**REPORT ON PROCEEDINGS BEFORE**

# COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

## REVIEW OF THE HEALTH CARE COMPLAINTS COMMISSION'S 2023-24 ANNUAL REPORT

**At Macquarie Room, Parliament House, Sydney, on Monday 23 June 2025**

**The Committee met at 9:30.**

### PRESENT

Dr Joe McGirr (Chair)

| **Legislative Council** | **Legislative Assembly** |
|---|---|
| Dr Amanda Cohn | Mr Tim Crakanthorp (Deputy Chair) |
| The Hon. Greg Donnelly | Mr Michael Kemp |
| The Hon. Aileen MacDonald | |

### PRESENT VIA VIDEOCONFERENCE

**Legislative Assembly**

Dr David Saliba

**The CHAIR:** I begin today by acknowledging the Gadigal people of the Eora nation, the traditional custodians of the land on which we meet here today at the New South Wales Parliament. I pay my respects to Elders past and present, and extend that respect to other Aboriginal and Torres Strait Islander people who are either present here or viewing the proceedings online. Welcome to today's public hearing for the Committee on the Health Care Complaints Commission's review of the Health Care Complaints Commission's 2023-24 annual report. I am Dr Joe McGirr, Chair of the Committee. I am joined by my fellow Committee members, Mr Tim Crakanthorp, Deputy Chair and member for Newcastle; Dr Amanda Cohn, member of the Legislative Council; the Hon. Greg Donnelly, member of the Legislative Council; Mr Michael Kemp, member for Oxley; and the Hon. Aileen MacDonald, member of the Legislative Council. Our fellow Committee member Dr David Saliba, member for Fairfield, is online for today's hearing. I thank the Commissioner of the Health Care Complaints Commission, Mr Tansey, for appearing before the Committee today. The Committee appreciates his input into this review. I declare the hearing open.

**Mr JOHN TANSEY, PSM**, Commissioner, Health Care Complaints Commission, affirmed and examined

**The CHAIR:** Thank you for appearing before the Committee today to give evidence. Please note that the Committee staff will be taking photos and videos during the hearing. The photos and videos will be used for social media purposes on the New South Wales Legislative Assembly's social media pages. Please inform Committee staff if you object to having photos and videos taken. Can you please confirm that you've been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

**JOHN TANSEY:** Yes, Chair, I have.

**The CHAIR:** Do you have any questions about that information?

**JOHN TANSEY:** No, I don't.

**The CHAIR:** Would you like to make a short opening statement before the commencement of questions?

**JOHN TANSEY:** No, thank you, Chair. I'm happy to get going.

**The CHAIR:** We will now move to questions from the Committee. Before we begin, I wish to inform you that you may wish to take a question on notice and provide the Committee with an answer in writing. I will commence the questioning. My question is twofold. I'm just seeking your reflections on your time at the commission since you've started. You obviously came into the commission after there had been a couple of acting appointments and, as we've previously discussed at this Committee, there had been changes in the commission and some disaffection, perhaps, within the commission. The first question is your reflections on that. The second, connected to that, is that the strategic plan of the commission—the current one—ends in 2025; that is, it ends this year. I am interested in your reflections on the strategic planning process from here forward, and what you see as the main focus of that strategic plan for the commission?

**JOHN TANSEY:** When I first or previously appeared before the Committee, I think I was in week 12 of the job. I have stopped counting weeks and days, but it just so happens, I think, this is now week 50, so nearly a full year. Probably the thing that stays with me—and I'm pretty sure I said it the first time I appeared—is that the passion and commitment of the people at the commission is what drives us every day. Obviously, when I previously appeared, they were initial impressions, but the commitment and the hard work of the staff is absolutely enduring and is the thing I note and enjoy every day. That's really unwavering, and I think too maybe we'll talk about it a little bit further through the session. But that's something that I feel I've only seen strengthen as we've started to work together and consolidate our working relationship.

Clearly, with the benefit of a lot more time in the commissioner's seat, I now also have a more rounded understanding of the co-regulatory system in which the commission operates and a keen appreciation of the particular model that New South Wales has in the co-regulatory system, which I know the Committee will understand is quite different to the other States and Territories. We have a close cousin in the Queensland system but, apart from that, the Queensland and New South Wales models are quite different. Frankly, I am very pleased with the way that operates and of the capacity of the commission to contribute in that co-regulatory model. We have very solid relationships, I believe, with our co-regulators, both in New South Wales and at the Commonwealth level, and with my peers around the other States and Territories, which is a resource and a boon.

The other thing—and, of course, being an inquiry into the annual report, we will probably talk about annual report performance—that strikes me in the reporting year we are here to discuss is that the performance of the commission has been sustained not only in the year I came into and issued a report for a year I haven't been there but also now the year I have been there. I think that really continued and followed the commitment and performance of the commission. The people are a pleasure. I think the system is working reasonably well. I am very happy with the connections and the relationships and the partnerships we have with co-regulators and stakeholders and I think we are still managing to acquit our job very well. Those would be some of my reflections.

And then, Chair, you asked about strategic plans. You are absolutely right: The current plan expires this year in 2025. We have initiated planning already for the next strategic plan. Notionally, our assumption is that it would go for a further three years as well, so 2026-28 inclusive. We kicked that off just a couple of months ago with workshops of the executive leadership team. Largely, that was to convene and review some of the progress against the current plan. We are doing that, obviously, in the situation where not all of us, myself included, were here at the initiation of the previous plan or all the way through it. We took an opportunity to start reflecting on that and consider what may have changed and what we think remains consistent.

In fact, I think this week and next week we have facilitators that are helping us develop up that plan. They are undertaking some targeted workshops with stakeholders, both internal stakeholders—my colleagues at the commission are meeting a couple of different groups, a senior management group and an all staff group, to work with our facilitators on that. Workshops will be undertaken with some of our other regulators around the States and Territories with some of our colleagues, particularly those that have regulatory roles that are complementary or supplementary to the roles of the commission in the Ministry of Health. That will feed into that analysis of the broad environment and the operating context of the commission.

And I think, Chair, you asked where we see it going. I don't want to presume where that will go as we are wanting to get all of those insights and those perspectives into what we see as the challenges and opportunities. But I do think that a lot of the focuses and the priorities that were there in the previous strategic plan will probably carry through in some format because they are obviously looking at our operating environment and the needs and wants of our people, all of the business enablers and then the broader context of the health system. So I think there are going to be some continuing and ongoing issues as well as likely some new challenges and new contexts.

**The CHAIR:** Just to follow up on that, because you have commented on the strategic plan in the annual report that we are looking at, I am interested in how you think the commission has gone against that strategic plan. And secondly, from that, I bring to your attention that this Committee has itself had a number of concerns that we've raised with the previous commissioner in relation to engagement with culturally and linguistically diverse (CALD) communities and First Nations communities, for example, and more recently dealing with issues of birth trauma, the data and the way complainants have been informed and kept informed.

We've also raised concerns around practitioners and so on. Frankly, there are issues in terms of your own organisation and culture that surfaced as well. I'm interested in how you think this plan has gone. You said you expect it to continue. My view is that the new plan needs to pick up some of the concerns that this Committee has raised. I've mentioned culture and engagement with communities and responsiveness to complainants and practitioners, for example. Actually, I think there needs to be some changing of strategy or development of strategy—perhaps put it that way. Would you like to comment on that?

**JOHN TANSEY:** Yes. There's a lot in that question, Chair. Maybe I will take it in pieces. I think you started out by saying, "How do you think the plan has gone?" In fact, one of the elements we did, as I mentioned before—when the executive convened in the workshop, that was very much a reflection on the key focus areas of the plan, but also to inform that our facilitators ran a survey of the current executive around the focus areas in the plan. The broad assessment, as I recollect, was that for most of those priority areas, the plan had been started, but they had not been so advanced that we would say, "Tick. Done. Next." That informs my comment earlier that I think a lot of those focuses are necessary and will be enduring, apart from a couple of areas where I think there's a significant milestone achieved. One of the focus areas was the case management system, which has gone from being in prospect to now being in place. I'm sure we'll come back to that through the session today.

When I say a lot of those issues are enduring, I mean as focuses. I think the intent behind your question is more the operational activities, the nuts and bolts of activities and plans that sit behind the plan. I would agree, I think, with the thrust of your question, Chair, that most of those issues that are in the plan, some of which clearly the Committee has flagged previously, including in the review of the last two annual reports—they're very much in our mind, the issues around staff welfare. Wellbeing and engagement is absolutely a plank, and that's why I say I think the people will continue to be an absolutely critical focus. Our engagement with all communities, including particularly target communities—so yes, with First Nations communities and multicultural communities—will absolutely—I would never expect that they would not be a focus, to be honest, of the commission. I don't think you'd ever get to a point in almost any organisation where you were saying you had done that perfectly and no more effort was required.

The issue—without putting words in your mouth, Dr McGirr, I think you were talking about the practitioner engagement. I know we've talked particularly around that concept of practitioner distress. So those and the trauma-informed approach, that again you referred to, coming out of the birth trauma inquiry—those will absolutely continue to be focuses. They are absolutely areas where we know we want to do better and keep improving. All of those elements are why I say I think some of the focuses, the focus areas, are almost certain to remain consistent, but I think some of the activities and actions underneath will need to continue to evolve so that we can keep improving on how we actually operate in all of those areas.

**The CHAIR:** I might come back and pursue that because we have got different areas that we're going to cover today. It is quite encouraging to hear you recognise the importance of that. Sometimes strategic plans can reflect what an organisation wants to do, rather than responding to input. I note that you are taking input. It's also possible in strategic plans to hide issues in verbiage, if I can put it that way. For example, wanting a patient-centric system—putting the patient at the centre—is often used in healthcare organisations but sometimes honoured in

the breach. In this circumstance the engagement that we've touched on with particular communities—CALD communities and First Nations communities—really needs a definite focus and meat on the bones around that. We'll explore that as we go forward.

**Mr TIM CRAKANTHORP:** It's good to see you here again, Commissioner. I hope you've had a good nearly 12 months and I wish you well in the completion of your term. You mentioned in your response to Dr McGirr a focus on First Nations, and that's the nature of my initial set of questions. The report notes that work on the Reconciliation Action Plan is due to be completed in early 2025. Has that work been completed as planned?

**JOHN TANSEY:** Yes, it has. I'm very happy to report—and I think I probably said in evidence last time I was here—that I was aware that that work had kicked off seriously prior to my arrival. It's actually been building, gestating, in the commission for a while. Happily, in Reconciliation Week this year we launched the first RAP that the commission has ever had. It wasn't our only undertaking in Reconciliation Week, which had a really strong focus on activities and reflection, but our reflect-level reconciliation plan was launched that week. For those of you that are aware of the pathways of reconciliation plans, "reflect" is the very first stage and the first step.

It properly reflects that we know that a lot of the initial work we will do is around improving our understanding and capability across the organisation, and our engagement with communities, to really deepen our understanding and deepen our engagement as a way of lifting the cultural capability and cultural safety of the commission, so that we are properly skilled and capable to engage with First Nations communities. It's a really great milestone to get to but, like the best plans, it's actually the starting line, not a finish line. Getting to the document is the document and the plan, but all of the actions that come out of that plan now set some of the paths forward for us.

**Mr TIM CRAKANTHORP:** Have the First Nations staff within the agency been given the opportunity to contribute to that Reconciliation Action Plan?

**JOHN TANSEY:** Yes. We have only one member of staff who identifies as Aboriginal. Yes, they were invited to be involved, as was the broader staff cohort. The plan itself was developed through a staff group, together with the input, advice and expertise we got from our cultural advisers. Of course, part of the way anybody develops up a plan is to work with Reconciliation Australia through it as well. So, yes, Mr Crakanthorp, all staff, including our colleague who identifies as Aboriginal.

**The CHAIR:** You do have a target, I think, for First Nations staff members—3.3 per cent?

**JOHN TANSEY:** We may have had an explicit target in the past. I think last time we convened, we discussed a much broader range of KPIs that were identified in annual reports in the past and aren't there. I wouldn't quibble, though, with the substance of your question, Dr McGirr, because I think the point is that one of the outcomes we would look for through our plan is increasing our capacity to recruit and retain First Nations people in the staff of the organisation. As a very small organisation, that will sometimes be a little bit mathematically challenging. We would absolutely want to be a commission not only in respect of First Nations people but also broadly the community of New South Wales so that we do reflect the people we serve.

**The CHAIR:** To follow on from that, can I just say that I remember raising this issue with the previous Commissioner probably four years ago, and receiving assurances about engagement with First Nations communities. It's great that you've started a Reconciliation Action Plan, but as you pointed out, you're actually at the start now and beginning to reflect. I congratulate the organisation on that. Where I'm coming from is that that's been a long time coming. It's actually well behind many other parts of the public service.

The fact that you've not met that notional target in relation to staff members also indicates to me that in the past this issue hasn't been taken with the importance that it needs. I don't know if you have got any reflection on that, but it is a concern to me that it has taken this long to even start a Reconciliation Action Plan, particularly given the health outcomes of First Nations people and the clear barriers that I hear about in relation to First Nations people raising concerns about the system. I don't know if you've got any reflections on that. While it is good that you're starting, this is work that is well behind in my view and needs some urgency.

**JOHN TANSEY:** I will respond in a couple of parts. The reconciliation plan is a really important plan and series of commitments and actions for the organisation to deepen its understanding and capability of actions. I think you make a fair point that we're doing this in 2025 across the public sector. Some have done it much earlier than us. That's a fair observation, absolutely. I don't want to be seen to be ducking the question. I don't believe I can talk to what the level of effort or commitment was previously. What I do absolutely know is that when I came into the role, some of the very first discussions I had with senior colleagues was exactly around the enthusiasm for getting this done. That commitment had been there, and they had been working that up for quite a while. I think the total journey might be as long as five years that that had been percolating and being worked on.

I'd like to observe a distinction between the plan and what the commission is doing now and has done in the past for engagement with Aboriginal people. They are obviously complementary, but they are not the same. I believe you are not saying this, but for the sake of emphasis, it's not the fact that we have done nothing and waited to get to the plan as the starter pistol and then make the effort. I acknowledge that the Committee has raised these issues consistently at the annual reviews—the focus on engagement with target communities. We already do a really significant amount of work with First Nations committees as part and parcel of our core business of handling complaints and receiving complaints. I wouldn't want the Committee to think that nothing happens waiting for the plan. They are absolutely complementary ways forward.

We have a really significant level of activity, particularly for an organisation of our relatively small size, with First Nations communities and individuals. We travel around the State, both in metro and very particularly in rural, regional and more remote parts of New South Wales, engaging with communities, always with the stepping-off point—when we are out there doing that engagement, we are out there because we're working with communities, usually in the resolution mode of complaints. We leverage those visits to connect with communities and let people know who we are and what we do when we're out there trying to build those deep engagements. One of the things we know that is culturally appropriate and necessary is actually needing to have those connections and engagements and have that relationship ideally before somebody needs you.

People need to know you exist. There needs to be some level of engagement and familiarity for people to feel like we are relevant and useful and trusted by them before they need us, if they have a complaint about health care. We haven't been waiting for the reconciliation plan to do that. It certainly gives us some extra focus activities to get better and more culturally capable at it. I hear you, Dr McGirr, about your enduring interest in and perhaps concern around our levels of engagement. I would hope in my time in the chair I can work with you, including perhaps through some different reporting in the annual report that really lays out more transparently for the Committee and other avid readers of our annual report exactly where we go and the communities and individuals we work with, where that's appropriate, always respecting confidentiality. But we would like to lay that out a little bit more so that it's more objectively clear to the Committee and others where we go and who we're working with.

**Mr MICHAEL KEMP:** Can I ask a very succinct question, just quickly? How many staff are you responsible for currently, Commissioner?

**JOHN TANSEY:** Approximately 140 FTE is the current commission size.

**Mr MICHAEL KEMP:** So less than 1 per cent is the Aboriginal representation within your staff?

**JOHN TANSEY:** Correct, one out of 140. Again, I don't want to quibble. I respect the fact that people have choices. Our staff have choices about whether they identify or not. There could be other people who have First Nations heritage and don't formally identify it. But, yes, there's certainly only one staff member that I'm aware of who does.

**Mr TIM CRAKANTHORP:** Would you say it's a respectful and culturally safe environment?

**JOHN TANSEY:** Do you mean generally, Mr Crakanthorp?

**Mr TIM CRAKANTHORP:** Yes, is your organisation welcoming and respectful? Do people feel safe in terms of their First Nations—

**JOHN TANSEY:** I believe it is. We are absolutely minded to make effort to be as welcoming and as open and as appropriately engaging with all communities. I have not had feedback in my time in the role that raises major concerns for me to say that we are not. We would like to take a strengths-based approach in most of these areas. We are genuinely committed to doing this well and continuously doing it better, and we know that engagement with target communities can, almost by definition, have challenges. But I've certainly not had any feedback to say that we are not accessible or not culturally safe or capable. Certainly, going out to communities, the knowledge and feedback I have is that we have some quite rich relationships and would take pride in the fact that, particularly in more rural or regional communities, we are openly welcomed and invited back, which I think is a really significant and not to be understated indicator of good effort and good faith, particularly when we're dealing with First Nations communities.

**The CHAIR:** I'll just make this observation. I've just finished two years with a select committee in the lower House. We visited many parts of the health system in the State and invariably found health organisations that believed that they were receptive and were positive about reconciliation at the senior levels of their organisation. But our experience of talking to staff and patients and families on the ground was that that didn't always translate to the operation of the organisation. I think the Reconciliation Action Plan and the first step of

"reflect" is actually really important, because I think it challenges organisations who believe that they've got good intentions and that they're doing the right thing, but that's not always the case. I'll just make that as a comment.

**Dr AMANDA COHN:** Firstly, to pick up on this really important line of questioning, I'm aware of a number of complaints that have been made against practitioners or health services in western New South Wales because of quite negative outcomes experienced by Aboriginal patients. Is that cluster of complaints something that you're aware of? What processes does the commission have in place to identify whether this might actually be an issue with systemic racism?

**JOHN TANSEY:** Thank you, Dr Cohn, and thank you for broadly framing your question. I received a letter from you just last week about that with some more specifics. As your letter and your comments today reflect, I'd prefer not to go into the details of that while we've got matters underway, but we are absolutely aware of the particular instances that you're referring to. Our team were out in that specific community only two or three weeks ago, specifically for the purpose that we had received a cluster of complaints from that area, and we were out there working with communities and the services being complained about. We are yet to formalise our formal action out of that, so I don't want to say too much or get too far ahead of myself. I'd be happy to talk to you separately about it too, if that's constructive. But, yes, we are aware of those issues and the specific nature of the complaints from those areas. Those issues are exactly what we're working on with the community and the service providers.

**Dr AMANDA COHN:** I'm pleased to hear that cluster is something that you're aware of. I agree about not going into the details of any of the cases; I'm certainly not trying to breach anyone's confidentiality. My specific question is about what processes you have in place to identify whether this may or may not be an instance of systemic racism, notwithstanding that you are appropriately investigating each individual case.

**JOHN TANSEY:** Sorry, so you're partly asking about our process. If I speak in the broad, in the instances of these complaints that came to us, they were specifically raising issues of how people felt they were dealt with. If I can make a very broad distinction, there might have been clinical elements to it, with people seeking health services. But the predominant nature of the complaint was about people feeling they had experienced racism in the delivery of health services, as distinct from the actual clinical approach. That was the nature of the complaint coming to us, or a central element of the complaint, so we take that on as part of it.

Our work out there recognises that that's the experience of people that were making the complaints and I think can confirm that that's been their experience. Our activity is to work, as I said, with the complainants, individually or with their family and community where that's appropriate. The nature of resolution is that we are working with patients or complainants, and family and community, and the services. We need to have both parties agreeing, and voluntarily agreeing, to be part of the resolution for it to happen at all. We did have that. Exactly what we do now to take a more—if I can say—structured follow-through on what happens is what we're yet to resolve. But I would flag it is my expectation that there will be more—that we will formalise what we believe have been parts of those complaints and think about the best way to take that up with service providers.

**Dr AMANDA COHN:** I'd appreciate an update on that work when you're in a position to.

**JOHN TANSEY:** Yes, thank you.

**Dr AMANDA COHN:** I'd like to move to the recommendations of the birth trauma inquiry that specifically related to the work of the HCCC. I firstly thank you for your letter to the Committee back in March, which members of the Committee have all seen but which isn't yet a public document. Chair, I seek to table that document as part of today's proceedings so that I can refer to it.

**The CHAIR:** Thanks, Dr Cohn.

**Dr AMANDA COHN:** Firstly, in that letter you did identify some progress that's been made in responding to those recommendations, and thank you for that work. The document talks about organisational changes to support trauma-informed complaints management, including improving continuity of relationships with staff members to reduce people having to retell their story and also the assistance of the intake staff to support complainants to put their complaints in writing. Those things are both very welcome. I wanted to follow up specifically on the option for people to have assistance in putting their complaints in writing, which is really important for some people who have experienced trauma. Your letter said that in the 10 months since the transition at that time, about 75 members of the public had been supported. My question is why isn't this publicly promoted? If you visit the commission's website, it still very clearly states that all complaints must be made in writing.

**JOHN TANSEY:** Thank you, Dr Cohn. Can I reflect back to my previous appearance before the Committee, notwithstanding it was early days? I recollect you asked me about that then. I think I said it was something I would look into, and did afterwards. Even at that early stage, I really had an underappreciation of the fact that this was already an established approach of the commission and that we could do and did provide that

assistance. Informed by the recommendations of the birth trauma inquiry, we've bolstered our understanding and the intention of giving the Committee a fairly fulsome response and to try to share that with you. You've got me. I can't remember what's on our website right now; I don't have it up in front of me. I'll definitely make it an activity out of today to go back and see what we say there. Again, I know I said this last time but, legislatively, we are obliged to get complaints in writing. The absolutely critical stepping stone is that we can be the ones that put it in writing on behalf of or with the complainant if, for whatever reason, they're not able to access digital services and do it online—their language skills or for whatever reason. It doesn't need to be a complicated reason. If they need help to do it, we will do that.

The organisational change—again, I give credit to the organisation; this predates me—that was already in train in early 2024 was to try to get better alignment of those kind of public-facing elements of the commission. The Enquiry Service was moved from being another part of our organisation that did the resolutions and reviews, including the resolutions we were just talking about in community, and putting it at the very front of the organisation so that, where people are typically phoning us on the Enquiry Line and we can be answering very simple questions, the vast bulk of work that goes through the Enquiry Line will be providing people with information, guidance and helping them to find their way around to services.

Really importantly, it provides us, at first contact, the potential or the opportunity to recognise that what somebody is asking about actually sounds like it's the basis of a complaint. Therefore, from that first engagement, our staff can say, "It sounds to me like you might have experiences here that you're not happy with. If you wanted to formalise that into a complaint, we can help you with that." That's one of the express intentions of getting the enquiry serviced there, so that people can steward that enquiry, if it should be.

We're not soliciting complaints from people who don't want to do them. Where it comes to our understanding through that engagement that people have grounds for a complaint, and in discussing it with them, they say, "Yes, I actually would like to do it," we can help them do that. That has been there for a while. Attaching it to the Enquiry Service makes that transition absolutely more straightforward. You've got the warmest of warm referrals from enquiry staff to help people do that and straight into the intake function of complaints. I think that synergy lies behind the reasons that we've had such a significant uplift in the number of complaints that are made that way.

**Dr AMANDA COHN:** That certainly does sound like a more trauma-informed approach that the commission is taking, which is really welcome. I will read to you from your website, noting the page that I'm reading from hasn't been updated since 2020. This is under "Understanding Complaints", and then the page is entitled "Complaints process". It says:

> All complaints must be in writing and the easiest way to lodge a complaint is using our online portal. You can find out about the types of complaints the Commission manages or contact us for more information.

And then it goes on to say, "Once your written complaint has been received," et cetera. There is no mention that, "If you'd prefer to speak to someone, we can support you with this process. Please give us a call." I encourage you to take some of the credit for the good work you're doing and promote that to the community. My concern is there may be people who choose not to make a complaint because they don't know that that process is available to support them.

**JOHN TANSEY:** I'm sure that's a fair assumption. If people read that and take it on faith, and they accept that as the conditions or the rules and the barrier, and that discourages them from going further then, yes, that's absolutely not what we want. Without going on too much on a tangent, Dr Cohn, we are currently doing some planning work around a refresh of the website overall. I come back to Dr McGirr's earlier questions. As part of our active planning for how we do communications and engagement, we have a plan in development to start to align them with the strategic plan that is really trying to plan for and articulate how we're going to do all aspects of engagement and communications differently. A website refresh is absolutely part of it.

We know that website and digital access cannot be the be-all and end-all of how people find us and engage it. But if I could sum up the numbers, I think we have about 270,000 engagements through our website each year, so it's very important—a very important channel. And for exactly that reason, it needs to be clear and simple and actively support our accessibility. So I'll take that as a bit of homework out of today, to look at that. But yes, a website refresh is in planning and that's something we'll make sure is a part of it, if it isn't already.

**Dr AMANDA COHN:** I also wanted to follow up the issue of reporting on complaints about maternity or complaints that may relate to birth trauma. In your letter you explained the ways in which that's currently challenging. Moving forward, what options are there to address this? Is it something that the new case management system will improve, or are there other ways that the public can understand the volume of complaints relating to birth trauma?

**JOHN TANSEY:** I think in the letter—which the Committee has seen, but maybe not others listening into this—we were trying to be very frank and honest about what we think are the challenges. I wouldn't want to be in a position of saying, "Yes, thank you very much, we'll look at that and hope to do it soon." It remains quite a challenging reporting function because, as the letter lays out, our understanding of the full scope of experiences, maybe not always that the people experience but that we will put under the label of birth trauma, can be a significant cluster of experiences across a whole birth journey. It can involve a range of different clinical settings. It can involve a range of different health providers and practitioners.

Therefore, where our current data capture and reporting tends to look at definable areas of practice—so you can go into our report now and look at nursing and midwifery as the practitioner cluster, or obstetrics and gynaecology, and that's where you might go looking for some of those reports—certainly not everything in those domains would be a birth trauma matter. It can obviously relate also to nursing experiences in the community and community nursing, or with somebody's general practitioner. It is a genuinely challenging, broad range of areas of practice and facilities that could be part of that.

We don't report, at the moment, on how people might title their experience of health; it is by facility and practitioner. So it remains fairly challenging for us to think about how you would extract the elements of what we might call birth trauma and report on that as distinct from reporting on the settings or the areas of practice. I'm not saying it's impossible, nor would I say it is necessarily something that our new case management system makes immediately easier—"Press the birth trauma reporting button." There's no such button, without wishing to be flippant about it. It continues to be a pretty challenging reporting focus.

**Dr AMANDA COHN:** Given this is of such interest to the community and interest to the Parliament on behalf of the community, without that data how does the commission understand the volume of complaints in terms of your work to improve processes relating to birth trauma?

**JOHN TANSEY:** By that do you mean our processes in related—

**Dr AMANDA COHN:** Yes.

**JOHN TANSEY:** I think the letter also sets out that, notwithstanding that we may not be able to readily extricate data and report on it—the letter is reasonably detailed about what we actually do in practice now, internal to the commission, to understand some of the elements that might mean somebody's making a complaint to us that we could attach the label "birth trauma" to, even if the complainant doesn't use that language. It sets out that the way we now try and work in smaller teams, and have a more shared case management approach and case management familiarity with matters that are in small teams, means that the skilled officers of the commission would be able to recognise a complainant talking about the kind of experience that we think connotes that they've had a traumatic experience through birth, and we would work with them accordingly.

I'd also make the broader point that dealing sensitively in a trauma-informed experience is not limited to people whose trauma might've been through a birthing experience; it goes across the health experience. As the Committee would well understand, it's the nature of our work that people will commonly come to us with some level of trauma, even if they don't use that language. If they have had a really challenging or adverse outcome through the health system, that's exactly why they're coming to us. We would try and recognise and use appropriate methods, whether or not complainants use the language, through our understanding of the make-up of those complaints and actually endeavour, for all complainants across any issue they're coming to us with, to do that in a trauma-informed way.

**The CHAIR:** To clarify, it sounds as though the process is essentially a manual one, notwithstanding the new case management system. A team really needs to be aware that you may want to collect data on something called birth trauma; presumably there's some definition that goes with that. You've got teams now that could do that, but they've almost got to consciously tag a case as that for you to then, over a period of year, tell us how many cases there were and the outcomes from those cases. Is it?

**JOHN TANSEY:** Yes, I think that's a fair summation. It will always be intelligent humans doing our work. Our case management system can support and collect data in it, but it will always be the skilled people in the commission that are doing that work, human to human, when we're dealing with complainants, to listen to what they're complaining about and listen with skills and experience that we have, whether or not the complainant needs that—so being able to recognise the nature of the complaint and some of the features of it.

I'm happy to take it away as another piece of homework to think about how we might use the new system to do that. We already have facility in the system to put alerts on cases so that people going into a record in the system, which is properly bounded by people having need and the right of access to information—but we can put flags on the system now. For example, I've reviewed a few examples in the new case management system in the last few weeks and have personally observed the fact that it might put a banner up at the top that the complainant

is perhaps the adult child of somebody and their parent has passed away, and that the nature of their complaint is at the passing of a parent. Whenever you are opening up that file and looking at it, you're knowing that that's the life experience that sits behind the complaint, so you're always made aware at first flush that that's the specific character of a complaint.

**The CHAIR:** That is a great service for the complainant, so I appreciate that. Of course, it does get back to the issue of how difficult it is to collect the data, so we look, with interest, at how you try to resolve that going forward and acknowledge that it's going to be difficult. Thank you, Commissioner. We'll now take a short break and come back at 10.35 a.m.

**(Short adjournment)**

**The CHAIR:** Welcome back after the short break.

**Mr MICHAEL KEMP:** I might open with a statement, actually. Given that the limitations of your new management software are known, and given the importance of the birth trauma inquiry, I think it would be imperative that we set up a manual tracking system for those cases in particular. That's a very quick opening statement, if you'd like to respond at all.

**JOHN TANSEY:** Can I accept at the moment that it's more likely to be a limitation of me and my familiarity with the system than the system, necessarily. I'm actually really happy to work out whether and how we can do that. I'm not going to speak ill of the system, but we still need to grapple with it and work out how.

**Mr MICHAEL KEMP:** Yes, no worries, cheers. I just thought it was an important one to note. My particular interest area is around unregistered practitioner complaints and false-advertising complaints, but I think we've seen a lot of private hospital complaints out in the public eye at the moment. In the recent 2023-2024 year, we've also seen an increase of 13.2 per cent of complaints based around public hospitals. Is there anything that you attribute that to specifically?

**JOHN TANSEY:** I can't say with certainty what sits behind it, but the dynamic that we would be inclined to attribute it to is that, in recent years and with the well-publicised cost-of-living pressures on people, our working assumption is that perhaps people have been accessing public hospitals. I think hospital system data would bear this out. The actual presentations to hospitals have gone up, where people are trying to access free hospital care where they may feel like they can't afford community care with gap fees et cetera. So the pure volume of traffic into public hospitals has gone up. It's pretty much in keeping, then, with the volume increase in complaints.

**Mr MICHAEL KEMP:** So, if it's just a volume increase, is there anything that the commission can do to address that?

**JOHN TANSEY:** It's not easy to contemplate what we can do; I'll be honest. I mean, obviously the commission exists as a check and balance on all health services. We absolutely aspire to doing that well enough and being able to play it back to the health system, and providers in the health system, to share learnings and therefore inform their opportunity to do better. We absolutely do that. As you may well be aware, when we produce our quarterly reports—which we provide to the Committee and to the Minister—synchronised with that, we have meetings with the senior health colleagues as well, where we provide insights to them about the performance of public hospitals and public facilities in the broad profile of reporting.

We absolutely use that, and we do that with some granularity so that they can see, whether it's by geographical area or whether it's by specific facility, that complaints are actually reducing—and thereby improving—or notably increasing. We do do that with reference to the information we have about the instances of service. We can provide feedback to providers where their level of complaint is greater than the trend in their actual presentations, which suggests things being complained about, yes, are greater than the pure presentations. So we can and do do that, Mr Kemp.

**Mr MICHAEL KEMP:** I realise that complaint reporting is a clunky tool with the shift away from primary care onto the hospital system, but it is a tool. Obviously it would go towards helping to look at budgets et cetera as a report back to the ministry. I will come back to reporting back to the ministry later on but, where there's a cluster of complaints throughout a Local Health District (LHD) scenario, do you speak to that Local Health District in particular, or do you give generalised feedback across the ministry?

**JOHN TANSEY:** No, we will work with LHDs or subgroups of LHDs as well—can do and have done. I won't name names but there has been an instance already this year where we were aware of particular issues in an area and worked with the leadership of that LHD and had staff go up. We had been undertaking some resolutions up there. We had had some interest in us doing a complaint and patient safety presentation to the

group. When that offer became known by the leadership of the LHD, that was actually expanded. So a planned workshop for 20 ended up with attendees closer to 100 because of the utility of that information and the openness of the LHD to hear it, and hear it across the team at the LHD. That's probably a particularly constructive and useful way of having the complaints record become a resource for the health system and for health providers, because when they're open to hearing that and deeply engaging with potential lessons and improvement opportunities from it—

**Mr MICHAEL KEMP:** And you're waiting for the identification of an actual LHD before that's rolled out further? It's not something you think you can bring into best practice educationally?

**JOHN TANSEY:** We do that. I'm drawing on my memory of a particular instance we've had. It was particularly brought home to me too because in recent months I had an opportunity, at Secretary Pearce's invitation, to present to the Senior Executive Forum, which is the CEOs of all the LHDs and I think some of the pillar organisations as well. It was a big room. The particular CEO of that LHD involved, to colleagues in the room, talked to how valuable that session was and in fact encouraged colleagues to take up other opportunities and invitations. So I honestly believe we can do it, and I think there's a high level of receptivity for engaging and drawing on those lessons.

**Mr MICHAEL KEMP:** Good. If we change tack a little bit, in today's fast-paced internet influencer world, often without statistical backup or high-level qualifications behind it, we've seen a significant increase in the complaints from the non-practitioner space. How is that impacting and what effect is that having on the work of the commission?

**JOHN TANSEY:** Focus on the non-registered sector has effectively doubled in the reporting year we're talking about today, but that's from a very low base. We're talking complaints that were just touching double figures—so going from 11 to 20. It's not a huge volume of complaints. Nonetheless, it's been a particular focus of the commission in the past year. We haven't seen it yet coming out in annual reports, but we will post-30 June this year. We've had a major focus, for example, on cosmetic services. That would be one particular area. In the year just about to conclude, we've had an almost all-time high level of activity. We've been executing search warrants in facilities based on complaints.

We're not waiting for clusters of complaints to get to a level where we're intervening. We're looking in some instances at one or two complaints that look to us to be particularly serious and adverse, using that to do background investigative work on the facilities and providers, and then under a search warrant show up at their front door and undertake a fulsome search of the facility. So going to your question, the increases are from relatively small numbers to still relatively small numbers. Despite that, it's an absolute hotspot on our radar. Cosmetic services, in the time I've been in the chair, has been a particular absolute focus.

**Mr MICHAEL KEMP:** It's a very appropriate answer because you've answered my follow-up and then my sub-question and then my follow-up. In particular, I specifically wanted to highlight this because I'm suspecting that this year's statistics will be significantly worse. I'm really concerned about the safety of our community in this space, and I'm glad to hear that you've got a specific focus on it. Will you be feeding this year's statistics in immediate time back to the health Minister? Specifically, how are you going to work with the other compliance organisations and co-regulators? Because, again, I'm concerned about the community's safety around not just cosmetics but, in particular, around the cosmetics industry, which is so sought after at the moment.

**JOHN TANSEY:** If I can keep using cosmetic services as a very front-of-mind concern, because I think unfortunately it is the poster child for bad conduct by some unregistered practitioners. There are a couple of things. We've had, and been able to leverage, a lot of interest from mainstream media around this as well. We've had quite a high level of engagement, and we have been proactively releasing information and then, where appropriate, sharing further information where media are interested. I would hope maybe members of the Committee, given your particular interest in this area, would have noticed.

I think we've had a bit of a peak in some of that coverage we've had through this year. That is a specific regulatory tactic we've been trying to use. Where you're doing this work where you have some of the attractiveness elements of us undertaking search warrants, which the commission has done well before my time but it has been particularly a focus through this year, that has been getting us good traction. We've had a lot of media uptake, and that absolutely helps us to spread the word out there to people.

Mr Kemp, you asked about co-regulators. One of the absolute features of that as well is we have had fantastic collaboration with a range of health co-regulators. Across some of those activities, we've been out in the field with our New South Wales colleagues, whether it's the pharmaceutical services unit or the public health units. We have had Commonwealth colleagues such as the Therapeutic Goods Administration (TGA) joining us on some of those search warrant incidents. We have been actively trying to collaborate with colleagues on these

issues. It's a boon for them because they have expertise and some capability that sometimes we don't have. It deepens the strength when we, for example, execute a warrant and go out.

When we've got specialist pharmaceutical regulators there or we've got the TGA looking at equipment, it greatly increases the range of expertise in the room and the capability for people to identify whether it's drugs or equipment. Therefore, if we can identify noncompliances, we can take that evidence and impound them and broadly interdict those facilities. It has been fantastic collaboration from our colleagues, and it has absolutely strengthened our capacity to really have an impact. Some of those facilities we've seen, they have literally just shut up shop after we've been there.

**Mr MICHAEL KEMP:** I think there's also a space to be asking the co-regulators, maybe outside of this format, around the false-advertising complaints, because I don't have the data and I'm not sure that with your current changeover you'd be able to ratify that out, would you? Using your current system information, are you able to ratify out the false-advertising complaints? It's a particular interest of mine around provision of health care.

**JOHN TANSEY:** Again, I think it's something that our case management system helps us record, but we have to know it and get the information in the first place. Are we dealing with providers that, for example, purport to be qualified medical practitioners when they're not? Absolutely. Do we deal with people holding out to be practitioners when they're not? Yes, they are, and that would be an area we would particularly collaborate with—I didn't mention before—New South Wales police; we will work with them in some matters as well. When we're dealing with some of these practitioners, typically we'll actually get a cluster of issues. It would be typical to find people who don't hold recognised qualifications in New South Wales or Australia. They might be claiming to be a nurse when they're not appropriately trained. They might be holding out that they're a doctor when they're not. We will usually see, regrettably, complaints talking about people having the experience and having adverse impacts following cosmetic services.

When we're out there, we're dealing with unqualified people using inappropriate medicines or drugs and equipment, potentially with fake certificates on the wall, implying that they have, or purporting that they have, qualifications they don't have. We will get a cluster of issues, and we will work with our co-regulators, including, for example, if we're getting examples where—if, for example, we have a complaint that relates not yet to any adverse outcome from a service but somebody might report to them that they had a service from somebody and they found out subsequently the provider who they thought was a doctor was not, we will coordinate with our co-regulators about who is best placed and who has the most available powers to deal with that. But we are taking a very coordinated approach on that.

When the Chair asked me about opening comments, I think one of the things I reflected on is that I'm very happy with the way that we are working constructively and collaboratively with the co-regulators. One of the secrets, when we're a modestly sized organisation, to getting the best bang for our buck is to bulk up by working with other collaborators to increase our individual and collective leverage by making sure we're bringing all of those capabilities.

**Mr MICHAEL KEMP:** I might take that one offline for later. It's the middle of 2025, and we're talking about the 2023-24 reporting period. In this fast-paced environment where we are talking about concerning issues around the safety of our community based on practitioners and what they're keeping up with, how will you use the information in this report to influence your response to these types of threats right now?

**JOHN TANSEY:** We don't wait for the reporting in order to act. You're absolutely right: There is, unavoidably, a lag effect by waiting for a year to finish collating all the data, because putting together the annual report is quite an undertaking, and publishing that. You're right: By the time you get it, it's aged data. But day in, day out, we're not waiting for reporting to produce. The reality is that we are talking with each other in the organisation, looking at events in real time, as they happen, and applying our smarts to detecting drivers or patterns. We don't wait for a published report. I acknowledge the outside world needs to wait for some of that. We don't wait for that reporting to act on what we can see as either clusters of issues or concerning trends. Our reporting, internally, is at least monthly. Every month, when the executive meets, each branch of the commission is producing its own operational report. So we are monitoring what's happening—volumes, timeliness. That is one of the platforms we have for having a much more real-time discussion about what we're seeing.

**The CHAIR:** I've got a couple of comments. One is that I was very pleased to see that increase in the cosmetic surgery activity. It had been raised by this Committee a number of times in the past, and it's good to see a marked increase in activity. I just want to commend the commission for that, and I think you've given us a good explanation because you've clearly—I think your phrase was that you've used a regulatory tactic of publicising some of this. I look forward to more of that, and I share Mr Kemp's concerns.

Can I also put a question on notice to you about the increase in public hospital activity that you've attributed, in your report again today, to increases in emergency department activity? I'm not actually sure your data bears that out. It seems to me that the increase in the public hospital activity doesn't just relate to emergency medicine. It may just relate to a greater level of activity in the public hospital system overall, but it would be good to check that, if I could. I just put that to you on notice to go back and interrogate that a bit further. It's very easy to blame anything in the public hospital system to an increase in people going to the emergency department. I've been hearing that excuse for 30 years. Sometimes that's true, but your data suggests that there are complaints within the hospital system as well, not just in emergency medicine. I'll leave that there as a supplementary question.

**The Hon. AILEEN MacDONALD:** Commissioner, I note in your report that suicide- and mental-health-related complaints are increasing. I just wondered if there had been any themes that have emerged in these suicide-related complaints, and are there specific system failures that are being addressed? You can take that on notice.

**JOHN TANSEY:** Yes, I was going to say that I'm not feeling, sitting here, that I am close enough to the reflections. I would be happy to take that on notice or as a supplementary, if you would like. I don't know whether, Mrs MacDonald, there are particular parts of the report that you are drawing on for the question. Sitting here right now, I have not had it raised with me—from the collective wisdom of the team, are we seeing anything in the mental health space, including in suicides, where we're seeing a pattern or an attribution. Is there a particular piece of the annual report that piqued your interest?

**The Hon. AILEEN MacDONALD:** No, it was just in general. I might put these other questions on notice as well. Following on from the First Nations report, I note that last year when we did some recommendations we noted whether there was a verbal complaints process that could be initiated, given that sometimes First Nations people find it difficult with the process that is currently being used. Has something been implemented along that line?

**JOHN TANSEY:** Yes, it has. I draw on my earlier response to Dr Cohn. We were talking about assistance to complainants at that time in the particular context of birth trauma. The service that is there is there for anybody and everybody that feels they need assistance in order to make a complaint. So, yes, I acknowledge First Nations complainants or communities might also particularly value that. That is absolutely there and available to them, as it is to anybody that needs assistance to lodge a complaint in that way.

**The Hon. AILEEN MacDONALD:** With the Reconciliation Action Plan (RAP) that you are putting together, how will this improve cultural safety in complaint handling and investigation?

**JOHN TANSEY:** One of the most critical elements of our RAP, if I can use that acronym, and the reason why we consider we are at that first stage is that it is very openly and intentionally about raising the understanding and the awareness of everybody in the commission about the current and, of course, also the historical experience of Aboriginal people since colonisation, particularly in accessing health services. Understanding that people may come to us with a significantly different life experience and cultural experience of accessing apparently accessible and apparently mainstream services is an incredible—I don't want to use '70s language, but I am going to say that it is consciousness raising. That would be the old term we might have talked about.

It's people being explicitly and front-of-mind aware that complainants coming to us will have different life experience and different service experience, and adjusting the understanding of what that means about—how people complain and what they might complain of can be different. And then it's dealing with that in a way that is facilitative of the success of their complaint or the success of them making a complaint, and dealing with that complainant's family and community all the way through so that, for example, people feel engaged and continue with the complaint, and we don't lose that person and that complaint because something in our practice and our awareness causes them to give up on us or go away, for example. I find it hard to articulate. It's that profound level of understanding about the difference of experience and making sure that the way we provide services can deal with that and is cultural appropriate and safe, and that means the success of the journey of that complaint.

**The Hon. AILEEN MacDONALD:** Why does it need a plan? Why wouldn't we just be doing that anyway?

**JOHN TANSEY:** I think it's one thing to say you're going to do it and say, "Yes, we'll do it the other day." One of the beauties of a plan is you actually have an articulated commitment and you have activities to hold yourself to account to. In our reconciliation plan, I think there are 38 different actions. They are about the people in the commission, the systems and processes of the commission, the activities we do to engage with community and the way that—you really need it as an accountability and a clear and articulated approach to what you're

doing, which gives you guardrails but also holds you accountable. It's not just an aspiration and good intent; there's actually a plan. That means the staff of the commission can be party to that and part of the check to hold us all collectively accountable—are we actually doing what we've said we're doing in our plan?

**The Hon. AILEEN MacDONALD:** I might change tack. Voluntary assisted dying is now within the remit of the commission. How many complaints have arisen in this area since the Act came into force? What training have the commission staff received in handling these cases sensitively?

**JOHN TANSEY:** I'm sorry, I'm on a theme here with your questions. I might need to take that question on notice, if I may, around specific numbers. Again, I have not seen any particular reporting or identification of us having received complaints specifically regarding a voluntary assisted dying process. I have done a little bit of work myself, again, as an active learning example, in our new CHAMP system of looking at complaints where I have keyword searched for that. My slightly inexpert analysis of that would be that we have complaints where people might have been in a palliative process or otherwise had—and quite typically it will be the child of a parent raising matters with us. I'm not aware of complaints arising that are specifically about the voluntary assisted dying structured process. We do, as you would fully understand, get complaints about loved ones that have passed away and how that was managed. But, yes, happy to take the more specific question on notice.

**The Hon. AILEEN MacDONALD:** When there's a delay in diagnosis, can you provide examples of how delays in a diagnosis or treatment could contribute to poor outcomes or have contributed to poor outcomes in the past year? I suppose that's a bit long.

**JOHN TANSEY:** I'm not going to try and talk to specific examples. We certainly get complaints and that would be reflected in the reported statistics around, for example, access. One of the categories or types of service or nature of themes of complaints we would commonly report on is access to services. We will undoubtedly get complaints where people feel they couldn't access services or they had delayed access to services. The nature of their complaint is going to be "I believe that contributed to an adverse outcome." That's absolutely part of complaints profiling. As you would fully appreciate, in the annual report and elsewhere, we don't collect profiles of a whole range of complaints and report them or discuss them.

**The Hon. AILEEN MacDONALD:** How does the commission then follow up? If it was an access issue or it has identified one of those issues, how does it follow up to ensure that hopefully those kinds of things don't happen in the future?

**JOHN TANSEY:** That can happen in any number of ways, and quite often it will depend on what pathway within the options and pathways the commission has—how it goes down. I've already mentioned, a couple of times, resolutions. I might start there. If we have a complaint that comes in and the preferred way or the optimal way of addressing that complaint is to get the family together with the facility and talk about the experience—to use your example, if somebody feels like delays in access or provision of services contributed to an adverse event—one of the ways we will do that is to actually get the practitioners and the family together, sitting down. One of the reasons that those resolutions can be so beneficial is they allow people to share the records and share the experience of what happened. That can be powerful on both sides. Practitioners hear from families how they feel they were impacted by the way that service was provided and led to what they believe is an adverse outcome.

Families can hear from practitioners what they believe was in fact happening, because you can imagine, if a family is sitting at the bedside of a loved one and things are not going well, it's traumatic. There's a lot of activity. You're going to be experiencing heightened emotion. If, like me, you're not a clinician, you probably don't really know what's going on, so they can get the benefit of learning a lot more about what happened and sometimes understanding how much was going on that they didn't fully understand or appreciate at the time. If we did that in a resolution, it's the parties sitting across the table hearing and learning it together. If we have a matter where it might be a less high-impact matter and we refer it back to the facility for local resolution—so they sit with the patients and families to resolve matters—we will require, as a part of that, that they report to us on the outcomes of that resolution. It remains open to the parties, particularly the complainant, to come back to us with a complaint, if they're not happy with how that goes.

At that low level, it will happen like that. If you go to the other end of a practice, we might have conducted an investigation which is focused more particularly on a facility and might reflect or involve a number of complaints. We can, and do, formally write to the facility with a series of recommendations. Those are signed off by me personally. They will go to the CEO at the facility and then, depending on where it exists in the system, if appropriate—if it was a public facility—it might go to the CEO and the LHD as well. They're provided a copy of that investigation report and findings with a chance to respond, which we can then consider in the way of submissions. When we formalise that, we will write back to the facility with the report, with recommendations

and with a request or a requirement of them to report back on how they acquit those recommendations. Those would be a couple of examples of how we keep track of it and drive the findings through.

**The Hon. AILEEN MacDONALD:** In regional areas, I note that 50 per cent of complaints appear to be or are resolved. Do you believe that delays in diagnosis or access to care are being exacerbated by the geographic disparities?

**JOHN TANSEY:** I think it would be hard in the broad for me to sit here and talk about cause and effect. We certainly know through the complaints profile that people in rural and regional areas will sometimes complain of different things, so, yes, the geographic challenge of accessing services is almost a given. There will certainly be complaints based on whether or not people had timely access to certain facilities or specialities. That will pop up in complaints. If we're dealing with specific complaints, yes, we can work with families, the facilities and the outcomes to deal with what specifically happened. But, apart from that, as I've just said, I think for us it would be more recognising broad trends around some of the potential clinical outcomes and different access to services in regional and remote areas.

**Dr DAVID SALIBA:** My questions pertain to culturally and linguistically diverse communities and the commission's work in that space. As a prelude, can you talk about any updates there? I know you have been pretty active there, as we've spoken about before.

**JOHN TANSEY:** It absolutely remains a focus of our activity. The current period annual report we're looking at—I hope it lays out some of the dimensions of that. I know we've certainly made a point of trying to report on the engagements, right down to mentioning some of the organisations we're involved in. I would hasten though to reassure you that that is an area where we are still planning to do more and do better. We are in the final throes of finalising a communication and engagement plan, as I referred to before. That will be a building block of the next strategic plan. Community engagement, community outreach and particularly working with focus communities is one of the key planks of that strategy, together with a website refresh that I referred to before with Dr Cohn.

It is absolutely an area where we want to do more. It's not a competition, but I suspect that we do slightly better at the moment with First Nations communities—that might surprise people—than we necessarily do with culturally and linguistically diverse communities. But as a general focus it is absolutely there. Some of the challenges in engaging with multicultural communities—I think I referred to it last time I was here—is where our appreciation and understanding of the diversity of those groups just gets greater and greater. But there is an even greater—it's almost a numerical challenge, I would say. Our multicultural communities, in population numbers, are far greater than First Nations communities. It's just a bigger challenge to try and engage, but we remain absolutely committed and focused.

**Dr DAVID SALIBA:** Are there any synergies between HCCC and Multicultural NSW? Has there been any joint work to promote those outcomes?

**JOHN TANSEY:** Yes. One of the things we're particularly looking at in our strategy is trying to join up a little bit more, similarly—as I was answering Mr Kemp's question before on the unregistered practice place, one of the things we're going to try and do more of or do differently is combine with other agencies and actors in the sector so that more of us are able to engage with community and present. We've been talking with some other, smaller independent bodies and some of the other integrity bodies about how we can join forces and engage with community, not only because that potentially might be more efficient for us to leverage but also because we think that it might actually be more beneficial to communities if they are able to engage with more parts of the public service at one time, rather than all of us going out one at a time and trying to engage with communities. Whether it is Multicultural NSW or whether it is some of our other fellow regulators like the Ombudsman's office, we're actively looking at how we can collaborate together and amplify our impact that way.

**Dr DAVID SALIBA:** Yes, because it would be good to leverage. I know in Multicultural NSW, Joe La Posta does some great work in building relationships. It would be good to leverage those relationships to pump out those messages. Are there standalone engagement and outreach activities? That's the first aspect with respect to CALD groups. The second aspect to that is funding. Has there been additional funding assigned to that or not really? In the absence of that, how do we mitigate?

**JOHN TANSEY:** I think the first question is, do we have a standalone resource? We have consistent resources. Our communications engagement team is two people. Two full-time officers share that role, but I would emphasise that they do that as the expertise point and the anchor point within the commission. The role of engaging with communities is actually spread more widely than just those two officers. While they bring expertise and help anchor the logic of who we're working with and how we're working, it is an activity more broadly across the commission staff to be part of that engagement. As I've mentioned today and I note I've said before, our resolutions

team, who are out in community undertaking resolutions, will often add to their activity by connecting with community groups and focus community groups when they're out there. That's particularly the case when we're in regional and remote New South Wales, and we're trying to leverage the time in community and travel costs et cetera. The funding for that activity is consistent. I think it's budget day tomorrow, so I probably shouldn't be pre-announcing any budgets.

**Dr DAVID SALIBA:** Fair enough.

**JOHN TANSEY:** But our budget for the next year will have some enhancement, slightly above cost-of-living increases, but the resourcing for those activities will remain largely as they are now.

**Dr DAVID SALIBA:** The final aspect of this is engagement. I heard earlier on during your responses that you were talking about how complaints must be in writing, and the commission can help complainants put that in writing. I just know that when I deal with CALD communities, particularly out in my neck of the woods, it is a bit of a deterrent for people to put stuff in writing because, one, their writing skills aren't the best. It's intimidating for them. Apart from awareness activities of the HCCC, do you find that there are any specific nuances that we need to do with respect to the complaints process to help CALD complainants actually get through that process with their welfare maintained?

**JOHN TANSEY:** Again, as I've said in response to some of the other questions, if people need assistance for us to render the complaint in writing—and that's including because perhaps English is not their first language or they're not proficient in English—we will do that where necessary. We can do that with the benefit of interpreter services as well. Those very front-door potential barriers to accessing us, we will work with people of non-English-speaking background to try to facilitate that. We also make sure that core resources of the commission are translated into a broad range of community languages, as well, so that if people are accessing their own information, they can hopefully find it in their own community language, as well as some of our Easy Read resources. So, yes, we will apply ourselves and our resources as best we can to absolutely facilitate people making complaints, including where the English language is the barrier.

**Dr DAVID SALIBA:** I'll finish off with a comment as opposed to a question. I find or have been told that when people and newly arrived families come here, trust in government institutions is hard to earn, considering where they've come from and what they've escaped. I'm not directing this at the commissioner; I think it's all government entities, to be fair. Ways to build trust with certain vulnerable people from these communities, I think, are important to factor in and strategise for to ensure that what they do—something bad will probably happen to them from a health perspective, and it's like, "I can't complain; otherwise I'm not going to get treated in the future" or "It's not a good thing to do" or "They're going to turn on me," or whatever the case may be. It's just something to note as part of your CALD strategy moving forward, please. Thanks so much, Commissioner. You do great work.

**JOHN TANSEY:** Thank you. I know you said that was a statement, not a question. We are absolutely aware of the experience and background of some people. Our work has included working with the refugee advocacy service, for example. Exactly as you've said, we know that some people may not come to us because their in-country experience will be that government is not their friend and they don't go looking to government for help.

**The CHAIR:** Mr Donnelly is currently absent, attending to some other matters. He will return, and I know he's very keen to ask some questions around the case management system. In the meantime, can I take the opportunity, with the indulgence of the Committee, to follow up on another issue in relation to welfare treatment of practitioners about whom complaints are made. This issue has come to my attention in recent years because of figures that seem to show quite a high rate of practitioners taking their own lives when subject to investigations. Admittedly, this often refers to Australian Health Practitioner Regulation Agency (AHPRA) data rather than the HCCC's. Nevertheless, what is cited is the impact of vexatious complaints and the impact of delays in handling complaints.

We've raised this previously with you. We've made recommendations in our previous report. The Government has supported, or supported in principle, those recommendations. I'm interested to hear from you, Commissioner, on what you think the next 12 months will hold. Hopefully this will be part of the strategic plan as well, both in terms of rapid dealing with vexatious complaints and being mindful of supporting practitioners. There are two aspects to that, clearly: making sure that they have access to appropriate support but also a timeliness in response—perhaps even some KPIs around the timeliness of responding and following up on information—so that there are not long periods before a practitioner hears what is happening in a circumstance where they are often extremely anxious about the outcome. I'm happy to revisit parts of that, but you've probably got the gist of it. I'd appreciate your comments on those aspects.

**JOHN TANSEY:** If I can start with vexatious—and I'm pretty sure Mr Donnelly asked about this in our previous hearing as well—we're absolutely attuned to the risk of people making either vexatious or frivolous complaints. That's absolutely clearly in our sights. The Government response to your previous review—or in the previous annual reports, we provided a bit of input to that. It flags the fact that we already have an absolute statutory power to discontinue complaints. If we find that something is frivolous or vexatious, we can discontinue it at the earliest stage of the complaint. To the gist of your question, that should absolutely cut off the fact that people who are subject to those complaints experience any distress or anxiety because they're having to extend the dealing with vexatious complaints. We can do that where we determine that, and we do it now.

The other elements of your question are right. We're aware of the fact that a complaint being made against a practitioner can create anxiety. It doesn't matter how rapid or how well we deal with it, highly trained and career-focused practitioners who have a complaint made against them can take it very deeply from day one. We know that, and we try and act accordingly. Yes, it's right also to reflect, based on data, that one of the things that can most contribute to anxiety is if things do not progress rapidly, and that draws it out, and/or where people the subject of the complaint don't know what's going on and they're simply lacking information on what's going on. Our approach in trying to keep practitioners informed really, in fact, mirrors—I think we formally tabled the letter that we provided to the Committee in response to the birth trauma recommendations, which deals with how we try to sensitively deal with the complainants who may have experienced trauma and how we therefore set up our case management and our communications with them.

The flip side of the coin is we use the same logic and process in how we approach dealing with practitioners. When we're engaging with practitioners around complaints, we will make contact with them. We apply a case management approach with them—similar as we do with complainants—so that they know there is going to be a smaller group of people who are aware of the nature of the complaint. They don't have to repeat the story repeatedly to different people; we retain that information in our case management system so we can more sensitively deal with it. And when we first engage with them, we endeavour to inform them and be really clear in helping to try and manage their expectations about when and how we will communicate with them through the life of a complaint. If it's going through assessment, if it then goes into the longer phase of investigation, we will take their advice on how they prefer to be communicated with.

It's an interesting element that goes to some of the findings and recommendations the Committee has made before around whether we should have KPIs for communication. The emphasis I would want to bring is that it's actually more important that we have explicit and customised ways of communicating with practitioners who are the subject of a complaint. Simply communicating at regular cadences to hit a KPI might be well intentioned, but it could actually add to anxiety if we're communicating with people to hit a KPI, only to tell them there's nothing. A call or an email from the commission might give them heart palpitations or increased blood pressure on the day.

Our preference would be having very clear expectations and communications with people, so that they know what kinds of steps or stages in a complaint will necessitate communicating with them, and being very clear with them that they know they can communicate with us at any time if they're feeling anxious and want an update. We endeavour to set that up as well and as clearly as possible from the get-go, with the intention of trying to reduce the stress of dealing with us. It is absolutely part of that initial kicking off of the case management that we will make practitioners aware of the support services that they can access, whether that's through their medical defence insurers or other industry and stakeholder professional bodies. We will absolutely make them aware of that at the time. That's also information that's available on our website.

Part of our planning for forward activity is that we are planning in the second half of this year—which is nearly now—to convene a round table on the practitioner side with practitioners' representative groups and some other industry stakeholders. We want to get people around the table and directly hear from them and be informed from the perspectives they have about what we may be doing at the moment that's working and other impacts and other strategies we can put in place that they think would improve the experience of practitioners.

**The CHAIR:** I commend you on the concept of convening a round table. It would be interesting to know the organisations invited to that and the timing of that. This is an area that needs input from those organisations. I take your point around a KPI that requires contact every few weeks leading to contact that may cause anxiety. I have been thinking about the flip side of that, which is what I've heard about prolonged periods of non-contact, and then suddenly there's a development that could be distressing as well. I'm not convinced that we don't need some sort of KPIs about regular communication. I would have thought that if you've got a KPI about regular communication, it's clear that you say to the person about whom the complaint is made that you'll be contacting them every so often, even if it's just to say there's nothing. It may be beneficial.

Again, that might be information, one way or the other, that comes out of the roundtable process. I'm just pleased that you're looking at that. This issue of communication on a regular basis is something that the commission can do to improve this for health practitioners. I'm looking forward to that and to the next annual report perhaps having a report on that. You said that instead of a KPI, you might have a prescribed way of acting. I'm not sure what the phrase was that you used, but it was a process or a prescribed thing that you will follow in relation to people about whom a complaint is made. It would be good to see that, when and if it becomes available, and to have that publicly available, because then everyone will know what to expect from you about the process.

At the moment, the uncertainty and anxiety is certainly one factor. I make those comments and look forward to hearing the outcomes of the round table. Just on this issue, there is another part of it about making people aware of support services. Of course, some people belong to organisations that will provide that, but some people don't, or the organisations that they belong to don't provide those support services. Has any thought been given to what you would do in that circumstance, if a practitioner does not have access to those support services?

**JOHN TANSEY:** Absolutely. And, of course, not every practitioner we deal with will necessarily be in an area of practice where there are as well-developed or sophisticated peak groups as well. The advice or information we would provide to people about other support services to go to—very widely available, so they would relate to other 24/7-accessible counselling and support lines as well. It doesn't have to be practitioner specific. Whether it's Lifeline or ReachOut, we provide information about all the different modes and types of services. So it's not only those ones that are industry or practitioner specific.

**The CHAIR:** You're aware of that issue. Good. Given that Mr Donnelly still isn't here, can I now pursue another area with you, and that is, the issue of organisational culture. This came up at the last hearing because of the People Matter Employee Survey (PMES) survey results, and there'd been a couple of acting commissioners. You reflected on this when we last heard from you. Could you offer some information on how things have progressed in relation to organisational culture? Is there any update on measures in relation to that? What actions have been taken, and so on, in terms of the organisation?

**JOHN TANSEY:** We have, essentially, fully embraced the necessary challenge of coming to grips with the feedback we were getting from the team on culture. When I previously appeared, I think we were at that point where the PMES survey on the year 2024 had been conducted. We obviously didn't have the results, but I was able to say at that stage a couple of things had changed. We'd taken a different approach to how the survey was conducted and then, the report we got back, that was borne out. We were able to get results that were able to give us feedback at a more granular level, so that we could compare and contrast the experiences of people in the different teams and divisions of the commission, which helps us understand particular hotspots where we needed to work on engagement.

Fast-forward to October, when as agencies we started to get those results. I think it would be fair to say that the PMES results there were tending to be as bad as we might have thought. They were necessarily tough feedback on how the commission had been tracking. We asked people to give us their full and frank input, and they did. And I think then the most important thing is what we did with that. We had a really extensive effort, through the back end of last year and continuing to this year, of working directly with staff about unpacking the PMES results. This is my experience across the public sector, not just in this role. The results will give you very clear KPIs and some other feedback on what's working or what's not, or how people are experiencing it. It won't always unpack for you, though, cause and effect.

So one of the other things we did with staff, both in teams and as part of larger group activities, is provide people safe opportunities to unpack—"Tell us what sits behind your responses, so we understand at a more granular level and we can target responses better." We did that in 2024, from when we got the results in October—I think they're publicly published then in November—through to Christmas, so that we started the new year with a clear, new action plan for the PMES actions. And then what we have continued to do is share all of those activities, try to make sure that we're continuing to keep what we're doing to bring those actions to life open and transparent to people, again, so that they can hold us accountable on are we doing it and is it working. So, for example, every month we have an all-staff town hall. Some people are in the office, some online, but absolutely everybody can attend that. At absolutely every one of those town halls, we have a focus on one of the six key areas in our PMES action plan—"What are the activities?", "How are we going?"—so that it's front of mind for people and we're putting ourselves up to scrutiny about how we're going with those activities.

We also did our own-generated pulse survey in March of this year, about six months along from the PMES results themselves. That was an opportunity to give people a chance—again, through survey format—to give us feedback in a couple of domains. It asked them to tell us how they were experiencing our actual plan—"Are you aware of the activities?", "Do you think we're actioning them?" and "Do you think they're starting to make things better?" Then separately we asked people to give us feedback again on some of the questions in the

domains that are in the PMES—"How are you feeling about your workload, your welfare, your wellbeing, your engagement with your work?" and "How are you going with getting feedback from managers and planning for your work?

Happily, across all of those domains, we were starting to see a really positive shift from the red zone to the green zone. We were absolutely starting to see people reporting significantly improved experience across all those domains. We've still got some time to run on this action plan before the PMES cycle starts again in August. It's been a really major focus of activity and I would hope staff have experienced it as a very frank and open engagement on "Tell us what's working, tell us what you'd like to see us do differently, and tell us what's got to change." It was the staff's feedback that structured those actions.

**The CHAIR:** Are you able to outline the six activities or six areas of the activities that you've been working on?

**JOHN TANSEY:** I absolutely can. If it was of interest to the Committee, I'm happy to give you a copy offline of the plan on a page we have for the PMES action plan. We've got them in—

**The CHAIR:** That would be good actually. Thank you.

**JOHN TANSEY:** Okay, I'm happy to do that. We structured the plan in three key elements: areas to sustain, because those are areas that people told us they like and they're part of their positive engagement—"Keep doing it," "Don't lose sight of it"; areas where we knew we needed to improve outright, either to do better in areas we might've been doing okay or significantly improve in areas that we weren't; and working towards, because we also wanted to be transparent that there were some areas where we would not make a material change overnight and it would be the stuff of continuous efforts.

In the sustain areas, the focus areas were staff recognition, teamwork and events, communications and flexible working. People told us they don't think they got recognised often enough for not only doing their own job well but when they particularly exceed expectations—so staff recognition is a focus. People told us they wanted to have more opportunity to mingle with colleagues, learn and understand from what other divisions did so we all understand our contribution to the commission, but also sometimes just get together as colleagues and have a bit more fun off work—so teamwork and events was part of it.

Communications was a major focus and probably one of the areas where I'm happy to say we've had the starkest improvement. People wanted more frequent communication, communication across different domains, so we now, after every executive meeting, publish a little bulletin on the intranet hub to all the staff about the major things we talked about so they know what we're focusing on—they know where it's focused on them or other practice and procedures of the commission. People love flexible working so there are obviously elements around continuing to support that flexible working.

Some of the improved focus areas were welfare and wellbeing, recruitment and change management. Staff were feeling that their welfare and wellbeing was not as good and as robust as they needed, so we've had a major focus on supporting those areas. Recruitment was an area where people felt like there wasn't sufficient transparency. There had been concerns over time about perceptions of favouritism or other noncompliant recruitment, so we've done a power of work on more capable recruitment and more transparency around recruitment in the commission. On change management generally, people weren't feeling like they had the support when major changes were being undertaken. For example, with the case management system, Complaints Handling and Management Program (CHAMP), we've made that the absolute focus of doing change better. It's not the only area, but it's a landmark area for trying to improve our change management. This might sound like survey overload, but we actually put a survey out to staff last week inviting their feedback on how well we've done on managing the change of the new case management system.

The two other areas, in working towards other tougher nuts to crack—one is learning and development. People wanted better options and maybe more sustainable access to learning and development to support their career and professional growth. The other is workloads. There were probably some areas of the commission more than others that were really feeling the burden of a workload. Again, we know that that can be more challenging to turn around when, year on year, we're seeing increases of complaints—not off the charts, but significant complaints. So continuing to focus on that has been a real focus and will continue to be because, yes, it's a more long-run area to turn around. Those are the focus areas. As I said, Chair, I am happy to provide you a copy.

**The CHAIR:** Just as a matter of interest—flexible working. The Government has been pretty strong on reducing working-from-home options. How has that played out with the HCCC?

**JOHN TANSEY:** The memo that I think you're referring to that came out from the Premier's Department—was it maybe August or September? Maybe it was around the time we convened last time in

September. It came out and obviously it had a bit of coverage and commentary, perhaps not always as accurate as the memo itself. The memo, at its heart, said that work is done, in the main, at workplaces. The commission, prior to my arrival, had a kind of notional commitment to people having a blend of three-two: Our broad guardrail is people looking, over time, at working three days in the office and having up to a couple of days where they can work flexibly. We've maintained that. It works fine for the commission.

I'm very conscious, too—I think, in offering flexible work, probably one of the constraints we have is that, given that we are a one-site, one-location organisation, we try to support flexibility too, including where it allows people to work from more distant locations. The Premier's memo, I would interpret as being consistent with how we're operating. As I said, feedback from PMES is that the flexibility in work is appreciated by people and it continues to operate well for us.

**The CHAIR:** Since you've just mentioned case management, and Mr Donnelly's not here, we're all very keen to hear about the case management system, which we spent some years waiting for in anticipation. I understand from what you've said that it's up and operational and you're in the process of conducting a survey about how you handled the change management in relation to that. Can you give us an update on the case management system and overcoming the teething difficulties that were there? It is always a major undertaking for an organisation to do an update like this, so we are keen to hear.

**JOHN TANSEY:** When we convened previously in September of last year, we were planning, at that stage, for a go live by the end of last calendar year. We made a brave attempt and didn't quite pull it off, so we ended up with the then-planned go-live in late November, early December of 2024. We did that on the Monday—major gear change over the weekend to go live on a Monday. Initially it seemed to be operating as well—as in, the new environment deployed and it looked like it was functioning. But we became aware, in a pretty short time, that some of the data hadn't landed in the new system in the way that we had hoped. We made, at that point, what I characterised as a courageous decision to roll back the go-live.

One of our major concerns was that, if we were operating suboptimally for too long, it would impair our delivery of services. It ran the risk of leading to backlogs in complaints and, as I'm sure you appreciate, for a little while, while you're introducing a new service, some of the other features are turned off. So we decided that it was better to admit that it hadn't worked perfectly, roll back and re-plot our go-live, which is what we did. We subsequently successfully went live with the system on 31 March this year. The system remains live and, I'm delighted to report, functional. We are absolutely still in the relatively early learning and teething issues phase, but so far so good. The system is operating. There's absolutely a need now for staff across the division to learn all the functionality and the intended operation of the system, and get used to it is a wholly new operating environment. It's not only that the system itself is different, but also some of the environment and the way the environments interact is new. But prospects are very good. We're happy with it so far. I don't know whether there are other particular questions about aspects of it.

**The CHAIR:** I'm interested in the better functionality that you anticipate—because, of course, that's the whole point of doing it—as well as the better data. But I think the functionality was one of the key focuses. I'm interested in whether you've observed any improvements in the operations of the HCCC as a result of the software. It may be a bit early, particularly, as you say, because people haven't learnt the functionality of the system yet. I am interested in your reflections on any improvements in terms of functionality already and what you would anticipate.

**JOHN TANSEY:** Chair, I won't claim to have seen reportable improvements in functionality yet, but they're absolutely there built into the system. I will outline some of the things that we're seeing that, over time, will generate benefits. The old system was an old-format, 20-year-old case management system that then didn't necessarily directly integrate with other services. We ran email separately and we ran our record management system separately. By contrast, the new system has the case management system itself integrated with our email system and with our RecordPoint SharePoint system. So we're operating in a single environment.

It also has, for the first time, structured workflows in the system. So for people using the system, we can ensure they are set up to use it in the same way and that it drives workflows. The work is literally pushed from one function and officer to another. I see that myself. I used to see documents and approvals outside the system via email. I now get it in CHAMP if I'm being asked to consider and sign off, for example, on an interim prohibition order, or whatever. So that simple mechanical logic of continuing to push the work through so that it can't get lost and it keeps travelling is in there.

We have management tools that allow us to have some of the transactional KPIs embedded in the system. The system will warn you if you're on the countdown to the timeline for making an assessment or issuing a decision letter out of an assessment. We have the capacity to structure dashboards, where we can give them to all team members to show them how they're tracking on all their work and their deliverables, but they're also

configurable by staff. Different staff and managers can format their own dashboards to enable them to track and report on work. So some of those basic things that we had to generate or draw out and reflect on are absolutely there enabled in in the system.

We have better ingestion and flow-through of the data. For example, where people are lodging on the online portal and through the online complaints form, that now populates into the database of the system. There's no risk of losing data or human error in transferring it. It goes straight through. So there is better integrity, better privacy protections and security, and removal of human error in data transfer. We have cautiously and prudently adopted a little bit of AI inside the system.

It's not actually making decisions, but, for example, we have a headline AI reader inside the system—which, again, I've seen and used myself—where AI inside the complaint will generate a simple summary of the complaint. Despite the number of potential parts of a complaint or the length of it, AI will generate a little synopsis—for example, "This complaint is about Mr McGirr of Wagga Wagga, who is complaining about his experience at XYZ hospital and is concerned that the conduct of doctor X and nurse Y may have led to the adverse outcome of a parent that might have passed", or something. Using a little bit of smarts, then, that helps anybody going in, having an orientation to the complaint.

**The CHAIR:** Presumably the AI at some point could generate correspondence.

**JOHN TANSEY:** No, it does not. At the moment, the functionality is purely for a top-of-screen summary about the topic of the complaint.

**The CHAIR:** No, I guess it was a question about whether it could at some point in the future generate correspondence, and I guess my thinking from that is would that be an efficiency. Obviously letters like that would have to be checked, but I'm not sure if that is part of the functionality of the system.

**JOHN TANSEY:** Potentially, yes. I think you're right. We are dipping our toes in the water of AI in a couple of ways. It's locked inside that limited functionality in the case management system. Separately, we're looking a little bit at starting to use it on our internal intranet, because we'd like to explore how we might have a little in-commission chatbot that helps team members identify core information or resources, learning articles or knowledge articles available to them inside.

Yes, the potential for using AI to improve our work, I think, is there. I'll admit that my own conservatism or cautiousness around it is that I would want to understand and have really appropriate protections around how we use AI because, as a novice, I understand that it's predicated on AI accessing information, transferring it to large language models that are somewhere else in the world and then doing smart stuff and spitting it back to us. We're keenly aware at all times around the privacy and security protections of the information we would want.

I would need to be convinced that if we were using that, we had absolutely watertight security around the privacy and sensitivity of the information, wherever it went, before we were deploying it. Some of the other efficiencies separate to AI—our new CHAMP system has templates in it for emails you will send, templates in it for the correspondence that we will send, so we're already harnessing some of those efficiencies and removing error or individual variation within the CHAMP system.

**Mr MICHAEL KEMP:** I want to go back to before we got into the AI side of that. Commissioner, based on your earlier answer around reporting mechanisms from the new software management, I'd like to ask a question on notice and for you to advise us in the future, if possible. It's easy to use the birth trauma question that came up earlier. Can you please identify a method that's within the system to extrapolate data out in relation to specific types of complaints? With the technology that's around these days, whether that's AI or something else, I think it's really important that we are streamlining and improving our processes as we go forward, using data at all times. I would just ask that in the future, you could identify to us a method of collecting the data as a management tool.

**JOHN TANSEY:** I'm happy to take the question on notice, but I can give you a little bit of a snapshot now. We are already talking about differently warehousing our data so that we are better able to potentially extract data, know it and hold it static as it was at a point of time, securely warehouse that data in a data warehouse and then have cubes. I don't know if that's the right jargon to use or not, but we actually have secure loads of data at points in time, which would then allow us over time to do more comparison of data, time-bounded. At the simplest level, it shows you how things are changing because the data is locked at a point in time.

**Mr MICHAEL KEMP:** That's exactly my question. Even if it's manual tags, obviously it doesn't matter how you tag it or whether that's picked up through your system or not, as long as that data is available at a later date.

**The CHAIR:** I know Mr Crakanthorp has a question, but I will just follow on from that really good question from Mr Kemp. It seems to me that if we use the birth trauma example or the case for a way of interrogating the system to identify the cases—and I appreciate that you spoke earlier about how teams can flag particular cases. It seems to me that you've got enough categories—for example, under treatment, professional conduct and communication/information. You've got enough subcategories there, if you actually studied a number of cases that were identified by your teams as birth trauma, that you might be able to map them across to particular subcategories there and then generate a report that relates to maternity care, where these particular concerns come up. If you've got that AI capacity, it seems to me that might be a really useful way of doing that. Once you've got that methodology sorted, you could apply it to other inquiries that we might have in relation to complaints. That's actually quite exciting. You just mentioned that you do summaries of cases using AI. I presume that isn't going off to some large language model and that you're comfortable with the security of that. But, for other uses, you would need to be careful about that, and I accept that, given the sensitivity of this information.

**JOHN TANSEY:** That's correct. The limited use we have at the moment is locked inside the system, and it's literally just doing a smart summary of the complaint.

**Mr TIM CRAKANTHORP:** Very briefly, touching back on the topic of First Nations and Dr Cohn's correspondence, I am just wondering if you can provide an update, when you do have one, of the investigations on the racism and/or lack of service from that in the Central West? I know you'll probably respond to Dr Cohn's correspondence. Maybe you could provide a similar response to us or just an update.

**JOHN TANSEY:** If I can take that on advisement—obviously, one of our principal concerns is to retain and protect the privacy, particularly of the complainants but also of facilities or services involved. If I can take it, I'd happily—and I have already said to Dr Cohn—think on an appropriate way to provide an update while preserving the privacy of complainants and others. But I understand your inference, and I'm happy to try and keep you apprised.

**The CHAIR:** Your evidence in relation to my question about support for those people who may not have access to a support organisation—can you just remind me what you said around that? I may need to follow up with a supplementary question. I asked, if a health practitioner does not have ready access because they don't belong to a professional organisation or they're not in an industry where they can get that care, what does the HCCC do to make sure that they have support?

**JOHN TANSEY:** I was suggesting that—and I'm just looking to see if I've got a copy. This is a bit Luddite of me, but I actually have a printout of the website pages. I was flagging that, as well as directing people or giving them information about more practitioner- or sector-specific services, we will provide links to 24/7 crisis lines. Lifeline is one of them and Beyond Blue is another one, as well as a whole range of associations across the practice areas. I can certainly share with you, Dr McGirr, the links on the website. But the generic ones, as I said, are Beyond Blue and Lifeline.

**The CHAIR:** I'm sure they're very good organisations, but this is, in a way, a quite niche area. In relation to your round table where you're seeking comment on ways to improve this process, can I just ask that you perhaps ask the organisations you meet with—the organisations, I presume, that will represent practitioner groups—whether they have any specific recommendations about resources that should be made available for health practitioners?

**JOHN TANSEY:** Yes.

**The Hon. AILEEN MacDONALD:** Can I make a correction? I did ask a question where I referred specifically to suicide, and I have to apologise. It's not in your report. I was being more general, so I'll have to go back. I was probably wanting to be specific about mental health, and I confused myself by saying suicide. I do apologise for saying that you had it in your report when it wasn't actually there.

**JOHN TANSEY:** I'm happy to take a revised question on notice around what you are interested in.

**The CHAIR:** That brings us to the end of our session. Thank you, Commissioner, for appearing before the Committee today. You will be provided with a copy of the transcript of today's proceedings for corrections. Committee staff will also email you any questions taken on notice from today and any supplementary questions from the Committee. We ask that you return answers to questions taken on notice and supplementary questions within 14 days of the date on which questions are sent to you. That concludes today's public hearing. I thank my fellow Committee members, Committee staff, Hansard and staff of the Department of Parliamentary Services for their assistance in the conduct of today's hearing. I wish everybody a good rest of the week.

**(The witness withdrew.)**

**The Committee adjourned at 12:00.**