Submission

No 3

INQUIRY INTO THE OPERATION OF THE HEALTH CARE COMPLAINTS ACT 1993

Organisation:

Name: Dr Neil and Mrs Ruth Willetts

Telephone: 9416 5537

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Partially Confidential

We request that consideration be given to extending the remit of the HCCC such that they are able to investigate health administrators as well as clinicians, for the following reasons derived from our personal experience:

Following the suicide of our daughter in February 2003 after she had been allowed to abscond from the Lindsay Madew Unit of Hornsby Hospital, we lodged complaints with the HCCC concerning the multiple failures of both the clinicians (doctors and nurses) and the administrators in charge of the Unit. These, in our view, all failed in their duty of care to our daughter (see our letter of 28.10.04).

We have now received the final outcomes of all these complaints, which are totally unsatisfactory to us.

After they had received our letter of complaint, the HCCC informed us (their letter of 20.6.05) that they were unable to investigate the three administrators involved:

"It is the opinion of the Commission that OR and OC's roles in this matter were administrative roles and therefore it is not appropriate the Commission consider any action against these under the relevant Registration Acts. The Commission will therefore be taking no further action in relation to these personnel..."

They did, however, review the overall situation within the LMU; they concluded that our complaints were substantiated and listed the various deficiencies but did not identify the persons responsible or require accountability (their letter of 14.3.06, attached).

We therefore repeated our complaints about the administrators to the North Sydney Central Coast Area Health Service (AHS) itself (our letter of 19.11.04), which consequently established an investigation into these. The Chief Executive of that time commissioned an independent Report, produced at great length and cost and with considerable delays, by a notable Sydney Senior Counsel. This Report was highly critical of the administrators.

However, instead of accepting the conclusions of this external report, the AHS then carried out a further in-house review that was initially allowed to override this independent Report so that no disciplinary action was taken against the administrators. This decision was reversed by two subsequent Chief Executives and disciplinary action **was** taken against two of the administrators. This action was however, reversed yet again when challenged for lack of "procedural fairness" in the Industrial Relations Commission. The final outcome of the AHS's dysfunctional investigation process was to fail to discipline any of the administrators despite the strong evidence against them and the criticisms made in the independent Report.

The AHS investigation was unsatisfactory for the following reasons:

(a) There was no established, pre-determined process for such an investigation within the AHS. The one set up by the Chief Executive at that time was on an *ad hoc* basis and took 4 years to produce a wrong and unjust outcome (see our letter of 11.11.08 to Mr Daly, the current CE, attached).

In contrast, the HCCC already has acceptable investigatory procedures in place.

(b) The AHS's investigation was compromised, since they allowed the external review by the Senior Counsel to be overridden by the subsequent in-house review ("Advice") which in our view was incomplete, uninformed, prejudiced and insulting (see our letter of 20.6.07 to the Chief Executive, minuting a meeting with him on 14.6.07).

This demonstrates the danger of serious conflicts of interest that arise in an internal investigation and the great temptation of in-house staff to "whitewash" the offenders.

(c) We were refused access to the Senior Counsel's independent Report, even though we had participated in this investigation with the understanding that we would receive a copy. Also it is obviously central to our understanding of what had happened to our daughter in the LMU and consequent "closure". We were forced by the then Chief Executive to request access to this Report under FOI, which was first refused. This decision was reversed by the two subsequent Chief Executives but is still subject to objection in the Administrative Decisions Tribunal by one of the administrators. We are still waiting to see this report more than two years after it was completed.

In contrast, investigative reports were made available to us by the HCCC as of right – as indeed should be the case.

(d) The clinicians and administrators were able to play one another off against each other. Thus, the HCCC told us on the one hand (Investigation Report of 25.1.06), that the two doctors and the two most offending nurses could not be prosecuted since the "systems" (policies and procedures – the responsibility of the administrators) of the LMU within which they were working, were too poor to allow their admittedly poor practice to be disciplined:

Observation Characterisation (Clauses 24 – 25) "Overall, it appears as though there was a failure of the hospital to put in place a single observation category system at the one time and …instead there appears to have been several different policies overlapping in time and content, during KW's stay… This confusion will be more appropriately addressed in the investigation into the hospital administration and hence there does not appear to be any evidence to suggest that either WJ or NF fell significantly below an acceptable standard of care…..

Medical Record (Clause 36) "Overall within the LMU, 'documentation was sparse and often lacking in detail regarding the care plan including observation level to be initiated based on risk assessment'. This however is part of a broader systemic issue with regards to the administration of the hospital and will be investigated in more detail there.

Communication (Clause 46) "Overall there appears to have been very poor communication … but there is not enough evidence to suggest that either NG or WJ themselves acted significantly below the acceptable standard of care as the systemic issues in place at the time appear to be inappropriate and a major contributing factor to the confusion surrounding the clinical care of KW. The issue of communication

seems more appropriately addressed with the hospital administration and senior nursing staff involved."

<u>Documentation</u> (Clause 75) "In regards to documentation (of nursing observation level) 'how this decision is recorded, the format used and who records it is a matter of hospital or area health service policy.' Therefore, there is not enough evidence that either NF or WJ fell below an acceptable standard of care and this issue will be more appropriately discussed with regards to the Commission's investigation into the hospital administration.

<u>Adequacy of Standard of Care</u> (Clause 81) "The environment in which KW was staying appears not to have enabled medical staff to provide the optimal care. Taking into account the systemic issues of the hospital, the care JW and NF provided was of an adequate standard."

On the other hand and in total contrast, the subsequent in-house "Advice" accepted and followed by the AHS in its investigation of the administration systems criticised by the HCCC, argued that the responsibilities and accountabilities were actually those of the clinicians, not the administrators:

"The most reasonable reading, is that if there was a critical error (due to policy confusion), it is more likely to have been in clinical practice and communication. The possibility of clinical misconduct is being investigated by the HCCC."

"The view might be put that managers are, by nature of their position, accountable for the act and omissions of those they manage. This is untenable in clinical and health care management settings, where clinical staff are trained, employed and deployed precisely because they are autonomous professionals. The management task is to establish systems (including policy) to allow safe and effective exercise of that autonomy."

"While administrative systems in the LMU were plainly wanting, those failings are likely to be much less significant than possible clinical oversights and failure to follow policy as a cause of KW's successfully absconding."

Even this in-house "Advice" admitted problems with the policies and procedures at LMU – but then attempted to absolve the administrators of all responsibility for this and for failing to ensure that these imperfect policies and procedures were being correctly used and failing to audit this:

"We acknowledge that notwithstanding the above, the system failed to pick up the incomplete and confused implementation at LMU"

"Clearly, administrative systems at LMU and HKHS more generally were imperfect, and these imperfections were a factor in the absconding of KW. This view has been accepted by the Area Health Service in its correspondence with the HCCC and by implication in its correspondence with (us)"

"While the imperfect administrative environment obviously did contribute to KW's successfully absconding, it is difficult to attribute those imperfections—even as non critical factors - to OC and OR"

"While administrative systems in the LMU were plainly wanting"

(e) The person who combined the roles of Consultant Psychiatrist and Clinical Director at the LMU totally evaded criticism by the (very slow) AHS investigation of his Clinical Director role since he retired in the interim. This would not have happened if the HCCC had investigated him in his role as Clinical Director as well as that of Consultant Psychiatrist, especially since he was also criticised in the independent Senior Counsel Report.

The final outcome of the separate HCCC and AHS investigations, then, was that no full and proper accountability was required of doctors, nurses or administrators. This is despite the convincing evidence showing that the administrators did not establish policies and procedures that provided an appropriate framework for clinicians, the clinicians did not comply with these anyway and management did not properly audit either the policies and procedures or compliance.

This outcome is unacceptable since it does not protect the safety of future patients within the NSW health system but instead perpetuates a culture of non-accountability and low standards of practice and compliance. The final outcome sends entirely the wrong message to AHS staff and gives little comfort to future patients that similar life-threatening incompetencies will not recur in the future.

If the HCCC could have carried out **all** the investigations, of doctors, nurses **and** administrators and then integrated all of the conclusions, a much more reliable and just outcome would have resulted.

We therefore strongly recommend that the HCCC's remit be extended to require them to investigate health administrators as well as clinicians.

We believe that for fairness, investigation into the conduct of doctors and nurses should include two peer reviewers rather than just one.

Following the suicide of our daughter in February 2003 after she had been allowed to abscond from the Lindsay Madew Unit of Hornsby Hospital, we made several complaints to the HCCC about both doctors and nurses involved in her care.

The initial investigation into the doctors found them not sufficiently at fault to warrant prosecution or any form of discipline. In our view the one peer reviewer involved, disregarded some evidence, was very accepting of "poor practice" and had a high tolerance of failure to follow procedures and protocols. We were therefore extremely disappointed with the outcome of the investigation and requested that the case be reinvestigated with a second peer reviewer (our letter of 26.4.2006).
Although the evidence was, in fact, re-reviewed by the HCCC, it/they refused to have a second peer reviewer participate in this. Their argument (Letter 1.9.2006) was that

"For the Commission to obtain a further expert review report it would be necessary to show that a fair minded observer might entertain a reasonable apprehension that the expert might not have brought an impartial and unprejudiced mind to the task of providing their opinion."

We strongly believed that on the above basis another expert reviewer **was** required. The HCCC disagreed. As a result, after a review of the first investigation without a new reviewer, the HCCC confirmed its original conclusion not to prosecute or discipline the doctors.

Given that there may always be a conflict of interest with doctors investigating doctors and nurses investigating nurses, having two reviewers would provide less potential bias and be more likely to result in more appropriate and just outcomes.