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Submission by the Health Rights Commission

Bundaberg Base Hospital Commission of Inquiry

19 May 2005

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1. Introduction

Reference is made to the letter dated 3 May 2005 from Mr Anthony J.H. Morris QC to the Commissioner, Health Rights Commission which invited the Health Rights Commission ("HRC") to prepare a submission in respect of the issues raised in the Terms of Reference of the Bundaberg Base Hospital Commission of Inquiry ("the Inquiry")[1].

In this Submission it is proposed to consider the following matters being:-

- The statutory functions of the HRC;
- A brief history of the HRC;
- Key policy considerations relevant to the future operation of the HRC;
- Scope of the role of the HRC and
- An overview of the complaints received by the HRC in respect of the Bundaberg Base Hospital.

[1] See Gazette Notice dated 26 April 2005.

2. Statutory Functions of the HRC

The statutory functions of the Health Rights Commission are set out in section 10 of the *Health Rights Commission Act 1991* ('the HRC Act').

The relevant functions of the HRC as detailed in s.10 of the HRC Act are to:-

(a) identify and review issues arising out of health service complaints;

(b) suggest ways of improving health services and of preserving and increasing health rights;

(c) provide information, education and advice in relation to –

  (i) health rights and responsibilities; and

  (ii) procedures for resolving health service complaints;

(d) receive, assess and resolve health service complaints;

(e) encourage and assist users to resolve health service complaints directly with providers;

(f) assist providers to develop procedures to effectively resolve health service complaints;

(g) conciliate or investigate health service complaints;

(h) inquire into any matter relating to health services at the Minister's request;

(i) advise and report to the Minister on any matter relating to health services or the administration of the HRC Act;

(j) provide advice to the Health Rights Advisory Council;

(k) provide information, advice and reports to registration boards; and

(l) perform functions and exercise powers conferred on the Commissioner under any Act.

Included as Schedule 1 to this Submission is a current organisational chart of the HRC.

Section 11 of the HRC Act then provides that in performing these functions, the Health Rights Commissioner ("Commissioner") is to act independently, impartially and in the public interest. The Commissioner reports to the Parliament through the Minister for Health, but the matters

upon which the Minister can direct the Commissioner are 'limited, specific and clearly set out in the legislation'.[2]

The present Commissioner, Mr David Kerslake commenced with the HRC in August 2002.

The Commissioner's primary function is to receive, assess and resolve individual health service complaints. Section 57 of the HRC Act provides that a complaint may be made to the Commissioner –

(a) that a provider has acted unreasonably by not providing a health service for a user;

(b) that a provider has acted unreasonably in the way of providing a health service for a user;

(c) that a provider has acted unreasonably in providing a health service for a user;

(d) that a provider has acted unreasonably by denying or restricting a user's access to records relating to the user in the provider's possession;

(e) that a provider has acted unreasonably in disclosing information in relation to a user;

(f) that a registered provider acted in a way that would provide a ground for disciplinary action against the provider under the *Health Practitioners (Professional Standards) Act 1999*;[3]

(g) that a provider acted in a way that would provide a ground for making a complaint against the provider under s.102 of the *Nursing Act 1992*; or

(h) that a public or private body that provides a health service has acted unreasonably by:-

(i) not properly investigating; or

(ii) not taking proper action in relation to:

a complaint made to the body by a user about a provider's action of a kind mentioned in paragraphs (a) to (g).

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[2] Hon. K.V. McElligott, Minister for Health, Second Reading Speech, *Hansard* 26 November 1991.

[3] The Commission's interaction with registration boards is discussed in more detail below. While there are some synergies between the respective bodies, there are also areas where the statutory responsibilities of the HRC and registration boards are quite distinct.

In determining whether a health service provider has acted unreasonably under section 57 of the HRC Act, the Commissioner is to have regard to the generally accepted standards of health services expected of providers of the kind[4], together with the following principles as mentioned in section 39 (3) of the HRC Act being:

(a) that an individual should be entitled to participate effectively in decisions about the individual's health;

(b) that an individual should be entitled to take an active role in the individual's health care;

(c) that an individual should be entitled to be provided with health services in a considerate way that takes into account the individual's background, needs and wishes;

(d) that an individual who –

(i) provides a health service; or

(ii) provides care for another individual receiving a health service:

should be given consideration and recognition for the contribution the individual makes to health care;

(e) that the confidentiality of information about an individual's health should be preserved;

(f) that an individual should be entitled to reasonable access to records concerning the individual's health; and

(g) that an individual should be entitled to reasonable access to procedures for the redress of grievances with respect to the provision of health services.

Section 30 of the HRC Act provides that in performing a function and exercising a power, the Commissioner –

- is to proceed with as little formality and technicality, and with as much expedition, as is practicable; and
- is not bound by rules or the practice of any court or tribunal as to evidence or procedure.

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[4] Subsection 57 (2) (b) of the HRC Act.

In performing a function and exercising a power, the Commissioner must also have regard to the rules of natural justice[5].

Section 71 of the HRC Act provides that before accepting a health service complaint for action, the Commissioner must first be satisfied that the complainant has made a reasonable attempt to resolve the matter with the health service provider[6], unless it is clearly impracticable to do so.[7] The Commission has directly accepted a significant number of complaints against Dr Jayant Patel having assessed that it would be unreasonable in the current circumstances to insist that complainants first attempt to resolve the matter with the Bundaberg Base Hospital.

Before accepting a complaint for statutory action, the Commissioner is required to consult the provider's registration board about the complaint[8]. In making a decision about the action to be taken, the Commissioner must have regard to any comments made by the relevant board. Section 53 of the *Health Practitioners (Professional Standards) Act* also requires registration boards to consult with the HRC about all complaints they receive.

Section 77 provides that if the Commissioner receives a health service complaint about a registered provider, believes that the provider poses an imminent threat to public safety and therefore, considers that immediate suspension of the provider's registration may be necessary, the Commissioner must then immediately refer the complaint to the provider's registration board. The HRC has not referred its complaints about Dr Patel to the Board as the Board advised that Dr Patel's registration had expired and they had declined to renew his registration.

On the basis that a complaint is not immediately referred to a registration board, the HRC would in accordance with the provisions of the HRC Act[9] then proceed to assess the matter. Once the Commissioner accepts a complaint for action there is a requirement to give written notice to the health service provider against whom the complaint was made[10].

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[5] Subsection 30 (2) of the HRC Act.

[6] This is referred in this Submission as 'direct resolution' and is discussed in s.71(2)(a) of the HRC Act.

[7] Instances where the Commissioner would generally regard it as impracticable include where allegations are made of serious breaches of professional conduct (such as sexual misconduct), or where there is a clear evidence of a threat to public safety. The Commission's policy is also to accept complaints in the first instance where the complainant may, for language or cultural reasons, find it difficult to take up their concerns with the provider on their own behalf.

[8] See s.71(3) of the HRC Act.

[9] See Division 2 of Part 5 of the HRC Act.

[10] See s.72 of the HRC Act.

Section 76 of the HRC Act provides that the Commissioner is to assess a complaint within 60 days of starting the assessment. Provision is made for the assessment period to be extended by a further 30 days if necessary.[11]

Section 78 of the HRC Act provides that during assessment, the Commissioner may 'seek and obtain information the Commissioner considers appropriate'. However, it should be noted that the Commissioner has no power to compel parties to respond to a complaint or to provide information during assessment. In seeking and obtaining such information the Commissioner may invite a response or may request information from the provider against whom the complaint was made, or request advice from a practitioner who subsequently treated (or provided a second opinion to) the complainant.[12] The HRC has no express power under the HRC Act to compel the provision of such information or advice.

The actions open to the Commissioner following acceptance and assessment of a complaint depend in part on whether the complaint is one against an individual registered provider or against a provider other than a registered provider[13]. Registered providers are covered by section 74 of the HRC Act whereas 'non-registered' providers are dealt with by section 73 of the HRC Act.

In either case, it is open to the Commissioner to close a case following assessment on the basis that the service was found to be reasonable, or that the matter was able to be resolved informally.

If the Commissioner finds, following assessment, that further action on a complaint is warranted, the following options are available.

For a complaint against a provider other than a registered provider to:

(a) conciliate the complaint under part 6 of the HRC Act;

(b) investigate the complaint under part 7; or

(c) refer the complaint to another entity[14].

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[11] The clear intention of this section is to ensure that complaints are dealt with in a timely way. The Commission's experience, however, is that this section has, if anything, acted as a barrier to timeliness. This issue will be examined in more detail later in this submission.

[12] A 'third party'.

[13] A 'non-registered' provider could be an individual practising in an alternate field that is not regulated by a registration body, but more commonly an organisation such as a public or private hospital, nursing home or hostel.

[14] Other entities typically might include the police (in the case of serious sexual misconduct complaints) or the (Commonwealth) Commissioner for Complaints in the case of complaints about nursing homes.

For a complaint against a registered provider the only further action that is open to the Commissioner following assessment is to try to resolve the complaint by conciliation, if the Commissioner considers that it can be resolved in that way[15], or to refer the matter to the provider's registration board. The Commissioner has no power to conduct his own investigations of individual registrants. That power was removed by the *Health Practitioners (Professional Standards) Act 1999*. Only a registration board has the power to formally investigate issues relating to a registered provider.[16]

A practical effect of the above mentioned legislative change is that the Commissioner now has no power to require an individual registered provider to participate in the Commission's processes. As previously stated, there is no power to compel a response from a provider during the assessment phase. Because the Commissioner has no authority to investigate a registrant, there is therefore no power to require the provision of information at that stage.[17] Even though the Commissioner has the power to conciliate a complaint, participation in conciliation is entirely voluntary.

In summary, for a complaint about the health service provider, say by a hospital, the Commissioner has a number of options, including assessing, conciliating or investigating the complaint. The decision as to what course is pursued may depend upon whether the complainant is seeking an individual remedy such as compensation, whether the complaint raises broader systemic issues which warrant investigation in the public interest, or whether there is a need to exercise compulsory powers to obtain information.

For a complaint against an individual registered provider, the actions available to the Commissioner are limited to assessing the complaint, conciliating it or referring it to the provider's registration board.[18]

Given the requirement to proceed with a minimum of formality,[19] the Commission strives to resolve the vast majority of the complaints that it receives during the more informal assessment phase if that is at all possible. Information that is gathered during the assessment phase may be sufficient to prompt the provider to offer a suitable remedy, or to effect changes to systems or

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[15] Subsection 71(4) of the HRC Act.

[16] The Commissioner's sole power to require the provision of information falls within the category of 'non-registered' providers (such as a hospital), when undertaking a formal investigation under Part 7 of the Act.

[17] This has been the case since amendments to the HRC Act consequent upon the passage of the *Health Practitioners (Professional Standards) Act*. These changes will be dealt with in more detail later in this submission.

[18] This can result in quite convoluted and overlapping processes and enquiries in certain circumstances, such as where a complaint is made about a health service performed by an individual doctor in a hospital setting.

[19] Section 30 of the HRC Act.

procedures that will prevent the problem from occurring again. Alternatively, cases may be closed during assessment following a detailed explanation to the complainant as to why the service was reasonable in the particular circumstances. In cases where the information obtained in assessment supports a claim for compensation or some other significant remedy, it would be quite likely that the matter would be moved into conciliation.

The Commission's conciliation functions are set down in Part 6 of the HRC Act. Conciliation is a voluntary process by which the parties to a complaint may undertake discussions and obtain information or independent advice in a confidential setting.

Conciliation allows for a range of outcomes and frequently a dispute can be resolved in a way that is collaborative, amicable and satisfactory to both parties. Independent opinions are frequently obtained as a basis for determining claims.

Where the Commissioner and a registration board agree that a matter should be referred to the registration board, the Commissioner must hold off conciliating the complaint until the registration board completes its own investigation[20]. The one exception is where the health service provider agrees to commence conciliation for the sole purpose of arranging a financial settlement or other compensation and the board agrees that the conciliation will not compromise or interfere with its own investigation.

Set out in Schedule 2 is a diagram which provides a high level overview of the complaints processes which are provided for in the HRC Act.

[20] Section 75 of the HRC Act.

3. Brief History of the HRC

The HRC was established by the *Health Rights Commission Act 1991*. It has been reported that there was universal support for the creation of a statutory mechanism to deal with health complaints.[21] The Act was largely modelled on a conciliation model that had previously been introduced in Victoria.[22] The Victorian and Queensland 'conciliation model' has since been widely followed in all other States and Territories. The exception is New South Wales which has introduced a combination of conciliation, registration and prosecutorial functions.

Under the HRC Act the Commission was also vested with the power to investigate particular matters as specified under the legislative framework.

Prior to 2000, the public interest investigative functions vested in the HRC, authorised it to investigate complaints against both registered and non-registered health service providers. In effect, the HRC was able to conduct formal investigations of both organisations (such as hospitals) and individual practitioners. Although the HRC has never had the power to compel the provision of information during the initial assessment phase, prior to 2000 the obtaining such information was never an issue in practice. If a provider declined to provide any information necessary to assess a complaint, it was then open to the HRC to place the matter into investigation and obtain the information by using its coercive powers. The fact that such powers existed meant that they rarely needed to be used in practice. This was because there was little to be gained by a provider declining to cooperate with the HRC's enquiries.

In 2000 the HRC's powers were amended following the commencement of the *Health Practitioners (Professional Standards) Act*. The HRC retained the power to investigate complaints against 'non-registered providers',[23] but the HRC no longer has any power to investigate complaints against individual registrants. In the case of individual registrants, the HRC still had the power to assess or conciliate complaints, but following these legislative amendments only registration boards had the power to formally investigate complaints against individual registered providers.[24]

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[21] *Hansard*, 12 November 1999 at 5095

[22] *Health Services (Conciliation and Review) Act 1997*

[23] Organisations such as hospitals and nursing homes, as well as individual practitioners from fields not regulated by registration boards.

[24] Attention is drawn to the changed role of the HRC in referring registrants to their respective boards since the commencement of the Health Practitioners (Professional Standards) Act. Prior to 2000, if the HRC received a complaint about an individual registrant it would discuss the complaint with the relevant registration board to decide who would address the complaint. There was no requirement for the boards to take complaints referred by the HRC, but even where the HRC assessed or investigated such matters itself, it could still make recommendations for disciplinary action to a board at the end of that process. Since 2000 the HRC has had no power to investigate

The HRC has since been able for the most part to obtain the cooperation of registered providers in supplying relevant information in response to the complaints its has received. Nevertheless, it is appropriate to observe that these amendments have impacted on the HRC's ability to deal with complaints in a comprehensive and timely manner. It is not unusual for a provider to decline to respond to a complaint in assessment and instead ask that the matter be immediately referred to conciliation, where any information that is provided attracts privilege. This can tend to 'force the hand' of the Commissioner, who under section 74(4) of the HRC Act is the one charged with deciding whether a case is suitable for conciliation. The Commissioner may then be faced with closing the complaint, thus denying the complainant the right to have their claim reviewed by an independent body.[25]

In substitution for removing the HRC's power to investigate individual registrants, the 2000 amendments require that as an accountability mechanism registration boards must provide a report to the Commissioner on each investigation they conduct. The Commissioner is empowered to comment on these reports, but has no power to veto a board's decision. The Commissioner may, however, alert the Minister for Health to any concerns about actions taken or not taken.[26]

The 2000 amendments also formalised the requirement for regular consultation between the HRC and registration boards, enabling the respective bodies to make submissions to each other on complaints they received.[27] This had not previously been a statutory requirement but it should be noted that as a matter of policy and practice, regular consultation had taken place before this time.

In common with similar 'watchdog' agencies in Queensland and elsewhere, the pressure on the HRC's reactive complaints processes is unrelenting. The HRC receives in excess of 4500 formal complaints and enquiries each year, in addition to numerous other enquiries that do not fall within jurisdiction. Historically, the HRC has experienced considerable difficulty in handling such a large volume of, often highly complex and sensitive, complaints. Resource

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individual registrants, but it is required to consult with the relevant board before commencing assessment of a complaint and following assessment.

[25] The only other options would be to refer the matter for consideration by the relevant registration board. This may not be a viable option given (a) that boards will only take action where a matter complained of is of sufficient seriousness and (b) that boards in any event have no power to consider or recommend individual remedies.

[26] Explanatory Notes, *Health Practitioners (Professional Standards) Bill 1999* p.7

[27] *Ibid,* p.5

constraints have meant that, although not overlooking its educative and advisory functions, the HRC has had to focus principally on complaints handling and systemic oversight.[28]

Previous Commissioners have also drawn attention to the strict legislative timeframes for assessments of complaints which, in addition to resource constraints, have had an adverse impact on the timelines and efficiency of the HRC's operations.

In 2001, a review of the HRC's operational effectiveness was undertaken by the Consultancy Bureau, led by Mr Peter Forster. A survey of health service providers, consumers and other stakeholder groups revealed that the length of time taken to finalise complaints was an area of significant concern.[29] The review also noted that while the HRC had adopted a comprehensive approach to the handling of health complaints, a conservative risk-averse culture had resulted in reluctance to manage cases expediently for practical outcomes.[30]

The review resulted in a wide range of recommendations being endorsed by Cabinet. Significant recommendations included that the HRC should streamline its complaint handling processes to ensure more timely responses; adopt an active strategy of not actioning complaints unless complainants had demonstrated reasonable attempts to resolve complaints directly with health service providers and to seek to resolve complaints wherever possible by conciliation rather than more formal investigation.

In response to the review, the HRC has now placed greater emphasis on direct resolution and has moved to adopt more streamlined, user-friendly complaints processes. In particular, a more flexible approach has been taken to the time restrictions set down in Section 76 of the HRC Act. Section 76 requires that complaints be assessed within specified timeframes.[31] Historically, the HRC sought to stick rigidly to those timeframes, even though for a variety of reasons they proved to be impracticable.[32] In many cases the end result was that complaints were often referred to another stage just because the time frame for assessment had expired, not because they had actually been deemed suitable for either investigation or conciliation. Cases that were referred in this way then began to accumulate at the next stage, leading to inevitable delays and significant backlogs.

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[28] See Section 10 of the HRC Act.

[29] Department of the Premier and Cabinet, *Report of the Review of the Health Rights Commission.* February 2002, Executive Summary, p.i

[30] *Ibid,* p.ii

[31] Within 60 days, with an additional 30 days extension available in prescribed circumstances.

[32] For example, a provider may have been unavoidably delayed in making a response, or an independent expert may have been delayed in providing advice through commitments to his own patients.

The review suggested that the time restrictions on dealing with complaints in assessment should be relaxed. The HRC had previously received legal advice that these time frames were directory, not mandatory. In accordance with that advice and the review recommendations, cases are now kept longer at the assessment stage, only being referred for more formal statutory action where the nature or complexity of the case so warrants. Through this less rigid approach to statutory timeframes and by bolstering its intake and assessment units, the HRC has over the past two years virtually eliminated the previous backlog of complaints.[33] A higher number of cases are now resolved at an early stage, an outcome that has been welcomed by both health consumers and providers.

As at 30 June 2004 the HRC had 330 active cases. This compares favourably with around 507 active cases at 30 June 2003 and 820 open complaints at June 2001[34], prior to commencement of the review.

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[33] Health Rights Commission *Annual report 2002 – 2003* pp. 3-5

[34] HRC Annual Report 2000-2001, p.6

4. Key Policy Considerations

As mentioned above, the HRC Act was subject to a number of amendments associated with the commencement in 2000 of the Health Practitioners (Professional Standards) Act. There are a number of further changes that, if made, would it is submitted strengthen the statutory oversight of health services in Queensland.

4.1 Commissioner's power to investigate of his own initiative

Under the current legislation, the Commissioner does not have 'own motion' powers. By virtue of Sections 31 or 32, the Minister for Health may direct the Commissioner to investigate a particular matter or conduct an inquiry but otherwise, the Commissioner has no power to proceed with a matter unless a specific complaint is received.[35]

There have been a number of instances in the past where serious public interest and systemic issues have come to attention as a result of reports in the media, but where the HRC has been unable to take action because it did not receive a formal complaint. There have also been occasions, in the past, where the HRC received a complaint against one practitioner and, in the course of its enquiries, became concerned about the care provided to the same patient by a different practitioner. The HRC has not been able to proceed to deal with the additional matters on its own initiative in the absence of a complaint made under the HRC Act.

Consideration should be given to providing the Health Rights Commissioner with 'own motion' powers along the same lines as those held by the New Zealand Health and Disability Commissioner. If such a model were adopted, the Commissioner would be empowered to act on his own initiative only where there appeared to be an immediate risk to the health or safety of a user of a health service, or where the Commissioner is satisfied that the matter is sufficiently serious to warrant an investigation in the public interest.

The provision of "own motion" powers is not unusual as these types of provisions have been included in other ombudsman style legislative frameworks.

In making these observations it is noted that ss.31 and 32 of the HRC Act do authorise the Minister to both give directions and to direct that an inquiry be held in relation to a particular matter. There have been some instances, in the past, where the Commission has raised with the

[35] Where the Commissioner undertakes a formal investigation or Inquiry, he has the power to require provision of information or records or to obtain oral evidence on oath. For an Inquiry directed by the Minister, the Commissioner is empowered to conduct hearings. An Inquiry hearing is a judicial proceeding for the purpose of chapter 16 of the Criminal Code.

Minister an issue and a relevant direction from the Minister under ss.31 or 32 of the HRC Act has been provided. However, in practice, the HRC often will be quite limited in terms of the evidence that it holds on the particular matter. This can in practice, then restrict the capacity of the HRC to raise matters with the Minister, on the basis that it simply does not hold enough evidence about the matter and the Minister might also have insufficient evidence to justify the making of a relevant direction under ss. 31 and 32 of the HRC Act given that such decisions will involve the exercise of a statutory discretion under the HRC Act.

Circumstances could arise whereby the public discussion of a particular matter does alert the HRC to a potentially important issue. In such a case it might well be advantageous in the public interest for the Commissioner to then conduct an initial review and investigation into that matter. This type of situation could appropriately be addressed if the Commissioner had "own motion" powers of investigation.

4.2 Requiring health providers to advise patients of rights of independent review

The HRC has received over 100 complaints or enquiries from patients of Bundaberg Base Hospital since the beginning of April 2005 when the relevant media discussion intensified. Notwithstanding, these complaints the HRC is concerned at the number of instances where people were previously unaware of the existence of the HRC or of their right to seek independent review of their concerns without recourse to legal action. This is all the more disturbing given the potential costs of litigation and the fact that in comparison the HRC's services are free. Some of those persons who did contact the HRC no doubt did so having sighted the newspaper advertisements that were placed by the HRC once the extent of local concerns in Bundaberg became apparent. The HRC does not have the resources, however, to carry out such advertising throughout Queensland on a regular basis.

The HRC also notes that some complainants have expressed concern as to the manner in which their complaints were handled at Bundaberg Base Hospital. There have been suggestions made to the HRC that their concerns were responded to in a dismissive way.

This raises the question whether health bodies within the HRC's jurisdiction should be required, as part of their internal complaints procedures or in their response to correspondence or other communications where patients have expressed concerns, to provide information about the independent avenues of review. This is akin to the requirement for government agencies to advise of available external review rights when processing Freedom of Information requests. Such a change would contribute to an open, accessible and accountable complaints system.

As part of that accountability, the question arises as to whether central internal investigation units in Queensland Health, such as Internal Audit, should also be required to advise the HRC of

the commencement and outcome of any investigations that they undertake in relation to patient care.

The HRC for its part will continue to publicise its own role as far as possible within the limits of its resources and drawing on the experience gained in dealing with the complaints raised in respect of the Bundaberg Base Hospital.

The HRC has already determined that it will embark on a program of regular visitations to regional areas with a view to increasing public awareness of and access to the services provided by the HRC.

4.3 Power to obtain information

The HRC obviously cannot assess and resolve complaints satisfactorily without access to relevant information. However, as previously stated, in the case of individual providers (who account for approximately 60% of complaints received) the HRC's powers are limited to inviting a response. There is no power to compel a provider to respond, or to furnish information such as clinical records. By and large, the HRC's role is well respected and complaints are able to be resolved through the cooperation of providers. Nevertheless, there is potential for lack of accountability if providers decline to participate and if, as a result, the HRC cannot take the complaint further. Even where the matter is considered sufficiently serious to refer to the relevant registration board, such bodies are only empowered to consider professional conduct or disciplinary issues. They have no power to consider whether remedies for individual complainants may be warranted. In other words, if a provider declines to participate in the HRC's processes a complainant's only option may then be to pursue legal action. This would entirely defeat one of the key purposes of the HRC Act being to provide an alternative means of effectively, efficiently and inexpensively resolving medical negligence claims.

At the very least, serious consideration should be given to empowering the Commissioner to compel providers to supply information at the assessment stage, thus allowing complaints to be fully explored by an independent Alternative Dispute Resolution body. Such an approach has recently been adopted in New South Wales[36] and is under consideration in the Northern Territory[37].

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[36]See s.214 of the *Health Legislation Amendment (Complaints) Act 2004*.

[37] Discussions Paper: Review of the Health and Community Services Complaints Act 1998.

4.4 Statutory time frames

As previously stated, the HRC's legal advice is that the timeframes specified in Section 76 of the HRC Act are directory, not mandatory. However, it is worth noting, that corresponding legislation in Western Australia contains a 'savings' provision to the effect that the validity of any outcome of a health service complaint is not affected by a failure to observe a time limit[38].

The HRC believes that, for the avoidance of doubt, the HRC Act should also include such a savings provision.

4.5 Current separation of investigation and conciliation functions

The specialised nature of certain positions at the HRC has become an issue in dealing with cases in a timely and efficient way. A HRC officer who is a conciliator must not be involved at all in the investigation of health service complaints[39].

The Consultancy Bureau commented on this problem in its review. It recommended that the HRC implement a less specialised structure in order to:

- achieve greater flexibility in the allocation of staff resources;
- minimise redundancy in complaint processing functions; and
- ensure complainants need only provide full details of their complaints to the HRC on one occasion.

Faster closure times and prevention of backlogs, for which the HRC had been criticised in the past, were identified as benefits of this approach.

One way to build on this recommendation would be to adopt a less restrictive legislative approach in this regard as now applies in Western Australia ie. to enable Commission officers to both conciliate and investigate cases provided that they do not do so for the same complaint.[40] Under the New South Wales legislation, an officer may not investigate and conciliate the same complaint if to do so might interfere with the conciliation process. The Australian Capital Territory and Northern Territory Acts provide the greatest flexibility, placing no restrictions on conciliators also being involved in investigations. However, it might reasonably be assumed

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[38] See Section 58, *Health Services (Conciliation and Review) Act 1995*, Western Australia

[39] See s.83 of the HRC Act.

[40] See s.47 of the *Health Services (Conciliation and Review) Act 1995.*

that in practice these Commissions would also be conscious of any interference with the conciliation process.

The role of the HRC is essentially reactive in the sense that is has no control over the number or types of complaints that it receives at any point in time or the proportion that will be conducive to informal resolution, conciliation or investigation. It is therefore important to have the flexibility to allocate staff as the needs arise. Greater flexibility could be achieved by allowing conciliators to also conduct investigations, perhaps on the proviso that an officer does not investigate and conciliate the same complaint. This would not adversely affect the integrity of conciliation in any particular case.

4.6 Coordination of investigations conducted by the HRC and registration bodies

The HRC recently conducted a major investigation of a case where concerns were raised about systemic failures at a hospital. In the same case, two different registration bodies examined the conduct of individual practitioners. All parties to the complaint had to wait until all three bodies had finalised their investigations before the findings were known.

It may be that a legislative review should be undertaken to ensure that in the future:-

- Such overlapping investigations are conducted in harmony;
- That from a timing point of view, that the important findings from the respective investigatory bodies are made available to all affected parties. This can be important in practice. The position of registered providers, patients and complainants could, for example, in overlapping investigations be affected by a finding by the HRC as to whether there were, or were not, systemic problems within the relevant health service facility. Without co-ordination between the various investigations issues of fairness in terms of the inter-relationship between the various investigations could well arise; and
- There needs in practice to be better co-ordination between the relevant investigatory bodies in these circumstances.

5. Scope of the Role of the HRC

From time to time comments are made that review bodies such as the HRC are "toothless tigers". This section of the Submission will address some misconceptions that may exist as to the role of the HRC and the outcomes that it is capable of delivering under the framework established by the HRC Act.

Approximately, 11000 complaints have been received by the HRC since its inception concerning health services in Queensland. Just over 45 % of these complaints have resulted in outcomes that are favourable or satisfactory to the complainant. The resolutions might include an apology or acknowledgment that a health service should have been performed better; access to treatment that had been unreasonably denied; a remedial procedure; refund of fees; an *ex gratia* payment; or financial settlement of a claim for medical negligence. The flexibility of outcomes which are available under the HRC Act and pursuant to the HRC's processes has clearly been of benefit to past complainants. Many of the resolutions achieved in dealing with past complaints would have been unachieved by the use of traditional dispute resolution processes.

There is clear evidence to suggest that conciliation is both an effective and user-friendly alternative to litigation in medical negligence claims. Medical defence bodies, hospital insurers and many legal firms now advise their clients to attempt to settle cases in conciliation, saving both parties the time, distress and legal costs that would otherwise be associated with court action. Financial outcomes have ranged from modest *ex gratia* payments and reimbursement of costs, to settlements approaching one million dollars.

The HRC's annual reports have also regularly recorded recommended changes to health systems and procedures. Some examples in this regard are:-

- A wide-ranging review of public health services provided to an indigenous community that resulted in an increased level of resources, more culturally appropriate provision of services and improved consultation with the community; and
- Review of admission policies and procedures at a public hospital which also contributed to a review of procedures across Queensland for the retrieval of patients from regional areas.

The Commissioner also has the power to refer a complaint about a registered provider to a registration board. Over the years, there has been an increase in the number of complaints being referred to registration boards, both following the initial assessment stage and following

conciliation.[41] The HRC seeks to work co-operatively with both health consumers and providers but as an independent investigatory agency it has a track record of acting robustly and persistently to achieve fair outcomes in the public interest.

Pursuant to s.35 of the HRC Act the Commissioner may, at any time, give to the Minister for Health a report providing information in relation to the activities of the HRC. Such reports may cover the results of investigations and may canvass systemic or public interest issues. The Minister must table the report in Parliament within 10 sitting days of receiving the report.

Recently, there have been some media reports that have discussed the role and functions of the HRC[42]. In this regard it is useful to clarify some aspects of the HRC's functions. This is particularly so in light of the roles of other health regulatory bodies.

It is quite clear from the legislative framework which has been established in Queensland that the HRC is not responsible for matters relating to the registration of individual health providers. Accordingly, decisions as to whether a health practitioner is entitled to be registered in Queensland are clearly a matter for the appropriate registration board. The HRC Act recognises this fact by requiring the Commissioner in specified circumstances to refer certain health services complaints to the appropriate registered provider's registration board[43].

Similar observations are apposite in relation to the issue of registration and monitoring of overseas trained medical practitioners. As noted above, the HRC currently has no role, nor any powers, with respect to the registration of such practitioners and absent a complaint, no responsibility in respect of their ongoing assessment and monitoring.

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[41] Since 1991 the HRC has referred almost 1000 cases to registration bodies for consideration of possible disciplinary or other action.

[42] The *Courier Mail* on 5 May 2005 reported that the HRC had failed to discover in an investigation conducted some years ago that a senior psychiatrist had been found guilty by an overseas registration body of harmful sexual relations with two patients. The implication from the article was that the HRC had a responsibility to conduct comprehensive checks in relation to the registration of individual health providers. Clearly registration processes are in Queensland the responsibility of the relevant health registration bodies.

[43] See s.68 of the HRC Act.

6. Complaints received by the HRC in respect of the Bundaberg Base Hospital

The HRC has responded promptly to recent concerns which have been raised with it about Bundaberg Base Hospital when they first became known[44]. A HRC officer was sent to Bundaberg on 18 April 2005 to ensure that anyone with concerns about their health care had ready access to our services. Preliminary interviews were conducted with, or enquiries received from, over 100 people. A total of 48 individuals have now lodged formal written complaints with the HRC. The HRC is still awaiting written confirmation of some complaints and/or written authority to access the records of individual patients. It is possible that some persons who made an enquiry with the HRC might ultimately decide not to pursue action with the HRC.

Most of the complaints received by the HRC relate to health services provided by Dr Patel. However, a small number of the complaints that have been received by the HRC relate to the provision of health services by other health practitioners at the hospital. A special unit has been established within the HRC to deal with all recent complaints relating to the Bundaberg Base Hospital as a matter of priority. The focus of the initial actions by this unit have been to identify those people who appear to be in need of further medical treatment e.g. cases where there was an assessed need for urgent medical treatment or remedial surgery. Other necessary assistance has also been identified on a case by case basis eg. by the provision of counselling or the obtaining of a second expert medical opinion. This review was done immediately and the relevant information has been provided to the Bundaberg Health Service District to assist it in identifying and prioritising patient needs.

The relevant unit within the HRC has now commenced assessing all cases where a written complaint has been received and the unit is also following up other persons who made an initial enquiry. As part of the HRC's processes the unit is also reviewing previous complaints that have been made to the HRC about the Bundaberg Base Hospital.

The HRC has notified Bundaberg Base Hospital of all complaints that it has received. The HRC has requested the Bundaberg Base Hospital to forward to the HRC copies of the relevant medical records for all patients in respect of which a written complaint has been received by the HRC and an authority to access records has been provided. The Bundaberg Base Hospital has agreed to these requests for information. At this time the HRC is proceeding to deal with all of these cases under its informal assessment processes and has been able to do so with the full co-operation of the Bundaberg Base Hospital and Queensland Health.

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[44] Being the complaints received after 1 April 2005.

The HRC has also outlined to the Acting District Manager a proposed method of dealing with these complaints. Essentially, that process entails obtaining full patient records (both from the hospital and from other health service providers where relevant) and then forwarding such records together with a copy of the complaint, to expert medical advisers for independent advice in respect of the relevant complaints. The HRC has prepared a list of suitably qualified independent experts for this purpose. These experts will be drawn from outside of Queensland Health and in many cases will be interstate medical practitioners. As such advice is obtained by the HRC from these independent experts it will then be shared with the relevant parties to assist them in resolving claims. To date, the HRC has identified 21 cases where such independent medical advice will be sought. This figure will clearly increase with further analysis by the unit within the HRC and as more formal complaints are received.

6.1 Common complaint issues

Based on an analysis of the formal complaints received to date and in light of informal enquiries recently conducted in relation to the Bundaberg Base Hospital, the HRC has to date identified the following common themes.

The majority of the concerns raised by the complaints received by the HRC relate to surgical procedures undertaken by Dr Patel particularly in relation to bowel, abdominal and gall bladder surgery. In a significant number of these cases, consumers/complainants have reported serious complications and adverse outcomes resulting from surgery.

Many people who underwent surgery have indicated that they subsequently had further surgery to repair complications or address original symptoms that had not been resolved. A number of these persons state that they underwent multiple surgeries and had extensive hospital admissions or outpatient care. Some of these patients continue to report ongoing symptoms.

A substantial number of people have indicated that they suffered from post-operative infections. Some claims have been made that there was a delay in diagnosing or treating infections and that the infections resulted in serious illness and prolonged recoveries including ICU admissions.

There are a significant number of cases where patients allege that they were discharged prematurely or that they did not receive adequate follow up. These cases commonly involved the patient being readmitted, sometimes on more than one occasion.

Other common complaints received involved allegations that patients had been misdiagnosed or that there was a delay in diagnosing their condition.

The Commission has also received complaints that include concerns about the development of post-operative hernias. In some cases the complaints involve claims that hernias were poorly repaired, took some time to identify and treat, or persisted despite reparative surgery.

6.2 Systemic issues

Based on the information available to date, the HRC will be paying particular attention to the following systemic issues which, to date, have been raised by the complaints received by it in respect of the Bundaberg Base Hospital.

The HRC will be examining the scope of surgical practice at Bundaberg Base Hospital and the processes for referring patients who are scheduled for major surgery to tertiary hospitals. The HRC will also be looking at the processes that were in place at the Bundaberg Base Hospital for obtaining patient consents and whether the patient consents obtained were appropriate.

The HRC is also concerned by the number of complaints where the complainant was unclear about whether their surgery was undertaken due to the presence of disease. The HRC will be examining whether adequate diagnostic investigations were conducted at the Bundaberg Base Hospital.

Another systemic issue that is raised by the complaints relates to infection monitoring and control at the Bundaberg Base Hospital. Issues such as how individual incidences of infection are recorded and then reported and who is, or should be, responsible for this task will be examined? Other issues raised in this regard are what systems were in place to alert hospital management or Queensland Health officers in relation to high rates of infection? Relevant information will be sought and analysed by the HRC with reference to applicable best practice guidelines.

The HRC has also identified concerns in the complaints in relation to the issues of early discharge and inadequate patient follow up. The HRC in this regard will review the Bundaberg Base Hospital's discharge and follow up procedures and the availability of relevant resources.

Another area of concern raised in the complaints relates to the issue of complaints handling at Bundaberg Base Hospital. It seems that the Bundaberg Base Hospital did not have its own Patient Liaison Officer. The HRC will be examining whether at the Bundaberg Base Hospital there was a culture that welcomed complaints, and whether complaints were responded to openly, fairly and appropriately[45]. The issues as to whether information from the complaints was fed back into quality improvement practices at the Bundaberg Base Hospital will also be examined.

However, at this stage, a degree of caution needs to be exercised when interpreting the above information and observations. In a number of cases, the HRC is still awaiting copies of relevant

[45] See the national Open Disclosure Project being conducted by the Australian Council for Safety and Quality in Health Care.

patient records and expects to soon be in a position to commence obtaining the necessary independent expert opinions. These opinions will be helpful not only in terms of reviewing individual complaints but because they may help in identifying the nature and extent of any systemic issues at the Bundaberg Base Hospital. Obtaining this information is being treated by the HRC as a high priority.

6.3 Other complaints

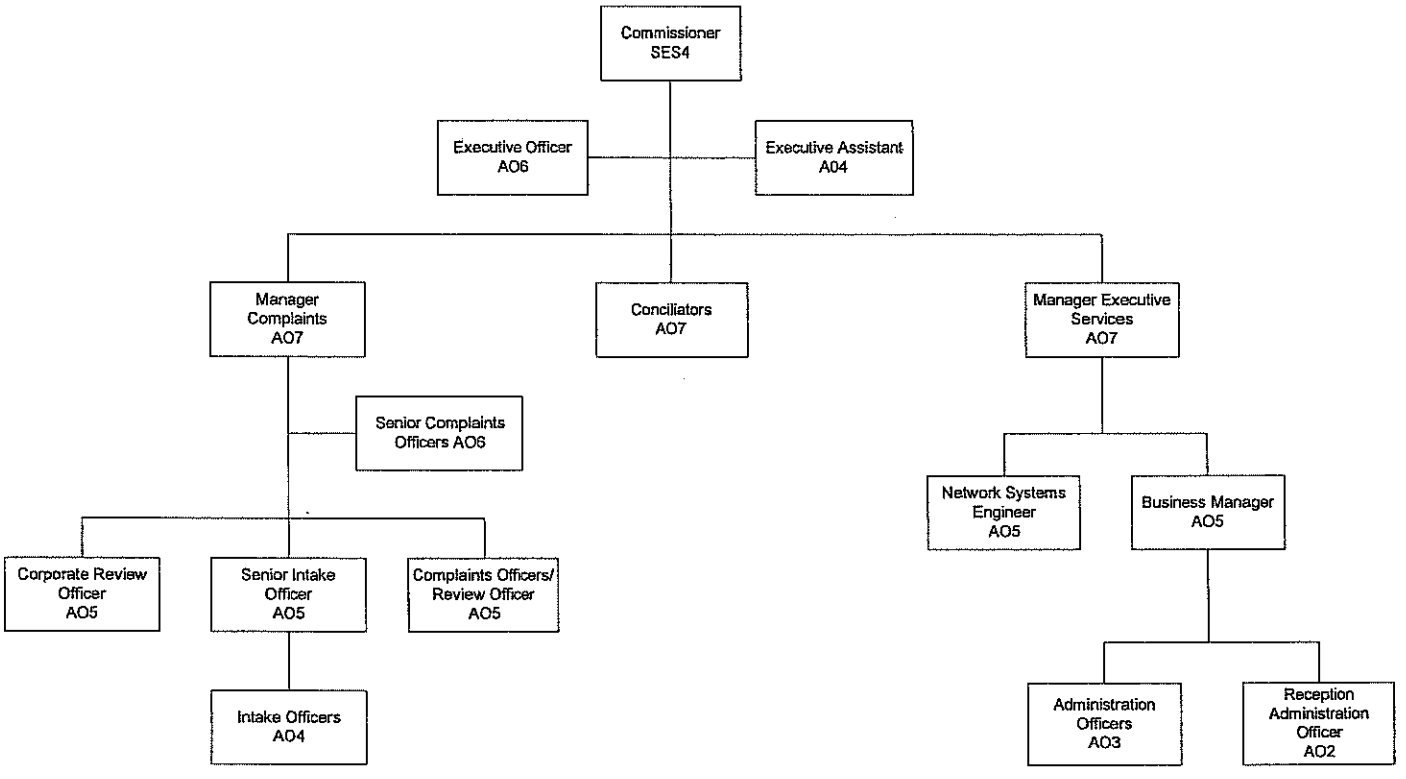
The Terms of Reference for the Commission of Inquiry require it to inquire into any substantive allegations, complaints or concerns relating to the clinical practice and procedures conducted by Dr Patel or other medical practitioners at the Bundaberg Base Hospital.

The HRC is aware of a series of other complaints concerning another Senior Staff Specialist at the Bundaberg Base Hospital. Some of these matters have been investigated by the Medical Board and opinions were sought from several expert medical advisers. The Medical Board forwarded to the HRC a report of its investigation for comment in accordance with s.116 of the *Health Practitioners (Professional Standards) Act*. The HRC did not agree with the Medical Board's findings and after further representations by the HRC, including a meeting by the Commissioner with the Medical Board, the Board then agreed to obtain an additional expert opinion.

This case is an important illustration of the independence of the HRC and of its preparedness to carefully review issues arising out of the investigation of health service complaints to ensure, in the public interest, appropriate accountability of all parties to such processes.

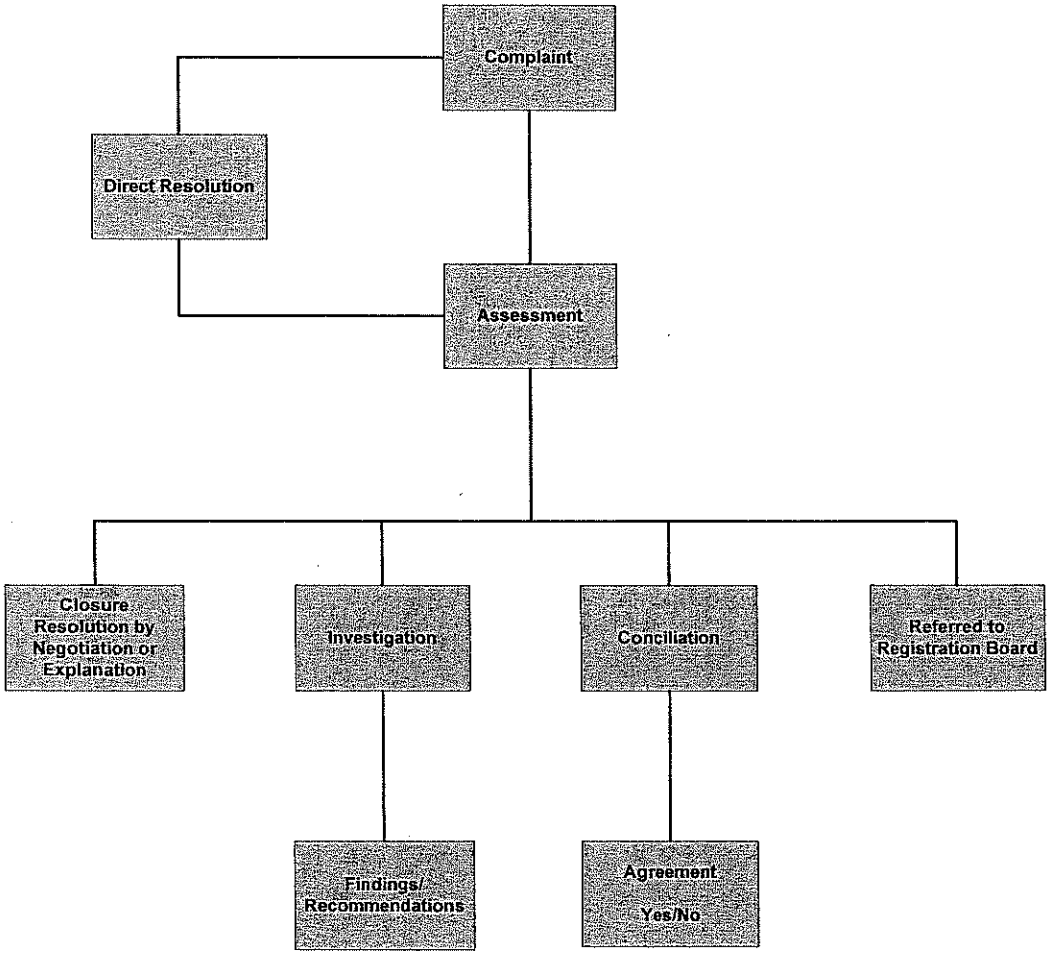
Schedule 1

Health Rights Commission - Organisational Chart



Schedule 2

Overview of Complaint Processes



"DK2"

Patient Key Code	Complaint number	Complainant	Patient	Date complaint received	Complaint involves Dr Patel
P71	050102	Alexander, Michelle	Alexander, Noel (decd)	12/05/2005	Yes
P165	050253	Anderson, Helen	Self	19/07/2005	Yes
P346	050092	Armstrong, Keren Lee	Hanna, James Lesley (decd)	10/05/2005	No
	050070	Armstrong, Robert William	Self	3/05/2005	Yes
	050173	Badke, Fred	Self	9/06/2005	Yes
	050053	Bailey, Kevin	Self	27/04/2005	Yes
P97	050061	Barber, Rhonda	Self	29/04/2005	Yes
P171	050087	Bender, Vicki	Self	4/05/2005	Yes
P243	050178	Betteridge, Rhonda	Kerr, Kathleen (decd)	8/06/2005	Yes
P175	050136	Blight, Darcy	Self	24/05/2005	Yes
P178	050226	Braund, Annie	Braund, Kerry (decd)	29/06/2005	Yes
P50	050204	Broome, Priscilla	Self	22/06/2005	Yes
P181	050210	Buckley, Katherine	Self	27/05/2005	Yes
	050047	Burns, Aileen	Self	27/04/2005	No
	050046	Bury, Evelyn	Self	26/04/2005	Yes
	050057	Cameron, Colin	Cameron, Janice	28/04/2005	No
P207	050132	Cauley, Naomi and Finch, Blanche	Finch, Raymond (decd)	20/05/2005	Yes
	050188	Coley, John	Self	16/06/2005	No
	050189	Coley, Stuart	Self	6/06/2005	No
	040036	**Connelly, George**	Self	15/03/2004	No
P15	050083	Cox, Nelson	Self	5/05/2005	Yes
P109	050062	Cuthel, Dawn	Self	29/04/2005	Yes
P164	050174	Dargusch, Jayne	Ainslie, Frances (decd)	9/06/2005	Yes
P16	050096	Deakin, Phillip	Self	10/05/2005	Yes
	050240	Doak, Leila	Self	12/07/2005	No
	050150	Dorran, Jessie	Dorran, Noel (decd)	26/05/2005	Yes
	050095	Douch, Kelly	Self	10/05/2005	Yes
	050186	Ell, Ian	Self	14/06/2005	Yes
	050107	Ellis, Stanley Joseph	Self	12/05/2005	No
	050243	Filmer, Suzanne	Self	12/07/2005	Yes
P126	050256	Flemming, Ian	Self	22/07/2005	Yes

Patient Key Code	Complaint number	Complainant	Patient	Date complaint received	Complaint involves Dr Patel
	50267	Forrester, Michelle	Self	2/08/2005	Yes
	050119	Fowles, Nora	Self	18/05/2005	Yes
	050084	Gibson, Valerie Joyce	Self	5/05/2005	Yes
	050157	Giddy, Susan	Self	2/06/2005	No
	050086	Goddard, Carol	Self	4/05/2005	No
P220	050121	Grambower, Phillip	Grambower, Janice (decd)	18/05/2005	Yes
P224	050139	Green, Daphne	Green, Leonard Frederick (decd)	25/05/2005	Yes
P20	050044	Halter, Trevor	Self	26/04/2005	Yes
	050100	Henderson, Jennifer	Self	12/05/2005	No
P292	050103	Henderson, Jennifer	Ryan, Thomas (decd)	12/05/2005	No
	050098	Hendricks, Margaret	Self	12/05/2005	Yes
P230	050071	Holder, George	Self	3/05/2005	Yes
	050049	Hopton, Donna Beverley	Self	27/04/2005	Yes
P114	030375	**Hosking, Tim**		22/12/2003	No
	050099	Howard, Margaret	Self	12/05/2005	Yes
	040106	**Huhsmann, Hans**	Self	3/08/2004	No
P107	050060	Hurford, Terence	Self	29/04/2005	No
	050232	Hurley, Ronnetta	Self	6/07/2005	Yes
	050079	Jackson, N 'Kerry'	Self	4/05/2005	Yes
	050059	Johnson, George D	Self	29/04/2005	No
	040034	**Johnston, Ruth**		9/01/2004	No
P137	050068	Jones, Elwyn George	Self	3/05/2005	Yes
	050248	Karan, Serab	Self	20/07/2005	Yes
	050041	Karnauchow, Leo	Self	26/04/2005	Yes
P21	050058	Kemps, Judy	Kemps, Gerry (decd)	29/04/2005	Yes
	050055	Kleiss, Christophorus	Self	28/04/2005	No
	050080	Knight, Jean	Knight, George (decd)	4/05/2005	No
P2	050093	Knust, Alan	Self	10/05/2005	Yes
P350	050039	Lambert, Eleonor Iris	Self	21/04/2005	No
	050052	Lealiifano, Leanne	Lealiifano, Matteo	27/04/2005	Yes
	050073	Leather, Judy	Dorfler, Henry (decd)	3/05/2005	No
P5	050067	Lee, Coral	Self	3/05/2005	Yes

Patient Key Code	Complaint number	Complainant	Patient	Date complaint received	Complaint involves Dr Patel
P108	050035	Lester, Vicki	Self	18/04/2005	Yes
	050094	Loudan, W	Self	10/05/2005	No
	050246	Mallett, Katrina	Self	13/07/2005	Yes
P103	050065	Matteschek, Megan	Self	3/05/2005	Yes
	050054	McDonald, Dorothy	Self	27/04/2005	Yes
	050078	McKay, Sidney Michael	Self	4/05/2005	No
	030369	**Millerick, Allan**		12/12/2003	No
P267	050130	Monaghan, Brian	Self	23/05/2005	Yes
	050215	Morrell, Lesley	Self	30/06/2005	No
P28	050237	Morris, Mavis	Morris, Mervyn (decd)	12/07/2005	Yes
P30	050064	Nagle, Erlinda	Nagle, Eric (decd)	29/04/2005	Yes
	050089	Pauza, George (1 of 2)	Self	5/05/2005	No
	050090	Pauza, George (2 of 2)	Self	5/05/2005	Yes
P104	050051	Peterson, Douglas Gregory	Self	27/04/2005	Yes
P34	050066	Phillips, Bernadette	Phillips, James Edward (decd)	3/05/2005	Yes
	050050	Rhodes, Doreen	Self	27/04/2005	Yes
	050063	Robbins, Desmond Francis	Self	29/04/2005	Yes
	050006	**Roll, Daniel**		2/02/2005	No
	050097	Sanders, Edward Charles	Self	10/05/2005	Yes
	050128	Saunders, Donna	Self	19/05/2005	No
P285	050082	Saville, Wendy and Punch, Douglas	Punch, Tori	5/05/2005	Yes
	050113	Scott, Allan	Self	13/05/2005	Yes
	050203	Small, Anna	Self	22/06/2005	Yes
	050252	Smee, Patricia	Smee, Darren (decd)	21/07/2005	No
P298	050147	Smith, Christopher	Self	31/05/2005	Yes
	050185	Snowden, Vera	Self	14/06/2005	Yes
	050238	Steel, Tanya	Stanley, Jaykeb	6/07/2005	Yes
	050122	Stimpson, Michael	Stimpson, Vivienne Rae (decd)	19/05/2005	No
P38	050056	Stuart-Sutherland, A.R	Stuart-Sutherland, Jean	28/04/2005	Yes
	050069	Sullivan, Kevin	Self	3/05/2005	Yes

Patient Key Code	Complaint number	Complainant	Patient	Date complaint received	Complaint involves Dr Patel
P41	050101	Swanson, Nancy	Self	12/05/2005	Yes
?P116	050045	Taylor, Richard James Lee	Self	26/04/2005	No
P102	050043	VanVliet, Lyn	Self	26/04/2005	Yes
	050160	Vidler, Eileen	Self	31/05/2005	No
P98	050085	Walk, Graham Keith	Walk, Keith (decd)	5/05/2005	Yes
	050072	Watson, Audrey	Self	3/05/2005	Yes
	050166	Welldon, Glenda	Self	16/05/2005	No
?P324	050187	Whalley, Richard	Self	9/06/2005	No
P46 and P329	050077	Williams, Charles Percival	Williams, Grace Margaret (decd)	4/05/2005	Yes
P182	050117	Williams, Heather	Carter, Matthew Charles (decd)	10/05/2005	Yes

"DK3"

Patient Key Code	Enquiry number	Caller	Patient	Date call received	Complaint involves Dr Patel
	051191	**Allsopp, Fran**	**Self**	**4/03/2005**	**No**
	051914	Archer, Matthew	Archer, Bevan (decd)	5/05/2005	Not stated
	047521	**Armstrong, Pauline**	**Self**	**29/03/2004**	**Not stated**
	051831	Bailey, Deanne	Self	27/04/2005	Yes
P208	051666	Baker, Norman	Ford, Leanne (decd)	19/04/2005	Yes
	051830	Berry, Francis	Self	27/04/2005	Yes
	045672	**Biggs, Shannon**	**Self**	**21/10/2003**	**Not stated**
	046067	**Blair, Angela**	**Self**	**24/11/2003**	**Not stated**
	052097	Bloom, Tracy	Self	17/05/2005	Yes
	045824	**Brown, Daryl**	**Self**	**3/11/2003**	**Not stated**
	051685	Brown, Fran	Brown, Patricia (decd)	19/04/2005	No
	049621	**Brown, Ken**	**Unknown**	**28/09/2004**	**Not stated**
	051734	Brown, Nicole	Self	21/04/2005	Yes
	052139	Brown, Nicole	Self	19/05/2005	Not stated
	044665	**Catley, Graham**	**Catley, Donna**	**25/07/2003**	**No**
	051889	Clark, Trevor	Self	3/05/2005	Yes
	050198	**Cranston, Megan**	**Troy, Chris**	**23/11/2004**	**No**
P96	**048491**	**Crosby,Beryl**	**Self**	**22/06/2004**	**Yes**
	051708	Dalfour, Leon	Self	20/04/2005	No
	048426	**Davis, Julie**	**Self**	**16/06/2004**	**No**
P198	052776	Dempsey, Laurence	Self	12/07/2005	Not stated
P198	**046238**	**Dempsy, Laurence (Laurie)**	**Self**	**8/12/2003**	**Not stated**
	044484	**Ebdon, Sue**	**Self**	**10/07/2003**	**No**
P208	051945	Ford, Cliff	Ford, Leanne (decd)	9/05/2005	Not stated
	044669	**Foster, Ian**	**Self**	**25/07/2003**	**Not stated**
	044772	**Fuller, Lyn**	**Carr, Janet**	**5/08/2003**	**No**
	045177	**Gaits, Audrey**	**Unknown**	**8/09/2003**	**Not stated**
	047586	**Goggi, George**	**Self**	**1/04/2004**	**Not stated**
	043646	**Goodman, Anne-Marie**	**Self**	**14/04/2003**	**Not stated**
	044685	**Gorlickq, Trisha**	**Self**	**28/07/2003**	**Not stated**
	044411	**Grill, Janette**	**Self**	**2/07/2003**	**No**
	051823	Grills, Sharon	Self	27/04/2005	No

Patient Key Code	Enquiry number	Caller	Patient	Date call received	Complaint involves Dr Patel
	045752	**Hall, Lynette**	**Self**	**28/10/2003**	**Not stated**
	047345	**Hancock, Tania**	**Self**	**15/03/2004**	**Not stated**
	051726	Harvey, Amy	Self	21/04/2005	No
P124	**051219**	**Hicks, Dale**	**Self**	**9/03/2005**	**No**
	045272	**Higgins, Gary**	**Self**	**15/09/2003**	**Not stated**
	051646	Hosler, Gary	Self	18/04/2005	Yes
	043528	**Hunter, Ross**	**Cooper, Julie**	**3/04/2003**	**Not stated**
	049402	**Jensen, June**	**Jensen, Craig**	**10/09/2004**	**Not stated**
	051843	Jenson, Christopher	Self	28/04/2005	No
P236	051885	Johnson, Cheryl	Johnson, Barry (decd)		Yes
	047806	**Jones, Crystal**	**Self**	**21/04/2004**	**Not stated**
	046542	**Jones, Helena**	**Self**	**12/01/2004**	**Not stated**
	047807	**Jones, Helene**	**Self**	**21/04/2004**	**Not stated**
	048993	**Kath, Thomas**	**Belthouser, Lesley**	**5/08/2004**	**No**
	047959	**King, Penny**	**Self**	**6/05/2004**	**No**
	043510	**Knable, Dennis**	**Self**	**2/04/2003**	**Not stated**
	051342	**Lake, Zoe**	**Lake, Unknown**	**16/03/2005**	**Not stated**
	044337	**Lawrence, Alana**	**Richards, Naamah**	**25/06/2003**	**No**
	050467	**Lee, John Benedict**	**Self**	**21/12/2004**	**Not stated**
	050375	**Lee, Mark**	**Self**	**10/12/2004**	**Not stated**
	052657	Mac Adam, Alistair	Unknown	1/07/2005	Not stated
	044578	**Maguire, Karen**	**Self**	**17/07/2003**	**No**
P353	052045	Mellish, Angela	Self	16/05/2005	Yes
	051483	**Messenger, Rob**	**Various**	**23/03/2005**	**Yes**
	048994	**Middleton, Ray**	**Self**	**5/08/2004**	**No**
P65	**046946**	**Mitchell, Sharon**	**Self**	**16/02/2004**	**Not stated**
	051772	Moon, Collin	Self	26/04/2005	No
	047809	**Moroney, Patricia**	**Quinlan, Tara**	**22/04/2004**	**No**
	046763	**Morrell, Roberta**	**Morrell, Mark**	**2/02/2004**	**Not stated**
P343	**043961**	**Morris, John**	**Bradley, Maryse**	**20/05/2003**	**Not stated**
P270	051765	Mowbray, Lorraine	Self	22/04/2005	Yes
	043498	**Mulvena, Jessica**	**Self**	**1/04/2003**	**Not stated**
	051991	Munro, Darrell	Self	11/05/2005	Yes

Patient Key Code	Enquiry number	Caller	Patient	Date call received	Complaint involves Dr Patel
	051840	Munro, Jan	Self	28/04/2005	Yes
	044491	**Norman, Ruth**	**Self**	**10/07/2003**	**No**
	051265	**Norman, Ruth**	**Self**	**14/03/2005**	**No**
	044393	**O'Brien, Dennis**	**Self**	**1/07/2003**	**Not stated**
	051836	O'Hehir, Kevin	O'Hehir, Chris	27/04/2005	Yes
	051809	Parkins, Elaine	Self	27/04/2005	No
P99	**049251**	**Parsons, Linda**	**Self**	**27/08/2004**	**Not stated**
	050490	**Pashley, Amanda**	**Self**	**23/12/2004**	**No**
	051833	Peter	Unknown	26/04/2005	Unknown
	048271	**Quast, Roslyn**	**Quast, Lauren**	**2/06/2004**	**No**
P337	052066	Rasmussen, Karen	Rasmussen, Ken	11/05/2005	Not stated
P101	051725	Raven, Sue	Mcann, Ryan	21/04/2005	Yes
	051717	Reynolds, Rebecca	Self	20/04/2005	Yes
	051997	Rosengren, Pam	Morgan, Virginia	11/05/2005	Not stated
	043762	**Ruffell, Tracey**	**Self**	**29/04/2003**	**No**
	052847	Sandham, Sammy	Self	18/07/2005	Not stated
P293	**051278**	**Saroglia, Cassandra**	**Self**	**15/03/2005**	**Yes**
	044769	**Shirley**	**Self**	**5/08/2003**	**Not stated**
	052080	Simpkins, Faine	Simpkins, Lauren (decd)	17/05/2005	Yes
	052082	Simpkins, Faine	Simpkins, Lauren (decd)	17/05/2005	No
	047251	**Smith, Geoffrey**	**Self**	**8/03/2004**	**Yes**
	048945	**Sprought, Ken**	**Lyall, Pauline**	**2/08/2004**	**No**
	051754	Stanley, Lee	Stanley, Jaykeb	22/04/2005	Yes
	044005	**Swallow, Kathryn**	**Self**	**23/05/2003**	**Not stated**
P41	**043927**	**Swanson, Nancy**	**Nixon, Peter**	**13/05/2003**	**No**
	044259	**Swinton, Terry**	**Self**	**17/06/2003**	**No**
	045387	**Thomas, Jackie**	**Thomas, Jason**	**24/09/2003**	**Not stated**
	051912	Thompson, Carol	Thompson, Carol	5/05/2005	Not stated
	049067	**Thompson, Jacqui**	**Thompson, David**	**12/08/2004**	**Not stated**
	046073	**Thomson, Robin**	**Self**	**24/11/2003**	**Not stated**
	052183	Tonkovic, George	Self	23/05/2005	Not stated
	051784	Unknown	Unknown	26/04/2005	Unknown
	052024	Vallance, Peter	Self	12/05/2005	No

Patient Key Code	Enquiry number	Caller	Patient	Date call received	Complaint involves Dr Patel
	051814	Wolfendale, Kathleen	Self	27/04/2005	No