, LLB
Christina King, LLB, Bec.

Hearing Officers
Michael Wade, BCom.
Zoe Bowman, BA, LLB

Investigation Officers
Christina Hart, BA(Hons) BSoc Studies
Rosemary Pendlebury, JP, RN, RMN, DNE, RN(NCUSA)
Moira Kelly, JP, BA(SocWk), MSW, GradDip Rel Ed., B.Th.
Giles Yates, MA, PhD(Bioethics)
Noelle Taoube, RN, BHSc, MPH
Arlene Chattakar Aitkins,BA (Hons), SRN, SCM.
Elizabeth van Ekert, BA, DipEd
Antoinette Younes, JP, MA, LLB, GDLP.
Vivienne Flynn, RN, GradDip (Health Science) (HIV Studies)
Eva Crisp, BSc (Hons) JP

Resolution Officers
Amanda Hadley, BSc PMC
Paul Conroy, (Acting) BA, Dip Ed

Telephone Inquiry Officers
Winsome Ely
Janette Campbell (Acting)

Manager, Patient Support Office
Bruce Greetham RN, MM

Patient Support Officers
Brian McMahon
Bernadette Liston, BA
Teresita Indolos, Grad DipHP,(BA, B.Sw. - Philipines)
Mark Hodges, BSocSc (Psy)
Ellen Palmer, BSocWk.
Kate Ryder, MPH, BA (Hons).
Valerie Keen, BSocStud.
Irene Sullivan

Complainant Liaison Officer
Sonia Belen-Balitactac, MD, BSc, FACBS (philippines)

Publications/Information Officer
Maida Talhami, BA

Commissioner's Executive Assistant
Diane Veness, BA

Executive Assistant to Directors
Sara Coutinho

Administrative and Clerical Staff
Robin Parsons, David Cornish, Rod Dalziel, Loryn Bird, Estella Fanella JP, Mirella Jennings, Jackie Liong JP, Carmen Sitta, Carole Song, Sue Russell, Linda Calver, Kelly Ann Davies.

Temporary Staff

Manager, Informations Technology
Bran M'Cithech

Snr. Investigation Officers
Vicki Dendtler, (P/T) BSc.(App.Psych.)
Chris Williams, Assoc Dip Ed , BTh, BTheol.

Special Projects
Amanda Cornwall, LLB

Resolution Officers
Peta Kava (P/T), RN, BA, LLB
Gretel O'Toole

Clerical Support Officers
Kristin Thomas
Nasrin Schonberger

Medical Advisers
Dr Eric Fisher MBBS FRACGP GRCGP
Dr Glenda Peel MBBS
Dr Julie Gottlieb MBBS
Dr Wal Grigor AM MBBS FRACP

Staff who had been employed during part of the year or who are currently on leave from the Commission:

Jenny Brown, Kirsten Horne, Karin Daugulis, Catherine Maxwell, Silvana Manno, Susan Urquhart, Damian Legg, John Haydock, Simon Cohen, Michael Kinchington, Vera Orr, Donna Heeps, Virginia McMasters, Karrie Pattingale, Stella Donaldson, Helen Huszar-Welton, Tracey Lloyd-Eakin.

Appendix F: Access

Office address:

Level 4, 28-36 Foveaux Street
Surry Hills NSW 2010
(Wheelchair access via Belmore Lane)

Postal address:
Locked Mail Bag 18
Strawberry Hills NSW 2012
Fax: (02) 9281 4585

Hours of business:
9.00am to 5.00pm Monday to Friday

Telephone (02) 9219 7444

Toll Free in NSW 1800 043 159

TTY service for the hearing impaired
(02) 9219 7555

Website: http://www.hccc.nsw.gov.au

E-mail: hccc@hccc.nsw.gov.au

Interpreters can be arranged to discuss a complaint

Patient Support Officers

It is best to contact Patient Support Officers by telephone:

Penrith/Blue Mountains	(02) 4724 3870
Western Sydney	(02) 9839 1506
South Eastern Sydney	(02) 9382 8129
Northern Sydney	(02) 9926 8184
South Western Sydney	(02) 9828 5710
Central Sydney	(02) 9767 8300
Newcastle/Hunter	(02) 4921 4943

For people in rural or remote areas, ring the Commission on (02) 9219 7444 or toll free.

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