Submission

No 15

INQUIRY INTO THE OPERATION OF THE HEALTH CARE COMPLAINTS ACT 1993

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Date Received: 1/12/2008

SUBMISSION TO THE PARLIAMENTARY JOINT STANDING COMMITTEE ON THE HEALTH CARE COMPLAINTS ACT 1993

Submissions by the New South Wales Nurses' Association

Background

1. The Parliamentary Joint Standing Committee on the Health Care Complaints Act ("the Committee") is undertaking an inquiry ("the Inquiry") into the operation of the Health Care Complaints Act 1993 ("the Act") with particular reference to the assessment and investigation of complaints including matters connected with the Committee's statutory functions. The Committee has invited the NSW Nurses' Association ("the Association") to make a submission to the Inquiry.

Terms of Reference

2. The Inquiry is examining the operation of the Act with particular reference to:

(a) the identification and removal of any unnecessary complexities in the New South Wales health care complaints system;

(b) the appropriateness of the current assessment and investigative powers of the Health Care Complaints Commission ("the Commission"); and

(c) the effectiveness of information sharing between the Commission and Area Health Services and Registration Authorities in New South Wales.

3. The Committee will also report to Parliament on any matters connected with the Committee's statutory functions.

Previous Submissions

4. The Association has made submissions to previous reviews of the Act:

(a) Submission to the Commission Review Committee dated 27 May 1997;

(b) Submission to the Joint Committee on the Health Care Complaints Commission, Inquiry into Conciliation Processes with the New South Wales Health System dated 18 May 2000;

(c) Submission to the Committee on the Health Care Complaints Commission Inquiry into the Procedures followed during Investigations and Prosecutions dated August 2001;

(d) Submissions to the Committee on the Health Care Complaints Commission Inquiry into the Procedures followed during Investigations and Prosecutions – Response to Discussion Paper dated February 2003.

5. It is noted that many of the issues raised and subsequent associated recommendations by the Association in these previous submissions have not been adopted.

Role of the Association

6. The Association has been identified by the Committee as having expertise relevant to the operation of the Act.

7. The Association's expertise relevant to the operation Act comes from the provision of services to members in matters relating to the Act. These services include assisting members throughout the complaint process - that is, initial legal advice when advised of a complaint, providing responses to complaints and/or conduct inquiries; the evidence to put before disciplinary tribunals; and representation before disciplinary bodies.

8. It is the Association's experience that there has been a continual rise in the number of complaints made against nurses (specifically registered nurses, registered midwives and enrolled nurses).

9. It is also the Association's experience that there is a significant increase in the number of nurses subject of complaints who are not assisted by the Association or legal advisers through the process and subsequent conduct/disciplinary inquiries. It is therefore imperative that the processes undertaken by the Commission in the assessment and investigative process by transparent and procedurally fair.

Procedures followed during investigation process

Time frames

10. The Act sets out the procedures to be followed by the Commission once a complaint is made. In setting out the procedures, the Act provides limited time frames in which certain things are to be undertaken.

11. Section 10 of the Act commences the statutory requirements of assessment and investigative processes once a complaint has been made against a health practitioner or health service provider. However, for the purposes of these submissions, the relevant provisions commence at s. 16.

12. The time frames provided by the provisions of ss. 16, 21, 22 & 28 are, in toto, too long – at least 240 days (approximately 8 months. Further, of major concern is that the provisions s. 16(7) and s. 28(7) could result in significant increase in the period time to undertake the assessment and investigative processes.

13. The Association submits that a more reasonable time frame would be:

(a) providing further particulars of the complaint pursuant to s. 21: 28 days;

(b) Commission to assess the complaint pursuant to s. 22: 28 days; and

(c) Commission to notify the health practitioner of its decision pursuant to s. 28: 28 days.

14. These time frames are in line with that provided for in s. 40 in respect of the health practitioner responding to the investigation and decision to prosecute which in fact is an unreasonably limited period of time. It is submitted that a health practitioner under investigation should be given more time to respond in the course of an investigation because of:

(a) the desirability to take advice;
(b) time required to gather supporting evidence;
(c) time to properly respond.

15. This is particularly important because if a response by the health practitioner may result in a complaint being dismissed and complaint not prosecuted thereby saving costs to the public purse.

Notice & Contents

16. Another major concern to the Association from a procedural fairness and transparency perspective is the provision of ss. 16(6) and 28(6):

> *"(6) 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 <u>may</u> give such form of notice."*

17. It is submitted that this subsection should be amended to read:

> *"(6) If subsection (4) applies to a complaint, some form of notice must be given to the person or persons subject of the complaint in a manner that will not affect the health or safety of a client or putting any person at risk of intimidation or harassment."*

18. That is, it should be mandatory that any person subject of a complaint should have notice of that complaint.

19. Further, s. 16(7) and s. 28(7) are of major concern. The provisions of those subjections provide for ongoing, without any limitation, 60 day periods in which the Commission may or may not give notice of a complaint thereby, in a manner which ultimately circumvent the statutory requirements relating to timing of assessment, investigations and/or prosecution of complaints. This creates a very significant disadvantage to any person subject of a complaint insofar as firstly not being aware of a complaint made against them for a very long period time and secondly resulting in a excessive delay in prosecution of a complaint with a consequence of being required to recall specific events or incidents long in the past.

20. The Commission should be statutorily required to advise a person who is subject of a complaint or <u>potentially</u> a subject of a complaint of this fact <u>at all times</u> in the investigative process. There are many examples of health practitioners receiving

correspondence from an Investigation Officer containing words which suggests that he/she is not the subject of the complaint being investigated when in fact they are or potentially are. They also are not given any right to not self-incriminate. This is fundamentally wrong and there can be no justification for a person subject of or potentially subject of a complaint having fewer rights than a person subject to a criminal investigation.

Statutory Limitations

21. This situation is exacerbated by there being no statutory limit on the time in which a complaint may be received by the Commission or in relation to an investigation being conducted. The implications of this are enormous. For example:

(a) In *Shelley* (2006) the complaints went to matters that occurred in 1998 through to 2001. The respondent nurse was criticised as being evasive and untruthful because she could not recall the specific details of what she did or did not do on particular occasions in that period. Witnesses for the Commission were of little value for the same reason.

(b) In *Jutt* (2001) the complaint related to an alleged incident in September 1995 but the complaint was not made to the Commission until July 1998 and did not come before a PSC until October 2000. Consequently independent verifying witnesses on crucial points (for both the complainant and respondent nurse) were unable to be found because memory had disappeared.

22. Proceedings for an offence under the *Occupational Health and Safety Act 2000* must be instituted within two (2) years after the act or omission alleged to constitute the offence or a coroner's report being made (if relevant). Prosecutions for summary offences under the *Crimes Act 1900* are to be instigated within six (6) months of the offence being committed. Proceedings relating to personal injuries have a three (3) year time limitation from the time of the injury or knowledge thereof for commencement. These all provide guidance and in a number of instances there is action under the Act and one of the above.

23. There are also numerous instances where the Commission takes an inordinate period of time to investigate a complaint and/or recommending to the registering body that disciplinary action take place. In one case, the Commission recommending to the Nurses and Midwives Board that a registered nurse be counselled in relation to engaging in a personal relationship with an ex-client. The Board did not accept the recommendation and required that the complaint be prosecuted as professional misconduct. It took over 12 months for the Commission to initiate the prosecution.

24. As has previously been submitted by the Association there should be amendments to the Act are required to impose statutory time limitations for:

(a) lodging a complaint (in line with the Occupational Health and Safety Act, ie two years); and

(b) instituting proceedings before the relevant body.

Assessment of Complaints

25. Section 19 requires the Commission to assess a complaint on its receipt but specifically excludes a matter to be investigated in accordance with s. 59. That exclusion should be removed. All complaints should be assessed prior to investigation, not the least for the dual purpose of:

(a) determining that the complaint is not malicious or vexatious; and

(b) determining that the complaint is within the statutory time frame that should be inserted in the Act (see submissions at paragraphs 19 through 22).

26. Section 20 of the Act should be amended to make clear that assessment is required to determine that the complaint is not malicious or vexatious and that it is within the statutory time frame that should be inserted in the Act.

Associated Complaints

27. Section 22A provides for associated complaints to be taken into account during the assessment process.

28. The Association submits that this section should be amended to make clear that:

(a) any associated complaint should be in accordance with statutory time frames (as per submissions above); and

(b) the only previous findings or determinations of a professional standards committee or tribunal which specifically relate to the current complaint – that is a breach of prior findings, determinations and/or orders.

Impartiality of investigations

29. The Note to Division 5 of the Act relevantly states:

"*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*." [emphasis added]

30. This raises two major concerns which the Association submits the Committee should address.

(a) The investigation commences from the point of assuming merit in the complaint and the guilt of the health practitioner; and

(b) it removes a fair and impartial system of investigation.

31. As previously submitted, the rule of law demands the principles of justice, fairness and due process. Innocent until proven guilty is fundamental to that demand. Accordingly, the purpose of the investigation should be akin to the purpose of an investigation for a coroner's inquiry - impartially collecting the evidence from all possible sources to be assessed by a separate body as to whether a complaint should be prosecuted.

32. It was previously submitted by the Association that the Act be amended:

(a) by removing the second sentence from the Notes to Division 5 immediately preceding s. 29;

(b) to add to the Objects a new object as to the Commission recognising the rights of health providers to a fair and impartial system for the handling of complaints;

(c) to create two separate and distinct bodies:

(i) an investigation unit whose function is to impartially investigate complaints; and

(ii) a prosecutor's office to determine prosecution is warranted (akin to one of the functions of police prosecutions and the DPP).

33. The Association is disappointed that only the amendment set out in paragraph (c) above has occurred. Further, it is the Association's experience that notwithstanding the creation of a Director of Proceedings responsible for determining whether or not prosecution is warranted, there has been no fundamental separation of the two roles and it has not lead to a fair and impartial system.

34. The Commission consistently relies upon the investigations carried out by other bodies or persons to support the prosecution of the complaint and does not carry out any independent investigation.

35. Further, it is the Association's experience that prosecutions are instituted each time the investigations unit recommends it: that is, there would appear to be no independent assessment by the Director of Proceedings as to the sustainability of the evidence.

36. In previous submissions, the example of Humphries was cited. In that matter, the Commission relied solely on an alleged investigation conducted by the Director of Nursing of a private nursing home. The "investigation" failed to take into account the cause of death of a resident (which had in fact given rise to the "investigation" and complaint) and paid no attention to the circumstances and events of the day on which the patient first exhibited signs of a serious health crisis. Further, the DON had played a significant role on the day of the patient's demise. At page 14 of the Reason for Decision , the PSC stated:

"9.1 Presentation and preparation of the case

The committee faced many difficulties in considering this case, in part, because the issues were complex, but mostly because the case as presented by the Commission had

significant gaps. For example, the Commission's case appeared not to have taken account the cause of death and its relationship to the particulars. The final submission in this matter appears not to have taken account of any of the significant evidence heard during the hearings. An added difficulty was that the committee had no summaries of the professional profiles or curriculum vitae of any of the witnesses. More seriously, the Commission's case relied on statements collected by …… Nursing Home, some of which were unsigned and some had been amended in handwriting. The committee's view of these statements is outlined above, however, the committee wishes to emphasize the limitations of these statements and the extent to which they can be relied upon for their accuracy or respect for natural justice. Finally, original documents were not made available to the Committee nor could they be readily located by ……..

"9.2 The Committee respectfully recommends that the Nurses Registration Board review the bases and forms of evidence on which complaints against nurses are investigated and progressed through the disciplinary mechanisms within the provision of the Nurses Act of 1991. The committee was disturbed that much of the written evidence in this case was gathered in circumstances where natural justice did not appear to have been respected. In this case, it was clear that the statements tendered in evidence and used as the basis on which complaints were investigated and brought before the PSC were gathered within the line of seniority and power relations in the workplace such that those who had the most formal power in the organisation in which the events occurred were able to investigate those less powerful. There was little evidence of the principle of independence being applied to the initial inquiry by the management of ……. Nursing Home or of natural justice being respected in the processes of assessing the evidence. What was, in effect, an internal inquiry by the management of a nursing home, became de facto <u>the</u> inquiry for the Commission (with the addition of the peer reviewer's assessment, the value of which was compromised to the extent that the evidence provided to her was itself compromised. The outcome, in this case, was that a registered nurse, against whom there was no evidence at the time of the incident, except that she was rostered on duty during the

two nights prior to Mr ……. death, became the subject of a disciplinary hearing in circumstances that cannot be described as fair or just."

37. Unfortunately, the problems identified by the Professional Standards Committee in *Humphries* still frequently arise.

38. The attitude of the Commission in investigation and subsequent prosecution processes, that is an assumption of guilt on the part of the health practitioner and a refusal to undertake independent, impartial investigations continues to result in complaints being prosecuted in circumstances where the independent evidence collected established that the complaint against respondent nurse was not sustainable.

39. As previously submitted, *George's* case is a good example of the Commission not conducting impartial and factual investigations with consequential unnecessary waste of costs (PSC members and court officers; hearing days; witness costs including peer reviewers and legal costs for the prosecutor and respondent).

40. That case is an old example however, what is disturbing is that the experience of the *Humphries, George, Eagle* and *Jutt* cases have not resulted in change.

Reference of Complaints to be dealt with by Registration Authorities

41. It is unfortunately the experience of the Association that while it has no difficulty with statutory provisions of s. 25B of the Act, there are consistently considerable difficulty with the recommendations of the Commission to the registration authorities, and in particular the Nurses and Midwives Registration Board.

42. The difficulty experienced is that there is a complete lack of consistency in the recommendation of prosecution. There are many examples of the Commission recommending prosecution of unsatisfactory professional conduct (and therefore to go before a PSC) and recommending prosecution of professional misconduct (and therefore a Tribunal) on similar facts such as inappropriate breach of professional boundaries or assaulting patients/clients. These examples include cases where far

more serious misconduct on stronger evidence is prosecuted before a PSC and a weaker case before a Tribunal.

Expert Assistance

43. Section 30 of the Act provides that in investigating a complaint the Commission may obtain a report from a person who is sufficiently qualified or experienced to give expert advice on the matter the subject of the complaint which is commonly referred to as a peer review.

44. The Association's experience in relation to complaints against nurses is that this is standard practice and the practice has a number of faults.

(a) The investigation is carried out on an assumption that the health practitioner has engaged in the conduct alleged thereby setting the entire framework of the investigation.

(b) From that point, when the Commission sends a letter to the "expert" it requires the expert to assume the complaint is factually valid. What it does by way of providing the respondent's response and supporting evidence is inconsistent - on some occasions it will send the respondent's s. 40 response or statement as to the complaint and others it will not.

(c) Further, on most occasions, the request to the expert is often before the entire investigation is completed. As a result, the "expert" usually receives allegations against the health practitioner which are not pursued against them and/or not substantiated on all relevant facts. These inclusions and/or lack of sustainable facts potentially negatively impact on the resulting report and impinges on both impartiality and general natural justice.

(d) It has been the Association's experience that this underlying assumption more often than not detracts from the objectivity of the report and any subsequent oral testimony before a disciplinary body.

(e) What should occur, as a matter of fairness to a complaint subject, is for expert evidence as to whether the alleged conduct falls below standards should only be obtained at the conclusion of the investigative process for the dual purpose of determining:

(i) whether a complaint should be prosecuted;

(ii) whether the complaint is unsatisfactory professional conduct and/or professional misconduct.

45. Complaints have been received by the Association members who have been sought out by the Commission to conduct a Peer Review and have done so and the pressure they have felt to be under. Issues raised include:

(a) feeling as is they are a tool for the commission to ensure a "guilty" outcome in a complaint prosecution;

(b) having no opportunity to discuss or clarify any of the issues with the Commission despite the material provided containing many assumptions;

(c) pressure on them to support the legal argument around which the prosecution is built;

(d) having their opinion on other factors they considered important discounted.

46. A further flaw in this process is that the "expert" is being asked to assess the conduct alleged (and assumed to have occurred) against professional/peer standards for the purpose of orders by the relevant disciplinary body, say for example pursuant to s. 64 of the Nurses Act. This is a complete confusion of what should be happening in this process. Section 30 does not state the purpose of a seeking a report of an expert other than that any report received may be used in disciplinary or related proceedings.

47. If an expert report is to be sought, it should only occur at the end of the investigative process and only for the determination of whether to proceed to prosecute a

complaint and if so, the substance of the complaint (that is, unsatisfactory professional conduct and/or professional misconduct).

48. The experience of the Association is that these "expert" reports, which are in essence peer review reports:

(e) set out the conduct alleged;

(f) state whether the conduct is a breach of professional standards;

(g) state the level of disapproval by the "expert" and peers of similar standing of the conduct.

49. This is not an investigative process. These reports are used by the disciplinary body to decide if there has been a breach of professional standards, and subsequently in deciding appropriate orders (for example under s. 64 of the Nurses' Act). It is submitted that there should be a clear distinction between expert evidence in the investigative process and peer review for disciplinary tribunal purposes.

50. A further problem is that the definition of "expert" contained in s. 30 of the Act is very broad. In practice, this results in the relevance of the "expertise" being questionable. There are many instances where the expert has not practiced in a clinical capacity for many, many years including on some occasions decades.

51. Further, the Commission appears to regularly use the same "experts" regardless of the area of practice of the health practitioner. It is submitted that, when seen in light of the complaints to the Association by its members of pressure to support a "win" (see above), the Commission uses only those persons who they know are the harshest critics of practitioners and who will not be moved to an objective appraisal.

52. 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. For example, it is common practice for the "experts" not to receive patient/client nursing notes; details of the education and experience of the respondent nurse and contextual matters such as

staffing levels and patient mix at the time of the alleged conduct on which they are to express an opinion.

53. 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.

Amending complaints

54. The failure of the Commission to conduct a proper and objective investigation and collection of evidence is, in the Association's experience, demonstrated by the fact that complaints before disciplinary tribunals are regularly changed either immediately before or in the course of the disciplinary body hearing the complaint. For example, in almost every case in which the respondent nurse was represented by the Association before the Nurses' Tribunal in the period 2000 - 2007, the complaint was changed in this way. To date in 2008, this practice has continued on a frequent and regular basis. In one instance, the Commission sought to change the complaint at the conclusion of final submissions on behalf of the respondent nurse (Eagle).

55. It is submitted that this is at the least a denial of natural justice and, at its highest, an abuse of process. Unfortunately it is a practice tolerated and, in some instances encouraged, by the relevant body.

Evidence considered sufficient to prosecute

56. The cases of Humphries and George referred to previously demonstrate the inadequacy of evidence the Commission considers sufficient to support a prosecution. These cases were but two where the evidence put forward to support a prosecution has been inadequate and insufficient and have continued since the Association's previous submissions to the Committee in 2001. In all of the cases, it was clear from the outset that the evidence was not capable of reaching the

requisite standard of proof but the Commission pursued the prosecution including in circumstances where the Association has made submissions on the part of the nurse that the prosecution be withdrawn because the evidence clearly and objectively established that the complaint could not be substantiated.

57. Leaving aside the question of the financial waste of such prosecutions, there is also an extraordinary and completely unnecessary toll placed on the respondent, and in many instances on witnesses.

Deficiencies in performance

58. It is the Association's experience that many of the problems associated with assessment, investigation and subsequent prosecutions of complaints result not from the legislative framework but the deficiencies in the performance of the Commission in meeting its statutory obligations. The overwhelming experience of the Association for many years has been the failure of the Commission to administer the Act with any or adequate regard for the rights and legitimate interests of health practitioners.

59. One such problem is the Commission's lack of objectivity in assessing the complaint. The Commission tends to rely upon the uncorroborated evidence of the complaint and seeks no objective witnesses.

60. Another very difficult issue that is frequently experienced by the Association is that the Commission puts itself in the position of supporter/advocate of the complainant.

61. Clearly there are cases in which complainants have been the subject of serious misconduct by health practitioners and this can be that this can be a very traumatic experience, particularly in cases of sexual misconduct or professional negligence.

62. However, it is submitted that the role of the Commission is that of investigator and prosecutor, not social/psychological support and advocate. It is more appropriate that support be provided by trained professionals through a separate and distinct unit such as provided through the Support Unit attached to the Coroner's Court.

63. A major issue with the conduct of the Commission is the regular practice of withholding or ignoring evidence in the prosecutorial process as submitted elsewhere in these submissions.

64. In this process, the Commission would appear not to understand its role as a prosecutor and what obligations arise from that role and in particular the obligation to release all information and documentation associated with the complaint to the respondent health practitioner.

Other relevant matters

65. Witnesses and the respondent are not warned of their right not to self-incriminate.

66. What is clear is that the assumption of truth of the complaint adopted from the commencement of an investigation colours the process from that point forward. Unlike any other area of law, the presumption of innocence is over-ridden at all stages of the investigative and prosecutorial process. Natural justice, including procedural fairness, should be equally available to complainants and respondents. The role of the Commission in respect of complaints should be investigative and prosecutorial, not complainant advocate.

Discontinuance of dealing with a complaint

67. In its submissions in 2001, the Association wrote:

> "*A major problem experienced by the Association is the Commission's failure to pay regard to the power granted by s. 27 of the Act to "discontinue dealing with a complaint". It would appear the Commission is of the view that the broad discretion it is granted in s. 27, particularly subsection (2), is fettered by the obligation created by s. 23(1)(b) to investigate. This raises a number of points.*
>
> *The Commission concludes far too readily that a complaint:*
>
> *(a) raises a significant issue of public health or safety; and/or*
>
> *(b) raises a significant question as to appropriate care or treatment; and/or*
>
> *(c) provides grounds for disciplinary action against a health practitioner; and/or*

(d) involves gross negligence on the part of a health practitioner.

It does so because it chooses to take too broad a view of "significant" and regards too many matters as raising "significant issues of public safety". Consequently it pursues weak, stale or otherwise unsustainable complaints and complaints not verified by statutory declaration. Further, it pursues them in an over-zealous and over-protective manner in a driven belief it is required to continue dealing with the complaint when an objective assessment would lead to the view there is not a significant issue of public health and/or safety."

68. Unfortunately nothing has changed in the intervening 7 years. There must be direction, statutorily or otherwise, as to what is meant by "significant. This could be done by way of a statutory definition or in the alternative, specific criteria set out in the Act that the Commission must take into account in deciding whether to dismiss or pursue a complaint.

Conclusion

69. The Association thanks the Committee for the invitation to make submissions. Further, it would welcome any opportunity to discuss these matters with the Committee by way of an appearance before it.

Brett Holmes
General Secretary
28 November 2008