

PARLIAMENT OF NEW SOUTH WALES



Committee on the Health Care Complaints Commission

Operation of the *Health Care Complaints Act 1993*

Final Report

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Membership and staff

Chair	Hon Helen Westwood AM MLC
Deputy Chair	Mrs Judy Hopwood MP, Member for Hornsby
Members	Mr Matthew Brown MP, Member for Kiama Hon David Clarke MLC Hon Kerry Hickey MP, Member for Cessnock Hon Nathan Rees MP, Member for Toongabbie (from 25 February 2010) Rev Hon Fred Nile MLC
Former members	Mr Matthew Morris MP, Member for Charlestown (from 21 June 2007 to 6 January 2010)
Staff	Mr Mel Keenan, Committee Manager Ms Cheryl Samuels, Research Officer Ms Jacqueline Isles, Committee Officer Mr John Miller, Assistant Committee Officer
Contact Details	Committee on the Health Care Complaints Commission Parliament of New South Wales Macquarie Street Sydney NSW 2000
Telephone	02 9230 3060
Facsimile	02 9230 3052
E-mail	chccc@parliament.nsw.gov.au
URL	www.parliament.nsw.gov.au/healthcarecomplaints

List of Abbreviations

ADA	Australian Dental Association (NSW Branch)
AHS	Area Health Service
Avant	A major national medical defence organisation
CEC	Clinical Excellence Commission
HCCC	NSW Health Care Complaints Commission
HPR Act	Health Practitioner Regulation Act 2009
HSA	Health Services Association of NSW
MPA	<i>Medical Practice Act 1992</i>
NCOSS	Council of Social Service of New South Wales
NHWT	National Health Workforce Taskforce
NZ Code	New Zealand Code of Health and Disability Services' Consumer Rights
NZHDC	New Zealand Health and Disability Commission/Te toi hau haura
PIAC	Public Interest Advocacy Centre
SAC 1	Severity Assessment Code 1
The Act	<i>Health Care Complaints Commission Act 1993</i>
The Board	NSW Medical Board
The Charter	Australian Charter of Healthcare Rights
The Directive	NSW Health Department Open Disclosure Policy Directive
The National Agency	Australian Health Practitioner Regulation Agency
The National Boards	National Health Practitioner Boards
The National Scheme	National Registration and Accreditation Scheme for the Health Professions
The Nurses' Association	New South Wales Nurses' Association

Terms of Reference

That, pursuant to the functions of the Joint Parliamentary Committee on the Health Care Complaint Commission under s 65(1)(b) and s 65(1)(d) of the *Health Care Complaints Act 1993* to report to both Houses of Parliament, with such comments as the Committee thinks fit, on any matter appertaining to the Commission or connected with the exercise of the Commission's functions to which, in the opinion of the Committee, the attention of Parliament should be directed, and to report on any change that the Committee considers desirable to the functions, structures and procedures of the Commission:

the Committee examine the operation of the *Health Care Complaints Act 1993*, with particular reference to:

1. the identification and removal of any unnecessary complexities in the New South Wales health care complaints system;
2. the appropriateness of the current assessment and investigative powers of the Health Care Complaints Commission; and
3. the effectiveness of information-sharing between the Health Care Complaints Commission and Area Health Services and Registration Authorities in New South Wales,

and report to Parliament on any matters connected with the Committee's statutory functions.

Chair's Foreword

If one uses the term employed... in the 1980s [to describe] the health field as a 'strife of interests', a more apt description of the working environment of complaints commissions would be that of a minefield. In threading their way through that explosive terrain, the Commissions may not always satisfy consumer expectations. Nonetheless, it is undoubtedly true that they have made a major contribution to the creation of the heightened climate of provider accountability which has characterised Australian health care systems at the turn of the century.¹

These words were written on the 20th anniversary of the establishment in New South Wales in 1984 of the world's first ever Health Complaints Unit, the precursor to the NSW Health Care Complaints Commission. Since that Unit's establishment, bodies resembling the Commission to varying degrees have become the norm across Australia and New Zealand, as the accountability of healthcare providers – whether individuals or organisations - has become recognised as a pivotal part of the provision of healthcare generally.

In the Commission, New South Wales has a highly professional body which works closely with the various registration authorities and relevant government agencies to investigate serious complaints relating to health services and health service providers, under the provisions of the *Health Care Complaints Act 1993*. The Act expressly mandates the Commission to undertake this role with the protection of the health and safety of the public as its paramount concern.

In doing so, the Commission threads across "explosive terrain", as the Health Care Complaints Act is not one which is disposed either to practitioners or to health care consumers; rather, it is an Act "for handling complaints in a fair and appropriate way".² In handling complaints in this manner, the Commission will regularly disappoint both complainants and those the subject of complaints, despite its best endeavours. In monitoring and reviewing the exercise of the Commission's functions, it is the role of the Committee on the Health Care Complaints Commission to ensure that the systems put in place by the Commission to fulfil those best endeavours strike the appropriate balance.

The genesis of this Inquiry was the Committee's disquiet that the NSW health care complaints system was overburdened by complexity, which in turn led to fractured lines of communication, and avoidable errors. On this point, Committee Members acknowledge that effective communication is essential to the proper functioning of a first class modern healthcare system:

Communication systems are a crucial component of the information infrastructure of any health care organisation, not just as pipes through which information flows, but as the systems where humans share, discuss and eventually decide upon clinical actions.³

¹ Dr D Thomas, "Walking through minefields: Health Complaints Commissions in Australia", *The Australian Health Consumer*, No1, 2003-2004, p.13.

² H Turnbull, Legal Manager Disciplinary Services, Avant, *Transcript of Evidence*, 4 March 2010, p. 15.

³ P J Toussaint and E Coiera, "Supporting communication in health care", Editorial, *International Journal of Medical Informatics*, 2005, Vol 74, No 10, p. 81.

Nonetheless, the Committee has not confined itself to considering issues of communication, but has borne in mind all those suggestions from stakeholders which arose from its first call for submissions, and then in supplementary submissions made in response to its Discussion Paper, and in evidence to the Committee at its public hearing. I would like to take this opportunity to thank all those individuals and organisations which invested the time and effort in apprising the Committee of their views. I am confident that a reading of this Report will show that Committee Members have based their decision-making on the evidence of those parties with the most immediate and in-depth practical experience of the Act's operation.

I am aware that many who have assisted the Committee in its deliberations over a quite considerable period of time have also been heavily involved in preparing for the National Registration and Accreditation Scheme for the Health Professions. When the Committee first resolved to undertake this Inquiry in September 2008, the National Scheme was still in its infancy, and it was on the basis of the considerable change which the Scheme would entail that the Committee delayed the conduct of its own Inquiry. I am pleased to note that in June 2009 it was announced that New South Wales had negotiated with the other Australian jurisdictions to maintain the Health Care Complaints Commission as an integral part of a co-regulatory structure. More recently, the *Health Practitioner Regulation Act 2009* and *Health Practitioner Regulation Amendment Bill 2010* have established the framework for the NSW health care complaints system. The Committee has given consideration to all of these important changes in the body of its Report.

Undoubtedly, the key to threading one's way through a minefield is maintaining balance. "Balance" has indeed characterised the approach which the Committee has consistently taken in weighing up evidence and drafting its responses in the preparation of this Report; and it will continue to characterise the manner in which the Committee exercises its oversight functions under Part 4 of the Health Care Complaints Act.



Hon Helen Westwood AM MLC
Chair

List of Recommendations

RECOMMENDATION 1: That the *Health Care Complaints Act 1993* be amended by adding a new s 3A(5A) in the following terms:

The exercise of roles under this Act by the Commission and the related government agencies shall be governed by the following principles:

- Accountability: Decision-making authorities must be accountable to the New South Wales community in carrying out their statutory functions,
- Transparency: Decision-making processes should be open, clear and understandable for both the consumers and the professions,
- Fairness: Decision-making authorities should maintain an acceptable balance between protecting the rights and interests of patients and those of the practitioners,
- Effectiveness: The regulatory system should be effective in protecting the public from harm and supporting and fostering equity of access and the provision of high-quality care,
- Efficiency: The resources expended and the administrative burden imposed by the regulatory system must be justified in terms of the benefits to the New South Wales community,
- Flexibility: The regulatory system should be well equipped to respond to emerging challenges in a timely manner, as the health care system evolves and the roles and functions of health professionals change.9

RECOMMENDATION 2: That the Health Care Complaints Commission continue to monitor the effectiveness of its communication with persons who are the subject of complaint, seeking the input of the agencies such as registration authorities, the Area Health Services, NSW Department of Health and Avant. 15

RECOMMENDATION 3: That the statutory remit of the Joint Parliamentary Committee on the Health Care Complaints Commission be expanded to monitoring and reviewing the exercise of the functions of the NSW Health Professional Councils.23

RECOMMENDATION 4: That the *Health Care Complaints Act 1993* be amended so that the Health Care Complaints Commission can conduct investigations of its own motion, where such investigations relate to an issue of public interest or public safety that relates to the functions of the Commission.26

RECOMMENDATION 5: That the Note to Division 5 of the Health Care Complaints Act 1993 be amended by the deletion of the second sentence.30

RECOMMENDATION 6: That s 22 of the *Health Care Complaints Act 1993* be amended to provide that, in “exceptional cases”, at the expiry of the 60 day period the Commission may review the progress of an assessment, defer the decision if it is considered appropriate in the circumstances, and advise the complainant of reasons for doing so.31

RECOMMENDATION 7: That the *Health Care Complaints Act 1993* be amended to provide for the mandatory provision of written reasons by the Commission for assessment and post-investigation decisions to both the complainant and the respondent.34

RECOMMENDATION 8: That the Health Care Complaints Commission work with the NSW Department of Health and the NSW Clinical Excellence Commission to establish and publish a knowledge database providing the outcomes of investigations to assist in the improvement of health systems.43

RECOMMENDATION 9: That the *Health Care Complaints Act 1993* be amended by a new s 16(5A) in the following terms:

The Commission must give notice of the making of a complaint to the current employer of the person against whom the complaint has been made if the Commission considers on reasonable grounds that the giving of the notice is necessary to investigate the matter effectively or it is otherwise in the public interest to do so.....51

RECOMMENDATION 10: That, on receipt of a request from the Health Care Complaints Commission for information relating to a complaint against a practitioner employed by, or contracted to work for, an Area Health Service, the Area Health Service supply to the Health Care Complaints Commission only that information which is both sufficiently recent and reasonably relevant to the investigation of the current complaint.52

RECOMMENDATION 11: That the *Health Care Complaints Act 1993* be amended to provide that:

- an Area Health Service must report to the Commission all incidents classified as SAC 1 under the Department of Health's Severity Assessment Code; and
- the Commission must assesses each such incident with a view to establishing whether it is to be investigated by the Commission, and report back to the Area Health Service on the results of its assessment in a timely manner.55

Chapter One - Background

Conduct of the Inquiry

Background to the Inquiry

- 1.1 In June 2008, the Committee tabled the report of its Inquiry into the conduct of the investigation by the Health Care Complaints Commission [the Commission] into the complaints made against ex-practitioner Graeme Reeves. Among the Report's recommendations was that the *Health Care Complaints Act 1993* [the Act] be the subject of a thorough review, to identify any unnecessary complexities in the health care complaints system in New South Wales.
- 1.2 In subsequent correspondence, the Committee was advised by the then-Minister for Health, Hon Reba Meagher MP, that as the proposed National Registration and Accreditation Scheme for the Health Professions [the National Scheme] was to include a national complaints handling scheme, the NSW Department of Health did not intend to undertake a review of the Act.⁴ As the new scheme was not intended to be introduced until July 2010, Committee Members were concerned at this loss of momentum for change at the State level.
- 1.3 Accordingly, at its meeting of 25 September 2008, the Committee resolved to undertake its own Inquiry, pursuant to its statutory responsibilities. The Inquiry was advertised, and the Committee received 27 submissions. However, as the momentum for the national complaints handling scheme grew, the Committee deferred the conduct of its inquiry, in order to establish whether or not New South Wales would retain its co-regulatory system.

Reforms since Reeves

- 1.4 In March 2009, Dr Andrew McDonald MP, Parliamentary Secretary for Health, introduced amendments to s 21A and s 34A of the Act, adopting the recommendations previously made by the Hon Deirdre O'Connor in her 2008 review of the *Medical Practice Act 1992* and by the Committee. These amendments came into force in May 2009.
- 1.5 Under the amendments, the Commission now has the power to require any person to provide information, documents or evidence of the purpose of the assessment or investigation of a complaint; the power to consider associated complaints; and the power to reopen old cases that had been closed due to insufficient evidence.

Discussion Paper

- 1.6 The Hon John Della Bosca MLC, the then-Minister for Health, also announced in June 2009 that the NSW Health Care Complaints Commission would be retained as a component of the National Scheme.
- 1.7 Given this, the Committee felt that it was important to highlight the issues raised in submissions received for its inquiry into the operation of the Act and, on 24 September 2009, tabled a Discussion Paper containing 29 Issues for discussion.

⁴ Hon R P Meagher MP, Minister for Health, Correspondence to Hon Helen Westwood MLC, Chair of the Committee on the Health Care Complaints Commission, 1 September 2008.

Background

- 1.8 Following the publication of its Discussion Paper, the Committee called for another round of submissions and 22 additional submissions were received.⁵ The Committee then held a public hearing on 4 March 2010 at which 17 witnesses gave evidence.⁶
- 1.9 While the Committee does not have the remit to examine the operations of a national authority, the National Scheme will undoubtedly have both immediate and long-term effects on the investigation of health care complaints in New South Wales. Accordingly, Committee Members felt that would be a somewhat incomplete Inquiry were they not cognisant of these changes at the national level, and the Committee sought the evidence of witnesses as to their expectations of the likely impact of the National Law in their area of expertise.

National Registration and Accreditation Scheme for the Health Professions

- 1.10 In 2006, the Council of Australian Governments (COAG) agreed to a national health workforce reform package aimed at better preparing the health workforce for the changing healthcare needs of the Australian community. One project for practical solutions to issues of workforce reform was a National Registration and Accreditation Scheme for the Health Professions, which was to be implemented by State-based legislation, and would commence in July 2010.
- 1.11 The Committee had grave concerns that the scheme originally proposed envisaged a return to a model of self-regulation which had been discredited and abandoned in a range of jurisdictions;⁷ or, as the Public Interest Advocacy Centre [PIAC] described it, a “move back to an unfettered system of peer review”.⁸
- 1.12 The fact that the proposed scheme was based largely on the health care complaints system currently operating in Victoria was a matter of particular concern, given that this system had recently been the subject of strong criticism by the Victorian Ombudsman in his *Report of an Investigation into issues at Bayside Health*.⁹
- 1.13 On this point, the Committee subsequently received a submission from Ms Beth Wilson, Health Services Commissioner, Victoria, in which Ms Wilson suggested that the reference in the Discussion Paper to strong criticism by the Victorian Ombudsman is a “very misleading part of the *Discussion Paper*” which “should be corrected”.¹⁰

⁵ See Appendix 1 for the full list of submissions received.

⁶ See Appendix 3 for the list of witnesses.

⁷ Specifically, the Committee considered that the proposed model would not have been as effective as the NSW co-regulatory model in meeting the National Health Workforce Taskforce’s own criteria for a health complaints system, which are to:

- ensure that public protection is paramount;
- maintain a high degree of transparency; and
- be appropriately accountable

Practitioner Regulation Subcommittee, Health Workforce Principal Committee. 2008. Consultation Paper, *Proposed arrangements for handling complaints, and dealing with performance, health and conduct matters*, October 2008, Australian Health Ministers’ Advisory Council, p. 4.

⁸ PIAC. 2008. *Maintaining consumer focus in health complaints: the key to national best practice*, 24 November 2008.

⁹ See Ombudsman Victoria. 2008. *Whistleblowers Protection Act 2001, Report of an Investigation into issues at Bayside Health*, <<http://bit.ly/667OjS>>

¹⁰ Submission no. 36, Health Services Commissioner Victoria, p. 1.

- 1.14 In the light of these concerns, the Committee further examined the content of the Victorian Ombudsman's Report. Committee Members concluded that, while much of that Report and recommendations were focussed on the financial transgressions of an individual practitioner, the core issue was that he was able to abuse the traditional system of practitioner peer review. Accordingly, the Committee did not agree with Ms Wilson's suggestion that there was anything misleading in the Discussion Paper.¹¹
- 1.15 The Committee also notes the comment in Ms Wilson's submission that the co-regulatory framework in operation in New South Wales seems to be "an inefficient use of scarce resources". The Committee respectfully cannot agree with Ms Wilson's suggestion that:
- [t]ransferring all responsibility of complaints management to the relevant Registration bodies would potentially decrease the level of duplication inherent in the [NSW] system.¹²
- 1.16 Indeed, the Committee notes evidence from the President of the NSW Physiotherapists Board to the effect that, rather than have the State stand alone by retaining the Commission as independent complaints handling body, her organisation would have preferred the other States "to come along with New South Wales".¹³
- 1.17 Similarly, the NSW Branch of the Australian Medical Association has expressed its support for the maintenance of the current system in New South Wales:
- We again wish to formally acknowledge the considerable support of the NSW Government to date in advocating for the concerns of all health professionals in NSW. We appreciate that the decisions of the NSW Government to preserve our internationally recognised systems will ensure the best protection of the patients of NSW.¹⁴
- 1.18 Finally, the Committee is pleased to note the following evidence of Mr Peter Dodd of PIAC at the public hearing on 4 March 2010:
- We also note the maintenance of the HCCC as an independent assessment and investigation and prosecution body under the national regulation scheme for health professionals... and I acknowledge the role of this Committee in relation to getting a good outcome for the consumers of New South Wales in terms of maintaining the Commission in that role.¹⁵
- 1.19 The Committee is pleased to have had the opportunity to play an active role in the retention of the Commission as an independent complaints-handling body, by way of direct representations to the then-Minister for Health, Hon John Della Bosca MLC.

Health Practitioner Regulation Act 2009

- 1.20 As noted in the Chair's Foreword, it was announced in June 2009 that the NSW Health Care Complaints Commission will be retained as a component of the national complaints handling scheme. In November 2009, the Minister for Health, Hon Carmel

¹¹ Letter from Hon Helen Westwood AM MLC, Committee Chair, to Ms Beth Wilson, Health Services Commissioner, Victoria, 20 November 2009.

¹² Submission no. 36, Health Services Commissioner, Victoria, p. 3.

¹³ A Deans, President, New South Wales Physiotherapists Registration Board, *Transcript of Evidence*, 4 March 2010, p. 61

¹⁴ See Hon Carmel Tebbutt MP, Minister for Health, Legislative Assembly *Hansard*, 11 November 2009.

¹⁵ P Dodd, Solicitor, Public Interest Advocacy Centre, *Transcript of Evidence*, 4 March 2010, pp. 20-21.

Background

Tebbutt MP, introduced the *Health Practitioner Regulation Act 2009* [the HPR Act] as a further step in establishing the National Scheme.

- 1.21 The National Law creates the Australian Health Practitioner Regulation Agency [the National Agency] and National Health Practitioner Boards [the National Boards] for each of the regulated health professions. The effect of each jurisdiction applying the National Law - and therefore a national entity of the same name and membership being established in each jurisdiction - is that only one national entity of that name is created rather than multiple entities of that name, one in each jurisdiction.
- 1.22 The National Law establishes ten National Boards for the health professions within the National Scheme.¹⁶ The extensive functions of the Boards are listed in Appendix 4.
- 1.23 The National Law also recognises co-regulatory jurisdictions¹⁷ - such as New South Wales - that will have jurisdiction-specific arrangements for health, performance and conduct matters that are substantially equivalent to those of the National Scheme. It ensures that decisions of co-regulatory authorities in those jurisdictions regarding registered health practitioners and students are implemented by the National Scheme to secure protection of the public.
- 1.24 A co-regulatory jurisdiction may adopt and apply the National Law, and use State legislation for handling complaints about health, conduct or performance matters. Section 150 of the National Law clarifies the relationship between a National Board and a participating jurisdiction's health complaints entity - e.g., the NSW Health Care Complaints Commission - in relation to the receipt and preliminary assessment of a notification or complaint.¹⁸
- 1.25 These changes obviously create extra complexity for the system in New South Wales. The current State registration and accreditation bodies will be replaced by a national system with headquarters in Melbourne. Thus, there will be State bodies - Professional Councils - appointed by the NSW Minister for Health, which will report 'vertically' to the national bodies, but will interact 'horizontally' with the Health Care Complaints Commission.
- 1.26 Ms Leanne O'Shannassy noted in evidence to the Committee that the NSW Department of Health is:

very hopeful that we will be able to make it work, but it will be complicated. The biggest risk we need to manage is because we will have two systems, we do not want people falling in between. That is really important. That is the focus of a lot of the work we are doing.¹⁹
- 1.27 The final stage in this legislative process was the introduction into the Legislative Assembly of the *Health Practitioner Regulation Amendment Bill 2010* on 20 May

¹⁶ These are the Chiropractic Board of Australia, Dental Board of Australia, Medical Board of Australia, Nursing and Midwifery Board of Australia, Optometry Board of Australia, Osteopathy Board of Australia, Pharmacy Board of Australia, Physiotherapy Board of Australia, Podiatry Board of Australia and Psychology Board of Australia.

¹⁷ A "co-regulatory jurisdiction" means a jurisdiction in which the Act applying the National Law declares that the jurisdiction is not participating in the health, performance and conduct process provided by Divisions 3 to 12 of Part 8. See s 6 of the *Health Practitioners Regulation Act 2009*.

¹⁸ See Appendix 5

¹⁹ L O'Shannassy, Director - Legal and Legislation, NSW Department of Health, *Transcript of Evidence*, 4 March 2010, pp. 51-52.

2010. This Bill, *inter alia*, establishes the separate complaints handling system in New South Wales, in co-regulation with the National Scheme. It is discussed in detail at paragraphs 2.51 to 2.57.

Principles of a complaints handling system for the 21st Century

1.28 As noted in the Discussion Paper, the Committee has been cognisant of other Australian jurisdictions, and overseas jurisdictions where comparisons are appropriate, in considering the operation of the Act.²⁰ It has concluded that the optimal way to ensure the protection of the health and safety of the public is a health care complaints system governed by the following principles:

- **Accountability:** Decision-making authorities must be accountable to the New South Wales community in carrying out their statutory functions;
- **Transparency:** Decision-making processes should be open, clear and understandable for both the consumers and the professions;
- **Fairness:** Decision-making authorities should maintain an acceptable balance between protecting the rights and interests of patients and those of the practitioners;
- **Effectiveness:** The regulatory system should be effective in protecting the public from harm and supporting and fostering equity of access and the provision of high-quality care;
- **Efficiency:** The resources expended and the administrative burden imposed by the regulatory system must be justified in terms of the benefits to the New South Wales community; and
- **Flexibility:** The regulatory system should be well equipped to respond to emerging challenges in a timely manner, as the health care system evolves and the roles and functions of health professionals change.²¹

1.29 The Committee appreciates that these principles are not always in harmony; rather they are, at times, competing aims which need to be held in an appropriate balance. Committee Members were particularly pleased to note the view of the Council of Social Service of NSW [NCOSS] that the Commission's current operation is largely in accordance with these principles.²² However, NCOSS stressed to the Committee that:

it is important that these principles are formalised and promoted to enhance and strengthen the operation of the complaints handling system in NSW.²³

1.30 As PIAC noted in its Response to the National Health and Hospitals Reform Commission's *Draft Principles for Australia's Health System*:

We need... to move from closed responses to adverse and critical incidents to systems that seek to understand the factors that led to such incidents and how we can prevent them recurring. Openness and transparency are vital elements of this approach.²⁴

²⁰ See, e.g., Ontario Health Professions Advisory Council. 2001. *Adjusting the balance: a review of the Regulated Health Professions Act*, p. 3.

²¹ See, also, Victorian Department of Human Services. 2003. *Regulation of the health professions in Victoria: a discussion paper*, p. 10.

²² NCOSS, *Questions answered after hearing*, 29 March 2010, p. 2.

²³ NCOSS, *Questions answered after hearing*, 29 March 2010, p.2.

Background

1.31 It was also suggested to the Committee that the very success of the NSW co-regulatory system in balancing these competing interests was a key reason for the widespread support for retaining the Commission in any national scheme:

... compared to other jurisdictions... there is a very high degree of transparency, which I think is important both for a clinician facing a disciplinary process as well as important for a consumer and a regulator and for the public at large.

There is a high degree of accountability partially because of that transparency and partially because you have boards and an independent investigator and prosecutor, and there is also a high degree of focus on the public protection and public interest.²⁵

1.32 The Commission responded to the Committee's mooted principles in considerable detail, and Committee Members thought it was both appropriate and fair to include this response in its entirety:

Accountability – decision-making authorities must be accountable to the NSW community in carrying out their statutory functions.

An important aspect of accountability is explaining the Commission's role to the general community and relevant stakeholders. The Commission provides a considerable range of information on its role and functions through the Commission's website, community outreach activities, and annual reports. In handling individual complaints, the Commission explains to the complainant and the health service provider(s) involved how the complaint is being handled and the reasons for the Commission's decisions.

The Commission is accountable for its overall performance to both the Minister for Health and the Parliamentary Committee on the Health Care Complaints Commission. To this end, the Commission provides quarterly reports to the Minister and the Committee on its recent complaint-handling work as measured against key performance indicators.

The accountability of the tribunals that hear and determine the Commission's disciplinary proceedings against individual practitioners is reflected in the requirement that the proceedings are open to the public, and that the reasons for tribunal decisions are made public. More recently, Medical Professional Standards Committees (PSCs) have also been required to conduct their proceedings in public and to make their decisions publicly available.

Transparency – decision-making processes should be open, clear and understandable for both the consumers and the professions.

As discussed above, the Commission provides detailed information on its complaint-handling processes to both the consumers of health services and the health organisations and practitioners providing those services. The Commission has put considerable effort into ensuring that this information is clear and understandable. In addition, detailed reasons are provided to explain the Commission's decisions.

Fairness – decision-making authorities should maintain an acceptable balance between protecting the rights and interests of patients and those of practitioners.

The Commission is required to be independent in dealing with complaints, and is well attuned to the challenge of striking an appropriate balance between the rights and

²⁴ Ms Robin Banks, CEO, PIAC to Dr Christine Bennett, Chair, National Health and Hospitals Reform Commission, 30 May 2008.

²⁵ L O'Shannessy, Director - Legal and Legislation, NSW Department of Health, *Transcript of Evidence*, 4 March 2010, p. 50.

interests of patients and those of the health practitioners who have provided the services and treatment in question.

The *Health Care Complaints Act* affords procedural fairness to health service providers the subject of complaint at crucial stages of the complaint-handling process, allowing them to respond to the complaint and to any proposed adverse comment or action by the Commission. The Commission is very careful to comply with the requirements of procedural fairness.

Where a complainant is dissatisfied with the Commission's decision on their complaint, they have a statutory right to a review of the Commission's decision. The Commission's reviews are conducted thoroughly, and detailed reasons for the review outcome are provided to the complainant.

Effectiveness – the regulatory system should be effective in protecting the public from harm and supporting and fostering equity of access and the provision of high quality care.

The protection of the public from harm is achieved through:

- the Commission's recommendations to hospitals and other health facilities for systems improvement
- the prosecution of disciplinary proceedings against registered practitioners before the relevant health professional tribunal or professional standards committee
- the making of prohibition orders and public statements in circumstances where unregistered health practitioners have breached the Code of Conduct for Unregistered Health Practitioners and pose a risk to public health or safety.

Fostering equity of access and the provision of high quality health care is achieved through the Commission's resolution processes – for example, the Commission can often assist the patient and the health service/practitioner the subject of complaint to overcome previous difficulties in relation to communication and/or the provision of care and treatment.

Efficiency – *the resources expended and the administrative burden imposed by the regulatory system must be justified in terms of the benefits to the New South Wales community.*

The statutory regime under the *Health Care Complaints Act* for the handling of complaints about health services – together with the management of the Commission's operations within that regime – is efficient, in the sense that appropriate resources are allocated to the handling of individual complaints. Serious matters are dealt with the resource-intensive processes of investigation and, where appropriate, the prosecution of disciplinary proceedings against individual practitioners. Less serious matters can be dealt with more appropriately through the Commission's assisted resolution and conciliation processes.

Flexibility – *the regulatory system should be well equipped to respond to emerging challenges in a timely manner, as the health care system evolves and the roles and functions of health professionals change.*

Notable examples of the flexibility of the system to deal with emerging challenges include:

- The Commission has improved consultation processes with the Area Health Services and the Department of Health to ensure that the Commission's recommendations to public health organisations for system improvements are as practical as possible.

Background

- The Commission has increasingly developed its liaison with relevant stakeholders. For example, the Commission's Consumer Consultative Committee has provided the opportunity for the Commission to develop very good relationships with a range of organisations representing health consumers. The Commission has also developed its relationship with the Clinical Excellence Commission, and provides its investigation reports and recommendations to the CEC to assist the CEC in its work on improving the safety and quality of health care.
- A Code of Conduct was introduced for unregistered health practitioners, and the Commission was given the power to make prohibition orders and to issue public statements and warnings in relation to practitioners who have breached the Code of Conduct.
- There were significant amendments to the *Medical Practice Act* in response to some of the issues highlighted by the case of Dr Graeme Reeves:
 - The processes and decisions of Medical PSCs are now better informed, through the inclusion of a presiding legal member on any PSC.
 - PSC proceedings have been made open to the public
 - The reasons for PSC decisions are available to relevant stakeholders and the general public.

The Commission's comments above under "Efficiency" are also relevant here. Complaints are continually assessed by the Commission under section 20A of the Act to ensure the appropriate allocation of resources to individual complaints.²⁶

1.33 The Committee notes that s 3A of the Act provides an outline of the Commission's role in relation to government agencies with functions in connection with the health care system. This section was added to the Act in 2004, with the express purpose of setting out in the legislation "which agencies and organisations in the health system have responsibility for improving standards."²⁷

1.34 However s 3A(6) of the Act provides as follows:

This section is explanatory only and does not affect any other provision of this Act, or any other Act, or any instrument made under this or any other Act.

1.35 Accordingly, Committee Members consider that an amendment to s 3A of the Act would send out a powerful message to the relevant government agencies, practitioners and health care consumers as to the principles governing the health care complaints system in New South Wales, without affecting the other provisions of the Act, due to the operation of s 3A(6).

RECOMMENDATION 1: That the *Health Care Complaints Act 1993* be amended by adding a new s 3A(5A) in the following terms:

The exercise of roles under this Act by the Commission and the related government agencies shall be governed by the following principles:

- **Accountability:** Decision-making authorities must be accountable to the New South Wales community in carrying out their statutory functions,

²⁶ Health Care Complaints Commission, *Questions answered after hearing*, pp. 2-5.

²⁷ Hon M Iemma MP, Minister for Health, Legislative Assembly *Hansard*, 26 October 2004.

- Transparency: Decision-making processes should be open, clear and understandable for both the consumers and the professions,
- Fairness: Decision-making authorities should maintain an acceptable balance between protecting the rights and interests of patients and those of the practitioners,
- Effectiveness: The regulatory system should be effective in protecting the public from harm and supporting and fostering equity of access and the provision of high-quality care,
- Efficiency: The resources expended and the administrative burden imposed by the regulatory system must be justified in terms of the benefits to the New South Wales community,
- Flexibility: The regulatory system should be well equipped to respond to emerging challenges in a timely manner, as the health care system evolves and the roles and functions of health professionals change.

Chapter Two - A complex health care complaints system

Healthcare organisations deliver services in an increasingly complex social and organisational environment. This complexity is further magnified by increasing public and stakeholder scrutiny.²⁸

Introduction

2.1 This Chapter deals with the Inquiry's first Term of Reference. Issues raised with the Committee about unnecessary complexities in the health care complaints system were:

- the practicalities of making a complaint;
- additional problems facing complainants with special needs;
- communication generally; and
- the wide range of Registration Authorities required to be dealt with.

Australian Charter of Healthcare Rights

ISSUE 1: That s 3 of the *Health Care Complaints Act 1993* be amended to include a fifth object "to uphold the rights set out in the *Australian Charter of Healthcare Rights*".

ISSUE 2: That the *Health Care Complaints Act 1993* be amended to include a provision that the Health Care Complaints Commission should consider the *Australian Charter of Healthcare Rights* when assessing or otherwise dealing with a complaint

ISSUE 3: That the *Australian Charter of Healthcare Rights* be added as a Schedule to the *Health Care Complaints Act 1993*.

2.2 Committee Members acknowledge the widespread acceptance of the concept of patients' rights in the contemporary healthcare discourse:

Patients or consumers of health care services increasingly expect that health care providers will operate in a manner that acknowledges the right of the consumer to knowledge, autonomy, and respect... and of patient safety as a component of wider clinical governance and a central operational principle of Australian health care organizations... For this reason health care providers are under increasing scrutiny from governments and stakeholder organisations to respond to service users' preferences, concerns and complaints.²⁹

2.3 These first issues raised by the Committee related to directly linking the conduct of the Commission's investigation of health care complaints to the *Australian Charter of Healthcare Rights* [the Charter] developed by the Australian Commission on Health Safety and Quality in Health Care. These various approaches were raised by the Public Interest Advocacy Centre [PIAC], who considered that the Commission's current assessment and investigative powers would be strengthened by direct

²⁸ E Merrick, R Iedama and R Sorensen, *Exploiting Complexity and Enhancing Adaptability: Creating opportunities for communication solutions in health services*, IPAA, National Congress, Sydney, 2008, p.1.

²⁹ E Merrick, R Iedama and R Sorensen, *Exploiting Complexity and Enhancing Adaptability: Creating opportunities for communication solutions in health services*, IPAA, National Congress, Sydney, 2008, p.6.

reference to the Charter. Specifically, PIAC referred to the comparable model in New Zealand, where there is a legally-enforceable *Code of Health and Disability Services Consumers' Rights* [the NZ Code].³⁰

2.4 The proposal was supported by the majority of the supplementary submissions, with qualified support from the NSW Physiotherapists Board, but not supported by the Commission, the Australian Dental Association (NSW Branch) [ADA], or Avant.³¹ Indeed, in its supplementary submission, the Commission suggested that if the Commission were required as a matter of law to uphold and enforce the Charter:

a whole new infrastructure for the determination of complaints would be required. In New Zealand, complaints about a breach of the charter are prosecuted before a court, which makes enforceable determinations as to the rights of the parties. Amendments to the Health Care Complaints Act to put such a system in place would require the establishment of a separate court or tribunal before which the Commission could prosecute complaints about breaches of the Charter.³²

2.5 Nonetheless, the Committee notes the evidence from the Commissioner of the Health Care Complaints Commission, Mr Kieran Pehm to the effect that the Commission does not object to the Charter *per se*:

We support the existence of the charter. We contributed to the National Patient Charter of the Australian Commission on Safety and Quality in Health Care.... We see the issue that once you take the step of making them legally enforceable, you greatly expand the complaint-handling process and mechanisms to determine whether there has been a breach of a particular right in the circumstance of a particular complaint.³³

2.6 The Committee also notes that the submission of Avant³⁴ made the pertinent point that to specifically link the Commission's exercise of its powers to the Charter had the potential to create the impression that the Commission was a "partisan advocate of patients' rights", rather than the independent body envisaged by the Act.³⁵

2.7 PIAC's position was defended at the public hearing on 4 March 2010 by Mr Peter Dodd, who noted that he had been informed by staff of the New Zealand Health and Disability Commission/Te toi hau haura [NZHDC] that the NZ Code is accepted by health professionals and consumers in New Zealand, and that he was not aware of any evidence that its effect had been to increase complaints. Rather, he suggested that such a move in New South Wales would be in keeping with patients' existing view of complaints arising from infringement of their "rights".³⁶

2.8 The Committee notes that the obligation under the NZ Code is to take "reasonable actions in the circumstances to give effect to the rights, and comply with the duties" in the Code. In short, the rights of healthcare consumers and providers under the NZ Code are as follows:

- the right to be treated with respect;

³⁰ Submission no. 25, Public Interest Advocacy Centre, p. 9. See also Australian Commission on Safety and Quality in Healthcare. 2008. *Australian Charter of Healthcare Rights*, <<http://bit.ly/ddz46P>>

³¹ Submission no. 33, Health Care Complaints Commission, pp. 1-3; Submission no. 48, Australian Dental Association (NSW), p. 2; Avant, *Questions answered after hearing*, p.10.

³² Submission no. 33, Health Care Complaints Commission, p. 2.

³³ K Pehm, Commissioner, Health Care Complaints Commission, *Transcript of Evidence*, 4 March 2010, p.36.

³⁴ A major national medical defence organisation

³⁵ Avant, *Questions answered after hearing*, p.10.

³⁶ P Dodd, Solicitor, Public Interest Advocacy Centre, *Transcript of Evidence*, 4 March 2010, p. 20.

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- the right to freedom from discrimination, coercion, harassment, and exploitation;
- the right to dignity and independence;
- the right to services of an appropriate standard;
- the right to effective communication;
- the right to be fully informed;
- the right to make an informed choice and give informed consent;
- the right to support;
- rights in respect of teaching or research; and
- the right to complain.³⁷

2.9 However, an examination of the Casenotes of the Director of Proceedings of the NZHDC shows that, since 2003, only eight matters have been brought before the New Zealand Human Rights Review Tribunal pursuant to the Charter.³⁸ Accordingly, the Commission's concerns as to the practical outcome of legally-enforceable rights would appear to be exaggerated.

2.10 Nonetheless, having regard to the potential for further complicating health care complaints handling in New South Wales, and for damaging the perception of the Commission as an impartial investigative body, the Committee does not recommend the direct linking of the *Australian Charter of Healthcare Rights* to the conduct of the Commission's investigation of health care complaints. The Committee notes that the Charter is already available for access on the Commission's website,³⁹ and is confident that the Commission will use the Charter as a means of informing its exercise of its functions under the Act, such that the protection of the health and safety of the public must be the paramount consideration.

Public Health Organisations

ISSUE 4: The following amendments be made to the *Health Care Complaints Act 1993*:

- that s 3A(4) give full recognition to public health organisations as the primary legal entities responsible for their own management and control of clinical issues;
- that s 25 and 25A require the Commission to directly inform a public health organisation of a complaint made against it; and
- that s 43 require a public health organisation to make any submissions in response to a Commission's recommendations or comments directly to the Commission.

2.11 Section 3A(4) of the Act notes that public health organisations are responsible for achieving and maintaining adequate standards of patient care and services, which may include a role in resolving complaints at a local level. Their role involves liaising with the Commission and registration authorities.

2.12 In its submission, the Health Services Association of NSW [HSA] raised concerns that the *Health Services Act 1997* inappropriately deems the Director-General of the Department of Health to be personally responsible for the governance of public

³⁷ NZ Health and Disability Commissioner website. *Home>The Act and the Code>The Code of Rights>The Code Summary*, <<http://bit.ly/9gskLa>>

³⁸ NZ Health and Disability Director of Proceedings website. *Home>Casenotes*, <<http://bit.ly/alxLXQ>>

³⁹ Health Care Complaints Commission website. *Home>Information>Information For Health Consumers*, <<http://bit.ly/ayOgPe>>

health organisations, as evidenced by the requirements under s 25(1) and s 25A for the Commission to inform the Director-General of a complaint, but not the public health organisation involved.⁴⁰

- 2.13 The HSA further noted that some public health organisations claim that they are not directly informed about complaints, and are therefore unable to directly manage them; and that responses from public health organisations to the Commission under s 43 of the Act have on occasion been changed without consultation with the public health organisation.⁴¹
- 2.14 Five supplementary submissions supported, or did not object, the proposed amendments. The New South Wales Nurses' Association [Nurses' Association] expressed concerns that adopting the amendment to s 43 might result in a situation where responsibility for incidents on which complaints are based is placed on individuals, and not appropriately recognised as a wider failure of the system.⁴²
- 2.15 In its response, the Commission went into some detail as to the notification process, which the Committee considers is appropriate to include in the Report. It noted that, pursuant to s 16(1) of the Act, the Commission must notify a public health organisation, except in some limited circumstances,⁴³ of any complaint that has been made about that organisation. This section provides that the Commission must give written notice to the person against whom the complaint is made of:
- the making of a complaint;
 - the nature of the complaint; and
 - the identity of the complainant.
- Notice must be given no later than 14 days after the Commission's assessment of the complaint.⁴⁴
- 2.16 The Commission went on to point out that it is required - under three separate sections of the Act - to notify the Director-General when it receives a complaint about a health organisation. First, s 17 states that the Commission must also notify the Director-General when it receives such a complaint. Secondly s 25 provides that the Commission must notify the Director-General of any complaint if it appears that the complaint involves a possible legislative breach.⁴⁵
- 2.17 Third, s 25A provides that the Commission may refer a complaint to the Director-General if it is of the opinion that the complaint relates to a matter that could be the

⁴⁰ The submission notes that while it is expected that the Director-General would notify the public health organisation, that is not a requirement under the Act: Submission no. 7, Health Services Association of NSW, pp. 3-4.

⁴¹ Submission no. 7, Health Services Association of NSW, p. 4. Section 43(1) provides that if, at the end of the investigation of a complaint against a health organisation, the Commission proposes to make recommendations or comments to the health organisation on the matter the subject of the complaint, it must first inform the health organisation of the substance of the grounds for its proposed action and give the health organisation an opportunity to make submissions.

⁴² Submission no. 32, NSW Nurses' Association, p.1; see also A Butler, Professional Officer, NSW Nurses' Association, *Transcript of Evidence*, 4 March 2010, p. 42.

⁴³ Section 16 provides for some limited circumstances in which the Commission is not required to notify the health service provider of the complaint. See the Commission's response to Discussion Paper Issue no. 23, Submission no. 33, Health Care Complaints Commission, p. 23.

⁴⁴ Submission no. 33, Health Care Complaints Commission, p. 7.

⁴⁵ Submission no. 33, Health Care Complaints Commission, p. 7.

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subject of an inquiry by the Director-General under s 71 of the *Public Health Act 1991* or under s 123 of the *Health Services Act*.⁴⁶

- 2.18 In relation to the above requirements, the Commission emphasised that any complaint about a public health organisation which the Commission referred to the Director-General under s 25 or s 25A would also have been notified to the relevant public organisation under s 16.⁴⁷ The Commission also pointed out that, notwithstanding the referral of a matter to the Director-General, the Commission could continue to deal with the complaint if it concerned the professional conduct of a health care practitioner or a health service affecting the clinical management or care of a patient (provided that, as required under s 123 of the *Health Services Act*, the service was a wholly or partly government-funded service).⁴⁸
- 2.19 With respect to the proposed amendment to s 43, the Commission also confirmed that it complies with its obligations under s 43(1) which requires that if the Commission proposes to make recommendations or comments to the health organisation at the end of an investigation, it must first inform the health organisation of the reasons and give it the opportunity to make submissions.⁴⁹
- 2.20 The Commission also pointed out that while public health organisations made submissions directly to the Commission, it was usual for the Clinical Governance and Risk Management Branch of the Department of Health to request the public health organisation to provide its response to a draft investigation report to the Department as well as to the Commission. This was done because the Department needed to consider the practical impact of proposed system improvements in relation to a particular public health organisation as well as their possible general application across the NSW health care system.⁵⁰
- 2.21 The Commission did not concur with the assertion of the HSA that, on some occasions, submissions of public health organisations were changed by the Department of Health without consultation. As previously stated, it confirmed that it received submissions on draft investigation reports directly from public health organisations and stated that it was unaware of an input into those responses by the Department.⁵¹
- 2.22 Having regard to the concerns of the Nurses' Association and the explanation of the process provided by the Commission; and the fact that these matters were raised in one submission, without supporting documentation, the Committee does not recommend the amendments to ss 3A(4), 25, 25A and 43 which are set out in Issue 4.

Communication

ISSUE 5: That the Commission review its procedures for advising practitioners that they are under investigation, with a view to providing detailed information of what to expect from that process, including statutory timeframes, and of any support services which might be available.

⁴⁶ Submission no. 33, Health Care Complaints Commission, p. 7.

⁴⁷ Submission no. 33, Health Care Complaints Commission, p. 8.

⁴⁸ Submission no. 33, Health Care Complaints Commission, p. 8.

⁴⁹ Submission no. 33, Health Care Complaints Commission, p. 8.

⁵⁰ Submission no. 33, Health Care Complaints Commission, p. 8.

⁵¹ Submission no. 33, Health Care Complaints Commission, p. 9.

- 2.23 A number of the original submissions referred to the need for better liaison between officers of the Commission and complainants.⁵² It was suggested that some of the problems associated with the healthcare complaints system - as well as the perception of those problems within the wider community - stem from a lack of adequate communication about how the system and the processes work.⁵³
- 2.24 With the exception of the Commission itself, there was general support for this proposal. The Hunter New England Area Health Service suggested that Clinical Governance via the Senior Complaints Officer for the Area Health Service [AHS] be identified as the person who could “provide support and advice to clinicians responding to a complaint”.⁵⁴
- 2.25 The Commission’s supplementary submission noted that it has already “extensively reviewed” its process for advising complainants that their conduct is under investigation, and provides detailed information on its website about its investigative processes.⁵⁵ The Commission’s standard letter is attached as Appendix 6.
- 2.26 While the Committee accepts that there has been considerable improvement in the Commission’s communication with practitioners subject to complaints, it considers that it is important for the Commission to keep itself informed of any failures in this regard, particularly if doing so may expose any pattern of communication breakdown, whether it be, e.g., by profession or locality. Accordingly, the Committee considers that it is vital for the Commission to be constantly monitoring the timeliness and efficiency of its communication with practitioners. The issue of communication is dealt with in more detail in Chapter 4 of the Report.

RECOMMENDATION 2: That the Health Care Complaints Commission continue to monitor the effectiveness of its communication with persons who are the subject of complaint, seeking the input of the agencies such as registration authorities, the Area Health Services, NSW Department of Health and Avant.

Complainants with special needs

ISSUE 6: That the Health Care Complaints Commission develop guidelines or criteria by which either “best endeavours” may be measured, or by which a client’s capacity to understand might be assessed.

- 2.27 In its submission, the Department of Ageing, Disability and Home Care noted that people with an intellectual disability often have communication disabilities, which can limit their ability to effectively utilise the services of the Commission, should they

⁵² Submission no. 6, Greater Southern Area Health Service, p. 2; Submission no. 19, Royal Australasian College of Physicians, p. 3.

⁵³ See, e.g., Submission no. 2, Clinical Excellence Commission, p. 1; Submission no. 8, Country Women’s Association of NSW, p. 2; Submission no. 9, NSW Consumer Advisory Group - Mental Health Inc, p. 3; and Submission no. 26, NSW Department of Health, p. 4.

⁵⁴ Submission no. 40, Hunter New England Area Health Service, p. 1.

⁵⁵ See Health Care Complaints Commission website. *Home>Complaints>What if a complaint is made about me*, <<http://bit.ly/97UGhQ>>

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need to make a complaint about a practitioner.⁵⁶ Again, there was general support in the supplementary submissions for the proposal in Issue 6. However, Carers NSW suggested that rather than developing guidelines or criteria, the Commission should consult with the NSW Trustee and Public Guardian, as “capacity to understand” is already defined under legislation.⁵⁷

2.28 However, in its supplementary submission the Commission sets out the changes which it has already made to facilitate the use of its services by people with an intellectual disability, including participating in the development of “Healthier Lives - Rights and complaints” fact sheet with the NSW Council for Intellectual Disability (see Appendix 7).⁵⁸ Accordingly, the Committee is satisfied that the proposal contained in Issue 6 will not appreciably improve the access to the Commission’s services for people with an intellectual disability, and does not recommend its implementation.

Health practitioners registration

2.29 As noted in Chapter 1, the Committee’s Inquiry into the operation of the Act has been carried out parallel to the introduction of the National Registration and Accreditation Scheme for the Health Professions [the National Scheme].

2.30 In the course of the public hearing on 4 March 2010, the Committee took evidence from a number of organisations to determine their role in the consultation process for the National Scheme, and how they expected the scheme to impact on their operations.

2.31 Generally, the organisations consulted by the Committee had been, to varying degrees, active participants in the development of the scheme. For instance, a number of organisations responded to consultations;⁵⁹ attended forums;⁶⁰ held discussions with NSW Department of Health;⁶¹ lobbied Members of Parliament;⁶² and/or made submissions to Parliamentary Committee Inquiries.⁶³ As would be expected, the NSW Department of Health provided advice on the development of the agreement and had carriage of the implementation of the agreement, including the development of legislation.⁶⁴

2.32 A number of organisations expressed their support for the retention of the Commission.⁶⁵ As the Commission will continue to administer complaints handling processes in New South Wales after the introduction of the scheme, some

⁵⁶ Submission no. 11, Department of Ageing, Disability and Home Care, p. 1.

⁵⁷ Submission no. 30, Carers NSW, p. 1. See also s 3 (2) of the *Guardianship Act 1987*.

⁵⁸ Submission no. 33, Health Care Complaints Commission, p. 11.

⁵⁹ PIAC; Avant; NSW Nurses and Midwives Board; NSW Physiotherapists Registration Board; NSW Nurses’ Association.

⁶⁰ Avant, *Questions answered after hearing*, p 4; Public Interest Advocacy Centre, *Questions answered after hearing*, p.1.

⁶¹ NSW Nurses and Midwives Board, *Correspondence in response to questions*, p. 3; NSW Nurses’ Association, *Questions answered after hearing*, p.1.

⁶² NCOSS, *Questions answered after hearing*, p.1.

⁶³ PIAC, *Questions answered after hearing*, p.1.

⁶⁴ NSW Health, *Questions answered after hearing*, p.1.

⁶⁵ NCOSS, *Questions answered after hearing*, p.1; Avant, *Questions answered after hearing*, p. 5; NSW Nurses and Midwives Board, *Correspondence in response to questions*, p.3; PIAC, *Questions answered after hearing*, p. 2; NSW Nurses’ Association, *Questions answered after hearing*, p. 2.

organisations considered that there would be little change in their interactions with the Commission.⁶⁶

2.33 Among the results of the National Scheme anticipated by stakeholders were:

- better communication with other jurisdictions, including the exchange of information;⁶⁷
- consistency of approach in relation to accreditation and regulation;⁶⁸ and
- mobility between jurisdictions.⁶⁹

2.34 However, concerns were raised about a number of specific issues relating to the operation of the scheme. For instance, NCOSS raised concerns about possible duplication between retained State bodies and their federal equivalents:

There is potential for the effectiveness of the national registration scheme to be undermined if there are not adequate systems and procedures in place to ensure timely communication of information about practitioner misconduct in other states and territories through the National Boards to the NSW Health Professional Councils and visa versa.⁷⁰

2.35 NCOSS considered “that the effectiveness of this system must be monitored and evaluated after an appropriate period of operation”.⁷¹

2.36 The NSW Nurses and Midwives Board expressed misgivings about the accreditation of educational programs and the independence of the process. They also stressed that communication channels to ensure the compliance of conditional registrants will need to be in place for the co-regulatory model to function effectively.⁷²

2.37 Committee Members agree that ongoing monitoring of the incipient co-regulatory system of health care complaints handling is vital to avoid unnecessary duplication between New South Wales bodies and those of the National Scheme on the one hand; and complainants or practitioners “falling between the cracks”, on the other.

Dental Technicians

2.38 Although dental technicians have been registered in New South Wales since 1975, this will no longer be the case under the National Scheme. Consequently, dental technicians will be obliged to practise in accordance with the Commission’s Code of Conduct for Unregistered Health Professionals.

2.39 The Committee notes that the rationale behind this is that, whereas dental prosthetists may attend upon and deal directly with their own patients, dental technicians do not see patients and may only undertake technical work on the written

⁶⁶ NCOSS, *Questions answered after hearing*, p.2 ; Avant, *Questions answered after hearing*, p. 5; Northern Sydney Central Coast Area Health Service, *Questions answered after hearing*, p. 2.

⁶⁷ NSW Department of Health, *Questions answered after hearing*, p. 1; Greater Southern Area Health Service, *Correspondence in response to questions*, p. 1; NSW Physiotherapists Registration Board, *Questions answered after hearing*, p. 2.

⁶⁸ NSW Physiotherapists Registration Board, *Questions answered after hearing*, p. 2; NSW Nurses’ Association, *Questions answered after hearing*, p. 1.

⁶⁹ NSW Physiotherapists Registration Board, *Questions answered after hearing*, p. 2; NSW Nurses’ Association, *Questions answered after hearing*, p. 1.

⁷⁰ NCOSS, *Questions answered after hearing*, p. 1.

⁷¹ NCOSS, *Questions answered after hearing*, p. 1.

⁷² NSW Nurses and Midwives Board, *Questions answered after hearing*, p. 3.

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order of a dentist or a dental prosthetist.⁷³ However, this was disputed in the submission from the NSW Dental Technicians Board:

In some cases the patient will arrive with the crown un-cemented so that the Dental Technician can try the crown in and out as often as required until the patient is satisfied with the colour match. The Dental Technician may also have to fit a partial denture to the new crown or bridge and be required to handle the patient's denture as part of the process.⁷⁴

2.40 Indeed, in evidence to the Committee, the current Chair of the Board, Ms Meredith Kay, noted a recent case in Victoria where a patient contracted hepatitis C, and the source of infection was traced back to pumice used to polish the appliance which had not been sufficiently sterilised and cleaned.⁷⁵ Ms Kay expressed concern that the change under the National Scheme creates a situation whereby it is:

inevitable that the effect of untrained Dental Technicians teaching new workers in the industry will no doubt lower the standard of quality as time advances.⁷⁶

2.41 Ms Kay's particular unease was due to the attitude of recent dental graduates with whom she had spoken towards dental prosthetists (who will continue to be registered) and dental technicians (who will not):

When I ask them what they know about prosthetics and whether or not they are interested they say, "No. That is the work of the prosthetist or the technician." ... How do we provide appropriate gate-keeping mechanisms and governance with the issue of appliances if respect, trust and education are not there?⁷⁷

2.42 Committee Members are very concerned that the move to de-register dental technicians represents a dilution of the registration system which has been operating successfully in New South Wales for the past 35 years:

The Hon. DAVID CLARKE: So in the fifty-fifty situation, we have lowered the bar for States where we have a technicians board rather than raising the bar in the four that do not?

Mr MARTIN: That is the decision of COAG, yes.

Ms O'SHANNESY: I do not think you can take it on that. I think you need to go back. COAG and the Australian Health Ministers Advisory Council and the Australian Health Ministers Council have a series of criteria on which they test professions about whether they should be registered or not. They include public safety and public interest criteria. My understanding is... that those professions were all tested on that basis. My understanding has always been that the highest risk element of the dental technician profession has been prosthetists, so that was the area in which there was the most argument to maintain registration.

The Hon. DAVID CLARKE: They are the highest what?

Ms O'SHANNESY: The potential of public risk and seeing patients direct.

⁷³ See, e.g., Hon Carmel Tebbutt MP, Minister for Health, Legislative Assembly *Hansard*, 11 November 2009.

⁷⁴ NSW Dental Technicians Board, *Questions answered after hearing*, p. 2.

⁷⁵ M Kay, Chair, NSW Dental Technicians Registration Board, *Transcript of Evidence*, 4 March 2010, p. 4. See Dental Practice Board of Victoria. 2006. *Decisions of hearings - Mr Patrick Davies*, 24 October 2006, <<http://bit.ly/bLNr1L>>

⁷⁶ NSW Dental Technicians Board, *Questions answered after hearing*, p. 2.

⁷⁷ M Kay, Chair, NSW Dental Technicians Registration Board, *Transcript of Evidence*, 4 March 2010, p. 6.

The Hon. DAVID CLARKE: But that is all relative. There may be higher risk with them, but that does not mean that the risk coming from dental technicians should be ignored. These are all relative.

Ms O'SHANNESSY: Yes, but that is why COAG and AHMAC have criteria - so that there is a transparent process against which all professions can be tested. That was the process, I understand, that was used to determine who should be in and who should be out.⁷⁸

- 2.43 Moreover, Committee Members note that registration for dental technicians is being retained in Queensland;⁷⁹ and that Ms Leanne O'Shannassy, Director, Legal and Legislation of the NSW Department of Health, gave evidence to the Committee that there is no legal impediment to registration continuing in New South Wales.⁸⁰
- 2.44 However, the Committee also notes the following evidence from Ms O'Shannassy:
- The other point I would like to come back to with regard to dental technicians is that the unregistered code we have also provides a safety net in relation to any health service provider who is not currently registered. That provides a basic set of rules effectively through a negative licensing scheme, so there is a greater safety net in New South Wales than in any other jurisdiction outside of all the registered professional groups.⁸¹
- 2.45 Committee Members have maintained a keen interest in the Code of Conduct for Unregistered Health Practitioners since its introduction on 1 August 2008, pursuant to the *Public Health (General) Amendment Regulation 2008*. Under s 7 of the Health Care Complaints Act, a complaint may be made to the Commission against a health practitioner in relation to an alleged breach of the Code (see Appendix 9).
- 2.46 The Code requires, *inter alia*, that such a practitioner must provide health services in a safe and ethical manner, by complying with the following principles:
- (a) a health practitioner must maintain the necessary competence in his or her field of practice,
 - (b) a health practitioner must not provide health care of a type that is outside his or her experience or training,
 - (c) a health practitioner must prescribe only treatments or appliances that serve the needs of the client,
 - (d) a health practitioner must recognise the limitations of the treatment he or she can provide and refer clients to other competent health practitioners in appropriate circumstances,
 - (e) a health practitioner must recommend to his or her clients that additional opinions and services be sought, where appropriate,

⁷⁸ L O'Shannassy, Director Legal and Legislation, NSW Department of Health; I Martin, Assistant Director, Legal and Legislation, NSW Department of Health; *Transcript of Evidence*, 4 March 2010 p. 49. 'COAG' is the Council of Australian Governments.

⁷⁹ M Kay, Chair, NSW Dental Technicians Registration Board, *Transcript of Evidence*, 4 March 2010, p. 6. Also, e.g., the correspondence of 16 April 2010 from the A/Principal Coordinator, Dental Technicians Board and Dental Prosthetists Board of Queensland to the Registrar of the Dental Board of South Australia: <<http://bit.ly/bqliY7>>

⁸⁰ L O'Shannassy, Director Legal and Legislation, NSW Department of Health, *Transcript of Evidence*, 4 March 2010, p. 50.

⁸¹ L O'Shannassy, Director Legal and Legislation, NSW Department of Health, *Transcript of Evidence*, 4 March 2010, p. 50.

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- (f) a health practitioner must assist his or her clients to find other appropriate health care professionals, if required and practicable,
- (g) a health practitioner must encourage his or her clients to inform their treating medical practitioner (if any) of the treatments they are receiving;
- (h) a health practitioner must have a sound understanding of any adverse interactions between the therapies and treatments he or she provides or prescribes and any other medications or treatments, whether prescribed or not, that the health practitioner is aware the client is taking or receiving;
- (i) a health practitioner must ensure that appropriate first aid is available to deal with any misadventure during a client consultation; and
- (j) a health practitioner must obtain appropriate emergency assistance (for example, from the Ambulance Service) in the event of any serious misadventure during a client consultation.⁸²

2.47 While the Committee considers that retention of registration of dental technicians in New South Wales would have been preferable, Committee Members acknowledge the frankness of the Minister for Health in introducing the *Health Practitioner Regulation Amendment Bill 2009*, when she noted that “there are some areas where compromises have been made to reach agreement on a national system”.⁸³

2.48 Committee members note that dental technicians will be covered by the provisions of the Code of Conduct for Unregistered Health Practitioners, and that a breach of that Code may result in a complaint to the Commission which itself will continue to be oversighted by the Committee. Nonetheless, Committee members retain concerns that the health and safety of those patients in New South Wales using the services of dental technicians may be unduly compromised by the removal of registration in this State. Accordingly, the Committee will continue to closely monitor the nature and prevalence of complaints against dental technicians made to the Commission.

Registration Boards

ISSUE 7: That the various NSW Registration Acts be repealed, and replaced by a single Health Professionals Registration Act.

ISSUE 8: That a NSW Office of Health Practitioner Registration Boards be established to provide administrative and operational support to assist the various NSW Registration Boards and to assess complaints and undertake investigations on their behalf.

2.49 In its Discussion Paper, the Committee noted that one option to bring about the requisite transparency, consistency and fairness expected of all Registration Boards would be to enact an “umbrella Act”, whereby the separate registration Acts would be repealed, and replaced with a single “Health Professionals Registration Act”, while retaining the separately constituted Boards. An alternative was the establishment of an entity equivalent to the Queensland Office of Health Practitioner Registration Boards, an independent statutory Office which provides administrative and

⁸² Clause 3, Schedule 3 to the *Public Health (General) Regulation 2002*. The Code must be displayed on a health practitioner’s premises [cl 17(1)]; and is available online in ten languages other than English from the NSW Multicultural Health Communication Service website. *Home>Publications & Resources>Resources By Topics>Health Services*, <<http://bit.ly/c90Dl6>>

⁸³ Hon Carmel Tebbutt MP, Minister for Health, Legislative Assembly *Hansard*, 11 November 2009.

operational support to assist the various Queensland Boards to exercise and discharge their powers, authorities, duties and functions.

- 2.50 The Committee is pleased to note that there was general support for the introduction of a single New South Wales Health Professionals Registration Act, as enacting legislation for this was introduced into the NSW Legislative Assembly on 20 May 2010.
- 2.51 Under the *Health Practitioner Regulation Amendment Bill 2010*, the former NSW Registration Boards for the professions currently included under the National Law - chiropractic, dental, medical, nursing and midwifery, optometry, osteopathy, pharmacy, physiotherapy, podiatry, and psychology - will be replaced by NSW State Councils. State Councils will also be established as required by Order of the Governor for professions that are subsequently added to the National Law.
- 2.52 The Bill also provides for the establishment of Tribunals for each of the above professions; for the establishment of Professional Standards Committees for the medical and nursing and midwifery professions; and for the regulation of pharmacy businesses.
- 2.53 In terms of the registration of students - which in New South Wales had previously been limited to medical and dental students - the Bill provides for complaints to be made and action to be taken against a student where a student:
- has an impairment;
 - has been convicted or charged with a serious offence; or
 - where the student has breached a condition of registration.
- 2.54 The Bill provides for the composition of the NSW Dental Council, Medical Council, Nursing and Midwifery Council, Pharmacy Council, Physiotherapy Council and Psychology Council. These reflect the composition of the existing State Registration Authorities, with the addition of a dental prosthetist to the Dental Council, given that dental prosthetists will now be within its regulatory ambit.⁸⁴
- 2.55 In introducing the Bill, the Minister noted that after 12 months the size and composition of the State Committees of the National Boards may change, having regard to an analysis of the work undertaken and the cost of their maintenance. In line with those changes, the size and composition of the NSW Councils may also change.⁸⁵ In contrast, the composition of the NSW State Councils for chiropractors, optometrists, osteopaths and podiatrists will be set by Regulation, as for these professions it has been determined that there will be no State or Territory Committee of the relevant National Board. With regards to this, the Minister noted that:
- the numbers of complaints and other notifications that are made about members of these professions are at levels that indicate that the costs associated with maintaining large councils cannot be justified. Accordingly, the regulations will establish smaller councils, much like the boards' existing complaints screening committees, to undertake the relevant State functions.⁸⁶

⁸⁴ The Councils' membership is set out in the Act, as these are the professions for which the relevant national board has determined there will be a NSW State Committee with those committees initially comprising the current members of the State board. Similarly, existing members of the relevant boards will become the members of the State councils for those professions.

⁸⁵ Thus, cl 41E of the Bill provides that the composition of councils may be varied by Regulation. The Minister stressed that any such variation will be undertaken only after consultation with all stakeholders.

⁸⁶ Hon Carmel Tebbutt MP, Minister for Health, Legislative Assembly *Hansard*, 20 May 2010.

A complex health care complaints system

2.56 These proposed changes are in keeping with earlier evidence to the Committee from the Director, Legal and Legislation of the NSW Department of Health:

The area where it does get a bit more complex... is that in some of the smaller professional groups the National Board may not have a State body. Again we are talking about the national level. You have a professional group such as osteopaths. It is a very small profession nationally. It is not cost-effective for them to have separate State committees; it becomes a very onerous cost burden on the profession.

The other thing is that they have very few complaints. Whereas our major boards would be able to have monthly meetings and fill their agendas to manage these matters, for the very small groups they are not. So we are looking at making sure our legislation has a capacity that we can maybe use the same membership - for example, with osteopaths, having a national complaints committee, so we can draw on that membership as our State council when we need to use it.⁸⁷

2.57 As the proposals raised in Issues 7 and 8 will be addressed by the changes to be made by the *Health Practitioners Regulation Bill 2010*, the Committee makes no recommendations in relation to these Issues.

Parliamentary oversight

ISSUE 9: That a Committee on Health Registration Authorities be established with a remit over all NSW Registration Boards similar to that of the Committee on the Health Care Complaints Commission.

ISSUE 10: That the Public Bodies Review Committee resolve to review each Annual Report of all NSW Registration Bodies and report back to the Legislative Assembly on these reviews.

2.58 In its Discussion Paper, the Committee noted that concerns with respect to smaller registration authorities arise from to the potential for both practitioners and healthcare consumers to suffer from a lack of accountability, transparency and efficiency. The Committee considered that one means of overcoming this would be for effective oversight of those bodies by a Parliamentary Committee. This could be achieved either by the establishment of a new Committee, or by ensuring that each Annual Report of each Registration Board is examined by the Public Bodies Review Committee.⁸⁸

2.59 However, in supplementary submissions - and in evidence at the public hearing - it became apparent that stakeholders preferred that the Committee itself be given oversight responsibility for all registration authorities, or Health Professional Councils, as they will become. Committee Members were pleased to note the opinion of Avant that:

public scrutiny of the functions and operation of the co-regulatory system, through open hearings of the Parliamentary Committee, is an important aspect of open, responsible and accountable government, and provides an appropriate mechanism for change.⁸⁹

⁸⁷ L O'Shannessy, Director, Legal and Legislation, New South Wales Department of Health, *Transcript of Evidence*, 5 March 2010, pp. 51-52.

⁸⁸ The Public Bodies Review Committee is a current standing committee of the Legislative Assembly which examines the annual reports of all public bodies and enquires into and reports on the adequacy and accuracy of all financial and operational information, and on any matters arising from the annual report concerning the efficient and effective achievement of the agency's objectives.

⁸⁹ Avant, *Questions answered after hearing*, p. 18.

2.60 In its supplementary submission the Commission proposed that, as New South Wales will continue to have a co-regulatory model, the “appropriate course” would be to expand the remit of the Committee, so that the Committee can also review the exercise of the functions of the health registration authorities. The option of the Committee having an expanded remit was also supported by NCOSS.⁹⁰

RECOMMENDATION 3: That the statutory remit of the Joint Parliamentary Committee on the Health Care Complaints Commission be expanded to monitoring and reviewing the exercise of the functions of the NSW Health Professional Councils.

⁹⁰ A Peters, Director, NCOSS, *Transcript of Evidence*, 4 March 2010, p. 31.

Chapter Three - The assessment and investigative powers of the Health Care Complaints Commission

Introduction

- 3.1 This Chapter deals with the Inquiry's second Term of Reference. Issues raised with the Committee about the Commission's current assessment and investigative powers, generally related to:
- the conduct of the investigation process;
 - timeliness; and
 - the final outcomes of the process.

The power to investigate

ISSUE 11: That the *Health Care Complaints Act 1993* be amended so that the Health Care Complaints Commission can conduct investigations of its own motion, and so that investigations can be made more generally into the clinical management of care of patients in general.

- 3.2 In its original submission, the Commission made a number of suggestions to enhance its current assessment investigative powers, and the functions and powers of the Director of Proceedings. Two overarching suggestions were that the Act ought to be amended so that the Commission will be able to:
- conduct inquiries and investigations of its own motion, without the need for a complaint [s 7 of the Act]; and
 - inquire into complaints about a health service provider which affect the clinical management or care of patients in general, rather than that "of an individual client": ss 7(1)(b), 25(40)(b) & 25A(3)(b).⁹¹
- 3.3 This proposal was supported by the original submission from PIAC, which suggested that s 8 of the Act be amended to give the Commission discretion, in certain circumstances, to trigger the complaints process by its own motion.⁹²
- 3.4 An overwhelming number of supplementary submissions gave either support or qualified support, or did not oppose this proposal. Thus, the Royal Australasian College of Surgeons supported the Commission being able to conduct its own motion investigations, but did not agree with PIAC that the Commission is the

⁹¹ Submission no. 16, Health Care Complaints Commission, p. 2. See also Submission no. 3, Dr and Mrs Willets, which suggests the need to extend the remit of the Commission to investigate health administrators as well as practitioners; p. 1.

⁹² Submission no. 25, Public Interest Advocacy Centre, p. 4. Section 8 of the Act sets out who may make a complaint to the Commission. PIAC stressed that the obligation to comply with natural justice principles would remain - including the statutory notice provisions and timelines in the Act in dealing with complaints - and suggested that the Commission could initiate its own complaints in four particular situations:

- threats to public health and safety;
- adding new respondents or new issues;
- urgent matters for resolution; and
- broader investigations and inquiries.

appropriate body to undertake broader investigations and inquiries into the clinical management of care of patients in general.⁹³

- 3.5 In a similar vein to the PIAC submission, the Hunter New England AHS suggested the inclusion of specific circumstances in which Commission-initiation could occur.⁹⁴ For their part, the Nurses and Midwives Board supported the proposal in principle but did not support adding any new respondents to a complaint without consultation with the relevant registration authority, as originally suggested by PIAC.⁹⁵
- 3.6 Indeed, the only opposition came from the Australian Dental Association (NSW Branch) and Avant. The Association considered that the Commission's existing powers were sufficiently broad and that the Commission could not be both a notifier and investigator of a complaint; and suggested that if the Committee were to support this proposal, a "nominal notifier" with the authority to make such a decision "is preferable to some other anonymous process".⁹⁶
- 3.7 Avant noted that if the Commission has immediate concerns about a practitioner's conduct, it already has the power to refer the matter to the Medical Board and the matter can be dealt with under s 66 of the *Medical Practice Act 1992*; if the Board takes any action it is then required to refer the matter to the Commission for investigation.⁹⁷ Avant sees no necessity for the Commission to have the power to instigate investigations, or conduct enquiries of its own motion, and no basis for the proposed categories of action put forward by PIAC.⁹⁸
- 3.8 Moreover, Avant argues that such an extension of the Commission's current powers has the potential to lead to the transition of the Commission from a complaints body to a "general, free-ranging, permanent commission of inquiry":
- The need for achieving a balance between an individual's right to due process, to privacy, to the confidentiality of medical information, and the necessity for the Commission to carry out its investigative functions and to remain publicly accountable for its actions and processes requires a cautious approach to extending a grant of power. Commission officers are obligated to act within express powers conferred by statute and, in many cases, it is only the limitation of this power that imposes controls upon the infringement of individual rights. To expand and broaden powers in this way in our view is not justified.
- 3.9 By way of contrast, in its supplementary submission, the Commission suggested that the Issue 11 proposal did not go far enough, as the Commission ought to be able to initiate its own complaints as well as investigations. The Commission considered further that the circumstances in which it could initiate its own investigations should

⁹³ Submission no. 42, Royal Australasian College of Surgeons, p.1.

⁹⁴ Submission no. 40, Hunter New England Area Health Service, p. 1.

⁹⁵ Submission no. 46, NSW Nurses and Midwives Board, p. 3.

⁹⁶ Submission no. 48, Australian Dental Association (NSW), p. 2.

⁹⁷ Suspension or conditions to protect the public

(1) The Board must, if at any time it is satisfied that it is appropriate to do so for the protection of the health or safety of any person or persons (whether or not a particular person or persons) or if satisfied that the action is otherwise in the public interest:

(a) by order, suspend a registered medical practitioner from practising medicine for such period (not exceeding 8 weeks) as is specified in the order, or

(b) impose on a registered medical practitioner's registration such conditions relating to the practitioner's practising medicine as the Board considers appropriate: s 66 *Medical Practice Act 1992*.

⁹⁸ Avant, *Questions answered after hearing*, p. 11.

be specifically defined: a broadly expressed “own motion” power would permit the Commission to do so where it was in the public interest and would prevent providers instituting legal proceedings against the Commission in relation to the issue of jurisdiction.⁹⁹

3.10 Committee Members note that there are sound reasons behind both sides of the debate around the proposal of Issue 11, and that this is a clear example of competing aims which need to be held in an appropriate balance, as observed in Chapter 1.

3.11 The Committee also notes that in the Australian Capital Territory, the Health Services Commissioner falls within the purview of the ACT Human Rights Commission. That Commission may, on its own initiative, consider, by a *commission-initiated consideration*:

(a) an act or service that appears to the commission to be an act or service about which a person could make, but has not made, a complaint under this Act; or

(b) any other matter related to the commission’s functions.¹⁰⁰

Specifically, pursuant to s 94 of the ACT *Human Rights Act 2005*, a “health professional report” may be dealt with by Commission-initiated consideration.¹⁰¹

3.12 The ACT Human Rights Commission may consider an issue of public interest or public safety that relates to its functions. Examples of when it may be in the public interest are where a complaint appears to reveal a systemic problem about an activity or a service; or where the complaint, if substantiated, raises a significant issue for the ACT, or an issue of public safety.¹⁰²

3.13 Committee Members consider that the Commission should be given an expanded power, but note the specific concerns of those organisations which gave qualified support to this proposal. Accordingly, adopting a version of the ACT model provides a means of balancing the effectiveness of the Commission in protecting the public from harm and the fairness of protecting the rights and interests of patients and practitioners.

RECOMMENDATION 4: That the *Health Care Complaints Act 1993* be amended so that the Health Care Complaints Commission can conduct investigations of its own motion, where such investigations relate to an issue of public interest or public safety that relates to the functions of the Commission.

⁹⁹ Submission no. 33, Health Care Complaints Commission, pp. 13-14.

¹⁰⁰ Section 48 of the ACT *Human Rights Commission Act 2005*. A commission-initiated consideration must, as far as practicable, be conducted as if it were a consideration of a complaint.

¹⁰¹ A *health professional report* is a report about a health professional that may be made, or is made, under s 78 of the ACT *Health Professionals Act 2004*.

¹⁰² See s 48 of the ACT *Human Rights Commission Act 2005*.

Assessments

ISSUE 12: That the Health Care Complaints Commission make publicly-available guidelines, setting out the manner in which it determines how a complaint is to be dealt with under s 20(1) of the *Health Care Complaints Act 1993*.

- 3.14 Section 20(1) of the Act provides that assessment of a complaint is for the purpose of deciding how the Commission should deal with it, e.g., investigation, conciliation or referral to another body. In its original submission, Greater Southern AHS noted that there does not appear to be any guidelines as to how the Commission decides upon a course of action under s 20(1), and that there is a particular need for a set of guidelines as to what constitutes a matter which is appropriate for resolution, conciliation, or discontinuation.¹⁰³
- 3.15 These concerns were also raised in evidence to the Committee from the Director of Clinical Governance, Northern Sydney/Central Coast AHS:
- When a complaint is forwarded to the Health Care Complaints Commission we respond, do an investigation and provide our response to the Health Care Complaints Commission. If the complaint is resolved we receive notification about whether it is going for conciliation or investigation. We are not made aware of the criteria that are used in making those decisions. Some complaints are resolved while others go to conciliation but we are never made aware of the decision-making process and we do not know whether it is a criteria-based approach. It certainly does not appear as though it relates to the severity of the complaint that has occurred.¹⁰⁴
- 3.16 Supplementary submissions also overwhelmingly gave either support or qualified support, or did not oppose this proposal. The Nurses and Midwives Board supported the need for publicly available guidelines but believes that the conciliation process needs to be reviewed. There should be some protection for the participants and a provision for plea-bargaining.¹⁰⁵
- 3.17 With respect to conciliation, the Committee noted in the Discussion Paper that the types of complaints which the Commission will assess as suitable are likely to meet at least one of the following criteria:
- there was a breakdown in communication between the parties;
 - insufficient information was provided to the complainant;
 - an inadequate explanation was given for a poor outcome or adverse event;
 - the complainant is seeking an improvement in the quality of the particular health service; or
 - the complainant is seeking a refund or financial compensation as an outcome.¹⁰⁶
- 3.18 The sole exception to the support for this proposal was the Commission, which suggested that it would be both difficult and undesirable to prepare guidelines for

¹⁰³ Submission no. 6, Greater Southern Area Health Service, p. 1.

¹⁰⁴ Dr B Eather, Director Clinical Governance, Northern Sydney/Central Coast Area Health Service, *Transcript of Evidence*, 4 March 2010, pp. 8-9

¹⁰⁵ Submission no. 46, NSW Nurses and Midwives Board, p. 3.

¹⁰⁶ Discussion Paper, p. 13. See also Health Care Complaints Commission website. *Home>About Us>Organisational Overview>Health Conciliation Registry*, <<http://bit.ly/9FAwjW>>. The Commission also notes that a complaint will not be referred for conciliation if the complainant has clearly indicated that they do not wish to meet or interact with the provider again, and do not see conciliation as an appropriate way of resolving their complaint.

assessment of complaints because of the very broad range and differing levels of severity of complaints.¹⁰⁷ The Commission also noted that its notices to complainants and health service providers about its assessment decisions provide reasons for the Commission's decisions in relation to particular complaints.¹⁰⁸

3.19 Having regard to:

- the broad range of complaints considered by the Commission;
- the considerable amount of information available on the Commission's website;¹⁰⁹ and
- the fact that the Commission's assessment decisions provide reasons for its decisions in relation to particular complaints,

the Committee does not consider that it is necessary for the Commission to formulate publicly-available guidelines, setting out the manner in which it determines how a complaint is to be dealt with under s 20(1) of the Act.

3.20 Nonetheless, the Committee stresses the need for the Commission to maintain clear and open lines of communication with all parties concerned with its investigation of a complaint.

ISSUE 13: That s 20(1) of the *Health Care Complaints Act 1993* be amended to provide that assessment of a complaint includes determining whether that complaint is malicious or vexatious.

3.21 In its original submission, the Nurses' Association suggested that s 20 of the Act should be amended to make clear that assessment is required to determine that the complaint is not "malicious or vexatious".¹¹⁰ In response, the Commission noted that there was no need for such an amendment, as s 27(1) of the Act already provides that the Commission may decline - "discontinue dealing with" - a complaint that is "frivolous, vexatious or not made in good faith".¹¹¹

3.22 However, in evidence before the Committee, the Association advised that their concern had been that:

the proposed amendment was suggesting that a notification could be made to an Area Health Service before assessment without it first being clarified that it may be vexatious. We wanted to be clear that notification should not be made until that assessment has been made.¹¹²

3.23 As this matter has been clarified, the Committee makes no recommendation with respect to Issue 13.

The investigation process

ISSUE 14: That, when a report is requested from a health practitioner, an information package is provided which outlines the roles, powers and processes of the Health Care

¹⁰⁷ Submission no. 33, Health Care Complaints Commission, p. 14.

¹⁰⁸ Submission no. 33, Health Care Complaints Commission, p. 14.

¹⁰⁹ See, e.g., Health Care Complaints Commission website. *Home>Information>Information For Health Providers*, <<http://bit.ly/dhBbfY>>

¹¹⁰ Submission no. 15, NSW Nurses' Association, p. 6.

¹¹¹ Submission no. 33, Health Care Complaints Commission, p. 15.

¹¹² A Butler, Professional Officer, NSW Nurses' Association, *Transcript of Evidence*, 4 March 2010, pp. 40-41.

Complaints Commission, and contains clear plain English information regarding the possible use of any written report, and the rights of the author of the report.

- 3.24 A number of submissions raised issues with respect to the manner in which the Commission currently conducts its investigations. Specifically, the Australasian Faculty of Rehabilitation Medicine noted that when its members are asked to prepare reports, either as witness or clinician under investigation, they are not provided with information regarding the role and processes of the Commission, or the rights of those being investigated.¹¹³
- 3.25 Supplementary submissions generally welcomed this proposal, with Avant noting that it supports:
any review by the Commission of its procedures and the content of information provided by it to both healthcare professionals and patients particularly in relation to possible use of any written report, and the rights of the author of the report.¹¹⁴
- 3.26 In its response, the Commission set out the nature of the information that it provides to, and is available to, health practitioners about the Commission's role, powers and complaint-handling processes in response to Issue 5 above. With respect to *how* a report or response may be used, the Commission pointed out that its standard notification letter to a health provider advises them that a copy of their response to the complaint will be given to the complainant, unless they ask that their response should not be released (see Appendix 6).
- 3.27 Moreover, the Commission's website now includes a page entitled *What if a complaint is made about me?* which includes the following information about the use of the practitioner's response:
Will my response to the complaint be provided to the complainant?
You can opt for your response to be used for assessment purposes only. This means that a copy would not be released to the complaint without your consent.¹¹⁵
- 3.28 Whilst the Committee has already noted the importance of all parties to an investigation process being fully informed of their rights and responsibilities, it considers that the Commission already provides the requisite information to respondents, and to those involved in preparing reports. In particular, Committee Members note the detail contained on the Commission's website on "Information for Health Providers" (see Appendix 8); and that the Commission conducts regular training for its expert reviewers.¹¹⁶

ISSUE 15: That the Note to Division 5 of the *Health Care Complaints Act 1993* be amended by the deletion of the second sentence.

- 3.29 In its original submission, the Nurses' Association raised an important issue about the fundamental impartiality of the Commission's investigation process. The submission points out that the Note to Division 5 of the Act (Investigation of complaints) provides as follows:

¹¹³ Submission no. 19, Royal Australasian College of Physicians, pp. 1-2.

¹¹⁴ Avant, *Questions answered after hearing*, p. 12.

¹¹⁵ Submission no. 33, Health Care Complaints Commission, p. 15.

¹¹⁶ See Health Care Complaints Commission website. *Home>Information>Information For Expert Reviewers*, <<http://bit.ly/aTiwy1>>

The assessment and investigative powers of the Health Care Complaints Commission

The bulk of Commission investigations under this Division will deal with matters arising under health registration Acts relating to health practitioners. The Commission will investigate with a view to moving to prosecution of the complaint before the appropriate professional board, committee or tribunal...

- 3.30 The Association suggests that the second sentence of the Note raises two major concerns, namely that:
- the investigation commences from the point of assuming merit in the complaint and the guilt of the health practitioner; and
 - it removes a fair and impartial system of investigation.¹¹⁷
- 3.31 This proposal was supported by all of the supplementary submissions, except that of the Royal Australasian College of Surgeons. The College did not agree with the implication that the Commission was “assuming merit in a complaint or was assuming the guilt of the health practitioner”, or that the sentence in question “precludes the possibility of a fair and impartial process of investigation”.¹¹⁸
- 3.32 The Committee agrees with the College that the Commission is empowered to investigate complaints fairly and impartially, and capable of applying principles of natural justice. However, Committee Members also consider that the second sentence of the Note to Division 5 of the Act is open to misinterpretation, and that it is in the public interest for the Act to be clear as is possible.

RECOMMENDATION 5: That the Note to Division 5 of the Health Care Complaints Act 1993 be amended by the deletion of the second sentence.

Timeliness

ISSUE 16: That s 22 of the *Health Care Complaints Act 1993* be amended to provide that, in “exceptional cases”, at the expiry of the 60 day period the Commission may review the progress of an assessment, defer the decision if it is considered appropriate in the circumstances, and advise the complainant of reasons for doing so

- 3.33 Pursuant to s 22 of the Act, the Commission must carry out its assessment of a complaint:
- (a) within 60 days after receiving the complaint; or
 - (b) if, under s 21, the Commission has required the complainant to provide further particulars of the complaint, within 60 days after the date by which the Commission specified that those particulars were to be provided.¹¹⁹
- 3.34 However, a significant number of submissions suggested generally that the current system is slow to act on complaints and respond to complainants.¹²⁰ Specifically, the

¹¹⁷ The Association stressed the purpose of the investigation should be for the purpose of impartially collecting the evidence from all possible sources to be assessed by a separate body as to whether a complaint should be prosecuted: Submission no. 15, NSW Nurses' Association, p. 7.

¹¹⁸ Submission no. 42, Royal Australasian College of Surgeons, p. 1.

¹¹⁹ However, s 92A of the *Health Care Complaints Act 1993* requires the Commission to assess, investigate and, where appropriate, prosecute as quickly as practicable a range of complaints which relate to the protection of public health, e.g., a complaint under s 54 of the *Chiropractors Act 2001*.

Department of Health noted concerns with respect to the 28-day time frame for a health service provider to respond to serious complaints. In its original submission, the Department raised a particular issue, suggested by the South Eastern Sydney and Illawarra AHS, that, in exceptional cases, the Commission ought to “review the progress of the assessment at 60 days and defer the decision if it is considered more expedient to do so”.¹²¹

3.35 In its supplementary submission, NCOSS disagreed with the proposal, noting that the Commission should retain the discretion to determine where there are exceptional circumstances and:

apply the principles underlying the Act of procedural fairness and due process to inform the complainant and the respondent of the delay and the reasons for it, and to finalise the matter expediently.

3.36 The Nurses’ Association suggested that, in order to avoid indefinite prolongation, any proposed amendment ought to include a “more prescriptive definition of any additional time period”.¹²²

3.37 While the Committee appreciates the timeliness concerns of NCOSS – and of many others who made submissions to its Inquiry – the Committee also notes the comment of the Commission in this regards that:

an amendment of the sort proposed would create an express legislative basis for the Commission’s current practice of extending the 60 day timeframe in exceptional cases of this type.¹²³

3.38 The Committee considers that legislative clarity around an existing administrative practice of the Commission will ultimately make for a better working relationship between the Commission and health service providers responding to serious complaints. Moreover, Committee Members note that, in 2008-09, 88.9 per cent of complaint assessments were finalised by the Commission within this 60-day timeframe; and that the Committee will continue to keep a very close watch on the timeliness of the Commission’s complaints-handling.

RECOMMENDATION 6: That s 22 of the *Health Care Complaints Act 1993* be amended to provide that, in “exceptional cases”, at the expiry of the 60 day period the Commission may review the progress of an assessment, defer the decision if it is considered appropriate in the circumstances, and advise the complainant of reasons for doing so.

¹²⁰ Submission no. 9, NSW Consumer Advisory Group - Mental Health Inc, p. 4; Submission no. 15, NSW Nurses’ Association, p. 3; Submission no. 19, Royal Australasian College of Physicians, p. 2; Submission no. 27, Positive Life NSW, p. 4; Submission no. 25, Public Advocacy Centre, p. 11; Submission no. 8, Country Women’s Association of NSW, p. 2; Submission no. 20, NSW Physiotherapists Registration Board, p. 1.

¹²¹ Submission no. 26, NSW Department of Health, p. 6.

¹²² Submission no. 32, NSW Nurses’ Association, p. 2.

¹²³ Submission no. 33, Health Care Complaints Commission, p. 17.

ISSUE 17: That the *Health Care Complaints Act 1993* be amended to require that an investigation under Division 5 must be conducted as quickly as practicable having regard to the nature of the matter being investigated.

3.39 In its Discussion Paper, the Committee noted that the Victorian *Health Professions Registration Act 2005* established a legal requirement for investigations to be conducted as quickly as practicable, which was based on reasoning which echoed the issues raised in submissions to this Inquiry:

Some consumers lacked confidence in the transparency and fairness of complaints handling under the previous Acts, with commissioned research identifying problems such as long timeframes to settle complaints, perceived lack of procedural fairness and no formal appeal rights for complainants.¹²⁴

3.40 There was general support for this proposal, although, the ADA noted “as quickly as possible” needed to be more precisely worded.¹²⁵ The submission from Avant made the valid point that:

[i]f the Act is to also provide that investigations must be conducted as quickly as practicable, then it should also make clear that investigations should not be expedited at the expense of procedural fairness and a thorough understanding of the issues.¹²⁶

3.41 However, the Committee notes the response from the Commission that s 29A of the Act already provides that the investigation of a complaint “is to be conducted as expeditiously as the proper investigation of the complaint permits”, which addresses concerns relating to both the timeliness and the thoroughness of an investigation.¹²⁷

3.42 Accordingly, the Committee makes no recommendation in respect of the proposal raised in Issue 17.

Procedural fairness

ISSUE 18: That the *Health Care Complaints Act 1993* be amended to provide for the mandatory provision of written reasons by the Commission for assessment and post-investigation decisions.

3.43 The Commission refers complaints about individual practitioners for formal investigation where, if substantiated, the complaint would provide grounds for disciplinary action, or involves gross negligence on the part of a practitioner. The purpose of an investigation is to obtain information so that the Commission can determine the most appropriate action (if any) to take, and its focus is on the protection of public health and safety.¹²⁸

3.44 The Committee notes that s 28(1) of the Act requires the Commission to give the parties notice in writing of the Commission’s assessment decision. Where the Commission decides:

- to “discontinue” dealing with the complaint, i.e., take no further action on the complaint;

¹²⁴ See Victoria Department of Human Services. *Health Professions Registration Act 2005: Why were the reforms needed?*, <<http://bit.ly/929lc8>>

¹²⁵ Submission no. 48, Australian Dental Association (NSW), p. 3.

¹²⁶ Avant, *Questions answered after hearing*, p. 13.

¹²⁷ Submission no. 33, Health Care Complaints Commission, p. 18.

¹²⁸ Health Care Complaints Commission website, *Complaints > Complaints Process*, <<http://bit.ly/9XzAoG>>

- not to investigate the complaint – which may involve referral of the matter for resolution or conciliation; or
 - to refer the complaint to the Director-General, or to another person or body,
- s 28(8) specifically provides that the Commission’s notification to the complainant of the decision must include the reasons for the decision.
- 3.45 Where the Commission decides to investigate the complaint, the reason for deciding to investigate a complaint will necessarily be based on one or more of the grounds listed in s 23,¹²⁹ and the Commission advises the parties to the complaint of the relevant reason(s).
- 3.46 Pursuant to s 41(1), the Commission must notify the parties and the appropriate registration authority in writing of “the results of the investigation, the action taken, and the reasons for taking that action”. Where the Commission decides to refer a complaint about a registered health practitioner to the Director of Proceedings to consider disciplinary proceedings, the Commission will limit the details of its reasons for the decision so as not to prejudice the conduct of any prosecution.
- 3.47 Under s 45(1), that the Commission must notify the parties to the complaint of “the results of the investigation”. The Commission notes that while this provision does not expressly require the Commission to give reasons for the decision:
- ...in practice the Commission always gives detailed reasons for its decision to both the complainant and the health organisation by providing them with a copy of the Commission’s investigation report.¹³⁰
- 3.48 If the investigation report makes comments or recommendations, s 42(3) specifically provides that the report must include the reasons for the Commission’s conclusions and recommendations.
- 3.49 In its original submission, PIAC argued that the Act should be amended to include legislative provisions that:
- mandate the provision of written reasons for assessment and post-investigation decisions; and
 - provide for both internal and external review of assessment and post-investigation decisions.¹³¹
- 3.50 In evidence to the Committee, Mr Peter Dodd from PIAC noted the following:
- ... history shows that people have not always received reasons for all assessment decisions... Because these decisions are so important to people's lives, they should have to give reasons...it is not just a question of giving reasons; it is giving an explanation to people if their complaint has not been proceeded with, which are the words they usually use. People should get an appropriate explanation. In the past, that certainly has not happened. In principle they should provide as much reason as they feel able to so people understand why the decision has been made.¹³²

¹²⁹ Namely, that the complaint either raises a significant issue of public health or safety, or a significant question as to the appropriate care or treatment of a client by a health service provider; or, if substantiated, would provide grounds for disciplinary action against a health practitioner, would involve gross negligence on the part of a health practitioner, or would result in the health practitioner being found guilty of an offence under Division 3 of Part 2A of the *Public Health Act 1991*.

¹³⁰ Submission no. 33, Health Care Complaints Commission, p. 19.

¹³¹ Submission no. 25, Public Interest Advocacy Centre p. 7.

¹³² P Dodd, Solicitor, Public Interest Advocacy Centre, *Transcript of Evidence*, 4 March 2010, pp. 22-23.

3.51 The Committee is pleased to note that there was complete support for this proposal in the supplementary submissions, with the Commission expressing no objection to the proposal. However, the submission from Avant raised some additional issues of procedural fairness:

Despite the provision of a section 45 investigation report (which is *not* always provided, in practice) the reasoning behind a decision to proceed with a prosecution is not clear...

It is Avant's submission that key decisions should be explained by the provision of adequate written reasons. Importantly in our view, there should also be a mechanism for decisions made following conferrals between the Medical Board (or other registration body) and the Commission to be reduced to writing which can be provided as a matter of course.

Without reasons, it is not possible to advise a practitioner as to whether or not any review - internal or judicial review of administrative action - should be sought. Review of administrative decision making is a fundamental right and as a matter of policy should be available to both Complainants and Respondents.¹³³

3.52 The Committee agrees that, having regard to procedural fairness, reasons for decisions following conferrals between the Commission and the relevant registration authority should be provided to the respondent as a matter of course.

RECOMMENDATION 7: That the *Health Care Complaints Act 1993* be amended to provide for the mandatory provision of written reasons by the Commission for assessment and post-investigation decisions to both the complainant and the respondent.

Internal review

ISSUE19: That the *Health Care Complaints Act 1993* be amended to provide for a statutory internal review process for the Health Care Complaints Commission, based on complaint handling best practice.

3.53 PIAC's original submission noted that, whereas the Act currently provides for internal reviews under s 28 (review of assessment decision by complainant) and s 41 (review of decisions made under s 39 – post-investigation decisions by complainant), neither section provides any guidance as to how a review is to be conducted and who is to conduct the review.¹³⁴ Accordingly, PIAC recommended the adoption by the Commission of a statutory internal review process, based on complaint handling best practice.¹³⁵

3.54 This would be characterised by:

- complainants and respondents having a right to request a merits review after any critical decision in the complaints process;
- reviews conducted and decided by delegated officers where there is clear separation from the Commissioner who effectively makes the initial assessment and investigation decisions under the Act;

¹³³ Avant, *Questions answered after hearing*, pp. 13-14.

¹³⁴ Currently s 28 reviews are drafted by Resolution Officers and signed off by the Commissioner.

¹³⁵ Submission no. 25, Public Interest Advocacy Centre, p. 8.

- mandatory provision of written review decisions with reasons;
- procedural fairness principles that apply and both complainant and respondent should have an opportunity to respond and provide additional submissions and evidence if a Commission decision is subject to review; and
- time limits should be placed on a party's opportunity to respond and the Commission's response after that.¹³⁶

3.55 The Committee notes that there was general support for this proposal. NCOSS stated that:

the intended purposes of codifying the review process is not to require the review of all decisions, but rather to provide greater clarity around how reviews are to be conducted, who is to conduct the reviews, and the principles that should apply to the review process.¹³⁷

3.56 The sole exception opposing the proposal was the submission of the Commission, which went into considerable detail about its current internal review practice, as set out below:

Complainants are entitled to request a review of the Commission's assessment decision (other than a decision to investigate the complaint),¹³⁸ and a review of the outcome of the investigation into a complaint about a health practitioner.¹³⁹

Health service providers who are subject to a complaint do not have a right to request a review of a decision by the Commission. However, they are entitled to respond to complaints, and have a right to make submissions in respect of investigation decisions and outcomes.¹⁴⁰

Reviewing assessment decisions

The Commission's review of an assessment decision is conducted as follows:

The file is referred to one of the Commission's Resolution Officers who was not involved in the original assessment of the complaint. This officer conducts a detailed review of the file, and may consider additional information and advice from one of the Commission's internal advisers. The officer then makes a recommendation to the Commissioner about whether the original assessment decision should be confirmed or changed. The Commissioner conducts his own review of the matter, and finalises correspondence to the complainant to advise them of the outcome of the review. The Commissioner's letter includes detailed reasons for his decision.

In 2008-09, there were 281 requests for a review of the assessment decision (8.4% of the total number of assessments). During the same period, 272 reviews were finalised. In 261 of these cases (96%), the original assessment decision was confirmed – there were only 11 cases in which the Commission decided to alter the original assessment decision.

Reviewing investigation decisions

The Commission's review of an investigation decision is conducted as follows:

The file is referred to an investigation manager other than the investigation manager who supervised the investigation. This officer conducts a detailed review of the file, and

¹³⁶ Submission no. 25, Public Interest Advocacy Centre, p. 9.

¹³⁷ NCOSS, *Questions answered after hearing*, p. 3.

¹³⁸ Section 28(9) of the *Health Care Complaints Act 1993*.

¹³⁹ Section 41(3) of the *Health Care Complaints Act 1993*.

¹⁴⁰ Sections 40 and 43 of the *Health Care Complaints Act 1993*.

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may take into account additional information and/or advice from one of the Commission's internal medical advisers. The officer then makes a recommendation to the Commissioner as to whether or not the investigation should be re-opened. The Commission conducts his own review of the matter, and finalises correspondence to the complainant to advise them of the outcome of the review. The Commissioner's letter includes detailed reasons for his decision.

In 2008-09, the Commission received four review requests and finalised six reviews. In only one of the six reviews was a decision made to re-open the investigation.¹⁴¹

- 3.57 Ultimately, the Commission concludes that "conducting a more extensive and detailed statutory process for internal reviews of all assessment decisions and investigations would be overly bureaucratic and unduly cumbersome".¹⁴² This conclusion was put to PIAC's Mr Peter Dodd at the Committee's public hearing on 4 March 2010:

Mrs Judy Hopwood: Having regard to the experience of your clients, do you consider that this is a reasonable response? I note that part of the remit of this Inquiry is to identify any unnecessary complications.

Mr Dodd: People who have busy jobs always say that something extra will add an extra burden. I think there are some positive reasons why there should be a more extensive review system implemented. I note that a few years ago the Commission did have a committee that looked at reviews of complaints. That was disbanded; that was never statutory. I do not know if there is evidence of that providing any more burden on the organisation but it did allow consumers another place to go...

I think I can say that consumers often are frustrated by that process. They seek a review, they get a letter signed off by the Commission usually saying "The Commission upholds the previous decision." I do not know whether consumers come away from that with a great deal of satisfaction. Consumers would be a lot more satisfied if they thought there was some independence in the review and perhaps that, if they wanted to, they had somewhere further to go after that first step.¹⁴³

- 3.58 The Committee recognises that unsatisfied complainants would have little sympathy with the Commission's concerns that a statutory internal review process would be "unduly cumbersome". However, Committee Members are concerned that codifying the review practice would tend to prolong the investigation process to an undesirable extent; and are mindful of the suggestion of NCOSS that what is required is an "appropriate balance between the general intended purpose of the review and the practical requirements of the Commission's operating context".¹⁴⁴
- 3.59 Accordingly, having regard to the existing review mechanisms of the Commission, the Committee considers that, rather than amend the Act to provide for statutory internal review, the best means of ensuring that the Commission is responsive to the

¹⁴¹ The Commission also noted that in the case of complaints about registered health practitioners, the Commission is required to consult with the relevant registration board in relation to the assessment decision [s 12 of the Act]. Health service providers subject to investigation are entitled to make submissions in relation to the matter [ss 40 & 43 of the Act]. If a registered health practitioner is the subject of disciplinary proceedings, they are entitled to present evidence and make submissions at the hearing of the proceedings before the relevant disciplinary body. There is also the opportunity for judicial review of decisions made by the Commission. Submission no. 33, Health Care Complaints Commission, p. 20.

¹⁴² Submission no. 33, Health Care Complaints Commission, p. 20.

¹⁴³ P Dodd, Solicitor, Public Interest Advocacy Centre, *Transcript of evidence*, 4 March 2010, pp. 20-21.

¹⁴⁴ NCOSS, *Questions answered after hearing*, p. 3.

concerns of complainants is for the Committee itself to closely monitor the Commission's decision-making reviews.

Peer review

ISSUE 20: That in the event of disagreement between the Commission and a Conduct Committee, or its equivalent, as to:

- the peer reviewer chosen by the Commission; or
- the standard applied by a peer reviewer in investigating a complaint,

the Commission is to seek a further opinion prior to completing the investigation of the complaint.

ISSUE 21: That s 30(1) of the *Health Care Complaints Act 1993* be amended to provide that "At the end of the Commission's investigation process, the Commission may obtain a report from a person (including a person registered under a health registration Act) who, in the opinion of the relevant registration authority, is sufficiently qualified or experienced to give expert advice on the matter the subject of the complaint."

3.60 In its submission, the NSW Medical Board raised the issue of peer review as part of the investigation process, and in particular:

the way in which the Commission feels bound to follow the opinions expressed by the expert or peer in an investigation notwithstanding the sometimes unanimous divergence from those views expressed by the medical members of the Board at the time of consultation.¹⁴⁵

3.61 Whilst the Board acknowledged the difficulty of selecting peers to review a practitioner's work, it suggested that where its own Conduct Committee considered that the wrong expert/peer has been chosen, or that that person has applied the wrong standard, the Commission ought to be obliged "to at the very least seek a further view."¹⁴⁶

3.62 The College of Surgeons was particularly concerned with these Issues. According to the College, a peer reviewer must be appropriately qualified *and* experienced in the matter which is the subject of a complaint:

It is essential that a peer reviewer of surgery be both appropriately qualified **and** experienced, and to be either currently active procedurally in the field relating to the subject matter of the complaint or to be within 5 years of being procedurally active in that field of practice.

... The College is concerned that some of the peers selected by the HCCC in the past have not been generally regarded as appropriate peers.¹⁴⁷

3.63 The Nurses' Association also expressed serious concerns with the process of peer review. According to the Association, problems include the following:

- the peer reviewer is required to assume that the complaint is factually valid, thereby detracting from the objectivity of the ensuing report;
- the request occurs before the completion of the investigation;

¹⁴⁵ Submission no. 21, NSW Medical Board, p. 3.

¹⁴⁶ Submission no. 21, NSW Medical Board, p. 3.

¹⁴⁷ Submission no. 42, Royal Australasian College of Surgeons, p. 2. Emphasis in original.

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- the broad definition of expert in s 30 of the Act results in the relevant expertise being questionable; and
- the same experts are used by the Commission regardless of the area of practice.¹⁴⁸

3.64 Avant supported these comments and noted further that:

[t]he better course is for a process of continued review to take place, and for changes and modifications to be reassessed, as necessary, and in particular that the peer reviewer is given **all** the material upon which the Commission intends to rely to the extent that it relates to the questions asked of the reviewer. That same material must also be provided to the respondent.¹⁴⁹

3.65 According to Avant, the Commission does not routinely provide all the material under consideration to the respondent, but only what the particular officer considers to be “relevant”.¹⁵⁰ However, the Committee notes that this is in keeping with the current provisions of s 30(2A) of the Act.¹⁵¹

3.66 In response to the concerns of the Nurses’ Association, the Commission noted as follows:

- the expert is not required by the Commission to assume that the complaint is factually valid. The Commission’s procedures stipulate that, where there are conflicting accounts of events, the expert should provide an opinion based on the complainant’s version – and also an opinion based on the health service provider’s version; and
- the suggestion that an expert report should be obtained “at the end” of the Commission’s investigation process is misconceived. This opinion has to be obtained during the investigation so that it can guide further investigation – and, if it is critical of the practitioner, be provided to the practitioner as a matter of procedural fairness, so that the practitioner can make submissions on the matter, as required by s 40 of the Act.¹⁵²

3.67 The Commission also noted that it chooses its expert for a particular investigation from its “list of experts” database, sourced from the various health professional colleges and associations after consultation.

3.68 In evidence to the Committee, the Commissioner noted that:

[i]n reality we brief appropriate experts. We go to the colleges to nominate experts. The College of Surgeons has been very good on that front; it was very quick and it gave us names and we recruited experts through the college. In fact it is our first port of call because it has the experts, the fellows, and it knows people of good standing and reputation. I would not have a difficulty if it were changed from sufficient to appropriate. I am not sure whether there would be a lot of practical difference.¹⁵³

¹⁴⁸ Submission no. 15, NSW Nurses’ Association, pp. 11-12. The Nurses’ Association re-iterated these concerns in its letter to the Committee on 29 March 2010.

¹⁴⁹ Avant, *Questions answered after hearing*, p. 15. Emphasis in original.

¹⁵⁰ Avant, *Questions answered after hearing*, p. 15.

¹⁵¹ Section 30(2A) provides that, if the Commission seeks to obtain a report from a person under this section in relation to a complaint, the Commission is to provide the person with all relevant information concerning the complaint that is in the possession of the Commission.

¹⁵² Submission no. 33, Health Care Complaints Commission, p. 22.

¹⁵³ K Pehm, Commissioner, Health Care Complaints Commission, *Transcript of Evidence*, 4 March 2010, pp. 38-39.

3.69 With respect to the issue of peer review, the Commissioner advised the Committee that, within the medical profession, “peer” tends to imply a person of *equivalent* training and experience, whereas, the Act refers to “experts”:

In investigating a complaint, the Commission may obtain a report from a person (including a person registered under a health registration Act) who, in the opinion of the Commission, is sufficiently qualified or experienced to give expert advice on the matter the subject of the complaint: s 30(1).

3.70 Thus, the Commission may seek assistance from a more experienced health care practitioner who can provide expert evidence on the standard of service and conduct expected of someone at a more junior level of training and experience. The Committee considers that it is not necessarily implicit in such a process that a more experienced practitioner will impose a higher standard on the practitioner under investigation. Indeed, Committee Members consider that this level of expert analysis would be likely to inspire public confidence in the process.

3.71 With respect to the suggestion that a further expert report should be obtained, the Commission notes that this creates difficulties for its conduct of disciplinary prosecutions, as the Commission must disclose all expert reports to the respondent practitioner. The Commission also notes that practitioners may call and rely upon their own expert(s) to challenge the evidence of the Commission’s expert.¹⁵⁴

3.72 Moreover, Committee Members are pleased to note that the Board itself considers that this situation surrounding peer review has markedly improved, as noted by the Registrar:

There is less conflict at that point of consultation where the Commission has come in and said, “We think this”. The Board members have said, “We think that”. Previously there was much more of a tendency for the Commission to stand firmly on the opinion that the Commissioner got whereas now there is a greater tendency for them to get a second opinion or perhaps to get the expert presented with the Board’s concerns about the expert opinion, perhaps ask further questions and so on as put to the Board.¹⁵⁵

3.73 The Committee is also pleased to note that the Commission is actively recruiting and training experts.¹⁵⁶

3.74 Having regard to the Commission’s responses to the specific concerns raised, and to the evidence of improved relations between the Commission and the Board in particular with respect to the use of peer review, the Committee does not make any recommendations with respect to Issues 20 and 21.

ISSUE 22: That a new s 30(1A) be inserted into the *Health Care Complaints Act 1993* to provide that “At the time of seeking the opinion of the expert, the Commission shall provide the expert with all of the evidence relating to the complaint in respect of which the expert’s opinion is sought.”

3.75 In its original submission, the Nurses’ Association made the following observation with respect to the provision of information by the Commission to experts:

¹⁵⁴ Submission no. 33, Health Care Complaints Commission, p. 22.

¹⁵⁵ A Dix, Registrar, NSW Medical Board, *Transcript of Evidence*, 4 March 2010, p. 54.

¹⁵⁶ Health Care Complaints Commission website. *Home>Information>Information For Expert Reviewers*, <<http://bit.ly/aTiwy1>>

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It has been the Association's experience on a number of occasions that the "expert" has admitted in cross-examination that the documentation received from the Commission has been of an extremely limited nature.

... The obvious consequence of this failure to provide such documentation is that the "expert" is required to express opinions based on inadequate information and make assumptions on crucial matters of which they have no objective information. It follows that it there is a strong possibility that if all objective material was given to the "expert" prior to their assessment and report, the prosecution of the complaint would not eventuate.¹⁵⁷

3.76 However, the Commission's supplementary submission noted that the proposal in Issue 22 is unnecessary, given that it is already dealt with in s 30(2A) of the Act:

If the Commission seeks to obtain a report from a person under this section in relation to a complaint, the Commission is to provide the person with all relevant information concerning the complaint that is in the possession of the Commission.¹⁵⁸

3.77 The Committee notes that the supplementary submission from the Nurses' Association made no further reference to the proposal. Accordingly, the Committee makes no recommendation in respect of Issue 22.

ISSUE 23: That s 16(6) and s 28(6) of the *Health Care Complaints Act 1993* provide that if subsection (4) applies to a complaint, some form of notice must be given to the person or person subject of the complaints in a manner that will not affect the health or safety of a client or putting any person at risk of intimidation or harassment.

3.78 With respect to procedural fairness, the Nurses' Association noted that s 16(6) and s 28(6) of the Act currently provide as follows:

If the Commission decides that subsection (4) applies to a complaint but that some form of notice could be given of the complaint without affecting the health or safety of a client or putting any person at risk of intimidation or harassment, the Commission may give such a form of notice.

3.79 The Nurses' Association submitted that the notification requirements should be mandatory.¹⁵⁹ In evidence to the Committee, representatives of the Nurses' Association stressed that the issue was a combination of situations in which nurses have not received actual notification until *after* they have become aware of an actual complaint; and where matters have been commenced but do not come to a hearing until at least four or five years later.

3.80 In response, the Commission notes that s 16 of the Act provides that the Commission must give written notice of the making of a complaint, the nature of the complaint and the identity of the complainant to the person against whom the complaint is made. However, the Commission is not required to do so where it considers on reasonable grounds, that the giving of the notice will or is likely to:

- (a) prejudice the investigation of the complaint;
- (b) place the health or safety of a client at risk; or

¹⁵⁷ Submission no. 15, NSW Nurses' Association, p. 14.

¹⁵⁸ Section 30(2) was added by the *Health Legislation Amendment (Complaints) Act 2004*.

¹⁵⁹ Submission no. 15, NSW Nurses' Association, p. 4.

(c) place the complainant or another person at risk of intimidation or harassment: s 16(4).

3.81 However, the Commission *must* give the notice if it considers on reasonable grounds that:

(a) it is essential, having regard to the principles of natural justice, that the notice be given; or

(b) the giving of the notice is necessary to investigate the matter effectively or it is otherwise in the public interest to do so: s 16(5).¹⁶⁰

3.82 The Commission notes that s 28 of the Act contains provisions of the same type as those in s 16 with respect to the notification to a health service provider of the decision to investigate a complaint. The Commission argues that the provisions of s 16 and s 28:

strike an appropriate balance between the general need to notify the health service provider of the nature of the complaint, and the rights of complainants and “whistleblowers” who may be legitimately afraid of adverse repercussions resulting from making a complaint.¹⁶¹

3.83 The Committee acknowledges the enormous strain placed upon nurses or any health care practitioners who are aware that they are the subject of a complaint. However, the Committee notes the “natural justice” provisions in s 16(5) of the Act, and is particularly concerned with ensuring that potential “whistleblowers” are not discouraged from coming forward.

3.84 Committee Members note that holding the Commission to account of its use of powers is at the core of the Committee's oversight responsibilities. Accordingly, rather than recommend the proposed amendment, the Committee will closely monitor and report on the Commission's use of notification under s 16 of the Act.

Outcomes

ISSUE 24: That s 39 of the *Health Care Complaints Act 1993* be amended to provide that, at the conclusion of an investigation, in the event of disagreement between the Commission and the relevant registration authority, the most serious course of action proposed by a party should be followed.

3.85 Section 39 of the Act sets out the options available at the end of the investigation of a complaint against a health practitioner.¹⁶² In its submission, the NSW Medical Board raised concerns that, although s 39(2) of the Act requires the Commission to

¹⁶⁰ See also s 16 (7): On the expiration of each consecutive period of 60 days after the complaint is assessed, the Commission must undertake a review of a decision not to give notice under this section (or to give notice in some other form as referred to in subsection (6)) unless notice under this section has already been given or the Commission has discontinued dealing with the complaint.

¹⁶¹ Submission no. 33, Health Care Complaints Commission, pp. 23-24.

¹⁶² These are to:

- refer the complaint to the Commission's Director of Proceedings;
- refer the complaint to the appropriate registration authority (if any) for consideration of the taking of action under the relevant health registration Act;
- make comments to the health practitioner on the matter the subject of the complaint;
- terminate the matter;
- refer the matter the subject of the complaint to the NSW Director of Public Prosecutions; or
- take action under s 41A, which is to make a prohibition order, or a public statement giving warnings or information about a health practitioner and health services provided by that practitioner.

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consult with a registration authority before deciding on a course of action, there is no requirement for the Commission to give equal weight to the expressed opinion. The Board suggests that there should be either consensus, or a replication of the requirement under s 13 of the Act that the more serious course of action should be followed.¹⁶³

3.86 In response, the Commission notes that disagreements between itself and registration boards are rare. The Commission also notes that it - unlike the various boards - is subject to a statutory requirement to justify its decisions against those criteria; and in practice, registration boards rarely do give a comprehensive statement of the reasons for their position. Finally, the Commission argued that if such a course were to be adopted, it could lead to wasteful prosecutions, and:

severely compromise the integrity and independence of the Commission's Director of Proceedings, who would, in effect, be obliged to prosecute matters which she had determined were not in the public interest and had little likelihood of success.¹⁶⁴

3.87 Both the ADA and Avant were also strongly opposed to the proposal. Avant also stressed the potential wastefulness of this process, and noted that:

if a Board and the Commission cannot agree on a proposed course of conduct it is manifestly unfair to a respondent to proceed upon the most serious avenue available merely because consensus cannot be reached.¹⁶⁵

3.88 The Committee notes again the general tenor of the evidence given by the Registrar of the NSW Medical Board at the public hearing on 4 March 2010 to the effect that the working relationship between the Board and the Commission has markedly improved since the Board put in its submission (see para 3.72).

3.89 Having regard to this, and to the cogency of the arguments put forward against the proposal in Issue 24, the Committee does not recommend its implementation.

ISSUE 25: That a new s 29AB be inserted into the *Health Care Complaints Act 1993* requiring the Health Care Complaints Commission, at the completion of an investigation to conduct a review of the process, to be made public to the extent that is appropriate.

3.90 The Health Services Association of NSW [HSA] noted that the Act currently does not require the Commission to review the investigation process following the conclusion of an investigation. The HSA considered that such a review would allow for an ongoing assessment of the Commission's investigation processes.

3.91 Support and opposition in the supplementary submissions was almost evenly divided on this Issue. For example, the Nurses' Association supported the proposal, provided that requisite resources to conduct the reviews were provided, and that the process did not delay other matters.¹⁶⁶

3.92 Avant suggests that as there is currently no process for results of reviews or audits to be made available to the public, and that it is an important means of achieving transparency and public accountability. Accordingly, Avant supports the proposal in

¹⁶³ See, e.g., s 13(1) of the Health Care Complaints Commission Act 1993: If either the Commission or the appropriate registration authority is of the opinion that a complaint (or any part of a complaint) should be investigated, it must be investigated.

¹⁶⁴ Submission no. 33, Health Care Complaints Commission, p. 24.

¹⁶⁵ Avant, *Questions answered after hearing*, p. 15.

¹⁶⁶ Submission no. 32, NSW Nurses' Association, p. 3.

principle, “whilst remaining mindful of the administrative burden it would impose upon the Commission”.¹⁶⁷

- 3.93 According to both PIAC and the Commission, the proposal is unnecessary, given that complainants already have the right to request a review. Moreover, the Commission queries how the suggested “publicity process” would work, having regard to the confidentiality provisions of the Act. However, the Commission does note that there are:

mechanisms under consideration by the Department of Health and the Clinical Excellence Commission ... to establish and publish a knowledge database providing the outcomes of investigations and root cause analysis to assist in the improvement of health systems.¹⁶⁸

- 3.94 Having considered both sides of the argument, the Committee does not consider that the legislative amendment proposed in Issue 25 is necessary. However, the Committee is strongly of the view that the results of Commission investigations should be used as a means of continuous improvement in the health care system of New South Wales. The issue of the availability of information obtained in the course of root cause analyses is considered in Chapter 4 (see paras 4.11 to 4.24).

RECOMMENDATION 8: That the Health Care Complaints Commission work with the NSW Department of Health and the NSW Clinical Excellence Commission to establish and publish a knowledge database providing the outcomes of investigations to assist in the improvement of health systems.

¹⁶⁷ Avant, *Questions answered after hearing*, p. 16.

¹⁶⁸ Submission no. 33, Health Care Complaints Commission, p. 25.

Chapter Four - Information sharing

If information is the lifeblood of healthcare, then communication is the heart that pumps it. Every information exchange is a communication act, whether it is the exchange that occurs between two people or two machines.¹⁶⁹

Introduction

- 4.1 The Chapter deals with the Inquiry's third Term of Reference. Issues raised with respect to information-sharing between the Commission and Area Health Services [AHS] and Registration Authorities, include Area Health Services not being informed of complaints relating to practitioners, or not being updated on such complaints.

Professional relationships

- 4.2 At the outset of this Chapter, the Committee is pleased to be able to note that there was general acknowledgement among stakeholders in the NSW healthcare complaints system that they had healthy working relationships with the Commission. For example, the Director of Clinical Governance at Northern Sydney/Central Coast AHS noted as follows:

First and foremost, overwhelmingly we have a collegiate relationship with the Health Care Complaints Commission [HCCC] and we work closely with it on a lot of issues. There are some ongoing issues relating to transparency of process. Notwithstanding that, I state for the record that we have a collegiate relationship with the HCCC.¹⁷⁰

- 4.3 The Committee heard similar evidence from the Australian Dental Association (NSW Branch):

We are satisfied that the relationship between health care complaints and the regulatory body as it stands in New South Wales, from our perspective, is a good and strong one that goes on to serve the interests of the public and the profession.¹⁷¹

- 4.4 It would appear that this is in part due to a process of continuous improvement undertaken by the Commission since the Committee commenced its Inquiry, as suggested by the Registrar of the NSW Medical Board:

I think it is fair to say that the relationship between the Commission and the Board has improved significantly. Quite a few of the things we raised have been taken on board by the Commission, so that there has been less of what I think we identified as friction between us about some professional issues over that period.¹⁷²

- 4.5 Importantly, this stance was also supported by Avant, the leading legal representatives for medical practitioners in Australia:

¹⁶⁹ P J Toussaint and E Coiera, "Supporting communication in health care", Editorial, *International Journal of Medical Informatics*, 2005, Vol 74, No 10, p 79.

¹⁷⁰ Dr B Eather, Director Clinical Governance, Northern Sydney/Central Coast Area Health Service, *Transcript of Evidence*, 4 March 2010, p. 8; See also L O' Shannessy, Director Legal and Legislation, NSW Department of Health to Mr Mel Keenan, Committee Manager, 11 May 2010.

¹⁷¹ Dr M Fisher, Chief Executive Officer, Australian Dental Association (NSW), *Transcript of Evidence*, 4 March 2010, p. 2. See also, e.g., A Deans, President, New South Wales Physiotherapists Registration Board, *Transcript of Evidence*, 4 March 2010, p. 61; letter from the NSW Dental Technicians Registration Board to Mr Mel Keenan, Committee Manager, 31 March 2010; and NSW Nurses and Midwives Board, *Correspondence in response to questions*, p. 3.

¹⁷² A Dix, Registrar, NSW Medical Board, *Transcript of Evidence*, 4 March 2010, p. 53.

It would be fair to say that it is constantly improving its processes and its approach... Nowadays there is much more evenness towards both complainant and respondent. I think that is particularly important. [The Health Care Complaints Act] is not an Act for complainants; this is an Act for handling complaints in a fair and appropriate way.¹⁷³

- 4.6 Nonetheless, issues continue to arise in respect to communication and information-sharing, and these will be considered in this Chapter.

Open Disclosure

ISSUE 26: That, in dealing with complainants throughout, and at the conclusion of, the complaint process, the Commission adopt the principles outlined in NSW Health's Open Disclosure Policy Directive (PD2007_040).

- 4.7 In its submission, Greater Southern AHS noted that, whereas all NSW Health Agencies are required to comply with the Department's *Open Disclosure Policy Directive* (PD2007_040) [the Directive], the Commission does not do so.¹⁷⁴ In its Discussion Paper the Committee noted, whilst the Commission is not bound by the Policy Directive, it agreed with Greater Southern AHS that the provision by the Commission of a report at the end of the complaint process may not necessarily meet the needs of a complainant.
- 4.8 Whilst the Committee notes that the considerable majority of supplementary submissions either supported or did not oppose this proposal, in this instance Committee Members consider that the contrary view is the more appropriate. As noted by the ADA, a Commission investigation is *not* part of the NSW Health open disclosure process, and the Commission should not be required to adopt the relevant policy:
- In short, the processes are quite separate and have different objectives and therefore the two should not be intermingled.¹⁷⁵
- 4.9 Similarly, Avant argues the Commission's perspective in complaint handling is often quite different from that of the public bureaucracies to which the Directive applies;¹⁷⁶ and the Commission rejected the applicability of the Directive to the conclusion of its complaint-handling process.¹⁷⁷
- 4.10 The Committee agrees that the aims of the Directive do not sit easily with the investigative role of the Commission, and makes no recommendation in respect of Issue 26. Nonetheless, the Committee stresses the need for the Commission to give all parties as full an explanation as possible at the conclusion of an investigation or prosecution.

¹⁷³ H Turnbull, Solicitor-Manager Disciplinary Services, Avant, *Transcript of Evidence*, 4 March 2010, pp. 15-16.

¹⁷⁴ According to the Directive, open disclosure is the process of "communicating with a patient and their support person about a patient related incident [which] provides an ethical framework for staff and Health Services to fulfill their duty of care to patients and their support person": NSW Department of Health. 2007. *Policy Directive: Open Disclosure*, <<http://bit.ly/dgprH4>>

¹⁷⁵ Submission no. 48, Australian Dental Association (NSW), p. 4.

¹⁷⁶ Avant, *Questions answered after hearing*, p. 16.

¹⁷⁷ Submission no. 33, Health Care Complaints Commission, p. 26.

Root Cause Analysis

- 4.11 Pursuant to Division 6C of the *Health Administration Act 1982*, a Root Cause Analysis [RCA] team is appointed by a health service organisation to review reportable incidents. On completion of this review, the team is required to prepare a report in writing that contains:
- a description of the incident;
 - a causation statement indicating the reasons why the RCA team considers the reportable incident concerned occurred; and
 - any recommendations by the RCA team as to the need for changes or improvements in relation to a procedure or practice arising out of the incident.¹⁷⁸
- 4.12 An RCA team does not have authority to conduct an investigation relating to the competence of an individual in providing services, but it may provide a report to a health service provider where it considers that the reportable incident raises matters that involving professional misconduct or unsatisfactory professional conduct.¹⁷⁹
- 4.13 The Health Administration Act also imposes statutory protections and confidentiality requirements - statutory privilege - on RCA team members, in order to facilitate full and open participation by clinicians in the review process.¹⁸⁰

Statutory privilege

- 4.14 Statutory privilege for RCA reviews was introduced as a result of recommendations made by the 2004 Inquiry into Camden and Campbelltown Hospitals conducted by Bret Walker SC. The Inquiry also recommended that these provisions be reviewed after a period of three years from their commencement.¹⁸¹ Thus, in June 2009, the Department of Health issued a Discussion Paper reviewing this statutory privilege. Key recommendations were that it be retained, but that Departmental policy be amended to clarify that, as part of the Open Disclosure process, patients and families may receive a copy of the RCA report.¹⁸²
- 4.15 However, the view of the Commission is that the RCA privilege is:
fundamentally incompatible with the process of open disclosure that has been promoted by the Department of Health within the public health system. The Commission has therefore suggested that the RCA privilege should not be maintained or, if it is, should be extended to allow the use of information gathered during the process to provide open and frank explanations to patients and their families about adverse events.¹⁸³

¹⁷⁸ *Health Administration Act 1982*, s 20O(3).

¹⁷⁹ *Health Administration Act 1982*, s 20N.

¹⁸⁰ *Health Administration Act 1982*, ss 20P - R.

¹⁸¹ NSW Health. August 2009. *Review of statutory privilege in relation to root cause analysis and quality assurance committees under the Health Administration Act 1982 - Final Report*, p. 4. The NSW Legislative Council General Purpose Standing Committee No 2 also recommended that statutory privilege be reviewed, in its 2004 report into complaints handling within NSW Health: <<http://bit.ly/bu6aJs>>

¹⁸² Open Disclosure Guidelines already require the Health Service to provide the patient and their support person with details of the RCA report, together with an explanation of the report in plain English; a summary of the factors contributing to the incident as established by the RCA review; and information on measures to be implemented to prevent a similar incident occurring: NSW Department of Health. 2009. *Open Disclosure Guidelines*, p. 9, <<http://bit.ly/arGJeQ>>

¹⁸³ Health Care Complaints Commission, *Annual Report 2008-09*, p. 11.

- 4.16 In evidence to the Committee, the Commissioner noted that the Commission's stance on the availability of RCA information is that the current system does not address the concerns of complainants, patients or family members:

Mr Pehm: Because the root cause analysis investigation is designed to look at improving the system, it is not a detailed forensic investigation, if you like. It is not done in public, there is no exposition of exactly what happened and who did what and when. ... So, from a family's point of view they do not get a full picture and a good understanding, or at least an understanding, that satisfies them as to exactly what happened. With a lot of people, particularly in a situation where they lose a loved one in an adverse incident in a hospital, they need to know all the details of what happened because there is the feeling of "Well, if only I stopped that doctor" or "If only I had asked would that have made a difference."

...Our position is that the information gathered during a root cause analysis should be able to be used for open disclosure with the family, but that privilege should apply for use of that material in legal proceedings, to address the clinician concerns that the material can be used against them. There has just been a review of this by the Department of Health. We were the lone voice with our position. All of the other submissions were very strongly in favour of retaining the current privilege.¹⁸⁴

- 4.17 The Committee notes that this was also the conclusion of Commissioner Peter Garling SC in his Report on the Special Commission of Inquiry into Acute Care Services [the Garling Inquiry]:

The Root Cause Analysis process takes several months and is concentrated on systemic issues. Many times, the family is looking for a person to hold responsible. Establishing the expectations about the process is as much a problem as the process itself. It is apparent to me that the gap between families' and carers' expectations and what a Root Cause Analysis is designed to achieve has not always been handled well.¹⁸⁵

- 4.18 Mr Warren Anderson also informed the Committee that he had found the report of the RCA review of his daughter Vanessa's death at Royal North Shore Hospital to be somewhat formulaic in describing what had in fact occurred:

Mrs JUDY HOPWOOD: In August 2005, just before Vanessa died, legislation came into being that imposed strict restrictions on the extent to which and to whom information gathered during the RCA, the root cause analysis investigation, could be disclosed. I would just like you to comment on the root cause analysis and how much you could find out...

Mr Anderson: ... As I said, a person came to me that had a similar problem up at Nepean Hospital and sent a copy of their root cause analysis for me to have a look at and I could have been reading Vanessa's... I asked the question: How is this information of the root cause analysis disseminated throughout the hospitals so that we do not have this problem happening all the time? "It doesn't. It stays within the hospital". What? I thought that is what root cause analysis was all about, to feel out a mistake and make sure that mistake does not happen again. To say, "Oh no, that information stays within the hospital", I could not work that out.¹⁸⁶

- 4.19 The Committee noted in its review of the Commission's 2008-09 Annual Report that the reluctance on the part of persons involved in the process to volunteer full and

¹⁸⁴ *Transcript of Evidence*, 4 March 2010, p. 37.

¹⁸⁵ Special Commission of Inquiry into Acute Care Services in Public Hospitals in NSW, 2008, conducted by Peter Garling SC, vol.2. p. 562.

¹⁸⁶ W Anderson, *Transcript of Evidence*, 4 March 2010, p. 26.

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honest information without this being subject to privilege was understandable.¹⁸⁷ Nonetheless, the Committee believes that patients and their families should have access to as much information as possible in order to fully understand what happened during a critical event.

- 4.20 The Committee concurs with the evidence to the Garling Inquiry of Professor Clifford Hughes of the Clinical Excellence Commission [CEC] that there is a need to “establish a database for RCA reports with appropriate classification of reports to enable objective analysis.”¹⁸⁸ Wider access by practitioners to this material would allow them to learn from others’ mistakes. As Commissioner Garling noted:

Patients and relatives of patients have an expectation that when a root cause analysis is conducted, the findings and recommendations will have a wider dissemination than the clinical unit in which the adverse incident occurred. I wish to make a recommendation about this.¹⁸⁹

Accordingly, he recommended that within twelve months of handing down his Report, the CEC should establish searchable intranet accessible to all NSW Health staff, which contains all RCAs.¹⁹⁰

- 4.21 As noted at paragraph 3.93 of the Report, the Commission has informed the Committee that the Department of Health and the CEC are currently exploring ways to establish and publish a knowledge database providing the outcomes of investigations and root cause analysis to assist in the improvement of health systems.¹⁹¹

- 4.22 The Committee notes that the State Government supported the recommendation of Commissioner Garling, and in its response to his Report stated:

This functionality will be incorporated within the planned upgrade of the existing Incident Information Management System application. If required as an interim measure, a web based application will be developed.¹⁹²

- 4.23 Committee Members reiterate their support for the Commission to work together with the Department and the CEC, as set out in Recommendation 8.

Communication with Area Health Services

ISSUE 27: That, where an Area Health Service has referred a complaint to the Health Care Complaints Commission, the Commission keep the Area Health Service informed of the progress of that complaint on a monthly basis.

- 4.24 In its Discussion Paper, the Committee was pleased to note the statement of the Northern Sydney Central Coast AHS suggesting that information sharing had “improved significantly, with systems in place so that questions raised by the HCCC can be answered quickly”.¹⁹³

¹⁸⁷ Review of the 2008-09 Annual Report of the Health Care Complaints Commission, p. 6.

¹⁸⁸ Special Commission of Inquiry into Acute Care Services in Public Hospitals in NSW, 2008, conducted by Peter Garling SC, vol.2. p. 632.

¹⁸⁹ Special Commission of Inquiry into Acute Care Services in Public Hospitals in NSW, 2008, conducted by Peter Garling SC, vol.2. p. 633.

¹⁹⁰ Recommendation 74 of the Special Commission of Inquiry into Acute Care Services in Public Hospitals in NSW

¹⁹¹ Submission no. 33, Health Care Complaints Commission, p. 25.

¹⁹² NSW Department of Health. 2009. *Caring Together - The Health Action Plan for NSW*, p. 34.

¹⁹³ Submission no. 17, Northern Sydney/Central Coast Area Health Service, p. 1.

- 4.25 However, the submission from Greater Southern AHS noted that the Commission does not have a mechanism in place to keep an AHS informed about the progress of an investigation, and suggested that a monthly update of an investigation's progress would be useful, particularly where the matter has been referred by the AHS itself.¹⁹⁴
- 4.26 With respect to the flow of information, Dr Eather of the Northern Sydney/Central Coast AHS suggested in evidence that, for an AHS, it was a process of balancing the risk management of a matter of sufficient seriousness that it is being investigated by the Commission against the rights of a practitioner who has been suspended from clinical duties, or on leave with or without pay for considerable amount of time:
- ...So the opportunity to be able to provide feedback or for us to have some understanding of the progress of that, notwithstanding the privacy issues - and we do not want the detail necessarily - is it still under investigation; has it been referred for independent peer review, we are waiting for the review to come back; just so that we had some ability to track the progress would be really important, particularly for the staff members in question.¹⁹⁵
- 4.27 On this point, NCOSS argued that improving the processes of the Commission generally requires better communication for *all* of the parties involved, not simply the relevant AHS. Thus, the same processes and procedures should apply, regardless of "whether you are in the Area Health Service, a GP, a nurse, a podiatrist or a complainant".¹⁹⁶
- 4.28 Moreover NCOSS makes the point that a monthly report may not be appropriate in all circumstances:
- It is pointless having formal report-backs to complainants if there is not much to report, as long as communication channels remain open, and people are aware that sometimes things take a little longer than you would like and that sometimes things move more quickly.¹⁹⁷
- 4.29 Effective communication is undoubtedly the key to limiting the occurrence of incidents which lead to health care complaints, and to the efficient investigation of those which do take place. The Committee agrees with the submission of NCOSS that ongoing communication between the Commission and *all* those parties involved in the complaints handling process is vital. The Committee also agrees that "codifying" the process of communication to a monthly report is not necessarily the best means of achieving an appropriate and constructive flow of information.
- 4.30 Accordingly, the Committee does not consider it necessary to recommend the proposal contained in Issue 27. However, Members cannot stress too strongly the need for the Commission to maintain a degree of communication with all parties to a complaint, which is as detailed and regular as is reasonable in the circumstances of that complaint.

¹⁹⁴ Submission no. 6, Greater Southern Area Health Service, p. 2. The Commission noted that its powers under the Act to consider concerns about the adequacy of health services can only be exercised on receipt of a specific complaint. If there is no such complaint, the Commission cannot conduct some form of "independent review" of a matter referred by an AHS. The Committee has clarified this with Area Health Services, which now understand that the Commission will contact the relevant patient and family, who will become the complainant: Health Care Complaints Commission, *Questions answered after hearing*, p. 2.

¹⁹⁵ Dr B Eather, Director Clinical Governance, Northern Sydney/Central Coast Area Health Service, *Transcript of Evidence*, 4 March 2010, p. 10.

¹⁹⁶ A Peters, Director, NCOSS, *Transcript of Evidence*, 4 March 2010, p. 30.

¹⁹⁷ A Peters, Director, NCOSS, *Transcript of Evidence*, 4 March 2010, p. 30.

ISSUE 28: That the *Health Care Complaints Act 1993* be amended to provide that where a person is named as an individual respondent to a complaint, and that person is employed by, or contracted to work for, an Area Health Service, that Area Health Service be notified by the Commission that the complaint has been made.

4.31 A number of Area Health Services raised the issue of notification in circumstances where a practitioner is working at one AHS, but the complaint relates to conduct, etc., at another AHS.¹⁹⁸ Under s 16 of the Act, the current AHS-employer is not notified until the complaint has been assessed; and, as noted by the Department of Health, that AHS may also hold relevant information and/or be investigating a concurrent complaint against the clinician which may be relevant when taken together with the complaint before the Commission.¹⁹⁹

4.32 Four submissions supported this approach.²⁰⁰ In its response to Issue 28, the Commission noted that it has no objection to notifying the employers of individuals of all complaints, and the Department of Health welcomed the Committee considering whether the Act should be amended in this regard.²⁰¹

4.33 According to Avant, such notification to a healthcare professional's employer should only be made where there is some identifiable reason for doing so, such as a danger to the health and safety of the public, in which case Avant notes that it is more than likely that the Medical Board will exercise its powers under s 66 and subsequently notify the employer.²⁰² It is the experience of Avant that the detrimental effect of a complaint to the Commission on a health professional cannot be overestimated:

It is a matter of frequent grievances to us from our membership that a respondent feels he has been pronounced guilty before he or she has been tried. It does nothing for this perception of unfair treatment to find that one's employment is under extreme and unwarranted scrutiny because a complaint has been made, and there are many sad cases of practitioners being forced out of their place of employment not because of any finding against them but because of a poisoned work environment.²⁰³

4.34 The Committee refers again²⁰⁴ to s 16 of the Act which provides as follows:

The Commission must give written notice of the making of a complaint, the nature of the complaint and the identity of the complainant to the person against whom the

¹⁹⁸ See Submission no. 6, Greater Southern Area Health Service, p. 2; Submission no. 17, Northern Sydney Central Cost Area Health Service, p. 1; and Submission no. 18, Hunter New England Area Health Service, p. 2.

¹⁹⁹ Submission no. 26, NSW Department of Health, p. 7.

²⁰⁰ These were from the North Coast Area Health Service; the Victorian Health Services Commissioner; the Royal Australasian College of Surgeons; and the Australian Council on Healthcare Standards.

²⁰¹ NSW Department of Health, *Questions answered after hearing*, p. 3.

²⁰² Pursuant to s 66(1), the NSW Medical Board if at any time it is satisfied that it is appropriate to do so for the protection of the health or safety of any person or persons (whether or not a particular person or persons) or if satisfied that the action is otherwise in the public interest:

(a) by order, suspend a registered medical practitioner from practising medicine for such period (not exceeding 8 weeks) as is specified in the order, or

(b) impose on a registered medical practitioner's registration such conditions relating to the practitioner's practising medicine as the Board considers appropriate.

²⁰³ Avant, *Questions answered after hearing*, p. 17. See also, L Nash, et al, "The response of doctors to a formal complaint", *Australian Psychiatry*, vol. 14, no. 3, September 2006, p. 246.

²⁰⁴ See paras 3.80-3.81.

complaint is made. The notice must be given not later than 14 days after the Commission's assessment of the complaint under Division 4.

- 4.35 The Commission is not required to give notice where it considers on reasonable grounds, that the giving of the notice will or is likely to:
- (a) prejudice the investigation of the complaint;
 - (b) place the health or safety of a client at risk; or
 - (c) place the complainant or another person at risk of intimidation or harassment: s 16(4).
- 4.36 However, the Commission *must* give the notice if it considers on reasonable grounds that:
- (a) it is essential, having regard to the principles of natural justice, that the notice be given; or
 - (b) the giving of the notice is necessary to investigate the matter effectively or it is otherwise in the public interest to do so: 16(5).
- 4.37 The Committee considers that the principles set out in s 16(5) may provide a middle way between properly investigating a complaint, and providing procedural fairness to a person against whom a complaint has been made.

RECOMMENDATION 9: That the *Health Care Complaints Act 1993* be amended by a new s 16(5A) in the following terms:

The Commission must give notice of the making of a complaint to the current employer of the person against whom the complaint has been made if the Commission considers on reasonable grounds that the giving of the notice is necessary to investigate the matter effectively or it is otherwise in the public interest to do so.

ISSUE 29: That, on requesting a response from an Area Health Service to an individual complaint against a practitioner employed by, or contracted to work for, that Area Health Service, the Health Care Complaints Commission specifically request from the Area Health Service information on any other complaints or practice-based concerns in respect of that practitioner.

- 4.38 In its original submission, Hunter New England AHS suggested that, when an AHS is asked for a response to a specific complaint, and may be in possession of additional information which it considers may be relevant, there was uncertainty as to whether then AHS ought to provide any such additional information.²⁰⁵

²⁰⁵ Submission no. 18, Hunter New England Area Health Service, p. 1. On this point, the Committee flagged that there might be relevant privacy concerns relating to both the practitioner and his or her clients. In response, the Commission considers that as s 11 of the *Health Records and Information Privacy Act 2002* applies to organisations that are health service providers – and therefore to an AHS - under the health privacy principles set out in Sch 1 to HRIPA, an AHS can disclose confidential health information to the Commission if it believes that the disclosure is reasonably necessary for the Commission to discharge its functions. Where there is any doubt, the health organisation may suggest to the Commission that it should issue a notice under s 34A of the Act requiring the production of the relevant information.

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- 4.39 The Commission is of course keen to obtain information from an AHS regarding complaints or concerns about health practitioners contracted/employed by the AHS, and noted that that it will “pursue such matters appropriately where is any suggestion of a broader problem in relation to the practitioner’s practice or conduct”.²⁰⁶
- 4.40 However, both the ADA and Avant strenuously opposed this proposal, with the ADA of the opinion that the Commission is already in possession of sufficiently broad powers to facilitate the collection of this information;²⁰⁷ and Avant on the basis of procedural fairness:
- Basic tenets of procedure limit the seeking of information to that which is relevant to the issues, in this case the investigation which is curtailed by the scope of the inquiry into the complaint - and should become not an unlimited, uncontrolled fishing expedition... It is inappropriate to consider that such an intrusive and excessive power should be used against an individual, when there are no countervailing provisions requiring accuracy, protection or justification.²⁰⁸
- 4.41 Avant also made the valid point that if an AHS is in fact in possession of information about a healthcare professional whom the AHS reasonably believes poses a risk of harm to the public, then the AHS should notify the Commission, or refer the matter to the Board under the relevant legislative provisions.²⁰⁹
- 4.42 The Committee considers it is in the best interests of both the complainant and the respondent that all information relevant to an investigation be made available to the Commission. Moreover, any uncertainty surrounding the provision of information by an AHS may unnecessarily delay timely investigation of a complaint. Thus, the Committee notes that the Nurses’ Association supported this proposal, with the important qualification that the Commission:
- specifically requests only that information for any complaints or practice-based concerns which is relevant to the handling of the current complaint and is sufficiently recent to be of relevance to the current complaint.²¹⁰
- 4.43 Committee Members consider that this approach provides the requisite balance between the complete and timely supply of information, and the rights of the respondent to have only relevant information considered in the investigation of a complaint.

RECOMMENDATION 10: That, on receipt of a request from the Health Care Complaints Commission for information relating to a complaint against a practitioner employed by, or contracted to work for, an Area Health Service, the Area Health Service supply to the Health Care Complaints Commission only that information which is both sufficiently recent and reasonably relevant to the investigation of the current complaint.

²⁰⁶ Submission no. 33, Health Care Complaints Commission, p. 27.

²⁰⁷ Submission no. 48, Australian Dental Association (NSW), p. 4.

²⁰⁸ Avant, *Questions answered after hearing*, p. 17.

²⁰⁹ Avant, *Questions answered after hearing*, p. 17.

²¹⁰ Submission no. 32, NSW Nurses’ Association, p. 3.

Mandatory Reporting – Severity Access Code 1

- 4.44 In the course of evidence at the public hearing, the issue was raised as to whether there should be mandatory reporting to the Commission of incidents which have been classified as a Severity Assessment Code 1 [SAC 1]. The concept of a SAC was explained by Dr Bernadette Eather in the following terms:

It is a matrix; it is a severity assessment code for incidents and complaints that occur... There is the consequence to the patient and then the frequency is the other part of the matrix that that would occur. So a SAC 1 incident is defined as death unrelated to the natural cause of illness and differing from the immediately expected outcome. These are usually as a result of an error in the health care system resulting in the death of a patient. That is obviously the most serious consequence. So it is: serious, major, moderate, minor and none. So in the matrix it is really the frequency, this is likely to occur once or twice a week, say a medication error, which unfortunately occurs daily but they very rarely result in a serious adverse event in terms of the consequence to the patient. It is essentially a matrix, with SAC 1 being the most severe and SAC 4 being no harm to the patient - it may be something that happens frequently with no resulting harm.²¹¹

- 4.45 Dr Eather also made the practical point that, as the time frame for responding to matters raised by the Commission is shorter than that of the Department, the concern is that the Commission's matter may be dealt with first, even though according to the SAC matrix the Departmental issue is the more serious.²¹²

- 4.46 The Committee notes that a key driver for making incidents such as a SAC1 subject to mandatory reporting to the Commission is the fact that prospective complainants may not themselves wish to make a complaint due to personal reasons. While the Committee recognises the importance of the right to choose *not* to make a complaint, in some instances this may mean that very serious matters are not subject to investigation:

Mrs JUDY HOPWOOD: I can think of at least two serious issues where the relatives, for whatever reason, did not take it further, but it should have been investigated totally regarding an inappropriate mix in a ward situation. I will not go into the circumstances because it could identify the case. That situation was not taken forward because of family issues. The health system needed to be informed about that particular one...

Mr PEHM: I agree with that. There are lots of reasons why people do not complain, whether it is grief or trauma or they want to put it behind them, where serious issues are raised and need to be investigated.²¹³

- 4.47 In the course of the hearing, the Commissioner indicate that the Commission had given consideration to mandatory notification to, and investigation by, the Commission of serious incidents, such as the unexpected death of a patient, without the need for a complaint. Accordingly, the Committee sought further evidence as to why the issue of mandatory notification had not been pursued.

- 4.48 In its response, the Commission noted first that its role under the Act does not currently extend to "the review of issues concerning the adequacy or quality of health

²¹¹ Dr B Eather, Director Clinical Governance, Northern Sydney/Central Coast Area Health Service, *Transcript of Evidence*, 4 March 2010, p. 13.

²¹² Dr B Eather, Director Clinical Governance, Northern Sydney/Central Coast Area Health Service, *Transcript of Evidence*, 4 March 2010, pp. 10-11. See also H Turnbull, Legal Manager Disciplinary Services, Avant, *Transcript of Evidence*, 4 March 2010, p. 18.

²¹³ *Transcript of Evidence*, 4 March 2010, p. 36.

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services that are not the subject of a complaint". Further, it maintained that there are other processes currently in place to examine serious adverse incidents, such as Root Cause Analysis, pursuant to which the incident is investigated:

with a view to identifying any systemic problems that contributed to the incident and, if appropriate, making recommendations intended to overcome or minimise such problems in the future.²¹⁴

- 4.49 Where a RCA team identifies possible misconduct by a healthcare practitioner, that must be referred to the Chief Executive of the relevant AHS; and the team may refer issues of poor performance. The Chief Executive must in turn notify the Commission and/or the relevant registration. In addition, the work and recommendations of RCA teams are also reviewed by the NSW Clinical Excellence Commission.
- 4.50 The Commission also noted that, as there was little evidence that the existing processes were "seriously inadequate", or that significant issues of public health and safety were not being managed, it had previously not been considered necessary to recommend mandatory notification of SAC 1 incidents. However, having further considered the issues in light of the Committee's question, the Commission advised that it has no difficulty with all SAC 1 matters being notified to it by Area Health Services.
- 4.51 However, it was suggested that, rather than requiring investigation of every such matter, the Commission should be able to conduct an assessment, to decide whether the particular matter warrants investigation. The Commission's position was based on the following reasons:
- existing processes to examine the incident may have already satisfactorily addressed the matter - the RCA team may have made appropriate recommendations for systems improvements;
 - the patient and/or the patient's family may be satisfied with the explanation of the incident provided through the "open disclosure" process, and with the outcome of the RCA process;
 - there may be no issues of possible misconduct by individual practitioners requiring investigation under one or more of the criteria set out in s 23 of the Act;²¹⁵ and/or
 - further investigation of the incident by the Commission would involve an unnecessary and inappropriate duplication of effort, with no useful outcome at the end of the investigation, and create unnecessary stress for health service providers.²¹⁶
- 4.52 Having regard to the nature of a SAC1 incident and the differing investigative "angles" of the Department of Health and the Commission,²¹⁷ the Committee considers that mandatory notification of SAC1 incidents - with the Commission

²¹⁴ Health Care Complaints Commission, *Questions answered after hearing*, p. 6.

²¹⁵ Namely, that the complaint either raises a significant issue of public health or safety, or a significant question as to the appropriate care or treatment of a client by a health service provider; or, if substantiated, would provide grounds for disciplinary action against a health practitioner, would involve gross negligence on the part of a health practitioner, or would result in the health practitioner being found guilty of an offence under Division 3 of Part 2A of the *Public Health Act 1991*.

²¹⁶ Health Care Complaints Commission, *Questions answered after hearing*, p. 6.

²¹⁷ See H Turnbull, Legal Manager Disciplinary Services, Avant, *Transcript of Evidence*, 4 March 2010, p. 18.

obliged to assess each such incident, but not necessarily further investigate it – is an appropriate way to ensure all serious incidents are examined by the Commission.

RECOMMENDATION 11: That the *Health Care Complaints Act 1993* be amended to provide that:

- an Area Health Service must report to the Commission all incidents classified as SAC 1 under the Department of Health's Severity Assessment Code; and
- the Commission must assesses each such incident with a view to establishing whether it is to be investigated by the Commission, and report back to the Area Health Service on the results of its assessment in a timely manner.

Appendix 1 – Submissions

No	Organisation
1	Dr Brendan Thomas O'Sullivan
2	Clinical Excellence Commission
3	Dr Neil and Mrs Ruth Willetts
4	[Confidential Submission]
5	Chinese Medicine Registration Board of Victoria
6	Greater Southern Area Health Service
7	Health Services Association of NSW
8	Country Women's Association of NSW
9	NSW Consumer Advisory Group
10	Aged Care Commissioner
11	Department of Ageing, Disability & Home Care
12	Carers NSW
13	Council on the Ageing (NSW)
14	Australian College of Midwives NSW Branch
15	NSW Nurses' Association
16	Health Care Complaints Commission
17	Northern Sydney Central Coast Area Health Service
18	Hunter New England Area Health Service
19	Royal Australasian College of Physicians
20	NSW Physiotherapists Registration Board
21	NSW Medical Board
22	Pharmacy Guild of Australia, NSW Branch
23	NSW Institute of Medical Education and Training
24	Australian Dental Association (NSW Branch)
25	Public Interest Advocacy Centre
26	NSW Department of Health
27	Positive Life NSW

Supplementary Submissions

No	Organisation
28	Dr Brendan Thomas O'Sullivan
29	NSW Psychologists Registration Board
30	Carers NSW
31	Royal Australasian College of Physicians
32	NSW Nurses' Association
33	Health Care Complaints Commission
34	North Coast Area Health Service
35	Aged Care Commissioner
36	Health Services Commissioner, Victoria
37	Greater Southern Area Health Service
38	Public Interest Advocacy Centre
39	NSW Physiotherapists Registration Board
40	Hunter New England Area Health Service
41	NCOSS
42	Royal Australasian College of Surgeons
43	Positive Life NSW
44	NSW Consumer Advisory Group
45	People with Disability Australia
46	NSW Nurses and Midwives Board
47	Australian Council on Healthcare Standards
48	Australian Dental Association (NSW Branch)

Appendix 2 – Supplementary Submission Summary

Summary of submissions indicating support for or opposition to issues raised in Discussion Paper

Issue	Supported or no objection	Qualified support	Not supported
Issue 1: That s 3 of the Health Care Complaints Act 1993 be amended to include a fifth object “to uphold the rights set out in the <i>Australian Charter of Healthcare Rights</i> ”	29, 32, 36, 38, 41, 44, 45, 47, 46	39	33, 48
Issue 2: That the Health Care Complaints Act 1993 be amended to include a provision that the Health Care Complaints Commission should consider the <i>Australian Charter of Healthcare Rights</i> when assessing or otherwise dealing with a complaint...	29, 32, 33, 36, 38, 41, 44, 45, 47, 46	39	48
Issue 3: That the <i>Australian Charter of Healthcare Rights</i> be added as a Schedule to the Health Care Complaints Act 1993	29, 32, 36, 38, 41, 44, 45, 47, 46	39	33, 48
Issue 4: The following amendments be made to the Health Care Complaints Act 1993: <ul style="list-style-type: none"> • that s 3A(4) give full recognition to public health organisations as the primary legal entities • responsible for their own management and control of clinical issues; • that s 25 and 25A require the Commission to directly inform a public health organisation of • a complaint made against it; and • that s 43 require a public health organisation to make any submissions in response to a Commission’s recommendations or comments directly to the Commission 	29, 34, 36, 42, 48	32 (points 1 & 2)	32 (point 3), 33, 46
Issue 5: That the Commission review its procedures for advising practitioners that they are under investigation, with a view to providing detailed information of what to expect from that process, including statutory timeframes, and of any support services which might be available	32, 35, 41, 42, 46	36, 40, 48	33
Issue 6: That the Health Care Complaints Commission develop guidelines or criteria by which either ‘best endeavours’ may be measured, or by which a client’s capacity to understand might be assessed.	29, 32, 38, 41, 42, 44, 48	36, 45, 46	30, 33
Issue 7: That the various NSW Registration Acts be repealed, and replaced by a single Health Professionals Registration Act.		29, 32, 37, 38, 41, 48, 46	36, 39
Issue 8: That a NSW Office of Health Practitioner Registration Boards be established to provide administrative and operational support to assist the various NSW Registration Boards and to assess complaints and undertake investigations on their behalf.	46	32, 41, 45, 48	36, 39

Issue	Supported or no objection	Qualified support	Not supported
Issue 9: That a Committee on Health Registration Authorities be established with a remit over all NSW Registration Boards similar to that of the Committee on the Health Care Complaints Commission	46	33, 38, 41, 48	32, 36
Issue 10: That the Public Bodies Review Committee resolve to review each Annual Report of all NSW Registration Bodies and report back to the Legislative Assembly on these reviews	29, 32, 46	38, 41, 48	33, 36
Issue 11: That the Health Care Complaints Act 1993 be amended so that the Health Care Complaints Commission can conduct investigations of its own motion, and so that investigations can be made more generally into the clinical management of care of patients in general.	29, 36, 30, 38, 39, 41	33, 35, 40, 42, 46	48
Issue 12: That the Health Care Complaints Commission make publicly-available guidelines, setting out the manner in which it determines how a complaint is to be dealt with under s 20(1) of the Health Care Complaints Act 1993	29, 32, 39, 42, 48	38, 46	33
Issue 13: That s 20(1) of the Health Care Complaints Act 1993 be amended to provide that assessment of a complaint includes determining whether that complaint is malicious or vexatious	32, 35, 39, 48, 46	40, 45	33, 42
Issue 14: That, when a report is requested from a health practitioner, an information package is provided which outlines the roles, powers and processes of the Health Care Complaints Commission, and contains clear plain English information regarding the possible use of any written report, and the rights of the author of the report	29, 32, 36, 38, 41, 42, 48, 46	39	33
Issue 15: That the Note to Division 5 of the Health Care Complaints Act 1993 be amended by the deletion of the second sentence	32, 33, 41, 48, 46		36, 42
Issue 16: That s 22 of the Health Care Complaints Commission Act be amended to provide that, in “exceptional cases”, at the expiry of the 60 day period the Commission may review the progress of an assessment, defer the decision if it is considered appropriate in the circumstances, and advise the complainant of reasons for doing so	33, 36, 42, 44, 46	32, 45	41, 48
Issue 17: That the Health Care Complaints Commission Act 1993 be amended to require that an investigation under Division 5 must be conducted as quickly as practicable having regard to the nature of the matter being investigated	29, 32, 36, 42, 44, 46	39, 45, 48	33
Issue 18: That the Health Care Complaints Act 1993 be amended to provide for the mandatory provision of written reasons by the Commission for assessment and post investigation decisions	32, 33, 35, 36, 38, 41, 42, 48, 46		

Issue	Supported or no objection	Qualified support	Not supported
Issue 19: That the Health Care Complaints Act 1993 be amended to provide for a statutory internal review process for the Health Care Complaints Commission, based on complaint handling best practice	32, 38, 41, 42, 44, 48, 46		33, 36
Issue 20: That in the event of disagreement between the Commission and a Conduct Committee, or its equivalent, as to: <ul style="list-style-type: none"> • the peer reviewer chosen by the Commission; or • the standard applied by a peer reviewer in investigating a complaint, • the Commission is to seek a further opinion prior to completing the investigation of the complaint 	33, 46	32, 48	42
Issue 21: That s 30(1) of the Health Care Complaints Act 1993 be amended to provide that “At the end of the Commission’s investigation process, the Commission may obtain a report from a person (including a person registered under a health registration Act) who, in the opinion of the relevant registration authority, is sufficiently qualified or experienced to give expert advice on the matter the subject of the complaint.”	29, 32, 33, 46	48	38, 42
Issue 22: That a new section 30(1A) be inserted into the Health Care Complaints Act 1993 to provide that “At the time of seeking the opinion of the expert, the Commission shall provide the expert with all of the evidence relating to the complaint in respect of which the expert’s opinion is sought.”	32, 42, 46	48	33
Issue 23: That s 16(6) and s 28(6) of the Health Care Complaints Act 1993 provide that if subsection (4) applies to a complaint, some form of notice must be given to the person or person subject of the complaints in a manner that will not affect the health or safety of a client or putting any person at risk of intimidation or harassment	32, 42, 48, 46		33, 38
Issue 24: That s 39 of the Health Care Complaints Commission Act 1993 be amended to provide that, at the conclusion of an investigation, in the event of disagreement between the Commission and the relevant registration authority, the most serious course of action proposed by a party should be followed	29, 39, 42	32, 46	33, 36, 48
Issue 25: That a new s 29AB be inserted into the Health Care Complaints Act 1993 requiring the Health Care Complaints Commission, at the completion of an investigation to conduct a review of the process, to be made public to the extent that is appropriate.	29, 42, 44, 46	32	33, 36, 38, 41, 48
Issue 26: That, in dealing with complainants throughout, and at the conclusion of, the complaint process, the Commission adopt the principles outlined in NSW Health’s Open Disclosure Policy Directive	32, 34, 36, 42, 44, 47, 46		33, 48

Issue	Supported or no objection	Qualified support	Not supported
Issue 27: That, where an Area Health Service has referred a complaint to the Health Care Complaints Commission, the Commission keep the Area Health Service informed of the progress of that complaint on a monthly basis.	29, 32, 34, 36, 42, 47, 46		33, 41, 48
Issue 28: That the Health Care Complaints Act 1993 be amended to provide that where a person is named as an individual respondent to a complaint, and that person is employed by, or contracted to work for, an Area Health Service, that Area Health Service be notified by the Commission that the complaint has been made.	34, 36, 42, 47	33, 37, 40	32, 48, 46
Issue 29: That, on requesting a response from an Area Health Service to an individual complaint against a practitioner employed by, or contracted to work for, that Area Health Service, the Health Care Complaints Commission specifically request from the Area Health Service information on any other complaints or practice-based concerns in respect of that practitioner.	33, 34, 42, 47	32, 39, 40	48, 46

Appendix 3 - List of Witnesses

Name	Organisation	Position
Dr Matthew Fisher	Australian Dental Association (NSW)	Chief Executive Officer
Ms Meredith Kay	Dental Technicians Registration Board	Chairperson
Dr Berni Eather	Northern Sydney Central Coast Area Health Service	Director, Clinical Governance
Ms Helen Turnbull	Avant	Solicitor-Manager, Disciplinary Services
Mr Peter Dodd	Public Interest Advocacy Centre	Solicitor
Mr Warren Anderson		
Ms Alison Peters	NCOSS	Director
Ms Solange Frost	NCOSS	Senior Policy Officer
Mr Kieran Pehm	Health Care Complaints Commission	Commissioner
Mr Kim Swan	Health Care Complaints Commission	Executive Officer
Ms Annie Butler	NSW Nurses' Association	Professional Officer
Ms Linda Alexander	NSW Nurses' Association	Legal Officer
Ms Leanne O'Shannessy	NSW Department of Health	Director, Legal and Legislation
Mr Iain Martin	NSW Department of Health	Assistant Director, Legal and Legislation
Mr Andrew Dix	NSW Medical Board	Registrar
Ms Anne Deans	NSW Physiotherapists Registration Board	President
Ms Debra Shirley	NSW Physiotherapists Registration Board	Deputy President

Appendix 4 – Section 35(1) of the *Health Practitioner Regulation National Law*

35 Functions of National Boards

- (1) The functions of a National Board established for a health profession are as follows
- (a) to register suitably qualified and competent persons in the health profession and, if necessary, to impose conditions on the registration of persons in the profession;
 - (b) to decide the requirements for registration or endorsement of registration in the health profession, including the arrangements for supervised practice in the profession;
 - (c) to develop or approve standards, codes and guidelines for the health profession, including -
 - (i) the approval of accreditation standards developed and submitted to it by an accreditation authority;
 - (ii) the development of registration standards for approval by the Ministerial Council; and
 - (iii) the development and approval of codes and guidelines that provide guidance to health practitioners registered in the profession;
 - (d) to approve accredited programs of study as providing qualifications for registration or endorsement in the health profession;
 - (e) to oversee the assessment of the knowledge and clinical skills of overseas trained applicants for registration in the health profession whose qualifications are not approved qualifications for the profession, and to determine the suitability of the applicants for registration in Australia;
 - (f) to negotiate in good faith with, and attempt to come to an agreement with, the National Agency on the terms of a health profession agreement;
 - (g) to oversee the receipt, assessment and investigation of notifications about persons who -
 - (i) are or were registered as health practitioners in the health profession under this Law or a corresponding prior Act; or
 - (ii) are students in the health profession;
 - (h) to establish panels to conduct hearings about -
 - (i) health and performance and professional standards matters in relation to persons who are or were registered in the health profession under this Law or a corresponding prior Act; and
 - (ii) health matters in relation to students registered by the Board;
 - (i) to refer matters about health practitioners who are or were registered under this Law or a corresponding prior Act to responsible tribunals for participating jurisdictions;
 - (j) to oversee the management of health practitioners and students registered in the health profession, including monitoring conditions, undertaking and suspensions imposed on the registration of the practitioners or students;

- (k) to make recommendations to the Ministerial Council about the operation of specialist recognition in the health profession and the approval of specialties for the profession;
- (l) in conjunction with the National Agency, to keep up-to-date and publicly accessible national registers of registered health practitioners for the health profession;
- (m) in conjunction with the National Agency, to keep an up-to-date national register of students for the health profession;
- (n) at the Board's discretion, to provide financial or other support for health programs for registered health practitioners and students;
- (o) to give advice to the Ministerial Council on issues relating to the national registration and accreditation scheme for the health profession;
- (p) if asked by the Ministerial Council, to give to the Ministerial Council the assistance or information reasonably required by the Ministerial Council in connection with the national registration and accreditation scheme;
- (q) to do anything else necessary or convenient for the effective and efficient operation of the national registration and accreditation scheme;
- (r) any other function given to the Board by or under this Law.

Appendix 5 – Section 150 of the *Health Practitioner Regulation National Law*

150 Relationship with health complaints entity

- (1) If the subject matter of a notification would also provide a ground for a complaint to a health complaints entity under a law of a participating jurisdiction, the National Board that received the notification must, as soon as practicable after its receipt -
 - (a) notify the health complaints entity that the Board has received the notification; and
 - (b) give to the health complaints entity -
 - (i) a copy of the notification or, if the notification was not made in writing, a copy of the National Agency's record of the details of the notification; and
 - (ii) any other information the Board has that is relevant to the notification.
- (2) If a health complaints entity receives a complaint about a health practitioner, the health complaints entity must, as soon as practicable after its receipt—
 - (a) notify the National Board established for the practitioner's health profession that the health complaints entity has received the complaint; and
 - (b) give to the National Board—
 - (i) a copy of the complaint or, if the complaint was not made in writing, a copy of the health complaints entity's record of the details of the complaint; and
 - (ii) any other information the health complaints entity has that is relevant to the complaint.
- (3) The National Board and the health complaints entity must attempt to reach agreement about how the notification or complaint is to be dealt with, including -
 - (a) whether the Board is to deal with the notification or complaint, or part of the notification or complaint, or to decide to take no further action in relation to it; and
 - (b) if the Board is to deal with the notification or complaint or part of the notification or complaint, the action the Board is to take.
- (4) If the National Board and the health complaints entity are not able to reach agreement on how the notification or complaint, or part of the notification or complaint, is to be dealt with, the most serious action proposed by either must be taken.
- (5) If an investigation, conciliation or other action taken by a health complaints entity raises issues about the health, conduct or performance of a registered health practitioner, the health complaints entity must give the National Board that registered the practitioner written notice of the issues.
- (6) If a notification, or part of a notification, received by a National Board is referred to a health complaints entity, the Board may decide to take no further action in relation to the notification or the part of the notification until the entity gives the Board written notice that the entity has finished dealing with it.
- (7) If a National Board or an adjudication body takes health, conduct or performance action in relation to a registered health practitioner, the Board that registered the practitioner

must give written notice of the action to the health complaints entity for the participating jurisdiction in which the behaviour that provided the basis for the action occurred.

(8) A written notice under subsection (5) or (7) must include—

(a) sufficient particulars to identify the registered health practitioner; and

(b) details of—

(i) the issues raised about the health, conduct or performance of the registered health practitioner; or

(ii) the health, conduct or performance action taken in relation to the registered health practitioner.

Appendix 6 – Standard letter from the HCCC to Health Practitioner

File:
Contact:
Phone:
Email:

Name and address

PRIVATE AND CONFIDENTIAL

Dear Dr

Complaint made to the Office of the Health Care Complaints Commission by * concerning care and treatment of * at *

On *date* the Commission received a complaint from *complainant* concerning the care and treatment of *subject* at *name of health care facility* on *date(s)*. I enclose a copy of the complaint for your information.

The Commission, in consultation with the NSW Medical Board, has now assessed the complaint and determined that your care and treatment of *name of subject* warrants investigation by the Commission. The reason for this decision is that this complaint raises significant questions about *your care and treatment of name of subject or if applicable/your conduct/or outline issues*.

The purpose of the investigation is to obtain further information in order to determine what, if any, further action is required. During the investigation, you will have an opportunity to make submissions. The Commission will give full consideration to your submissions before making a final decision about the appropriate outcome of the investigation.

At the end of an investigation the Commission has a number of options open to it including one or more of the following:

- referring the matter to the Director of Proceedings for a decision whether to prosecute a complaint before a disciplinary body (either a Professional Standards Committee or a Tribunal);
- referring the complaint to the NSW Medical Board with a recommendation about any disciplinary action the Commission considers appropriate in respect of the complaint;
- making comments to you about the matter;
- taking no further action.

Please note that if it becomes apparent at any stage of the investigation that no further action is warranted, the investigation will be terminated.

Please provide a response to the Commission which addresses the following questions and/or issues:

I have enclosed, for your records, a copy of an authority from *name of person giving authority* authorising you to provide information to the Commission. (and/or if applicable) I have enclosed a copy of the medical record for *name of subject*.

Please provide your response within 21 days as I am required to investigate this matter without delay.

You may wish to notify and/or consult your legal adviser or professional indemnity organisation in relation to this matter.

Please contact me on 9219 extn or by email to name@hccc.nsw.gov.au regarding this letter if you have any questions.

Yours sincerely

Name
Investigation Officer
Date

Appendix 7 – Rights and complaints fact sheet



NSW Council for Intellectual Disability

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Rights and complaints

Key facts

If a person with intellectual disability does not get a fair deal from the health system, it is okay to make a complaint. And if the person suffers from inadequate health care, they might be able to seek compensation.

There are independent complaints bodies you can go to. But, usually it is best first to try to sort the problem out with the service.

A right to good health care

Under the UN Convention on the Rights of Persons with Disabilities, people with disabilities have a right to good health care. You cannot take health professionals to court for breaching this right but you can expect the service to take a complaint seriously.

The NSW Patient Safety and Clinical Quality Program spells out what any person, including people with intellectual disability, can reasonably expect from health professionals, eg good quality care, to be treated with respect and clear complaints procedures.

The *Health care policy and procedures* of DADHC NSW (now the Department of Human Services) spell out what funded disability accommodation services should do to help their residents stay healthy.

General tips for making a complaint

- It is usually best to raise a concern as soon as the problem arises. It may be useful to ask a health professional to explain why they acted as they did, before deciding whether to make a complaint.
- It may be quickest to sort out the concern face-to-face or by a phone call. And, if that does not work, write a letter or email.
- Stick to the facts and try to be calm and clear.
- Be ready to listen to the service provider's point of view.
- Tell the person what you need from them. Is it an explanation, or an apology? Do you want them to do something?
- Politely tell them what you will do if the concern is not resolved.
- Keep records of what happens - the health problem and what you do about it.
- Be persistent, and try again if they do not respond the first time.

The main ways to make a complaint are –

- **Talk to the service provider directly.** Sometimes, this is enough to solve the problem informally.
- **Contact the provider's supervisor.** This may be a more senior doctor, manager or head of the organisation.



NSW Council for Intellectual Disability

- **Contact a formal complaint organisation.** Often, these organisations can look at the health service's records and say whether they did the wrong thing.

Complaint handling organisations

NSW Health

The NSW Department of Health handles complaints about services that it runs, including community health centres and public hospitals. You can complain to the service or to the head office of the Department.

DADHC (now Department of Human Services)

You can complain to the Department about the services it provides or funds.

Health Care Complaints Commission

An independent body that handles complaints about health services and individual professionals. If you want a language interpreter, you can contact the Commission through the Telephone Interpreter Service (TIS) on 131 450.

Ombudsman NSW

Handles complaints about DADHC and funded disability services, and about administrative failings in other government health services. The Ombudsman also reviews the deaths of people with disabilities in residential care.

Discrimination complaints

Under anti-discrimination law, it is unlawful for health services to discriminate on the basis of disability, eg refusing to offer heart surgery because a person has Down syndrome. Also, health services must make reasonable adjustments to their services to meet the needs of a person with a disability. If you think these rights are breached, contact the Disability Discrimination Legal Centre or the Intellectual Disability Rights Service for advice. They might suggest you complain to the Anti-Discrimination Board NSW or the Australian Human Rights Commission. These bodies can investigate and conciliate complaints. In some cases, complaints lead to compensation or orders for services to comply with the person's rights.

Suing for damages

If a person is badly injured or suffers great pain or distress because of the negligence of a health professional, you can consider suing for damages in court. You would need to talk to a solicitor who has experience in negligence law.

Where to get help

Anti-Discrimination Board NSW

(02) 9268 5555

www.lawlink.nsw.gov.au/ADB

Australian Human Rights Commission

(02) 9284 9600

Complaints: 1300 656 419

complaints@humanrights.gov.au

www.humanrights.gov.au

DADHC (now Department of Human Services)

(02) 8270 2000

www.dadhc.nsw.gov.au/dadhc/Contact+DADHC/Information+Feedback+and+Complaints.htm

Disability Discrimination Legal Centre

1800 800 708 (NSW only)

www.ddlcnsw.org.au

Level 1, 418A Elizabeth Street, Surry Hills, NSW 2010, Australia
Phone (02) 9211 1611 Fax (02) 9211 2606 Toll Free Phone 1800 424 065

NSW CID acknowledges the assistance of the NSW Department of Ageing, Disability and Homecare
www.dadhc.nsw.gov.au





NSW Council for Intellectual Disability

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Health Care Complaints Commission
 (02) 9219 7444 Free call: 1800 043 159
hccc@hccc.nsw.gov.au
www.hccc.nsw.gov.au

Intellectual Disability Rights Service
 (02) 9318 0144
 Free call 1800 666 611
info@idrs.org.au
www.idrs.org.au

NSW Health
 (02) 9391 9000
nswhealth@doh.health.nsw.gov.au
www.health.nsw.gov.au

Ombudsman NSW
 (02) 9286 1000
 Toll free: 1800 451 524
nswombo@ombo.nsw.gov.au
www.ombo.nsw.gov.au

For more information

Health care policy and procedures, DADHC NSW
www.dadhc.nsw.gov.au/NR/rdonlyres/C21BABCf-6001-400F-9D38-E4042FAD6281/4644/HealthCarePolicyandProceduresMar07amendedJuly2009.pdf

Patient Safety and Clinical Quality Program NSW
www.health.nsw.gov.au/policies/pd/2005/PD2005_608.html

Tips for making complaints
www.ombo.nsw.gov.au/complaints/tipsmakingcomplain.html

UN Convention on the Rights of Persons with Disabilities
www.humanrights.gov.au/disability_rights/convention.htm

You might be interested in these fact sheets

- **Consent to medical treatment**

This fact sheet was written in July 2009. See www.nswcid.org.au for updates.

The fact sheet contains general information only and does not take into account individual circumstances. It should not be relied on for medical advice. We encourage you to look at the information in this fact sheet carefully with your health professional to decide whether the information is right for you.

Level 1, 418A Elizabeth Street, Surry Hills, NSW 2010, Australia
 Phone (02) 9211 1611 Fax (02) 9211 2606 Toll Free Phone 1800 424 065

NSW CID acknowledges the assistance of the NSW Department of Ageing, Disability and Homecare
www.dadhc.nsw.gov.au



Appendix 8 – Responding to a complaint

The following guidelines are aimed to assist practitioners in how to deal with complaints made to them or about them and the health service they provided.

Resolving complaints

It is generally recommended to deal with complaints directly when they occur and try to resolve them locally with the patient or the person that complains.

The following guidelines provide some tips on how to best manage complaints at an early stage.

Why do people complain?

Many people have high expectations about treatments and about health service providers.

People complain because:

- they want an acknowledgement that something went wrong and an explanation of why
- they want an apology for the distress they experienced
- they do not want to see other people facing a similar problem
- they want to improve the service for themselves or others in the future
- they want someone to be blamed, punished or held accountable for what happened
- they want compensation.

It is important to keep in mind that people generally complain because they are dissatisfied. A complaint can be an opportunity to increase understanding of the patient's perspective. It can also help to improve the service that you offer.

Please remember that the person making the complaint may have found it quite distressing to do so and may have had difficulties in putting their experiences down on paper.

In the vast majority of situations people make a complaint because they genuinely believe that something went wrong. Only very few people complain just to cause trouble.

Tips for responding to a complaint

- Acknowledge the complaint
- Try to resolve the complaint directly with the complainant
- Be aware of differing views of what happened and what was said
- Reassure the complainant
- Have a complaint handling mechanism already in place

Every complaint is different, so the approach to resolving it will differ depending on:

- the nature of the complaint (the seriousness and the complexity)
- the complainant's wishes
- the issues the complaint raises

More information for health providers

[Australian Charter of Healthcare Rights](#)
[Responding to a complaint - summary](#)
[Responding to a complaint lodged with the Commission](#)
[Investigating complaints](#)

- how the complaint came to you.

Acknowledge the complaint

When people get a response to their complaint, they often see this as a sign that their concerns are being taken seriously.

Acknowledge their concerns and experiences, and take responsibility for what happened. Often the complaint may well be on the way to being resolved.

It is important to give the person a clear time frame in which the complaint will be addressed and contact details of the person responsible.

It can be helpful to outline the plan of action in investigating and responding to the complaint.

Try to resolve the complaint directly with the complainant

Wherever possible, invite the person who made the complaint to talk directly. It is important to clarify the issues and the desired outcomes.

The reason for a person's complaint may not always be clear in the written version. Most complainants greatly value the opportunity to talk about what happened and to tell their point of view and this can be also useful in guiding your response.

If the matter can be resolved immediately, then a written response can follow to confirm the agreed action.

Be aware of differing views of what happened and was said

Many complaints involve issues with communication. Patient and provider can have different perceptions and understandings about what happened and what was said.

Reasons for this may be that:

- A person with a health problem is in a vulnerable situation.
- Health service providers assume that their information or explanation has been clear when in fact the patient or the patient's family may not have understood it.
- The person has been given conflicting information from other people. This may be from other treatment providers or media reports or general opinions from others.

Who is telling the truth

'Who is telling the truth' may not be relevant in cases where communication and perceptions are the main issues.

Where there are differing accounts or points of view, it is important to acknowledge this without dismissing the complainant's point of view.

Perceived cover-up

Many complainants believe that all incidents/conversations are on record, so if there is no record then they may believe there has been a tampering with the records or there is a cover-up.

Many complainants have a concern that their point of view will not be listened to and that the staff will 'defend each other' and stick together.

Reassure the complainant

People who make complaints are often worried that there will be some kind of negative consequences for their ongoing care.

It is important to offer reassurance throughout the complaints process that this is not the case. Make sure that the person will not be discriminated against or victimised as a result of making a complaint, and the fact of making a complaint will not affect the person's treatment.

Also offer reassurance that the complaint will be kept confidential, and that there will not be a reference to the complaint in the complainant's health record, unless they want that to happen.

Have a complaint handling mechanism already in place

Evidence suggests that effective complaint handling and resolution decreases the risk of the complaint leading to legal action.

Responding to a complaint will be easier if you already have a system in place to deal with complaints. This should include a practical mechanism by which complaints are welcomed, received, investigated and resolved.

Inform the consumers/patients about how you will manage their complaint. Responding appropriately to a complaint can restore trust and prevent a minor grievance escalating.

General complaint response principles

Timeliness

Respond as soon as possible to complaints, even if it is just to explain the process and give a commitment to a certain timeframe.

- Stick to the timeframe given.
- Keep the complainant informed.
- Give the reasons for any delay.

Address all aspects of the complaint

- Provide a full response so that important issues are answered and the complainant can see that the complaint has been taken seriously.
- Explain the process of investigation.
- Acknowledge areas of disagreement or varying accounts without dismissing what the complainant has said.

Remember

- Try not to be defensive.
- Acknowledge the distress of the complainant.
- Apologise if appropriate, but in any event be sympathetic.
- Acknowledge any errors that did occur.
- Try to understand the situation from the complainant's perspective.
- Find out what will assist the complainant to resolve the matter

and their preferred options for resolution, for example, a written response, a phone discussion, changes in policy or procedure, a meeting.

- Avoid official or technical language, jargon and clichés.
- Consider cultural background and the possible use of interpreters.

Lessons learned

Outline what happened, how it happened, what is being done to stop it happening again, and that you are sorry that it happened.

If the complaint is about one of your staff

- Listen to the staff member's point of view and be aware of conflicts of interest.
- If you are the manager of the staff you are very likely to want to support the staff member by believing them/taking their side/accepting their point of view.
- Assist the staff member to acknowledge the complainant's point of view.
- If possible, separate the support of the staff member and the complaint handling mechanism.

Guidelines for a written response to a complaint

It is best in a written response to:

- acknowledge that voicing concerns is appreciated
- acknowledge the distress and the person's experience
- say what has been done to investigate the complaint
- state what has been done/could be done to address the concerns
- mention any changes or action taken or that are being considered as a result of the complaint
- offer an opportunity to discuss further, with choice of options (meeting, telephone, written)
- reassure the person that they can receive further service, if needed, without any concern about having made a complaint.

The following guidelines are aimed to assist practitioners in dealing with complaints made about them and the health services they provided.

The reasons why people lodge a complaint with the Health Care Complaints Commission include:

- they want the matter to be looked at by an external body
- they want someone to be blamed, punished or held accountable for what happened
- they want compensation.

Be aware of your reaction to a complaint about you

It can be a distressing experience to receive a letter from the Commission with a formal complaint from a patient. You may experience a range of reactions, including:

- Disappointment or anger that the person has taken their complaint to an external body rather than discussing it directly with you.
- Surprise, because the person seemed to be satisfied at the time.
- Frustration, because you have already spent time trying to resolve the complaint and now you are being asked again to deal with the matter.
- Worry, because your actions may be criticised.
- Defensiveness, because you think you were doing your best in good faith and in difficult circumstances.
- Concern about the fact that the Commission or the registration body is involved.
- Disagreement with the complainant's account of what happened or the circumstances that led to the complaint being made.
- Concern the complaint is not justified but has been taken seriously by the Commission.
- Unsure of who to talk with about the complaint or what you should do.

Provide your perspective

If a written complaint is lodged with the Health Care Complaints Commission, you will generally be notified about the complaint. You will receive a copy of the complaint and will be able to respond to the complaint before a decision is made about the action to be taken on the complaint.

Seek support

When you receive a complaint, we suggest that you consult with your insurer and/or a relevant senior person – supervisor, manager, consultant – while protecting the confidentiality of the complainant. If you are employed in the Public Sector, you may wish to contact the Complaints Manager of your hospital or Area Health Service.

Your confidentiality

The Commission notifies the complaint to the health care providers

More information for health providers

[Australian Charter of Healthcare Rights](#)
[Responding to a complaint - summary](#)
[Responding to a complaint directly](#)
[Investigating complaints](#)

involved in the complaint. This may include the hospital or organisation you work for, if they were also named in the complaint.

The Commission may request medical record or other relevant information from the hospital or facility you work for to assist in its assessment of the complaint. This may make them aware of the complaint.

If the Commission decides to formally investigate the complaint, it will notify you and the relevant employer.

Otherwise, the Commission cannot notify your employer under its legislation.

What happens next Assessing the complaint

When a complaint about a health provider is received, the Commission will assess the complaint as quickly as possible. Depending on the nature of the complaint, some of the key steps are:

- contacting the complainant to clarify the complaint
- notifying you – the provider – and seeking a response to the complaint
- obtaining health records in cases where the complaint raises concerns about clinical issues
- seeking clinical advice.

The Commission has nursing and medical advice available to assess health care or treatment provided. The Commission assesses all relevant information, including any expert advice.

If you are a registered health practitioner, the Commission must consult with your Registration Board prior to making a decision.

The possible outcomes of assessment are:

- The Commission can discontinue dealing with a complaint. This may be due to the age of the matter, the lack of evidence of wrongdoing, or that it might be better dealt with by some alternative means of redress.
- Often a complaint may be referred to assisted resolution. With the assistance of a neutral Resolution Officer, all parties attempt to resolve the complaint. Participation in assisted resolution is voluntary.
- The complaint may be referred to the Health Conciliation Registry, which maintains a panel of independent conciliators. They can facilitate a meeting of the parties to the complaint and guide them in seeking a resolution of the issues that underlie the complaint. Conciliation is a voluntary and confidential process.
- Complaints about individual health practitioners may be referred to the relevant Registration Board to be dealt with by them. Actions that the Registration Boards may take include counselling, as well as impairment or performance assessment.
- Where the complaint raises a significant issue of public health or safety; significant questions about the appropriate care or treatment of an individual; or, if substantiated, would provide

grounds for disciplinary action or involve gross negligence, it may also be referred to formal investigation by the Commission. The focus of an investigation is the protection of public health and safety rather than trying to obtain redress for individual complainants.

The Commission notifies both you and the complainant about the outcome of an assessment in writing within 14 days after the decision was made.

Review of an assessment decision

The complainant can request a review of this decision. An independent officer of the Commission will analyse the handling of the complaint and the Commissioner decides whether the original decision should be altered.

Investigating the complaint

If your complaint is referred for investigation, an Investigation Officer is assigned to the case, and will contact you. The Commission is obliged to notify your employer that you are being investigated.

During an investigation, it may be necessary to obtain statements and a further more comprehensive medical expert review.

At the end of an investigation, if there is any proposed adverse outcome, you will receive a letter stating the proposed outcome. You will have the opportunity to respond within 28 days. Your submission will be taken into account before reaching a final decision. Again, if you are a registered practitioner, the Commission will consult with your Registration Board, before reaching a final decision.

In the case of individual practitioners, the Commission may, at the end of an investigation:

- Terminate the investigation and take no further action.
- Make comments to the health practitioner.
- Refer the complaint to the appropriate Registration Board to take action under the relevant health legislation. In some cases, the Registration Board may have the power to refer the practitioner for performance or impairment assessment. The Registration Board may also decide to counsel the practitioner about the conduct that is subject of the complaint.
- Refer the complaint to the Director of Proceedings to consider disciplinary proceedings against the practitioner.
- The Commission may also refer an investigation to the Director of Public Prosecution where there is evidence of criminal conduct.

Under the *Health Care Complaints Act* the complainant can request a review of the investigation decision concerning individual practitioners. When such a review is requested, an Investigation Manager that was not previously involved in the handling your complaint, and the

Responding to a complaint lodged with the Commission - Health Care Complaints Co... Page 4 of 4

Commissioner, will analyse the investigation to decide whether it should be re-opened

Prosecuting a complaint

If the complaint is referred to the Director of Proceedings, she will independently determine whether to prosecute it before a disciplinary body. The Director of Proceedings must consider certain criteria when determining whether to prosecute a matter:

- the protection of the health and safety of the public
- the seriousness of the alleged conduct
- the likelihood of proving the allegations
- any submissions made by the health practitioner concerned.

Generally, complaints which may lead to a finding of unsatisfactory professional conduct are referred to a Professional Standards Committee that is constituted by the relevant Registration Board.

Prosecutions for professional misconduct are generally heard before a Tribunal, which has the power to suspend or deregister a practitioner.

More information

The Commission is an independent organisation. You can always [contact us](#) if you need more information.

For any questions relating to a current complaint against you or your health service, please contact the responsible Officer. You can find the contact details of your case officer on the top of any correspondence that is addressed to you. To be able to help you faster, please state the case number when contacting the Commission.

Appendix 9 – Code of Conduct

The Code of Conduct is prescribed by the Public Health (General) Regulation 2002.

1 Definitions

In this code of conduct: **health practitioner**, **health registration Act** and **health service** have the same meanings as in the Health Care Complaints Act 1993.

Note. The Health Care Complaints Act 1993 defines those terms as follows:

health practitioner means a natural person who provides a health service (whether or not the person is registered under a health registration Act).

health registration Act means any of the following Acts:

Chiropractors Act 2001	Dental Technicians Registration Act 1975	Dental Practice Act 2001
Medical Practice Act 1992	Nurses and Midwives Act 1991	Optical Dispensers Act 1963
Optometrists Act 2002	Osteopaths Act 2001	Pharmacy Practice Act 2006
Physiotherapists Act 2001	Podiatrists Act 2003	Psychologists Act 2001.

health service includes the following services, whether provided as public or private services: (a) medical, hospital and nursing services, (b) dental services, (c) mental health services, (d) pharmaceutical services, (e) ambulance services, (f) community health services, (g) health education services, (h) welfare services necessary to implement any services referred to in paragraphs (a)–(g), (i) services provided by podiatrists, chiropractors, osteopaths, optometrists, physiotherapists, psychologists and optical dispensers, (j) services provided by dietitians, masseurs, naturopaths, acupuncturists, occupational therapists, speech therapists, audiologists, audiometrists and radiographers, (k) services provided in other alternative health care fields, (k1) forensic pathology services, (l) a service prescribed by the regulations as a health service for the purposes of this Act.

2 Application of code of conduct

This code of conduct applies to the provision of health services by:

- (a) health practitioners who are not required to be registered under a health registration Act (including de-registered health practitioners), and
- (b) health practitioners who are registered under a health registration Act who provide health services that are unrelated to their registration.

Note. Health practitioners may be subject to other requirements relating to the provision of health services to which this Code applies, including, for example, requirements imposed by Part 2A of the Act and the regulations under the Act relating to skin penetration procedures.

3 Health practitioners to provide services in safe and ethical manner

- (1) A health practitioner must provide health services in a safe and ethical manner.
- (2) Without limiting subclause (1), health practitioners must comply with the following principles:
 - (a) a health practitioner must maintain the necessary competence in his or her field of practice,
 - (b) a health practitioner must not provide health care of a type that is outside his or her experience or training,
 - (c) a health practitioner must prescribe only treatments or appliances that serve the needs of the client,
 - (d) a health practitioner must recognise the limitations of the treatment he or she can provide and refer clients to other competent health practitioners in appropriate circumstances,
 - (e) a health practitioner must recommend to his or her clients that additional opinions and services be sought, where appropriate,
 - (f) a health practitioner must assist his or her clients to find other appropriate health care professionals, if required and practicable,
 - (g) a health practitioner must encourage his or her clients to inform their treating medical practitioner (if any) of the treatments they are receiving,
 - (h) a health practitioner must have a sound understanding of any adverse interactions between the therapies and treatments he or she provides or prescribes and any other medications or treatments, whether prescribed or not, that the health practitioner is aware the client is taking or receiving,
 - (i) a health practitioner must ensure that appropriate first aid is available to deal with any misadventure during a client consultation,
 - (j) a health practitioner must obtain appropriate emergency assistance (for example, from the Ambulance Service) in the event of any serious misadventure during a client consultation.

4 Health practitioners diagnosed with infectious medical condition

- (1) A health practitioner who has been diagnosed with a medical condition that can be passed on to clients must ensure that he or she practises in a manner that does not put clients at risk.
- (2) Without limiting subclause (1), a health practitioner who has been diagnosed with a medical condition that can be passed on to clients should take and follow advice from an appropriate medical practitioner on the steps to be taken to modify his or her practice to avoid the possibility of transmitting that condition to clients.

5 Health practitioners not to make claims to cure certain serious illnesses

- (1) A health practitioner must not hold himself or herself out as qualified, able or willing to cure cancer and other terminal illnesses.
- (2) A health practitioner may make a claim as to his or her ability or willingness to treat or alleviate the symptoms of those illnesses if that claim can be substantiated.

6 Health practitioners to adopt standard precautions for infection control

- (1) A health practitioner must adopt standard precautions for the control of infection in his or her practice.
- (2) Without limiting subclause (1), a health practitioner who carries out a skin penetration procedure within the meaning of section 51 (3) of the Act must comply with the relevant regulations under the Act in relation to the carrying out of the procedure.

7 Appropriate conduct in relation to treatment advice

- (1) A health practitioner must not attempt to dissuade clients from seeking or continuing with treatment by a registered medical practitioner.
- (2) A health practitioner must accept the right of his or her clients to make informed choices in relation to their health care.
- (3) A health practitioner should communicate and co-operate with colleagues and other health care practitioners and agencies in the best interests of their clients.
- (4) A health practitioner who has serious concerns about the treatment provided to any of his or her clients by another health practitioner must refer the matter to the Health Care Complaints Commission.

8 Not to practise under influence of alcohol or drugs

- (1) Must not practise under the influence of alcohol or unlawful drugs.
- (2) A health practitioner who is taking prescribed medication must obtain advice from the prescribing health practitioner on the impact of the medication on his/her ability to practice and must refrain from treating clients in circumstances where his/her ability is or may be impaired.

9 Health practitioners not to practise with certain physical or mental conditions

A health practitioner must not practice while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that detrimentally affects, or is likely to detrimentally affect, his or her ability to practice or that places clients at risk of harm.



10 Health practitioners not to financially exploit clients

- (1) A health practitioner must not accept financial inducements or gifts for referring clients to other health practitioners or to the suppliers of medications or therapeutic goods or devices.
- (2) A health practitioner must not offer financial inducements or gifts in return for client referrals from other health practitioners.
- (3) A health practitioner must not provide services and treatments to clients unless they are designed to maintain or improve the clients' health or wellbeing.

11 Health practitioners required to have clinical basis for treatments

A health practitioner must not diagnose or treat an illness or condition without an adequate clinical basis.

12 Health practitioners not to misinform their clients

- (1) A health practitioner must not engage in any form of misinformation or misrepresentation in relation to the products or services he or she provides or as to his or her qualifications, training or professional affiliations.
- (2) A health practitioner must provide truthful information as to his or her qualifications, training or professional affiliations if asked by a client.
- (3) A health practitioner must not make claims, either directly or in advertising or promotional material, about the efficacy of treatment or services provided if those claims cannot be substantiated.

13 Health practitioners not to engage in sexual or improper personal relationship with client

- (1) A health practitioner must not engage in a sexual or other close personal relationship with a client.
- (2) Before engaging in a sexual or other close personal relationship with a former client, a health practitioner must ensure that a suitable period of time has elapsed since the conclusion of their therapeutic relationship.

14 Health practitioners to comply with relevant privacy laws

A health practitioner must comply with the relevant legislation of the State or the Commonwealth relating to his or her clients' personal information.

15 Health practitioners to keep appropriate records

A health practitioner must maintain accurate, legible and contemporaneous clinical records for each client consultation.

16 Health practitioners to keep appropriate insurance

A health practitioner should ensure that appropriate indemnity insurance arrangements are in place in relation to his or her practice.

17 Certain health practitioners to display code and other information

- (1) A health practitioner must display a copy of each of the following documents at all premises where the health practitioner carries on his or her practice:
 - (a) this code of conduct,
 - (b) a document that gives information about the way in which clients may make a complaint to the Health Care Complaints Commission, being a document in a form approved by the Director-General of the Department of Health.
- (2) Copies of those documents must be displayed in a position and manner that makes them easily visible to clients entering the relevant premises.
- (3) This clause does not apply to any of the following premises:
 - (a) the premises of any body within the public health system (as defined in section 6 of the Health Services Act 1997),
 - (b) private hospitals or day procedure centres (as defined in the Private Hospitals and Day Procedure Centres Act 1986),
 - (c) premises of the Ambulance Service of NSW (as defined in the Health Services Act 1997),
 - (d) premises of approved providers (within the meaning of the Aged Care Act 1997 of the Commonwealth).

Concerned about your health care?

The Code of Conduct for unregistered health practitioners sets out what you can expect from your provider. If you are concerned about the health service that was provided to you or your next of kin, talk to the practitioner immediately. In most cases the health service provider will try to resolve them. If you are not satisfied with the provider's response, contact the Inquiry Service of the Health Care Complaints Commission for a confidential discussion on

(02) 9219 7444 or toll free on 1800 043 159.

If your complaint is about sexual or physical assault or relates to the immediate health or safety of a person, you should contact the Commission immediately.

What is the Health Care Complaints Commission?

The Health Care Complaints Commission is an independent body dealing with complaints about health services to protect the public health and safety.

Service in other languages

The Commission uses interpreting services to assist people whose first language is not English. If you need an interpreter, please contact the Translating and Interpreting Service (TIS National) on 131 450 and ask to be connected to the Health Care Complaints Commission on 1800 043 159 (9.00 am to 5.00 pm Monday to Friday)

More Information

For more information about the Health Care Complaints Commission, visit www.hccc.nsw.gov.au.

Contact the Health Care Complaints Commission

Office address: Level 13, 323 Castlereagh Street, SYDNEY NSW 2000,
9.00 am to 5.00 pm Monday to Friday
Post address: Locked Mail Bag 18, STRAWBERRY HILLS NSW 2012
Telephone: (02) 9219 7444 or toll free in NSW 1800 043 159
Fax: (02) 9281 4585
E-mail: hccc@hccc.nsw.gov.au
People using telephone typewriters please call (02) 9219 7555



Appendix 10 – Committee Minutes

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 14)

Thursday 23 October at 9.00 a.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Mr Matt Brown MP, Hon David Clarke MLC, Hon Kerry Hickey MP, Mr Matthew Morris MP, Hon Fred Nile MLC.

...

5. Review of the Health Care Complaints Commission Act 1993

The Chair referred to the Terms of Reference distributed.

Moved by Hon Fred Nile MLC, seconded by Mrs Judy Hopwood MP:
'That the draft Terms of Reference be adopted'

Moved by Mr Matthew Morris MP, seconded by Hon David Clarke MLC:
'That the Terms of Reference be published on the Committee website'; and
'That the Committee advertise the Inquiry into the operation of the *Health Care Complaints Act 1998* in appropriate media, calling for submissions by the deadline date of 28 November 2008.'

The Chair adjourned the meeting at 9.25 am.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 15)

Thursday 30 October 2008 at 9.00 a.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Mr Matt Brown MP, Hon David Clarke MLC, Hon Kerry Hickey MP, Mr Matthew Morris MP.

Apologies

Hon Fred Nile MLC

...

6. Review of the Health Care Complaints Commission Act 1993

Members noted that:

- the Inquiry would be advertised Wednesday, 5 November 2008 in the Government notices in the *Sydney Morning Herald* and the *Daily Telegraph*;
- a Press Release would be distributed this week; and
- the Secretariat is preparing a list of organisations from which submissions would be invited. The Chair invited Members to notify the Secretariat if they had any specific suggestions.

The meeting closed at 9.30 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 16)

Thursday 27 November 2008 at 9.00 a.m.

Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Mr Matt Brown MP, Hon David Clarke MLC, Hon Kerry Hickey MP.

Apologies

Mr Matthew Morris MP, Hon Fred Nile MLC.

3. Inquiry into the operation of the *Health Care Complaints Commission Act 1993*

i) Publication of submissions received:

The Chair informed Members that, due to persons being named in Submission No.4, it would be prudent not to publish that submission, based on the advice of the Clerk-Assistant Committees.

Moved Mrs Judy Hopwood MP, seconded Mr Matt Brown MP:

‘That submissions Nos 1,2 and 5 - 7 be published on the Committee’s website, with the following exception:

- the two letters attached to Submission No. 3 be treated as confidential and the identity of persons mentioned in the submission be suppressed prior to publication’;
- Submission No. 4 be treated as confidential and the Committee write to Ms Nelan advising her of this.’

ii) Acceptance of late submissions

The Chair noted that requests for extensions had been received from the AMA (NSW), the Department of Health, and the Public Interest Advisory Centre [PIAC]. Members discussed the possibility of late submissions and the need to anticipate further developments during the Parliamentary recess.

Moved Mrs Judy Hopwood MP, seconded Mr Matt Brown MP:

‘That the Committee invite and accept submissions to the Inquiry as the need arises, prior to the finalisation of the report of the Inquiry.’

The Chair adjourned the meeting at 9.30 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 17)

Thursday, 4 December 2008 at 1.35 pm
Room 1043, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Mr Matt Brown MP, Hon Kerry Hickey MP.

Apologies

Hon David Clarke MLC, Mr Matthew Morris MP, Hon Fred Nile MLC.

...

4. Inquiry into the operation of the *Health Care Complaints Commission Act 1993*

Publication of submissions received:

Moved Hon Kerry Hickey MP, seconded Mr Matt Brown MP:

‘That submission numbers 8 - 19 be published on the Committee’s website.’

The Chair adjourned the meeting at 1.40 pm.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 18)

Wednesday, 4 February 2009 at 10.00 a.m.
Room 1102, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Hon David Clarke MLC, Mr Morris MP, Rev Hon Fred Nile MLC

Apologies

Apologies were received from Mr Brown, Mr Hickey and Mrs Hopwood.

3. Inquiry into the operation of the *Health Care Complaints Commission Act 1993*

Resolved, on the motion of Mr Clarke, seconded by Rev Nile:

‘That submissions Nos 20 - 27 be published on the Committee’s website.’

The meeting was adjourned at 10.10 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 19)

Thursday, 5 March 2009 at 9.05 a.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Mr Matt Brown MP, Hon David Clarke MLC, Mr Matthew Morris MP, Rev Hon Fred Nile MLC

Apologies

Mr Kerry Hickey MP

...

5. Inquiry into the Operation of the Health Care Complaints Commission Act 1993

i) The Chair referred to the memorandum relating to David Charles Lindsay. Resolved, on the motion of Mr Brown, seconded by Mr Morris:

‘That the Committee decline to accept Mr Lindsay’s submission dated 1 December 2008; and write to Mr Lindsay:

- clarifying that it has not accepted his correspondence of 1 December 2008 as a submission to its Inquiry into the Operation of the *Health Care Complaints Act 1993*; and
- pointing out to him the limits of the Committee’s remit under s 65(2) of the *Health Care Complaints Act 1993*.’

ii) The Chair referred to the timetabling memo circulated, and asked for Members’ comments. Resolved, on the motion of Rev Nile, seconded by Mrs Hopwood:

‘That the Committee proceed with the Inquiry by way of issuing a Discussion Paper in the Spring Parliamentary Sitting of 2009, with a view to conducting public hearings and tabling its Report by the end of that sitting.’

The Chair adjourned the meeting at 9.20 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 20)

Thursday, 26 March 2009 at 9.06 a.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Hon Kerry Hickey MP, Mr Matt Brown MP, Hon David Clarke MLC, Mr Matthew Morris MP, Rev Hon Fred Nile MLC

...

4. Correspondence

(i) *Lindsay*

The Chair referred Members to the Briefing Note circulated. Resolved, on the motion of Mr Brown, seconded by Mr Hickey:

'That the Committee write to Mr Lindsay, referring to the provisions of s 90C of the *Health Care Complaints Act 1993*, and again declining to accept his correspondence as a submission to the Committee's Inquiry into the operation of the *Health Care Complaints Act 1993*.'

The Chair adjourned the meeting at 9.20 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 23)

Thursday, 3 September 2009 at 9.03 a.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Mr Matt Brown MP, Hon David Clarke MLC, Hon Kerry Hickey MP, Mr Matthew Morris MP, Rev Hon Fred Nile MLC

...

6. Review of operation of the Health Care Complaints Act 1993

The Chair referred to the Briefing Note distributed at the meeting. Members noted and agreed to the following revised timetable for the above inquiry:

- i) Meet Thursday 24 September 2009 to consider final Discussion Paper;
- ii) Once adopted, give interested parties 4 weeks to respond;
- iii) Collate and assess the responses - and decide whether hearings are necessary - with a view to meeting in the week beginning 16 November 2009;
- iv) If hearings are required, aim for the week beginning 30 November 2009; and
- v) Table in the week beginning 7 December 2009 (currently a sitting week).

The Chair closed the meeting at 9.19 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 24)

Thursday, 24 September 2009 at 9.10 a.m.
Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Hon Kerry Hickey MP, Mr Matt Brown MP, Mr Matthew Morris MP

Apologies

Mrs Judy Hopwood MP, Hon David Clarke MLC, Rev Fred Nile MLC.

7. Inquiry into the Operation of the *Health Care Complaints Act 1993*

i) Consideration of Chair's draft Discussion Paper

Resolved on the motion of Mr Morris, seconded by Mr Hickey:

'That the draft Discussion Paper and recommendations be considered *in globo*'.

ii) Adoption of Report

Resolved on the motion of Mr Brown, seconded by Mr Hickey:

'That the draft Discussion Paper be the Report of the Committee and that it be signed by the Chair and presented to the House'

Resolved on the motion of Mr Brown, seconded by Mr Hickey:

'That the Australian Commission on Safety and Quality in Health Care's *Australian Charter of Health Care Rights* be appended to the Discussion Paper.'

iii) Publication of the Discussion Paper

Resolved on the motion of Mr Morris, seconded by Mr Brown:

'That the Chair and the Secretariat be permitted to correct stylistic, typographical and grammatical errors.'

Resolved on the motion of Mr Brown, seconded by Mr Hickey:

'That, once tabled, the Discussion Paper be placed on the Committee's website'

iv) Matters outside of the Inquiry's Terms of Reference

Resolved on the motion of Mr Morris, seconded by Mr Hickey:

'That the Committee write to the Health Care Complaints Commission requesting its response to relevant matters which were raised in submissions to the Inquiry, but which were outside the Terms of Reference of the Inquiry.'

The Chair closed the meeting at 9.20 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 25)

Thursday, 12 November 2009 at 9.03 a.m.

Room 1102, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Mr Matt Brown MP, Mr Matthew Morris MP, Hon David Clarke MLC

Apologies

Hon Kerry Hickey MP, Rev Hon Fred Nile MLC.

...

4. Inquiry into the operation of the *Health Care Complaints Act 1993*

i) Publication of submissions received in response to the Discussion Paper.

Resolved, on the motion of Mr Morris, seconded by Mrs Hopwood:

‘That the Committee publish on its website Submissions No 29 to 48.’

ii) Submission No 28 from Dr Brendan O’Sullivan

Resolved on the motion of Mrs Hopwood, seconded by Mr Morris:

‘That the Committee:

- accept Dr O’Sullivan’s correspondence as a submission;
- not publish it due to the adverse comments contained therein; and
- write to Dr O’Sullivan advising him that the Committee has resolved to adopt this course of action, and that the Committee will not enter into any further correspondence on these resolutions.’

iii) Submission No 36 from Ms Beth Wilson, Victorian Health Services Commissioner

Resolved on the motion of Mr Brown, seconded by Mrs Hopwood:

‘That the Committee write to Ms Wilson, advising her that:

- having regard to the content of the Victorian Ombudsman in his Report of an Investigation into issues at Bayside Health, the Committee agrees that, while much of that Report and recommendations were focussed on the financial transgressions of Professor Kossman, the core issue was that he was able to abuse the traditional system of practitioner peer review; and
- the Committee does not agree with her suggestion that the reference to strong criticism by the Victorian Ombudsman is not a “very misleading part of the Discussion Paper” which “should be corrected”.’

iv) Correspondence from Mr William Leslie

Resolved on the motion of Mr Brown, seconded by Mrs Hopwood:

‘That the Committee write to Mr Leslie, advising him that it is unable to accept his correspondence as a submission, as it does not consider that it falls within the Inquiry’s second Term of Reference, but advising him that the issue of peer review within the procedures of the Health Care Complaints Commission will be considered in the course of the Inquiry.’

v) *Correspondence from the NSW Medical Board and Health Quality and the Complaints Commission of Queensland*

Members noted the contents of the letters.

The Chair closed the meeting at 9.15 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 26)

Thursday, 26 November 2009 at 9.02 a.m.

Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair) Mrs Judy Hopwood MP (Deputy Chair)

Hon David Clarke MLC Hon Kerry Hickey MP

Mr Matthew Morris MP

Apologies

Mr Matt Brown MP, Rev Hon Fred Nile MLC.

...

5. Inquiry into the operation of the *Health Care Complaints Act 1993*

i) Dr Yolande Lucire

The Chair referred to the Briefing Note distributed at the meeting, noting that there was not sufficient connection with the Inquiry’s Terms of Reference for her material to qualify as a submission. Resolved, on the motion of Mr Hickey, seconded by Mr Morris:

‘That the Committee write to Dr Lucire:

- advising that the Committee does not consider that her document constitutes a submission to the Inquiry and will not enter into any further correspondence on this issue; and
- returning the document to her.’

ii) Dr O’Sullivan

The Chair noted that Dr O’Sullivan had emailed the Committee a submission which had purportedly been amended by the removal of names. She said that the Committee Manager, Mel Keenan, had sought the advice of the Clerk-Assistant (Committees) and it was agreed that this had no bearing on the Committee’s earlier decision to accept his submission; not publish it; and not enter into any further correspondence on this issue.

iii) Public Hearings

Resolved on the motion of Mrs Hopwood, seconded by Mr Hickey:

‘That the Committee endorses the attendance at the public hearing in February 2010 of the organisations and individuals indicated in the draft list of witnesses distributed to Members.’

Ms Hopwood noted that at the previous meeting she had proposed the NSW Nurses and Midwives Board as witnesses. However, the Board had informed her that its views would be represented by the NSW National Nursing Council (Conduct Committee), already included on the draft list of witnesses.

The Chair closed the meeting at 9.10 a.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 27)

Thursday, 4 March 2010 at 9.30 a.m.

Jubilee Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Hon David Clarke MLC, Hon Kerry Hickey MP, Rev Hon Fred Nile MLC, Hon Nathan Rees MP

Apologies

Mr Matthew Brown MP

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4. Witnesses appearing at public hearing

NSW Nurses and Midwives Board and Greater Southern Area Health Service

The Chair noted that representatives of the NSW Nurses and Midwives Board and Greater Southern Area Health Service were unable to attend at the hearing and propose that the Committee forward to the organisations the list of written questions distributed to Members.

Resolved on the motion of Mr Hickey, seconded by Mrs Hopwood:

‘That the Committee forward to the NSW Nurses and Midwives Board and Greater Southern Area Health Service the questions relating to the Inquiry into the Operation of the Health Care Complaints Act 1993 as agreed.’

Northern Sydney/Central Coast Area Health Service

Resolved on the motion of Mrs Hopwood, seconded by Reverend Nile:

‘That a representative of the Northern Sydney/Central Coast Area Health Service appear at today’s public hearing.’

The Chair adjourned the deliberative meeting at 9.40 a.m.

7. Operation of Health Care Complaints Act 1993 – Public Hearing

The Chair declared the meeting open at 10.00 a.m. and made some opening remarks on the conduct of the Committee's Inquiry.

The following witnesses were sworn and examined:

Ms Meredith Robyn Kay, Chairperson, Dental Technicians Registration Board, and Dr Matthew William Fisher, Chief Executive Officer, Australian Dental Association (New South Wales branch).

The Chair noted that as time was limited on the day, the Committee may wish to send additional questions after the hearing and these would be made public on the Committee's website site. The witnesses agreed to provide a written reply.

Evidence concluded, the witnesses withdrew.

The following witness was affirmed and examined:

Dr Bernadette Ivy Eather, Director, Clinical Governance, Northern Sydney Central Coast Area Health Service.

The Chair noted that as time was limited on the day, the Committee may wish to send additional questions after the hearing. The witness agreed to provide a written reply.

Evidence concluded, the witness withdrew.

The following witness was sworn and examined:

Ms Helen Jane Turnbull, Solicitor-Manager-Disciplinary Services, Avant.

The Chair noted that as time was limited on the day, the Committee may wish to send additional questions after the hearing. The witness agreed to provide a written reply.

Evidence concluded, the witness withdrew.

The following witness was affirmed and examined:

Mr Peter George Dodd, Solicitor, Public Interest Advocacy Centre.

Evidence concluded, the witness withdrew.

The following witness was sworn and examined:

Mr Warren Henry Anderson, plumber and representative of the public.

The Chair noted that as time was limited on the day, the Committee may wish to send additional questions after the hearing. The witness agreed to provide a written reply.

Supplementary Evidence

Mr Anderson tabled a set of his family's correspondence with the Health Care Complaints Commission concerning the case at Royal North Shore Hospital of his deceased daughter Vanessa Anderson.

Resolved on the motion of Reverend Nile, seconded by Mrs Hopwood:

'That the correspondence of Mr Anderson be included as evidence taken at today's public hearing.'

Evidence concluded, the witness withdrew.

The Chair adjourned the hearing at 12.50 p.m. to reconvene at 1.45 p.m.

The following witnesses were affirmed and examined:

Ms Alison Peters, Director, NCOSS.

Ms Solange Frost, Senior Policy Officer, NCOSS.

The Chair noted that as time was limited on the day, the Committee may wish to send additional questions after the hearing. The witnesses agreed to provide a written reply.

Evidence concluded, the witnesses withdrew.

The following witness was sworn and examined:

Mr Kieran Tibor Pehm, Commissioner, Health Care Complaints Commission. Mr Kim Swan, Executive Officer, Health Care Complaints Commission (not sworn) accompanied Mr Pehm at the witness table. He did not give evidence.

The Chair noted that the Committee would send additional questions after the hearing. The witness agreed to provide a written reply.

Evidence concluded, the witness withdrew.

The following witness was sworn and examined:

Ms Linda Mary Alexander, Legal Officer, New South Wales Nurses' Association.

The following witness was affirmed and examined:

Ms Annie Butler, Professional Officer, New South Wales Nurses' Association.

The Chair noted that the Committee may wish to send additional questions after the hearing. The witnesses agreed to provide a written reply.

Evidence concluded, the witnesses withdrew.

The following witnesses were affirmed and examined:

Ms Leanne O'Shannessy, Director – Legal and Legislation, New South Wales Department of Health and

Mr Iain Martin, Assistant Director – Legal and Legislation, New South Wales Department of Health.

The Chair noted that as time was limited on the day, the Committee may wish to send additional questions after the hearing. The witnesses agreed to provide a written reply.

Evidence concluded, the witnesses withdrew.

The following witness was affirmed and examined:

Mr Andrew Edward Dix, Registrar, New South Wales Medical Board.

The Chair noted that the Committee may wish to send additional questions after the hearing. The witness agreed to provide a written reply.

Evidence concluded, the witness withdrew.

The following witness was sworn and examined:

Ms Anne Lesley Deans, President, New South Wales Physiotherapists Registration Board.

The following witness was affirmed and examined:

Ms Debra Shirley, Deputy President, New South Wales Physiotherapists Registration Board

Evidence concluded, the witnesses withdrew.

Resolved on the motion of Mrs Hopwood, seconded Mr Rees:

That the Committee publish the transcript of the witnesses' evidence on the Committee's website, after making corrections for recording inaccuracy, together with the answers to any questions taken on notice in the course of today's hearing.

Mrs Hopwood proposed a resolution to write to the Medical Board regarding the need to seek correction of published articles misrepresenting foreign trained doctors in the media. Mr Clarke suggested obtaining the advice of the secretariat in the first instance as to whether it is within the Committee's power to raise this matter with the Board. The Chair noted that the matter would be further deliberated following receipt of the secretariat's advice.

The Chair declared the hearing closed at 4.47 p.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 28)

Monday, 19 April 2010 at 1.33 p.m.

Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair), Mrs Judy Hopwood MP (Deputy Chair), Hon Kerry Hickey MP, Rev Hon Fred Nile MLC, Hon Nathan Rees MP

Apologies

Mr Matt Brown MP, Hon David Clarke MLC.

3. Correspondence

iv) From Therese Mackay

The Chair noted that emails were received on 8 March, 23 March, and 2 April 2010, requesting permission to make a late submission to the Inquiry into the Operation of the *Health Care Complaints Act 1993*, and requesting leave to speak to Committee at a public hearing.

It was agreed that, given the highly personal nature of the information provided by Mrs Mackay, it would not be advisable that this material be made public by the Committee. Copies of the emails were distributed at the meeting.

v) From Ian and Dana Rose

The Chair noted that an email was received on 12 March 2010 requesting details about making a submission to an Inquiry. A copy of the email was distributed at meeting.

Resolved *in globo* on the motion of Mrs Hopwood, seconded by Mr Hickey to deal with the correspondence as follows:

- 'That the Committee accept Mrs Mackay's submission to the Inquiry into the Operation of the *Health Care Complaints Act 1993*, but that it be kept confidential.
- 'That the Committee write to Mrs Mackay advising that it has noted the information in the material provided by her, but that it will be kept confidential; and that the Committee will be holding no further public hearings for this Inquiry.'
- 'That the Committee write to Mr and Mrs Rose, advising them that the Committee is no longer taking submissions to the Inquiry into the Operation of the *Health Care Complaints Act 1993*; providing them with information relating to the Inquiry; and advising them that they still able to bring matters to the Committee's attention outside the Inquiry process, provided that they are within the Committee's remit under the Act.'

7. Inquiry into Operation of Health Care Complaints Act

i) Responses to questions sent to the Nurses and Midwives Board and Greater Southern Area Health Service

The Chair noted that responses were received from the NSW Nurses and Midwives Board on 24 March 2010 and the Greater Southern Area Health Service on 26 March 2010.

Resolved on the motion of Mrs Hopwood, seconded by Reverend Nile:

‘That the responses from NSW Nurses and Midwives Board and Greater Southern Area Health Service be published on the Committee’s website.’

ii) Responses to questions after 4 March 2010 hearing

The Chair noted that responses had been received from all witnesses (except Avant, Mr Warren Anderson and NSW Health) and that responses were distributed to Members on 13 April 2010 and 16 April 2010, and had been published on the Committee’s website.

With respect to NSW Health, the Secretariat had received advice on 16 April 2010 that the responses would be sent as soon as the Director-General had signed off on them.

iii) HCCC response to questions after public hearing on 4 March 2010

The Chair noted that the response from the Health Care Complaints Commission included specific details of Vanessa Anderson’s case. It was not recommended that these be made public, but be for the Committee’s information only.

Resolved on the motion of Mrs Hopwood, seconded by Mr Hickey:

‘That the Commission’s answer to the Committee’s question “Can you provide full details about the Commission’s assessment of Warren Anderson’s complaint?” be considered confidential, and not published on the Committee’s website.’

iv) Mr Warren Anderson’s evidence at public hearing on 4 March 2010

The Chair noted that the Committee had resolved to accept a number of letters as evidence to the Inquiry. Given the highly personal nature of the information contained therein, it was not recommended that this material be made public by the Committee.

Resolved on the motion of Mrs Hopwood, seconded by Mr Hickey:

- ‘That the evidence tabled by Mr Anderson be marked confidential and not published on the Committee’s website.
- That the Committee write to Mr Anderson to advise him of the Committee’s decision, and to note that the information will nonetheless inform the Committee’s deliberations.’

v) Letter to NSW Medical Board concerning “fast-tracked doctors”

The Chair noted that at the Committee’s last meeting, Mrs Hopwood had proposed that the Committee write to the NSW Medical Board regarding the need to seek correction of published articles misrepresenting foreign trained doctors in the media; and Mr Clarke had suggested obtaining the advice of the Secretariat as to whether it is within the Committee’s power to raise this matter with the Board.

She said that, having regard to the extent of the Committee’s remit under s 66 of the *Health Care Complaints Act 1993*, it did not appear that forwarding such a letter to the NSW Medical Board would in fact be within the Committee’s jurisdiction.

The Chair declared the deliberative meeting closed at 4.30 p.m.



Chair



Committee Manager

Minutes of Proceedings of the Committee on the Health Care Complaints Commission (No. 30)

Wednesday, 2 June 2010 at 9.03 a.m.

Waratah Room, Parliament House.

Members Present

Hon Helen Westwood MLC (Chair)

Mrs Judy Hopwood MP (Deputy Chair)

Mr Matt Brown MP

Hon David Clarke MLC

Hon Kerry Hickey MP

Rev Hon Fred Nile MLC

Hon Nathan Rees MP

2. Inquiry into Operation of Health Care Complaints Act 1993

i) Consideration of Report

Resolved on the motion of Mrs Hopwood, seconded by Rev Nile:

‘That the draft report be considered *in globo*’.

The Chair called for amendments.

Resolved on the motion of Mrs Hopwood, seconded by Mr Clarke:

‘That the word "consider" be omitted from paragraph 2.48 and that "retain concerns that" be inserted instead;

That the words "will not" be omitted from paragraph 2.48 and that "may" be inserted instead;

That the word "Nonetheless" be omitted from paragraph 2.48 and that "Accordingly" be inserted instead.’

Committee Members agreed that the sections on Root Cause Analysis and Open Disclosure be moved from the end of Chapter 3 to Chapter 4 which was to be re-titled "Information Sharing".

ii) Adoption and Publication of Report

Resolved on the motion of Mrs Hopwood, seconded by Mr Rees:

‘That the draft report be agreed to with amendment’.

Resolved on the motion of Rev Nile, seconded by Mrs Hopwood:

(a) ‘That the draft Report, as amended, be adopted as the Report of the Committee and that it be signed by the Chair and presented to the House.’

(b) 'That the Chair and the Secretariat be permitted to correct stylistic, typographical and grammatical errors.'

(c) 'That, once tabled, the Report be placed on the Committee's website.'

The Chair noted that she would table the Report on Thursday 3 June in the Legislative Council, and by Mrs Hopwood in the Legislative Assembly. The Take Note Debate in the Legislative Assembly would be adjourned to Friday 11 June 2010.

Chair

Committee Manager

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