REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE HEALTH CARE COMPLAINTS COMMISSION ANNUAL REPORT 2015-16

At Macquarie Room, Parliament House, Sydney on Monday, 8 May 2017

The Committee met at 10:00 am

PRESENT

Mr A. Crouch (Chair)

The Hon. L. Amato
The Hon. W. Secord
Mr M. Taylor
Ms K. Washington

The CHAIR: I am delighted to declare this hearing open. I welcome the Commissioner and her senior officers from the NSW Health Care Complaints Commission to the Committee for the purpose of giving evidence on matters relating to the 2015-16 annual report of the NSW Health Care Complaints Commission.

Before the proceedings commence, I remind everyone to switch off their mobile phones as they can interfere with Hansard recording equipment. If your phone is on silent, please switch it off immediately. In accordance with section 65 (1) (c) of the Health Care Complaints Act, it is a function of the parliamentary joint Committee on the Health Care Complaints Commission to examine each annual report of the Commission and to report to Parliament any matters arising out of it.

SUE DAWSON, Commissioner, Health Care Complaints Commission, affirmed and examined

TONY KOFKIN, Director of Investigations, Health Care Complaints Commission, sworn and examined

KAREN MOBBS, Director of Proceedings, Health Care Complaints Commission, affirmed and examined

CELIA MURPHY, Acting Director of Assessments and Resolution, Health Care Complaints Commission, affirmed and examined

The CHAIR: Do any of the witnesses have questions about the hearing process?

Ms DAWSON: No, Chair.

The CHAIR: Commissioner, would you like to make an opening statement?

Ms DAWSON: I would like to acknowledge your appointment as Chair of the Committee, Mr Crouch. I very much look forward to working with you. I also acknowledge the new members of the Committee, Mr Taylor and Ms Hodgkinson. We look forward to the discussion today. Obviously we are very proud of the work of the Commission and any opportunity to talk about it is a welcome one for us.

The CHAIR: In that case, we will move on to questions straightaway. One of the things I noted as part of the annual review was the increase in the time taken to process the reviews: only 9.8 per cent of the requests for reviews of assessment of complaints were processed within a four-week period, which is well below the Health Care Complaints Commission target of 90 per cent. The target of four weeks was reduced from the original six weeks. Do you believe that the four-week period may not be suitable to review those complaints given the swing in the results?

Ms DAWSON: Thank you for that, Chair. Obviously one of the real challenges that the Commission faces is that in a circumstance of increasing volumes and complexity of complaints we are now in a position where we have more than 6,000 complaints a year, and each and every one of those complaints is important to us. We have a 60-day statutory time frame to assess each complaint. That is 60 calendar days, so that is a very short period of time to come to grips with what are often very complex, sensitive and searching issues that we need to deal with. In terms of what we place absolute priority on, of course we want timely results for complainants—of course we do—but we also want to assess things in a high-quality way, so we are conscious that that has led to a little bit of a blowout in timeliness. I guess our sense is that, in a world where complaints are more complex, perhaps some tolerance around time frames is quite important because from our point of view the one thing you cannot compromise and you can cannot take shortcuts on is the proper examination of complaints that are about the wellbeing of individuals in a way that delivers procedural fairness to the providers and the health organisations that are involved. Our responsibility under the Act and paramount consideration is protection of public health and safety. That is our pre-eminent consideration, and we regret that time frames at the moment are very difficult to achieve and we are realising that objective.

The Hon. WALT SECORD: I have a follow-up question: What do you propose to cut the time frame problems?

Ms DAWSON: What do I propose in order to meet time lines?

The Hon. WALT SECORD: What would you like to see happen? Do you need more resources? Would more staff or a funding injection assist you with cutting the time frame?

Ms DAWSON: It would be unrealistic of me to say that I would not of course welcome more resources. That would be an incredibly useful thing. That aside, I think that some acceptance that there is a certain proportion of complaints where realistically we might need to accept that a good outcome will take longer—just a consciousness around that and an acceptance of it—and an acceptance that, to the extent that we have a 60-day time frame, it is a laudable and important aspiration for the vast proportion of complaints but sometimes we will not be able to get there. The thing that I am very conscious of going forward is that in order to get a better balance between good outcomes and time frames I need to invest in making a transition from a very cumbersome, paper-driven complaints process to an electronic process. Of course, these are the things that are difficult to invest in when your absolute priority on a day-to-day basis is investing in your frontline staff and your operational effort. Some of those business improvements are difficult to achieve, so that is certainly something we want to focus on.

The Hon. WALT SECORD: What is the average time frame from a person making a complaint to you considering it resolved?

Ms DAWSON: My understanding, and Ms Murphy could help me with the precise number, is that at the moment the average days taken to assess a complaint is 56 days. Is that correct, Ms Murphy?

Ms MURPHY: I cannot remember off the top of my head.

Ms DAWSON: I am going to say 56; it might be 56.5 or thereabouts.

The Hon. WALT SECORD: Around 56 days.

Ms DAWSON: Yes. Sorry, it is 57 days, actually.

The Hon. WALT SECORD: It takes 57 days to assess. When you say "assess', what does that mean? Does it mean "There's merit in this" or "This is a just a vexatious complaint: Chuck it out the window"?

Ms DAWSON: Fifty-seven days is the time it takes for us to say, "Having received this complaint, having sought all records and responses, are we of a mind to discontinue it because it may be considered that we have not been able to substantiate the issues raised in that complaint?" We may discontinue it with comments. We may decide it is of a serious nature and it may need to be investigated. We may find that the issues raised may be about a practitioner who could be impaired and they need to be referred to the relevant professional council to join a health program, or there may be a performance issue where the very best response from the council might be mentoring or additional training and development, so we would refer it to the council at that point.

The Hon. WALT SECORD: What would happen after day 57? What is the next stage?

Ms DAWSON: For each scenario something different would happen. I am sorry; I am not trying to introduce complexity. There is inherent process complexity, so let me go through that. If we were discontinuing a complaint, we would simply write to the practitioner and the parties. If discontinuing with comments, we would take particular effort to add to that letter, guidance and instructions to the practitioner on areas for improvement—whether it is in record keeping or communication.

I will pause here because I have missed an important step; I apologise. For every complaint that is about a registered health practitioner we must consult with one of the relevant 14 professional councils. So there is a consultation stage. I will now duck back into what we are actually consulting on. I have already been through the processes for discontinuing ones. If we are referring something for investigation, it will go straight into the Investigation Division—to Mr Kofkin—and we would commence preparation of an investigation plan, which would be about delving down and doing a much more forensic analysis of what there is to see: Is there a significant departure, what do the experts say, are there more witnesses, et cetera?

That is what would happen in an investigation. If a matter was referred to one of the professional councils, they may bring the practitioner in for a cognitive assessment, for instance, in the health program, or they may seek further information about any medical conditions they may have that may be affecting their performance. In performance-based issues they would typically bring them in for counselling and/or other action. We may refer a matter to another body, just to complete the full suite of possible outcomes. So if a matter is really about a privacy breach, we would link into the Privacy Commissioner. If it were a matter relating to an aged care facility, similarly, we would refer it to the national Aged Care Complaints Commissioner. I could go on, but those are all of the possible outcomes that would apply.

The CHAIR: Does that answer your question, Mr Secord?

The Hon. WALT SECORD: No, it does not.

Ms DAWSON: It does not?

The Hon. WALT SECORD: No. What would be the average time after the 57 days for an investigation path? That is where I want to go.

Ms DAWSON: Our key performance indicator [KPI] is for investigation. I can see where you are heading—it is the end to end. From the time a person makes a complaint, when is our activity likely to be completed? We talked about the initial 60 days. Once something goes into investigation, we are required to expedite our investigations and take all due efforts to deliver a timely investigation. We aim, in almost all circumstances, to have investigations completed in six to 12 months. Where we have a difficult complaint we are finding it difficult to achieve that 12-month time frame. So if we have an investigation in which there is one provider who might be operating across public hospitals and private hospitals in various different circumstances and where there may be dozens, if not more, patients of different kinds involved, we need to delve down into those. But our objective is to complete an investigation within a very realistic time frame.

Once something is investigated, if there is a decision to take disciplinary proceedings, we must then refer that recommendation to the Director of Proceedings. The Director of Proceedings has time frames within which to determine what forum to use. So it is true that when a complaint is going through disciplinary proceedings it will take 18 months or sometimes two years, depending on the circumstances. If it is going to a tribunal there may be a delay. Those are factors outside our control.

The Hon. WALT SECORD: In the annual report it says that in the last five years the number of complaints to the HCCC has increased by 47.1 per cent. Is that because of awareness in the community of your activity? Is it an increase in the number of problems? What is the reason for that 47.1 per cent increase?

Ms DAWSON: I will make a couple of observations first, if I may. The increase in the volume of health care complaints received is a national and an international phenomenon. It is not unique to New South Wales. There is nothing particularly special going on here. Having said that, we have looked at the international and national evidence and data on this and found there are a number of things driving it. We have reported on this on page 15 of the annual report. It is really good. I am sorry; I am proud of the analysis that we have been able to undertake in relation to the volume of complaints. It is clear from that that there is no single factor driving complaints. There are obvious issues relating to the pressures of the ageing population, which leads to an escalation in demand for health services. Also, as we age, there is a manifestation of more significant chronic health conditions. So there is an issue about the increasing use of the health service.

In relation to other issues, one of the real factors that the international research points to is the particular effect of increasing community awareness and empowerment. Patients have taken ownership of their health. They are better informed. They use a wider range of practitioners. For individual health consumers there is not a posture of deference to the practitioners, so much as a questioning disposition: "Am I getting the best treatment? I have done some research about my condition and what is available, and I would like to know more about why I have not been offered that form of treatment." There is just a lot more information that people can source. They may wish to test whether the option that was chosen for them was the best that could be achieved in their circumstances.

The other really important thing is that, when you talk to complainants, individuals say to us, "When something goes wrong, we simply want to know that an independent lens has been put over what has gone, and we are really comfortable using the Health Care Complaints Commission for that purpose." I could go through some of the other factors, but I think those two factors—the ageing population causing increased demand, and community awareness and empowerment—are really important.

The CHAIR: Basically, are you saying that the increase in complaints that we have seen in New South Wales to the HCCC is not a phenomenon? Are you saying that it basically fits in with what is happening nationally and internationally—the standards are pretty much emulated around the world?

Ms DAWSON: That is correct. I note, for instance, that in the annual report on page 15, the percentages of increases in Queensland and Victoria are very much on par with ours. The UK experience is exactly the same. So, yes, it is a sort of trend that follows through all jurisdictions. It is not to do with the standards of care so much as those other factors that I was talking about.

Ms KATE WASHINGTON: Further to the questions that Mr Secord was asking about the length of time, I am aware of a particularly complex case and complaints that have come to you which I understand has taken 2½ years from the time of complaint for it to be resolved or referred. It is currently with NCAT [NSW Civil and Administrative Tribunal], who has told the complainants that it will not be able to come to the case until 2018. So in terms of the length of time from an initial complaint to any kind of resolution for the complainant, which does involve a large class of people, is that a reasonable outcome for those complainants?

Ms DAWSON: My earnest objective for any matter that comes in to the Commission is to assess it quickly and to meet our statutory obligation to expedite the investigation. When a matter goes to the Director of Proceedings, as I said earlier, some of those delaying factors are not within our gift. It may take time for a matter to be listed, for the parties to be ready and so on. Ms Mobbs may be able to add to that side of it. As for our own processes I am conscious, as is Mr Kofkin, that once something goes into investigation, particularly where there is a novel aspect—not novel as in something to celebrate or a narrative, but something new and different—and something that involves cross-jurisdictional issues, it is complex.

In some cases we have complaints that involve perhaps the Therapeutic Goods Administration where there are questions about access to medical devices and how that whole situation worked. There may be an international dimension to the issue where there may be class actions going on in other jurisdictions. Our challenge is to be aware of the whole landscape and draw on the evidence pieces that are emerging and make sure we have the best case we can assemble. Two and a half years I would have to say with respect is an outlier

in timing terms, very much so. It suggests to me that the complaint you are thinking about has profound complexity. We have done our best, if there are those complexities, to chase down all the evidence and assemble the best case we can.

Ms KATE WASHINGTON: Are there impediments that the Commission encounters to properly investigate the cross-jurisdictional issues between agencies, regulators, as well as State and international boundaries? Does the Commission have impediments to accessing information that would allow a more timely investigation of those complex complaints?

Ms DAWSON: If a matter is within jurisdiction, within New South Wales, we have excellent data exchange and information exchange protocols in place. Once we are dealing with Commonwealth bodies and situations where there is material that we need to get from other countries, obviously there is a greater investigative difficulty. In some cases we need to get extensive information from the Therapeutic Goods Administration, Medicare or other national bodies and that does take more time than we would like on occasion.

Ms KATE WASHINGTON: Is there something we could be doing to allow those pathways? It must be frustrating in terms of Commonwealth agencies and the transfer of data and information if there is a lack of timeliness in that transfer. Is there more that could be done to improve the transfer of information?

Ms DAWSON: Yes. I am delighted to be able to say that having raised these issues with our Commonwealth counterparts, this week sees the first meeting of a forum that has been convened called the Consumer Health Regulators Forum. It has been convened by the Australian Competition and Consumer Commission and it will involve the Private Health Insurance Ombudsman, Therapeutic Goods Administration, Australian Health Practitioners Regulation Authority and I have been invited to join that committee for the very purpose of exploring, from a State perspective, the impediments to the exchange of information that will assist investigations. We have been making approaches to our Commonwealth counterparts on this issue for some time and this is a good result from that. We will have an opportunity in that forum to identify cases where we are experiencing difficulty in accessing information and to perhaps design a framework around which data exchange and information exchange can work more smoothly.

The CHAIR: Will that committee include your counterparts from other States?

Ms DAWSON: At the moment I am representing them as the Chair of the Healthcare Complaints Commissioners Conference for this year. I will be involving and representing them as appropriate. They will have an opportunity to identify impediments to data exchange, I will be able to represent that and we may change or increase the representation from the State healthcare complaints entities.

Ms KATE WASHINGTON: The case that I am referring to and the complaints involve the use of transvaginal mesh, that has been aired through Hunter media particularly, involving women across Australia and internationally. I am wondering how the Commission responds to complaints where one practitioner is receiving a lot of complaints about one particular device or surgical procedure. I saw in the report there is a reference to one complainant making lots of complaints, but I am talking about a lot of complainants making one complaint about, albeit, obviously different surgical procedures but largely around the same device and the same practitioner.

Ms DAWSON: One of the things that we would routinely consider in any assessment we undertake is whether an individual practitioner is the subject of other similar complaints or other complaints that do not seem similar but could potentially be relevant. Prior complaints are always part of our assessment process. They are one of the weighing factors that we use to say, "Okay, there is more to see here, there are a number of patients and similar facts." We would typically expedite that sort of case into investigation, which is the action that was taken in this situation.

Ms KATE WASHINGTON: Does the Commission have adequate powers to protect people in circumstances where a complaint is not resolved but there is enough weight of evidence to suggest that more people might be harmed if action is not taken?

Ms DAWSON: Here is where another complexity in the healthcare complaints system comes in, which is our co-regulation function with the professional councils. The professional councils are established under the national law and one of their important functions in relation to registered health practitioners is to consider immediate action whilst a complaint is being assessed, or investigated or prosecuted. At any point is there a sufficient need—so is it appropriate in the public interest—for there to be conditions placed on the registration of that practitioner or is it appropriate for that practitioner to be suspended or prohibited from dealing with a particular class of patients in the interest of protecting public health and safety? Any such decision, whether suspension, prohibition or conditions, will remain in place until such time as a decision has

been made as to whether to take disciplinary action and/or complete an investigation. There is a protective aspect within the domain of the professional councils.

Ms KATE WASHINGTON: In circumstances where a doctor has retired, or a health professional has retired, is the Health Care Complaints Commission's role ended? Ultimately, that is the strongest outcome that can be achieved through a complaint, for them to be deregistered. If a doctor retires does the Commission cease to pursue its complaint or will it continue down that path so that people may get an opportunity to understand what it is that has happened?

Ms DAWSON: Yes, it is an important complexity. I guess your interest is in where a practitioner is the subject of—

Ms KATE WASHINGTON: Multiple complaints.

Ms DAWSON: —multiple complaints and perhaps in the legal process of being brought before a tribunal or a professional standards committee.

Ms KATE WASHINGTON: Yes.

Ms DAWSON: There are particular decisions to be made throughout the process. Ms Mobbs can elaborate on them.

Ms MOBBS: Once a matter is referred for consideration of disciplinary action, there is a number of criteria that I take into account. One of them is obviously protection of the public. There is also the likelihood of proving the complaint. Protection of the public has a lot of different factors and it really depends on the matter. If somebody retires from practice, there is no prohibition on continuing the matter; it can still be prosecuted. If it relates to a professional standards committee [PSC], it is unlikely in that case that someone would be cancelled or suspended. In that instance something that may be taken into account is that there may be little use in proceeding with the matter in terms of protection of the public if the person is already off the register and the highest outcome that might be achieved would be conditions on registration. It is that balancing act of public funds versus the outcome.

Ms DAWSON: The other thing I would add is that if a practitioner had retired or taken themselves off the register, any decision for us to discontinue that matter at the point of investigation or legal proceedings would be accompanied by notification and provision of all of the materials relating to that investigation or action to Australian Health Practitioner Regulation Agency [AHPRA]. If that practitioner re-presented for registration at a future point, AHPRA would consider all of that material in relation to whether that person was fit and proper to be registered. That would be under consideration. That is essentially the guard to re-opening the door.

The Hon. WALT SECORD: Can I re-ask the question?

Ms DAWSON: Yes.

The Hon. WALT SECORD: Can you escape if you retire?

The CHAIR: I think Ms Mobbs has answered that question.

The Hon. WALT SECORD: I would like a clear answer on that.

Ms MOBBS: Can I continue, because I was only part of the way through? There is another aspect to it, obviously, in relation to tribunal proceedings where there is the possibility of cancellation or suspension—taking someone's name off the register. We have proceeded against many, many practitioners who have either retired or taken their name off the register. Usually in that case, either at the PSC level or the tribunal level, there will be an affidavit by the practitioner that they are taking their name off, they will never seek to re-register and they understand that if they do, that complaint can be brought against them. As the Commissioner has indicated, when we decide not to prosecute for any reason, we advise the national authority, AHPRA, provide information to them and indicate that we are willing to assist in the future in terms of whether that party would be re-registered. We also retain the option that if for any reason they were to be re-registered, we would be able to take prosecution action again in the future. The practitioner is also advised of that at the time.

In terms of tribunal proceedings, however, other material may lead us to decide that it is appropriate, notwithstanding the cost of proceedings, and in the public interest to proceed with a matter. It may be for a general deterrence reason; we may feel that it is not appropriate that the practitioner is seen to be able to take their name off and perhaps escape prosecution action. We also look at the other options that come from prosecuting a practitioner. If they are cancelled or suspended, we have the option to seek what is called a prohibition order from the tribunal. That is a really strong and wide-ranging order that a tribunal can make,

prohibiting that practitioner from practicing not only in their profession but also in other health professions as well.

With a psychiatrist, for example, we may decide to prosecute, notwithstanding the fact that they have taken their name off the register, to seek a prohibition order stopping them from offering counselling services or any other health service in the future. I do not think there is any one answer. I look very carefully at the individual case. I look at submissions and do a very careful balancing exercise. If there is a complainant, a patient or a family, I often involve them, discussing those issues with them and taking into account any concerns or views that they may have.

Mr MARK TAYLOR: Commissioner, I pass on my appreciation of your staff in this increasingly complex and voluminous area.

Ms DAWSON: Thank you.

Mr MARK TAYLOR: One of the roles of the Commission is also outreach and community engagement. Could you run through workshops, presentations to various groups et cetera in 2015-16?

Ms DAWSON: Thank you, Mr Taylor. That is a really important part of our work. Everybody across the Commission is very conscious that there are some things we really want to achieve in our outreach program. One is that we recognise that there are particular classes of complainant that may need assistance to access the complaint system. They may be located in more remote areas, they may not be aware of the work of the Commission, they may not have English as their first language or they may be in a particularly vulnerable group—perhaps they are people with mental health issues or whatever. A very important part of our outreach program is to make sure that we are communicating the role of the Commission very clearly and accessibly to some of those segments of the community.

We are also very committed to going beyond raising awareness of the work of the Commission to raising the capability of people to navigate the complaints systems. For instance, we run very tailored workshops out in Indigenous communities through which we ensure that the community understands how to best access or enter the complaints system if they wish to make a complaint. For some of those vulnerable people, at the point of making the complaint we also have particular techniques for assisting them where they may have difficulty. Our Inquiry Service is an absolutely important frontline service that assists people to make a complaint if it is difficult for them to do so, including actually working with them to prepare the complaint, to scope their issues and to be really clear about what their concerns and expectations are. Our Inquiry Service is really a jewel in the crown of the Commission's work.

We are also very conscious that there are many, many faces to the health system out there. We want to be sure that the health service providers are also well equipped in their complaints management capabilities, so we run workshops for health service providers of every complexion, whether they are community based providers or within our local health districts. We talk to them about what best practice complaints management at the frontline looks like, because we so often say the very best way to deal with a complaint is to have a minimum of time between the incident occurring and some positive response to it. Our outreach program involves workshops with local health districts at which we get nurses, clinicians, clinical governance folk and the executive membership of those organisations sitting down with us and talking about how they are going to deliver the best result in terms of meeting their obligations under the national quality standard to have a first class complaints management system and to be increasingly responsive to the needs of their patients and their families.

Sometimes we may have a fairly disempowered patient. We want people to understand the importance of responding to families and how to do that—how to manage a good open disclosure conversation. Those are hard conversations to have. Practitioners are naturally wanting to be assisted developing their skills to have good open disclosure conversations. These things are all the focus of our outreach program. Just to round off—as you see I am proud of that part of our work so I could go on at length and am happy to do so. We have also, of course, written guidance for people in the 20 community languages and so on, that give people a very clear picture of how they can engage with us and what they can expect when they do.

Mr MARK TAYLOR: And it is the case, is it, that with the increased number of complaints coming in unfortunately you have to redirect resources to those complaints, rather than towards the education proactive role?

Ms DAWSON: Yes, you are right to say that we do very, very much prioritise our operational functions. Our core business is best practice complaints management and investigation and prosecution. But we need to look to making technology and communications breakthroughs our friend here. We focus on doing more webinars and electronic education wherever we can. We are also in a dilemma where, in this world of health

care complaints management, there really is not a lot of substitute for good face-to-face education and communication. It is hard because the thing we are saying to doctors—you will see in the annual report—a real thread about communication, communication, communication. And when communication breaks down between practitioner and patient, then a complaint will almost surely follow. We actually are very mindful that everything we do is about best practice communication, but it is challenging.

Mr MARK TAYLOR: On that communication point, I take you to the issuing of public warnings. Can you just run us through how a decision is made to make a public warning and of particular interest to me is the measurement of any effectiveness of those warnings.

Ms DAWSON: Yes, I can certainly do that and Mr Kofkin might like to have the opportunity.

Mr MARK TAYLOR: There was a warning put out about a cosmetic procedure during the year.

Ms DAWSON: Yes, cosmetic surgery and medical procedures.

Mr KOFKIN: The most recent public warning was the Medical Weightloss Institute [MWI]. So, how do we do that? First of all, there needs to be a complaint generated, even though the Commission can make its own complaints in certain circumstances like we did a few years ago with AVN [Australian Vaccination-skeptics Network]. So with MWI we received a number of complaints from consumers who had undertaken a so-called medical weight loss program where they paid up to $5,000 for a program which had no scientific basis at all. The claims were that there had been a breakthrough discovery, a link between hormones and weight loss and this breakthrough discovery would result in the lowering in the production of insulin and cortisol and therefore you would burn fat more easily and your metabolism would quicken and then basically you could sit down and lose weight by doing nothing. That was the long and short of it really. We received a number of complaints. The business model, the modus operandi was, there were some general practitioners who claimed to be weight loss specialists, they would ensure there was some pathology and get blood tests. So each program had a tailor-made program for each patient that gave it some veneer of respectability. There were meant to be nurses, there were meant to be life coaches, psychologists et cetera who were going to help these individuals to lose weight.

We received many, many complaints; we received responses from a number of practitioners, from the people who owned the clinic, from pharmacies who were actually compounding the medication as well—because they were compounding medication such as phentermine or metformin, which is for diabetes and is contraindicated for people suffering from renal impairment. And we discovered, the tipping point for us in our investigation when we realised how serious this was in terms of a risk to public safety, obviously there are consumer issues and the Commission was talking about how these things cross over for fair trade and the Australian Competition and Consumer Commission [ACCC] but when we started actually drilling down in terms of the type of medication which has been prescribed, when there was no proper health assessment—these are Skype consultations, sometimes from overseas doctors—no consultation with the individual's regular GP to see if there were any other health issues—we discovered a few times where the actual medication regime was dangerous. Therefore, we could show that link between the health and safety of the public. At that point we decided to make a public warning.

So we gather all the evidence from a number of different sources and then myself, the Commissioner and one of our legal officers in the Investigations Division, we have a look and make sure that we have a sound basis to make a public warning. That is what we did with MWI, that is what we also did with another public warning the Commission made in relation to non-registered practitioners carrying out invasive medical procedures, botox but also double eyelid surgery. That is the process. It really is gathering as much information as you can from all the different sources and making sure that you can actually identify that link between the risk and the dangers to the public.

Ms DAWSON: So, to round that off, the power to issue a warning, how is that decision anchored? It extends from section 94A of the Act which provides that: If during an investigation the Commission is of a view that issuing a public statement about a particular treatment or a health service is necessary to protect the public health and safety and that any further delay in issuing the statement poses a risk to an individual or to public health and safety, the Commission may cause a public statement to be made. So Mr Kofkin has highlighted a couple of examples where, during an investigation it did become clear that the best interests of the patient, the health and treatment of the individual, seemed to be secondary to some other motivations. That is the point at which we will act.

The Hon. WALT SECORD: Ms Dawson, back to the point my colleague Kate Washington raised about the vaginal meshing, would it not have been appropriate to issue a warning about that to the community,

taking up the procedures and the way you describe what should have happened? Should that not have occurred involving the Hunter vaginal meshing matters?

Mr KOFKIN: I think, in relation to that, the product had not been recalled, it had been cancelled, so the product was no longer available, which is significantly different. And as well, we knew that we had the clinicians who had been using the product who were on conditions not to use the product any more. So there was not that type of risk because there were other factors which prevented the clinicians from using that tissue fixation system [TFS] device because the Therapeutic Goods Administration [TGA] had withdrawn it basically. But, in future, that is certainly something the Commission could look at. We also need to think about what the role of the TGA is in relation to these matters. As you know, there is a Senate inquiry coming up soon and the TGA has a large part in that Senate inquiry in relation to their processes and procedures.

I just go back in relation to what Mr Taylor was talking about, in terms of how do you know they work? That is a difficult question, obviously. What I can say in relation to the public statements we make, in terms of prohibition orders for non-registered practitioners, I receive phone calls from all over the world where individuals have been applying for work and certain checks have been carried out. People like to Google these days as a referee check and they have seen our statements of decision. Our statements of decision do not have any jurisdiction. They do across Australia now but they do not have jurisdiction overseas. But they speak for themselves, when someone can access a statement of decision and look at the grounds. So the public warning does have a big impact, I have no doubt—MWI basically are out of business now.

However, the problem for the Commission—and lots of the other regulators around the country—is about how you stop these people morphing and creating a new company and starting off again, in Victoria or elsewhere. Because the profits are absolutely huge, they really are. What you actually find is that it takes a while for the regulators to catch up. A bit like the police sometimes. It takes time. By the time you catch up, all the money has been made and that is what they are motivated by. As the Commissioner said, they are not motivated by improvements in people's health; they are motivated purely by making millions and millions of dollars.

The CHAIR: I have a follow-up to Ms Washington's question about the procedure. My understanding is that the TGA had cancelled the device. I am assuming that there were no subsequent practices carried out once the TGA had cancelled the device. Is that correct?

Ms KATE WASHINGTON: To jump in, I understand that this device has morphed into various devices, so whilst one device may have been—

The CHAIR: Banned by the TGA.

Ms KATE WASHINGTON: —correct—it has had a number of different names—

The CHAIR: Different incarnations.

Ms KATE WASHINGTON: —and a number of different incarnations.

The CHAIR: Mr Kofkin, is that similar to what you said before, that it is a moving game?

Mr KOFKIN: I think there is a distinct difference between organisations such as MWI and medical devices which are licensed by the TGA. There are similarities, but I think there is a distinct difference in terms of how the Commission would make a public warning in relation to those issues. By the time the Commission received those complaints in relation to TFS, as you know, the complaints were historic and some of them went back a number of years as well. I think the TGA at that point had not actually withdrawn the device but it did very shortly after the Commission received its first complaint due to the outstanding work of one of the complainant's husbands. But there is a distinct difference. If we were to encounter something like this again in the future, there would certainly be potential for the Commission to make a public warning and work more closely with the TGA and maybe put some more pressure on.

Ms KATE WASHINGTON: Particularly given that our whole medical system relies on informed consent, and if you have not got that in the public domain and everyone is saying that these people are good people. I take your point in relation to devices, but the device was still being used by doctors and health practitioners.

Ms DAWSON: Yes, and the opportunity that we have to raise exactly these issues with the TGA about not just what our individual points of entry to health regulation are but how they can all work together in a more effective way so that the situations are dealt with in a timely way and the most comprehensive way. That concerns us. That is why we are proud to be at the table at the new consumer health regulators forum. The other thing I want to say is that the provision that allows the Commission to issue a warning during an investigation is a relatively new one. It was only introduced in 2015. Prior to that we could only issue a public warning under

section 41A, which is the section that deals with a warning after an investigation is completed, generally only useful in the context of non-registered practitioners. This was a really important addition to the regulatory armoury, and it is one that we have now started to use whenever it is prudent to do so.

The CHAIR: I have a follow-up question in relation to Mr Taylor's question. What form do the notices that the HCCC gives out take? What is done when notifying the public?

Mr KOFKIN: Sorry?

The CHAIR: When the HCCC issues a warning—

Mr KOFKIN: A prohibition order, yes, or a public warning.

The CHAIR: —what processes are involved? How is the public informed?

Mr KOFKIN: First of all we put the public warning on our website. In fact, if you were to go to our website now and look at media releases, the first thing that would come up is the MWI warning. We also draft a media release, and that media release is disseminated to a number of media outlets. It goes to all of the health professional councils, it goes to AHPRA and it goes to all of the main media outlets as well. They are always picked up. In fact, if you were watching the news on Channel 9 on the weekend, it showed the story of the fake doctor-dietician who claimed to work for the Adelaide Crows and the Canterbury Bulldogs, claimed to be a doctor and claimed that he could cure cancer. We made a prohibition order and the following day when that press release went out it was picked up by Channel 9. They are picked up by the media outlets because they are real stories of interest. They are a very interesting angle in relation to those types of—

The Hon. WALT SECORD: On that note, can Ms Dawson bring us up to speed on the latest on the fake doctor who worked at a number of hospitals—Gosford, Manly, Wyong and Hornsby—for 11 years? What is the status of your examination?

Ms DAWSON: It is not a review that is being undertaken by the Health Care Complaints Commission; it is an inquiry being undertaken by the Ministry of Health. The question is best directed to it.

The Hon. WALT SECORD: Have you had any complaints or inquiries about it?

Ms DAWSON: We have not.

The Hon. LOU AMATO: Following Mr Secord's question regarding the fake doctor, what has been undertaken to ensure that that does not happen again? What has been undertaken to ensure something similar does not happen in the pharmaceutical and other medical professions?

Ms DAWSON: I had the benefit of attending a national conference of healthcare complaints entities last week. The Australian Health Practitioners Regulatory Authority, the registration body, the front line of registering health practitioners in New South Wales—it is not a State-based function—was basically talking about the conversation it is having with immigration authorities and so on about who is best placed to ask and answer the question, "What are your overseas qualifications?" and, to the extent that we are relying on it in an Australian context, "How are they verified?" I can report back to you that that is where that issue is.

The Hon. LOU AMATO: "How can you identify that these qualifications do belong to this person here?"

Ms DAWSON: Yes, that is right.

The Hon. WALT SECORD: Good question, Lou.

Ms DAWSON: Yes, it is a good question.

The Hon. WALT SECORD: How does that occur?

Ms DAWSON: I think that there are all sorts of bodies at national level, and I am more than happy to try to take that on notice and have some of the—

The Hon. WALT SECORD: Do we have many cases of investigations into fake doctors?

Ms DAWSON: Not in New South Wales. Mr Kofkin was talking about the whole question of a non-registered practitioner holding themselves out as having qualifications and so on and so forth.

The Hon. WALT SECORD: That is what I would call a fake doctor. Mr Kofkin, are there many instances of people whom I would describe as fake doctors but whom you would describe as people who put themselves up as having, but who do not have, the appropriate medical background?

Mr KOFKIN: There is a distinct difference. A fake doctor—in terms of the one I believe was from India, he was a registered practitioner, so he has used falsified documents to obtain registration, whereas the non-registered practitioners have no qualifications in medicine, they do not have a medicine degree and they have never been registered before. They are providing health services sometimes where they do not require a degree in medicine, and other times they are enhancing their qualifications, saying that they are a doctor, a physio or a pharmacist et cetera. For those types of offences, the Commission will investigate those non-registered practitioners but we can also refer the practitioner to AHPRA as well, which has the authority to prosecute them for holding out.

The Hon. WALT SECORD: In 2015-16 how many people did you investigate who fit the category you have just described, as holding themselves up to have certain qualifications that they did not have?

Mr KOFKIN: Just a couple—I think two.

The Hon. WALT SECORD: What happened to them?

Mr KOFKIN: We made prohibition orders for both of them.

The Hon. WALT SECORD: Did they go to court? Did they end up with criminal charges, or did they just get a slap on the wrist? What happened to them?

Mr KOFKIN: I cannot really comment on anything which may be ongoing with the police, but there are times on many occasions when we investigate these matters when we do refer them to the police.

The Hon. WALT SECORD: What were these two individuals doing?

Mr KOFKIN: The one that was in the media over the weekend claimed to be a qualified dietician and nutritionist. He claimed to have worked in numerous local health districts and he was providing care and treatment, dietary and dietician advice to some patients who were also suffering from cancer, and he had absolutely no qualifications. He did not have a degree.

The Hon. WALT SECORD: He did not even have a degree?

Mr KOFKIN: No. He had done some training in nutrition. Again, he is one of these individuals who built up a very impressive CV which had absolutely no merit whatsoever.

The CHAIR: It had no substance behind it.

Ms DAWSON: No.

The Hon. WALT SECORD: What was the second case?

Mr KOFKIN: The second individual was a counsellor. He claimed he was a psychologist.

Ms DAWSON: I fear we may be straying into some issues that might have some—

The CHAIR: While it is interesting, there is the scope of the HCCC's report.

The Hon. WALT SECORD: This relates directly to the activity of the HCCC in 2015-16. I would like the witnesses to continue.

Mr KOFKIN: One of the matters is currently before NCAT, so we cannot comment on that. Just to give you a flavour, there are many occasions when non-registered practitioners inflate their qualifications and their experience and knowledge. If you look at our website you will see a number of decisions in relation to that. Ian Pile, a medical herbalist, claimed that he could cure cancer. He was caring for a lady who had colorectal cancer which had metastasised. She was very unwell; she was dying. She did not have too long to live, and he claimed that he could cure her cancer by providing her with these herbs which made her very sick. He made her so sick that, unfortunately, the quality time she wanted to spend with her family was not available.

The Hon. WALT SECORD: What happened to this character?

Mr KOFKIN: We made a prohibition order against him, as well as making a public statement.

The CHAIR: I would like to ask a question with regard to our previous meeting with the Commissioner with regards to the local health districts. You were going to undertake visits with the local area health districts after being appointed to the job. I remember asking you that question when I was here last year. Can you explain the outcomes of those visits and what took place?

Ms DAWSON: Yes. I had the privilege to undertake a set of scheduled visits to each and every local health district in New South Wales during the course of 2015-16. Some of them were actually nudged into 2016-17, but that is when they occurred—or thereabouts. I was able to sit down with the chief executives, the

executives and clinical governance directors of each local health district and talk to them about the volume and pattern of complaints in the local health districts, and how they compared to other local health districts and whether there were any particular issues or patterns that differed. I was able to receive from them advice on their own complaints handling procedures and satisfy myself that they were investing heavily in their local resolution activities consistent with the National Safety and Quality Standards.

I was able to hear from them areas where our own administrative processes were cumbersome for them and where they felt they could assist us in a more efficient way if we streamlined our processes. I will give you an example. Before I made that visit, we would typically say to a local health district in relation to a complaint, "Please provide us the medical records for Mrs Smith." They would diligently go and collect the five boxes of records relating to the treatment of Mrs Smith over a period of time. There may have been a number of admissions. We are now gradually improving our practices so that we scope up front what we really need to know about Mrs Smith. "Please advise on what occurred immediately following her admission on 15 May, and for all parts of her care thereafter, including her discharge papers." That has introduced an efficiency that means that we get a more focused set of records and documentation. That is good for the health district and it is good for us to be able to focus our efforts.

We have also talked to the local health districts about the need for us to close the loop with our investigations. As you will see from the annual report, our complaints, a proportion of the time, lead to us referring something back to local health districts for local resolution because the matter is really about the service that the person got from the hospital that they presented to—perhaps the time that they spent in emergency or perhaps the open disclosure meeting did not really cover all of their needs or they have not had access to their records. Those are things that can be dealt with more effectively locally. But once we referred something to a local health district for local resolution we did not have any way of knowing what they did with it. It was a bit of unfinished business, if you like. So we negotiated with each of the local health districts that in relation to every single complaint that we refer to them for local resolution they will now advise us about the point at which they have resolved it and what they have done to resolve it, so that we know more about what the individual's journey through the whole complaints system has been about.

Finally, we also used those visits to get a sense of what support we could offer the local health districts in terms of training and development. That was the source of our design of the 2016 training and development program for local health districts, where we have been able to roll out a program of training to each and every LHD that deals with some core modules of effective frontline complaints management, but also workshops with them particularly difficult cases they had with complainants or with patients and their families, and how they might have handled them differently, and how they can handle them in the future. We also looked at what best-practice open disclosure looks like. So we are using our most skilled resolution people to do some training and development out there in the front line of health care on the back of those LHD visits. We are getting very good feedback from that.

The CHAIR: Every LHD has now undertaken that. I am a bit surprised that when complaints were handed back to the LHD they did not come back to the HCCC with the finalisation. That is now in place and that is standard practice.

Ms DAWSON: Correct. It was a weakness in the system that I identified very early on.

The CHAIR: That was identified through those meetings with the LHDs?

Ms DAWSON: No. I think we discussed it at the last hearing of this Committee as being a particular weakness, and we committed to addressing that problem and we have.

The Hon. WALT SECORD: Ms Dawson, you talked about patterns with the LHDs. What LHD had the largest single number of complaints against it?

Ms DAWSON: The largest single number of complaints against an LHD, I think, was against the John Hunter—

The Hon. WALT SECORD: The John Hunter? Is that Hunter New England?

Ms DAWSON: Yes. But I counsel against using just the raw number of complaints because they also have more than twice the number of services delivered. Even though there is a higher number of complaints they have excellent performance when you look at the high volume of services that they provide to outpatients and the like. It is very good performance.

The CHAIR: So there is a correlation between the number of services versus the number of complaints, effectively.

Ms DAWSON: Yes, that is right. There is no outlier in that regard.

The Hon. WALT SECORD: Taking it a different way, if you were to shine a spotlight onto complaints what would be the local health district with the largest number of complaints, taking into consideration the number of procedures performed or the number of consultations conducted?

Ms DAWSON: There is no outlier in that regard. I am happy to take the question on notice.

The Hon. WALT SECORD: Please take it on notice.

Ms DAWSON: My analysis indicates that when you look at the percentage of complaints relative to the volume of presentations, the number of surgeries done and so on, that they are all pretty much on a par.

The CHAIR: Mr Secord, I am mindful of the fact that you have had multiple questions overlapping.

The Hon. WALT SECORD: I do not want to hear questions about webinars and things.

The CHAIR: I am sorry that you do not want to hear those questions, but I have to give every person a chance.

The Hon. WALT SECORD: As parliamentarians we have a responsibility to ask great questions.

The CHAIR: Every person in this room has the opportunity to ask questions. I will go back to Mr Amato, because he has only had one question so far.

The Hon. LOU AMATO: The Commission received 197 complaints about pharmacists in 2015-16. While that is a decrease of 6.6 per cent there has been an increase of 18 per cent since 2013-14. Can you identify what types of complaints they were and what has been done to address those issues?

Ms DAWSON: Can you pinpoint reference me on the page you are looking at?

The Hon. LOU AMATO: Page 17.

Ms DAWSON: I can comment on that generally and then Mr Kofkin may add to that. In relation to pharmacists, the types of complaints that we get vary considerably. The complaint may relate to the dispensing of medications, extensive dispensing of Schedule 4 and Schedule 8 medications in an inappropriate way, and Mr Kofkin can talk about that. There are many lower level complaints that relate to the wrong medication being dispensed in the Webster-pak or the Webster-pak included outdated old medication. There are some very minor complaints about the dispensing of generic medication rather than the specific prescribed medication and a failure to ask the individual whether they were happy to be prescribed the generic medication.

Usually off the back of that the differential cost of the medication, whether you got the brand medication or generic medication. The complaints vary in type. You will get complaints where actually the pharmacist is well intentioned. They will look at the prescription and they will go, "I am not sure that is the right medication for what this individual is describing to me." They might say to the individual, "Actually, I cannot dispense that medicine because." The individual will feel aggrieved by that.

The Hon. LOU AMATO: Because they cannot read the script?

Ms DAWSON: There might be an error in prescribing. You might find that an adult dose has been prescribed for a child. The pharmacist will say, "Is this for you, madam?" "No, this is for Johnny." There has been an error and the pharmacist may say, "Here is the script back, you need to go back to the doctor." And the individual will experience that as: hang on a minute, I have just been through that hoop, and now I have to do it again.

The Hon. LOU AMATO: It is good to hear there are a lot of pharmacists who are diligent in their work.

Ms DAWSON: There are. That is one side of it. There are some serious complaints relating to pharmacists and Mr Kofkin will speak of that.

Mr KOFKIN: Yes, there are. I spoke about those issues about a year ago in terms of the relationship between companies and general practitioners and pharmacists who are compounding medications off label.

The Hon. LOU AMATO: Could you speak up?

Mr KOFKIN: The compounding of medications off label on a very large scale when there is no therapeutic benefit and no prescription. We are talking about anabolic steroids, peptides, human growth hormone and phentermine. We have a number of investigations ongoing, sometimes for 18 months, due to the large scale compounding. That has driven complaints against pharmacists. Within a pharmacy there will be the

owner and a number of other pharmacists working there as well and they are all accountable to uphold professional standards. That would increase complaints and investigations.

There has been a drive through big pharmaceutical companies in terms of protecting their businesses—quite rightly. And we have received complaints where companies have made allegations that there are pharmacists who are compounding—again phentermine—when there is a commercial product available such as duromine. If there is a commercial product available the pharmacist should not be compounding that product unless there is a really good reason why they should be. That will generate complaints where the industries are becoming impatient with the compounding of products when there is a commercial product available.

Mr MARK TAYLOR: Commissioner, from an internal organisation point of view, there are some talented staff in the organisation. What are you doing to help drive the retention of corporate knowledge amongst the staff and cross training?

Ms DAWSON: It is an important point. Complaints management is difficult and challenging and a great deal of resilience is required and we need the most experienced people to continue to be resilient. There are a couple of dimensions to our work. One is to make sure that every single staff member of the Commission has access to resilience training, so they are deeply skilled at dealing with sensitive cases and difficult complainants who have been traumatised by their care. That is particularly important and we want to support them in that so they can go on the long journey. That side of things is important. We have also taken the view that in order to redesign our business processes and make them more sustainable and workloads more sustainable we need to draw on the knowledge of our staff about what they do now, why they do it now and what opportunities there are to improve what they do now.

In essence, making sure that the experience, skill and knowledge of each and every member of the organisation is helping us to identify systems improvements or process improvements that will get us to a point where we have a better balance between timeliness and outcome. We can talk more about that if you are interested. It is building on the internal knowledge of the organisation. Finally, the third prong to it is what we call a master class program, where we get individuals in the organisation sharing case studies of things that have gone well and things that have gone not so well as a guide to improvement. We also bring our partners in to the Commission to try to teach us about how the Commission looks to them and how we can work best with them. Our work with the local health districts is one example and Justice Health is another. We get Justice Health to come in regularly to talk to us about their changes in policy about treatment and access. We are conscious of and familiar with what decision-making is occurring in other organisations and how we can work with them.

Mr MARK TAYLOR: Is it the case that some other jurisdictions around the country are extracting knowledge from you at a national get-together of similar organisations?

Ms DAWSON: Yes. That is an important part of what we do. One of the things we have spent a lot of time sharing our knowledge on over the last 18 months is that New South Wales has been at the forefront of regulation of unregistered practitioners. That has not been something that other jurisdictions have done. With a move towards a national code of conduct for unregistered practitioners the question on everybody's lips is, "How do you go about this?" We have been privileged to sit down and have seminars and workshops with Queensland, Victoria, the Australian Capital Territory and others about what does it look like when you are doing best practice regulation for non-registered practitioners? How do you scope the issues?

It is a different scenario to dealing with a registered practitioner where there is a lot of infrastructure around the regulation of a registered practitioner such as the professional councils and well-established standards promulgated by the colleges or the ministry, or whatever. With unregistered practitioners we do not know how many there are. They come in many colours, flavours and sizes. It surprises us. How do we deal with them effectively? How do we bring together experts in order to assess the quality of the care that they give? How do we deal with the gathering of witness statements? How do we conduct hearings for them? All of that stuff is deep expertise that the Commission holds and we are proud to be able to share it nationally.

The CHAIR: That would be inherently difficult when people are practising medicine in hotel rooms, I assume?

Ms DAWSON: Yes, indeed. That is why some of those scenarios have tested our inventiveness in terms of how to use the broad powers we have got. We have search powers, we have notice powers and so on. We have also got very good operational relationships with others who can also help us with that such as police and the Pharmaceutical Regulatory Unit. We utilise that when we are thinking about how do you deal really effectively with the beauty practitioner in the apartment in Five Dock, or wherever else it might be? What do you need? Who needs to be there?

We would typically want to be using our powers well, but standing side by side with the Pharmaceutical Regulatory Unit, the police or whatever to get the best result from any operation that we might find ourselves conducting.

The Hon. WALT SECORD: Ms Dawson, your annual report states that there have been 177 complaints against psychologists, which is an 18.8 per cent increase. What is happening in that area? Why is there a spike of almost 20 per cent?

Ms DAWSON: It is something that we are looking at too. It is a very good question. There is more to do, but the sense so far is that boundary violations with psychologists seem to be the biggest issue—boundary confusion on various different scales. Those practitioners are often in a quite heavily contested space—for instance, in family law issues where a psychologist might be called upon to give an assessment of a member of a family where there is a family law action in place. They may not be court ordered. If they are court ordered, we do not have jurisdiction over them. But if they are not and there is simply some treatment going on of, perhaps, a young person that is involved in that sort of scenario then there are issues that arise that may be about the consent of an estranged parent or may even be about the fact of that person seeing a psychologist. That is what I mean by a contested space or an awkward space. Then there is the fact that with psychologists the relationship is naturally one of trust and one that is conducted in relative privacy. As it does with psychiatrists, that enlivens real potential for transference that might be a bit abused, if you like.

The Hon. WALT SECORD: When you say "boundary violations", is that what you are referring to?

Ms DAWSON: Boundary violations come on a spectrum. They could be anything from the situation in which you had a patient and you loaned them $1,000 because they needed $1,000, and that was an inappropriate thing for you to do when you had a therapeutic relationship with them—that would be a boundary violation—or you invited the person out after their session for a social activity. That would not be good either because it would disrupt the therapeutic relationship. But you might then find that there are other more serious forms of boundary violation as in the case studies on page 37 and page 43 of the annual report.

The Hon. WALT SECORD: Are the investigations still ongoing in relation to Dr Phadke or have they been resolved?

Ms DAWSON: We have indicated that our investigations in relation to that matter will be finalised around July.

The Hon. WALT SECORD: Is there any ongoing investigation involving Dr Grygiel?

Ms DAWSON: Yes. That investigation too is ongoing and we expect a similar timeframe—around July for elements of that. It is multifaceted, as you know, but certainly for the treatment provided at St Vincent's and Macquarie Hospital it will be around the timeframe, give or take. We are in the final stages of winding up those aspects but then of course there are the Central West issues.

The Hon. WALT SECORD: Ms Dawson, you touched on the Bathurst-Orange clinics. What is the timetable on that?

Ms DAWSON: I will defer to Mr Kofkin. Certainly we are looking to wind up all of those matters this calendar year. We are literally in the process of seeking expert advice and so on. They are very complex matters.

The Hon. WALT SECORD: Do you have any concerns about Dr Phadke returning to practice?

The CHAIR: The Commissioner can make a decision whether she wants to answer that question.

Ms DAWSON: It is not a matter for me to comment on.

The Hon. WALT SECORD: Recently there has been some media coverage on some privacy breaches when medical records of about 1,000 patients were found in an recycling bin in Ashfield. Do privacy breaches generally and this matter in particular come across your desk?

Ms DAWSON: This matter itself has not come before us and is the subject of appropriate investigations and reviews by the Ministry. From time to time, and not in relation to this instance, we may get complaints about practitioners not appropriately securing records or, on the other hand, not releasing them where they should. We do have issues relating to records but not on that matter.

The Hon. WALT SECORD: Can you take this question on notice? In the 2015-16 year, how many complaints in relation to privacy breaches were filed with the Commission and what were their outcomes?

Ms DAWSON: By proxy I will say that, yes, we can take that on notice. The way in which we would derive that is to identify the number of complaints that were assessed as "referral to the Privacy Commissioner", because that would be our most immediate action.

The CHAIR: Given the sensitivity of mental health issues, what has the Commission undertaken as to how it will work more closely with those vulnerable complainants to look at reducing those sorts of complaints? There has been a spike in those numbers, so what is the Commission doing to actively assess them?

Ms DAWSON: We are doing some very important things there. Firstly, by and large when we assess a complaint involving a mental health matter there is naturally a vulnerability that we need to recognise. Recognising that, we are often more alive to the idea of dealing with that matter through our Resolution Service rather than through local resolution or other options. Why? Because more often than not there are caring family members who are concerned about how their loved one is being dealt with, particularly if they have multiple admissions—perhaps they have been in and out of a facility—and whether there is a good understanding on the part of a particular facility that is used about how well their loved one is being cared for. We often use resolution as a way of bringing the family together with the health service provider to come to some really good agreements about what happens when the patient at the centre of the issue has an episode that needs to be dealt with quickly, effectively and sensitively and having regard to all that has gone before—continuity of care. We are very much in that mode when we get mental health complaints.

We have also taken a couple of opportunities to examine the systemic issues in mental health facilities. You will see in the annual report there is a particular case study around the way in which we used an individual complaint to identify a range of concerns that we had about the operation of a specialised mental health facility and the need to look at all of their practices relating to the observation of high-risk patients overnight, the collocation of high-risk patients in one room and so on. We had concerns about those. So what we have done is made a point of looking carefully for those systemic issues, using our investigative powers, and then used our powers to make recommendations for change to health organisations to drive systems improvements. Those are a couple of immediate things we have done. In addition to that I have formed a partnership with the Mental Health Commissioner to try to infuse into our organisation training and development about how to deal with mental health complaints from the individual's perspective and what practices should be promulgated out in organisations so that people are aware of those when they are assessing complaints.

Finally, in relation to the National Forum of Health Care Commissioners that I convened last week, we invited along the Victorian Mental Health Commissioner to have a whole session about issues relating to mental health. And one of the key, important points that came out of that was the importance of ensuring that where an individual with a mental health problem is presenting to the emergency department, how effective are they in dealing with both their physical presentation and the mental health issues at the same time? So that is a really good conversation around practice and standards in that space.

The Hon. LOU AMATO: To follow up, the graph regarding the complaints shows that complaints have gone up, but has the number of mentally ill patients also increased in comparison to the complaints?

Ms DAWSON: Is your question whether the proportion of complaints relating to mental health issues remains the same?

The Hon. LOU AMATO: Yes in regard to the number of patients or has the number of patients also increased?

Ms DAWSON: We have not particularly examined the number of mental health patients. What I can tell you is that the proportion of total complaints that relate to mental health has remained about the same, at about 12 per cent. But we have not asked ourselves the question whether the growth in the population of mental health patients is greater than 12 per cent.

The Hon. LOU AMATO: I am just curious to see whether or not it is going up and, if it is going up, why it is going up. And whether that relates to perhaps drug abuse in society or whether there are other social issues contributing to the issue of mental health.

Ms KATE WASHINGTON: Remaining in the mental health side of things, which is of great interest to me and to my community, I attended a community forum on mental health last week along with 500 people, which highlights the interest and engagement that is going on outside the metro area. Among the things raised at that community forum was a lot of discussion about people trying to access services, in particular, acute services. Because there are very few lower level preventative health services, people become more acute and that might be the time that they start to engage with health practitioners. Do the complaints you receive capture people that try to access health services and do not succeed, particularly in the acute mental health space?

Ms DAWSON: Your complaint may be: I was unable to get access to either a community health service or a health organisation service. It may be that your complaint is an access problem.

Ms KATE WASHINGTON: Is that in your statistics? Does it come under the mental health side or does it come under—I think it was a statistic about "unable to access"? I am wondering how it is captured.

Ms DAWSON: It is captured in many different ways. Let me point you to one way in which we capture it, which is chart 35 on page 57. We undertook particular analyses of mental health complaints and we examined the issues that arose in mental health complaints compared to all other complaints and what we found there was that, interestingly enough, access issues in mental health complaints were a smaller proportion of the complaints received than they were access in all health complaints. What we have not done, and I do not want to overreach and say we will do it because it might not be possible, but what I do not think we have done is to say: What is the metro/non-metro breakdown of that, firstly, and secondly, to what extent are those access difficulties relevant to accessing acute service support versus community health services? I do not know whether we can answer that but I am happy to give it a red-hot go.

Ms KATE WASHINGTON: Commissioner, I would love a breakdown, particularly around the regional and metro access to services, particularly mental health services, if that is possible. That would be interesting.

Ms DAWSON: As I say, I am not sure if it is but I understand the motivation behind your question, so we can have a look at that.

Mr MARK TAYLOR: In relation to complaints, obviously there is difficulty with communication between doctors and patients at times but particularly in the emergency situation in public hospitals where there is a lot going on and complications. Can you run us through complaints in that area or improvements you have seen or have not seen or recommended?

Ms DAWSON: Yes, I can. I think the emergency area, I guess to state the obvious, is the place where it all comes together in a particularly difficult way. You have got such a diversity of people presenting; you have got the usual challenges with triaging; you have got issues relating to possibly limitations on some of the diagnostic tests that you can order, depending on the time of the day and so on. But we do actually break down our complaints about health organisations by practice area and I am referring you, if I may, to table A7 on page 118, which is the table that breaks down the proportion of complaints about emergency medicine. And there what we see is that, of all the complaints made about hospitals, the public hospitals, the emergency medicine dimension of it attracts about 20 per cent of those complaints. And that is interesting because, in some senses, with all of those challenges and dynamics you might have expected that to be a little more. But not so much.

And I think that what we see when we talk to complainants, particularly where there has been a progression in the clinical journey from the emergency ward into surgery or whatever, it is not really that first presentation generally that is problematic so much as what happens next. So, just anecdotally, that is the figure that flows out of our complaints data.

The Hon. WALT SECORD: Ms Dawson, I take you back to the reference to psychologists. More than 18 per cent—what do you put that down to? Has there been an increased awareness that they can complain or what is the reason for the spike?

Ms DAWSON: I talked a little bit about some of the particular aspects of the context within which psychology services are being provided. And I did say something that I think is worth repeating, which is typically in the delivery of psychological services you are dealing with a situation where there is a vulnerability on the part of the patient to start with—that is a given, just because their emotional state in some way is troubled. I think secondly, that we are in an evolving, a maturing, if I can put it that way, environment around psychological issues and mental health issues where people are seeking help. It is something that they understand it is important to do. It is something that they understand, particularly when they have got a physical health problem, sometimes coupling it with getting assistance with the emotional impacts of that condition is really important.

I do not know what the source of data would be for whether more of us are utilising psychological services and whether that is something that is washing in. But I would not be surprised because it does go with that whole phenomenon that I was talking about earlier about health consumers building a broader suite of practitioners that they use to deal with their spectrum of health needs, be it allied health services, psychological services or physical health services.

The Hon. WALT SECORD: Mr Kofkin, are people holding themselves out with a lack of qualifications or is it mostly, as you say, boundary violations?

Mr KOFKIN: Yes, as the Commissioner said, mainly significant boundary violations: sexual relationships with very vulnerable patients, sometimes over a number of years; financial exploitation.

The Hon. WALT SECORD: Ms Dawson, have you made any recommendations to the Government on what it should be doing to respond to this increase?

Ms DAWSON: We are in the process of understanding and analysing it. It is a matter that is of concern to us, so we are analysing it and that is where we are up to with it. Our focus is of course on each and every matter that comes before us and taking the immediate, necessary action. If this continues to be a pattern, this is a spike that we are not quite fully understanding yet and we need to see—

The Hon. WALT SECORD: Is there a spike on previous years?

The CHAIR: Yes. If you look at the results, they were constant and there has been a spike in the last 12 months.

Ms DAWSON: Yes, that is right. We need to understand that. It is a small number of practitioners, so it is a matter of us unpacking that and understanding it a bit more, because before one makes representations or observations it is useful for us to know what the drivers are, so that is an evolving thing.

The Hon. WALT SECORD: Does your area of jurisdiction come into areas regarding people who claim to provide advice on vaccinations and things like that?

Ms DAWSON: Yes.

The Hon. WALT SECORD: Have you had any complaints or done any work in this area?

Ms DAWSON: We get complaints from time to time, as does the Australian Health Practitioners Regulation Authority, which involved—was it chiropractors?

Mr KOFKIN: Yes, it was.

Ms DAWSON: A large number of chiropractors were proffering opinions on vaccinations and the unwanted effects, in their view, attributable to vaccinations. There is quite a lot of work being done at national level on that question, I know, and from time to time we do get vaccination matters and then it is a question of whether the matter that is being brought before was a question of the failure to administer a vaccination when one was required, wrong vaccination and so on as opposed to a narrative about vaccination.

The Hon. WALT SECORD: I am more concerned about countering the anti-vaccination movement. Can you refresh my memory as to what happened with the chiropractors? Was it a group or an individual? Mr Kofkin, did you investigate it?

Mr KOFKIN: No, they were not investigated.

The CHAIR: There was no formal investigation.

The Hon. WALT SECORD: I know there were concerns that individual chiropractors were telling people not to have vaccinations.

Ms DAWSON: Completely, and we did refer those to AHPRA, being the appropriate body to regulate that on the basis that it is AHPRA that deals with either holding out or misleading and deceptive advertising, which is the limb on which I think it progressed the chiropractor issues. But the chiropractor issues, to answer your question, dealt with both individual chiropractors and certain organisations that were taking an anti-vaccination posture. Friends of Medical Science is, I think, one such organisation.

The Hon. WALT SECORD: Are you aware that today's *Medical Journal of Australia* has an article about overservicing or overtreatment by doctors? Do you get many complaints in that area?

Ms DAWSON: Busy as I was preparing for the hearing, I have not yet read today's *Medical Journal* article. However, I will respond to the substance of your question—

The Hon. WALT SECORD: You must be aware of the issue. Maybe Mr Kofkin could enlighten us on that.

Ms DAWSON: I think I can help—if you do not mind, Mr Kofkin.

Mr KOFKIN: Commissioner, the floor is yours.

The CHAIR: I am also aware that Mr Secord has snuck in three questions when he should have had one. This will be his final question.

Ms DAWSON: From time to time we do get complaints relating to practitioners providing more care and treatment than would be expected. A couple of areas where that arises would be dentistry and also ophthalmology.

The CHAIR: I have a question that relates to your comments regarding the local health districts and your meetings with them. Would you look at conducting similar sorts of meetings and consultations with private hospitals and health providers, given the outcome you had with local health districts?

Ms DAWSON: Certainly. Bearing in mind resource constraints, absolutely. It is our great wish to influence right across the system, in all elements of the system, and if we were able to establish that kind of rapport with private health providers that would be great. We are making inroads in that direction, but we need to do more. I am happy to take that as a suggestion for an area for further development and improvement.

The Hon. LOU AMATO: I have a question regarding Indigenous communities. Does the Commission have a separate report to compare how the Indigenous community is faring in relation to the greater community?

Ms DAWSON: No, we do not. We do not have a separate report but, as I said earlier, in planning and designing our outreach work we particularly have an emphasis on the Indigenous community. I should also note that of the 14 professions there is also an Aboriginal and Torres Strait Islander professional stream. It does not have its own council at the moment, but talking to other commissioners over recent days there is an increasing number of Aboriginal and Torres Strait Islander providers registering in New South Wales, which is a really welcome thing from our point of view. Your question goes more to communities, I think, and we do not particularly at the moment segment our reporting by Indigenous complainants. On our complaints form I think we ask people to signal indigeneity but they do not always do so.

The Hon. LOU AMATO: I understand it is probably a box that you can tick, but I wanted to see whether there was a comparison. Obviously there should be a happy equilibrium across the system, but I wanted to see whether or not they had different issues and complaints to the rest of the community.

Ms KATE WASHINGTON: Commissioner, is there any increase or obvious trend arising from the implementation of the National Disability Insurance Scheme, particularly around the mental health side of things but also more generally?

Ms DAWSON: Not yet. We have not seen too much yet, although we do get complaints in this space, of course. Some of the sorts of complaints that we get are actually a little bit challenging in terms of jurisdiction of decision-making. For instance, we get the issue of carers in individual homes under the Home Care Service, but they are providing more personal care services rather than health services. They are not doing the showering and medication; they are doing more of the cleaning and so on. There is a complex jurisdictional issue there that we confront from time to time. We do get some complaints relating to the treatment of people with disability in an acute care environment, and we treat those as we would any other complaint, but it is not a discernible trend upwards. In terms of NDIS which is really about some of the community-based services, no, I cannot say that we do, but we are very conscious of the need for us to work very closely with the soon to be appointed NDIS Complaints Commissioner. A national complaints commissioner for NDIS is soon to be appointed. We want to sit down very quickly with them and talk about the interface between any complaints that we get and a very smooth referral pathway into the NDIS commissioner. That is evolving.

Ms KATE WASHINGTON: Further to your comments about the complex jurisdictional aspects of home care and the provisions of those services, is that made more difficult from your perspective because it is now with a private provider?

Ms DAWSON: I do not think that it is necessarily whether it is to do with a private provider or a public provider. It is more to do with the role and function of the individual provider. What are they doing? Are they delivering a health service and, if so, what does that mean in the context of a complaint that we get? I would not really characterise it as a public/private thing. I would characterise it more as the question of what is a health service in the broader context of disability services delivery.

Ms KATE WASHINGTON: Indeed, given that feeding somebody a meal could mean life or death if they have diabetes.

Ms DAWSON: Completely. Those things are very important for us to understand and get much clearer.

Mr MARK TAYLOR: Obviously in the complex environment that we are now getting into, you would have a lot of dealings with other government agencies—police and NSW Fair Trading. Obviously a number of memorandums of understanding [MOUs] are in place. How are they going? Do you have any comment on those, and who are they with?

Ms DAWSON: The MOU digest. I might talk about a couple of the most important ones that work well for us. We have an MOU with the NSW Police Force. That is extremely important for us, particularly in the investigation space, because if we have a practitioner who may be subject to criminal charges, for whatever reason, we want to be able to draw on their evidentiary materials. We also want to be helpful in their quest in terms of being able to provide intelligence that we have. So our data and information exchange protocol is a really important signature piece of the investigation framework that Mr Kofkin has in place. I think it is fair to say that it works extremely well. It involves accelerated access to information through a single designated entry point into the NSW Police Force. That relationship is very strong and functional. I will ask Mr Kofkin whether he wants to comment.

Mr KOFKIN: No. I just completely agree. It has gone from strength to strength, really. We have Chief Inspector DCI David Laidlaw, who is our single point of contact. He is very responsive to our requests. It works very well.

Mr MARK TAYLOR: Without getting into the specifics of your two-way exchange, obviously.

Mr KOFKIN: Absolutely, yes. I am the single point of contact in the Commission in terms of police requests. It works very well. It is important to have that personal relationship. That is why this has developed so well in terms of our professional personal relationship. It has made a big difference. We also have an MOU with the Coroner. We will provide material to the Coroner, and vice versa. Although it is not an MOU, we have a very good working relationship with Medicare in terms of providing the Commission with prescribing details. They are responsive most of the time but they have their own pressures. Certainly if something is urgent and we phone the right person then we get that data fairly quickly.

Mr MARK TAYLOR: What about the overlap with NSW Fair Trading types of issues?

Ms DAWSON: That is a really challenging interface because, typically, an individual will feel that if they have a particular billing problem or they want a refund for a medical device that did not work or whatever, those are matters for NSW Fair Trading. We do not have a formal MOU with them but we have the ability to refer things to them. In doing so, we highlight the specific issue that we believe is within their jurisdiction.

There are a couple of other MOU or protocol types of arrangement that I think are absolutely central to us being effective. One is with the Pharmaceutical Regulatory Unit [PRU]. Tony may wish to talk about that operational interface some more, but I cannot over-emphasise the importance of us being able to get really precise, granular information about the way in which an individual pharmacy, or whatever, is managing their medicines and dispensing, in order to help us build a picture as to whether that dispensing is off the radar and warranting a corrective action. Before I pass on to Tony with respect to that—because it is a good and important relationship to describe—we also have a lot of important arrangements in place with the individual professional councils. I am talking about those ones that have an inspectorial or audit type of function.

The Pharmacy Council of New South Wales has the ability to go in and look at individual pharmacies closely and forensically. Then, of course, we seek to get the material back from that. Often that will be on the back of us notifying them that we have a complaint. We may not be sure what there is to see, but we would like them to use their powers to have a very close look. That relationship is very important. It is the same with dentistry. Let me not detract from the importance of describing the PRU interface.

Mr KOFKIN: The Commission, the Ministry and PRU have worked together closely for a number of years. For example, sometimes the Commission will receive a complaint where it appears there might be some inappropriate prescribing. We refer that complaint to the PRU because the PRU can visit the practitioners. They can use their powers. If they have enough evidence they can take away their Schedule 8 and Schedule 4 prescribing rights. They can then attend certain pharmacies and obtain their dispensing data. They can also obtain material from the Office of Chemical Safety, which will have all of the analysis in terms of the dispensing and the heat maps in terms of where there are particular dispensing hot spots throughout the whole of New South Wales. Invariably, what happens is that when we receive a complaint we will refer it to the PRU. It will come back with a lot more information for us to investigate and potentially prosecute.

We also have a really good relationship with the Public Health Units, as a result of these non-registered practitioners. We walk in partnership with the PRU and the Public Health Units when we are carrying out these operations, because the PRU can seize all of the unauthorised medication and the Public Health Unit are looking at infection control issues. They can make prohibition orders as well. So the Commission works together with

the PRU and the Public Health Units very well in relation to the non-registered practitioners and infection control measures, as well.

The CHAIR: I know Mr Secord is itching to get a question in. Mr Secord you have one question.

The Hon. WALT SECORD: One question. I notice that on page 114 you have the breakdown of medical practitioners. There are 30 Chinese medicine practitioners. Are there any trends—is there anything unusual—with respect to that? Thirty complaints seem to be quite a lot.

Ms DAWSON: It is a small sample. It has trended upwards but has remained a relatively unpredictable but small slice of complaints. I guess I have observed before in these hearings that people are starting to think about working at the frontiers of medicine to receive health services. Chinese medicine is an example of that. People are wanting, I guess, to experiment with that.

The Hon. LOU AMATO: It is alternative medicine.

Ms DAWSON: Yes, they use alternative medicine as a complement to Western medicine. We are watching this space with regard to that issue. There are not high numbers but it is interesting. There are some important scope-of-practice issues there, too. By that I meant I ask, "Is it within the scope of Chinese medicine to practice threading?"

The Hon. WALT SECORD: What is threading? Did I ask an embarrassing question?

Ms KATE WASHINGTON: No, it is just awful.

The Hon. WALT SECORD: I do not know what threading is.

Ms DAWSON: There is a way of treating facial lines by placing a thread—

Ms KATE WASHINGTON: I had a significant case in my past life.

The CHAIR: We may not want this detail.

The Hon. WALT SECORD: I am curious, what is threading?

Ms DAWSON: That is exactly what it is. It is treating usually a facial line with a subdermal thread.

The Hon. WALT SECORD: This is occurring in Sydney, New South Wales?

Ms DAWSON: It is an example of something that might occur. We have only ever come across it once and we were challenged by the concept. It is an example of the sorts of areas—

The Hon. WALT SECORD: What happened? Did you find that someone was doing threading and did you investigate?

Ms DAWSON: Somebody made a complaint about that particular issue.

The Hon. WALT SECORD: What happened? Could you enlighten me, Mr Kofkin?

Mr KOFKIN: That matter was referred back to the council. The individual left the country and went back to China, so it was difficult to obtain further information. It was also difficult obtaining information from the complainant. If you Google "threaders", which is the first thing I did because I had not heard of it before—

The Hon. WALT SECORD: I had not heard of it until this morning.

Mr KOFKIN: —there are medical practitioners throughout this country who provide that procedure. They are qualified and trained and they use pain killers and anaesthesia. It is well known—obviously not in this room—but it is well known around the world.

Ms KATE WASHINGTON: As a cosmetic procedure.

Mr KOFKIN: Yes. As a cosmetic procedure.

The Hon. WALT SECORD: You euphemistically referred to this whole area as "frontiers of medicine"?

Ms DAWSON: Yes.

The CHAIR: I have a final question. Since we met last time the Commission has introduced the option of "discontinue with comments" for the low level complaints that you identified earlier. How has that new option impacted complaints handling and what feedback have you had from complainants and health practitioners about the option of "discontinue with comments"?

Ms DAWSON: I think this has been a really important initiative in terms of the outcomes of complaints. The complainants will often say to us, "Look, we accept that this is not a really serious issue but it has irked us and we really think that practitioners could and should do better". It is usually around very low level issues such as the way in which records are kept, the way in which information is given to the complainant about things like vaccination shots and the order and sequencing of them, or about things like whether the practitioner has a restriction on being able to prescribe certain medicines—Schedule 4 or Schedule 8—or not.

The individual patient may walk in and say, "I would like to be prescribed this particular drug," and the practitioner says, "I cannot prescribe that. You will have to make another appointment". The practitioner is doing the right thing not prescribing beyond their registration, but it is a deep annoyance for the individual. The sort of thing we would say to the practitioner in those cases is: "If you cannot prescribe certain things, that ought to be in the awareness of the patient before they make the appointment. You need to improve your appointment making practices or improve your information to families when they are bringing their children in for immunisation so they know what the immunisation cycle is and so they can get the blue book and so on." We found that the complainants are saying, "We just wanted to know that that will not happen to the next person who presents with that issue or when I go again that that will not keep happening to me." The determination of "discontinue with comments" means we get a good effect in terms of the improvement of the behaviour of practitioners.

Another really good example of it is that we have a pattern of complaints about medico-legal assessments where it is again a very sensitive area with a lot of contest around the preferred outcome for the individual presenting for the assessment and it is quite awkward. We have been saying to medico-legal assessors over the last 12 months is: "It is probably really helpful for you, with the consent of the person you are assessing, to properly record the assessment so it is clear what you have assessed and why." We are finding that that has reduced the number of complaints about medico-legal matters quite significantly. It has been welcomed by both the complainants and the providers.

The CHAIR: I thank Ms Mobbs, Mr Kofkin, Ms Murphy and the Commissioner for appearing before the Committee. The Committee may have additional questions in writing. Your replies to those questions will form part of your evidence and will be made public. Are you happy to provide a written reply to any further questions?

Ms DAWSON: Absolutely.

(The witnesses withdrew)

(The Committee adjourned at 12:05)