REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

INQUIRY INTO THE OPERATION OF THE HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on Thursday 4 March 2010

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The Committee met at 10.00 a.m.

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PRESENT

The Hon. H. M Westwood (Chair)

Legislative Council	**Legislative Assembly**
The Hon. D. J. Clarke	Mr K. A. Hickey
Reverend the Hon. F. J. Nile	Ms J. Hopwood
	Mr N. Rees

CHAIR: I will make some opening remarks on the conduct of the Committee's Inquiry. One of the main functions of the Committee on the Health Care Complaints Commission under section 65 (1) (d) of the Health Care Complaints Act 1993 is to report to Parliament any change that the Committee considers desirable to the functions, structures and procedures of the Health Care Complaints Commission. It was with this responsibility in mind that the Committee recommended, in the wake of its Inquiry into the conduct of the Commission's investigation into the complaints made against ex practitioner Graeme Reeves, that the Health Care Complaints Act be the subject of a thorough review to identify any unnecessary complexities in the health care complaints system in New South Wales and that the Committee itself would undertake this review.

However, after receiving submissions, the Committee decided to defer the conduct of this Inquiry as the impetus escalated for a national registration and accreditation scheme, an important component of which was to be a uniform national health care complaints handling system. The Committee has serious concerns that the scheme which was originally proposed by the Health Workforce Principal Committee of the National Health Workforce Task Force would be a retrograde step towards a system of self-regulation, which had certainly in the Committee's view been discredited not only in New South Wales but in other jurisdictions. Committee members were therefore very pleased when the then Minister for Health, the Hon. John Della Bosca, MLC, announced in the Legislative Council on 23 June 2009 that New South Wales had brokered an agreement for the retention of the Health Care Complaints Commission as a component of the national scheme.

The ensuing New South Wales Health Practitioners Regulation Act 2009 specifically provides that New South Wales will not adopt the national law complaints model set out in divisions 3 to 12 of part A of the national law. The new National Registration Boards will be expressly precluded from dealing with complaints about matters occurring in New South Wales, and those matters must be referred to the relevant State authorities, including the Health Care Complaints Commission. Thus the Commission will continue to be responsible for investigation and prosecution of serious disciplinary matters under the Health Care Complaints Act. While the Committee does not have the remit to examine the operations of a national authority, the proposed national scheme will undoubtedly have both immediate and long-term effects on the investigation of health care complaints in New South Wales. Accordingly, it would be a somewhat incomplete Inquiry were the Committee not to be cognisant of these changes at the national level, and the Committee will be seeking the evidence of witnesses as to their expectations of the likely impact of the national law in their particular area of expertise. We had further announcements yesterday about the further proposals of the Commonwealth Government to make significant changes to health care provision across the nation, which will undoubtedly have an impact on health care providers and consumers in New South Wales.

Ms MEREDITH ROBYN KAY, Chairperson, Dental Technicians Registration Board, Macquarie Hospital, North Ryde, and

DR MATTHEW WILLIAM FISHER, Chief Executive Officer, Australian Dental Association (New South Wales branch), 69-71 Nicholson Street, St Leonards, sworn and examined:

CHAIR: I thank the witnesses for appearing today. I understand that you have been issued with a copy of the Committee's Terms of Reference and also some information for witnesses appearing before Parliamentary Committees. Is that correct?

Dr FISHER: Yes.

CHAIR: What is your occupation, and in what capacity are you appearing before the Committee today?

Ms KAY: I am the director of the Northern Sydney-Central Coast Area Health Service, and I am appearing before the Committee today as the Chairperson of the Dental Technicians Registration Board of New South Wales.

Dr FISHER: I am an adjunct associate professor, and I am appearing before the Committee today as the Chief Executive Officer of the Australian Dental Association (NSW Branch) Ltd.

CHAIR: As time is limited the Committee may wish to send you some additional questions in writing. Would you be happy to provide a written response to those questions?

Ms KAY: Absolutely.

CHAIR: And they would then be made public on the Committee's website. Would you like to commence with an opening statement before I turn to the members for questions?

Dr FISHER: Firstly, I appreciate the opportunity to come and speak to the Committee. The Australian Dental Association has 3,800 members in New South Wales. We are the professional association representing dentists. We have had significant inputs into the national registration and regulation process at both a State and Federal level, and equally we have had significant inputs between the Health Care Complaints Commission [HCCC] and the Dental Board of New South Wales to have the dual outcomes of ensuring safety matters with regard to the public and ensuring that the profession continues to practise appropriately in the community, which we understand occurs. It is a very safely practised profession, and specifically with health care complaints we work actively with the HCCC in an educative way to give the complaints officers an understanding of dentistry. We are satisfied that the relationship between health care complaints and the regulatory body as it stands in New South Wales, from our perspective, is a good and strong one that goes on to serve the interests of the public and the profession.

Ms KAY: Thank you for having time to speak to us today. I am here to represent the Dental Technicians Registration Board. One of the issues that I think is paramount in our minds is the deregistration of dental technicians across New South Wales. Following on from Dr Fisher's comment, it is all about safety and quality of health care, the provision of quality health care to the public of New South Wales. Without that regulatory ability of the Board—it may not be the Board that does it, but to have that profession regulated is vitally important because of the ongoing quality and safety in the provision of that service to the public. I would be happy to discuss that further and the range of issues that we are concerned about.

The Hon. DAVID CLARKE: Could I just ask whether you would like to do that now?

Ms KAY: Certainly. I think the issues are touched on, certainly across issues 7, 8 and 9 in the document that we have been provided. I think the main issue for me on behalf of the Board is, as I said, quality, safety, the ongoing ability to provide a well-skilled and appropriate workforce. It is certainly about appropriate health outcomes for individuals and ensuring that the health consumer is in a position to purchase and obtain quality ongoing appliances that people require for their ongoing health. Another thing is that quite often within the health sphere the oral health condition of people is a little downplayed. I strongly believe that people's oral

health status affects their general wellbeing and their ability to seek employment, and their socioeconomic ability can be greatly affected by poor oral health status.

So, while we appreciate and are glad that dental prosthetists will have ongoing registration, which is fabulous, it is about how we ensure that the quality of those people who are becoming prosthetists are what we want. So without the building blocks of being a dental technician first and having the concreted, honed professional skills and ability that are required, how do we ensure that the quality of those people is what we need to provide care to our community? It is about ensuring that what we provide through registered people, particularly dentists, is of quality, and we need to ensure that. Another thing is that all of the professions that will be registered will have a scope of practice. They will all have a model of clinical governance, which is important and vital.

Dental therapists and dental hygienists are required to practice under oversight of a dentist, which is a strong, robust model which helps ensure safety. After deregistration dental technicians will not have such clinical governance or practice oversight, which is a significant concern to the profession and to the Board. We are not here to advocate the continuation of the Board. How that regulation occurs is important but that is not what we are after. It is about ensuring that there is some way to regulate and monitor that whole practice of dental technology.

Mrs JUDY HOPWOOD: Would you be able to give some real examples of why it is so important to remain registered in New South Wales?

Ms KAY: Sure. I think some real examples are that we do have people practice outside their scope. People provide services to the public and quite often to the vulnerable public. I think that often the groups that are targeted are the vulnerable, not so well informed health consumers, quite often of culturally—or cultural groups so they stay within their own ethnicity and they seek services from people from that ethnic group. That is not to cast aspersions on people from different ethnicities. It is about people wanting to get cost-effective health care and they look around and ask for that health care from people they know, and people provide that health care, which is quite often outside their scope. Yes, we do have some fairly recent evidence or examples of that, some of which have been in the media quite recently.

We also have examples of people providing things or using materials that are not safe and not of Australian standards. Certainly there are cheaper ways to do things that we would strongly advocate against. Cheapest is not always the best health gain or outcome for the consumer. It is also about continuing professional development. I am sure everybody in the room would agree that is really important. Part of the strength of the national scheme is to ensure that people stay abreast of trends. The health environment is dynamic: things are happening all day every day. We need to ensure that all of our health care providers across the whole dental team are aware of that.

If we look at what is happening worldwide, many other places are registering and bringing into the registration fold not just dental technicians. Recently in the United Kingdom they also registered dental assistants. That indicates that we need to ensure that quality and safety is paramount. It is also about the dental team. Matthew started to allude to that a moment ago. As we are looking for health efficiencies and effective health care provision, with my other hat on now, I know how constantly challenging it is to provide cost-effective valuable health care. We will be looking to increase the scope of practice and to maximise the skills of all of the health care team. Therefore, as the dental technician is a vital component of that, we need to ensure that that group of people is as valued and supported and governed as well as any of the other groups. That is a real challenge for the dental oral health sphere at the moment within New South Wales.

Mr KERRY HICKEY: What is the status of this regulation in other States?

Ms KAY: I will confer because the people behind me will have probably the dead-accurate answer. Queensland just recently said it is going to continue regardless of the new national registration. The reason dental technicians are not going to be registered initially with the new national registration is that they are not registered in all States and Territories in Australia. That is the platform for why they have been left out at this stage. The issue we have is that the national registration body is moving forward. We all recognise that it is a huge task and as they progress forward they have collected into their fold in the first and second catchments those who are registered nationally, which is a very obvious move for them and I can absolutely understand why they have done that.

We also need to be mindful that as they are moving forward they are actually bringing in other professional groups that they have not at first considered. One of my concerns or the concerns of the Board and industry people is that if the national movement then decides—we hope they do—in the future that registration of dental technicians is important, how do we from the New South Wales point of view then capture the group we have lost? What do we do with people now practising in the State who have not been through that registration or education process that we want? Do we need to grandfather them in? How do we catch them back? How do we then monitor places all of a sudden? But just to answer your question, dental technicians are regulated by legislation in four jurisdictions throughout Australia—that is, New South Wales, the Australian Capital Territory, Queensland and South Australia, and in New Zealand under our trans-Tasman Mutual Recognition Agreement.

Mr KERRY HICKEY: Are there cases in Victoria, Western Australia, Northern Territory or Tasmania where not being registered has been an issue?

Ms KAY: Yes. Recently we had a case in Victoria where a patient contracted hepatitis C. The investigation went back via the dental surgery where the appliance was issued. The source of infection was identified as the laboratory. The pumice, which is used to polish the appliance, had not been sterilised and cleaned and the patient contracted hepatitis C. If I could just continue a little, one of the issues cited or the reasons we do not need to worry so much about dental technicians is the minimal number of complaints we have had. I believe that is actually the reverse side of the coin. I actually think that the fact we have had a minimal number of complaints actually stands as a testament to the regulation currently in place, in that it is well governed. There are quite clear rules and responsibilities about the role of the dental technician and how that dental technician fits in with the dental team, and the whole dental team respects that and works around it. If we lose that, that is a significant issue and risk for the community.

Reverend the Hon. FRED NILE: Dr Fisher, your submission makes a strong response to issue 24 of the discussion paper. It states, in block letters, "We do not agree with this suggestion." You believe that the final say should always reside with the body that has the ultimate responsibility for protecting the health and safety of the public, that is, the relevant registration board. The discussion paper leaves up in the air the matter of which one has the strongest penalty. Why do you object to that?

Dr FISHER: If I go back to the statement that if the Health Care Complaints Commission and the Registration Board work in concert, you get the benefit of peer and consumer expertise that is affected through the Registration Board. They are the ones best positioned to judge the penalty around matters of practice, treatment and quality. If you go into the essence of the Registration Board, they get a group of peers supported by consumers. It is often said that they smack the dentist harder than the Health Care Complaints Commission. That is the view I have heard also from within New South Wales Health, and has been part of the discussion we have had. We are saying that to get an understanding of something like dentistry, which is a unique profession—it is targeted in a whole lot of ways through other safety and quality mechanisms—the Dental Board would be the most appropriate group to make a judgement on the quality of treatment. If it is matter of conduct and behaviour where it steps outside of what would be deemed professional treatment—we know there are matters at the moment being dealt with and others that do not actually relate to the practice of dentistry but more to the conduct of the practitioner with an individual staff member—and that triggers a criminal process, then the Health Care Complaints Commission is often the most appropriate place for that to be managed. Where it is a matter of treatment, we have always supported the role of the Dental Board in providing advice back to the Health Care Complains Commission about the impact on public safety.

I would just like to pick up on a comment Meredith made. In the end, this whole discussion around registration and regulation is about people being appropriately credentialed to be granted the privilege to practise in the community. Certainly our role with our members is to continue to remind them of the privilege they are given through the regulatory mechanisms to do what they do, which is a service of benefit from a health outcome perspective. I would ask anyone sitting around the table how well do you understand what happens to you when you go to the dentist. I know that I do not, even given the insights I have. That is where the value of the peer review board—the Dental Board—comes in to actually make a judgement about the quality of treatment in the public's best interest. That explains the strength of our submission around issue 24.

Reverend the Hon. FRED NILE: Your main point is to draw a distinction? If the complaint refers to professional matters, the Board deals with it, and the Commission deals with non-professional matters?

Dr FISHER: In many respects that is the way it is done. I am aware in speaking to Mr Pehm and Dr Lockwood of the amount of interaction between Health Care Complaints Commission and the Dental Board. I think that from both their perspectives that works well to ensure the public's interests are being met.

The Hon. DAVID CLARKE: Ms Kay, are you saying that you are facing deregulation as a body simply because other jurisdictions in Australia do not have regulation?

Ms KAY: That is correct.

The Hon. DAVID CLARKE: In other words, it is more a dumbing down rather than an uplifting process? That seems to be a very disquieting situation to me.

Ms KAY: I agree. Our concern is that other States and Territories have made their call to deregulate or not register for various reasons, which is historical to the States. New South Wales chose to register dental technicians back in 1975 because of the concern about ensuring there were appropriate training, quality and safety mechanisms to ensure the safety of the public.

The Hon. DAVID CLARKE: And it has worked well?

Ms KAY: It has worked well. It is also very disquieting—that is a very valuable term—to us because dental technicians or dental technology is a craft, the same as many professional groups, which has now developed over a period of years to become a significant professional group that is aiming constantly to improve and to keep abreast of what is happening in the health care sphere. To be honest, it is absolutely ridiculous to dumb down that group and actually remove that regulation when it is so desperately trying to get, and has succeeded, to that professional level and to be a valued, useful, cost-effective member of the health-care team.

CHAIR: Have you been given an indication of when national registration will occur for dental technicians?

Ms KAY: I do not believe so.

CHAIR: It is not planned for the next round?

Ms KAY: No.

CHAIR: Professions are being captured over time.

Ms KAY: Yes, and all the planned announced next groups have not included dental technicians. It is an issue that has focused not just on New South Wales. The issue is national. People are concerned about it nationally and across New Zealand. New Zealand also is concerned under the Trans-Tasman Mutual Recognition Scheme. It is a whole lot of things. It is not just about New South Wales. The other thing is the transient health population. It is great that the national registration has come in because that enables Australia as a whole to move its health professionals around and for people to move in and out of the Australian Capital Territory or from Albury to Wodonga and all of those things, which is fabulous. But this is a significant issue for us that has been a gap that has been left.

Dr FISHER: Could I just make one comment?

CHAIR: Certainly.

Dr FISHER: To have a full understanding of the national registration and regulation you have to go right back to the Productivity Commission report, which set this ball rolling. In some respects you then have the other events as you have referred to in your briefing and the position that's put about public confidence and public safety. It started off as a national registration to give mobility and things like that. We put our submissions and contended there were some easy fixes to that. You can look at the mobility of lawyers from a national registration perspective. If it then came down to the regulation, it then started to look at what was being driven by the original Productivity Commission. It is a complex area, which is what health is. From a dentistry perspective, will the safety of dentistry be improved as a result of what has gone on? It would be hard for me to say yes it will; it is a very safely practised area. We get notifications through a relationship with an insurer. You can read in our statement that of services delivered, the actual error is less than 0.05 per cent, and that is through

direct notification. Will that change as a result of this? No, because the competency development, the credentialing and then the privileging process still happens. Will the cost of delivering the services change? Most likely, because there are different overlays. I sit on the Primary Care Committee of the Australia Commission on Safety and Quality in Health Care, so I am cognisant of all matters coming forward in practice accreditation. That is likely to increase compliance costs as well. Will it give a demonstrable benefit? Time will tell. I think it might give a confidence perspective, but that is different to a change in quality.

Mrs JUDY HOPWOOD: The Minister indicated that there would be deregulation of dental technicians in New South Wales. The reason for that deregulation is that dental technicians have no contact with patients. Would you like to comment on that premise?

Ms KAY: Yes, I would like to comment. That is not strictly true. Dental technicians have contact with the patients. At times they are required to do clinical photography or shade taking. There are times when, under the current scope, they contact patients. Our concern is also about people who do not adhere to the scope. There is what we commonly refer to as a swinging door situation between a laboratory and a dental surgery. If we followed the scope of practice there should not be an issue. Our concern is that when that scope of practice or restriction is removed what happens to unregistered groups who expand and undertake other work? I would like to quote something apt in the new Act relating to how a registered practitioner cannot direct another registered practitioner to undertake work outside the scope of practice, which is great. If a dentist in our group asked or directed a dental therapist, dental hygienist, oral health therapist or dental prosthetist to do something outside his or her scope, that would not be acceptable.

But for the unregistered person there seems to be a limitless array. We already have a situation where, under appropriate supervision, that is useful. Other providers in the health team such as dental assistants are now burgeoning into other areas in this scope of practice, which is great. They are educated, supported and supervised, which is cost-effective and useful health care provision. But that will not necessarily be the case with dental technicians. Without some sort of regulation we cannot guarantee that people will not go outside their scope and go outside their range of competence. When they are not competent and they do not follow guidelines, that is when we get into all sorts of strife, and that is when members of the vulnerable public become those who are most at risk.

The Hon. DAVID CLARKE: Even if, on the whole, technicians do not come into contact with the public, their work certainly does.

Ms KAY: Their work certainly does. That is a very valid point.

The Hon. DAVID CLARKE: There can be negligent consequences for those who are not up to the appropriate standards?

Ms KAY: Absolutely.

The Hon. DAVID CLARKE: Will you be suggesting that as a reason why they should remain registered?

Ms KAY: Absolutely. That is a very valid reason. One of the significant issues for us relates to quality and standards. I am not a dentist so I cannot make a comment. However, I speak to many people. With the new education courses for dentists, many of the areas surrounding prosthetics or the supply and fit of dentures seem to be reducing. I speak to many people, for example, new graduates and so on. When I ask them what they know about prosthetics and whether or not they are interested they say, "No. That is the work of the prosthetist or the technician." It seems to be reducing. My other query is: How do we provide appropriate gate-keeping mechanisms and governance with the issue of appliances if respect, trust and education are not there?

CHAIR: Thank you for appearing before the Committee today. As I indicated to you earlier, we would like to send you some questions on notice, as we did not ask you a number of questions. We will be making public those answers and the transcript of your evidence.

Dr FISHER: As some of the issues that were raised have a certain complexity to them, the Committee might need to look at them further. I would be happy to comment on those issues. A lot of it centred on competency development and in which sector it is happening. There was also the credentialling mechanism and, ultimately, the outcomes for the public. I am sure that some of the things that were raised will require further

comment if the Committee is to be able to make a good judgment, in particular, relating to the aspect of oral care. You referred earlier to all the reforms that are going on and there might be more to come in that area.

CHAIR: I suspect so. Thank you very much, Ms Kay and Dr Fisher.

(**The witnesses withdrew.**)

BERNADETTE IVY EATHER, Director, Clinical Governance, North Sydney Central Coast Area Health Service, affirmed and examined:

CHAIR: On behalf of the Committee, thank you for your willingness to appear before us today at late notice. I understand that you have been issued with a copy of the Terms of Reference of the Committee's Inquiry and also with some information relating to witnesses appearing before Parliamentary Committees. Is that correct?

Dr EATHER: Yes, it is.

CHAIR: In what capacity are you appearing before the Committee today?

Dr EATHER: As Director, Clinical Governance, North Sydney Central Coast Area Health Service.

CHAIR: Because of time limitations there might be questions that we will be unable to ask you today. Would you be willing to provide written responses to questions that the Committee might forward to you?

Dr EATHER: Yes.

CHAIR: Those answers will appear as evidence on our public record. Do you wish to make an opening statement?

Dr EATHER: Thank you for having me. I feel slightly lonely, being one representative for the Area Health Services, the large institutions from which we have come. First and foremost, overwhelmingly we have a collegiate relationship with the Health Care Complaints Commission [HCCC] and we work closely with it on a lot of issues. There are some ongoing issues relating to transparency of process. Notwithstanding that, I state for the record that we have a collegiate relationship with the HCCC.

The Hon. DAVID CLARKE: You referred to transparency of process problems. Would you like to elaborate on that aspect?

Dr EATHER: Certainly. When a complaint is forwarded to the Health Care Complaints Commission we respond, do an investigation and provide our response to the Health Care Complaints Commission. If the complaint is resolved we receive notification about whether it is going for conciliation or investigation. We are not made aware of the criteria that are used in making those decisions. Some complaints are resolved while others go to conciliation but we are never made aware of the decision-making process and we do not know whether it is a criteria-based approach. It certainly does not appear as though it relates to the severity of the complaint that has occurred.

The Hon. DAVID CLARKE: Have you raised that concern?

Dr EATHER: We would raise those questions. It is not always a surprise when that information comes back. Based on our experience, we meet with complainants, provide them with additional information and provide our response to the HCCC, and we are confident that it will reach a resolution. However, occasionally when some go for conciliation and investigation we ask why that is occurring. I have not seen the list of criteria that is used to determine those decisions.

Reverend the Hon. FRED NILE: When you are notified do you notify other people? Are you involved in notifying the doctor or the person who is perceived to be the centre of the complaint?

Dr EATHER: Yes, certainly. I am the designated senior complaints officer for the North Sydney Central Coast Area Health Service. I would screen any complaint that comes in from a risk management point of view. I determine whether anything needs to be done to contact the complainant or the Coroner and I ensure that officers are made aware of that. I then forward that to the health service or to the hospital directly and it would then be investigated. It might involve particular staff in a ward or a unit, or it might directly involve the medical or nursing staff. They provide a response and I sign off on all the final responses that go back to the Health Care Complaints Commission.

Mr NATHAN REES: What difference is there, if any, between the screening to which you just referred with regard to employers such as staff specialists as distinct from visiting medical officers [VMOs]?

Dr EATHER: Are you referring to complaints about an individual clinician?

Mr NATHAN REES: Yes.

Dr EATHER: It depends on whether our employees are contracted employees or permanent staff members. The overwhelming majority of complaints that we receive relate to systems or processes of care rather than to individual clinicians. They tend to relate to issues of communication around care, as they were not informed about treatment options. Although an individual clinician may respond—it would be sent if it were either a VMO or a staff specialist—complaints tend to relate more to systems of care, so we treat them equally.

Mrs JUDY HOPWOOD: I would like to delve into the area of Service Check Registers. A few comments have been made relating to the right of review and to information contained in Area Health Services relating to employees and Service Check Registers. What reviews might take place if a practitioner were aggrieved about the way in which a complaint were made or processed, and information existed about that employee?

Dr EATHER: Certainly. A concern or complaint about a clinician would be managed under the management guidelines and processes for concerns or complaints about clinicians. We would have followed those processes to investigate the case and the clinician would have been advised that that was occurring. It would be rare for someone to be placed on the Service Check Register without being formally notified and without having gone through a formal identification of the issues to be raised that would be under investigation, who would be the investigating team, and the process and timeline of the investigation. If the end result were, for instance, unsatisfactory personal conduct and a person was suspended from duty during that time, depending on the risk that we perceived for patient safety, he or she would automatically go on the Service Check Register.

If, at the conclusion of the investigation, we found it not to be unsatisfactory professional conduct, we would have an opportunity to remove the name from the Service Check Register. Grievances primarily would come back to me as Director, Clinical Governance. I would then review that process of investigation to ensure it was suitably independent and at a peer review level. In some instances a dental practice might be sent through internally to the health service senior dentist. If we are talking about dental technicians they do not work at the level of a dentist so we would ensure that we had somebody on the review team with equivalent experience and training to make a judgment about whether or not it was unsatisfactory professional conduct. I conduct a review of all that to ensure there has been a degree of transparency in the process, and I determine whether or not that grievance is to go further.

Mrs JUDY HOPWOOD: If the person or the employee is still unhappy does it go to the Director-General or does it go further?

Dr EATHER: Certainly it would be notified through the Chief Executive to the Director-General that that individual was not satisfied that their name remained on the Service Check Register, that they disagree with that. So we would normally refer that back through to the department.

Mrs JUDY HOPWOOD: Would you have an opinion about whether or not there should be a more independent review to take it out of the Area Health Service in terms of perhaps some things that could be vexatious— I am just broadly looking at it—to give it a more independent, like a third review, if that should be necessary?

Dr EATHER: Certainly if it was to get through all those processes, then referring it to a third party for a review of that outside of, say, myself as a director of clinical governance, I think that there would certainly be opportunity to do that and I do not think we would be averse to that occurring. Normally in the first instance, particularly if it was something that was vexatious, we would rather try and manage that internally first.

Reverend the Hon. FRED NILE: I note that in your submission you were concerned that the Health Care Complaints Commission should give a monthly update on an investigation to keep you informed of the progress of the investigation. That is not happening?

Dr EATHER: No. Sometimes significant periods of time can go before we receive any information about where the process of investigation is up to. The particular difficulty that we face with that is, say for instance it is a staff member, there have been sufficient concerns that that has gone to the Health Care Complaints Commission; it is about an individual clinician. As an Area Health Service, from a risk management point of view, we may have suspended them from clinical duties, and although we may have done an internal investigation we are waiting for the review of the Health Care Complaints Commission.

If it is a member of nursing staff, for instance, they might be off with pay for some considerable amount of time. If it is a VMO they might be off without any pay for a considerable amount of time. So the opportunity to be able to provide feedback or for us to have some understanding of the progress of that, notwithstanding the privacy issues—and we do not want the detail necessarily—is it still under investigation; it has been referred for independent peer review, we are waiting for the review to come back; just so that we had some ability to track the progress would be really important, particularly for the staff members in question.

Reverend the Hon. FRED NILE: You have also raised the issue that there should be some ability for you to ask the Health Care Complaints Commission to conduct an independent review where there has not been a complaint, but the Commission does not have the power to investigate matters unless there is a complaint. What is the purpose of an independent review where you have suspicion about the conduct of someone in your area of responsibility?

Dr EATHER: I am not sure if that came particularly from our area. Do you know what issue number it was that that was pertaining to?

CHAIR: I think it was something that the Commission actually raised, that sometimes they find the Area Health Services—it is not specifically the Northern Sydney Central Coast Area Health Service—but some health services do request a review, but that is not something that the Commission has the power to conduct, they can only, as Reverend the Hon. Fred Nile said, respond to a complaint. In their submissions I think they were just commenting that there is this misconception out there. So I guess the question is, is that a misconception that is also apparent within your Area Health Service? Do you refer matters for review?

Dr EATHER: I can completely understand how that misconception occurs, and sometimes it is negotiating, particularly, the responsibility of the Chief Executive to notify regulatory bodies about "on reasonable grounds" when they feel there has been unsatisfactory professional conduct and what constitutes "on reasonable grounds". Therefore, I think occasionally it can be referred to the HCCC to determine whether or not we now have reasonable grounds to suspect that. So I can see how that might occur.

I think we are quite clear that we cannot be the subject of the complaint and the complainant at the same time. If we were to refer something to the HCCC it will come straight back to us to say, "Please investigate". So I understand how that misconception may occur. But certainly we are quite clear that complaining about ourselves means that we would get the complaint back anyway. It is not necessarily a process conducive to getting an outcome, so we would not do that.

CHAIR: That does clarify it, because that was one of the issues they raised in their submission to us.

Dr EATHER: And sometimes it may just be the uncertainty of should this be referred to the HCCC. So I can see how that could occur.

Mrs JUDY HOPWOOD: I might ask, just on that point, do you think there are certain incidents that occur that should mandatorily be referred to the HCCC and immediately taken out of the hands of the Area Health Services?

Dr EATHER: It is really difficult, I suppose, from a very pragmatic point of view around how to navigate some of those significant concerns. We provide, under New South Wales health policy, a Severity Assessment Code [SAC] to our incidents and complaints that occur. So we stratify all complaints and all incidents that occur. That is very different for the HCCC; there is no stratification in terms of what constitutes for us a SAC 1, in which there would be an incident, the death of a patient as a direct result of the provision of health care. The definition is very clear: death unrelated to the natural course of illness and differing from the immediate expected outcome for the patient. We would do an investigation around the systems of care.

But there is no, I suppose, equivalent stratification within the HCCC about what would constitute an automatic notification. We are very clear around professional conduct of staff; what we would instantly notify the Medical Board, for instance, about impaired clinicians. I will say it is a little bit of a grey area in that case. There is nothing that would be an automatic notification. We will get SAC 1 incidents, there are also semblable event—suicides and things—that may never be the subject of a complaint but we would investigate that regardless. So unless there were some criteria or stratification of complaints, if a SAC 1 came in, that would automatically go to the HCCC. But without that stratification it is very hard to know. And when you are a clinician on the ground you take any complaint seriously. When you are close to it and you are close to the family and they have suffered as a result of your care it feels like the worst thing that has ever happened to you as a clinician. So trying to put some objectivity around it is really important.

CHAIR: Is there a view within the Area Health Service about that issue of stratification, because that very point is something that was raised in other submissions, that they are not categorised as what are seen as more significant to perhaps less serious complaints?

Dr EATHER: Certainly representing my Area Health Service, but it is certainly something we discussed as directors of clinical governance across the State, there is that sense of—and I suppose it harks back to the question of Reverend the Hon. Fred Nile—the transparency about what might go to resolution and what might go to conciliation. Some of the most serious complaints go to resolution very quickly and sometimes that is where we are a bit—"What criteria have you applied?"—when we apply a very different rating on the severity of those. So I think that would be very helpful in terms of what that process is, certainly from the outcome but also what we are required to notify.

It is also around the assessment. The time frames for the HCCC are different to the rest of our time frames within NSW Health. We have a KPI—a key performance indicator—for our health service that complaints reach resolution within 35 days. The Health Care Complaints Commission time frame is shorter. So, say I have an intensive care unit, for instance, at St Elsewhere's and we were to send the two complaints in on the one day: one of them is a SAC 2, so it is a much more serious rating, and one is a SAC 4. The requirement for the nursing unit manager or director of that intensive care unit is that they respond to the HCCC complaint first because we have a much shorter time frame. Yet a complaint that has come maybe through the Minister's office or has come directly to the health service, we have a longer period of time. I am not saying people do not make a common sense judgement and of course address the one most serious, but under the requirements the HCCC must be answered first regardless of how severe that incident is. That is just from a practical point of view.

The Hon. DAVID CLARKE: How do you see the national scheme specifically impacting on your Area Health Service?

Dr EATHER: Sorry, the national scheme?

CHAIR: Accreditation and registration.

Dr EATHER: Sorry, in relation to the accreditation. I think it is probably something the particular craft groups would have a much more academic opinion about or more informed opinion than I would have. Often when you are dealing with an individual, a complaint about an individual clinician, it is then quickly going, "What board are they registered under?" I am quite clear on what the Medical Practice Act is and we know what the notification for that is. So having some uniformity around that would be helpful in terms of having a code of conduct for all professionals registered. But I think their particular craft groups would probably be able to provide a more informed response to that than I would.

Mrs JUDY HOPWOOD: Just referring to Committee members taking their oversight role seriously, is there anything you would like to suggest which would assist the Committee to exercise its oversight role?

Dr EATHER: No. As I said, thank you very much for the opportunity to come here. I think they were the main points covered. I think, particularly putting on my director of clinical governance hat, patient safety and clinical quality—being the sole reason I am employed in the Area Health Service—is really looking at issue 28 around the health service being informed about when a complaint is made directly to the Health Care Complaints Commission about an individual clinician. Again, what is the severity of that complaint and the need for us, from a patient's safety point of view, to be informed about that?

I understand the issue at the moment is that the Area Health Service be notified that the complaint has been made. But perhaps that should be extended to all areas of employment. Obviously, a lot of our, particularly, medical staff work in the private sector as well. So notifying all employment bodies if it is a significant concern raised about a clinician.

CHAIR: If you get that notification then is there a course of action that is prescribed for the Area Health Service?

Dr EATHER: We currently do not receive that notification back from the HCCC. We tend to be the notifier, so we are often the detectors of a complaint or we are notified about the complaint and then we would refer that to usually the Registration Board or, obviously, pending the due process, to the HCCC. But we do not get the information back. The Medical Board do provide us information back. If they know a clinician was working at a private hospital and there had been a complaint and conditions on the registration about that, that will be notified back to a public employer. But we certainly do not currently get that information from the HCCC. So a very serious significant concern could be raised about their conduct in private practice that we are currently completely unaware of and they continue to practice in our health facility.

Reverend the Hon. FRED NILE: I noticed in the submissions that were sent to us by Wendy Hughes that you are very complimentary about the actual HCCC and its operation. You use the words, "It has improved tremendously overall". So that has been your experience?

Dr EATHER: Yes, definitely.

Reverend the Hon. FRED NILE: We have been working to try to help get that improvement. We are very pleased if it is actually working out in practice.

Dr EATHER: It is. I think too, as I said, we do have a very collegiate relationship with them: the ability to ring up and, of course, moving into the information digital technology, having everything emailed and scanned. It was very difficult for us when everything had to come hard copy with original signatures and that, realistically, would eat into five days of our investigation time. So just small things like that. But certainly, the contact; if they are unsure they will contact us. If we are concerned that we do not know why this has gone to conciliation, then the ability to pick up the phone and ask the questions, although we are not necessarily aware of what the criteria are. But those processes have certainly improved and we do have a good relationship with them, which is pretty vital for certainly me in my position.

CHAIR: In your role in clinical governance do you have a lot of contact with individual complainants—that is, health consumers or carers of health consumers? If so, do you have a perception of their experience of the Health Care Complaints Commission? Do you find that complainants are satisfied? Are they concerned about the lengths of time or lack of contact or are they very satisfied?

Dr EATHER: Obviously I can only speak from personal experience. I tend to deal with individual complainants unfortunately when the most severe incidents have occurred. Primarily we like the hospitals and health services to be able to manage those themselves. The reality is that a lot of complainants do not identify with an Area Health Service—they do not know who we are. My role is often more governance to ensure sure that the systems are in place within the hospitals and health services. Equally, there are complainants who want nothing to do with the hospital administration, particularly in the most serious of adverse events. So I would then provide that role. Usually my role would be an open disclosure after an investigation had occurred: these are the findings and this is the incident that occurred. Certainly I have provided personal assistance to some of our complainants who then say, "Well I am not happy." I then say, "There is the Health Care Complaints Commission" and I will go through that process with them.

I am not sure that the open disclosure policy that we would follow in public health is necessarily occurring with the Health Care Complaints Commission—it may well. My understanding is that they receive the contact and the written report but the value of sitting down face-to-face with somebody with a report and saying, "This is what has been found. Are there any other questions?" We live in such an asynchronous world already in terms of communication and being able to have that face-to-face communication is really important. I have not had many direct complaints that all they got was a piece of paper. Having said that, I will occasionally get follow-up letters that say, "The Health Care Complaints Commission has said they have resolved it but I remain unhappy. They are not going to reinvestigate. What are you going to do?" The value of sitting down with people

obviously can never be undervalued. I certainly encourage that the open disclosure policy that we follow very closely should really be matched with the Health Care Complaints Commission.

Mr NATHAN REES: There is one element I would like you to explore for us. The more transparent a system is and the more open disclosure there is around adverse incidents or sentinel events or whatever on the face of it appears to be a good thing, and I do not think people would argue with that. The downside for administrators and governance of the day is, of course, that when you get the cultural change right the number of incidents increases. In your experience has there been a change towards more open disclosure by clinicians and facilities in recent years? If so, do you think that is sustainable?

Dr EATHER: Yes, definitely we are moving much more and the policy is being widely used. We have, as you know, the process of the root cause analysis after SAC 1 events. Certainly in our Area Health Service the final two recommendations in every report we do is: first, that the clinicians and staff in the ward or unit that the incident occurred are provided feedback on the investigation; and second, that the patient or their family are provided with the outcome of that investigation. I think what we are seeing more is that there has been open disclosure; an incident has occurred, an apology has been offered and that is often the end of it from the family's point of view. We are getting a lot better at then coming back in a month's time and saying, "These are the findings of the investigation and these are the improvements that our area, our hospital, our State are making as a direct result of what happened to your family member." I think that is really powerful for a family. Most people complain because they want an apology and they want to know it is not going to happen to somebody else. Our ability to say, "This is what we have done" is the positive, and we are really enjoying being able to say in the worst possible incidents and outcomes that occur that we have the opportunity to see some improvement.

I think we are getting there. I think for the smaller incidents, as in those that are less severe in terms of not resulting in great harm or a near miss, it is probably not as entrenched as that is just par for the course. But certainly for the most severe, the SAC 1 and SAC 2 incidents, we are getting a lot better at doing it. It is really hard. We are doing a lot of work on skilling-up our senior medical and nursing staff on how to do that. So we are getting there and from my role as Area Director of Clinical Governance we are trying to ensure that that process does occur by embedding it into a recommendation for all our root cause analysis. Yes, I think we are getting there. We tell people that it is actually the right thing to do and the question always is, " Will I get sued if I say sorry?" The answer is, "It is very clear under civil liability that no, you will not." So saying sorry is a good thing and we really try and encourage that.

Mr KERRY HICKEY: Will you explain to me very briefly what SAC 1 and SAC 2 represent?

Dr EATHER: It is a matrix; it is a severity assessment code for incidents and complaints that occur. We can apply it to both clinical and corporate, but primarily it is clinical. There is the consequence to the patient and then the frequency is the other part of the matrix that that would occur. So a SAC 1 incident is defined as death unrelated to the natural cause of illness and differing from the immediately expected outcome. These are usually as a result of an error in the health care system resulting in the death of a patient. That is obviously the most serious consequence. So it is: serious, major, moderate, minor and none. So in the matrix it is really the frequency, this is likely to occur once or twice a week, say a medication error, which unfortunately occurs daily but they very rarely result in a serious adverse event in terms of the consequence to the patient. It is essentially a matrix, with SAC 1 being the most severe and SAC 4 being no harm to the patient—it may be something that happens frequently with no resulting harm. We place that into the grid, the 20-point matrix, and we do the same with a complaint.

CHAIR: The time for questions has expired. On behalf of the Committee I thank you for your time. Again, it has been such very short notice—

Dr EATHER: I know. I only had 24 hours notice so I hope I have answered all your questions.

CHAIR: Your evidence has been very helpful. The Committee secretariat will probably send you some further questions for you to provide a written response.

Dr EATHER: Certainly.

(The witness withdrew)

(Short adjournment)

HELEN JANE TURNBULL, Solicitor-Manager—Disciplinary Services, Avant, Level 28, 580 George Street, Sydney, sworn and examined:

CHAIR: I understand you have been given a copy of the Committee's Terms of Reference for the Inquiry?

Ms TURNBULL: I have, thank you.

CHAIR: You have received some information for witnesses appearing before Parliamentary Committees?

Ms TURNBULL: I have.

CHAIR: In what capacity are you appearing before the Committee today?

Ms TURNBULL: I appear for Avant, which is the largest defence organisation in Australia for health practitioners.

CHAIR: We may run out of time for questions today. If we do, the Committee may write to you with some questions. Would you be willing to respond to those in writing?

Ms TURNBULL: More than happy—and happy to elaborate, as well.

CHAIR: Do you wish to make an opening statement?

Ms TURNBULL: A very short one, if I may. Thank you for the opportunity of appearing before the Committee. Avant certainly appreciates that. As we are the largest indemnity organisation in Australia, with approximately 49,000 members, we have a wide range of assistance that we can give to particular members. The assistance can range from helping out in civil proceedings, in coronial and in criminal proceedings, but just as importantly, in professional conduct. Professional conduct can be divided in three ways, as you are aware: into performance, into health, and into actual disciplinary proceedings.

Over the years we have been working closely with the Health Care Complaints Commission from the very early days, even before 1993. We have formed a relationship with both the Health Care Complaints Commission and the Medical Board and have been able to have ongoing discussions and resolving difficulties over many years. We played a significant part in the Campbelltown Inquiry. I personally acted for the 45 doctors that were in the Campbelltown Inquiry in the disciplinary process. Avant has that intricate knowledge and I have been in this area for many years. I have some specific expertise.

Reverend the Hon. FRED NILE: I have a general question. How fair do you think the HCCC is in regard to complaints against doctors and the operation of Medical Boards and so on? Are you happy with the operations?

Ms TURNBULL: It would be fair to say that it is constantly improving its processes and its approach. I think that it has come a long way from the early days when the unit was set up and it was extremely pro complainant and extremely prosecutorial. Nowadays there is much more evenness towards both complainant and respondent. I think that is particularly important. This is not an Act for complainants; this is an Act for handling complaints in a fair and appropriate way. In that respect, the more balance there is of power between the HCCC and the Medical Board in a co-regulatory model, the fairer they are and the better is the result. So, yes, I believe that things have improved. There are things that could improve more. Certainly there have been some big inquiries in the past which have shown up significant shortcomings. However, the Medical Board and the HCCC have improved.

Reverend the Hon. FRED NILE: Some of the medical bodies are critical of the HCCC being both a notifier and an investigator. Do you see any tension in that area?

Ms TURNBULL: I am not sure what you mean by notifier. It is a difficult situation because elsewhere in Australia, if I take correctly what your question means, in many States the medical boards are the complainant. They can be the investigator, they can be the prosecutor, and they can be the decision maker all in

one body. Common sense and an issue of fairness spring to mind. That is unfair and it is inappropriate because it smacks of an incestuous nature within the board and does not give full rights to the individual. With the HCCC, they became a separate body because of this issue of concern, and they developed this co-regulatory model. If you give further powers to the HCCC that combine those different roles, that reduces the chance of the individual having the appropriate procedural fairness or the appropriate rights and natural justice. So, yes, there are difficulties in combining a number of roles in one body.

Mrs JUDY HOPWOOD: Do you consider the recent legislative changes—for example, the introduction of mandatory notification—have made noticeable improvements to the health care complaints system in New South Wales? What has your client's experience been of the introduction of mandatory notification for practitioners?

Ms TURNBULL: No, I have not noticed any difference. There is a lot of uneasiness outside in the profession. Of real concern, or one of our real concerns, is the doctor who may be suffering from depression and who is desperate to speak to his colleagues about it; someone to maybe step in and take over the early morning session to help him out. He can work. He is capable of working. There are no issues of concern to his colleagues, and he is very keen to help himself. The way to help himself in the health environment is to talk to colleagues and work in a team environment.

He cannot do it. He is afraid. He is afraid that that colleagues will say, "This doctor has got depression. I must report." There is an air of nervousness. “We do not know what mandatory reporting is all about, but we feel that if anyone approaches us with a health problem, or if there is any issue at all about some sort of sexual misconduct, then we need to report.” So there is this sense of isolation, this sense of feeling that we are not coming together. Certainly it goes very much against the premise of programs that have been set up to assess health professionals getting out there in the workforce, like the performance program and the impairment program.

The Hon. DAVID CLARKE: What is a practical way around this problem that you raise?

Ms TURNBULL: It appears that mandatory reporting is here to stay. It is quite clear that it is in the national legislation adopted by the national law, and therefore it is something that the public feel they need to have in the legislation. In that respect we need to educate our health practitioners, the Boards and the complaints bodies as to what it means by mandatory reporting. The New South Wales Medical Board has an excellent guideline where they involve the interested stakeholders, including a range of defence organisations, to make it very clear in commonsense language when you should mandatory report and when you should not. That would be the first step in relation to this coming legislation in New South Wales.

Mr NATHAN REES: What about the scenario where you have a medical practitioner who is on some sort of program for dealing with, for example, their substance abuse issue and they continue to practise? Would you see them as a patient?

Ms TURNBULL: I do not see why not. A good doctor is a good doctor, no matter what the problems are. This is the qualification: If he is under some sort of program or structure that supports him in working, we do not want to lose those health practitioners because they may have a depressive illness or they may have some form of addiction. We are only human, and health practitioners are no different. You go to a doctor because he is good. If he has a problem, and if it is under control and there is a good structure around him, where he is maybe on urine testing, maybe on blood testing, he might be having a supervisor, he might have a mentor, he might have conditions on his registration which say he cannot do the nature of this work, then why not?

Mr NATHAN REES: But do you have a view on whether the patient should be aware of any of those things?

Ms TURNBULL: I believe the patient should be aware that there are employment restrictions on the practitioner's registration, and that is what happens now. I believe that is sufficient information to indicate that the New South Wales Medical Board is satisfied that that health practitioner is out there practising safely according to these conditions. It may well indicate on the register that there are health conditions, but I do not see that it is important for the patient to know what health conditions are on that registration. I believe that it is much more important to protect the individual practitioner, to assist him in getting back into the work.

Mr NATHAN REES: Walk me through why it is more important for a defence organisation to know than it is a patient?

Ms TURNBULL: I did not say that; I said the doctor or other health practitioner. I believe that the Medical Board has taken on a role of looking after these people. I believe it does an excellent job in relation to the health program, as internationally recognised. It places conditions on the registration that provide security for the public. That is its paramount consideration when it is running this program: the protection of the public. If the Board places conditions in relation to employment on the registration that is for public knowledge, I consider it sufficient. It is of no relevance to the patient whether there is a condition on his registration saying that he needs thrice-weekly urine testing; there is no relevance at all. It does not help that patient to decide whether he should be going to see that doctor or not.

The Hon. DAVID CLARKE: But it is relevant to the patient that there is urinary testing for drug abuse? That is important to the patient, is it not?

Ms TURNBULL: You have to look at it that someone has taken responsibility for this particular practitioner. It is not the patient; it is the Medical Board. It is important for the Medical Board to know that he or she might not be attending the thrice-weekly urine testing, or that the test results have come back. Therefore, the Board takes instant action in dealing with those sorts of cases. It is a question of: How do we best protect the patient? How we best protect the patient is by putting in a structure or conditions on the registration to look after these health practitioners.

A patient is not trained in urine testing; a patient is not trained on what is the consequence of a health practitioner being ordered to attend psychometric testing. They do not know what are the consequences of that psychometric testing, whether it is a good result or a bad result. The Medical Board is stepping into the shoes of the public to look after the patients. The patients should not take on that burden of reading a list of conditions that might send them off on a wild tangent.

The Hon. DAVID CLARKE: The patient may be happy to take on the burden of knowing whether or not a doctor who is treating them has a drug addiction. Should they not have that choice?

Ms TURNBULL: I believe that it is a balance between a health practitioner getting back to work, if he has a problem. I believe that having the knowledge out there that there is a body that is looking after these doctors, and knowing that it is a body that has very strict control over these individuals, alleviates the need for patients to know these conditions. I say that, having a list of conditions for urine testing, or for psychometric testing, or for supervision, unless we release all the reports that relate to his history, the fact that he might be having thrice-weekly testing now but he has not touched drugs for the last two years—does that mean that when that comes off onto the register he is not going to be able to work because not one patient is going to turn up at his door? I think the best approach is for the doctors to be controlled by a body, and that the patients will have the information that shows that there are conditions on their registration and that if they have any concerns they have full rights to ring the Medical Board and talk to them further.

CHAIR: Are the practitioners that you represent also of that view? Would they and the colleagues they are working with, or perhaps that they are referring patients to, want to know that information? Have they expressed a view to you?

Ms TURNBULL: In relation to their health conditions?

CHAIR: Yes.

Ms TURNBULL: The Medical Board requires that. The Board requires that the colleagues he works with have a full set of the conditions. It requires that the head of the practice should have a copy of the conditions, and that it is mandated, so that the colleagues are fully aware of, and are watching out and caring for their health practitioner, and watching out if there are any problems—as far as I am aware.

Reverend the Hon. FRED NILE: There has been a lot of publicity about the high premiums that doctors have to pay for insurance in certain areas so they will not practise in those areas. Do you have any view on that, or about what can be done to make the system work more efficiently?

Ms TURNBULL: I think that is not in my area of expertise. Certainly I can take the question on notice and get our corporate advice on that. However, I can answer it in general terms. There is always this balancing act between government involvement and defence organisations, and the fact that specific specialisations such as obstetricians and gynaecologists have a higher claim. The pragmatics of it are that there will be a higher premium which will follow. It is a question of a balancing act as to whether you even out the premiums across the board or whether you target certain professions and say, "This is your claims history as a profession as a whole and this is the premium that we can charge." I am not an expert in this area, and certainly I can take that question on notice. But the reality is that it is an ongoing and difficult problem.

Reverend the Hon. FRED NILE: Obviously given some of the large payouts, there is a way of having a cut-off level—?

Ms TURNBULL: That is right. There are certain cut-off levels that have been introduced since the crisis many years ago, and certainly those sorts of governmental processes have been working to the defence organisations' advantage—well, to the members' advantage, not to the organisations' advantage. Remember, we are a mutual organisation, we are here for our members; we are not profit-making.

Mr KERRY HICKEY: Do you consider that there is consistency in the decision-making between health care complaints and the Area Health Services across New South Wales?

Ms TURNBULL: I believe that there are two separate areas, and the HCCC is obviously directed by its Act. The health services are directed by policy directives and by levels of conduct, that is, SAC 1, SAC 2, for example. Therefore they come from a different angle and therefore often there is a variation in relation to maybe the same matter but they are taken in a different way. For instance, with the Health Care Complaints Commission they obviously are investigating serious complaints and they will have to consider whether conduct is significantly below the standard and whether it meets satisfactory professional conduct. In relation to health services, they only have to think about that as a referral on to the Medical Board but the reality is that there is a difference between mindset with policy directives, so I can see that there is a divergence and we do experience it.

Mrs JUDY HOPWOOD: Membership of Avant is open to registered Australian health care professionals and medical students. With respect to New South Wales, in Avant's experience, do any registration bodies function more efficiently and effectively than others with respect to complaints handling?

Ms TURNBULL: I consider that the New South Wales Medical Board is an extremely good example of how well a Board is run. That is not to say there are not issues with any regulatory authority but in comparison the Medical Board is much more sophisticated. It has over the years that I have been involved with it developed two incredible programs, the performance program and the impairment program, where they have moved away from the disciplinary process and followed the international lead, I think, from Canada and places such as that where they have recognised that there are ways of looking after the health practitioners to bring them up to standard without disciplining them or striking them off.

CHAIR: Thank you. There will probably be some other questions that we have not got to today because we are out of the time we allocated for you. So we will send those to you and we would appreciate it if you will be able to reply to those in writing.

(The witness withdrew)

PETER GEORGE DODD, Solicitor, Public Interest Advocacy Centre, Level 9, 299 Elizabeth Street, Sydney, affirmed and examined:

CHAIR: In what capacity are you appearing before the Committee today?

Mr DODD: I am appearing on behalf of the Public Interest Advocacy Centre [PIAC].

CHAIR: I understand that you have been provided with a copy of the Committee's Terms of Reference for the Inquiry.

Mr DODD: Yes, I have.

CHAIR: I am sure, because I know you have appeared before other Committees, you will have information for witnesses appearing before Parliamentary Committees.

Mr DODD: Yes, I am aware of that.

CHAIR: Would you like to make an opening statement before we go to questions?

Mr DODD: Yes, I will make some initial comments. Our submission sets out the history of PIAC, especially in relation to the Health Care Complaints Commission. PIAC was there at the formation of the Health Care Complaints Commission after the Chelmsford Royal Commission, and was active in the formation of the HCCC. So we have a long history of involvement in these issues. We also note the maintenance of the HCCC as an independent assessment and investigation and prosecution body under the national regulation scheme for health professionals. That issue formed part of our earlier submissions, and I acknowledge the role of this Committee in relation to getting a good outcome for the consumers of New South Wales in terms of maintaining the Commission in that role.

PIAC is dissatisfied that that model is not being adopted Australia wide. I guess that is not a matter for this Committee but I just think it should be put on the record that we are a little bit disappointed that that model has not been adopted throughout Australia. PIAC has also had a long history in campaigning for a Charter of Health Care Rights, and we positively welcomed the decision of the Australian Health Ministers, I think it was in 2008, to adopt the charter. But the charter is out there somewhere. What PIAC is saying is that it needs to be enforceable, and it is an important part of our submission that the charter should be one of the reference points for assessing health care complaints, and that is why we have submitted that it should be a schedule to the Act and included in the Act.

PIAC's submission also emphasised the need for greater accountability and transparency in deliberations by the Health Care Complaints Commission. We acknowledge that the HCCC has got a lot better in this area recently, and certainly more recently has been adopting the practice of giving reasons for some of its decisions. We think it is time now that that should be mandatory and that the Commission should give its reasons for all its decision. Finally, in terms of this opening submission, in our last submission last year we raised the issue of whether the Commission should accept non-written complaints, and I think there are strong reasons for that that are set out in the report. I note that we now have the national health practitioners regulation national law and section 146 allows that to accept non-verbal complaints. So we will have a situation where perhaps someone contacts the national body with a complaint, that complaint is not in writing and then it will be referred to the HCCC as part of the new regime. So in effect there will be non-verbal complaints in the system. So what we are submitting is that the HCCC should catch up with most other organisations, such as the New South Wales Ombudsman, and accept non-written complaints.

Reverend the Hon. FRED NILE: In your evidence a moment ago you were confusing non-verbal with non-written.

Mr DODD: Sorry, yes, I did. We want verbal complaints accepted. I am sorry if I have made a slip there. If you are a disadvantaged person out there it is very difficult for someone to say over the phone, "No, put it in writing", and in particular if it is a situation where there needs to be some urgent attention given. It is just a restriction that I think is unnecessary. As I said, most organisations of a similar nature accept complaints over the phone. They all say, "Please put it in writing if you can", and I would advise people, and I think the HCCC is continuing to advise people it is better to put a complaint in writing. That would be almost my advice to people,

but that does not mean that if someone does not want to do that they should not be allowed to do that and have that complaint have equal force.

Reverend the Hon. FRED NILE: You mentioned that you would like the Australian Charter of Health Care Rights to become a schedule to the Act.

Mr DODD: Yes.

Reverend the Hon. FRED NILE: What would be the practical impact of that on the number of complaints and other matters?

Mr DODD: I do not know whether it would have any. If you are saying it would increase the number of complaints, I would doubt that. It is very interesting, in the last couple of weeks I was in New Zealand and I had a chance to talk to some people on the Health and Disability Commission there and they have had for a long time a system where they have a charter of health rights, which is part of their complaints system. They tell me that that is accepted by health professionals and consumers in New Zealand. I do not think there is any evidence there that that increased the number of complaints. I would think—and this is just speculation—that if you were to look at the written complaints that have been received by the Commission, you would probably find that people talk a lot about their rights being violated or that they are being discriminated against by a health body, more than they say, "Yes, my standard of care has been breached" or "Yes, I have suffered a significant departure from standards". People think now in terms of rights. So I do not think it would have any potential to increase the number of complaints but I think it would make it a lot easier for consumers to understand and I think it would also help focus the attention of health practitioners and health providers that they have to look after consumer rights.

Mrs JUDY HOPWOOD: Pursuant to the Public Interest Advocacy Centre's submission, the Committee's discussion paper raised the issue of amending the Health Care Complaints Act to provide for a statutory internal review process for the Health Care Complaints Commission based on complaint handling best practice. The Commission, at page 19 to 20 of its supplementary submissions, examines its current review process in some detail and concludes that, "conducting a more extensive and detailed statutory process for internal reviews of all assessment decisions and investigations would be overly bureaucratic and unduly cumbersome". Having regard to the experience of your clients, do you consider that this is a reasonable response? I note that part of the remit of this Inquiry is to identify any unnecessary complications.

Mr DODD: People who have busy jobs always say that something extra will add an extra burden. I think there are some positive reasons why there should be a more extensive review system implemented. I note that a few years ago the Commission did have a committee that looked at reviews of complaints. That was disbanded; that was never statutory. I do not know if there is evidence of that providing any more burden on the organisation but it did allow consumers another place to go. There are a few examples, because I thought coming here there might be some question about this and there are a few examples. I mean, the Commonwealth Therapeutic Goods Administration legislation has a statutory scheme. Admittedly it says the Minister makes the decision but I think in reality it is a review process in which there is that internal review. There is some analogy there.

In New South Wales we have freedom of information legislation. If you do not like the decision that is made by the first FOI officer you have a right of internal review. That is a very clear set out statutory provision, and consumers then know how their complaints and their requests for reviews are being dealt with. At the moment it is a very ad hoc system where you write a letter to the Commission, a resolution officer reviews it and then does a draft, and then the Commissioner finally ticks it off. It is not a very transparent system. It is one where the Commissioner is effectively reviewing his own decision, and I think that in itself raises difficulties.

As PIAC said in its submission, we have had so-called tort law reform where it means the avenues that people have to seek answers are very limited in terms of health complaints. So it is not an insignificant thing that someone makes a health care complaint and then the Commission decides not to act on it or the Commission decides to refer to somewhere which they have a disagreement about. The whole process should not be treated lightly. Therefore, there should be an appropriate process or review that is set out in the legislation and not just the sort of unhelpful reference to reviews that are in the current Act.

Reverend the Hon. FRED NILE: Are you implying that the Health Care Complaints Commission has made a lot of unsatisfactory decisions in dealing with complaints?

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

CHAIR: I do not know if you have had the opportunity to read the supplementary submission from the Commission, but it responded to the Public Interest Advocacy's suggestion about the charter, "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." Basically, it argues that a whole separate court or tribunal would have to be established for breaches of the charter. Do you have any comment?

Mr DODD: As I said, I have just been in New Zealand talking to people who work in that system. My comment would be that people who complain about a breach of the charter get treated exactly the same as someone who makes a complaint in New South Wales. Sometimes it is treated seriously and investigated and may go to disciplinary proceedings. Court proceedings are referred to there, but that is a rare event. Most of the time it is dealt with the same way as here. It is a resolution process. They have an extensive advocacy service that also deals with complaint resolutions more informally. Like New South Wales, a majority of complaints go into that stream. Every complaint is dealt with. When the Commission accepts a complaint, it assesses it according to the standards. There is no reason it could not also assess the complaint as to whether it breaches the Charter of Health Care Rights.

If it is a serious complaint, it would be investigated and go along the disciplinary path; if not, it is sent on another path. As I said earlier, people now think in terms of rights; they do not think necessarily in terms of breaches of standards or serious departure from standards. They think, "I have a right to reasonable treatment" or "I have a right to access my records" or something like that and "It has been breached." Returning to the question, I do not really think it is going to add a great deal of work, but it is a way of thinking about consumer rights, which is a positive way and is different to the way we think about it. I have to ask, the New South Wales Government, the Commonwealth Government and all the other Australian governments adopted this charter, for what purpose, unless it has some meaning? One way to give it meaning is in this context where it is part of how we determine health care complaints. Another way might be somehow in the accreditation process, but with facilities.

Otherwise, as I said earlier, it is somewhere out there in the ether without any real meaning. We support the charter, but the way it is now does not have any meaning for consumers. The only way to give it meaning is to put it in something like the Health Care Complaints Act. I notice that the HCCC objected to it being made a schedule to the Act. I am not quite sure why. You would make it a schedule to the Act so that if the charter were changed, you could change the schedule. If you just have a reference to it in the Act and the charter changes, then you have a problem. The other question is accessibility for people. The Commission has the charter on its website and that is great, but it would be far better if it were part of legislation that people could call upon.

Reverend the Hon. FRED NILE: Does the Health Care Complaints Commission consider some problems would arise if the charter became a schedule to an Act and needed to be reviewed? Sometimes documents are drafted, for example, a code of rights, but are not in legislative terms or jargon. Would you agree?

Mr DODD: There is always a balance between accessibility for consumers and writing things in plain English and having appropriate words for legislation. You have to find that balance. The New Zealand charter is in accessible form and is in fairly general terms. The Australian charter on health care rights is even more general. I do not think the Commission would object to any of the actual content of the charter because what is in it is fairly non-contentious. I do not think anyone would find any contention at all with what is in the charter.

Mrs JUDY HOPWOOD: Could you explain to the Committee the input PIAC had in the development of the national health care complaints handling scheme?

Mr DODD: PIAC participated in some of the early discussions. We certainly made a submission in relation to the first paper that was released. There was also a discussion in a meeting held in Sydney. It was for the whole of Australia but PIAC did attend that meeting in relation to the consultation process. PIAC also is a member of the Australian Consumers Health Forum, which also has conducted discussions with the Federal Government and the other parties involved in that process. We have been critical of that consultation process. National bodies tended to be asked; State bodies were not, even though it affected the rights of consumers in the States. That meeting in Sydney was for the whole of Australia and there were about two or three consumer representatives—a lot more representatives from the health professions and the Boards. We have made the comment on several occasions that the consultation process has not been fabulous, let us put it that way. Nevertheless, we have used the opportunities we have had to put our views. Early on PIAC and NCOSS wrote to all members of Parliament on that issue because we were very concerned about the outcome for New South Wales consumers. As I said earlier, we were pleased about the outcome at least for New South Wales consumers that came from former Minister Della Bosca's decision to not allow New South Wales to go on the national scheme path for assessment and prosecution of complaints.

The Hon. DAVID CLARKE: The only addition is that you would like an appeal process?

Mr DODD: Yes. There needs to be more independence in who makes the decision. Other organisations handle that by having designated people making review decisions. I am not going to put any proposition forward. I suspect there needs to be another step for people to take it either to the ADT or another body. I think there needs to be more guidance to consumers about what that whole process is about and what outcomes they can expect. Social Security probably is the most complicated example where you get a decision from Social Security, then you seek any internal review, then you can go to the Social Security appeals tribunal and then you can go to the AAT. I am not suggesting that procedure directly can be adopted, but it is probably the best example of how statutory internal reviews can work.

CHAIR: In the original submission PIAC argued that the Health Care Complaints Act should be amended to mandate the provision of written reasons for assessment post-investigation?

Mr DODD: Yes.

CHAIR: The supplementary submission we received from the Commission noted that the Act already requires written reasons. Given this apparent anomaly, are you aware of examples where written reasons have not been given?

Mr DODD: Certainly about assessment decisions, history shows that people have not always received reasons for all assessment decisions. As I said earlier, I think the Commission has improved in that regard and I think more decisions are being made, but they do not have to. Because these decisions are so important to people's lives, they should have to give reasons. I guess what we are also saying is that it is not just a question of giving reasons; it is giving an explanation to people if their complaint has not been proceeded with, which are the words they usually use. People should get an appropriate explanation. In the past, that certainly has not happened. In principle they should provide as much reason as they feel able to so people understand why the decision has been made.

The Hon. DAVID CLARKE: Particularly in an area dealing with their health, which is something of great importance to them?

Mr DODD: Yes. People feel very strongly about lots of issues, but they certainly feel strongly about their health rights. It affects people's lives. An injury, a mistake by a hospital, a mistake by a doctor can have great consequences on their life. They will not necessarily be ones where they can take it to court and sue in the civil jurisdiction, but they want answers and they want to be able to have confidence that appropriate decisions are made. Two- or three-line letters, which has happened in the past, are not satisfactory in those circumstances. People want more.

CHAIR: An earlier witness from an Area Health Service suggested that there should be a face-to-face interview and that the complainant should be taken through the reasons. Would you support that? Do you believe that is appropriate?

Mr DODD: I do not know about face-to-face. When we are talking about assessment decisions, it would be a good policy if there were some contact after all assessment decisions. That does not happen now. I

think it would be a good thing if someone from the Commission in some way ran through those issues with people. I think that would be great. In some circumstances the Commission should talk to people. If you ring up the Commission and seek an answer someone will probably talk to you. As a matter of policy that would be good. I do not know whether it has to be face-to-face; I think the telephone is fine for that sort of thing. I think that would be a very good idea.

Sometimes people come away very frustrated about decisions that the Commission has made. We understand that the Commission has a limited jurisdiction, but members of the public do not understand that. There is nowhere else for them to go. As a Public Interest Advocacy Centre we do not take all comers and give them advice, but occasionally I talk to people about it. If the Health Care Complaints Commission will not deal with their health care complaints there is nowhere for them to go. There is that limited review process and there is nowhere else. It is not feasible for the vast majority of the public to go to a solicitor and to start talking about suing. There is probably no basis and no economic loss.

These decisions are important; therefore, people should be given every explanation in writing. It is important that they are given an explanation in writing. I do not know whether I would agree with some little chat if it were provided instead of a written reason. Every effort should be made to explain to people the reasons for these assessment decisions. That would apply also at the end of the investigation process. That is another point at which the Commission can determine a complaint. Sometimes it would decide after that not to proceed any further with it and people again would be dissatisfied and would need a full explanation as to why that decision had been made.

Mr NATHAN REES: Mr Dodd, essentially we touched on the power and balance issues when an individual is trying to navigate a vast system characterised by experts and all the rest of it. You have given a couple of practical suggestions about how an individual can be supported through that process—whether it is the capacity to make non-written complaints or to use the report-back mechanism. Are there any other practical components? I suspect everyone here has seen individuals for whom the initial injury, for want of a better term, has been well and truly overtaken by events and they become caught up in events rather than the initial incident.

Mr DODD: Yes.

Mr NATHAN REES: One way of ameliorating that is through better communication with someone. Could other practical measures be put in place that we have not canvassed?

Mr DODD: I think the measures that we have canvassed are the main measures. It is also an ethos—being open, being willing to talk to people and being able to deal with them. I am not reflecting on anyone in the Commission and I am not saying that there is not that, but it is important to remember that the Commission has other pressures. It is probably why it is a good reason to have up-front health care rights. In some ways it puts consumers in the driving seat. When you talk about standards, peer reviews and all those things you find that consumers are removed from that. But if you talk about health care rights you find that consumers are very much a part of that. I think that is important. I do not know how you would legislate for that, but the Government has to provide resources to a body such as the Health Care Complaints Commission to provide that. There must be a consistent policy of getting out into the community and telling people what the Commission can do. I think it happens already but it has to be resourced.

The comment that I am about to make has not gone through the PIAC processes. It might be an idea for this Committee to look at whether Aboriginal and Torres Strait Islanders are aware of what the Commission can provide. I know that the Commission has one officer who looks at those issues. I am not questioning its competence or its ability, but is that enough given the health problems of Aboriginals and Torres Strait Islanders in New South Wales and in the rest of Australia? One thing that you and people such as PIAC can think about is how to do that better in the future.

CHAIR: Thank you for your submission and for taking the time to appear before the Committee today.

Mr DODD: Thank you.

(**The witness withdrew.**)

WARREN HENRY ANDERSON, Plumber, 8/115 Ocean Street, Narrabeen, sworn and examined:

CHAIR: I understand that you have been issued with a copy of the Committee's Terms of Reference and you have also been given information relating to witnesses appearing before Parliamentary Committees?

Mr ANDERSON: Yes.

CHAIR: In what capacity are you appearing before the Committee today?

Mr ANDERSON: I am a plumber and I appear here as a representative of the public.

CHAIR: Following our time with you today we might like to ask you some questions. Would you be comfortable providing written answers to some questions that we might forward to you?

Mr ANDERSON: No problem.

CHAIR: Do you wish to make an opening statement to the Committee?

Mr ANDERSON: I have sat in this seat before at another Parliamentary Inquiry that was chaired by Reverend the Hon. Fred Nile. Let me give you the public's perspective of the HCCC. Over a five-year period a lot of people have come to me and said that they were inquisitive about how the HCCC handled our case. I have correspondence relating to the HCCC—letters that I sent to the Director-General of NSW Health and to someone else. There is a general consensus that the HCCC is toothless when it is looking at cases such as this. I am being upfront but that is the position that we have reached. There are repercussions relating to the HCCC and there are limits as to what action it can take in regard to a practitioner or to a department. This is from the public's perceptive.

When reading it one finds that it is worded very softly. I have been through the system and I now know what it means. I have been to hearings and for the past 4½ years I have been through a learning process since Vanessa died. I now understand a lot more. Before I did not know what the acronym HCCC meant and I did not know what it stood for. The majority of information that the HCCC brought together relating to Vanessa's case, which was thorough, was what made up our case for the Coroner. However, you will see the astronomical amount of correspondence that I sent to the HCCC to get that happening. The Commission said, "We have got a case here. I am sorry that we have not been reading this. We had better look at this case." It was only because of my relentless correspondence that we got something happening in the HCCC.

Another issue is the autonomy of the HCCC in relation to the Department of Health, their ability to report to one other, and the cynicism in the general public. People say, "Why go to the HCCC? It is just reporting to the Government." I am being straight down the line because that is where it is. From a general perspective the HCCC has a big grey area. It is set up as a commission to investigate problems, and ours was one such problem. However, there is this general consensus. I was told a million times that I was wasting my time and that I should not go there.

CHAIR: It is not seen as independent?

Mr ANDERSON: Absolutely not. I have correspondence that shows that. A report comes to me from the HCCC that has to be signed off first by the Commissioner. Do you see the cynicism? Correspondence from the then Health Minister went to the HCCC inquiring about our case—correspondence straight from the ministry. To me that is cynicism. To people in the community they are the mice in charge of the cheese. The general public loses credibility in the HCCC. I am being straight, but that is where it is. In my case, the case investigator was exceptional. But my wife, my family, my friends and I were relentless in persuading the Commission that we had a case. We got over that hump but we found that to be extremely frustrating.

People are climbing up the hill but they are dropping back down because it is all too hard. I was blessed because I had a close family, a close environment and all that support. Eventually we established the truth about what happened to Vanessa. The HCCC played a big role in that, but it would not have done so if we had just left it. It was only a momentary thing but that is what we experienced.

CHAIR: You are saying that you believe it was due to your tenacity and perseverance?

Mr ANDERSON: I have it in black and white; I have the correspondence. I was lucky that I had the opportunity and the resources to go through this process relentlessly. I do not believe many people would have the resources and the support that my wife and I had to do what we did and to get where we got with the case. This occurred on 8 November 2005. This year I should be making a speech at my daughter's twenty-first birthday, but I will not be able to do so.

I am here trying to get to a point where Vanessa's death is going to mean some change. That is all I have said. I have never been vindictive to anyone; I have never actually gone down the path of criticising anything other than the system, and the system is wrong. That is where we are at the moment. The Health Care Complaints Commission in the early instances was not getting fluent information from the Royal North Shore Hospital back to them. The cover-ups and the things that we had to put up with were unbelievable, and that is what people in the first instance with the Health Care Complaints Commission find. As I said, it was perseverance to get to a point where the Health Care Complaints Commission did do a great job.

Mr KERRY HICKEY: I hear very clearly what you are saying. You are articulating it very well. How do you see fixing that initial problem of getting over that hump? With the experience you have faced and the problem you have faced what do you see are the changes that are needed?

Mr ANDERSON: I think to start with, with getting people on side—empathy. We were a nuisance. We were picking at trying to find out what happened with Vanessa and there was the empathy that started off from the hospital—and the fact that there was no transparency there coming back for the information for the Health Care Complaints Commission. My call is that that is where there was not the cooperation. If I saw cooperation and transparency at the hospital helping out with the Health Care Complaints Commission inquiry I would say "fantastic", but I did not see that.

Mr KERRY HICKEY: So you are saying the Area Health Services need to probably work more closely with the families that have been putting the complaints forward?

Mr ANDERSON: Absolutely. We had a meeting a week after Vanessa died and it was transparent, I can tell you. They were saying that a couple of things could have gone wrong. Then after that meeting the shutters went down, and it was visible that the shutters went down and we had been cut off from any information that could have come. The way the meetings were being run we said, "Look, we can't go to Royal North Shore Hospital. We just can't stand to go there".

The Hon. DAVID CLARKE: Was the problem individuals or the system?

Mr ANDERSON: I believe that yes, there was an individual that was looking after the thing at the Royal North Shore Hospital, that is for sure. But that individual was answering to someone; there were other people that knew what we were asking and the questions we were asking and it was quite clear that we were not getting the answers. To us, the cynicism with the whole system rose from that, from that initial part where our uppermost thing was to find out what happened to Vanessa.

The Hon. DAVID CLARKE: Why do you think you were not getting the answers?

Mr ANDERSON: Quite simply, from our perspective, there were things they did not want us to know—that is straight down the line—and that was proved. But I had to go through that process. I knew and they were not listening to the people that knew—they were there, they saw what happened. There was no empathy in regard to that.

Mr KERRY HICKEY: Do you think they were worried about litigation rather than trying to be transparent?

Mr ANDERSON: If they were worried about litigation, if that be the case—and you saw the contents of my correspondence that I had sent to them where I was calling on them from the perspective of a parent that lost a child to know what happened—I did not even have solicitors involved; there was nothing there in regards to litigation. All we were going down the line of was finding out why our 16-year-old daughter, who was, as they described, the wellest person in that ward, died on the night of 8 November. That is all we wanted to know. As far as litigation is concerned, at that time, in my frame of mind, to me it was all a blur at that stage of the game, and all we wanted to know was why our daughter died, and those facts, the cover-ups, the meetings that

were happening to and fro that came out from the coroners—we had to have a coroners to find out what really happened. The last thing a family grieving after something like that needs, is to go through that, and that is what I had.

The Hon. DAVID CLARKE: What specifically would you recommend to deal with that situation that you had to go through? What would you put in place to deal with that?

Mr ANDERSON: The answer to that question is—and in the ideal world—not to be in that position in the first place. That is my answer to that. My main problem at the moment I am trying to get over is four and a half, five years down the track we are still in the same spot. I do not care what anyone says, we are still where we are. We tried to introduce a law that was so simplistic—down the line. I just said, "I want something". We have got the Garling report going, we have got the report from the Inquiry that was done with Mr Nile chairing. Who knows who has followed up on what the outcomes of that Inquiry were? Who knows what the status of any of those recommendations are? I asked a question about one of the doctors through the Health Care Complaints Commission who had been put on conditions: Is she being monitored? No-one knew. There was no ongoing look at that person to say, "She is under supervision". There was nothing to say she was supposed to have done a course. Had she done a course? "No, but she's enrolled in it"; "No, she's not enrolled in it"; "She's going to enrol in it next week". This is the cynicism that is set up by the public, and that is where it is coming from. I am not Robinson Crusoe on this, I have got to say.

Mrs JUDY HOPWOOD: There are two angles to this question. You have described how difficult it was to get the notice of the Health Care Complaints Commission in terms of actually investigating. In August 2005, just before Vanessa died, legislation came into being that imposed strict restrictions on the extent to which and to whom information gathered during the RCA, the root cause analysis investigation, could be disclosed. I would just like you to comment on the root cause analysis and how much you could find out, and also whether or not you think there is a case for mandatory reporting to the Health Care Complaints Commission, given the seriousness of an incident—which there is not at the moment—going from an Area Health Service to the Health Care Complaints Commission.

Mr ANDERSON: I will answer the second one first. To me that is a lay-down misere; that is, you have got such a serious incident like we have, it should be mandatory: it should be one-way traffic through there to get the transparency. At that stage on something that is that serious that happened with us, and I know I am the parent talking here, but it should be all about the people that have been affected by all this. That is what it should be about. I know that the clinicians surrounding Vanessa's case were terribly affected. I know that the nurse that walked off the coroner's stand was crying her eyes out. I know how affected she was. I went up and I embraced her and said, "Darling, it's not your fault. You were there on the night; you were in a position you should not have been in because you didn't have the skill". She knew that. She did not have the experience, and she is now placed in the situation that she has got to live with that for the rest of her life, and that is the system that has put her in that situation.

From that point of view, I find from the root cause analysis scenarios, to me they were very generic in terms of what was the situation. As I said, a person came to me that had a similar problem up at Nepean Hospital and sent a copy of their root cause analysis for me to have a look at and I could have been reading Vanessa's. It happened up at Nepean Hospital two years ago or something; it has happened at Royal North Shore Hospital. I asked the question: How is this information of the root cause analysis disseminated throughout the hospitals so that we do not have this problem happening all the time? "It doesn't. It stays within the hospital". What? I thought that is what root cause analysis was all about, to feel out a mistake and make sure that mistake does not happen again. To say, "Oh no, that information stays within the hospital", I could not work that out.

Reverend the Hon. FRED NILE: Thank you again for coming in, Mr Anderson, and for your cooperation with all the inquiries that have been held. You mentioned correspondence. I wonder, Madam Chair, if it would help if that correspondence—he said he had some letters to the Health Care Complaints Commission—is included in his evidence today?

CHAIR: Yes.

Reverend the Hon. FRED NILE: I move that. As you know, in June 2007 the Department of Health introduced a policy of open disclosure for the public health system, and particularly the policy refers to the need for an apology for the distress felt by the patient and/or their family and an early explanation of the known facts.

If that policy had been in place in regard to Vanessa in 2005 would that have helped relieve some of the anguish and pain?

Mr ANDERSON: Absolutely. It does not bring them back but it gives you a signal that the people that matter are on your side, that the people that can make a change are sincere about making a change. That train of thought has been an us-against-them thing. The last thing a person wants to do when they are grieving on something like this is have an us and them. That is what made it more painful for us.

Reverend the Hon. FRED NILE: I think your persistence has helped to bring about these changes in policy and you should have some satisfaction.

Mr ANDERSON: I certainly hope it has and I certainly hope that people, God forbid, who have a similar fate have a better experience than what we had with that.

Mrs JUDY HOPWOOD: Thank you also for coming in again. It has been very valuable to the whole Inquiry into health to have people such as you, in the worst circumstances, coming forward. I would like to ask your opinion in relation to the processes of the Health Care Complaints Commission relating to the practitioners who were involved in looking after Vanessa in terms of consistencies with the way in which the Health Care Complaints Commission dealt with people or an individual who had performed perhaps a poor role.

Mr ANDERSON: I touched on that with the follow-up. What was very difficult to understand was that there were recommendations that were made by the Health Care Complaints Commission in relation to the doctors that were on Vanessa's case. Different doctors had different recommendations. One of the doctors in particular that perhaps was found to be more responsible than the other in fact pleaded guilty as charged, and I thought, "That's good. She has actually seen that that is the thing", and, again, not being vindictive or anything like that, but the situation was that we are then told by the Health Care Complaints Commission that she will not be required to have a hearing because she has pleaded guilty. Yet the other doctor, who was not quite at fault—she was there and she was found to have shortcomings with her treatment—had to go through that hearing.

We had the opportunity of going to that hearing—it was an open hearing. I realised when I was in that hearing there that the information that that doctor got through that hearing, the questions that were asked, in itself was a major training thing for that doctor. It was a learning process for her, and I could see it. I cannot for the life of me work out why when a doctor is guiltier than another doctor she is afforded the opportunity of not having a hearing, that the hearing still should not go on, when there should be a hearing. There are things that we get an opportunity to—my wife gave evidence at the hearing. We go there as a learning process. We are not going there to get stuck into anyone or anything—we never have. It is a learning process. Now that doctor had a learning process. The doctor that really was more at fault had missed what I see as a learning process. I just could not work that out. For the life of me I could not work out why that hearing—because she pleaded guilty to everything they said they did not need to have the hearing. I found that very hard and I find that difficult to understand too.

Mr NATHAN REES: Mr Anderson, thank you for your time. It is extraordinarily valuable for us to hear in detail the process that you have to go through. My question is in two parts. First, what was the nature of the argument that you put to the officer at the Health Care Complaints Commission that got it over the line, as you referred to it earlier, in terms of it being a serious issue that needed to be dealt with?

Mr ANDERSON: I remember the e-mail I sent actually diarising the amount of medication that Vanessa had received that night. Now to me that knowledge was already there—

Mr NATHAN REES: —and you should not have had to provide that information because that should have been in their purview already.

Mr ANDERSON: Basically I had to lead that in the correspondence I had with the Health Care Complaints Commission. I had to show them and I had to set up the chronology. I mean I am a plumber for God's sake. But I am reading this stuff saying—when you read the medication charts this 16-year-old girl had more opiates on that night in that ward than any other adult in that ward. It is not until those things are brought to the attention of that person. I still remember them saying—I knew I was over the hill; I knew I was starting to break through and get some notice.

Mr NATHAN REES: Secondly, you were clearly persistent in the face of a system that was not responsive. You mentioned the support of your mates and your family in particular.

Mr ANDERSON: Yes.

Mr NATHAN REES: In the event that someone did not have those supports around them, what could you do to help them out?

Mr ANDERSON: You know, I do not know—

Mr NATHAN REES: It is an unfair question.

Mr ANDERSON: You know the person would go into the ether. You know, for me it was yes, I am very strong willed and, yes, I do like to get through those sorts of things. I do not know, I really do not know how you would. I think more emphasis—and I know this is all up to resources—needs to be put onto that initial evaluation of the case. That first couple of contacts with the person they are talking to at the Health Care Complaints Commission, to try and treat that a little bit more in relation to listening to them. I think the thing is to listen to them and to hear what their case is, and not to make judgement on the fact that it is just another complaining parent talking about their kid; all that sort of thing. I think that is where we felt, on the first two or three occasions at the Health Care Complaints Commission, the empathy was not there in relation to listening to the case.

When it hit home was when I did a chronology of the drug taking, yet they already had that information but they had not read that information. It was there in words but not until I did the chronology of it and the timing of it and how it happened that they went, "Gees, look at what has happened here!" Then it went on from that. Getting over that line is the first part I think in those first two or three meetings. Because we were handed off to, I think it was called, a case manager—I just do not remember the name. When it was realised that there was a case then we were handed on to an investigator. It was not until we got on to the investigator that we could see we were going to get some help with it.

CHAIR: Thank you again for taking the time to appear before the Committee today. As other members have said, your contribution has been invaluable for our purposes in the review of this Act.

Mr ANDERSON: It is very important for us to know, and your feedback just then, that there has been change and Vanessa's death is something that is making a change. It is very frustrating when I hear of other cases that it is still happening—that is really what hurts at the moment. There are cases out there that you hear of all the time, especially the children. I guess I am biased towards monitoring children's cases and that sort of thing because of ours but it is very, very hurtful to hear that that sort of thing is still around and still happening.

(The witnesses withdrew)

(Luncheon adjournment)

SOLANGE FROST, Senior Policy Officer, Council of Social Service of New South Wales, 66 Albion Street, Surry Hills, 2010, and

ALISON PETERS, Director, Council of Social Service of New South Wales, 66 Albion Street, Surry Hills, 2010, affirmed and examined:

CHAIR: Welcome, and thank you very much for appearing today as witnesses. I understand that you already have a copy of the Committee's Terms of Reference and you have also been given information for witnesses appearing before Parliamentary Committees. Is that correct?

Ms PETERS: That is correct.

CHAIR: Following questions today, there may be some questions that the Committee has not been able to ask. Are you comfortable with the Committee forwarding those questions to you and replying in writing?

Ms PETERS: Yes.

CHAIR: Would you like to make an opening statement to the Committee on behalf of NCOSS?

Ms PETERS: Very briefly, if I might: I think members of the Committee are very well aware that NCOSS's focus is on the most disadvantaged and vulnerable people in communities in the State. It is in line with that that we have made a submission to this Committee. I should also point out that we have very much been informed by the submission made by the Public Interest Advocacy Centre [PIAC]. For the record, I should note that I am a director on the board of PIAC. However, that leaves aside the fact that for many years NCOSS and PIAC have worked very cooperatively around these issues. While our submission is somewhat brief, we have relied very much on the work that PIAC has done and that is before the Committee today.

Mr NATHAN REES: Can you fill us in on the input that NCOSS had regarding the development of the national scheme of accreditation?

Ms PETERS: To some extent, we had limited input into the development of the initial proposals. However, once those proposals became known, together with PIAC we responded quite strongly, given our concern is the nature of those proposals and what we felt would be a reduction in the capacity to effectively manage complaints in the best interest of the public of New South Wales as a result of those proposals.

We wrote, some might even say we lobbied, both Federal and State members of Parliament regarding those matters, and we were very pleased when the then Minister for Health, Minister Della Bosca, announced that through discussions with his Federal counterparts, the co-regulation system in New South Wales would be retained. To that extent, we have continued to watch further developments as to how the national scheme might operate with respect to registration of professionals, for example, and how that will impact on the work of the HCCC in this State and, indeed, other forums.

As you would be aware, we work also very closely with the Australian Council of Social Service and our other sister organisations in other States and Territories. We call ourselves the COSS network, and these sorts of issues are raised in those forums as well.

Mr NATHAN REES: Further to that, in the context of broader health reform that was flagged yesterday by the Prime Minister, jurisdictions across Australia struggle with shortages of skilled labour in the health sphere—whether it is bulk billing GPs in urban areas or obstetricians in rural areas, or whatever the story might be. The Productivity Commission previously flagged registration and related processes as at least being part of the issue with regard to the scarcity of skilled labour. What I am interested in hearing from you on is that it is one thing for us to have a robust accreditation and registration scheme, but at what point does that militate against the delivery of labour into those parts of New South Wales, in this instance, where we struggle to get skilled labour? What, if any, arrangements would you suggest to ameliorate that?

Ms PETERS: It is certainly the case that registration processes can appear to be quite restrictive. I am afraid I do not think we would have the capacity to make an effective call in terms of these particular areas and occupations. However, we would urge, when it comes to matters of public health, that where the previous standard is set, that is one thing; but ensuring that we have a robust system of registration that ensures that

people who are delivering health services have some form of appropriate accreditation and recognition of their skills and professionalism is still a valid thing to do. As I say, it is beyond our area of expertise to say what the standard should be and whether or not they militate against the workforce being developed further in those areas.

Mrs JUDY HOPWOOD: I note that the Committee and NCOSS are in agreement that the Commission has made considerable efforts to make its processes more user friendly in respect of language disability-mental illness issues. With respect to accessibility, would you like to expand on your support for PIAC's proposal—that complaints may be taken verbally?

Ms PETERS: Certainly with the people that NCOSS's focus tends to be on, being the most disadvantaged and vulnerable in our communities, there are a variety of reasons that make written complaints processes somewhat onerous for those people. It may be a case of disability; it may be a case of mental illness; it quite often is the case of a lack of education, understanding and awareness. However, that does not mean that they do not have valid concerns that should not be addressed through a formal and robust complaints process.

Given that many of these people spend a lot of time in the health system, it is absolutely vital that, if they have concerns or complaints, they can be addressed in a way that is useful to them and to the health system that is seeking to support them through whatever the conditions are. Certainly there are other processes—the Ombudsman, for example—where they are able to take verbal complaints and provide other assistance to people who may be seeking to make a complaint. That is certainly something we would be very supportive of, for those reasons.

Reverend the Hon. FRED NILE: Ms Peters, in your submission you say you support all the proposals in our discussion paper. However, in issue 27, in respect of the discussion paper's recommendation that progress of complaints be advised to the Area Health Service on a monthly basis, what is your position? I gather it is that everybody should be advised, not just the Area Health Service. Could you comment on that?

Ms PETERS: Certainly it is the view of NCOSS that part of the improvement of the processes of the Commission generally should be better communication for all of the parties involved. We do not see, for example, that the Area Health Service should have regular updates on how matters are progressing when other complainants are not in the same position. That would be our first point for why we do not particularly support this.

The other thing is whether or not a month is an appropriate time frame in particular circumstances. It may be; it may not be. It is pointless having formal report-backs to complainants if there is not much to report, as long as communication channels remain open, and people are aware that sometimes things take a little longer than you would like and that sometimes things move more quickly. However, our basic principle is that the same processes and procedures should apply, regardless of whether you are in the Area Health Service, a GP, a nurse, a podiatrist or a complainant.

Reverend the Hon. FRED NILE: Good. Certainly the person making the complaint should be a priority, I would have thought.

Ms PETERS: Absolutely.

The Hon. DAVID CLARKE: I think your submission has put your position very specifically and very clearly. It has taken away questions from us because you have answered them before we can come up with them.

Ms PETERS: Thank you. I place on the record that the work of PIAC in particular has informed our work as well.

The Hon. DAVID CLARKE: Very good.

Reverend the Hon. FRED NILE: In your submission, you refer to the mandatory provision of written reasons by the Commission for assessment and post-investigation decisions. You have also made a comment that the Health Care Complaints Act already requires written reasons under section 78 and section 41. Could you comment on that?

Ms PETERS: Again, this has come from the PIAC submission in particular. The ability to have written reasons for particular decisions along the way we see as being part of the transparency of the process and would also allow complainants to understand where matters are up to. Also, as part of an internal review process, should they be unhappy with the way an investigation is proceeding or decisions are made along the course of that investigation, they could then be in a better position to seek a review of those decisions, as is proposed elsewhere in the Committee's discussion document and supported in our submission as well.

Reverend the Hon. FRED NILE: You have cases where the HCCC does not give written reasons in those circumstances?

Ms PETERS: I am not aware, but we think it would be part of the good practice of complaint handling that it might be made more specific in legislation.

CHAIR: As there are no further questions, I thank you very much for your input. As the Hon. David Clarke said, and because PIAC's submission was very similar and we heard from PIAC just before the luncheon adjournment, we already had covered a lot of the ground. Is there anything else you would like to add that you have not covered?

Ms PETERS: I do not think so. I think our submission speaks for itself. However, if the Committee has any further questions, we are happy to take those questions on notice.

The Hon. DAVID CLARKE: Is there anything this Committee should be doing that might improve the position generally in the area you are given responsibility to oversee?

Ms PETERS: Certainly the ability to have oversight agencies is very important. We think it is important that there be Parliamentary Committees that also review that on a regular basis. It is a little hard for me to respond to your question just at the moment, in light of other decisions that are happening elsewhere and as we try to work through what those decisions might mean and therefore the consequences for such a procedure as this.

CHAIR: An earlier witness informed the Committee that there is a perception that the Commission is not independent of either the Department of Health or the Government. I wonder whether NCOSS has had any feedback from your constituent bodies of a similar perception? Do you see the Commission as acting independently of government? The witness suggested that they seem to be too closely linked.

Ms PETERS: It is an interesting one. I could understand how that perception might arise. I think it is fair to say that while NCOSS is always happy to suggest improvements for all manner of processes and policies in this area, when the proposed national scheme was announced it really did firm up our opinion that certainly the current work of the HCCC was too important to be lost in a different scheme that was being proposed. Again, while I would commend the Committee for looking at how those processes can proceed, it has certainly not been our experience that the HCCC is anything other than independent and transparent in its work. Yes, it might be able to improve on that, but it has certainly not been our experience that that is the case. We are, you might say, insiders in the process to some extent. I could understand how others who do not deal with these matters on a regular basis might form that view.

Mr NATHAN REES: As long as it is funded out of the common fund, someone is going to make that assertion. Is there any jurisdiction around the world that you are aware of that has adequately dealt with that issue?

Ms PETERS: I am not aware of that, personally.

Ms FROST: I note that the HCCC has done a fair bit of work in recent months around developing some resources to inform the public about its role. It has just released a DVD, and it has been quite active about trying to disseminate that through the community. I do not know whether it is in direct response to those perceptions, but I know they are trying to actively promote their work and encourage complaints from the community where appropriate.

Reverend the Hon. FRED NILE: With regard to issue No. 9, it was proposed to have another Parliamentary Committee giving oversight to the New South Wales Registration Boards. You have said that you

do not agree with that proposition and you would rather this Committee be given a more expanded remit or responsibility. Could you comment on that?

Ms PETERS: Certainly it was the view of NCOSS that there was some overlap between issues around registration and accreditation of health professionals and other health workers and the work of the HCCC that was so intertwined that it seemed to us to make sense for this Committee to have its remit expanded, rather than to set up another committee. This is particularly the case when, for example, investigations by the HCCC might lead to disciplinary action, which is being carried out by the relevant registration body. We felt that the issues were so connected that, rather than establish a whole new committee, it would be appropriate for this Committee to expand its remit, and have oversight of the two halves of the one question if you like.

CHAIR: Thank you, Ms Peters and Ms Frost. We appreciate your taking your time to appear before the Inquiry today.

(The witnesses withdrew)

KIERAN TIBOR PEHM, Commissioner, Health Care Complaints Commission, Level 13, 323 Castlereagh Street, Sydney, sworn and examined, and

KIM SWAN, Executive Officer, Health Care Complaints Commission, Level 13, 323 Castlereagh Street, Sydney, before the Committee:

CHAIR: I think each of you would have had received a copy of the Committee's Terms of Reference, and I am sure that over the years you have been provided with the information for witnesses appearing before Parliamentary Committees. As with most of our inquiries, there may be some questions that the Committee does not have the opportunity to ask you this afternoon. If we forward those questions to you, would you be happy to respond to us in writing?

Mr PEHM: Yes, of course.

CHAIR: Do you wish to make an opening statement before we commence questions?

Mr PEHM: I do not think there is any need to. We made a submission initially, which has informed the issues paper issued by the Committee. We made quite a detailed response to that, and I am happy to leave it there and take any questions.

Reverend the Hon. FRED NILE: Thank you for your attendance and your detailed submission, which covers a great deal of material and it will take us a lot longer than half an hour to analyse. I notice in your submission you have raised a whole number of areas where there should be amendments to the Health Care Complaints Act. I assume that you have forwarded those to the Health Minister to be considered, your submissions pages 3 and 4.

Mr PEHM: I am sure we sent a copy of the submission to the Minister, but many of the recommendations arise out of previous inquiries. There was an Inquiry by the Hon. Deirdre O'Connor post the Graeme Reeves matter. We made detailed recommendations there, some of which were picked up for immediate implementation and others which Ms O'Connor thought needed more detailed consideration. So the Minister's office should be well aware of the recommendations.

Reverend the Hon. FRED NILE: Are there any recommendations that you specifically would like our Committee to follow through? You have made a number in your submission which seem to be practical improvements.

Mr PEHM: I think all the amendments that we support in our submission we continue to support and seek the Committee's endorsement obviously if the Committee saw fit.

The Hon. DAVID CLARKE: You continue to be opposed to accepting oral complaints. We have heard some evidence from organisations that are very much in favour of oral complaints being received. Can you elaborate on your reasoning for taking that position?

Mr PEHM: I think the difficulty that we see from an operational point of view is at some stage you need a complainant to commit to a version of a complaint in writing—one that can be sent to the practitioners and the respondents for a response. The Commission works hard to assist people to make written complaints where there are difficulties with written expression or difficulties with the English language. The danger with a purely oral complaint—I mean, how it would work in practice, the Commission officer I presume would take down a record of the complaint, which we must have. If we forward that to the complainant to sign it is a written complaint. If it has the status of a complaint purely at the oral stage then there is some dispute about what was in it and the person can continue to make oral complaints but not commit to a written version. There is the potential for difficulty in managing any inquiries. You need clarity to put the complaint to the other side, to the respondents, and they need to have something clear that they need to answer and not be faced with complainants disputing that the matter had been accurately recorded and in fact they said other things that the Commission did not take down and then getting into arguments with complainants about whether you had fully and accurately presented an oral complaint.

The Hon. DAVID CLARKE: You mentioned that you try to assist those who come forward and make oral complaints who may not be in a position because of language or inability to put pen to paper. Can you elaborate for this Committee as to what forms of assistance you provide?

Mr PEHM: We have about 10 resolution officers who also act as inquiry officers and they take phone inquiries and people who walk in as well. They routinely, where the complainant has difficulty writing themselves, will take down a record of the complaint over the phone. We also, where matters are more complex, invite people to come in and bring documentation and we have interview rooms in the office where again they will sit down with an inquiry officer who will write up the complaint for them and if they do come in have it signed then and there.

The Hon. DAVID CLARKE: So what you are saying is you are actually converting oral complaints to written form in any event.

Mr PEHM: Yes.

The Hon. DAVID CLARKE: So you are saying this is a bit of a misnomer here because when anybody comes in or phones up to make an oral complaint you ensure that this is taken down and they are presented with it in written form and they can then sign that as a written complaint. Is that right?

Mr PEHM: We do. It might be stretching the definitions a little bit but where there are urgent cases—and this happens occasionally where a complainant might have an elderly relative who is facing discharge from hospital into a nursing home context and it is a very fraught situation—we will take that over the phone, reduce it to writing, assess it as a complaint and give it to our resolution officers so that they can act on it straight away. We do not insist on people signing complaints and having that delay if we mail it to them or try and get in touch with them. But you need at some stage a properly stated and clear complaint. In fairness to the respondents, they have to know what they are responding to.

The Hon. DAVID CLARKE: So the reality is that in fact these oral complaints are converted to written form.

Mr PEHM: Yes. I can understand the impulse from the consumer point of view, and there are disadvantaged consumer groups, most of which are represented on our consumer consultative committee and the Council for Intellectual Disability and people like that would prefer to be able to make oral complaints. I think it is not a substantial problem, the requirement that they do be in writing, given the demands of fairness for the practitioner side.

Mr KERRY HICKEY: Earlier today we heard from Mr Anderson with regard to how his complaint was handled. He brought forward an issue of trying to get his complaint over the hump so that the Health Care Complaints Commission would investigate. He said he felt to some degree isolated or the system was too hard to get it over the hump and get someone interested in it in regard to the normal course of events. Do you see that as an issue or not?

Mr PEHM: If it is coming from Warren Anderson, it is a legitimate perception and it may raise the same perception on the complainant's part that the oral complaint issue does. It is a fact that we have to operate within our resources and we cannot investigate every complaint. We have an assessment process which we have gone through on many occasions—I think most of the members of the Committee are familiar with. A lot of people come to us very aggrieved and they want investigations, and they see investigation as a sort of gold standard and that that is the only way the complaint should be handled. The Act sets out the thresholds for investigation. Investigations are also a very resource intensive business. If you are investigating you take statements from all witnesses—the nurses, other patients—so one complaint that is fully investigated consumes a great deal of resources.

A big problem with the Commission previously, and the reason why it developed the massive backlog of investigations was that it assessed too many matters for investigation and ended up having massive delays because the resources were not there to investigate them properly. So I think it is always a difficult decision and requires a lot of care and judgement as to where you draw that line. I can understand the perception of complainants and it is frequently expressed to us—well, not frequently—complainants can request a review of an assessment decision, and where the decision is not for investigation the tenor of the request for review will

often be "this is serious, this should be investigated", and we will review it very carefully and come to a decision.

We did investigate Warren Anderson's complaint. I cannot recall that the assessment process was particularly extensive or onerous. My recollection of that one is that we did decide fairly quickly to investigate that, but certainly I accept that that is a perception. It is a very real perception. We try to do as much as we can to explain the reasons for the decision and why the threshold is there and the criteria that the Act says requires investigation. But really the facts are, within the resources of the Commission, you cannot satisfy every desire for investigation.

Mrs JUDY HOPWOOD: Just further to Mr Hickey's question, in relation to Warren Anderson, because I think he is a good example, how much more serious does a situation have to be before the HCCC immediately recognises it? I believe him in his description of fighting hard to get the HCCC to notice this particular complaint. This was a SAC 1 complaint. That is the most serious where somebody has died in a manner which was totally unexpected. I quote from this: "It is a death unrelated to the natural course of the illness and differing from the immediate expected outcome of the patient management". I would like you to comment on whether there should be mandatory links between Area Health Services and other health facilities in relation to some incidents that occur, for example, the death of Vanessa Anderson, that it would immediately be investigated. It would not be a patient complaint or a relative urging the HCCC to take it on. What is your view of a mandatory link?

Mr PEHM: I have thought about that, and there are a few things to your question. I am not clear enough on the detail of Warren Anderson's complaint and how it was assessed to provide an informed response as to whether there was an unreasonable time or whether we dithered around and asked for further information. So I would like to get back to you—

CHAIR: You can take that on notice.

Mr PEHM: —on the detail and the dates that was received and so on. The issue of requiring a complaint, the Act currently requires a complaint and we abide by that. We have asked for an own-motion power so that we can initiate complaints of our own volition. The SAC 1 definition is a death in a hospital. I do not think it is necessarily linked to further criteria. Was that the actual criteria, the SAC 1, that the death is unrelated to the natural or expected cause?

Mrs JUDY HOPWOOD: Yes, that is right. It is the most serious, yes, that is correct.

Mr PEHM: I would not have an objection to mandatory notification of those matters and investigation by the HCCC because there is a difference between the root cause analysis investigation and a complaint that is investigated to provide explanations to them. No, I would not have a problem with it and I do not think the numbers are enormous. I did think about it but I cannot remember why we did not pursue it.

Mrs JUDY HOPWOOD: Maybe we could have further information on that, if you could locate a reason why if that was in a discussion or a meeting.

Mr PEHM: I will see what we have. I am not sure we took it very far. I will have to get back to you on that. I just do not have the information at the moment.

Mrs JUDY HOPWOOD: The reason I stress the possible need for mandatory connection is that you may not know about a complaint.

Mr PEHM: Exactly.

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

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

have been amendments to the Act to allow us to add issues into investigations. The evolution of the Act is going down that way anyway to give the Commission more discretion in the public interest, but at the moment it is still very much complaint based. Yes, people do not know that they can complain. We do as much as we can to get information out there about their rights to complain.

Mrs JUDY HOPWOOD: Some people know they can complain but for other good family reasons or whatever, as you identified, they do not complain?

Mr PEHM: Yes.

Mr NATHAN REES: Commissioner, you are seeking an expanded capacity to apply for search warrants in order to obtain evidence. I presume the ownership of medical records is a legal labyrinth. Could you outline your objective on this?

Mr PEHM: Where a doctor is working for a practice the ownership of the records resides in the practice because doctors come and go, and stand in, and there are locums et cetera,. We are applying for an expansion of our powers to take possession of records. At the moment the Act says we can inspect and copy records on the premises, but we can take them only with the consent of the owner of the records. We have run into situations where you could spend a day or longer with a portable photocopier copying records. It is more convenient for us to take that material back to the office, copy it and return it to the owner of the records as soon as possible. That is really the area of concern.

Reverend the Hon. FRED NILE: In your submission you have continued your opposition to the Charter of Health Care Rights being given some legislative power, such as in a schedule in an Act. One of your objections stated that it could require a separate court or tribunal, and you mention New Zealand. Did that happen in New Zealand?

Mr PEHM: New Zealand has a charter.

Reverend the Hon. FRED NILE: Was there a separate court or tribunal?

Mr PEHM: Yes, it has a court. I think it goes through the normal court system and the Supreme Court ultimately. The point we are trying to make is that once you have a charter of rights, it has some sort of enforceability. One of the problems with the charters of patient rights is that they are aspirational and very broadly expressed, "The patient has the right to the best possible care," for example. If you said that is a legal right and a breach of that right can be the subject of a finding, enforcement or penalty, then respondents are going to defend the meaning of "the best possible care" because it has consequences. While it is an aspirational document, which everyone agrees is a good thing and should be done, you do not get into that very litigious area where people engage legal counsel and fight about the meaning of the terms of the charter.

It is not that we object to the charter. We support the existence of the charter. We contributed to the National Patient Charter of the Australian Commission on Safety and Quality in Health Care. I do not necessarily object to enforceable rights. We see the issue that once you take the step of making them legally enforceable, you greatly expand the complaint-handling process and mechanisms to determine whether there has been a breach of a particular right in the circumstance of a particular complaint. It is likely that enforcement of a charter of rights or determining whether there has been a breach of them inevitably would lead to a greater resourcing of some sort, whether it is a separate court of patient rights or through the ADT. We might make a decision. It has to be appellable. Once these rights are enforceable you would go to the ADT. It expands the scope of the Commission significantly beyond what it does now. I am not averse to it, but it raises significant potential resourcing and capability issues.

Mrs JUDY HOPWOOD: Could you explain the Commission's position on privilege attached to root cause analysis?

Mr PEHM: Our position has been consistent for quite a long time. Privilege attaches to root cause analysis principally because clinicians feel uncomfortable with volunteering information in the context of an adverse incident because they fear it being used against them either in disciplinary proceedings or in civil litigation. Obviously, different clinicians have different views, but the position of their peak bodies appears to be that they will not participate in any investigation of an adverse incident unless whatever information they give is completely privileged. The problem with that is that the complainants are not part of the root cause analysis

investigation. Its purpose is to have systems improved and the rationale from clinicians is, "Well, it's better for us to volunteer full and honest information in a context where we are confident, safe and secure. That way, what we volunteer will be freer and more open and the recommendation will go to a change in the system so the same thing does not happen in the future." That is a reasonable position. It does not address the complainant or the patient's concern or survivors of the family of the patient.

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

When they are involved in the open disclosure process, which is also Health Department policy, they are given a copy of the final root cause analysis report, but it does not address their questions. Our position is that the information gathered during a root cause analysis should be able to be used for open disclosure with the family, but that privilege should apply for use of that material in legal proceedings, to address the clinician concerns that the material can be used against them. There has just been a review of this by the Department of Health. We were the lone voice with our position. All of the other submissions were very strongly in favour of retaining the current privilege. The way the review addressed the concern about patients' understanding of what happened was that it would be explained to them very clearly that root cause analysis would not address their concerns in detail and that the open disclosure process would have to be a separate thing.

Mrs JUDY HOPWOOD: Given the Anderson situation was a root cause analysis, could some doubt be cast upon the process that we really cannot see Area Health Services relating to root cause analysis and exactly what is put together because it is in-house, if you like? If they were reviewed and privilege still maintained but with more checks and balances, it could be cheaper and not so elongated. It is now 4½ years since Vanessa Anderson died. Her parents, Warren and Michelle, are just receiving closure now. What is your view on that? It could be manipulated a little bit if it is in-house and the Area Health Service is looking at the process.

Mr PEHM: Because it is a confidential process and is completely privileged, there will always be a perception that it is being manipulated. In fact, the Anderson case highlighted the whole problem. On having the open disclosure process and getting the root cause analysis report they felt there was a cover-up and it was not being properly investigated. We review root cause analysis reports as part of our investigations. The problem is not that they are covering up things; it is the way the conclusions are very broadly expressed. The focus is not on the patient's concerns; the focus is on improving systems. They are also not designed to address individual responsibility at all. They do not go into any detailed investigations of individual clinician responsibility. They are designed to improve systems rather than look at the conduct or misconduct of individuals. That is inadequate because the patients then do not get a complete picture of what went on because they are not given that detailed information about which clinician did what, when and why.

Mrs JUDY HOPWOOD: Surely the Commission should be given that if you are looking at the root cause analysis?

Mr PEHM: We are given the final report. However, we do not find them very useful for investigation because they are not the full picture and they do not go into the detail you need for a more forensic investigation. One possible outcome of an investigation is prosecution before a disciplinary tribunal. You are in a courtroom situation and everyone is going to be cross-examined: you have to be very sure about your case. You need a lot more detail. Root cause analysis is not designed to do that and does not do that. In our view, there is still disjunction between root cause analysis and what patients really want from open disclosure. Of course, we see the worst of it, and I have spoken to private litigation solicitors who say they have been to some very good open disclosure processes and the family has ended up crying on the shoulders of the clinicians and vice versa and things have been explained to their satisfaction. I guess I am not in a position to judge the whole picture, but certainly there is a disjunction between root cause analysis and people's expectations. We made our suggestions to the review that that information could be used to explain in detail to a family what had happened but, essentially, that was very strongly opposed by the clinicians.

Mrs JUDY HOPWOOD: Eventually, in the Anderson case the Coronial Inquiry uncovered a lot of what happened, but that was not without extreme pain to the family. Perhaps there could be a better way to conduct the root cause analysis?

Mr PEHM: And they had to go through a lot to get there. I am not sure of the extent to which that report is privileged but the root cause analysis [RCA] report in the Anderson case did not ignore the conclusions of the coroners; they were just so obliquely expressed.

Mrs JUDY HOPWOOD: Mr Anderson expressed that too.

Mr PEHM: Yes. That is the nature of root cause analyses; the findings are so obscurely expressed. They might mean something to clinicians and to those who are managing hospitals and reviewing things, but they do not tell patients very much.

Reverend the Hon. FRED NILE: In issue 21 in our discussion paper we talked about the peer review being conducted by people who are sufficiently qualified. The College of Surgeons said that it is not sufficient; they should be appropriately qualified. Do you have any comment on that? In your submission you do not make a comment one way or the other. However, you state that you use a list of experts.

Mr PEHM: The Act states "sufficiently qualified". The College of Surgeons believes that it should be "appropriately qualified". I must say that I struggle to see the distinction and to get into arguments about what is appropriate rather than sufficient. It does not seem to me to be a very practical point.

Reverend the Hon. FRED NILE: The way in which that term is being used sounds as though it is a higher standard?

Mr PEHM: I think the word "sufficient" would equate to the word "appropriate". If someone were sufficient to a task he or she would be appropriate to the task.

Reverend the Hon. FRED NILE: You would have no objection to the word "appropriate" being used?

Mr PEHM: No, I would not. In reality we brief appropriate experts. We go to the colleges to nominate experts. The College of Surgeons has been very good on that front; it was very quick and it gave us names and we recruited experts through the college. In fact it is our first port of call because it has the experts, the fellows, and it knows people of good standing and reputation. I would not have a difficulty if it were changed from sufficient to appropriate. I am not sure whether there would be a lot of practical difference.

CHAIR: Continuing that point the comment that you made is interesting. The College of Surgeons, in its submission, stated:

> It is essential that a peer review be regarded as a peer by members of the appropriate professional body."

It suggested that that had not been the case for some of the peers selected in the past by the HCCC. It does not sound as though that was your perception.

Mr PEHM: The whole issue of peer review is very entrenched in the medical profession. There seems to be an argument that if you take the word "peer" literally it is a person of equivalent training and experience. The Act talks about experts. For instance, look at the conduct of a registered medical officer [RMO], someone two years out, or a trainee in cardiothoracic surgery. I do not know whether it is appropriate. For a start you would find it difficult to recruit someone who is a peer. It is a concept that is dearly held in the medical world. I am not sure whether there is an equivalent legal translation. We do not think it is inappropriate to get an expert to look at the conduct of, say, an RMO. Our expert might be a Registrar who trains RMOs. In our view, clearly a Registrar is not a peer; he or she would be much more experienced. However, a Registrar works with and trains RMOs and is able to give expert evidence on the standard of service and the conduct expected of someone at that level of training and experience.

Similarly, we have used registered nurses to give expert opinions on the conduct of enrolled nurses who are more junior and who do not have as much responsibility. One nurses' tribunal has been a bit critical of that, although it did not reject the evidence on that basis. If you are too literal about a peer expert you can get into a lot of practical difficulties. Finally, I think it is difficult to comment on the Commission qualifying inadequate

experts or inappropriate experts without knowing the case. It might have happened. More recently we have put a lot of effort into recruiting and training experts. Over the past month or two we have had four sessions. It is partly up to the expert to judge whether he or she has sufficient experience. If the experts jump in and decide that they do and in someone else's opinion they do not, clinical practice is full of these grey areas and matters of opinion. I could not comment on the submission that we are inadequately choosing experts without knowing the details.

CHAIR: Thank you Mr Pehm and Mr Swan for appearing before the Committee today. As I indicated earlier, we will be forwarding questions to you.

Mr PEHM: Thank you. There were also the questions raised by Ms Hopwood.

(**The witnesses withdrew.**)

LINDA MARY ALEXANDER, Legal Officer, New South Wales Nurses' Association, 43 Australia Street, Camperdown, sworn, and

ANNIE BUTLER, Professional Officer, New South Wales Nurses' Association, 43 Australia Street, Camperdown, affirmed and examined:

CHAIR: Thank you for appearing before the Inquiry this afternoon. I understand that you have a copy of the Committee's Terms of Reference for this Inquiry and that you have been provided with information relating to witnesses appearing before Parliamentary Inquiries?

Ms ALEXANDER: Yes.

Ms BUTLER: Yes.

CHAIR: Ms Alexander, in what capacity are you appearing before the Committee today?

Ms ALEXANDER: I am a legal officer with the New South Wales Nurses' Association and that is the capacity in which I am appearing today.

CHAIR: Ms Butler, in what capacity are you appearing before the Committee today?

Ms BUTLER: I am a professional officer with the New South Wales Nurses' Association and that is the capacity in which I am appearing today.

CHAIR: If Committee members are not able to ask all the questions that they have for you, following the hearing we will forward some questions to you. Will you be able to respond to them in writing?

Ms BUTLER: Yes.

Ms ALEXANDER: Yes.

CHAIR: Do you wish to make an opening statement to the Inquiry?

Ms BUTLER: The only thing we wish to say is thank you for the opportunity to provide input into the Inquiry. In the discussion paper we note the considerations of some of the concerns that the association has raised before. We are pleased to see some of the suggested amendments in response to those concerns.

The Hon. DAVID CLARKE: Ms Alexander, it is suggested in the submission of the New South Wales Nurses' Association that the Act should be amended to make it clear that an assessment is required to determine whether a complaint is not malicious or vexatious?

Ms ALEXANDER: Yes.

The Hon. DAVID CLARKE: The Health Care Complaints Act already provides that the Commission may discontinue dealing with a complaint that is frivolous, vexatious or not made in good faith. I am a little confused. You are suggesting an amendment to the Act for something that it already provides.

Ms BUTLER: We were commenting on an issue raised in the discussion paper that we were considering at that point. We know that, under the Act, if an assessment is found to be vexatious it is dismissed. We were concerned that the proposed amendment was suggesting that a notification could be made to an Area Health Service before assessment without it first being clarified that it may be vexatious. We wanted to be clear that notification should not be made until that assessment has been made.

The Hon. DAVID CLARKE: You are wanting an amendment to provide exactly what?

Ms BUTLER: We are not wanting an amendment; we were commenting on a proposed amendment raised in the Committee's discussion paper. Are you asking us about issue 28?

The Hon. DAVID CLARKE: My understanding is that you have suggested that section 20 of the Act be amended. I am talking about section 20.

Ms BUTLER: You are talking about our previous submission, not about the most recent one.

The Hon. DAVID CLARKE: Has there been a change to your submission?

Ms BUTLER: No, there has not been a change to our submission.

CHAIR: There was an original submission and a supplementary one following the discussion paper.

Ms BUTLER: Following the release of the discussion paper. We are all a little confused. We note the requirement in the Act that an assessment must determine whether a complaint has been vexatious or malicious. I know what you are saying. What we asked for in the original submission was the addition of the word "malicious". In our secondary submission, which was in response to your discussion paper, we had concerns. We said this in relation to issue 28:

> That the Health Care Complaints Act be amended to provide that where a person is named as an individual respondent to a complaint ...

The Area Health Service then has to be notified. We had some concerns about whether that notification would occur prior to assessment. It could be—we have had experience with nurses before—that a complaint is made that is vexatious and the Area Health Service could take unwarranted action against that individual. That is what that issue is about. Previously we asked for the inclusion of the word "malicious".

The Hon. DAVID CLARKE: I think the Act talks about "frivolous, vexatious or not made in good faith". I think the words "not made in good faith" would have a wider meaning than the word "malicious" would they not?

Ms BUTLER: Yes.

The Hon. DAVID CLARKE: Would that not give even broader protection?

CHAIR: What you were saying was that it was about the suggestion that the Area Health Service be advised. It was in that context that you were making that suggestion.

Ms BUTLER: Yes. There are a couple of suggestions. There are two layers; that is what we have here.

The Hon. DAVID CLARKE: If a complaint comes in that is found to be malicious, vexatious, frivolous, or not made in good faith—I am sure we are talking about the same general area—it will be dismissed? Is that not already the practical result?

Ms ALEXANDER: That is correct. However, we do not want the Area Health Service notified until the Health Care Complaints Commission has determined that. In the past we have had experience of nurse members being dealt with accordingly, and it has been found by the Commission that it will not proceed with the matter because it has been vexatious or frivolous. However, the Area Health Service has already been notified and the member or the nurse suffers the consequences of that notification—a bit like mud being thrown.

The Hon. DAVID CLARKE: Are you saying that there have been situations when there have been findings against a member of your association?

Ms ALEXANDER: No, not findings; allegations have been made.

Mr KERRY HICKEY: And they have been stood down pending investigation.

The Hon. DAVID CLARKE: That clarifies the issue.

Reverend the Hon. FRED NILE: In your later submission to our discussion paper you indicated that you had reservations about issue 4?

Ms BUTLER: Yes.

Reverend the Hon. FRED NILE: You said:

The final amendment proposed in this issue risks the situation ...

You are aware of what you said in your submission. Can you comment further on that? Why do you not support the proposed amendment?

Ms BUTLER: It is a similar sort of concern in that we are concerned that a protection might be removed by this proposed amendment. At the moment hospitals and organisations and areas have to go through the Director-General, and without that occurring we have some concern that responsibilities for what, in effect, are systems failures could be placed on individual nurses or midwives. That is what that concern is about. We feel that that is more likely to occur without the process path that we have at the moment.

Mr KERRY HICKEY: In your submission your association says it is experiencing a continual rise in the number of complaints made against nurses. To what do you attribute the increase, and do you consider that the process of the health care complaints system in New South Wales contributes to this?

Ms BUTLER: That is clearly in the previous submission. It was not written by either one of us. Would we say that there is a rise in complaints?

Ms ALEXANDER: Yes.

Ms BUTLER: To what would that be attributed?

Ms ALEXANDER: I could attribute that to—and it is my opinion—the public are more aware of what their rights are, and I think that is a large contributing factor to the rise in complaints made. What was the other part of the question?

Mr KERRY HICKEY: Do you see this as a part of the health care complaints system? You are saying that the public are better educated in regards to health care complaints?

Ms ALEXANDER: Yes, that is how I see that.

Ms BUTLER: I think we are also meant to regard this as a positive feature. Obviously the association does a lot of work with NSW Health on a lot of safety issues with the CEC, and now, of course, post-Garling, and one of the things is not just the increased education in the public but increase of confidence, we hope, amongst health professionals themselves also to be able to bring issues.

CHAIR: Perhaps just to follow that train of thought, one of the things that I think has come out of some of the inquiries is that there is a different culture around reporting nurses, for example—certainly a different power relationship within the workplace, or there has been, where nurses are more often reported than doctors in similar circumstances. I think that is one of the things that certainly came out after the Inquiry into Reeves, on my reading of it. I do not know if you have got an opinion on that?

Ms BUTLER: We have a traditional—what we might regard as a bit of a power imbalance. You can have it between junior and senior clinicians of all types, and nurses can find it more difficult to bring to the attention of those who need to have it brought to them the conduct of doctors. So it can be that nurses are more often reported. I think we are going to find that we have to deal with this more directly once we see the implementation of national registration, because mandatory reporting has not been legislated for nurses and midwives in New South Wales and it will be now for everybody everywhere. That does not have to be a negative thing and we might regard that as providing some better protection for nurses and midwives in that circumstance, if that makes sense. When it is legislated it is a bit more powerful.

Mrs JUDY HOPWOOD: I would like to ask a question about the Service Check Register and the view of the association in relation to the review of perhaps somebody having an entry on the Service Check Register where they might want to have that looked at again at an Area Health Service level and then perhaps the Director-General. Are you of the view that there should be an independent review if there is still a dispute about the fact that a practitioner has an entry on a Service Check Register?

Ms BUTLER: Yes. We are not particularly well acquainted with the Service Check Register, Linda and I, as particular individuals. I am aware of it—and you are talking about the public service?

Mrs JUDY HOPWOOD: Yes, I am.

Ms BUTLER: I know that the association does have problems with it; it does have concerns with it. If we are looking at—excuse me if I get it a little wrong—a criminal record history—is this part of the service—

Mrs JUDY HOPWOOD: I do not think that is. I am talking more about an incident. On an employment form you would obviously have to indicate that. I think it is more the practical application of your job if there has been a complaint against you that this comes into play.

Ms BUTLER: We can only provide a limited answer to you now because we have only had limited discussions internally about it. We can provide follow-up information for you if you would like, because I might be getting a bit confused because there is now, of course, again, national registration new requirements. We have concerns about all sorts of crossovers and the numbers of checks and balances when one or two might suffice. But we would generally support the independent review. We are happy to provide more information.

Reverend the Hon. FRED NILE: In your first submission you made a strong argument that it should be mandatory that any person subject to a complaint should have notice of that complaint. The current wording talks about some form of notice could be given. You want that to be mandatory, that any person subject to a complaint should receive notice of that complaint?

Ms BUTLER: Yes.

Ms ALEXANDER: We do.

The Hon. DAVID CLARKE: Are there any situations that you are aware of where there have been complaints and there has not been notification?

Ms ALEXANDER: I understand that the Commission's view of delaying notification is to obtain evidence and to prevent a chance of any evidence being destroyed and then in the future not being able to have access to it. Nothing springs to mind but I think, again, in legislation there should be nothing left to chance in case that does arise in the future.

The Hon. DAVID CLARKE: Is there anything wrong with notification being delayed until evidence and documents, whatever might be needed, are obtained?

Ms ALEXANDER: The time delay that we have experienced, or members of ours have experienced, yes there is, because it goes on for quite a time and we have experienced matters being commenced one year and not coming to a hearing until at least four or five years after that. The whole time the members are aware. Either they have been stood down and had to find further employment elsewhere until the matter with the Health Care Complaints Commission has been finalised, and that is quite traumatic—

The Hon. DAVID CLARKE: Are you saying that there are cases that have been opened and just kept open with no notification—

Ms ALEXANDER: Without notification—sorry, I perhaps did not finish that. I will start again. A notification not taking place until after they have been suspended. So they are aware of an actual complaint but nothing has come from the Health Care Complaints Commission until a time after that.

The Hon. DAVID CLARKE: What justification has been given by the Health Care Complaints Commission for that?

Ms ALEXANDER: To my recollection, nothing.

The Hon. DAVID CLARKE: Has your body raised this issue with the Health Care Complaints Commission?

Ms ALEXANDER: I cannot comment whether that specific issue has been raised, but the time taken for the complete investigation has been taken up on several occasions with the Commission.

The Hon. DAVID CLARKE: Have you got a satisfactory response to your complaint?

Ms ALEXANDER: A satisfactory response would be that it does not occur. Following the Camden-Campbelltown Inquiry there were more staff put on at the Health Care Complaints Commission and things were dealt with in a timely manner on that occasion. But then that sort of went by the by and, from experience, it is back to almost what it was prior to that.

CHAIR: In terms of length of time taken?

Ms ALEXANDER: Length of time—from start to finish.

Reverend the Hon. FRED NILE: You mentioned there was a delay in the notification. Has it been a week, two weeks or a month?

Ms ALEXANDER: No, I said I could not comment specifically on delays of notification, but delays in general have been quite extensive.

Reverend the Hon. FRED NILE: I meant the notification.

Ms ALEXANDER: The notification, no, I cannot comment on that.

Reverend the Hon. FRED NILE: They may need a day or two to collect documents but they would not need a month?

Ms ALEXANDER: The Act says 60 days; they can take that long. No, I cannot comment on the specifics of that.

Mr NATHAN REES: The regulatory architecture here is for every action there is an equal opposite action. So if you were to truncate the time taken before the hearing so that it is not five years it is five months, or whatever it is, you are going to get the people who have complained saying there has not been adequate investigation of it in only five months. That is what we need to try to balance the different competing and legitimate expectations of all the parties in this. It strikes me though in what you are saying that the investigation of a particular complaint and preparation for appearance before a board might go for four or five years and it seems to me to be fundamentally unfair that the outcome of that is pre-judged in that your members are stood aside without pay or it gets too stressful and they leave and go and do something else. That, to me, would seem to be an issue around policy and procedure at an Area Health Service level as distinct from the activities of the Health Care Complaints Commission, or am I missing something?

Ms ALEXANDER: Probably not, but it is still something that the Health Care Complaints Commission are responsible for. If someone is under investigation and it starts in year one and goes on for a number of years, whilst we accept that the Commission is met with brick walls when it comes to obtaining doctors reports or various other sorts of information and then compiling their evidence, we accept that that will be occasion for delay, but not to the extent that our experience has been with the delay. I think for anybody to be placed under that sort of scrutiny—or shadow perhaps is a better word because it is not always scrutiny, it goes away for about 12 months and then another letter arrives—our members are traumatised by the delays that take place and in the end sometimes they are not guilty; the allegations have not been proven.

Mr NATHAN REES: There is a professional risk that attaches to any job, whether it is nursing or doctors or lawyers or whatever—that comes with the territory. What I am trying to determine is in the event that someone is the subject of a complaint and there is an ongoing collection of evidence, there is going to be some stress there, we all know that. To an extent I think it is perhaps unavoidable, but my question is more around the Area Health Services' responses in that situation.

In the case where CEO Hickey becomes aware of a complaint against Nurse Rees, he has the capacity to stand me down, presumably, before this case has been proven. There may be nothing to it but we are not going to know that and I am stood down in the meantime. That is what I understand you to say.

Ms ALEXANDER: Yes.

Mr NATHAN REES: What I am trying to understand is, in my mind that is an industrial issue and should be dealt with between Mr Hickey and my association, as distinct from a Health Care Complaints Commission issue.

Ms ALEXANDER: Yes, it can be.

Mr KERRY HICKEY: When I stand him down, I am just trying to clarify in my mind, you are saying that I did not notify Nurse Rees about the issue and why I stood him down?

Ms ALEXANDER: No, it is the delay. If a result by the Commission is made sometimes the industrial issue is left in abeyance until the Commission's hearing has been finalised, because it is more serious to lose your registration than to lose your job. That is how we view that. So, therefore, the industrial officers at the association withhold and try to keep the matter out of the industrial court first until the Commission's hearing has been finalised. I suppose what it boils down to is that if the Commission could deal with the matters in a more expedient way, and especially in the matters where they are found not guilty, the Area Health Service or the employer could be notified, and in my experience if the member has not resigned but has been terminated there is always a way of getting them back on the books. But when it takes four years, three years—anywhere between three and five years—it is a little bit too long.

Mr KERRY HICKEY: I would be very reluctant to reemploy Nurse Rees.

Ms ALEXANDER: And I bet Rees would not want to go back.

The Hon. DAVID CLARKE: And it is a terrible strain on the health practitioner in the meantime to have to wait through that period of time?

Ms ALEXANDER: Definitely.

The Hon. DAVID CLARKE: It is an unconscionable situation.

Ms ALEXANDER: I have known nurses who have decided not to return to nursing, and when we need the profession and we need the people in the profession, that is not a very satisfactory outcome.

CHAIR: You mentioned earlier that there is no reason or justification given for the length of time. Are they particularly complex matters or is it that the Health Care Complaints Commission is not able to get access to the records they need to complete their investigations? Do you even have a sense of what may be the cause?

Ms ALEXANDER: My sense?

CHAIR: Please feel free.

Ms ALEXANDER: I do accept, as I said before, that there would be delays that would be justifiable, but my sense is that is not always the case. Because I do not think anybody could delay something for as long as we have had matters delayed with legitimate reason.

CHAIR: Is it that they have had other priorities and there are limited resources?

Ms ALEXANDER: I expect that could be the case—resources and other issues, yes.

The Hon. DAVID CLARKE: But that is just an assumption on your part, is it not?

Ms ALEXANDER: It possibly is a little bit more than that given the time that is taken. I think it is a bit more than an assumption.

Mr NATHAN REES: If it was not five years and it was three years we would still be having the same discussion?

Ms ALEXANDER: Yes.

Mr NATHAN REES: Or even two years?

Ms ALEXANDER: Yes.

Reverend the Hon. FRED NILE: In paragraph 54 of your first submission you make the complaint that they keep amending the complaints before the tribunals?

Ms ALEXANDER: The Act allows that to happen—that is the first submission.

The Hon. DAVID CLARKE: I guess if there were these unconscionable delays, and you felt that justice was not being done, they would be matters you could refer to this Committee. Has that ever been done?

Ms ALEXANDER: No.

The Hon. DAVID CLARKE: Has your association, in those situations where you talk about five years, four years or three years, ever referred those matters to this Committee?

Ms ALEXANDER: Not specifically for that reason, but there have been suggestions between myself and counsel briefed in certain matters that perhaps we should take it higher when there have been other problems that we have come across.

The Hon. DAVID CLARKE: But in each situation you have made the decision not to?

Ms ALEXANDER: It has not gone beyond a discussion between counsel and myself. No, we have not taken it further.

The Hon. DAVID CLARKE: But you would be aware that there has always been the option to come to this Committee if you felt that justice was not being given to your members?

Ms ALEXANDER: I should answer that yes—

CHAIR: But you were not aware—

Ms ALEXANDER: No.

CHAIR: This Committee reviews the annual report of the Health Care Complaints Commission annually. There is another hearing coming up on 25 March when this Committee will be examining the 2008-09 Annual Report of the Health Care Complaints Commission. Please always keep in mind our role as a Committee if there are issues of concern about the Health Care Complaints Commission fulfilling its responsibilities.

The Hon. DAVID CLARKE: Justice should be given to your members but there should also be justice to the Commission, because there may be assumptions being made about the Commission that are not correct.

Ms ALEXANDER: I accept that.

The Hon. DAVID CLARKE: If this is in a state of limbo then everything is just hanging there. There are avenues open to you to have this pursued, if you think justice is not being done.

Ms ALEXANDER: Thank you for that.

Reverend the Hon. FRED NILE: You could send us examples of some of those cases and we could ask the Commission about them when we have them before us—they will be sitting where you are to answer our questions.

The Hon. DAVID CLARKE: I do not think we can buy into individual cases but we are talking about the process.

CHAIR: No.

Ms ALEXANDER: Yes.

The Hon. DAVID CLARKE: There has got to be fairness to practitioners but there also has to be fairness to the Commission.

Ms ALEXANDER: Certainly.

Mrs JUDY HOPWOOD: Can the association, or its legal advisors, in light of the increase in the number of nurses who are the subject of complaint, provide assistance through the process of all those cases and also provide assistance if there are subsequent conduct or disciplinary inquiries?

Ms ALEXANDER: I am not sure of your question.

Ms BUTLER: You are asking if we provide assistance to nurses?

Mrs JUDY HOPWOOD: I know that you do but can you provide it to all of the nurses—

Ms BUTLER: We provide it to our members.

Mrs JUDY HOPWOOD: To your members?

Ms BUTLER: Yes.

Mrs JUDY HOPWOOD: And all of your members if they require it?

Ms BUTLER: Yes.

Mrs JUDY HOPWOOD: And without exception?

Ms BUTLER: Without exception. That is why they are members.

Mrs JUDY HOPWOOD: Fair enough.

Ms BUTLER: It is not a service offered to non-members.

CHAIR: Thank you both for your attendance this afternoon. The Committee appreciates the evidence you have given. As we have said, please feel free to refer matters such as those to us and keep in mind that the Committee is to hold a hearing in a matter of weeks to review the Annual Report of the Health Care Complaints Commission.

Ms ALEXANDER: Thank you very much.

(The witnesses withdrew)

(Short adjournment)

LEANNE O'SHANNESSY, Director—Legal and Legislation, New South Wales Department of Health, 73 Miller Street, North Sydney, 2059, and

IAIN MARTIN, Assistant Director—Legal (Legislation), New South Wales Department of Health, 73 Miller Street, North Sydney, 2059, affirmed and examined:

CHAIR: If we do not get through all the questions that Committee members wish to ask, we will forward those to you and ask that you respond to them in writing. Do you wish to make an opening statement before the Committee asks questions?

Ms O'SHANNESSY: No.

Mr MARTIN: No.

Mrs JUDY HOPWOOD: With previous witnesses, we were discussing the Service Check Register. In relation to a Service Check Register, is it a requirement to have a criminal record noted in that service check record? That was an inquiry that was unanswered.

Ms O'SHANNESSY: No. The Service Check Register is supposed to work simply as a flag that there may be issues that require further consideration. All it will do is have that flag. Then, if it is a new employer or a new Area Health Service that is seeking to employ that person, they need to go and talk to a previous employer and get more information. But there is no criminal record on that Service Check Register. In fact, there is no information about the nature of the issue on that record.

Mrs JUDY HOPWOOD: Just one further question about the Service Check Register and the ability for the practitioner to ask for a review, I believe that at the present time it is through the Area Health Service and then after that it might be the Director-General. Is there an opportunity to have an independent review if the practitioner is not satisfied with the fact that they still have a notation on that Service Check Register?

Ms O'SHANNESSY: I should preface my remarks by saying that it is not my area that runs the Service Check Register, so my hesitation is based on that. But the review is to the Director of Corporate Governance through the Area Health Service, and we have had one or two of those occur. As for an external review, there is always an opportunity to take it to a court or tribunal, but there is no process within our policy to do so—to get a special, different, independent person, if you know what I mean.

Mrs JUDY HOPWOOD: Thank you.

Reverend the Hon. FRED NILE: We note that the consultation draft of the new Public Health Act 2010 has been distributed. Do you have the expectation that this might impact upon the operation of the New South Wales health care complaints system?

Ms O'SHANNESSY: Generally, no. As you may be aware, there is a code for unregistered health practitioners made under the Public Health Act. We are looking at some adjustments to that code possibly in the next six months, but the actual Public Health Act itself will not affect it. The only issue is that I think the current Public Health Act has a bunch of practice restrictions in it about different professions only being able to do spine manipulation, dentistry, and a number of others. They will be removed from the Public Health Act because they will be going into the national registration scheme. All States and Territories have agreed on what restrictions should be in, and they will be set in the national registration Act.

CHAIR: Earlier today we had the Dental Technicians Board appear before us. They were basically concerned about their deregistration as a consequence of the national system. Do you have any concerns about deregistration as a result of the national system? Was that something that New South Wales raised as an issue? I understand that model jurisdictions have a registration board for dental technicians, but not all States have had a registration board. New South Wales obviously has seen a need for one. In your negotiations for the national scheme, was it raised as an issue by the department?

Ms O'SHANNESSY: No. The main issue for us in relation to dental technicians is, as you probably are aware, that the Dental Technicians Registration Act registers dental technicians and dental prosthetists. Dental prosthetists see patients direct, so they have direct patient contact. Our concern has always been to ensure

that dental prosthetists and the practitioners who see the public should continue to be registered. Under the national registration scheme, prosthetists will be registered under the umbrella of dental providers, so that will continue.

If you look at the process for national registration, there were lots of different professional groups, with some registered in some States and some not in others. Basically it was a Council of Australian Governments [COAG] decision that that is where we put the line. I know Queensland is proposing to continue registration. We will stick with the COAG line. As you would all be aware, we have obtained substantial dispensation; we have been going on our own on a number of very important aspects of the regulatory regime, so I think we want to stick with the COAG view more generally.

The Hon. DAVID CLARKE: And as to the current view on the Dental Technicians Board, what are you proposing to do there?

Ms O'SHANNESSY: The Dental Technicians Board will cease to exist when national registration comes in. The registrants who are also prosthetists will be transferred to the jurisdiction of the Dental Board, and a prosthetists will be a representative on that dental body.

The Hon. DAVID CLARKE: Right. So you think it is in the best interests of the public to get rid of the Dental Technicians Board that has been doing a job for all these years, simply because they may not be dealing directly with the public in the same way as are other health practitioners? Is it not in the best interests of New South Wales consumers that there be this protection because they could suffer as a consequence of dental technicians not being registered?

Ms O'SHANNESSY: I guess it is not a matter of what my personal opinion is on that. It is just broadly that COAG looked at all of the professions. There are a large number of professions with limited registration. I think dental technicians were registered in very few jurisdictions.

Mr MARTIN: Dental technicians currently are registered in four jurisdictions out of eight. As Leanne says, COAG took the view that that should not continue in the same way that COAG took a similar view for speech pathologists who are registered in one or two other jurisdictions and optical dispensers who are registered only in New South Wales.

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

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

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

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

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

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

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

Reverend the Hon. FRED NILE: Although you did mention that Queensland will keep its registration, so there is no legal barrier to New South Wales retaining its registration if it wanted to.

Ms O'SHANNESSY: No.

Mr NATHAN REES: In your experience, is it not the case that practitioners, whether they are in dentistry or any other profession, will seek accreditation and registration as a matter of course in order to embed themselves as a player in the market?

Ms O'SHANNESSY: Yes. It is an interesting fact that registration of course is self-funded by the profession, yet most health service providers are quite keen to be registered because it gives a status to the profession and it gives a cachet that they are among the professions that have appropriate processes and boards and are recognised by government. So that is true, yes.

The Hon. DAVID CLARKE: That is a good thing, on the whole, is it not?

Ms O'SHANNESSY: I guess so. I really would not have a view one way or the other. From the government perspective, we need to make sure, though, that we are identifying professions where we think there is a need for regulation and a need for the system to underpin that. The other point I would like to come back to with regard to dental technicians is that the unregistered code we have also provides a safety net in relation to any health service provider who is not currently registered. That provides a basic set of rules effectively through a negative licensing scheme, so there is a greater safety net in New South Wales than in any other jurisdiction outside of all the registered professional groups.

Mr NATHAN REES: We have heard from a number of different organisations today. As I indicated to one of the previous groups giving testimony, the issue here is the balance between competing legitimate interests of the different players in the field—the complainant, the practitioner, the HCCC, the Area Health Service itself, and so on. Do you think the balance is about right in the system? Where I am going to is: Do you think that everyone in it gets what can be colloquially termed a fair go?

Ms O'SHANNESSY: I think there is always room for improvement, but I think I would just say that when we have gone through the national registration process, in some ways it is a surprise to me because the interests are so disparate that the health professional groups, the consumers and the institutional service providers are all very, very strong in their support for the system we have. It is based on the fact that they felt, compared to other jurisdictions—which is why I say there is room for improvement—there is a very high degree of transparency, which I think is important both for a clinician facing a disciplinary process as well as important for a consumer and a regulator and for the public at large.

There is a high degree of accountability partially because of that transparency and partially because you have boards and an independent investigator and prosecutor, and there is also a high degree of focus on the public protection and public interest. I think we have been emphasising those three themes over the last 10 years as legislation has changed and we have responded to various incidents, particularly on the last one and some of the changes we made to the Medical Practice Act in 2008 in relation to emergency powers and emphasising the public protection view. I think there is a relatively good balance, but it could always be improved. They are the three things we looked at in making further improvements.

Mrs JUDY HOPWOOD: In relation to the Service Check Register, I believe from my reading that the policy does not apply to affiliated health organisations or volunteers. Based on the department's experiences so far, are there any plans to expand this applicability?

Ms O'SHANNESSY: I probably could not answer that question because it is not in my area, but I am happy to take that question on notice, if you like, and we will get back to you with a response.

Mrs JUDY HOPWOOD: Thank you.

Ms O'SHANNESSY: I think the issue is that, with affiliates, they are effectively a private body, but we will take that on board.

Mrs JUDY HOPWOOD: Thank you very much.

Reverend the Hon. FRED NILE: I note that the New South Wales Department of Health, as far as I can gather, has made no submission in response to our discussion paper, which was meant to prompt some response from various concerned organisations. Are you planning to make some response, or do you have any

response now whereby you say that you agree in principle with all the issues, except for perhaps number 10 or 11, that would help us?

Ms O'SHANNESSY: I think we did write to the Committee. I guess from our perspective, we are currently in the midst of trying to transition our complaints scheme from a purely New South Wales complaints and registration scheme to a national scheme that involves registration at the national level and complaints at the State level. When we did write back, we put in a more detailed submission when the Committee initially issued its Terms of Reference. I think our recent response was more about saying, "This is a really good idea. We are more interested in what you, the Committee, and the people who make submissions to us say, so we can try to factor those in." I think that if there had been a report of the Committee in a parallel time frame, we could then have addressed some of those in the current legislation we need to put through.

But we would look at this as an opportunity to get the Committee's report, to provide a basis for us going ahead when we look at these processes in the future, which we will be doing. It is going to be a different system. I think there is lots of fertile ground for some policy development improvement, once we have got everybody settled down into the new system. I would have thought the Committee's report would be a really useful basis for us to start to do that.

Reverend the Hon. FRED NILE: It does help us, though, to get some response from you to the discussion paper.

Ms O'SHANNESSY: I am not sure what your time frames are now. But if the Committee would like a response, we will provide it. It is just the issue of the time frames.

CHAIR: If there are other questions, as I indicated we will put those questions on notice, and perhaps the written response to those questions will assist us.

Ms O'SHANNESSY: May I say, a large number of the recommendations also went to the administration of the Health Care Complaints Commission and the Medical Board, which we would probably tend not to make a comment on because it is those bodies that are in the best position to do that. We would probably normally seek their advice before we provided advice. I can think of a couple of recommendations where I would say, "That sounds like a good idea but I am not sure it needs to be legislative." That would be where you would be looking at the feedback you are getting from everybody. Obviously, sometimes you do not technically need legislation, but you might do it because it has some other weight that it gives to a particular issue. I think we would be happy to see if we could get back to you on those recommendations that are more legislative, and possibly falling within the Minister's portfolio and role to do some work. I think it would be very preliminary, because we would not want to push the barrow one way or the other. We would be looking to get the views that you collect back to us.

CHAIR: We certainly did receive submissions from a number of the Area Health Services across the State.

Reverend the Hon. FRED NILE: Obviously you are trying to work this national registration organisation. Is the fact that we are keeping our New South Wales health care complaints structure complicating your role, or are you pleased with that?

Ms O'SHANNESSY: The Minister met with the presidents of all the health profession boards this morning, and we did discuss the complexity. But I guess in principle we agree with it. We could not sacrifice the Health Care Complaints Commission; it was not going to happen. So, in the context that we had to maintain the Commission, we got the best deal we could have. We have maintained pretty extensive control over the substance of our complaints system, but it is quite complex and working through the operational issues is quite difficult. But we are working with the Australian Health Practitioner Registration Authority, which is the entity that will support the national scheme. Because we are building some good relationships with AHPRA, we are very hopeful that we will be able to make it work, but it will be complicated. The biggest risk we need to manage is because we will have two systems, we do not want people falling in between. That is really important. That is the focus of a lot of the work we are doing.

CHAIR: Has there been agreement about the make-up of the new boards and the representation on the existing State Boards?

Ms O'SHANNESSY: If you have delved into the national registration system you will know that there are things called National Boards and there will also be subcommittees of the Board, which will be called State Boards of the National Board. So it makes the terminology quite difficult. What we will be re-establishing, with the membership of our current State Boards, will be professional councils. We have used the term "council" as it gives a bit of authority to the body but it is also distinguishing it from the National Board so they have a clear identity. The intention is to try to give the councils the same membership as the State committees of the National Boards, so that there can be a joining together of knowledge and a bit of consistency.

Some of the registration and standards issues flow across, backwards and forwards. Knowledge about the sorts of complaints you are getting will influence what you think about registration, so it is really important. That is the aim. The agreement at ministerial level is that where there are State Boards of the National Board, they will have the same membership as the current State Boards for a period of 12 months. After that there might be some movement: the National Boards will be making recommendations. The area where it does get a bit more complex—and I guess this is a good example of the complexity—is that in some of the smaller professional groups the National Board may not have a State body. Again we are talking about the national level. You have a professional group such as osteopaths. It is a very small profession nationally. It is not cost-effective for them to have separate State committees; it becomes a very onerous cost burden on the profession.

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

CHAIR: Did you find a way around that issue of the registration fee and the proportion of it that was going to fund the national complaints system and New South Wales practitioners not wanting to pay for the national scheme? Did we find an answer to that?

Ms O'SHANNESSY: We have. Hopefully it will be implemented. We will make it be implemented. Because the New South Wales complaints system is going to be run differently, the other States were very concerned that they were not going to pay for what we were doing. Equally, our registrants were concerned that if they were going to use our system they were only asked to pay for our system; they were not asked to pay for the system everyone else was using. Under the national law there is the capacity for the Ministerial Council to make directions. It made a direction in November last year—and this is also part of the transparency issue—that there would be a single national fee but it would need to be assessed in two elements. There would have to be an assessment of how much the registration costs were going to be and how much the complaints costs were going to be, and that would have to be clearly available to us to know what the two components were.

In New South Wales the complaints element of the fee will be determined by our councils and our boards based on their budget for operation. We will then inform the National Boards of that, and our New South Wales registrants will pay that element, plus the national registration fee, and everyone else will pay the national-national fee. There is a view—and we are not sure if this will ultimately happen—that that should ultimately leave a rebate for New South Wales registrants, basically because at the same time as all of this is going on there is a Health Care Complaints Commission, which is funded completely by the Government at $10 million, and that is going to stay. You would think that because they are doing some of the things the complaints bodies would do it should be cheaper, but we are not sure about that; we are still working through the national fees. But that material will be transparent and we have a way that we can double check that our people are effectively only paying for our bit. Again, that is another complexity that we are working through.

CHAIR: Thank you both for appearing before the Inquiry this afternoon. We find your evidence valuable for the Committee's purposes. We will forward the questions on notice to you.

(The witnesses withdrew)

ANDREW EDWARD DIX, Registrar, New South Wales Medical Board, Punt Road, Gladesville, affirmed and examined:

CHAIR: I understand you have been given a copy of the Terms of Reference of the Committee's Inquiry and that you have the information available for witnesses appearing before Parliamentary Committees?

Mr DIX: Yes.

CHAIR: As we have done with other witnesses, we may forward to you questions that we do not have time to deal with this afternoon. If you would be able to respond to those questions in writing, it would be appreciated. Do you wish to make a brief opening statement before we proceed to questions?

Mr DIX: I do not think so. I heard a little bit of the last evidence, and obviously, as Leanne O'Shannessy has said, the Medical Board has been very much preoccupied with the transition of national registration for the last two or three years and the Commission, in a sense, has been to one side of that. We have been engaged in business as usual with the Commission, but at this point there is nothing in particular I feel we need to comment on. Perhaps I might just say, you are probably seeing the submissions we made a couple of years ago. Since that time, although there has not been any significant legislative change that I can recall directly on some of the issues we raised, I think it is fair to say that the relationship between the Commission and the Board has improved significantly. Quite a few of the things we raised have been taken on board by the Commission, so that there has been less of what I think we identified as friction between us about some professional issues over that period.

The Hon. DAVID CLARKE: The submission that had been presented by the Medical Board contains this statement:

> The Board continues to express concern at the use of experts/peers by the Commission, and in particular the way in which the Commission feels bound to follow the opinions expressed by the expert or peer in an investigation notwithstanding the sometimes unanimous divergence from those views expressed by the medical members of the Board at the time of consultation.

Concern is expressed here; obviously the Board feels strongly about this. Are you suggesting that there have been miscarriages of justice as a result of this situation?

Mr DIX: A couple of things. That is the submission that we made 27 November 2008 and, as I said in my introductory remarks, things have improved quite significantly since then. Prior to that time there were situations where the Board was of a view that a matter ought to be dealt with in a particular way and the Commission was of the view that it should be dealt with in another way and the way the legislation is constructed the Commission can prevail in particular circumstances, not in every set of circumstances. I could not say that there was a miscarriage of justice. It is a difference of opinion, often in the particular context we are talking about here, medical opinion and medical opinion often differs. So I would not go so far as to say a miscarriage of justice but it certainly was a point of friction to the point where we felt that it was important that it get raised here. But as I said in my introductory remarks, that has quite markedly improved in the last couple of years, whether as a result of what we said here or not, I do not know.

The Hon. DAVID CLARKE: So up until 2008 there could have been miscarriages of justice?

Mr DIX: As I said, there was difference of opinion about medical things but it is difficult to say whether that lead to it. Anything is possible but I could not comment more than that.

The Hon. DAVID CLARKE: Yes, there are differences of medical opinion but that statement says that they felt bound to follow one opinion even though they unanimously—those of medical background—were not of that view. You can have a divergence of opinion but this goes further than that. This says they felt bound to follow an opinion that they unanimously did not agree with. That is a very serious situation, is it not?

Mr DIX: As I say, we felt it was serious enough to warrant bringing it to the attention of this Committee and we had raised with the Commission as well, obviously, and we had discussed it on occasions. It was viewed as serious enough to warrant reference. Ultimately the Commission has to prosecute a case. They have their expert, their technical legal rules about what can and cannot be done in hearings before tribunals and

so on, and they were of the view that their expert had told them something and the fact that the Board, which had a slightly different perspective on it, I suppose it is fair to say, because we get not necessarily all the same material and so on. So there is always the potential for a variation of opinion or variance in opinions. But as I said, I think it has improved significantly.

The Hon. DAVID CLARKE: So up until 2008 had this concern been there for a number of years or was it something that just escalated and reached a crescendo in 2008?

Mr DIX: I think it had built up over a period. I think, as we said in our oral submission back then in 2008, that a lot of the operations, as you would expect, between the Board and the Commission are based on—in that we have a sort of modus operandi—but there are practices that develop and so on—and I think this was just something that had gradually emerged over a period of several years.

The Hon. DAVID CLARKE: I have one question following on from that. You may have addressed this. I was reading some of these comments so I may have overlooked those comments. You say that the situation has now improved. Is it improved or rectified? Would you put it as high as rectified itself or just improved?

Mr DIX: There are still differences of opinion. I cannot off the top of my head think of a situation recently where every medical member of the Board has said A and the Commission has said not A but there have been cases where we have said we will have to agree to differ on this because ultimately they have the final say but we have taken the view that something ought to be done but the Commission does not agree with it as the Act envisages and they can go ahead with it.

The Hon. DAVID CLARKE: So at the end of the day do you have to follow the advice, the opinions, of the experts/peers?

Mr DIX: The Commission has the final say as to how to dispose of a matter at the conclusion of an investigation. It is obliged to consult with the Board, the Board gives its opinion, it is up to the Commission then to decide whether it takes the opinion of the Board or its own advice.

The Hon. DAVID CLARKE: What is it that has improved since 2008?

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

The Hon. DAVID CLARKE: Is that something that happened from a specific date or incident or action in 2008, or is it something that has just evolved since 2008?

Mr DIX: I think it is an evolution. I do not think you could draw a line and say things got different on this day.

The Hon. DAVID CLARKE: But is there still room for improvement?

Mr DIX: There will always be differences of opinion. Sometimes we are right and sometimes they are right. Sometimes you can have half a dozen people who have a particular view, and as I say the Commission's expert will have access to and more time to mull over a whole amount of material. We get an agenda that is this thick every month and there is an enormous amount of clinical information in there and that will be dealing with a large number of complaints and members have to digest that, get the questions they can out of it, so there will always be differences of opinion. I think it would be unhealthy if there were not. I think that the concern we were expressing was that our opinion was not being given the weight which we believe it ought to but ultimately, as the legislation stands, it is the Commission's decision. That may be something that is open to change, but as I say it would be unhealthy if we agreed all the time.

Reverend the Hon. FRED NILE: In our discussion paper, issue 21, we talked about this peer review operation. The College of Surgeons was not happy with the words that we had drafted: "sufficiently qualified". They want "appropriately qualified". Does the Medical Board have a position on that?

Mr DIX: Certainly the Medical Board has not considered it. I am just thinking. "Appropriate" is a word that I would probably use. "Sufficient" sounds like you just got over the line whereas "appropriate" has a broader sense—

Reverend the Hon. FRED NILE: To a higher standard.

Mr DIX: I believe so, yes, but that is not an official—the Medical Board has not had occasion to think about it, to my knowledge. But I think that is not an unreasonable thing.

Reverend the Hon. FRED NILE: Were there any other issues we raised in our discussion paper where you have strong concerns, objections?

Mr DIX: No.

Mrs JUDY HOPWOOD: What has been the Board's experience of the introduction of mandatory notification of practitioners under the recent amendments to the Medical Practice Act?

Mr DIX: It has not made a major difference to the work that we do. We have received—I do not have the numbers at my fingertip—not a large number of mandatory notifications. It would be less than 20, the majority of which have not been technically speaking mandatory notifications. Somebody has thought, "I need to tell the Board about this" but in fact when you read the provisions of the legislation they do not actually have to tell us. But it is usually something that we should know about although not under the mandatory notification provisions. We made it clear at the time of their introduction that the provisions were reinforcing what we had considered and had promulgated as being appropriate things for people to notify the Board of anyway. So what the mandatory notification provisions were doing was reinforcing what practitioners ought to do anyway and it gave a bit of clout or a bit of muscle in the situation where someone did not do it. Remembering of course that they are actually directed at the person who fails to notify rather than the person who has done the notifiable offence or whatever it is.

Certainly there has not been any instance where we have had occasion to say, "You should have told us that under the mandatory notification provisions" and taken action against that person. So it has not made a big difference but I think it has raised awareness. Certainly, in the national legislation debate it has caused consternation in other jurisdictions that, I think unrealistically, think it will cause the sky to fall in but it does not. The biggest worry we have is that we would get the sort of nervous nelly notifications and we have got a few of those but generally we can just sort them out.

Reverend the Hon. FRED NILE: In the discussion paper there has been the suggestion that the reports of boards like the Medical Board be reviewed by a Parliamentary Committee.

Mr DIX: Sorry, do you mean the annual reports?

Reverend the Hon. FRED NILE: The annual reports.

Mr DIX: Yes.

Reverend the Hon. FRED NILE: Did you have any view on that, whether it should be by this Committee—the Committee has been set up to supervise the HCCC—or another Parliamentary Committee, or you do not agree with it in principal?

Mr DIX: I suppose I should first of all say that in three and a bit months the New South Wales Medical Board will cease to exist so what I say now about that is perhaps not all that relevant. The question of whether the boards established under the new legislation would have their reports reviewed would be something for other people to comment on. Our annual report is tabled in Parliament as is required and we assume that it is available for anybody and everybody to look at if they wish. So I do not think the Board has a view on that.

CHAIR: Does the Board have a view of how it will operate now within the national scheme? Do you perceive any difficulties as it comes into being?

Mr DIX: I did not hear all of Ms O'Shannessey's evidence before. There will be complications, there is no doubt about that. We have for various reasons chosen to opt out of the national scheme, which has added a significant layer of complication to what has to be done and working out the interaction between the national and the State parts will be difficult. Obviously there are organisational issues raised by that which we are dealing with at the moment. There will be a period, I suspect, after 1 July when there will be a certain amount of confusion and it is always a concern that things will fall between the cracks. The national implementation project, which has been running for two or three years, has done a huge job trying to bring together 80 different boards from around the country but there is a lot of work still to be done in the next three months. So I would say at this point that I would be astonished if it all goes absolutely smoothly. We have our fingers crossed that the disruption will be minimal.

Mrs JUDY HOPWOOD: I refer to a *Sunday Telegraph* article on 21 February. It is titled "Foreign doctors fast tracked" and states, "Foreign doctors are being fast tracked into Australia by bypassing the standard registration process despite statistics revealing that they are responsible for half of all medical error and disciplinary cases". Have you got any comments to make about that?

Mr DIX: I vaguely remember the article and unfortunately I have not read it recently, but there have been systems set up forever not to fast track but to find alternative pathways for international medical graduates to be registered in Australia as we still do not produce enough medical graduates or if we do they do not go to the places where they are needed. The pathways for international medical graduates were developed at a national level about three years ago, and I think it is fair to say that New South Wales has been the most assiduous in its assessment processes and making sure to the best of our ability that people are who they say they are and that they have the skills to practice in their jobs.

We were the first jurisdiction—we did this 10 years ago—where we actually required doctors going to what we would call higher risk situations like general practitioners and so on, not in closely supervised hospital positions, to undergo a clinical assessment by three or four practising clinicians who would set up an interview panel to interview the doctors for an hour on clinical matters and knocking back a substantial number. No system is foolproof. There have been people who have gone through that process and we have had to withdraw their registration because they have been proved not to be up to the task and we have had some complaints about some of them, some of which have been about clinical matters, some of which have been about behavioural issues, as is the case with locally trained doctors as well. As I recall seeing that *Sunday Telegraph* article, I guess my reaction is that it is something of a beat-up.

The Hon. DAVID CLARKE: Are the statistics correct or incorrect?

Mr DIX: Can you just read them again? It said that more than half the complaints relate to IMGs [international medical graduates]?

Mrs JUDY HOPWOOD: Yes. It states, "…despite statistics revealing they are responsible for half of all medical error and disciplinary cases" and it goes on to say "New rules introduced by the Royal Australian College of General Practitioners this month to plug the GP shortage allow overseas-trained doctors to work in Australia sooner and with less testing."

Mr DIX: I am glad you read that second sentence because it just demonstrates how poorly understood this is: the College of General practitioners does not register anybody. So, it cannot allow people to be registered. We have to deal a lot with ill-conceived articles in the media. I do not have figures at my fingertips, but it is not more than half of international medical graduates responsible for all complaints. I cannot remember the proportion of registrants who are IMGs, but I think it is about 30 per cent. It is fair to say that there is a disproportionate number of complaints about IMGs, but it is not more than half and it is not vastly disproportionate.

The Hon. DAVID CLARKE: There is a big difference between 30 per cent and over 50 per cent, is there not?

Mr DIX: Yes.

The Hon. DAVID CLARKE: Was there any response by the Board when that article appeared? If the statistics stated in the article of that widely circulated newspaper are not correct, should that not have been corrected?

Mr DIX: It depends how one chooses to deal with the media. My experience of dealing with the media has been that the more you try to correct it, the worse it gets. They do not publish things that actually correct what you say. We will pursue things if we need to but, generally speaking, these things are fish-and-chip paper the next day.

The Hon. DAVID CLARKE: Do you not think it would have been a good idea for a letter to have gone to the editor from the New South Wales Medical Board stating that those figures are not correct, that it is not over half, and that according to your calculations it is 30 per cent?

Reverend the Hon. FRED NILE: The 30 per cent figure is foreign doctors.

The Hon. DAVID CLARKE: That is right, we are talking about foreign doctors. Would that not be a good thing to do?

Mr DIX: Sometimes we believe if it is important, we respond, and sometimes we do not. In this case we chose not to.

The Hon. DAVID CLARKE: I am surprised at that decision. What percentage of doctors practising in New South Wales is foreign trained?

Mr DIX: As I said, I think it is around about 30 per cent, but I could not be absolutely sure.

The Hon. DAVID CLARKE: I am sorry, we may be at loggerheads. When I asked you whether that statistic was correct, that was a statistic that said more than half of the cases proved of medical errors, negligence—

CHAIR: And disciplinary.

The Hon. DAVID CLARKE: That is right.

Mr DIX: Again, this is the imprecision of the article. As I say, I have not got it in front of me, but if it is talking about medical negligence cases, we would not necessarily know about them because they are civil cases before the courts. If they are talking about medical disciplinary cases—

The Hon. DAVID CLARKE: You would know about those?

Mr DIX: I do not have that analysis at my fingertips. Something could be done to find out the details.

The Hon. DAVID CLARKE: Would it be a statistic that would generally be known to you as the Registrar of the New South Wales Medical Board?

Mr DIX: Well, obviously, it is not. No, I do not know off the top of my head.

The Hon. DAVID CLARKE: Can you take that on notice and come back to us?

Mr DIX: Yes.

The Hon. DAVID CLARKE: You say that the percentage of foreign-trained doctors is about 30 per cent?

Mr DIX: That is about right, yes. Also, I guess one has to define "foreign trained". There are an awful lot of United Kingdom graduates who are technically foreign trained and who have been here for a long period. They are the group I was talking about a few minutes ago who are the international medical graduates—who now include UK graduates as well, I might add—and who have come in through pathways other than the standard registration pathway and are here on temporary registration categories. There are lots of different ways you can cut it. I think the gist of that article is talking about people who have not done the Australian Medical Council exams and, even though they are of foreign origin, are treated the same as Australian graduates for the purposes of registration. I think the article is reflecting on that group.

The Hon. DAVID CLARKE: If statistics like that are published saying that more than 50 per cent of disciplinary cases involve foreign-born doctors and it is nowhere near that figure, is it out of place for me to suggest that it might be a good idea for the Board to reconsider that it should respond? That would not inculcate within the public a feeling of satisfaction with health practitioners in New South Wales. A great injustice may be being done to practitioners who are foreign trained. The correct figures should be placed on the record. Nobody can do it better than the New South Wales Medical Board.

Mr DIX: Okay. I suppose, as I said before, we have an attitude to the media, which is that we respond in some circumstances and in others we let it through to the keeper. As I said before also, my experience has been, particularly with a Sunday paper that comes out once a week and puts in something like this, it either gets ignored or else it gets buried. After a couple of very high profile matters where we were persistently trying to rectify blatant errors that kept on being made again and again by the press—one might almost say wilfully—we took the view that it is not worth it. We have a more important thing to do than to try to get journalists to actually publish corrections and so on. I saw the article in this case—someone drew it to my attention—and I said, "Well, we'll just let it go."

The Hon. DAVID CLARKE: I am just making comment on if I—

Mr DIX: I understand your comment, but I suppose it is just an attitude.

The Hon. DAVID CLARKE: Yes. To amplify the comments I made before, that newspaper has a readership of several hundred thousand people in New South Wales. Surely a letter to the editor, which I am sure would be published, putting forward the correct statistics would go a long way to putting the truth out there if, indeed, that is not the truth and the figures are quite different from what had been alleged in the article? Do you not think out of justice to medical practitioners and to inform the public of New South Wales that it would be worthwhile for the New South Wales Medical Board to take the trouble to send a letter to the editor?

Mr DIX: Well, I have doubt that would be definite—how you have been putting it.

Mr NATHAN REES: We could canvass that for some hours. The practical reality of you having raised this matter was simply to get a push for television. I share the Registrar's cynicism about the media treatment of medical services in this State. Notwithstanding the inaccuracy of the article, they may or may not publish a correction. The damage has already been done. In some of the paperwork I thought I saw reference to lay people being members of the disciplinary committee, is that the right term?

CHAIR: Conduct committee.

Mr DIX: Yes, there are lay members on board that committee.

Mr NATHAN REES: I do not expect you to reveal the nature of the dialogue or anything like that, but to what extent is there a diversion of views between the clinicians and the lay members about sanctions?

Mr DIX: It is not uncommon for the lay members to feel the doctors are being a bit tough. There are different levels at which they work. At the committee levels we determine how we think a matter ought to be handled. That is one we talked about earlier where we put our view and then the Commission has to take it away and decide what it is going to do with it. There is no general pattern. It is not like we have the doctors on one side and the lay members on the other.

Mr NATHAN REES: That is what I am getting at.

Mr DIX: No. We have had lay members for over 20 years. Fortunately, and I think it reflects the good sense of both sides, we have never got into an us and them kind of situation between the lay members and the doctors. There are differences of opinion. As I say, it is quite common for the lay members to be a bit surprised, particularly where, say, a complaint has been made, there has not been a bad outcome but the doctors are saying this is unacceptable practice. The fact there was no bad outcome does not actually mean that the practice was good. Similarly, when there has been a terrible outcome but no-one has actually done anything wrong. I am a doctor myself and I talk quite regularly to all members of the Board, obviously, and I have never got a sense that there is a strong view that one side or the other is dominating or has different opinions. I guess it is inevitable on a committee where you have a bunch of doctors and a lot of technical medical things are being discussed that sometimes it might be a bit difficult for the lay members to keep up with the technical things—I find that

myself. I think it is quite a healthy atmosphere. The Health Care Complaints Commissioner attends meetings with us. I imagine he would probably say the same.

Reverend the Hon. FRED NILE: You said a moment ago that the Medical Board goes out of existence in three months' time?

Mr DIX: Yes.

Reverend the Hon. FRED NILE: What structure will replace it? Will it be one of these medical councils?

Mr DIX: What will happen is that the Medical Board of Australia will take over the registration functions. It will be responsible for placing doctors on the medical register, which will enable them to practice throughout the country. The current Board and its members will form a committee of the Medical Board of Australia to deal with registration matters. Members of the current Board also will transition into the New South Wales Medical Council, which will be responsible for looking after the regulatory functions—complaints, performance, health matters—that are the balance of the Board's work and in fact occupy about 80 per cent of our time. So, most of the work will be done by the same people, but they will have to go to meetings where they will take off one hat and put on another depending on whether they are dealing with registrations or conduct matters.

Reverend the Hon. FRED NILE: So, from your point of view, the main change is the word "board" being replaced by "council"?

Mr DIX: I wish it were that simple. No, no. Staff is being split. A third of our staff will move across to a Federal entity in the city. The other staff will be moving from the Board as the employer, as an independent statutory authority, to become part of the government service. There will be different structures. It is quite a momentous change although we hope, from the point of view of the registrants and the public, it will not make much difference. You will still be able to make a complaint and it will get dealt with. However, internally it is quite a major change. It is not something that is particularly simple.

Reverend the Hon. FRED NILE: Will you still have a role? Will you be a Registrar in the new organisation?

Mr DIX: The staff other than senior staff, and I am senior staff, were guaranteed positions in the new structures. The vast majority of staff will move over. They are advertising the senior staff positions shortly. Of course, currently, we are free to apply for those.

Reverend the Hon. FRED NILE: It would be good to have that continuity of experience?

Mr DIX: Yes. I think the Board sees that too.

CHAIR: Will the same information that exists currently regarding restrictions on registration on practice be available?

Mr DIX: Yes.

CHAIR: At a national level?

Mr DIX: The national register will be on a website run by the Australian Health Practitioners Regulatory Authority [AHPRA]. It is setting up all the IT at the moment. We will dump our register onto that, which will pick up all of the existing registrations. The registration categories will have to be migrated into the new categories under the new legislation, although they substantially reflect what we do already. Any conditions on registration, any restrictions and so on, also will be transferred into the new system, which will then be publicly available on the website, as it is currently on our website.

CHAIR: Thank you for taking the time to appear before us this afternoon. It has been very helpful for our purposes.

Mr DIX: Thank you.

(The witness withdrew)

ANNE LESLEY DEANS, President, New South Wales Physiotherapists Registration Board, 4/98 Queen Street, Ashfield, sworn, and

DEBRA SHIRLEY, Deputy President, New South Wales Physiotherapists Registration Board, 104 Provincial Road, Fairfield, affirmed and examined:

Ms DEANS: At the moment I am managing a not-for-profit organisation. I have with me Debra Shirley, Deputy President of the New South Wales Physiotherapists Registration Board. Because of the way in which we operate we have a Complaints Screening Committee. Debra has a much closer working relationship with the HCCC. I felt that, while I was here representing the Board, it was appropriate to bring Dr Shirley in case you have questions for her.

CHAIR: Ms Deans, are appearing in your capacity as President of the Physiotherapists Board?

Ms DEANS: Correct.

CHAIR: Dr Shirley, are you appearing in your capacity as Deputy President of the Physiotherapists Board?

Dr SHIRLEY: Yes.

CHAIR: I assume that you have received information about the Terms of Reference of the Committee's Inquiry and information about appearing as witnesses before a Parliamentary Inquiry?

Ms DEANS: Yes.

CHAIR: Do you wish to make an opening statement?

Ms DEANS: We do not have a lot to say other than we have put in a submission with the points that we considered important. Similar to the previous witnesses we have also been actively engaged in the national process. To put it into perspective, there are around 7,000 registered physiotherapists in this State, so we are around the middle of the professions, and we receive a small proportion of complaints.

Reverend the Hon. FRED NILE: In your submission you talked about the Charter of Health Care Rights in the Health Care Complaints Act.

Ms DEANS: Yes.

Reverend the Hon. FRED NILE: You expressed concern and said that the charter does not include responsibilities. Could you elaborate on that?

Ms DEANS: Yes, that is correct. In fact, I think the brochure that I have here was provided with the submission. For some years we have had information about rights and responsibilities of patients, clients and consumers of services. Certainly patients have rights and it is important that they are recognised and respected. We also consider that patients have a responsibility to ensure that their treating practitioners have full information to be able to treat them properly. We felt it was important to get that point across.

Reverend the Hon. FRED NILE: Are you referring to their attitude to practitioners? Should they be responsible for cooperating with their practitioners?

Ms DEANS: Yes. I think that they have the right to refuse treatment. They have right to say that they do not want to go along with whatever is proposed. Physiotherapists are very much about fully assessing issues and problems, working out a plan of treatment in collaboration with the patient, and implementing the plan if the patient is happy to go along with that plan. There is then a process of reassessment as they progress through a treatment plan. It is important in the first instance for a physiotherapist to know the full information to be able to structure an appropriate treatment plan. It is important for physiotherapists to take into account issues of informed consent and all the rest of it. Patients have a responsibility to work with them cooperatively and to

respect the professionalism of the physiotherapist, but patients also have the right to say that they do not want to do what is proposed or to seek a second opinion. So there is a balance.

Mrs JUDY HOPWOOD: Does the Physiotherapists Board have a position on the proposition that, at the conclusion of an investigation in the event of a disagreement between the Commission and the relevant registration authority, the most serious course of action proposed by a party should be followed?

Ms DEANS: Yes, I think we would support that. There have been situations when, from a professional point of view, a case may be considered to be more serious. That is a normal and healthy thing. There are different perspectives that should be discussed and generally a resolution or consensus is arrived at. There may be occasions when there is a persistent view that one party or the other considers it to be more serious than the other party. If that is the case that is what should prevail. I do not know whether Dr Shirley would like to comment on that.

Dr SHIRLEY: I totally agree with and support what Anne just said. Let me give you my perspective. I sit on the Board's Complaints Screening Committee. I am one of the members of the Board that meets with a member of the HCCC to discuss physiotherapy complaints. Occasionally we have had situations when the HCCC would like to discontinue or terminate a complaint. It might have done some preliminary investigation or it might have conducted an investigation. I am a physiotherapist so I and the other physiotherapist member of the Board might feel there are issues that have not been fully appreciated by the HCCC in its investigation. We then ask for it to be further investigated.

Sometimes what we find difficult in those situations are the unnecessary delays. We then have to go through a process of terminating the original complaint and the Board having to lay a complaint, so the Board becomes the complainant. The machinations for that to happen unduly extend the process. As you pointed out, under section 13 (1) of the Health Care Complaints Act, that should be allowed to happen and the more serious view should be taken. We would like that to happen. At the moment the administrative processes seem to get in the way. It still gets dealt with but it takes longer than it should.

Reverend the Hon. FRED NILE: The process that you just mentioned of your committee meeting with the Health Care Complaints Commission seems to be working?

Dr SHIRLEY: In broad terms yes. We have had that kind of process for a long time. I have been on the Board since 1995, but I have not been on the Complaints Screening Committee all that time. Throughout that time we have had this arrangement. Since the introduction of the latest Act, which was in about 2002, we seem to have had a better relationship than we had previously. Things now happen a lot more expediently than they used to. Currently we are a lot happier than we might have been, say, 10 or 15 years ago.

Reverend the Hon. FRED NILE: That is very encouraging.

Dr SHIRLEY: Yes. It is a good relationship. Generally we are able to reach consensus on what needs to be done and what direction to take. The instances about which I was speaking earlier are only a few; they are not the norm.

Ms DEANS: I think it is fair to say that the HCCC has been quite responsive to us. We have talked about the Complaints Screening Committee handling specific complaints. We also have an annual planning session. Generally, the HCCC has been fairly responsive in coming and talking to us and discussing issues in that sort of forum. We have been able to work quite cooperatively with the Commission.

The Hon. DAVID CLARKE: It appears as though your Board is going along smoothly without any major complications or problems?

Ms DEANS: It is not without its day-to-day headaches in dealing with these issues. We have a very experienced Board. Amongst all our members we have about 100 years experience on the Board. At a national level the Chairs and Registrars have met annually for many years. I am a member of the National Board, and the members of that Board have all worked together for quite some time. It is quite a harmonious relationship. It does not stop us from debating issues or putting forward different perspectives, which as I said is an important and healthy part of the operation. It seems to work well. We are always looking for improvements.

The Hon. DAVID CLARKE: That is good and very reassuring.

CHAIR: Given that you have some experience on the National Board, do you have a perspective of the health care complaints system in New South Wales as opposed to other jurisdictions? Do you have a view about the benefits or disadvantages of the scheme in New South Wales?

Ms DEANS: Yes. I think ideally we would have liked all the other States to come along with New South Wales. In the absence of that, we are keeping the New South Wales complaints handling structure with the HCCC. The involvement of an independent body such as the HCCC in complaints handling is an important and valuable way to go. I support the direction that we have taken.

Dr SHIRLEY: Aside from having the HCCC as an independent body, our Board's Complaints Screening Committee, which is comprised of another physiotherapist Board member, a legal practitioner Board member and me, keeps information relating to names and details quarantined from other Board members. Every month they get a brief update on what is happening, for example, "We are awaiting a response" or, "It has now gone to the next level", or whatever it might be. However, they do not receive details about who are the complainants, or who are the physiotherapists under complaint. If it ends up at a Board inquiry the rest of the Board members can have that inquiry without any prior knowledge about the complaint.

Obviously, if that happens the Complaints Screening Committee would not take part in the inquiry. We try very hard to keep those processes as impartial as possible, should we need an inquiry. There is one other thing I would like to say about the National Board versus the way in which the State deals with complaints. I refer to our impaired practitioner provisions. As you probably know, in New South Wales we have not so much a disciplinary process; rather we have a supportive and rehabilitative process. My understanding is that the reason we wanted to keep it this way was that so it would not be separate.

Ms DEANS: There are impairment provisions in the national legislation, but impairment tends to be bundled in with complaints handling, particularly when we are looking for voluntary notifications from practitioners who might have some sort of health issue. We really do not want it bundled in with complaints; we want it in a separate stream so that it is seen as supportive. I think that has worked very well for us. We require notification of the impairment. The impairment itself is not the issue; it is whether it is likely to impact on practice and how it is managed. We get good information from physiotherapists with their annual renewals about how they are managing any significant health issues that they might have.

So those impairment provisions and the way they are handled and defining them separately to complaints—I mean a complaint may relate to or may be the result of an impairment—but by defining impairment as a separate stream I think is really important.

Reverend the Hon. FRED NILE: In regard to the discussion paper we put out in September last year, have you had a chance to look at that or to make any response to it?

Ms DEANS: I am sure that is the one we put a submission in and we went through the various issues that we considered were relevant to us. We have a number of issues that were similar to other health professions but there are obviously some differences between the various professions, so I am happy to answer any additional questions.

CHAIR: I think you know we did get that when you made an initial submission and then a supplementary one following the discussion paper. Thank you very much for taking the time to appear before our Inquiry today. We appreciate your evidence.

(The witnesses withdrew)

(The Committee adjourned at 4.47 p.m.)