REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE HEALTH CARE COMPLAINTS COMMISSION

REVIEW OF THE 2008-09 ANNUAL REPORT OF THE HEALTH CARE COMPLAINTS COMMISSION

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At Sydney on Monday 19 April 2010

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The Committee met at 2.00 p.m.

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PRESENT

The Hon. H. M. Westwood (Chair)

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

CHAIR: I declare the hearing open. It is a function of the Parliamentary Joint Committee on the Health Care Complaints Commission to examine each Annual Report of the Commission and report to the Parliament upon it in accordance with section 65 (1) (c) of the Health Care Complaints Act 1993. I would like to convey the thanks of the Committee for your appearance here today for the purpose of giving evidence on matters relating to the 2008-2009 Annual Report of the Health Care Complaints Commission. I am advised that you have been issued with a copy of the Committee's terms of reference and also a brochure entitled "Information for witnesses appearing before Parliamentary Committees", is that correct?

Mr PEHM: Yes, thank you.

CHAIR: That is more for Mr Wilson; both Ms Mobbs and Mr Pehm have had experience in the past.

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

KAREN BERNADETTE MOBBS, Director of Proceedings, Level 13, 323 Castlereagh Street, Sydney, and

ROBERT IAN WILSON, Director of Investigations, Level 13, 323 Castlereagh Street, Sydney, affirmed and examined:

CHAIR: The Committee has received a written submission from the Commission in response to some questions on notice. Do you wish that submission to form part of your evidence today?

Mr PEHM: Yes, I am happy for that, Madam Chair.

CHAIR: Before we proceed to questions, would you like to make an opening statement?

Mr PEHM: No, I do not think I need to. We will rely on the report and on the responses to questions. I am happy to take questions.

CHAIR: Why has the Commission consistently failed to meet its target in providing timely responses to the Minister's office and what is being done to rectify this situation? I am referring to one of the items in the Annual Report on page 12, if you would like to refer to that?

Mr PEHM: The year before the one we are reporting on, those responses were done by my Executive Officer personally and we decided to delegate that out to the officers who had carriage of the matters to draft the ministerials and then get them to her for checking and bring them to me. That is really the cause of the delay. The 14-day deadline perhaps was interpreted by the officers holding the file, not allowing enough time for the checking.

CHAIR: I am sorry?

Mr PEHM: I think the problem was caused because we delegated that function out to the individual case officers on the file. When I saw that figure I was not very happy with it and that has gone back to the executive officer to handle those requests personally now. I think you will see a much-improved figure for the current year.

Mrs JUDY HOPWOOD: Has the Commission considered providing any specific complaints handling related input to undergraduate training and/or professional development programs of health practitioners, especially doctors, dentists and nurses as these are the three health professions about which most complaints are received?

Mr PEHM: We do get requests from time to time from universities and training institutions and we meet those as best we can. I cannot give you the number of attendances we have done specifically for training purposes. One of the bigger initiatives in the last year was to produce the DVD explaining the role of the Commission, which the universities are very happy with and they are taking it up and lots of them are incorporating it into their training programs.

Mr NATHAN REES: This is possibly an unfair question. Are there any jurisdictions in the world that you are aware of that do this better than us and, if you are aware, what are the things that we should do to match them?

Mr PEHM: We would be the only jurisdiction, apart from New Zealand, where the investigation and prosecution of complaints is handled by an independent body from the professions—that I am aware of anyway. I think New Zealand does it well. So if there is any benchmarking, it would be New Zealand for New South Wales. For all the other jurisdictions in Australia, the complaints are handled by the registration boards. I did a bit of a comparison when we were making our submissions regarding the national registration process and it was very difficult even to get performance information from the boards throughout Australia.

The only international travel I have done has been to New Zealand and looked at their system and we modelled our Director of Proceedings position on their system to introduce some independence from the Commissioner in between the investigation and prosecution process. That came about as part of the package of reforms in 2005. We get quite a lot of interest from international delegations and I think on Thursday this week we have quite a big delegation coming back from the Chinese, who liked our system and thought they could learn from it and they are going to spend a whole day at the Commission.

Mrs JUDY HOPWOOD: Have you looked at Canada?

Mr PEHM: No, not in any detail.

Mrs JUDY HOPWOOD: Canada has done a lot of innovative work.

Mr NATHAN REES: I have a follow-up question of an entirely different dimension. On page 11 you have a table with the different components in the system, the number of complaints and so on. With regards obstetrics and midwifery, I do not understand how you have more investigations than there have been referrals to the Board?

Mr PEHM: Obstetric complaints, when they are made, generally have very serious outcomes. The consequences of mistakes or errors in that area are much more severe, generally speaking, in that you can have babies born with permanent disabilities.

Mr NATHAN REES: My question is how do you have more investigations by your people than there have been referrals to the registration boards? It seems to be atypical with all the rest of them?

Mr PEHM: The Commission investigates the most serious matters and the less serious matters where an outcome might be counselling of a practitioner or training and education, those matters are referred to the Board.

Mr NATHAN REES: I did not pick that from the flow chart; that is fine.

Mr PEHM: With obstetrics, because of the seriousness of the outcomes, there is a much higher proportion.

Reverend the Hon. FRED NILE: Mr Pehm, you have often helped with the process of your Commission by making suggestions about amendments to legislation and we have been able to succeed in getting those things carried through. Are there any other matters at this stage of your career and looking into the future where you feel some amendments would assist the Commission in its powers, et cetera, in carrying out investigations?

Mr PEHM: As you know, we have not been backward in putting things forward as they arise. I have to say that the Department has been very responsive and the Minister in taking legislative suggestions for change forward. There are another couple coming through, along with the national registration package, which involve the power to make interim provision orders in dealing with unregistered practitioners. That is a power we did not have; we could only make an order at the end of the investigation, where in urgent situations that might be difficult, and some expansion of the powers to search warrants, which I think we discussed at the last meeting, so, no.

Reverend the Hon. FRED NILE: Your wish list, as it were?

Mr PEHM: As I say, we have not been shy about putting them forward but there is nothing really pressing that comes to mind at the moment.

Mr KERRY HICKEY: In the executive summary 200 complaints were referred to by the Special Commission and 72 or 36 per cent were discontinued. That is a pretty high figure to discontinue. Is there any background to that?

Mr PEHM: A lot of people went to the Special Commission to voice their feelings about the health system. They had had bad experiences and they wanted the Commissioner to know how they felt. A significant number had already made complaints to the Commission, and we had dealt with those complaints one way or another. By law, the Special Commission had to refer to us every person that came before it. In lots of cases, we went back to the complainants and they were surprised that a complaint had been referred, because either they were happy with what we had done or they did not think any more needed to be done by us. The complaints to the Special Commission just ran the whole gamut, from the very serious to the perhaps less serious, and matters that had been dealt with before might explain the slightly higher discontinue rate.

Mr KERRY HICKEY: In 2008-09 you received 3,360 complaints, which raised 2.1 issues per complaint. In 2007-08 it was only 1.4 issues per complaint. Are we getting better at reading our complaints?

Mr PEHM: Yes. That is the short answer. The old database of the Commission only accommodated one issue per complaint. If the complaint was about poor treatment, bad communication and bad medication, you really had to pick the most important one. The new database caters for—I am not sure how many, but a large number. There has been a bit of a cultural change getting people to identify more issues. We think it is useful the more that are identified. It is certainly a topic in education forums. When I talk to a practitioner about what a complaint is about, rather than having one issue per complaint you can give them a broader idea. So we have been more diligent about identifying issues in complaints.

CHAIR: Commissioner, this is also about the trends in complaints. On page 18 of your report you talk about the increase in the complaints about public hospitals. My question relates to that. How is the Commission monitoring systemic issues arising from complaints about public hospitals, particularly for communicating them into the new Caring Together network?

Mr PEHM: At the end of an investigation into a public hospital we can make recommendations, and the hospital must report back to us about the implementation of those recommendations. We have about a 95 per cent implementation rate for recommendations. More broadly than that, because the health system is so scattered around the place and so localised, the Department has also set up a governance unit to keep track of both our recommendations and coronial recommendations. Our power relates to making recommendations about a particular institution. The Department's governance unit picks up those recommendations, and where they think they might be more widely applicable, they can take broader action to implement them across an Area Health Service or statewide.

There are some things that beg for statewide implementation. One was a radiation oncology patient who got 100 times the dose, or a much larger dose, than should have been given, so the procedures were reviewed and more double-checking of the dosage was introduced. That was picked up. Our power of investigation related to one institution. It was picked up by the Director-General and a policy directive—I am not sure of the title—was issued, so those changes were implemented statewide.

Other matters can be more particular to the level of institution, and there are different issues that arise in tertiary hospitals as distinct from rural hospitals and so on. We are also sending the investigation reports, where we make comments and recommendations, to the Clinical Excellence Commission. They tell us that the cases we have reflect the issues that they are working on. A very common one is the deteriorating patient after surgery. That is where, if something goes wrong—for example, if there is a nick or an organ is accidentally cut and sepsis sets in—it can be very difficult to pick up and the deterioration can be sporadic.

People can go along well for days and days, and then suddenly decline very quickly. The Clinical Excellence Commission's Between the Flags project is all about monitoring post-surgical periods. Of course, we do not claim credit for that, that is their project, but certainly our complaints fit into that. The Clinical Excellence Commission tells me they love getting our reports because they are the best teaching tools: for clinicians they are real-life stories. It is the difference between having an academic structure and lots of reasons and explanations why something is good, and a story of a real person who has suffered that sort of situation. They tell me they really appreciate getting the reports.

Reverend the Hon. FRED NILE: I note that your report states that 10 complaints had been made to the New South Wales Ombudsman's Office regarding the Health Care Complaints Commission. According to

your report, the complaints were examined and it was found that there was no basis behind the complaints. What sort of relationship do you have with the Ombudsman's Office? Is there some duplication? Does it assist you when the complaints go to the Ombudsman?

Mr PEHM: The Ombudsman generally defers to us on any health-related matters. If people go to them with a complaint about a health service practitioner or hospital, they will refer that to us and we will look at it. We participate with the Ombudsman in some training activities. There is a thing called the Good Service Forum, which is an outreach activity to rural and regional indigenous communities. I think what we are talking about here are complaints about the Commission, where complainants are dissatisfied with us. The Ombudsman oversights us as an administrative agency, the same as anyone else. People can go to the Ombudsman and complain about us.

I am not sure how many of those 10 were by the one person, but I think a substantial proportion of them may well have been. The Ombudsman has not seen fit to take any complaints against us through to a formal investigation. In some cases they have made preliminary inquiries; in others they have had contact with the same person at the same time as we have as well. Of course, you would like to have no complaints against you, but I guess dealing with a range of people as we do, there will probably always be some.

Reverend the Hon. FRED NILE: Does it amount to some duplication, with the Ombudsman backtracking over what you have been investigating?

Mr PEHM: No. And we liaise fairly early on. One area where there is potential for overlap perhaps more than others is in the Prison Medical Service. Prisoners will complain both about the conditions they are placed under and that medical orders are not enforced by Corrections staff. We cannot look at Corrections staff, although we can look at Justice Health. There have been a number of cases where we have had joint meetings with Ombudsman staff, our staff, and Justice Health to really sort out who should be doing what at an early stage.

Reverend the Hon. FRED NILE: So there is a good relationship between you and the Ombudsman?

Mr PEHM: Yes, it is a very comfortable relationship—not comfortable; it is a good working relationship. They do oversight us, after all.

Mrs JUDY HOPWOOD: Who was responsible for the complaint investigation audit and what was its ambit? How did the audit assess the Commission's investigations? I refer to page 39, where an internal audit found no breaches of statutory requirements.

Mr PEHM: We have an internal audit committee with an independent chair. Under its auspices, the Commission conducts two internal audits a year. Deloittes are the commissioned auditors. I think we have just signed up with them for another three years, or perhaps five years. Audits are really to look at compliance with procedures. We have an investigations manual, and they randomly select a number of files and look at whether or not the procedures have been complied with. They also make suggestions for change. This year we have had an audit on the way we manage our expert panel.

They made quite a few recommendations, which we think are very good ideas. That involves increased training of the experts, providing more feedback to experts, which we are starting to do, and doing a quality assurance or an assessment of experts—which is a bit difficult, because they are experts in their field—and we are rating them on timeliness and whether their report addresses the criteria in the Act that it should. We find them very useful. Luckily—or more due to good work, I think—we have had no glaring problems arise from all this. They rate them on a sort of 1 to 5 scale, with three being satisfactory. We have generally come in around the three or four scale, either good or satisfactory.

Reverend the Hon. FRED NILE: What measures does the Commission take to ensure the timely implementation of investigation recommendations, that they are implemented to the fullest extent, and that implementation is ongoing—I refer to page 43 of your report?

Mr PEHM: That is a difficult area and we have been giving quite a bit of thought to that lately. I must also say that at this stage we rely largely on the organisation, the health institution that we are investigating, to report back to us. That report back can include new policies, details of training and the number of staff who have gone through training, and they will do hand washing audits or audits of clinical note taking and they

report back to us with the results of those. When we conclude an investigation, we write to the organisation and say, "We have now made these recommendations. You have three months generally to advise us of the implementation." In some rare cases that is not long enough because they have to do a lot of consultation themselves about implementation with staff and so on, but they do report back and generally fairly fully. They also report to the Director-General who can pick up those recommendations for any wider implementation.

If we are satisfied with their report back, and we go back and ask questions as well, we count the recommendations as implemented. What we do not do, and what I think we have to look at, although there is a resource question, is going back six months later and nine months later to see that things are still in place. I have already raised that with the Director-General and that is not a problem from their point of view; it is really a question of designing an audit program almost that we could implement to track both the implementation and the longevity of the recommendations.

Reverend the Hon. FRED NILE: So of those 42 recommendations that were not implemented, or not by the deadline, were there any serious matters that would have concerned you that were not acted on?

Mr PEHM: No. The way the Act is structured is that if we are not satisfied with the action taken to implement the recommendations, we can report to the Minister and then to Parliament, but we have never found it necessary to do that. There are occasions where a hospital or an Area Health Service will itself have identified a problem and have started to implement a different solution. Our recommendation might be to develop a policy about this aspect and they might say that it is part of their broader program to address wider issues and that included. But, no, it is very difficult to think of actual examples of recommendations that have not been implemented—and I cannot think of any at the moment—but we have not thought any non-implementation serious enough to take any further action.

Reverend the Hon. FRED NILE: So they would be relatively minor matters?

Mr PEHM: Yes, minor or overtaken or superseded.

CHAIR: In the part of your Annual Report dealing with legislative changes you note that the most significant amendment is the provision that allows the Commission to require any person to provide information, documents or evidence for the purpose of the assessment or investigation of a complaint. Are you satisfied that these provisions will ensure that all the necessary history will in future be placed before the Commission when cases of malpractice and/or impaired performance are being assessed and investigated?

Mr PEHM: By "history" do you mean evidence for the particular case?

CHAIR: Yes, the history of the case.

Mr PEHM: Yes, I think the powers are sufficient. There is always a question with investigations that if you do not ask you do not get, and sometimes when you ask you get just what you asked for and no more, because people do not always volunteer everything they should. So there are always judgements to be made about how fulsome you believe the responses are and whether you should require more. But certainly it is a very useful power and allows the Commission to obtain all the relevant information, and it has come in very handy. Part of the problem with the old Commission, before we had this power, was that a provider could simply not respond or refuse to respond and there was really nothing the Commission could do. We have found some quite long matters in the old files where that had happened and the thing had gone on and on. We can bring things to a conclusion much more quickly now.

The power to require people for interview is also very important. Paper can only tell you so much. It has become a quite regular practice now for our investigators to attend hospitals and to interview clinicians on site, both do an inspection of the area and conduct interviews. That was a bit difficult to begin with because it is not something I think people were used to, but it seems to have bedded down fairly well and the areas are used to it now and the Nurses' Association has come along, not always willingly, but it is working reasonably well.

Mrs JUDY HOPWOOD: To what extent, if at all, does the Commission contribute to the professional development of healthcare practitioners other than doctors? Has the Commission consulted with the other professions to identify further opportunities for contributions to their professional development programs? I relate my question to page 18 where it says, "nurses have a higher proportion of complaints raising issues such as professional conduct than other health service providers".

Mr PEHM: We consult with registration boards regularly including the Nurses Board and others, but I must say that most of the professional work we do is with medical practitioners because it is the largest number of complaints and certainly the most serious of the complaints. I think perhaps there are more forums and venues for that to occur in the medical profession. The medical profession is very big on continuing education and there are conferences all the time where the Commission can be invited and does speak. We have covered nurses peripherally in some of those, dealing with obstetrics, dealing with midwifes and obstetricians where they have had joint conferences, and our resolution officers do presentations to nursing staff in hospitals as well. We did contact The College of Nursing when we were updating our expert nursing list and they were very helpful, but I must say most of our effort goes into the medical profession.

Mrs JUDY HOPWOOD: In relation to The College of Nursing, are there any courses available that you know of—I do not know of one—where you could make a contribution regularly?

Mr PEHM: I would be happy too. That is something we can search out actually.

Mr NATHAN REES: Do you make any assessment of people who are of non-English-speaking background or who do not have appropriate literacy levels and so on as to whether they are making it into the complaints process? Am I making any sense?

Mr PEHM: Yes, but not a systematic one. We do collect demographic information but the response rate is fairly low—I think about 20 per cent or so. So we do assess that and we put a lot of effort into assisting people to make complaints. Where we perceive there are difficulties with literacy, we will allocate the letter to an Inquiry Officer or ring the person up and talk to them about it and, if necessary, help them to write something down. With people of a non-English speaking background or culturally and linguistically diverse, as they are now called, we have a number of officers within the Commission who receive the Community Language Allowance Scheme who can talk to people who come in. We use them informally. There is also the Translation Interpreting Service. I just do not have the data as to the proportion of people of that sort of background.

Mr NATHAN REES: There is an awareness of it; that is sufficient. This may be covered in the Annual Report and I missed it. In the event of a practitioner who has had serial complaints made against him and for whatever reason investigation of the complaints has been discontinued, to what extent is previous form brought to bear on decision-making as to whether to pursue a complaint?

Mr PEHM: That is a good question. It was very specifically inserted into the Act to compel us to do that. It arose out of the Graeme Reeves case, the compulsion to do that. We had previously taken into account complaints histories. When we register a complaint, a computer will generate the previous complaints and cases against him. The legislative reform also allowed us to reopen cases that had been closed. The most obvious example is sexual misbehaviour where you might have two or three older complaints where there was insufficient evidence. A third one comes in and the Act specifically now allows us to go back and reopen the old ones.

Reverend the Hon. FRED NILE: In many cases you have a successful outcome as a result of complaints. Do you give feedback to the person who made the complaint, perhaps where the complaint led to important improvements in the system?

Mr PEHM: Yes. Again, the Act requires us to report back to complainants and also to any other person we think should be notified. The complainants at the end of an investigation get a copy of the investigation report, except where we are prosecuting an individual practitioner. Then they can always attend the prosecution. We do that so as not to prejudice the proceedings. The investigation reports are fairly extensive and thorough and they will set out the complaint, the nature of the investigation, what steps were taken, what the findings were and what the recommendations were. We write to them at the end of that. We also write to them when the hospital comes back and says, "We have implemented the recommendations." We provide the complainant with a copy of the material sent to us and give them advice that we now consider the recommendations to be implemented.

Reverend the Hon. FRED NILE: They can clearly see that their complaints led to those improvements? They can see the link?

Mr PEHM: Yes.

Mrs JUDY HOPWOOD: At last year's hearing you expressed the view that it might be suitable for the Commission and the Area Health Services to have input into practitioner area education conducted by the New South Wales Medical Board and you undertook to follow this up with the Chief Executives of the Area Health Services. Has there been any progress? Referring to the transcript dated 29 April 2009, the Chair asked:

> **CHAIR:** Are you aware of an education program that is being run amongst practitioners either within the organisations or within individual health services?

The second question from the Chair was:

> **CHAIR:** Do you think that this is something that the Commission could have some input into or make some recommendations on either to Government or various health care providers?

You answered:

> **Mr PEHM:** I am not sure of the details but I am reasonably sure the Medical Board has taken a role there. It is certainly—I meet fairly regularly with all the Chief Executives of the Area Health Services. But I will have a closer look at that. It might be that if the Medical Board is conducting a campaign, as I believe it is, we might have some joint input on that. That would be quite suitable.

Mr PEHM: I have to apologise because I have not followed that up in any specific terms at all. We have another round of meetings coming up with the area Chief Executives of the Area Health Services but they have concentrated on complaint and interagency liaison so we can get smooth flows of information. Again I can only apologise. It has slipped my mind. I would have read the transcript as well. It is something I will definitely take on board and get back to you on that.

Mr KERRY HICKEY: The Annual Report indicates that you continue to get feedback by sending out satisfaction survey assessments and decision letters. Have you considered any other methodology for measuring client satisfaction, as suggested last year? Would you consider arranging an audit conducted independently, at least on a trial basis?

Mr PEHM: We have considered other methods. Probably the most effective way is to commission a consultancy to interview people. An audit will just check that forms have gone out and forms have been returned and so on and check that our data is right, which I believe it is. The only other way we thought might be effective is to have someone independent to do a consultancy, which would involve focus groups, contacting individuals and getting them in for a meeting to talk about their experiences. We did not go with that last year, partly because the customer satisfaction process is not very old at this stage. And it is the expense of it as well, whether it is justified within our budget. You probably could not get away with it for much under $30,000 or $40,000 minimum, I would have thought. Certainly that is something my Communications Officer has raised as a possibility but we were not in a position budget-wise with other priorities to do it last year or this year.

Mr KERRY HICKEY: How long before you look at your client satisfaction outcomes, considering your system is fairly new? What would you consider fairly old?

Mr PEHM: The client satisfaction outcomes are pretty good, as they stand. What I am concerned about is the response rate. The response rate is fairly low. It is about 20 per cent. I am not sure what we can do to get that up. It may be that those people have had better experiences and are more prepared to respond rather than someone who is completely disgruntled, rips it up and throws it in the bin. I am not sure how you actually get around that. I guess the idea of commissioning a consultancy to randomly pick people and talk to them is that you would get that broader spread. That is where it may be valuable. It really came down to budget and whether it was a good expenditure for us to do that. I am still not sure it is actually.

Reverend the Hon. FRED NILE: Do you have lines of communication with the new Bureau of Health Information? Does it assist the Commission, particularly in solving systematic problems?

Mr PEHM: It is probably early days for the Bureau of Health Information. I think they are still recruiting and setting up. We have not had much to do with them directly. Most of our communication on systems issues is with the Clinical Excellence Commission. They will also have a very close working relationship with the Bureau of Health Information. We thought that was a very important issue, the availability of health information, and we made submissions to the Garling Inquiry to that effect. It is an excellent initiative.

But so far, I think, their job really is to look at the massive data that is input into the system by clinicians on the ground, and that is a vastly superior number to the number of complaints. I think it is 3,000 complaints and 120,000 clinical incidents entered by staff. Their job is to try to interpret all that and feed it back to staff so they can learn from it.

Reverend the Hon. FRED NILE: There will not be any problems of overlap?

Mr PEHM: No, I do not think so. Again, we have a more particular slice of the same market. Theirs is likely to be much broader from the clinician's point of view as well. Although complaints will be entered into it as well, it will be much more clinician data.

Mr KERRY HICKEY: The Annual Report notes a considerable increase in complaints around medical centres at correctional and detention facilities. What does the Commission attribute this to? Does the Commission consider that it is an area of concern that needs to be looked at? What action, if any, is being taken to curb the increase?

Mr PEHM: From 93 in 2006-07 to 106 to 138 last year, and the proportions are up as well.

Mr KERRY HICKEY: More prisoners?

Mr PEHM: Perhaps more prisoners. We are quite accessible to prisoners. We are on thier speed dial, like the Ombudsman, us and a few others, where prisoners can call out directly. So their inquiry line comes straight to us.

Mr KERRY HICKEY: Are the complaints real or are they fictitious?

Mr PEHM: They are all real enough. There is a proportion of complaints around the methadone, buprenorphine distribution in jails, and that is a significant number. That is a difficult matter of administration for Justice Health because there is a problem of diverting and trafficking internally and we get complaints about—people say they have been unjustly thrown off that program—and the explanation from Justice Health will be that they have been suspected of diversion.

Reverend the Hon. FRED NILE: How many would there have been out of that category? That might have accounted for quite a few of them.

Mr PEHM: I would not say quite a few. You notice them when they come in but it is only anecdotal; I do not think we have separately categorised them.

Mr KERRY HICKEY: Can we have access to that information?

CHAIR: Can we have more detailed information on those?

Mr KERRY HICKEY: Can you provide us with that information later on notice?

Mr PEHM: It might be in the description on the issues with the computer search. We could get that. There is also the problem with Justice Health, and I have alluded to this before, it is not just a Health problem, it is also a Corrections one. As I say, we have met with the Ombudsman to try and sort out those overlapping jurisdictions. They are not on the very serious side of things. There are big complaints about delays—

Reverend the Hon. FRED NILE: In treatment?

Mr PEHM: Delays in treatment, yes. But that is not an uncommon complaint in the general community and it is exacerbated in prisons because generally for any serious tests they have to go to Long Bay and then be treated out of Prince of Wales Hospital for any serious cancer-related sort of conditions and tests. There are all those security problems that Corrections has to put into place with the transfers and so on. Availability of medications—people might have had a medication on the outside, that they are used to getting, that they do not get on the inside; it is either Justice Health thinks it is not a necessary one or they have a substitute one that they dispense and deal with.

I think the only Justice Health one that has been serious enough for an investigation involved the transport of a prisoner who complained that he had a heart condition and that was not taken into account medically. We thought that was potentially a serious issue of health and safety and we did investigate that, and there were some amendments to the procedures internally as a result of that. We have also had a number of prosecutions of individual practitioners involving Justice Health.

Ms MOBBS: Two assaults, and I think another one in terms of records and not following regulations in terms of sign-off of records. So there has certainly been anecdotally an increase in the number of those types of matters coming out of Justice Health.

Mr KERRY HICKEY: The doctor assaulted the patient or the patient assaulted the doctor?

Ms MOBBS: Not within the last year's statistics.

Mr PEHM: No, it is not a doctor. I was talking about the system of Justice Health. There are also individual practitioners that we will investigate.

CHAIR: Do you have the same proportion of complaints about the system as opposed to practitioners as you would in the health system outside the justice system? It may be hard to get that figure because it is probably quite a small number.

Mr PEHM: We could try and find that out, although when we register an individual practitioner in that health system we would have to see if that linked to a Justice Health complaint or not. We can try and find that out.

CHAIR: It is about the system and the treatment within it rather than the practice of a practitioner. It may not be that easy to determine.

Reverend the Hon. FRED NILE: The doctors and nurses are employed by whom?

Mr PEHM: Justice Health, which is a department of the Department of Health rather than Corrections. They are health workers rather than prison officers.

Mr NATHAN REES: I do not think we have any private providers of medical services in the jails, do we?

Mr PEHM: I think in Junee there might be some, but I think in relation to the psychological and social work counselling type aspects. I am not absolutely sure about that.

Mr NATHAN REES: In the context of that other material it would be useful to know whether they are overrepresented or underrepresented in any complaints. It has been a concern of Justice Health for a long time that the private provision of health care is seriously questionable. I do not know whether there is a basis for that or not.

Mr PEHM: We can provide that information.

Mr NATHAN REES: If you could pretty readily extract the numbers it would be handy.

Reverend the Hon. FRED NILE: You identify where the complaints have come from, whether it is Long Bay, Junee or other prisons?

Mr PEHM: We might have to do a manual count, but there are only 138, so it would not be too difficult.

CHAIR: Junee is the only one until now.

Mr PEHM: I think Junee is the only long-term privatised one.

CHAIR: And it was until Parklea, and I think that over in Parklea it would be Justice Health. I think that was part of that contract.

Mr NATHAN REES: I am not even sure of Junee. I think they may use Justice Health. I cannot recall.

CHAIR: The RNs administer the methadone and I am not sure if they are Justice Health or not.

Mrs JUDY HOPWOOD: In relation to a response to the Registrar of the Medical Board, and it is dated 6 April, it is related to communications between the Commission and the Medical Board and it states that the Commissioner attends a monthly meeting with the members of the Board Committee and secretariat and the Board's Medical Director attends a weekly meeting with the Commissioner. I am just wondering, do you meet as often with other boards, for example, the Nurses and Midwives Boards?

Mr PEHM: No, the Medical Board is the most often because of the volume. With the nurses we have a teleconference with a subcommittee of their conduct committee. We have a monthly meeting and in between that, fortnightly, we have a teleconference to deal with new complaints. That is the most volume. I think all the others would meet monthly when the boards had their general meeting.

Reverend the Hon. FRED NILE: You might have to take this question on notice; it relates to the court's criticism. The Commission was recently subject to some serious criticism from the Court of Appeal with respect to its use of the power under section 66 of the Health Care Complaints Act to extend the suspension of medical practitioners. Do you consider that the extensions complained about are indicative of the manner in which the Commission uses section 66 and what are you doing to address the court's criticism?

Mr PEHM: I am not aware of that decision. Section 66 of the Medical Practice Act involves the suspension of medical practitioners, which is the role of the Medical Board rather than the Commission. So I am not sure whether that criticism is—

CHAIR: It was in relation to Dr Gorman's case.

Mr PEHM: The role of the Medical Board is to suspend practitioners that they believe are a danger to the health and safety of the public. We do not do that. Section 66 is their Act and their decision, but we know them as section 66 decisions.

Mr NATHAN REES: When I read that material it was not clear to me that the judge knew the demarks between the different organisations involved in this.

Mr PEHM: It is complex. I have not seen it but I would be happy to take it on notice and give you an answer as to whether it is our fault.

Reverend the Hon. FRED NILE: You could clarify that and then perhaps let the judge know.

Mr NATHAN REES: They are always so timely.

Mrs JUDY HOPWOOD: I refer to question on notice no. 9 and the code of conduct for unregistered health practitioners. Apparently the Minister is pursuing deregistration of dental technicians. If a practitioner were deregistered today for undertaking certain activities would he or she be able to practice after July, when registration is abandoned? Can you make recommendations about a profession that you believe should retain the requirement for registration? Dental technicians have raised with me at least one practitioner about whom they are seriously concerned.

Mr PEHM: We have been in touch with the Dental Technicians Registration Board with a view to advising about future coverage by the code of conduct. We have made the code available and explained how it will work. We have investigated a dental technician as well. We made a public statement on our website about a technician practising as a dentist—giving injections and so on. There would be no difficulty from our point of view investigating a dental technician who was no longer registered because he or she would be covered by the code of conduct if they breached any of those provisions. I have not thought about whether they should be registered, nor have I sought to buy into the issue. I think that the Department of Health's view is that no other State registers them.

Mrs JUDY HOPWOOD: Queensland is continuing registration.

Mr PEHM: I do not know.

CHAIR: It is the only jurisdiction that is.

Mr PEHM: We raised the issue about what we would do to educate dental technicians about the coverage of the code in our discussions with the Department. Its view seems to be that the technicians do not deal directly with patients—they should always work to a dentist and be referred. For that reason—because they do not deal directly with the public—the imperative for registration was not as great.

We get a small number of complaints about dental technicians. Those complaints are not serious; they are usually about ill-fitting dentures and refusal to remedy the situation. The only serious case involved a dental technician practising as a dentist without being registered. We investigated that case and issued prohibition orders. We also liaised with the police, and that kicked off an infection control investigation by the Area Health Service. On the broader question, I have not looked at recommending whether or not a profession should be registered.

Mrs JUDY HOPWOOD: Evidence given at our last hearing by the dental technicians' governing body indicated that they do have some contact with patients. They deal with teeth colour and other matters. It was not straightforward. However, the point of the question was whether you have an opinion about registration.

Mr PEHM: I do not.

CHAIR: Further on the question about unregistered health professionals, page 100 of the Annual Report indicates that fewer complaints were received in 2008-09 compared with the previous year. The Committee notes there were only 68 complaints for that year. Do you believe that this might reflect a deficiency in public awareness about the code of conduct for unregistered health professionals?

Mr PEHM: It might. It is hard to say what causes complaint numbers to fluctuate. It is not a great fluctuation. However, one would expect that with the code coming into force and the Commission making public determinations that there would be more complaints and awareness. We have liaised with all the professional associations, published the code of conduct and we have held evening seminars.

Health is a difficult area. My experience is that people are not aware of the avenues available to make complaints until something goes wrong. Then they will look around. I am not sure of the value of doing a widespread public education campaign about coverage of unregistered practitioners. We have had complainants directed to us by professional associations such as the therapeutic massage body. We have those channels working from the professional bodies.

It must also be said that the consequences of maltreatment by an unregistered practitioner are generally not serious. Of course, there can be extreme cases, such as the case before the coroner of a person fasting and suffering liver complications after consulting a naturopath. However, generally they have a fairly light touch and the consequences are not so significant that people are moved to make complaints. I do not know; I am speculating. We have put a lot of effort into promoting the code and education, but we have concentrated on professional groups because that is where we thought we would get the best return.

Mr NATHAN REES: The Commission has expressed a position on privilege that attaches to material unearthed in root cause analyses. Can you give the Committee an update on the consideration of those matters?

Mr PEHM: I think the Department recently conducted a review that has been published. It will provide some amendments to the Health Administration Act to tidy up the existing privilege. The Department has come to the view that the privilege should be retained and entrenched. I think we discussed with the Committee the last time we met how dearly held that is by practitioners.

Mr NATHAN REES: Is there a way around that? This is one of those situations where both ends of the argument are correct.

Mr PEHM: There does not appear to be. It depends on the greater public interest. At present the balance seems to be that the value in having practitioners come forward and declare errors for future learning is greater than the understanding of individual patients who might be affected by those errors. That is a public interest call that it is your job to make. We are impartial, but we understand the patients' perspective. We have

seen some awful cases that have aggravated the patient's family's suffering. Our position is informed by all of that. I can understand the other position and I understand how deeply entrenched is the practitioners' fear of complete open disclosure. That is a very strongly held position.

Reverend the Hon. FRED NILE: Page 20 of your report states that most complaints are about public hospitals. You explain that that is probably because of the large number of patients dealt with by public hospitals. Are there any other reasons? For example, are patients in private hospitals given information about the Commission's role? Are they encouraged to complain or discouraged?

Mr PEHM: Again, I would be speculating. I think private hospitals generally deal with less complex procedures where the chance of things going wrong is perhaps not as great as in the complex clinical presentations that public hospitals deal with. A lot of admissions to private hospitals are through private practitioners whom the patient has a relationship with, and their surgery or procedure would be done by that practitioner. As you know, in a public hospital you can turn up and be dealt with by a registrar. The public hospitals are training people all the time. We get a smattering of complaints, "I expected my private practitioner to do it" and it turns out that practitioner was just supervising a registrar in a public hospital. So that direct doctor-patient relationship that they have developed in the private sector militates against complaints as well, because they have that level of trust because if something does go wrong in the private sector, the practitioner, having seen their whole history and having dealt with them longer, is in a better position to give an explanation that they are happy with, rather than something going wrong in an operation with a junior registrar.

Certainly, public hospitals and the Department have been good, in our view, in getting information out about how to complain and they are responsive to complaints and they are not shy in sending complaints to us where they are unable to deal with them. I cannot think of where we have ever had a referral of a patient from a private hospital to us to complain about a private hospital. What the reasons for that might be I am not sure, but those would be some of the reasons why perhaps private hospitals generate less complaints than public.

Reverend the Hon. FRED NILE: You mentioned junior registrars a couple of times. Does that reflect that complaints come more from the level of action by those junior registrars or doctors in training rather than experienced, qualified doctors? Is that one of the reasons for the number of complaints?

Mr PEHM: It is a factor. In public hospitals people are being trained and to be trained they need to do procedures. I do not want to give the impression that they are less experienced or worse. What I was referring to was the patient's discomfort on learning they had been operated on by someone they consider to be junior and perhaps not as good as their private practitioner in a private hospital whom they have dealt with all along. I could not really say on the breakdown between medical practitioners whether there is more against junior, less experienced people or more experienced people. I do not know.

Reverend the Hon. FRED NILE: Some junior doctors have made complaints in the media that they have been working very long hours and this could lead to errors in dealing with patients if they are fatigued. Could that be a factor, the pressure within the public hospital system?

Mr PEHM: It could be. It is partly how they are trained too. Interns in public hospitals would go in the first year out of medical school and they work enormous hours, very long shifts, and in some cases they sleep in the hospitals. That is traditional, that is the way it has always been done. Whether it is a good system or not—certainly from the point of view of the interns it is not. They have support, though. They have more senior registrars and career medical officers and consultants, so the system is designed to support them. I would not venture an opinion on whether junior, tired people are making more mistakes giving rise to complaints or not.

Reverend the Hon. FRED NILE: Could you look into that, whether it is a factor?

Mr PEHM: We could try. I think it would be quite difficult. It would be anecdotal, and again we could look at cases, but I do not think we record the level of training and experience so that it would be accessible across a broad range and across the whole range of data, but we will give it some thought.

Mrs JUDY HOPWOOD: I note the considerable efforts the Commission has made in making its services more accessible and specifically that you propose to work with the Council for Intellectual Disability New South Wales to develop a further fact sheet that will contain more detailed information about the Commission's role and functions. I wondered how that is progressing?

Mr PEHM: It is well underway. We are currently doing the illustrations and we will be consulting again with the Council for Intellectual Disability shortly and we hope to have it finalised by the end of June.

Mr NATHAN REES: Perhaps this is not your purview, Commissioner, but why is the training of medical practitioners such an endurance test?

Mr PEHM: I do not know. It is not my purview. It is partly traditional, cultural. It is the way they have always been trained. I think it is a problem but as for all the reasons why that cultural position has become entrenched, I am not familiar enough with it. I am not a doctor and my first contact with the health system was in this job.

Mr NATHAN REES: It goes to a much broader issue, obviously.

Mr PEHM: Yes, they are very broad issues.

CHAIR: On page 26 of the Annual Report, assessing complaints, the Commission talks about implementing a module in its case management system Casemate, which allows it to capture systemic quality improvement results from the resolution of complaints as from 1 July 2009. Has the Commission given any consideration as to how it might use its knowledge base for quality improvements to communicate to complainants wider outcomes of their complaints? That is, to show how their cases had gone to improve the system, even though it may not give them satisfaction in their particular case? We are familiar with people not being satisfied with the outcome of their case but if they had some knowledge that it led to very good outcomes for the system, that may make people more satisfied with the process.

Mr PEHM: Definitely. The reason we are trying to record it more systematically is to feed into the issue we talked about earlier about our formal power to make recommendations after investigation for systemic change. Often in resolution processes complainants will get together with hospitals and practitioners, and the hospitals will agree that things need to be improved and they will start to put those in place. So the complainants will be advised that is part of the resolution of their individual complaints. I think we are waiting for more data to come out to publish more widely what systemic changes emerge out of resolution of complaints and see how it compares with the nature of the issues we are investigating.

CHAIR: I wonder if it would not be useful in the Commission's brochures to have information for people making complaints or just talking about some of the changes that have been made as a consequence of particular cases. I think often complainants have an expectation of an outcome that suits their specific needs. I think if they have an understanding that it is broader than that, that might be useful.

Mr PEHM: I think that is a good idea. We can use it in promotions to say to people that it is worth complaining, you can change things, things could change. Hospitals can tend to be quite monolithic in lots of ways when it goes beyond the individual patient care.

CHAIR: I think if you engage people and show it is worthwhile that the system takes note of their complaints and change can occur as a consequence of their complaint or their action.

Mr PEHM: I agree.

Mrs JUDY HOPWOOD: In reference to page 97, Appendix C, complaint statistics, in relation to communications: I note in 2006-07 there were 366; in 2007-08, 642; and in 2008-09 1,432, despite the fact that you have an elongated list of other ways or other categories. Over the page there are breakdowns. That seems to be an extraordinarily high jump. Do you have any comments to make in relation to that?

Mr PEHM: Probably the biggest single problem in the health system is communication, and the Clinical Excellence Commission will say the same thing and they are putting a lot of work into that. We touched on earlier about how we may be getting better at identifying issues, so that may account for part of the increase, but it is communication at so many levels between general practitioner and specialist. I mean, from the patient's point of view, the health system is this seamless thing where everyone should know about their condition and all the transfers of records should all be done instantly. The idea of patients having to turn up and tell the same story, even when they are in hospital, three times a day because the different doctors will come, and all that sort of stuff. In acute care in hospitals you have shifts changes and handover—and handover is a huge problem. Again the Clinical Excellence Commission is trying to address that. Just precisely what the new team coming in

is told about the patient's condition during the previous shift, those are the sorts of communication issues that can impact heavily on complainants.

So it is a lot bigger than just the practitioner's communication with the patient, which in itself can be a problem. When you are sick you are vulnerable and you want to be healed and you keen to hear not what you want but what will make you think you are going to be healed, so we get complaints about lack of informed consent where people are not advised of side effects and complications of surgery, so they have a poor outcome later and say, "I was never told that was going to happen". There are those sorts of direct communication problems but also the issue of communication between practitioners in the ongoing care of people. I have lost the original question.

Mrs JUDY HOPWOOD: I just wanted you to make a comment. I put to this Inquiry that what you have mentioned is not a late event. Being a nurse myself, these situations have occurred over a long time. I would like you to comment on whether you think the stress on the health system is contributing to that increase in communication problems? By stress, I mean reduction in staff numbers under staff establishment and when you are more likely to see the things that you are describing in terms of inter-practitioner communication with the patient?

Mr PEHM: If you are stressed and under strain, communication will suffer. It takes time to communicate properly with people and you need room to do that, so work pressures can contribute to poor communication. I am not in a position to say whether the stress is greater now and whether that is the main contributor to increased communication problems. I think the profession itself is only coming to appreciate how important communication is. Again, the Clinical Excellence Commission has done a lot of work in trying to identify that. I would not say that the sole factor is overwork and stress, although I think it is a contributing one. There are a lot of techniques you can use with patients to check that they have understood and to have them talk back their understanding of conversations you have had with them. There are tools you can use and diagrams and things that can improve communication. It is a complex issue with a lot of contributing factors and certainly stress can be a significant one.

Reverend the Hon. FRED NILE: What are the particular challenges faced by the Conciliation Registry with regard to assessments? Can you comment on the fact that a number of cases sent for conciliation are aborted because parties withdraw their consent?

Mr PEHM: Yes. I have been giving a lot of thought to conciliation lately and I do not think it is operating as well as it should be. There is a history to conciliation in that originally there was no assisted resolution in the Commission, which is a much less formal way of conciliating complaints. It is riven around with privileges that again come from the fear of practitioners that things that they say in resolving complaints are going to be used against them. It was set up as a separate unit of the Health Department and then brought back into the Commission.

I think the big problem with consent rates in conciliation is that people are not warmed up to the idea of the value of conciliation and what they can get out of it when something is sent for conciliation. Because the Registrar, like a court registrar, is more like an office, they make bookings; they get the complaint in, they book it in to an independent conciliator, arrange a meeting. In assisted resolution, the Resolution Officers can take a lot more time explaining to the complainants and finding out what they really want out of the complaint. People want different things and it is important to know what they want so as to be able to nurse them into a position where they are going to be amenable to resolution.

At the moment—and I am not sure that there is a different way to do this—at the Conciliation Registry, matters are allocated for conciliation, and the complainants will get a big long letter saying, "It has been sent for conciliation. This is the process. It is voluntary and do you consent?" With a resolution, the first thing they will get is a phone call, "Tell us more about your problem" and get them more involved. We are thinking actually—and we might do it this year—of having conciliation more as part of the assisted resolution process rather than an upfront option so that the Resolution Officers can warm the parties up to the prospects of conciliation, then put matters in that formal conference with the independent conciliator when we have got consent, so we think we can do more to obtain consent and encourage people to participate.

Reverend the Hon. FRED NILE: Who mainly withdraws the consent? Is it the medical side rather than the patient?

Mr PEHM: No, it is mainly complainants actually.

Reverend the Hon. FRED NILE: What would be the reason for that?

Mr PEHM: They do request reviews of the assessment decision to conciliate. They believe that with the matter being referred to conciliation, it is not being taken seriously enough. Sometimes they want retribution.

Reverend the Hon. FRED NILE: They want direct action?

Mr PEHM: They want investigation and they want people—

CHAIR: —held to account?

Mr PEHM: Held to account; they want individual practitioners sometimes struck off and they will say that—"I want them deregistered and conciliation is not what I want". We have the figures in there of the proportion of complainants to respondents.

Reverend the Hon. FRED NILE: There appears to be delays, even where they do consent, in finalising conciliation cases. In 2008-09 the Registry finalised half of the complaints within three months; 74 per cent within six months and 90 per cent within 12 months?

Mr PEHM: Yes, that is getting better, believe it or not. We tend, in conciliation, to leave it to the parties. In a way that was dealing with these consent problems. If the party said, "No, I do not consent", we would give them time to think about it. Often where a clinical error occurs with someone close, a loved one or spouse, everything is very raw and tender and people sometimes just cannot deal with the prospect. There may be a complaint and they want something done but they just cannot personally face it. What we are saying to them now is, "Look, you have made your complaint. You can make your complaint again when you are ready to deal with it", rather than just leaving complaints open and waiting for people to be prepared to participate.

Reverend the Hon. FRED NILE: You cannot force conciliation?

Mr PEHM: No, it is voluntary.

Reverend the Hon. FRED NILE: That is why it can take so long?

Mr PEHM: No, and you do not want to either, to put someone in a position where it can be counterproductive. We had a recent case where it was counterproductive to the practitioners as well because when the complainant got into the conciliation, she just vented and really gave them a piece of her mind, to use the colloquialism, and they got very affronted by that, so there was no resolution and no meeting of the minds. You do not want to put people in that situation unless you feel there is likely to be resolution.

CHAIR: Do you have a time line for those changes you have just outlined or are you further reviewing them?

Mr PEHM: Yes. I have asked my Director of Assessments and Resolution to come up with a proposal and he has discussed it within the office—this year, I would think; within the next financial year.

CHAIR: After July?

Mr PEHM: Yes.

CHAIR: Thank you for appearing before the Committee for its review of the Commission's 2008-09 Annual Report.

(Evidence continued in camera)