Submission

No 33

INQUIRY INTO THE OPERATION OF THE HEALTH CARE COMPLAINTS ACT 1993

Organisation: Health Care Complaints Commission

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<u>**HEALTH CARE COMPLAINTS COMMISSION**</u>

**SUBMISSION TO
THE PARLIAMENTARY COMMITTEE
ON THE HEALTH CARE COMPLAINTS COMMISSION**

**RESPONSE TO
THE DISCUSSION PAPER
*“INQUIRY INTOTHE OPERATION
OF THE HEALTH CARE COMPLAINTS ACT 1993”***

OCTOBER 2009

A complex health care complaints system

Issues 1, 2 and 3 – The Australian Charter of Healthcare Rights

That section 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"

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

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

Response

The submission by the Public Interest Advocacy Centre

In its submission to the Committee, the Public Interest Advocacy Centre (PIAC) has said:

> *PIAC would prefer to see the Charter of Healthcare Rights enforced directly by a body such as the HCCC through the Health Care Complaints Act. Here PIAC points to the New Zealand Model. PIAC recognises that this would be a change to how health complaints are dealt with in NSW as it would take the focus beyond simply an assessment of conduct against standards. In this model, an allegation of a breach of a Charter right would be a valid basis for complaint to the HCCC similar to a breach of standards.*
>
> *Alternatively, a more incremental change would be:*
>
> - *to amend the objects clause in section 3 of the Health Care Complaints Act to include a fifth object "to uphold the rights set out in the Australian Charter of Healthcare Rights"*
> - *to amend the Act 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*
> - *to include the Australian Charter of Healthcare Rights as a Schedule to the Act.*

In this way the Charter would still not be directly enforceable as in the New Zealand model, but the HCCC would still be able to take the Charter into account in assessment and other decisions.

A further benefit would be that, if the Charter became a Schedule to the Health Care Complaints Act, this would also lead to a greater awareness of the principles set out in the Charter by both consumers and health professionals. The HCCC could also promote the Charter as part of its public education activities.

The Commission's comments

The Commission supports the Charter of Healthcare Rights and made submissions to the Australian Commission during its preparation. The following comments are made in response to the suggestions by PIAC.

Issue 1

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.

It should also be noted that the various rights set out in the Charter are expressed in very general terms – meaning that determining whether there had been a breach of one or more of a patient's rights in the circumstances of an individual case could present considerable practical difficulties. Resolution of these difficulties would require the determination of a court of competent jurisdiction to develop a body of case law over time as to the application of the rights in a practical context.

At present, the Commission must investigate a complaint which:

- in the case of any health service provider, whether an individual health practitioner or a health organisation – raises "significant issues of public health or safety" or "a significant question as to the appropriate care or treatment of a client"

- in the case of an individual health practitioner – if the complaint were to be substantiated, would:
    - provide grounds for disciplinary action
    - involve gross negligence
    - result in the practitioner being found guilty of an offence under Division 3 of Part 2A of the *Public Health Act 1991* (that is, an offence of breaching a prohibition order or improperly advertising health services).[1]

There are also certain thresholds for the prosecution of a health practitioner. For example, in the case of medical practitioners, it is necessary for the Commission to establish:

- "unsatisfactory professional conduct" – that is, conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience, or

- "professional misconduct"' – that is, unsatisfactory professional conduct, or a number of instances of such conduct, of a sufficiently serious nature to justify the practitioner's suspension or deregistration.[2]

The addition of the rights in the Charter as enforceable rights would create a whole new class of investigations for the Commission, with consequent resourcing implications quite apart from those necessitated by the creation of a judicial or quasi-judicial structure required as set out above.

Issue 2

The Commission does not object to an amendment of the type canvassed in Issue 2.
In this respect, the Commission agrees with PIAC's point that the rights set out in the Charter could "provide a point of focus for discussions and negotations that take place in the resolution and conciliation processes"'.

Issue 3

The Commission does not consider it necessary or desirable to include the Charter as a Schedule to the *Health Care Complaints Act*, for the following reasons:

- The purpose of including the Charter as a Schedule to the Act is unclear. The legislation would need to set out the purpose of such an inclusion, otherwise the Charter would be given a legal status that it does not have, and was not intended to have in its development. Including the Charter as a Schedule could mislead both health care consumers and health care professionals as to the status of the Charter, and its impact on the complaint-handling process.

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[1] Section 23 of the *Health Care Complaints Act*,
[2] Sections 36 and 37 of the *Medical Practice Act 1992*.

- The Commission's website pages "Information for health consumers" and "Information for health providers" both include as the very first item a reference to the Charter, together with a link to the full text of the Charter on the Australian Commission's website.

- The Commission already promotes the Charter in its public education and other outreach activities.

Comments on the submission by Positive Life NSW and the HIV/Aids Legal Centre

The Commission notes that Positive Life NSW and the HIV/Aids Legal Centre have suggested that a more generous reading of the Commission's responsibilities under section 3(2) of the *Health Care Complaints Act 1993*, or an amendment to the Act, would allow the Commission to fulfil a broader "governance" role in the NSW health care system, through engagement with other parties in that system to improve health care quality, policy and practice.

It should be noted that the Commission was specifically established to deal with complaints about health service providers. In this respect, section 3(1) of the *Health Care Complaints Act* provides that the "primary object" of the Act is to establish the Commission as an independent body for the purposes of:

> *(a) receiving and assessing complaints … relating to health services and health service providers in New South Wales*
>
> *(b) investigating and assessing whether any such complaint is serious and if so, whether it should be prosecuted*
>
> *(c) prosecuting serious complaints*
>
> *(d) resolving or overseeing the resolution of complaints.*

It is in this particular context that section 3(2) of the Act provides that the Commission, in exercising its functions, must give paramount consideration to the protection of the health and safety of the public.

There are a number of other agencies that have general mandates to improve health care quality, policy and practice in NSW – notably, the NSW Department of Health and the Clinical Excellence Commission ("the CEC"), as well as the Australian Commission on Quality and Safety in Health Care. The Commission already liaises with these agencies, and provides them with relevant information arising from the Commission's performance of its complaint-handling functions to assist them in the performance of their responsibilities:

- Where the Commission's investigation of a complaint about a health organisation results in the Commission making draft recommendations to hospitals and the relevant Area Health Service for system improvements, the Commission consults with the Department of Health on the recommendations. The Commission also monitors the implementation of the Commission's recommendations through liaison with both relevant health organisations and the Department of Health.

- The Commission has recently begun providing the CEC with investigation reports by the Commission that contain recommendations for systems improvements in health organisations.

- The Commission has also contributed to the work of the Australian Commission on Quality and Safety in Health Care. For instance, the Commission made an extensive submission commenting on the draft Charter of Healthcare Rights. The Commission has also contributed to the ongoing "open disclosure" project by discussing the tensions between open disclosure and the statutory privilege conferred on root cause analysis (RCA) investigations in New South Wales, and attending a roundtable discussion on potential legal obstacles to open disclosure.

Conferring any further substantive governance responsibilities on the Commission would constitute a fundamental change to the Commission's role. Any proposal for a substantial extension of the Commission's current complaint-handling functions would need to carefully consider such matters as the appropriate scope of a governance role, and the need for the provision of extra resources to the Commission to ensure that it could properly perform this additional function.

Issue 4 – Complaints about public health organisations

That the following amendments be made to the *Health Care Complaints Act 1993*:

- section 3A(4) give full recognition to public health organisations as the primary legal entities responsible for their own management and control of clinical issues

- sections 25 and 25A require the Commission to directly inform a public health organisation of a complaint made against it

- section 43 require a public health organisation to make any submissions in response to the Commission's recommendations or comments directly to the Commission

Response

Public health organisations and the Director-General

It is the *Health Services Act 1997* that defines the respective responsibilities of public health organisations and the Director-General of the Department of Health.

Section 4 of the *Health Services Act* includes the following among the objects of the Act:

> *(a) to establish a system of area health services for the whole of the State so as to provide a more effective basis for the planning and delivery of health services within the State*
>
> *(b) to constitute statutory health corporations to deliver health services and health support services other than on the basis of a specified area*
>
> *(c) to recognise as affiliated health organisations certain non-government institutions and organisations that provide health services and health support services within the State that contribute significantly to the public health system …*

Section 6 defines the "public health system" as consisting of all the area health services, statutory health corporations and affiliated health organisations, as well as the Director-General in respect of the provision of ambulance services and certain health support services.

As to the manner in which public health organisations are entitled to manage their operations – section 24 provides that the affairs of an area health service are to be “managed and controlled” by the service’s chief executive, but section 25 qualifies this by stipulating that the chief executive, in exercising their functions, is “subject to the control and direction” of the Director-General.

Section 122 defines the Director-General’s responsibilities as follows (emphasis added):

> *(a) to facilitate the achievement and maintenance of adequate standards of patient care within public hospitals and in relation to other services provided by the public health system*
>
> *(b) to facilitate the efficient and economic operation of the public health system consistent with the standards referred to in paragraph (a)*
>
> *(c) to inquire into the administration, management and services of any public health organisation*
>
> *(d) to cause public health organisations (including public hospitals controlled by them) to be inspected from time to time*
>
> *(e) to recommend to the Minister what sums of money (if any) should be paid from money appropriated from the Consolidated Fund in any financial year to any public health organisation*
>
> *(f) to enter into performance agreements with public health organisations, to review the results of organisations under such agreements and to report those results (and make recommendations about the results) to the Minister*
>
> *(g) such other functions as may be conferred or imposed by or under this Act.*

It would appear that the functions and roles of public health organisations are already extensively set out in the legislation. A further definition in the *Health Care Complaints Act* may well give rise to confusion.

Notification of complaints to public health organisations

The Health Services Association (HSA) has said that some public health organisations have claimed the Commission has not informed them of relevant complaints, and that the Commission has also inappropriately informed the Director-General of complaints, rather than the public health organisations involved.

Section 16(1) of the *Health Care Complaints Act* provides that the Commission must notify the public health organisation of any complaint that has been made about that organisation:

> *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. The notice must be given not later than 14 days after the Commission's assessment of the complaint …* [3]

The Commission complies with its obligations under section 16 to notify public health organisations of complaints about them. The HSA has provided no evidence that the Commission has failed to comply with its obligations in this respect.

Notifications to the Director-General

Section 17 of the *Health Care Complaints Act* provides that, where the Commission receives a complaint about a health organisation, the Commission must also notify the Director-General of the complaint.

In addition, section 25 provides that the Commission must notify the Director-General of any complaint if it appears to the Commission that the complaint involves a possible breach of certain legislation and/or certain legislative provisions. This is because the Director-General has been given the power to enforce the legislation and provisions specified in section 25.

Section 25A also provides that the Commission may refer a complaint to the Director-General if the Commission is of the opinion that the complaint relates to a matter that could be the subject of an inquiry by the Director-General under section 71 of the *Public Health Act* 1991[4] or section 123 of the *Health Services Act 1997*.[5] It should be noted that section 25A(1) provides that such a referral can only be made with the consent of the Director-General.

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[3] Section 16 provides for some limited circumstances in which the Commission is not required to notify the health service provider of the complaint. For further discussion of this issue, see Issue 23 and the Commission's response to that issue.

[4] Section 71 of *Public Health Act* provides that the Director-General may inquire into any matter relating to the health of the public; any matter that authorises a direction by, or requires the approval or consent of, the Minister or the General; and any alleged offence under the *Public Health Act.*

Any complaint about a public health organisation which the Commission has referred to the Director-General under section 25 or 25A will, of course, also have been notified to the relevant public organisation under section 16,

Notwithstanding the referral of a complaint to the Director-General under section 25A, the Commission may continue to deal with the complaint insofar as it concerns the professional conduct of a health practitioner or a health service which affects the clinical management or care of an individual client.[6]

Responses by public health organisations

Section 43(1) of the *Health Care Complaints Act* provides:

> *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.*

The Commission complies with its obligations under section 43 by providing public health organisations with draft investigation reports containing the Commission's draft comments and/or recommendations and inviting submissions on the draft report.

The legal position – and, so far as the Commission is concerned, the actual position – is that public health organisations make submissions on the draft investigation report direct to the Commission. However, the Commission is also aware that the Clinical Governance and Risk Management Branch of the Department of Health usually requests the public health organisation the subject of the investigation to provide its response to a draft investigation report to the Department, as well as to the Commission. The reason for this is that, where the Commission has made draft recommendations to a particular public health organisation for system improvements, the Department wishes to consider the practical impact of the draft recommendations, as well as their possible general application across the NSW health care system. The Commission notes that this appears to be consistent with the responsibility of the Director-General under section 122 of the *Health Services Act* to "facilitate the achievement and maintenance of adequate standards of patient care within public hospitals and in relation to other services provided by the public health system".

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[5] Section 123 of the *Health Services Act* provides that the Director-General may inquire into the administration, management and services of any organisation or institution providing health services other than a public health organisation if those services are wholly or partly funded with money paid from the Consolidated Fund. However, the Director-General cannot conduct an inquiry under section 123 in respect of a private hospital, nursing home or day procedure centre.

[6] See section 25A(3) of the *Health Care Complaints Act*.

The HSA has suggested that, on some occasions, the public health organisation's submissions on the Commission's draft investigation report have been changed by the Department of Health without any consultation with the public health organisation involved. As noted above, public health organisations respond directly to the Commission, and the Commission is unaware of any input into those responses by the Department.

Issue 5 – Information for health practitioners

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

Response

To respond to the apparently ongoing concerns on the part of some health practitioners, the Commission has extensively reviewed its procedures for advising health practitioners that a complaint about their conduct has been made the subject of investigation.

The Commission provides information to practitioners about the Commission's complaint-handling and investigation processes, as well as the support services available to them in its standard letter – see the copy letter *attached* to this submission. This letter also invites the practitioner to contact the Commission's investigation officer if the practitioner has any queries about the investigation process.

In addition, the Commission has now included detailed information on its website for health practitioners about complaint-handling processes generally and investigations in particular – see the *attached* copies of the various information available on the Commission's website.

In relation to the question of information about investigation timeframes and support services, the "Frequently asked questions" section of the website includes the following:

> *How long will the investigation take?*
>
> *The Commission aims to finalise its investigations as quickly as possible. The majority of investigations are finalised within 6-8 months. The actual length of the investigation depends on the complexity of the case. The investigation officer will update you on the progress of the investigation.*

Where can I seek support?

Any health practitioner may seek support in responding to complaints. The following may be of assistance:

- *the complaints manager of your facility or Area Health Service*
- *your professional indemnity insurer*
- *a lawyer or legal representative*
- *another support person*

Issue 6 – Information with people with an intellectual disability

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

Response

The Commission's existing procedures for contacting complainants, and advising them of the outcome of assessments and investigations, require the Commission's assessment and investigation officers to telephone complainants, and discuss the outcome of the Commission's assessment/investigation and the reasons for the outcome. These discussions give Commission staff the opportunity to gauge the complainant's general level of understanding in relation to the matter, and to answer any questions that the complainant may have about the Commission's decision.

The Commission has also taken steps to ensure that its letters to complainants are written in "plain English". Commission staff have undertaken plain English writing courses.

The Commission considers that these measures address the concerns raised in the submission by the Department of Ageing, Disability and Home Care (DADHC), which appears to be made on the basis of general principle rather than specifically identified cases.

The reference to "best endeavours" in the *Health Care Complaints Act* appears to be somewhat misconceived, because the Act uses the term to govern the Commission's attempts to contact a person whose care is the subject of a complaint, although they are not the actual complainant. Where a complaint is made on behalf of a person with an intellectual disability or mental illness, the person making the complaint is usually in the best position to communicate with the person whose care is the subject of complaint.

The Commission also notes that the NSW Council for Intellectual Disability (NSW CID) has recently produced and launched a series of "Healthier Lives" facts sheets on health for people with an intellectual disability, as well as facts sheets designed to assist families, advocates, disability workers and other professionals. These facts sheets were developed as the result of a project developed by NSW CID and funded by DADHC. The Director of the Commission's Assessments and Resolution Division was one of a range of experts that CID NSW consulted to provide assistance in preparing the facts sheets.

Facts sheet 24 concerns "Rights and complaints" and was finalised in July 2009 – copy *attached* for information. This facts sheet says:

> *If a person with intellectual disability does not get a fair deal from the health system, it is okay to make a complaint. … There are independent complaints bodies you can go to. But usually it is best to first to try the sort the problem out with the service itself.*

The facts sheet includes some general tips for making a complaint. It lists the Health Care Complaints Commission as one of the agencies to whom a complaint can be made – describing the Commission "an independent body that handles complaints about health services and individual professionals" – and includes the Commission's telephone and email contact details and its website address.

The Commission also proposes to work with CID NSW to develop a further facts sheet which will contain more detailed information about the Commission's role and functions.

Issues 7 and 8 – Health professional registration boards

That the various NSW Registration Acts be repealed and replaced by a single Health Professionals Registration Act

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

Response

The Commission agrees with the suggestion that complaint-handling and disciplinary procedures in relation to the various types of registered health practitioners should be consistent, but has no firm views on the legal and administrative mechanisms to implement this position.

Issues 9 and 10 – Oversight of health professional registration boards

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.

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.

Response

The Commission supports the proposition that the operations of the health professional registration authorities should be subject to oversight by a Parliamentary Committee. As part of its oversight, the Parliamentary Committee should review the annual reports of the registration authorities.

Given that it is expected that the Commission and the registration authorities will continue to work together under a co-regulatory model of the type currently in operation in New South Wales, the Commission considers that the appropriate course would be to expand the mandate of the Parliamentary Committee on the Health Care Complaints Commission so that the Committee can also review the operations of the health registration authorities.

The Commission's assessment and investigative powers

Issue 11 – Own motion investigations

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

Response

The Commission made this proposal in its earlier submission to the Committee's inquiry, and continues to support the proposal, for the reasons detailed in that submission. Any new power should be in terms of the Commission initiating its own complaints, rather than being limited to investigations.

The Commission has noted the suggestions by PIAC as to the types of situations in which the Commission could appropriately initiate an “own motion” investigation. The Commission considers that it is unnecessary – and, indeed, would be undesirable – to specifically define these sorts of situations in the *Health Care Complaints Act* for the following reasons:

Threats to public health and safety

Section 3(2) of the Act already provides:

> *In the exercise of functions under this Act the protection of the health and safety of the public is the paramount consideration”*.

In addition, section 23(1)(b)(i) provides that the Commission must investigate a complaint:

> *if it appears to the Commission that the complaint … raises a significant issue of public health or safety.*

Adding new respondents or issues

Section 20A of the Act already provides:

> *(1) The Commission is to keep under review its assessment of a complaint while it is dealing with the complaint.*
>
> *(2) At any time while dealing with a complaint (including during or at the end of the investigation of a complaint) and after consultation with the appropriate registration authority, the Commission may revise its assessment of the complaint and take any of the following actions:*
>
> *…*
>
> *(f) change the person whose conduct appears to be the subject of the complaint or include another person as a person whose conduct appears to be the subject of the complaint*
>
> *(g) add to, substitute, amend or delete any of the specific allegations comprising the complaint (including add an allegation arising out of an investigation of the complaint that may not be the particular object of the complaint).*

Urgent matters for resolution

Ensuring that the “own motion” power was broad enough to cover making a complaint, as well as investigations, would cover PIAC’s suggestion.

Broader investigations and inquiries

Conferring a broadly expressed “own motion” power on the Commission to make complaints and to investigate them would be sufficient to permit the initiation of such investigations as the Commission considered appropriate and desirable in the public interest. If there were a defined list of situations where the Commission could exercise its “own motion” power, a health service provider who is the subject of complaint could argue that the list limits the Commission’s power to conduct “own motion” investigations. On this basis, they could challenge the Commission’s investigation and/or institute legal proceedings against the Commission in relation to the issue of jurisdiction.

Issue 12 – Guidelines on complaint-handling

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 section 20(1) of the *Health Care Complaints Act 1993*

Response

The Commission notes that the submission by the Greater Southern Area Health Service on this issue arises from a small number of complaints where the Area Health Service had been unable to resolve the complaint directly with the complainant. In these cases, the Area Health Service questioned the Commission’s decision to refer the complaint for independent resolution or conciliation, as it considered it inappropriate in view of its previous unsuccessful attempts at resolution. However, in some of these cases, the Commission’s referral was indeed effective in promoting resolution.

The Commission considers that it would be both difficult and undesirable to prepare guidelines for the assessment of complaints. The very broad range of complaints that can be made about health service providers, and the differing levels of seriousness in complaints, would make the criteria for assessment in any guidelines so broad as to be virtually meaningless. Furthermore, if detailed criteria were introduced, they would provide respondent health service providers who are resistant to the complaint-handling process with an opportunity to dispute the Commission’s assessment, thereby frustrating the intention of the Act. It should also be noted that the Commission’s notices to complainants and health service providers about its assessment decisions provide reasons for the Commission’s decisions in relation to particular complaints.

Issue 13 – Vexatious and malicious complaints

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

Response

There is no need for an amendment of the type suggested by the Nurses Association.

Section 27(1) of the *Health Care Complaints Act* lists the various grounds upon which the Commission is entitled to decline ("discontinue dealing with") a complaint. The very first of these grounds is that the complaint is "frivolous, vexatious or not made in good faith". Accordingly, the Commission is already entitled to decline a complaint on the ground that the complaint is "vexatious". A complaint which the Commission considers "malicious'" can, where appropriate, properly be declined by the Commission on the ground that the complaint was "not made in good faith".

Issue 14 – Reports by health practitioners

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.

Response

The Commission has already 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 – see the Commission's response to Issue 5 above.

In relation to the issue of how a report or response by the practitioner can be used, the Commission's 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.

In addition, the Commission's website now includes a page entitled "What if a complaint is made about me?". This page 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.*

The Commission also has the power to require practitioners to provide information for the purposes of the Commission's complaint assessment process – under section 21A – and/or for the purposes of a complaint investigation – under section 34A. Sections 21A(3) and 34A(3) provide that a person who is subject to a requirement to provide information must comply with the requirement unless they have a "reasonable excuse" not to do so.

Section 37A explains the scope and limits of how information and documents required from practitioners can be used:

> *(1) Self-incrimination not an excuse A person is not excused from a requirement under section 21A or 34A to give information, to answer a question or to produce a document on the ground that the information, answer or document might incriminate the person or make the person liable to a penalty.*
>
> *(2) Information or answer not admissible if objection made However, any information or answer given by a natural person in compliance with a requirement under section 21A or 34A is not admissible in evidence against the person in any civil or criminal proceedings (except disciplinary proceedings or proceedings for an offence under this Part) if:*
> *(a) the person objected at the time to doing so on the ground that it might incriminate the person, or*
> *(b) the person was not warned on that occasion that the person may object to giving the information or answer on the ground that it might incriminate the person.*
>
> *(3) Documents admissible Any document produced by a person in compliance with a requirement under section 21A or 34A is not inadmissible in evidence against the person in any proceedings on the ground that the document might incriminate the person.*
>
> *(4) Further information Further information obtained as a result of a document produced or information or answer given in compliance with a requirement under section 21A or 34A is not inadmissible in any proceedings on the ground:*
> *(a) that the document, information or answer had to be produced or given, or*
> *(b) that the document, information or answer might incriminate the person.*
>
> *(5) The Commission, the Commissioner or a member of staff of the Commission cannot be required (whether by subpoena or any other procedure) to produce, in connection with any proceedings, a document that contains any information or answer that has been obtained as a result of a requirement under section 21A or 34A if the information or answer is not admissible in evidence in those proceedings because of this section.*

The Commission wishes to point out that private health practitioners are required to be insured, and that this insurance usually covers complaints about their conduct. They therefore have readily available to them the support of insurers and lawyers in responding to complaints. This support can include advice about how responses can be used in the context of complaint-handling and investigation processes, disciplinary proceedings, and any relevant civil and/or criminal proceedings. Where a practitioner is working for a public health

organisation, the Commission encourages them to seek the assistance of that organisation. It should also be noted that nurses generally seek the advice of the Nurses Association, which usually strongly defends their position.

Issue 15 – The purpose of investigations

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

Response

The second sentence in the Note to Division reads as follows: "The Commission will investigate with a view to moving to prosecution of the complaint before the appropriate professional board, committee or tribunal …"

This sentence does not reflect how the Commission does, or should, conduct its investigations. Accordingly, the Commission supports the suggestion that the sentence in question be removed from the Note.

Issue 16 – Timeframes for the assessment of complaints

That section 22 of the *Health Care Complaints 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

Response

The Commission supports this suggestion. The Commission acknowledges the point raised by the Department of Health that, in complex cases which involve multiple services and providers, it may be difficult in practice for the relevant Area Health Service to prepare a comprehensive response to the complaint within 28 days. The Commission also notes 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.[7]

[7] The Commission notes that, in 2008-09, 88.9% of complaint assessments were finalised by the Commission with the statutory timeframe of 60 days,

Issue 17 – Timeframes for investigations

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

Response

The suggested amendment is unnecessary. Section 29A of the *Health Care Complaints Act* already provides that the investigation of a complaint "is to be conducted as expeditiously as the proper investigation of the complaint permits".

Issue 18 – Reasons for decisions

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.

Response

Assessment decisions

Section 28(1) provides that the Commission must give the parties notice in writing of the Commission's assessment decision. Where the Commission decides:

- to "discontinue" dealing with the complaint – that is, take no further action on the complaint
- not to investigate the complaint – which may involve referral of the matter for resolution or conciliation
- to refer the complaint to the Director-General, or to another person or body

Section 28(8) specifically provides that the Commission's notification to the complainant of the decision must include the reasons for the decision.

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 section 23, and the Commission advises the parties to the complaint of the relevant reason(s).

Investigations into complaints about health practitioners

Section 41(1) provides that 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.

Investigations into complaints about health organisations

Section 45(1) provides that the Commission must notify the parties to the complaint of "the results of the investigation". While it is true that 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. If the investigation report makes comments or recommendations, section 42(3) specifically provides that the report must include the reasons for the Commission's conclusions and recommendations.

The Commission has no objection to an amendment to the Act that would expressly require the Commission to give reasons for the outcome of its investigations into complaints about health organisations.

Issue 19 – Internal reviews

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.

Response

Complainants are entitled to request a review of the Commission's assessment decision (other than a decision to investigate the complaint)[8], and a review of the outcome of the investigation into a complaint about a health practitioner.[9]

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.[10]

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[8] Section 28(9) of the *Health Care Complaints Act*.
[9] Section 41(3) of the *Health Care Complaints Act*.
[10] Sections 40 and 43 of the *Health Care Complaints Act*.

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 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.

The Commission's comments

The Commission considers 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.

With respect to the suggestion that respondent health service providers should have a right to a "merits" review of an assessment decision to investigate a complaint – this would only serve to frustrate and prolong the complaint-handling process. 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.[11] As discussed above, health

[11] Section 12 of *the Health Care Complaints Act*.

service providers subject to investigation are entitled to make submissions in relation to the matter.[12] 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.

Issues 20 and 21 – Expert opinions

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

That section 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.*

Response

The Commission chooses its expert for a particular investigation from its "list of experts" database. The experts listed have been sourced from the various health professional colleges and associations after consultation with those bodies.

Issue 20

On a number of occasions, the Commission has requested that the registration boards – including the NSW Medical Board – nominate suitable experts for inclusion on the Commission list of experts, but the boards have declined to do so. It appears that the Medical Board would prefer a "veto" power in relation to experts used by the Commission.

Disagreements between the Commission and the Medical Board on the cogency of expert opinions are sometimes based on disputes about the application of the statutory standard for "unsatisfactory professional conduct", as defined in section 36 of the *Medical Practice Act*. The Board often seeks to impose a different standard, based on whether the conduct of the practitioner was "wilful, reckless, unprofessional or criminal".

The Board's suggestion that a further expert report should be obtained where it is dissatisfied with an expert opinion obtained by the Commission creates difficulties for the Commission's conduct of disciplinary prosecutions, because the Commission must disclose

[12] Sections 40 and 43 of the *Health Care Complaints Act*.

all expert reports to the respondent practitioner. Where there are conflicting expert opinions, it is difficult to argue that there is a generally applicable standard of conduct. It is open to practitioners the subject of prosecution to call and rely upon their own expert(s) to challenge the evidence of the Commission's expert – and, in fact, this often occurs.

Issue 21

In relation to the various concerns raised by the Nurses Association:

- The expert is not required by the Commission to assume that the complaint is factually valid. The Commission's procedures stipulate state 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.

- The suggestion that an expert report should be obtained "at the end" of the Commission's investigation process is misconceived. The expert's 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 section 40 of the *Health Care Complaints Act*.

- The Commission considers that the definition of an "expert" is appropriate. The Commission has discussed above how it compiles and uses its list of experts.

Issue 22 – Information provided to the expert

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.*

Response

There is no need for such an amendment. Section 30(2A) already specifically provides that the Commission must provide the expert with "all relevant information concerning the complaint that is in the possession of the Commission".

Issue 23 – Notification of complaints to health service providers

That sections 16(6) and 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 persons the 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

Response

Section 16 of the Act, which concerns the notification of complaints to health service providers, relevantly provides:

(1) 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. …

(4) This section does not require the Commission to give notice under this section if it appears to the Commission, on reasonable grounds, that the giving of the notice will or is likely to:
(a) prejudice the investigation of the complaint, or
(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.

(5) Despite subsection (4), the Commission must give the notice if the Commission 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.

(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 may give such a form of notice.

(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.

Section 28 concerns the notification to a health service provider of the decision to investigate a complaint, and contains provisions of the same type as those in section 16.

The Commission considers that the provisions of section 16 and 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.

Issue 24 – Decision following the investigation of a complaint about a registered health practitioner

That section 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

Response

Disagreements between registration boards and the Commission are rare. The Commission has a statutory basis and clear criteria for the position that it takes, and is required to justify its decision against those criteria. On the other hand, where the registration board is of the view that the practitioner should be prosecuted, it is not expressly required by the legislation to provide reasons for its position.

In practice, registration boards, including the Medical Board, rarely give a comprehensive statement of the reasons for their position. Rather, the matter proceeds through discussion with a number of Board members, who may hold different views.

If this proposal were to be adopted, the registration boards could, in effect, commit the expenditure of considerable amounts of public money to prosecutions, where they would have no responsibility for the conduct of the matter, the likelihood of success of the prosecution, or any liability for the respondent's costs if the prosecution were unsuccessful. It would also 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.

The Commission has put to the Medical Board that it does have the power to initiate its own prosecutions of complaints against medical practitioners under section 50 of the *Medical Practice Act*. On each occasion where this has been suggested, the Board has declined to take its own action.

Issue 25 – Reviewing investigations

That a new section 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.

Response

As noted above, complainants have the right to request a review of the outcome of an investigation, and respondent health practitioners and organisations have the right to make submissions on proposed investigation outcomes, comments and recommendations. The Commission also conducts regular reviews of its investigation processes and prosecutions as part of its professional development of Commission staff.

The purpose of the suggestion by Health Services Association is not entirely unclear. It is also difficult to see how the suggested publicity process would work, given the confidentiality provisions of the Act.

The Commission provides its completed investigations to the Director-General of the Department of Health and to the Clinical Excellence Commission. There are other mechanisms under consideration by the Department of Health and the Clinical Excellence Commission – also considered in the report of the Garling Special Commission – to establish and publish a knowledge database providing the outcomes of investigations and root cause analyses to assist in the improvement of health systems.

Issue 26 – Open disclosure

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.

Response

The Commission maintains close contact with complainants as part of its general complaint-handling procedures. This includes explaining the process, advising on progress, and discussing potential outcomes. This means that complainants are generally well prepared for the outcome of the complaint-handling process. The Commission usually provides complainants with responses from the health service provider(s) complained about, and also provides detailed reasons for its decisions. Complainants are provided with a copy of the investigation report that sets out the issues of complaint, the evidence that has been gathered, and the reasons for the Commission's decision. This should answer the questions that complainants have about the events that gave rise to their complaint. Complainants are also advised of their right to a review if they are dissatisfied with the outcome.

Open disclosure is a different process from complaint-handling. It requires the provider of the health service that led to an adverse outcome for the patient to openly discuss the reasons for that outcome directly with the patient and/or their family.

This issue has arisen from the submission of the Greater Southern Area Health Service, and can be attributed to one complaint where the complainant was deeply dissatisfied with the handling of her matter by the Area Health Service before it came to the Commission. The Area Health Service was apprehensive that, following the Commission's investigation, the complainant would publicly voice her dissatisfaction as she had in the past, attracting considerable local media coverage. The Area Health Service suggested that the Commission should provide some form of "open disclosure" and support to the complainant to assist her to come to terms with the Commission's report. This represents a misconception of the nature and purpose of open disclosure on the part of the Area Health Service. The complainant was provided with the Commission's detailed investigation report, which set out all the relevant evidence in relation to the events in question, and the reasons for the Commission's decision. There was no adverse reaction from the complainant to the Commission's report.

Information-sharing between the Commission and Area Health Services and registration authorities

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Issue 27 – Progress reports to Area Health Services

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

Response

Area Health Services remain under the misconception – despite the Commission's continual advice to the contrary – that they can refer difficult matters to the Commission for "independent review". However, the Commission's powers can only be exercised on receipt of a complaint – the Commission has no power to conduct "reviews" of referred matters.

In cases where the Commission has requested an Area Health Service to make the referral a "complaint", the response has been that the Area Health Service does not wish to make a complaint against itself.

In these circumstances, the Commission contacts the patient(s) and/or families concerned and ascertains whether they wish to complain – which they usually do. Subsequently, the Commission reports on progress to them. In such matters, the Area Health Service is treated as the respondent, and it is requested/required to provide responses and relevant evidence. The Area Health Service enjoys all of the statutory rights of a respondent under the *Health Care Complaints Act*, including the right to make submissions on any proposed comments and/or recommendations in the draft investigation report.

Issue 28 – Notification of complaints to a health practitioner's employer

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 the Area Health Service be notified by the Commission that the complaint has been made

Response

This issue was raised by the Committee in its letter to the Commission of 24 September 2009 as a matter that did not fall within the terms of reference for this inquiry. The Commission responded in detail to the issue in its letter of 7 October 2009. To summarise this response – the Commission is bound by the Act to only notify individual respondents, and not their employers, unless and until the complaint is made the subject of an investigation. The Commission's position is that it has no objection to notifying the employers of individual respondents of all complaints, but the Committee may wish to seek the views of individual health practitioners and their representatives in coming to a view on this issue.

Issue 29 – Requests to Area Health Services for relevant information about health practitioners

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.

Response

The Commission is very interested in obtaining information from Area Health Services regarding complaints or concerns about health practitioners contracted/employed by the Area Health Service, and will pursue such matters appropriately where is any suggestion of a broader problem in relation to the practitioner's practice or conduct.

The Committee has noted that “privacy concerns” relating to both the practitioner and their clients would need to be considered if the Commission were to adopt a practice of the nature suggested. The Commission is of the view that there are no relevant concerns in this respect. The *Health Records and Information Privacy Act 2002* (“HRIPA”) applies to organisations that are health service providers[13] – and therefore to Area Health Services. This means that Area Health Services, under the health privacy principles set out in Schedule 1 of HRIPA, can disclose confidential health information to the Commission if they believe that the disclosure is reasonably necessary for the Commission to discharge its functions. The Commission has previously explained this position in response to a number of inquiries by the Area Health Services. Where there is any doubt, the health organisation may suggest to the Commission that it should issue a notice under section 34A of the *Health Care Complaints Act* requiring the production of the relevant information.

[13] Section 11 of the *Health Records and Information Privacy Act.*