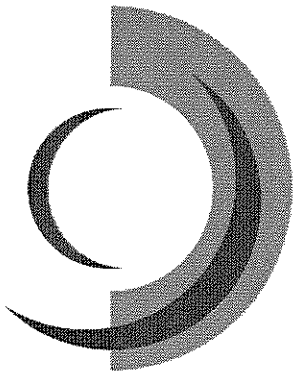
Submissions

Queensland Ombudsman



QUEENSLAND
ombudsman

Submission to the Bundaberg Hospital Commission of Inquiry

August 2005

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Abbreviations and Dictionary

ACSQHC	Australian Council for Safety and Quality in Health Care
ADR	Alternative dispute resolution
AORU	Audit and Operational Review Unit within Queensland Health
BHCI	Bundaberg Hospital Commission of Inquiry
CH	Caloundra Hospital
CJC	Criminal Justice Commission
CMC	Crime and Misconduct Commission
CC	Complaints Coordinator
D-G	Director-General
EARC	Electoral and Administrative Review Commission
ED	Emergency Department
EFT	Equivalent full time positions
Executive Director	Executive Director of Medical Services, Sunshine Coast Health Service District
HCCA	Health Care Complaints Act 1993 (NSW)
HCCC	Health Care Complaints Commission (NSW)
HDC	Health and Disability Commissioner
HPPSA	Health Professionals (Professional Standards) Act 1999
HRC	Health Rights Commission
HRCA	Health Rights Commission Act 1991
HAS	Health Services Act
HSP	Health service provider
IHSC	Independent Health Services Commission
MBQ	Medical Board of Queensland
NHS	National Health Service
NPSA	National Patient Safety Agency
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
OCHO	Office of the Chief Health Officer
OHPRB	Office of the Health Practitioner Registration Boards
OPSME	Office of Public Service, Merit and Equity
PCJC	Parliamentary Criminal Justice Committee
PD	Position Description
PID	Public Interest Disclosure
PSC	Professional Standards Committee of the QNC
QH	Queensland Health
QNC	Queensland Nursing Council
RCA	Root Cause Analysis
RCH	Royal Children's Hospital
RN	Registered Nurse
SCHSD	Sunshine Coast Health Service District
Tas	Tasmania
the Code	Code of Health of Health Rights and Responsibilities
The Commissioner	Commissioner of the Health Rights Commission
The Minister	Minister for Health
the policy	QH's Complaints Management Policy
Tribunal	Health Practitioners Tribunal
UK	United Kingdom
Vic	Victoria
WA	Western Australia
WPA	Whistleblowers Protection Act 1994

Foreword

By letter dated 3 May 2005, Commissioner AJH Morris QC invited me to lodge a written submission regarding:

- appropriate systems of accountability to ensure the proper processing, investigation and resolution of complaints about clinical practice and procedures at Queensland Health hospitals;
- the role of the Queensland Ombudsman in respect of such complaints; and
- the desirability or otherwise of establishing a specific 'Health Ombudsman' for Queensland.

Since then, the Bundaberg Hospital Commission of Inquiry (BHCI) has published several Discussion Papers, inviting submissions on specified issues.

Part 1 of this submission addresses issues relevant to Discussion Paper No 2, "Whistleblowers in the Queensland Public Health Sector".

Part 2 of this submission addresses issues relevant to Discussion Paper No 3, "Complaints Handling Systems in the Queensland Public Health Sector".

The key proposals made in respect of the three major subject areas covered in this submission appear as follows:

(a) the protection of whistleblowers - at section 5 of Part 1;
(b) QH's internal health complaint systems - at section 3.1.3 of Part 2; and
(c) a new external health complaints system - at sections 5.4 to 5.9 of Part 2.

David Bevan
Queensland Ombudsman

PART 1: Issues relating to protection of whistleblowers

1. Introduction

During the course of the inquiry, there has been considerable criticism of the response by Queensland Health (QH) to disclosures made by QH staff about clinical issues. The purpose of this part of the submission is to review the current process in QH for managing public interest disclosures (PIDs) and recommend improvements to that process to ensure that such disclosures are appropriately dealt with and those who make them are not subject to reprisal.

The broader issue of how to encourage staff to bring to attention issues of clinical concern or maladministration is beyond the scope of this submission. It involves fostering a culture in QH that strives for high standards of service and promotes openness and accountability. The emphasis needs to be on continual improvement and learning.

Such a change of culture must be driven from the top and must be supported by appropriate policies and procedures that evidence the organisation's commitment to these principles.

There are innumerable authorities advocating the value of both public and private sector agencies having in place systems that encourage whistleblowing. These are some examples:

> *"Whistleblowers have a vital role to play in the development of an open and effective public sector."*
> New South Wales Legislative Council
> Complaints handling within New South Wales Health
> Report 17, June 2004 page 62

> *"The genuine whistleblower should be seen as providing management with an opportunity for improvement and not as some 'rat under the house' requiring extermination."*
> New South Wales Ombudsman
> Protected Disclosure Guidelines
> 5th edition, May 2004 page iii

> *"Internal reporting of suspected misconduct and maladministration is vital to the integrity of the Queensland public sector. Employees who are prepared to speak up about wrongdoing or dubious practices are now well recognised as one of the most important and accurate sources of information about management problems and their possible solutions."*
> Crime and Misconduct Commission Chairperson
> Speaking up: Creating reporting climates in the Queensland public sector
> December 2004

2. The Queensland framework

The *Whistleblowers Protection Act 1994* (WPA), *Public Sector Ethics Act 1994*, *Public Service Act 1996*, and *Crime and Misconduct Act 2001* aim to create a work

environment in which proper standards of ethical conduct are widely understood and adopted. Under these Acts, public officials are required to report knowledge of serious wrongdoings using appropriate internal or external channels. Private citizens are encouraged to do the same.

2.1 Whistleblowers Protection Act 1994 Qld: An Overview

The WPA is administered by the Office of Public Service Merit and Equity (OPSME). The OPSME is responsible for providing advice and guidance to public sector agencies and officers and to private citizens, about their rights and obligations under the Act.

The Act gives protection to people who make a PID.

A PID by a public officer may be about conduct that is:

- official misconduct[1]
- maladministration that adversely affects anybody's interests in a substantial and specific way[2]
- negligent or improper management involving a substantial waste of public funds[3]
- a substantial and specific danger to public health or safety or to the environment[4].

Anybody may make a PID about:

- a substantial and specific danger to the health or safety of a person with a disability[5]
- an offence under certain legislation that is or would be a substantial and specific danger to the environment[6]
- a reprisal taken against anybody for making a PID[7].

The Act provides that disclosures must be made to an "appropriate entity"[8].

Any public sector entity is an appropriate entity to receive a PID about its own conduct (or that of its officers); about anything it has power to investigate or remedy; or if referred by another public sector entity[9]. The Crime and Misconduct Commission (CMC) is an appropriate entity to receive PIDs about official misconduct. The Queensland Ombudsman is an appropriate entity to receive PIDs about maladministration involving an entity within its jurisdiction.

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[1] s.15
[2] s.16
[3] s.17
[4] s.18
[5] s.19(1)(a)
[6] s.19(1)(b) and (c)
[7] s.20
[8] s.25
[9] s.26

Maladministration is defined to cover *"illegal, arbitrary, oppressive or improper public sector 'administrative action'"*;[10] and *"administrative action that is unlawful, arbitrary, unjust, oppressive, improperly discriminatory or taken for an improper purpose"*[11].

For a disclosure by a public officer about maladministration to be a PID, it must involve conduct that *"adversely affects anybody's interests in a substantial and specific way"*[12].

2.2 Queensland Health

QH has developed a document entitled *Policy and Procedures for the Management of Public Interest Disclosures* (September 2000) made in accordance with the Act. The purpose of the policy document is to ensure all employees, supervisors and managers of QH are aware of their responsibilities to report serious misconduct and other important matters affecting the public interest, and to establish procedures for persons wishing to make a PID.

The document includes procedures for QH employees, and persons external to QH, to make a PID in accordance with the Act. The document outlines the scope of a PID, sets out who a PID can be made to, and details the procedures to be followed once a PID is made.

These procedures require that a PID be brought to the attention of the Director-General, or nominated delegate, who then assesses the PID to determine its appropriate management and investigation. The Director-General, or nominated delegate, is also to assess whether any risk of reprisal exists and take all steps within the authority of QH to ensure that any employee who makes a PID is not disadvantaged as a result of making the disclosure.

Where requested by the person making the PID, QH must provide reasonable information to the whistleblower within a reasonable time about the action taken by QH on the PID and its outcome.

Within QH, the Audit and Operational Review Branch is responsible for recording disclosures, including the action taken and whether the PID was verified or substantially verified.

2.3 Review of the *Whistleblowers Protection Act 1994* Qld

The Parliamentary Crime and Misconduct Committee's *Three Year Review of the Crime and Misconduct Commission* (Report No 64 tabled in Parliament on 10 September 2004) made the following observations about the WPA:

> *"...the* Whistleblowers Protection Act 1994 *does not establish a centralised system by which one agency or authority is responsible for protecting whistleblowers in Queensland. Essentially each public sector entity has responsibility for receiving public interest disclosures about the conduct of their officers, managing the disclosure process and taking steps to protect its officers from reprisals."* (page 96)

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[10] s.8(3)
[11] schedule 6
[12] s.16

The Committee also referred to the observations made on this issue in the previous *Three Year Review of the CMC*:

> *"The 4th PCJC concluded that there was a gap in the oversight and coordination of whistleblower support across the public sector. In particular, no single body was charged with responsibility for supervising whistleblower support programs in public sector agencies. The 4th PCJC, while noting that the OPSME was in the process of addressing these apparent deficiencies, recommended that the Government give consideration to a full review of whistleblower protection in Queensland and the* Whistleblowers Protection Act 1994 *including a review of:*
>
> - *the roles of the CJC [now CMC] and the OPSME;*
> - *the need for an oversight body and inter-agency committee;*
> - *training and support of public sector managers and other public sector employees;*
> - *research needs in the area of whistleblower protection; and*
> - *reporting to Parliament on whistleblower protection."*
>
> (pages 99, 100; and 4th PCJC Three Year Review, Report No 55, pages 141, 142, 150, 151)

The Committee noted that while the Government had said it would give consideration to the above matters raised in the 4th PCJC report, the extent and nature of a review was to be given further consideration. The Committee recommended:

> *"That the Government give consideration to a full review of whistleblower protection in Queensland and the* Whistleblowers Protection Act 1994 *in accordance with the recommendations of the 4th PCJC in Report No 55."*
> (page 100)

Pursuant to this recommendation, the OPSME is preparing a report to the Premier of a review of the WPA. Some of the main ideas being considered are to:

- form an interagency committee of OPSME, CMC, Office of the Ombudsman, Queensland Audit Office, and the Department of the Premier and Cabinet for informal oversight of the administration of the Act;

- develop a whistleblower policy template to improve consistency of application across the large number of entities under the Act;

- build a network of whistleblower contact officers from entities for knowledge management; and

- add further education initiatives to the whistleblower website.

Although I support these ideas, I do not think they go far enough. In particular, they do not address the deficiencies in the current arrangements under the Act relating to the coordination, supervision or review of disclosures that do not involve official misconduct.

In my view, just as agencies must refer disclosures of official misconduct to the CMC for investigation and/or referral back (ss.38, 48 *Crime and Misconduct Act 2001*), so too should agencies have an obligation to refer disclosures involving serious

maladministration to the agency that has the statutory role of investigating maladministration, namely the Queensland Ombudsman.

The Ombudsman should be empowered to investigate these disclosures or to supervise or review the investigation of such disclosures by the relevant agency in the same way that the CMC can supervise or review agencies' investigations of official misconduct.

In the case of PIDs of maladministration received from QH staff that related to clinical/patient care issues, the Ombudsman would have the option of referring (under s.15 of the Ombudsman Act) the investigation to another complaints entity with appropriate expertise (for example, a remodelled Health Rights Commission (HRC) as recommended in Part 2 of this submission), and monitoring, and reviewing the outcome of, the investigation.

3. Interstate models: An Overview

The New South Wales, South Australian and Queensland Acts dealing with PIDs were passed in 1993 and 1994.

However, Victoria and Tasmania have passed much more recent (and almost identical) legislation in 2001 and 2002 respectively. Their legislation goes beyond the mere "nuts and bolts" of receiving, recording and reporting disclosures and protecting whistleblowers. It is more consistent with the recommendations of the Parliamentary Crime and Misconduct Committee and my proposal that my Office receive PIDs concerning serious maladministration.

Under the model operating in Victoria and Tasmania, if an agency proposes to:

- accept a disclosure as a PID, it must refer the disclosure to the Ombudsman who may investigate it or refer it back to the agency for investigation
- decline a disclosure on the basis that it is not a PID, or having investigated a matter as a disclosure decline to take any action in respect of it, the agency must notify the person who made the disclosure of his or her right to have the matter referred to the Ombudsman for review.

In this way, consistency is achieved in both the identification and investigation of disclosures.

The other recent Act (the Western Australian *Public Interest Disclosures Act 2003*) is similar to the Victorian and Tasmanian legislation in principle in that it seeks to produce consistency in the handling of PIDs. In particular it provides that the Commissioner for Public Sector Standards must:

- establish a code setting out minimum standards of conduct and integrity to be complied with by a person to whom a disclosure of public interest information may be made; and
- prepare guidelines on internal procedures for agencies to observe, with an Annual Report to Parliament on non-compliance.

As such it can be seen that the modern trend in this area is to go beyond an individual agency approach and to provide some degree of centralisation, to ensure that:

- agencies are appropriately administering their responsibilities under the Act so that the purposes of the Act are not defeated by misinterpretations, inconsistent approaches, inadequate investigations or lack of commitment; and
- this can be verified with much more confidence than is currently possible, without significant expense or delay and without creating another accountability agency.

3.1 New South Wales

The New South Wales model is similar to that in Queensland. The objective of the *Protected Disclosures Act 1994* NSW is to encourage and facilitate the disclosure, in the public interest, of corrupt conduct, maladministration and serious and substantial waste in the public sector by:

- enhancing procedures for making disclosures;
- providing for disclosures to be properly investigated and dealt with; and
- protecting persons from reprisals for making disclosures[13].

To be protected by this Act, a disclosure must be made by a public official to:

- an investigating authority;
- the principal officer of a public authority;
- another officer of the public authority to which the public official belongs or an officer of the public authority to which the disclosure relates, provided that it is in accordance with the authority's procedure established for this purpose; or
- in certain circumstances[14] to a member of Parliament or a journalist[15].

An investigating authority includes the Ombudsman[16].

Conduct is of a kind that amounts to maladministration if it involves action or inaction of a serious nature that is:

- contrary to law, or
- unreasonable, unjust, oppressive or improperly discriminatory, or
- based wholly or partly on improper motives[17].

Where a public official chooses to make a disclosure to the Ombudsman about conduct amounting to maladministration, to be protected by the Act, a disclosure to the Ombudsman is to be made in accordance with the *Ombudsman Act 1974* NSW, and the conduct is to be of a kind that amounts to maladministration[18].

The New South Wales Ombudsman has produced *Protected Disclosures Guidelines* (5th Edition May 2004) to give practical guidance to public officials who are charged with the responsibility for implementing the Act to assist them to meet management obligations.

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[13] s.3(1)
[14] s.19
[15] s.8
[16] s.4
[17] s.11(1)
[18] s.11(1)

The Ombudsman's primary roles in relation to protected disclosures involve dealing with disclosures about maladministration by public authorities or officials; and the implementation of the *Protected Disclosures Act 1994.*

An example of an agency that has put in place relevant procedures to assist in the implementation of this Act is New South Wales Health, which has developed a *Protected Disclosures Policy.*

The purpose of this policy is to set out procedures that will encourage and facilitate the disclosure, in the public interest, of possible corrupt conduct, maladministration, and serious and substantial waste in the public sector. The procedures are provided to staff to publicise and enhance the reporting processes to ensure that any disclosures are managed appropriately in accordance with the provisions of the Act. The policy also sets out the responsibilities of principal officers, managers and staff. For example, principal officers are responsible and accountable for, amongst other things:

> *"Leading by example to create an organisational culture that gives a clear message that making disclosures is encouraged and valued and corruption, maladministration and serious and substantial waste is not acceptable."* (page 15)

The policy describes how to lodge a complaint/protected disclosure to an officer within New South Wales Health or, if the public official wishes, to an external investigating authority – which for issues relating to maladministration is the Ombudsman (page 13).

The New South Wales Legislative Council Report 17 *Complaints handling within NSW Health* (June 2004) arose out of serious allegations about inadequate patient care at Campbelltown and Camden Hospitals, and followed an investigation by the Health Care Complaints Commission (9 December 2003). There were also several other related investigations including the Special Commission of Inquiry into Campbelltown and Camden Hospitals (30 July 2004).

In the context of analysing systemic issues relevant to complaint handling in the health system, the New South Wales Legislative Council Report found that the events which followed the making of complaints by staff *"resulted in enormous collateral damage to staff"* (page 46). Yet, the Report found that *"one of the most important 'cultural' issues raised by this inquiry is the need to encourage health professionals to report adverse events"* (page 46).

For these reasons the New South Wales Legislative Council Report said that *"finding ways to ensure health professionals are able to use formal channels for incident reporting, and therefore do not have to resort to whistleblowing, is an important challenge for this inquiry"* (page 46).

Nevertheless these findings give weight to arguments for the strengthening of the existing system for PIDs.

3.2 Victoria/Tasmania

Another model has been put in place by more recent similar legislation in Victoria (*Whistleblowers Protection Act 2001*) and Tasmania (*Public Interest Disclosures Act 2002*).

Under this model the Ombudsman's functions include:

- determining whether disclosures are PIDs;
- investigation of matters disclosed in PIDs;
- publishing guidelines to be followed by public bodies; and
- monitoring investigations by public bodies.
  (Vic s.38; Tas s.38)

The purpose of these Acts is to encourage and facilitate disclosures of improper conduct by public officers and public bodies, to protect persons making those disclosures and others from reprisals, and to provide for matters disclosed to be properly investigated and dealt with.

A person (public officer in Victoria) who believes on reasonable grounds that a public officer or public body has engaged in *improper conduct*, may disclose that improper conduct to the Ombudsman or the relevant public body. (Vic ss.5,6; Tas ss.6,7)

Improper conduct is defined as:

(a) corrupt conduct; or
(b) a substantial mismanagement of public resources; or
(c) conduct involving substantial risk to public health or safety; or
(d) conduct involving substantial risk to the environment –
that would, if proved, constitute –
(e) a criminal offence; or
(f) reasonable grounds for dismissing or dispensing with, or otherwise terminating, the services of a public officer who was, or is, engaged in that conduct. (Vic s.3; Tas s.3)

Disclosures under the Acts may also be made about detrimental action against a person in reprisal for a protected disclosure. (Vic ss.5,18; Tas ss.6,19)

In these jurisdictions, if a person makes a disclosure to a public body, the public body must conclude/determine whether the disclosure is a PID. (Vic s.28; Tas s.33)

In Victoria, if the public body concludes that a disclosure is a PID, the public body must notify the person who made the disclosure, and refer the disclosure to the Ombudsman for a determination as to whether it is a PID. (Vic s.29)

In Tasmania, if the public body determines that a disclosure is a PID, the public body must notify the person who made the disclosure, and notify the Ombudsman. (Tas s.34)

If the public body concludes/determines that a disclosure is not a PID, the public body must advise the person who made the disclosure that he or she may request the

public body to refer the disclosure to the Ombudsman for a determination as to whether it is a PID. (Vic s.30; Tas s.35)

Guidelines to assist agencies to comply with the legislation have been prepared by the Ombudsman in Victoria (*Whistleblowers Protection Act 2001, Ombudsman's Guidelines,* November 2001) and Tasmania (*Public Interest Disclosures Act 2002, Ombudsman's Guidelines,* November 2003).

The Ombudsman has a central role in handling disclosures of improper conduct made under these Acts. The role of the Ombudsman, as set out in the guidelines, involves:

- preparing and publishing guidelines to assist public bodies in interpreting and complying with the Act
- reviewing written procedures established by public bodies and making recommendations in relation to those procedures
- determining whether a disclosure warrants investigation
- investigating disclosures
- monitoring investigations where they have been referred to public bodies
- monitoring the action taken by public bodies where the findings of an investigation reveal that improper conduct has occurred
- reporting to Parliament where public bodies fail to implement recommendations made by the Ombudsman at the conclusion of an investigation
- collating and publishing statistics about disclosures handled by the Ombudsman
- educating and training public bodies.

(Vic p.5; Tas p.5)

It is recognised that the jurisdictional environment in which this model operates in Victoria and Tasmania is dissimilar to Queensland in a number of respects. In particular those States do not have a body equivalent to the CMC; and the definition of whistleblowing, or PID, is confined to what would be regarded essentially as official misconduct in Queensland (that is, conduct which if established would amount to a criminal offence or grounds for dismissal).

4. Research Project: "Whistling While They Work" Project – Griffith University

Whistling While They Work: Enhancing the theory and practice of internal witness management in public sector organisations is a three year (2005-2007) collaborative national research project being led by Griffith University and jointly funded by the Australian Research Council, five participating universities, and 12 industry partners. In Queensland the industry partners are the CMC, the Queensland Ombudsman and the OPSME.

The project will use the experience and perceptions of internal witnesses and first and second level managers to identify and promote current best practice in workplace responses to public interest whistleblowing, including strategies for preventing, reducing and addressing reprisals and other whistleblowing-related conflicts.

5. Proposed Model

Despite the jurisdictional differences that operate in Victoria and Tasmania, it is submitted that the essential features of the Victorian and Tasmanian model should be adopted in Queensland for the purpose of giving the Queensland Ombudsman supervisory jurisdiction over disclosures of serious maladministration to complement the CMC's supervisory jurisdiction over disclosures that may involve official misconduct.

Under the proposed model, agencies would have an obligation to refer to the Ombudsman all PIDs that involve serious maladministration but do not amount to official misconduct. The Ombudsman would:

- investigate the disclosure; or
- refer the disclosure back to the relevant agency (or another complaints entity with appropriate expertise) and supervise, monitor or review its investigation (as the CMC does in relation to official misconduct allegations); or
- refer a disclosure not amounting to maladministration back to the relevant agency or appropriate investigative body.

This would mean that two agencies, the CMC and the Ombudsman, would have responsibility for ensuring consistency across the full range of possible serious disclosures, working in a coordinated way through an interagency committee.

This would assist significantly in achieving consistency in application of the WPA and the conduct of investigations across the public sector.

In addition to the Ombudsman's Office conducting investigations itself, and supervising and reviewing individual agency investigations, the Ombudsman could periodically audit investigations by agencies of PIDs to identify any systemic deficiencies in the way such matters are being handled.

The Ombudsman's Office and the CMC could also advise and assist:

- agencies regarding the protection of whistleblowers; and
- existing and potential whistleblowers in relation to their rights, obligations and protections.

The roles for the Ombudsman and CMC referred to above are consistent with their existing statutory responsibilities. However, a better system is needed for assisting whistleblowers, and coordinating and monitoring the responses of agencies to PIDs, as recommended by the Parliamentary Crime and Misconduct Committee.

As mentioned earlier, disclosures of serious maladministration relating to clinical/patient care issues could be referred for investigation by another complaints entity with appropriate expertise (for example, a remodelled HRC, as recommended in Part 2 of this submission) with the Ombudsman monitoring, or reviewing the outcome of, the investigations.

Some additional resources would be necessary for the Ombudsman's Office to take on this role.

If these proposals work as intended, complaints of the kind made by staff of Bundaberg Hospital to their managers about Dr Patel, should be identified as complaints of serious maladministration, and referred to the Ombudsman. The Ombudsman would then decide whether to investigate the complaint, or refer it back to the agency or another complaints entity for investigation, while monitoring the timeliness and adequacy of the investigation, and reviewing its outcomes.

These proposals strike an appropriate balance between ensuring that agency managers accept responsibility for taking the necessary steps to identify and rectify maladministration in their agencies, and providing for independent external oversight of the system. The ability of the Ombudsman to monitor investigations in the health sector would also enable independent identification and analysis of any significant trends.

This additional safeguard should make it unnecessary to tamper extensively with the delicate balances that have been struck in the WPA to reconcile competing interests such as:

(a) the interest of the public in the exposure, investigation and correction of illegal or improper conduct, and dangers to public health and safety;
(b) the interest of the whistleblower in being protected from retaliation by the persons or organisation whose illegal or improper conduct has been reported, and in seeing that proper action is taken on the PID;
(c) the interests of persons against whom allegations are made which turn out to be inaccurate, or (worse still) against whom false or misleading allegations are made. Such persons are liable to suffer not only damage to their personal and/or professional reputations, but also the stress (and perhaps, expense) of being subject to investigation;
(d) the interests of an organisation affected by a PID in not having its operations unduly disrupted, causing unwarranted interference with its pursuit of its business or administrative goals. (The word "unwarranted" is a key qualification here. The interests of an employer in preventing destabilising and disruptive behaviour in an organisation cannot be regarded as an absolute value – especially where there is substance to allegations of corruption or serious maladministration); and
(e) the need to ensure that a system of whistleblower protection has safeguards against abuse by persons whose purported whistleblowing seeks only to further their own interests (for example, speculative allegations in order to claim protection from adverse personnel action that may have been justified on other grounds) rather than any genuine public interest.

Most whistleblower protection statutes provide, in effect, that the interests of the public in learning about allegations of illegal or improper conduct, or of dangers to public health and safety, must defer to the rights of a person or organisation accused of illegal or improper conduct to have their reputations protected from adverse publicity, until such time as the allegations are substantiated after investigation by a proper authority.

However, there is arguably scope for expansion of the categories of protected disclosure under the WPA, to more closely accord with the recommendations made by

the Electoral and Administrative Review Commission (EARC) in its "Report on Protection of Whistleblowers" (No 91/R4, October 1991) at paragraphs 5.67 to 5.82.

The Bundaberg Hospital experience indicates that it may be preferable that:

(a) any person (not just a public officer) should be entitled to obtain protection for disclosing to a proper authority a substantial and specific danger to public health and safety (thus protecting patients or their family members from reprisals such as defamation proceedings, or withdrawal of access to health services, for a disclosure made to QH, a Minister, the HRC, the Medical Board of Queensland (MBQ), etc); and
(b) any person should be entitled to obtain protection for a disclosure made (with an honest belief, based on reasonable grounds, in the accuracy of the information) to any person (including a journalist/media organisation) of information showing a serious, specific and immediate danger to the health or safety of the public (*cf.* clause 13 of EARC's recommended Whistleblowers Protection Bill).

Had such protections been available at the time concerns were emerging at Bundaberg Hospital about Dr Patel's surgical outcomes, more individuals may have come forward thereby increasing the pressure for remedial action.

PART 2: Issues relating to health complaints systems

1. Introduction

1.1 Purpose

The purpose of this submission is to:

- provide an overview of the current health complaints system in Queensland;
- identify deficiencies in the system and, by way of example, provide a case study of a complaint about the inefficiencies of the current system;
- review health complaint systems in other jurisdictions; and
- make recommendations for an enhanced system in Queensland.

There are two main aspects to the current health complaints system, namely, internal complaints management and external complaints management. This submission addresses both aspects.

Currently, there are three external bodies (other than the practitioner registration boards) that investigate health complaints in Queensland. They are:

- The HRC
- The Queensland Ombudsman
- The CMC.

1.2 Role of the Health Rights Commission

The HRC was established by the *Health Rights Commission Act 1991* (HRCA) in early 1992 as a specialist agency to provide the Queensland public with an independent and impartial means of reviewing, resolving and/or investigating health service complaints.

According to its mission statement, the HRC aims to provide *"an independent, impartial and collaborative health complaints system designed to improve health care services and promote health rights and responsibilities in Queensland."*

The principal responsibilities of the HRC are the receipt and assessment of complaints about a health service provider (HSP) and the resolution of disputes through conciliation. The HRC encourages the local resolution of all complaints consistent with the requirement in the HRCA that the complainant has taken all reasonable steps to resolve the complaint with the provider[19].

Complaints to the HRC are dealt with in one or more of the following stages:

- Intake;
- Assessment;
- Conciliation;
- Investigation.

All services provided by the HRC are free.

[19] s.71(2)

In addition to providing an independent and impartial avenue for resolving complaints, the HRC is able to recommend improvements to health practices and procedures based on information obtained from complaints and work collaboratively with HSPs to assist them to improve their own complaint resolution strategies.

According to its Annual Report for 2003-2004, the HRC received 4,281 complaints. I have been informed by staff of the HRC that approximately 64% of all complaints received by the HRC relate to private sector HSPs. In its second submission to the BHCI (at p.3, footnote 3), the HRC stated that complaints against public hospitals account for only 19% of complaints made to the HRC, with those against QH as a whole in the vicinity of 27%. Other public sector providers (for example, ambulance services, aboriginal health services, corrections health services) account for approximately 9%.

1.3 Role of the Queensland Ombudsman

The Ombudsman is an officer of the Parliament[20] empowered to deal with complaints about the administrative actions of Queensland government departments and public authorities, and local governments.

Under the Ombudsman Act, I have authority to:

- investigate maladministration by public sector agencies, in response to complaints, although I can also investigate on my own initiative;
- make recommendations to an agency being investigated about ways of rectifying the effects of its maladministration and improving its practices and procedures;
- consider the administrative practices of agencies generally and make recommendations, or provide information or other assistance, to improve practices and procedures.

If I consider that an agency's actions involve maladministration, I may provide a formal report to the principal officer of the agency. In my report, I may make recommendations to rectify the specific maladministration or to improve the agency's policies, practices or procedures with a view to minimising the prospect of problems recurring. In almost every case, the recommendations are implemented, making the Ombudsman's Office an effective mechanism to improve the standards of administrative practice for the ongoing benefit of the Queensland community.

I may cause a report to be tabled in Parliament:

- if the issues investigated are of significant public interest; or
- if my recommendations to the agency's principal officer are not implemented.

The Ombudsman can investigate administrative actions of an agency[21], including Queensland agencies that provide health services, deal with complaints about the provision of health services, and regulate the health service professions.

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[20] s.11(2) of the *Ombudsman Act 2001*

[21] as defined in ss.8 and 9 of the *Ombudsman Act 2001*

However, the Ombudsman is expected to liaise with other complaints entities to avoid inappropriate duplication of investigative activity[22] and would not ordinarily accept an initial complaint about the provision of a health service if the complaint more appropriately fell within the jurisdiction of the HRC, the MBQ (or another registration board), or the Queensland Nursing Council (the QNC).

Furthermore, in most cases, we will not accept a complaint unless the complainant has tried to resolve it with the agency which is the subject of the complaint.

In the 2004/2005 financial year, my Office received 339 health related complaints. Of those:

- 256 related to QH;
- 50 related to the HRC;
- 33 related to a registration board or the QNC.

In accordance with our normal practice in relation to QH complaints, many of the 256 complaints received (126) were referred to QH for internal review, while an additional 37 complaints were referred to the HRC or to the relevant registration board.

The Ombudsman received no complaints about medical services at Bundaberg Hospital, or about maladministration by health agencies in dealing with complaints about medical services at Bundaberg Hospital.

Complaints Management Project

Since March 2003, my Office has been helping public sector agencies (including QH) to improve their systems for managing customer complaints through our Complaints Management Project. The aim of the project has been to assist agencies by evaluating the strengths and weaknesses of their existing complaints management arrangements and identifying potential improvements. As part of this project my Office has also developed and published useful information to help agencies in developing effective complaints management policy and procedures.[23]

One of the principles underpinning the project is the importance of "frontline complaints handling" – that is, the timely resolution of complaints at the local level. Any good complaints management model should focus on resolving the bulk of complaints at the frontline, while also providing for further internal and external review. This principle has also guided the design of the new health complaints model we propose in this submission.

1.4 Role of the CMC

The CMC was established in January 2002 with the merger of the Criminal Justice Commission and the Queensland Crime Commission. The CMC's responsibilities include improving integrity in the Queensland public sector.

Under the *Crime and Misconduct Act 2001*, the CMC also has a responsibility to build the capacity of units of public administration to prevent and deal with cases of

[22] see s.15 of the *Ombudsman Act 2001*
[23] Queensland Ombudsman "Developing Effective Complaints Management Policy and Procedures", March 2004 and supporting Fact Sheets (can be accessed from www.ombudsman.qld.gov.au)

misconduct. The Act stipulates that action to prevent and deal with misconduct in a unit of public administration should generally happen in the unit.

Therefore most complaints are referred back to the agency concerned for investigation. As a result, senior management throughout the public sector are required to take responsibility for nurturing an integrity culture within their organisations.

The CMC continues to conduct or manage misconduct investigations where complaints involve complex, sensitive or serious allegations, or may require the use of CMC powers. It can also monitor, issue directions about, review and audit investigations conducted by a public official.

In the last financial year, the CMC received 231 complaints relating to QH. Of these matters, 13 were retained by the CMC for investigation, 172 matters were returned to QH to deal with and no further action was taken on 46 complaints.

2. A case study of a major investigation by the Ombudsman concerning a health related complaint – the Neville complaint

To demonstrate the deficiencies and inefficiency of the current health complaint system in Queensland and the consequential frustration for complainants, we present as a case study details of our investigation of a complaint made to us by Dr Gerard Neville and Mrs Lorraine Neville.

2.1 Background to the complaint

The Nevilles' complaint relates to events that occurred on 7 January 2002 after their daughter, Elise, aged 10, fell from the top of a bunk bed in a holiday unit at Caloundra, suffering a blow to the head.

After Elise's fall, at approximately 3.25am, the complainants rushed her to the Emergency Department at the Caloundra Hospital (CH). Elise was assessed by a registered nurse and the medical officer on duty at the time and sent back to the unit with her parents.

Elise's condition deteriorated and, at approximately 7.25am, she was transported in an unconscious state back to CH by ambulance. Elise was prepared for evacuation, and at approximately 9.40am she was transferred by helicopter to the Royal Children's Hospital (RCH) in Brisbane where she underwent emergency surgery.

On 9 January 2002, Elise died without regaining consciousness.

2.2 Summary of complaints

Shortly following Elise's death, the Nevilles lodged formal complaints with QH, HRC, MBQ and the QNC concerning the standard of care provided to Elise by nursing staff and the medical officer on duty, at the time of Elise's first and second presentations at CH. Their allegations included:

- unprofessional conduct;
- delay in providing appropriate treatment at the second presentation; and
- delay in transferring Elise to the RCH.

The Nevilles also raised concerns about a "Preliminary Investigation Report" into the circumstances of Elise's death prepared by the then Executive Director of Medical Services (Executive Director), Sunshine Coast Health Service District (SCHSD), as detailed below.

2.3 Responses by QH, HRC, MBQ & QNC to complaints

2.3.1 Response by QH

After the then Director-General of QH, Dr Robert Stable, was informed of Elise's death on 9 January 2002, he contacted the Executive Director, and asked that he "find out what happened in this matter and send a brief preliminary report to him (Dr Stable) as

soon as possible." The Executive Director furnished a report to Dr Stable on 11 January 2002, expressing his opinion that Elise's early management had been "reasonable".

Following receipt of the Nevilles' original letter of complaint dated 7 February 2002, Dr Stable provided them with a copy of the Executive Director's report together with copies of medical and departmental documents relevant to Elise's presentations to CH.

The Nevilles considered that these documents did not address their concerns but rather reinforced their legitimacy. In addition, they believed the Executive Director's report was "inept" and contained "deliberately false and misleading information" (allegations which, if proven, could amount to official misconduct).

The Nevilles outlined all their concerns in a 21 page letter to Dr Stable and sought a full investigation. Dr Stable's response was to advise the Nevilles that, given the HRC, MBQ, QNC and the State Coroner were likely to conduct their own investigations into the Nevilles' complaints, he did not propose to undertake any investigation until the outcomes of those independent inquiries were known.

In December 2003, the Nevilles brought their still unresolved concerns to the attention of Dr Steve Buckland, the then Acting Director-General of QH. Dr Buckland agreed to commission Professor Bryant Stokes (an experienced neurologist from Western Australia) to conduct an independent review of QH's response to the Nevilles' complaint, including the Executive Director's report.

The "Terms of Reference" provided to Professor Stokes were:

1. To review the management of children who present with head injuries at CH, including the adequacy of the systems and processes used by the hospital upon such presentation.
2. To examine the appropriateness of the Executive Director's report (including clinical and non-clinical components) and concerns raised by Dr Gerard Neville and Mrs Lorraine Neville.
3. To examine the appropriateness of Queensland Health's response to concerns raised by Dr Gerard and Mrs Lorraine Neville in respect of the management of their daughter Elise at CH when presenting with head injuries on 7 January 2002.
4. To make recommendations in relation to the above, including, if appropriate, improvements to the system and processes at CH.
5. Final report to be completed by 19 May 2004.

Professor Stokes presented his ten page report to Dr Buckland in early June 2004. His findings and recommendations can be found in Appendix 2. A copy of his report was provided to the Nevilles for comment.

While the Nevilles noted that Professor Stokes had made a number of significant adverse findings and recommendations, they did not consider that he had adequately addressed terms of reference 2 and 3; in particular, that he failed to consider the accuracy of the Executive Director's report.

The Nevilles raised these concerns at a meeting with Dr Buckland on 22 June 2004. The Nevilles have stated that, although Dr Buckland had shared some of their

concerns, he did not consider that there was anything further he could do, other than to forward to Professor Stokes a copy of the Nevilles' letter outlining their concerns with his report.

No further advice has been provided to the Nevilles by QH. In particular, they have not been informed of what actions, if any, QH has taken in respect of the findings and recommendations made by Professor Stokes (or indeed the findings and recommendations made by the HRC, referred to below).

2.3.2 Response by the HRC

On 28 March 2002, the Nevilles lodged a formal complaint with the HRC raising a number of concerns about systemic and individual clinical care issues in relation to the care their daughter received at CH on 7 January 2002, and about the Executive Director's report.

HRC's assessment

On 10 May 2002, the HRC informed the Nevilles that their complaints had been accepted for assessment and summarised the key issues as follows:

1. Care provided to Elise by CH;
2. Care provided by the attending medical officer at CH (referred to in this submission as the Doctor);
3. Care provided by the two registered nurses on duty at the time of Elise's first presentation to CH (referred to in this submission as RN 1 and RN 2);
4. The investigation report by the Executive Director.

HRC's investigation

The HRC completed its assessment of these issues on 8 August 2002 and retained for investigation issues 1 and 4 on the basis that they were "health service complaints" within the scope of s.57 of the HRCA. Because issues 2 and 3 were about a registered medical officer and two registered nurses, the HRC had a statutory obligation to consult with the MBQ and the QNC respectively, to determine whether each body would accept for further action the complaints about its registrants.

The MBQ agreed to accept for investigation the complaint about the medical officer. The QNC agreed to accept for investigation the complaint about one of the registered nurses but not the other.

The HRC directed its inquiries in relation to issues 1 and 4 to the District Manager of the SCHSD. While the SCHSD initially responded to the HRC's inquiries, it subsequently challenged the HRC's jurisdiction to investigate the Nevilles' allegations concerning the Executive Director's report. After seeking its own legal advice from Crown Law, the HRC informed the Nevilles on 16 July 2003 (approximately 15 months after first receiving the complaint), that it did not have jurisdiction to proceed with its investigation concerning the Executive Director's report because the allegations did not relate to an administrative service directly related to a health service.

Approximately six months later, after being informed that the MBQ had also refused to investigate the Nevilles' complaint against the Executive Director, the HRC

approached the Minister for Health (the Minister) to seek approval for it to investigate that complaint[24]. The HRC was informed that Dr Neville had recently met with the Director-General of QH, Dr Steve Buckland, and QH had undertaken to commission an independent review (by Dr Stokes) of its overall response to the Nevilles' complaints, including in respect of the Executive Director's report. In these circumstances, the Minister did not give approval for the HRC to investigate the Nevilles' complaint about the Executive Director's report[25].

HRC investigation report

The HRC provided its investigation report (a three page letter) to the Nevilles on 4 September 2003 (that is, approximately 18 months after having first received their complaint). The report did not include any adverse findings or recommendations. The HRC did note, however, that some changes had been made by the District following Elise's incident which impacted upon the CH. These include:

- Rostering medical staff on a 24 hour basis, rather than an "on call" schedule. The roster was said to ensure a medical officer has not been working continuous long hours should the officer be called during the night;
- Upgrading CH's services to the community as a result of some additional funding being made available to the District.

The HRC provided a copy of its investigation report to the District Manager of CH under a separate letter, which also included some additional comments that were not provided to the Nevilles. These comments related to the lack of medical notes taken on Elise's presentations and the adequacy of information contained on Head Injury Advice forms given to patients.

Complaint about HRC investigation

The Nevilles met with the Health Rights Commissioner (the Commissioner) on 12 September 2003 to inform him of their dissatisfaction with the outcome of the HRC's investigation. In particular, they queried the absence of any adverse findings or recommendations. The Commissioner provided the Nevilles with a copy of the HRC's letter to the District Manager which contained the additional comments. The Nevilles could not understand why these additional comments had not been included in the HRC's report. The Nevilles were not satisfied with the Commissioner's explanation that the comments dealt with minor issues and wrote to him in these terms:

> *"Your letter to* [the District Manager of Caloundra Hospital] *is hardly a "covering letter". It is actually further findings of your investigation and it contains details that are highly critical of Caloundra Hospital. It should have been given to us as a matter of course as we are the complainants in this matter. We are appalled by this double standard...*

[24] Section 3(3) of the HRCA provides that "*The Commissioner may with the written approval of the Minister, decide to treat a decision or action of an officer or employee of the department as if it were a health service.*"

[25] This has been identified as one of the problems with the current jurisdiction of the HRC which is discussed in more detail in section 3.4.3.

We are totally dismayed by what you have done. In fact we are no longer confident that the HRC is an unbiased and independent health complaints agency."

HRC review

Because of the Nevilles' numerous concerns about the adequacy of the HRC's investigation and report, the Commissioner agreed to conduct a review. On 28 June 2004, some nine months later, the Commissioner completed his review and issued a subsequent report. This 20 page report bore little resemblance to the HRC's earlier report. The Commissioner emphasised in his revised report that some of the issues raised by the Nevilles were intrinsically very difficult, and the HRC's re-examination of those issues had led to different conclusions. The Commissioner concluded that :

"Elise's tragic death has highlighted significant systemic issues at Caloundra Hospital".

Upon reconsideration of the "admission issue", the Commissioner concluded that, while there was not a formal policy of "Non- Admission of Children" in existence at the time of Elise's presentation, the word "policy" can be taken to denote not only a formally documented guideline or requirement, but also a common practice or a "culture" of behaviour. On that basis he held a serious concern that there appeared to be an informal understanding among at least some of the staff at CH, reinforced by common practice, that children were not to be admitted but were to be referred to the larger and better equipped Nambour Hospital if requiring additional treatment or admission. This concern was further supported by a memorandum from the then General Manager (Health Services), QH, to the District Manager of CH in which the General Manager specifically stated that he could not accept the continuation of the *"existing practice"* regarding the admission of children.

The Commissioner made a number of recommendations including:

1. QH investigate the introduction of an accredited course that would assist staff in smaller hospitals to be proficient in the current practices of emergency care of children as well as a process of specialist clinical oversight and review.
2. QH undertake periodic auditing to monitor the effectiveness of the changes already introduced at CH to ensure the changes are both effective and sustainable.
3. As a matter of urgency, the District Manager review the comments made by the Commissioner about the culture at CH and initiate appropriate action to bring about sustainable changes, so that there is no doubt in anyone's mind as to the level of care that can and should be afforded to children at CH. Senior management of QH should monitor the review.

2.3.3 Response by the MBQ

On 10 April 2002, the MBQ received a written complaint from the Nevilles about the actions of:

- the Doctor; and
- the Executive Director.

The MBQ considered the complaint at its next meeting with the HRC on 17 April 2002 and it was agreed that the complaint would be retained by the HRC for assessment. Upon finalisation of the assessment by the HRC, the MBQ met again with the HRC on 7 August 2002, and agreed to accept for investigation the complaint about the Doctor. At that stage, the HRC had retained for investigation the complaint about the Executive Director.

Investigation by MBQ

On 27 August 2002, the MBQ appointed an investigator from the Office of the Health Practitioner Registration Boards (OHPRB) to carry out the investigation. The OHPRB is responsible for carrying out investigations on behalf of the individual health practitioner registration boards. The Nevilles have advised that they were informed by the OHPRB that its investigation would take approximately six months.

The Nevilles initially approached the MBQ seeking interim action against the Doctor pending the outcome of the investigation into his conduct. However, the MBQ considered there was insufficient evidence to warrant suspending the Doctor or imposing any conditions on his registration pending the outcome of its investigation.

The Nevilles, relying on medical evidence that their daughter had died from a fully treatable injury, were disappointed by the MBQ's decision and sought a review. In support of their request for a review, they submitted an independent medical opinion prepared at their request by a Neurosurgeon that was very critical of the Doctor's management and concluded:

> *"In a responsible medical system, such as we enjoy, with such access to hospitals of ascending levels of sophistication, it is tragic and unacceptable that an event such as this should occur."*

Six months later, the MBQ advised the Nevilles that it had decided to reaffirm its earlier decision not to take any interim action against the Doctor.

After repeated complaints by the Nevilles as to the delay in the OHPRB completing its investigation, on 24 June 2003 the OHPRB appointed an external investigator to conduct the investigation. The Nevilles state that, at this point, it became evident to them that very little active investigation had taken place up to that time. The external investigator completed the investigation within six months and provided a draft investigation report to the MBQ for its consideration.

On 20 January 2004, approximately 17 months after receiving the complaint for investigation, the Board provided the Nevilles with a copy of the final investigation report. The finding of the MBQ was that:

> *"there is sufficient evidence to conclude that [the Doctor's] management of Elise Neville at her first presentation to Caloundra Hospital on 7 January 2002, constitutes unsatisfactory professional conduct."*

The MBQ referred the matter to the Health Practitioners Tribunal (the Tribunal) for hearing. On 8 November 2004, the Tribunal accepted a guilty plea by the Doctor and imposed a number of conditions/sanctions on his registration.

2.3.4 Response by the QNC

The QNC received a copy of the Nevilles' complaint on 11 April 2002.

In August 2002, following assessment by the HRC, the complaint about the two registered nurses (RNs) was referred to the QNC for action. The QNC accepted for investigation the complaint about RN 1 but declined the complaint about RN 2. The complaint about RN 1 alleged that she:

- displayed an uncaring attitude and unprofessional manner;
- failed to complete an appropriate triage assessment; and
- fabricated observations and recorded incorrect and misleading information on triage documentation.

An investigator was appointed by the QNC on 6 September 2002 to carry out an investigation. On 27 November 2003, the investigator completed the investigation and issued her report. In summary, the investigator found sufficient evidence to warrant a finding that there were concerns regarding the nurse's competence. The report also raised concerns about the conduct of RN 2.

The QNC sought legal advice, and the advice of a specialist in emergency medicine, in relation to the investigator's findings. After considering this further advice, the QNC resolved on 5 March 2004 to:

- await any inquiry/inquest by the Coroner before making a determination as to what action, if any, should be taken against RN 1; and
- initiate an investigation in relation to RN 2.

In a statement to this Office dated 21 June 2005 the Executive Officer of the QNC explained that the first recommendation was consistent with its previous practice in order to ensure that procedural fairness is accorded to nurses facing disciplinary action.

The QNC asserted that:

- if disciplinary action were to be instigated by the QNC prior to a coronial inquiry, a nurse's right to refuse to answer questions at a coronial inquest on the grounds of self-incrimination could be prejudiced; and
- if the QNC were to prefer a charge prior to a coronial inquest, a nurse would be at liberty to seek a stay of those proceedings from the Nursing Tribunal pending the outcome of that inquest.

On 19 March 2004, the QNC initiated an investigation into the conduct of RN 2. The investigator completed her report in July 2004 reaching the following opinion:

> *"The nurse, with her level of experience and knowledge, should have enquired further regarding the doctor's question and provided the doctor with additional options."*

While the investigator found the allegation was substantiated, she did not consider that RN 2's conduct amounted to discreditable conduct.

Action following investigation

Following finalisation of the investigation of the conduct of RN 2, the QNC sought the advice of senior counsel as to whether there was sufficient evidence to prefer a charge of gross negligence, malpractice or conduct discreditable to a registered nurse against RN 1 or RN 2.

After considering senior counsel's advice, and subsequent recommendations by the Professional Standards Committee (an advisory committee of the QNC), the QNC decided that it held concerns regarding RN 1's knowledge of triage assessment and functioning as a member of a multidisciplinary team. The QNC decided that, before preferring a charge against RN 1, it would convene a pre-charge "without prejudice" meeting to attempt to resolve the concerns raised by the Nevilles. This course of action was in accordance with QNC policy. As no formal disciplinary action was to be taken, the QNC believed it could proceed prior to the coronial inquest without potentially prejudicing the nurse's rights.

With regard to RN 2, the QNC did not consider there was sufficient evidence to warrant taking any disciplinary action. However, in a letter informing her of its decision, the QNC took the opportunity to remind RN 2 of her obligations as a nurse operating in a multidisciplinary team, as well as the importance of practising as a nurse in a manner that could not lead a reasonable person to form the view that she lacked empathy or was uninterested.

The Nevilles provided the QNC with a detailed submission dated 23 September 2004 outlining their concerns about the failure to take disciplinary action against RNs 1 and 2. The Nevilles reminded the QNC that the investigation reports supported their belief that the actions of the nurses had contributed to Elise's death. The matter was re-considered by the QNC at its October 2004 monthly meeting, where it reaffirmed its earlier decision not to take any disciplinary action against RN 2. It refrained from making any decision about RN 1 until it had sought further legal advice concerning some of the issues raised by the Nevilles' latest submission.

After a meeting with the Nevilles on 5 October 2004 to further discuss their concerns, the QNC wrote to RN 1 seeking a statutory declaration from her (by 17 November 2004) addressing a number of issues, in particular her triage assessment of Elise and a description of the steps she undertook to make the various assessments which she relied on in determining the Glascow Coma Scale (GCS)[26]. The Nevilles believed this information should have been obtained during the investigation and was relevant to determining what disciplinary action was justified.

RN 1's statutory declaration was not received by the QNC until May 2005 (some seven months after being requested). At the time of writing this submission, the matter is yet to be resolved by the QNC. Accordingly, 18 months after the investigation was completed, the Nevilles still do not know what disciplinary action is to be taken against RN 1.

[26] A standard test for head trauma patients.

2.4 The Nevilles' complaint to the Ombudsman

Following a meeting with an Assistant Ombudsman to discuss their complaint, on 24 December 2003 the Nevilles provided my Office with a brief covering letter and four A4 folders of documents in relation to their complaint. A detailed analysis of that material revealed a number of serious concerns raised by the complaint. Therefore, in accordance with s.22 of the Ombudsman Act, I commenced a preliminary inquiry into the Nevilles' complaint to determine whether my Office should investigate.

The complaint raised numerous concerns about the actions and decisions of various government agencies responsible for investigating the health services provided to Elise (namely, QH, HRC, MBQ and QNC).

2.4.1 Principal allegations about QH, HRC, MBQ and QNC

- The current health complaints system in Queensland is inadequate and inaccessible to the majority of complainants.
- Lengthy delays in the investigation and resolution of the Nevilles' complaints about the Doctor and RNs 1 & 2.

2.4.2 Principal allegations about QH

- Unreasonable refusal by the former Director-General (Dr Rob Stable) to carry out a full internal investigation into the circumstances surrounding Elise's death;
- Failure by QH to take action to suspend the Doctor and RNs 1 & 2 from duty, or limit their duties, pending the outcome of external investigations by their registrant boards.
- The Executive Director's report into the incident was false and misleading.
- The external investigation conducted by Professor Stokes (commissioned by the then Director-General of QH, Dr Steve Buckland, in early 2004) failed to adequately address its limited terms of reference.
- The medical retrieval process is inadequate.

2.4.3 Principal allegations about the HRC

- There was a 15 month delay in the HRC determining that it did not have jurisdiction to investigate the Nevilles' complaint about the Executive Director.
- There was a lengthy delay in the investigation process by the HRC.
- The HRC's initial investigation and report (dated 4 September 2003) into the Nevilles' complaint against CH was grossly inadequate in that:
    - it failed to cover all issues raised in the complaint;
    - many of the investigation findings were not supported by the facts;
    - no recommendations were made in the report for future improvements;
    - the HRC provided to the Nevilles a different version of the report findings from those sent to QH ;
    - the HRC failed to allow the Nevilles an opportunity to comment on the initial report prior to its release.

2.4.4 Principal allegations about the MBQ

- Delay in advancing and completing its investigation.
- Refusal to take any interim action to suspend, or impose interim restrictions on, the Doctor's registration pending the outcome of its investigation into his conduct.
- The MBQ's refusal to investigate the Nevilles' complaint against the Executive Director was unreasonable.

2.4.5 Principal allegations about the QNC

- Lengthy delays in the investigation of the complaints against RNs 1 & 2 and in the QNC making a decision as to what, if any, disciplinary action was to be taken against either or both RNs.
- Lengthy delay in finalising a review of its decision as to the disciplinary action to be taken against RN 1.
- Failure by the QNC to take appropriate disciplinary action against either RN.
- Failure to adequately investigate the Nevilles' allegation that RN 1 "fabricated observations and recorded incorrect and misleading information on triage documentation".

2.5 Ombudsman's investigation of the Neville complaint

The focus of our inquiry has been to review the administrative actions taken by each of the agencies in response to the complaints by the Nevilles. As a result of our preliminary inquiry we resolved to investigate the following:

- the adequacy of QH's response to the Nevilles' complaint;
- the adequacy of the current health complaint mechanisms in Queensland, and what changes should be made to provide a more efficient health complaints system;
- the health complaint mechanisms in other jurisdictions, to determine if there is a best practice model.

Our investigation is nearing completion and has identified a number of systemic issues of significant public interest. These include:

- unsafe working hours for doctors;
- a junior doctor being left in charge of an Emergency Department without adequate supervision and without appropriate clinical protocols;
- inadequate response by QH to an adverse event (for example, no internal investigation undertaken or "Open Disclosure" provided to the Nevilles);
- inadequate safety regulations in respect of bunk beds.

However, the focus of this submission will be on the research undertaken with a view to recommending a more efficient health complaints system for Queensland.

2.6 Issues raised relating to the health complaints system

2.6.1 Adequacy of response by QH, as the health service provider, to a complaint about an adverse event

The Nevilles raised their concerns about the treatment provided to Elise in a letter to the then Director-General of QH, Dr Rob Stable, on 7 February 2002 (approximately one month after Elise's incident). In particular, the Nevilles sought that the Director-General *"carefully investigate the culture of that (Caloundra) hospital.."* and *"investigate the events fully and independently of Caloundra Hospital and the Health Service District, and...take appropriate action"*.

In Dr Stable's response (on 11 April 2002) to the Nevilles, he stated:

> *"I understand that you intend to make formal complaints to the relevant registration bodies and the Health Rights Commission in relation to the health providers involved in the treatment of Elise on 7 January this year. Given that these bodies are likely to conduct investigations and that the matter is also in the hands of the Coroner, I do not propose to undertake any further investigations until the outcome of these independent inquiries become known."*

In considering the appropriateness of Dr Stable's decision not to investigate the Nevilles' complaints, the following factors should be considered:

- the complaints related to a significant adverse event[27]; and
- they raised a number of systemic issues, including an allegation that a culture of "non-care of children" existed at CH. In particular, this referred to an alleged "policy" that children could not be admitted to CH;
- they raised a number of concerns about the adequacy of the provision of health services by CH.

QH has since advised that, at the time of Elise's incident, it did not have an endorsed State-wide approach to adverse events or incident management. As mentioned previously, it was not until June 2004 that QH introduced its Incident Management Policy. Even so, having regard to the gravity of the concerns raised by the Nevilles about a culture of "non care of children" existing at CH, QH's decision not to conduct its own investigation is open to question.

In a letter to me dated 20 June 2005, the former Director-General of QH, Dr Steve Buckland, advised that:

> *"Queensland Health's consistently stated response to the incident has been to participate and assist, to the fullest extent reasonable, the various independent inquiries. The outcome of those independent inquiries has, from an early time, always been intended to guide where necessary an appropriate departmental response."*

[27] An "adverse event" is defined by the Australian Council for Safety and Quality in Healthcare as "An incident in which harm resulted to a person receiving health care."

However, Dr Buckland added that *"... The response of Queensland Health to the incident ... should not be taken as indicating that I consider that the Department's response/s to the incident was optimal".*

This view was shared by Professor Stokes (the independent external investigator appointed by Dr Buckland in April 2004 to investigate certain aspects of the Nevilles' complaint), who made these findings in his report of June 2004:

- *"Sadly QH has never conducted a formal investigation into events leading to the death of Elise, nor has it conducted a "root cause" analysis. In this manner Dr and Mrs Neville have been badly served.*
- *QH has not responded in an appropriate manner to Elise's parents in so much that no attempt would appear to have been made to discuss with the parents issues of systems which may have failed or been inadequate;*
- *'Open Disclosure' was difficult because of the legal framework set up to protect QH from liability and because no formal investigation was ever conducted."*

QH's existing Complaints Coordinators Handbook (which as previously stated was not in existence at the time of the incident) provides for a root cause analysis[28] to be undertaken as part of the process of investigating complaints. It recognises that root cause analysis supports a learning, informed organisational culture that focuses on improving systems rather than on punitive measures. The benefit of undertaking a root cause analysis is that it identifies factors that contribute to incidents, and also involves planning preventative measures (that is, measures to prevent recurrence) and developing control measures, including remedies, modifications or the development of systems to enable service recovery.

QH has advised that its recently established Patient Safety Centre has developed a two day Root Cause Analysis training program which is to be rolled out across Health Service Districts shortly.

I have made inquiries of QH to ascertain the complaint management policy and procedure in place at the time of Elise's death. QH advised that, at the time:

- there was no written procedure for complaints management within the District;
- although not clearly documented, there was a mechanism for managing complaints received via the HRC, and complaints directed to the District Manager;
- QH was establishing a policy and procedure on how to respond to a critical incident/adverse event; however, no policy or procedure had been introduced into all healthcare facilities;
- QH's current Health Complaints Management Policy was not introduced until after Elise's incident (effective date 31 August 2002);
- a formalised complaints management procedure was being developed at the time of the response, by the recently formed Clinical Governance Unit.

[28] Root Cause Analysis (RCA) is a retrospective approach to investigating incidents or near misses. It is already widely used to look at major industrial accidents. Systematically applying RCA can help discover the errors that contribute to system failures underlying adverse events or near misses and may uncover "root causes" that link a group of problems that don't seem to be related (for example, a variety of serious adverse events occurring during changes of shift). (Obtained from the Australian Council for Safety and Quality in Health Care, Spring 2003 Newsletter.)

It appears that QH's inadequate response to the Nevilles' complaint stemmed from an "ad hoc" approach to dealing with patient complaints.

2.6.2 Fragmented health complaints system

The most concerning aspect of the Nevilles' complaint was the inability of the current health complaints system to provide for one investigation that could cover all aspects of the complaint. The Nevilles saw their complaint as being essentially about one incident. However, the current health complaints scheme dictated that their complaint had to be split, and different aspects of it referred to different agencies for action.

In the last three years, there have been six separate inquiries (not including my inquiry) into aspects of the adverse incident involving Elise Neville (that is, by the State Coroner, HRC, MBQ, QNC and QH and by the CMC concerning the allegation of official misconduct against the Executive Director). Putting aside the involvement of the State Coroner and the CMC, the fact that this complaint necessitated investigations by the HRC, the MBQ and the QNC (as well as the investigation commissioned by QH as the HSP), is indicative of an inefficient, dysfunctional and compartmentalised health complaints system.

As a result, there were:

- four separate investigations by four different health related agencies, all acting under different legislation and with different internal policies and procedures;
- four different investigation reports delivered at different times and with different outcomes;
- considerable delays brought about by the numerous consultation processes during the assessment and investigation processes.

From the complainants' perspective, this is far from an optimal complaint process.

The Commissioner in the HRC's Annual Report for 2003-2004 commented on the obvious frustration for all parties involved with the Neville complaint in having to deal with a number of inquiries into the one incident with separate findings delivered at different stages. In his opinion an optimal complaint handling process would involve:

- a single report covering all of the issues which in turn would have provided a more complete picture of events; and .
- centralised complaint handling and information gathering processes, at least in the initial stages of dealing with a complaint.

A complaint handling process based on these principles will not only provide for a more timely and cost effective process, but also reduce the possibility of duplication of investigations, and uncertainty about who has jurisdiction to investigate what.

2.6.3 Lengthy process

Given the serious nature of the allegations raised by the Nevilles' complaint and the possibility of an ongoing risk to public safety, they expected, not unreasonably, that their complaints would be dealt with in a timely manner.

The following table summarises the health complaints process applicable to the Nevilles' complaint:

Process	Legislative basis	HRC	MBQ	QNC
Receipt of complaint by agencies	s.67 HRCA	28/3/02	10/4/02	11/4/02
1st consultation with HRC			17/04/02	1/5/02
HRC receives more specific complaints about the two nurses and Caloundra Hospital		2/5/02		
HRC accepts for assessment all complaints & seeks submissions from providers	s.69 HRCA	10/05/02		
HRC forwards copy of complaints about registrants	s.69 HRCA		10/5/02	10/0502
HRC consults with MBQ & QNC before making decision about what further action is to be taken	s.71 HRCA		7/8/02	7/8/02
Assessment by HRC completed and complaints referred to MBQ & QNC for further action	s.71 HRCA	7/8/02	7/8/02	7/8/02
Assessment period by HRC	s.76 HRCA	10/05/02 to 7/08/02 (89 days)		
QNC accepts for investigation complaint against RN 1				21/8/02
QNC appoints an investigator to commence investigation of RN 1				6/9/02
HRC commences its investigation in relation to CH, SCHSD, the Executive Director and other systemic issues	s.95 HRCA	24/9/02		
MBQ appoints an officer of the OHPRB as investigator to investigate complaint about the Doctor	s.73 HPPSA		27/8/02	
MBQ appoints an external consultant to take over investigation of the Doctor	S.73 HPPSA		24/6/03	
HRC completes its investigation of CH & SCHSD and issues first report (complaint about the Executive Director dropped due to lack of jurisdiction)	s.125 HRCA	4/9/03 (investigation takes approx 11 months)		
QNC completes investigation of RN 1 and produces its report				27/11/03 (investigation takes 14 months)
External consultant completes investigation on behalf of MBQ and report issued			2/1/04 (investigation takes approx 17 mths)	
QNC appoints an investigator to commence investigation of the Nevilles' complaint against RN 2				19/3/04
HRC conducts a review of its investigation and issues a 2nd report		28/6/2004 (review takes 9 months)		
QNC completes its investigation of RN 2 and issues a report				16/7/2004 (4mths)

The HRC, MBQ and QNC have provided responses to my Office's invitation to provide an explanation for the time taken to complete the different investigations into the Nevilles' complaint. A brief summary of their responses follows:

HRC

The Commissioner of the HRC advised that:

- A timeframe of 11 months to complete its investigation was not inordinate given the complexity of the investigation.

- A lot of information was gathered from a wide variety of sources.

- A review of the first report was conducted on the basis that after receipt of the first report, the Nevilles were able to better define the full extent of their concerns. As a result, the review warranted an actual re-investigation of aspects of their complaint.

MBQ

The MBQ advised that:

- The MBQ did not have any record of telephone conversations with the Nevilles on 25 October 2002 and 18 December 2002 in which they alleged they were told the investigation into their complaint about the Doctor would take approximately six months. Accordingly, it was unable to confirm or deny their assertions.

- The factors which resulted in a delay in commencing and finalising the investigation of the Doctor included the referral of the complaint to the HRC, untimely resignation of the investigator appointed on 27 August 2002, and the backlog of complaints faced by the Complaints Unit at that time.

- The delay in commencing an investigation into the Nevilles' complaint against the Doctor is explained by the fact that under s.51 of the *Health Practitioners (Professional Standards) Act 1999* Qld (the HPPSA), the MBQ is required to refer such a complaint to the HRC. Once referred, consultation takes place between the MBQ and the HRC to determine whether or not the MBQ will investigate the matter. At a meeting between the MBQ and the HRC on 17 April 2002, a decision was made to refer the Nevilles' complaint to the HRC for assessment. Once a complaint is referred to the HRC for assessment, the MBQ does not take any further action unless and until the complaint is referred back to it for further action. Pursuant to s.74 of the HRCA, the complaint was referred back to the MBQ for action on 8 August 2002. The MBQ then noted at its meeting on 27 August 2002 that an investigator was to be appointed.

- The appointed investigator resigned from his position on or about 6 June 2003, following unexpected leave in the three weeks prior to his resignation. This prompted the appointment of an external investigator on 24 June 2003.

- In August 2002, the MBQ had 295 investigations, with each investigator responsible for approximately 50 investigations. The Nevilles were advised by letter of 6 May 2003 that there was a backlog of complaints. Additional resources were allocated to the Complaints Unit from April 2003 to clear the backlog. This facilitated their complaint being referred to an external investigator on 24 June 2003.

QNC

The QNC provided detailed statements by its Executive Officer, and by the inspector who conducted the investigations of both nurses, which set out the actions taken by the QNC and the inspector in respect of the Nevilles' complaints. In summary, they advised:

- In accordance with its statutory duty, upon receipt of the Nevilles' complaint about the two nurses, the QNC consulted with the HRC as to what action should be taken. The HRC retained the complaint for assessment and then on 7 August 2002, referred the complaint back to the QNC for action. The QNC was precluded by the provisions of the *Nursing Act 1992* from taking any action on the complaint until the HRC had referred the complaint back to it for action.

- After seeking legal advice, the QNC agreed to investigate the complaint against RN 1 but not RN 2. An inspector was appointed by the QNC on 6 September 2002.

- In preparing the particulars of the complaint, the QNC sought advice from the HRC and its legal advisers, and consulted extensively with the Nevilles and a paediatric nursing expert and other experts.

- Particulars of the complaint were provided to RN 1 and she was given the opportunity to provide a submission in response.

- Upon receipt of her response, the inspector sought expert opinions from a paediatric nurse and a medical practitioner.

- QNC sought other relevant expert medical opinion and access to evidence which the State Coroner had obtained relating to Elise Neville's death.

- The investigation report was referred to QNC's solicitors for advice.

- Following receipt of this legal advice, further discussions were undertaken with one of the medical experts who provided expert advice to clarify the standard of nursing care he expected of an Emergency Department nurse in this matter. This further advice was referred back to the QNC's solicitors.

- Subsequent legal advice and the investigation report were referred to the QNC's Professional Standards Committee (PSC) for recommendations as to what action, if any, should be taken following the outcome of the investigation.

- A copy of the investigation report was then sent to RN 1, care of her lawyers, inviting her to make a further submission. This was done to satisfy the obligation imposed on the inspector pursuant to s.103(5)(b) of the Nursing Act.

- In accordance with a further statutory duty, the QNC also forwarded a copy of the investigation report to the Health Rights Commissioner for his comments. The Commissioner concurred with the conclusions reached in the investigation report, but expressed concern over the QNC's decision to await the outcome of the coronial inquest before making a determination in relation to the findings of the investigation report.

- An investigation was initiated in relation to the actions of RN 2[29] and an inspector was appointed on 19 March 2004. This was as a result of a recommendation by the PSC after considering the findings contained in the investigation report relating to RN 1. Once again, the QNC consulted with the HRC, and with its own solicitors, concerning the particulars of complaint in relation to RN 2.

[29] some 2 years after Elise's incident

- RN 2 was advised of the QNC's decision to initiate an investigation into her conduct and asked to provide a submission in response.

- The inspector completed her investigation in relation to RN 2 on 18 July 2004, and the report was referred to the QNC's solicitor for advice, and to the HRC for comments.

- The QNC's solicitors provided a brief to Senior Counsel to advise whether any action should be taken against RN 1 and/or RN 2.

- Upon receipt of Senior Counsel's advice, the matter was referred to the PSC for recommendations and then to the QNC for a direction as to whether disciplinary action should be taken against either of the two nurses.

A lengthy process was inevitable for a number of reasons, including:

- Certain statutory requirements caused delays, in particular the inability of the QNC to commence an investigation until the complaint had been referred back to it by the HRC for action.

- Extensive consultation undertaken (with nursing experts, legal advisers, the complainant and the HRC) to settle on the particulars of the complaint.

- Inviting submissions from the nurses in response to the particulars of the complaint, in accordance with natural justice considerations.

- Internal QNC processes including referral of matters to the PSC for advice and recommendations prior to consideration by QNC (noting that both only meet once a month).

- In this instance, the initial decision by QNC was to await the outcome of the coronial inquiry before making any determination as to what action, if any, should to be taken against the nurses. It was the usual practice of the QNC to await the outcome of any criminal action before finally deciding on whether to take disciplinary action. This practice reportedly developed because of a belief that any disciplinary action against a nurse was likely to be stayed pending the outcome of a coronial inquiry or relevant criminal charge. The QNC considered a stay was likely to be granted because, under the *Coroners Act 1958* (which applies to deaths occurring before December 2003) a person could refuse to answer questions before the coroner that might tend to incriminate him or her, and also decline to give evidence at a hearing of criminal charges against him or her.

In a letter to the Minister for Health dated 19 July 2004, the Executive Officer of the QNC informed the Minister that the average timeframe from the initiation of an investigation to the presentation of an investigation report to Council, is approximately six months. The letter stated that the investigation of RN 1 took longer than this average because of the complexity of some of the issues involved which required legal advice to be obtained on more than one occasion, as well as the commissioning of expert reports.

2.6.4 Delays in QH's implementation of recommendations, and in the MBQ and QNC finalising disciplinary processes

It must be remembered that the Nevilles' complaint raised serious allegations concerning the conduct and competence of medical and nursing staff employed in an Emergency Department of a regional public hospital, and systemic issues impacting on the quality of service provided by the hospital. Accordingly, it is necessary to consider whether the interests of the public were adequately protected during the time that investigations by the HRC, MBQ and the QNC were continuing.

It has already been noted that QH declined to conduct an investigation of the Nevilles' complaint, or a root cause analysis, on the basis that investigations were being undertaken by the independent health complaint agencies.

As a consequence of inquiries made of the SCHSD by the HRC in its initial investigation, the SCHSD implemented some changes that related to some of the systemic issues raised by the Nevilles' complaint. These included:

- As of 14 January 2002 (that is, one week after Elise's presentation), the rostering system was changed so that medical staff were rostered on a 24 hour basis (rather than "on call" between the hours of 10pm and 8am). It was claimed that this ensured that medical staff who had been working continuously long hours would not be called during the night.

- On 15 January 2002, a direction by the General Manager (Health Services) QH to the District Manager confirmed that he could not accept the continuation of the existing practice at CH regarding the admission of children. In other words, it was made clear to the SCHSD that children could be admitted to CH, and that nothing other than clinical considerations should determine the treatment to be provided.

- Certain actions taken by the SCHSD to increase staff awareness of documentation standards (for example, inclusion of documentation standards as part of continuing medical education sessions).

I recently asked QH to report on what steps, if any, it had taken in response to the recommendations included in the investigations reports prepared by the HRC and by Professor Stokes. In a letter dated 24 May 2005, the then Director-General of QH responded as follows.

<u>Professor Stokes report of May 2004</u>

In relation to Professor Stokes' report, QH stated that:

- there were two recommendations included in the body of Professor Stokes' report, and a further 12 recommendations listed in its conclusion;
- the two recommendations included in the body of the report were actioned by the Director-General during his meeting with the Nevilles on 22 June 2004;
- while not strictly in response to the other 12 recommendations, a number of initiatives had been implemented at District level which satisfied the substantive recommendations.

While the listed initiatives arguably go some way towards rectifying some of the issues raised by the recommendations, recommendations made by Professor Stokes which have a direct impact on the standard of care provided to the public (for example, that the Emergency Department should be staffed by experienced third or fourth year postgraduate doctors who have received training in Emergency Departments before going to Caloundra) appeared not to have been actioned, as of the date of QH's response to me.

HRC's report of June 2004

On 24 May 2005, QH wrote to the HRC outlining the actions taken by QH up to that date to implement the Commissioner's recommendations contained in his report of June 2004.

On 6 June 2005, the Commissioner wrote to the Director-General of QH seeking more detailed information concerning QH's specific responses to the first three of his substantive recommendations.

In summary, it appears from QH's responses that it has not taken action to ensure that the specific recommendations made by Professor Stokes and the Commissioner have been implemented. Rather QH has relied on other distinct processes (for example, other independent reviews already underway prior to the Commissioner's report, funding allocations and QH initiatives) to support an argument that some action has been taken. There is no clear indication that the recommendations have either been satisfactorily actioned, or appropriately considered (with stated reasons) as unsuitable for action.

Doctors working hours

QH also responded to my concern about the numbers of hours the doctor who treated Elise Neville had been working (approximately 19 hours) when Elise first presented for emergency care.

The then Director-General advised that he considered the issue of safe working hours for doctors to be a professional standards issue as opposed to an industrial relations issue. Therefore, he had approached the MBQ to accept the role of developing, implementing and monitoring standards that relate to safe hours of work for doctors. The MBQ agreed that the issue was consistent with both its legislative functions and strategic direction and that it was appropriate for it, as an independent statutory authority, to establish a standard, rather than a standard being developed by any one employer, professional association or college. I am advised that the MBQ has sought additional funding from QH to cover this project which has been estimated to take approximately two years.

Disciplinary action by the MBQ & QNC

Another issue raised by the Neville investigation was the time taken before disciplinary proceedings were undertaken. It took in excess of two and a half years before any disciplinary action was taken against the doctor who treated Elise. This is of particular concern given that the Health Practitioners Tribunal ultimately decided that specific conditions should be imposed on the doctor's registration.

The QNC took the same amount of time to reach a determination that some form of disciplinary action was warranted against one of the nurses investigated (RN 1) but, to date, no disciplinary action has been taken. This is partly due to the following factors:

- The Nevilles sought a review of the QNC's decision of 3 September 2004, as to what disciplinary action was to be taken.

- In response to a meeting with the Nevilles on 5 October 2004, the QNC sought a further statement from RN 1 which was requested to be provided by 17 November 2004.

- The nurse's statement was not received by the QNC until 17 May 2005 (six months later). Reasons for the delay include RN 1 changing her legal advisers and then making an FOI application to QNC on 10 February 2005.

- The Nevilles were asked to provide comment on the contents of RN 1's further statement which they did on 10 June 2005.

In a letter dated 2 June 2005, the Acting Executive Officer of the QNC informed me that, upon receipt of the Nevilles' response, it was intended that the matter would be referred back to its solicitors for further legal advice. I am informed that the matter has subsequently been referred to Senior Counsel for advice. Upon receipt of Senior Counsel's opinion, the QNC will be required to make a further determination whether the matter warrants referral to the Nursing Tribunal. On that basis, it may be some time before the matter is finalised.

Some of the delays in finalising disciplinary action against the doctor and nurses in this instance were arguably unavoidable. However, in my view, structural flaws in the health complaints system have contributed to the lengthy timeframe between the incident and finalisation of the disciplinary proceedings (2 ½ - 3 years).

3. The current health complaints system in Queensland

It should be noted that, while the HRC is considered to be the primary agency for dealing with health related complaints, it is only one element in a broad complaints system which includes formal complaint mechanisms in private and public hospitals (and other elements of the public health system), and the professional registration boards. Under the current health complaints system in Queensland, complaints can be directed to:

1. the relevant HSP;
2. the HRC and/or the relevant health practitioner registration board/QNC; or
3. the Ombudsman (if the complaint relates to a government agency within the Ombudsman's jurisdiction).

3.1. The relevant health service provider

The current system requires complainants to attempt to resolve their health service complaint at the initial point of service. This is reflected in the HRCA which provides[30]:

> *"Before deciding to accept a health service complaint for action, the commissioner is to be satisfied-*
>
> *(a) that all reasonable steps have been taken by the complainant to resolve the complaint with the provider:.."*

While there is currently no reciprocal legislative duty on an HSP to resolve a complaint with a complainant, it logically follows that for the system to work effectively, HSPs need to have adequate systems in place in order to receive complaints and respond to them in a timely manner. One of the statutory functions of the HRC is to assist providers to develop their own effective complaints handling procedures[31].

A useful guide to complaint handling is Australian Standard *AS4269-1995: Complaints Handling*, which sets out the essential elements for the management of complaints from inception to resolution or final determination (as the case may be), irrespective of the nature of the complaint or the size of the organisation receiving the complaint. The Standard, which is currently advisory only, provides information that can be used to design a process for handling complaints in both the public and private health sectors. The Standard specifies several essential elements for effective complaint handling, including:

- appropriate systems for recording complaints and their outcomes;
- appropriate reporting on the operation of the complaint-handling process against documented performance standards;
- regular reviews of the process to ensure that it is efficiently delivering effective outcomes.

Australian Standard *AS4269* is currently being reviewed and it is expected that it will be amended to substantially reflect the current international standard *ISO 10002-*

[30] refer s.71(2) HRCA
[31] refer s.10 HRCA

Quality Management - Customer Satisfaction - Guidelines for complaints handling in organisations which was introduced in July 2004. The ISO covers elements such as:

- visibility
- accessibility
- objectivity and impartiality
- confidentiality
- separating complaints-handling procedures from disciplinary procedures
- monitoring
- continual improvement.

My Office has also produced a number of publications designed to help public sector agencies make good decisions and manage complaints effectively. These publications are available on our website www.ombudsman.qld.gov.au and include:

- Developing Effective Complaints Management Policy and Procedures;
- Effective Complaints Management fact sheets; and
- Complaints Management Audit and Assessment checklist.

While these publications have been designed specifically for public sector agencies, any HSP could easily adapt them.

It is also important for an HSP to develop strategies for internal and external communication of its complaints management policy and procedures to ensure customers and staff know how complaints are handled by that organisation.

3.1.1 QH's complaints management framework

QH currently has a complaints management process based on the QH Complaints Management Policy (No. 15184 approved on 23 July 2002) which outlines how complaints are to be received and then handled. In developing the complaints management process, regard was had to *AS 4269-1995: Complaints Handling.*

The policy covers complaints received by any QH staff member about any aspect of a health service before, during or after the provision of a service. Complaints can be made verbally or in writing to QH by a user, their advocate, carer or family member, groups of consumers or consumer organisations, or general members of the public.

QH's Complaints Management Policy (the policy) is supported by a comprehensive "Complaints Management Handbook" (the handbook) as well as a "Guidance Document to the Queensland Health Complaints Management Policy". The handbook provides that the complaints process is an organised way of responding to, recording, reporting and using complaints to improve the service. It acknowledges that consumers want:

- it to be easy to make a complaint;
- to be listened to, understood and taken seriously;
- to be treated politely and with respect;
- staff to focus on solving the problem and not be defensive or give consumers the "run around";
- a timely response;

- the complaint to be investigated fairly with no cover-ups;
- to be told what is happening and what has happened and not be "left in the dark."

Once received, complaints are required to be assessed immediately and categorised as negligible, minor, moderate, major or extreme. Delegated staff at the point of service are required to attempt to resolve all "negligible and minor complaints". Complaints classified as moderate, major or extreme, plus any unresolved minor complaints, are to be referred to the complaints coordinator within each Health Service District. Where possible, such complaints are to be investigated and assessed and, where appropriate, referred to the District Executive.

Under the policy, the complaints coordinator for each Health Service District has several important duties including:

- Coordinating the complaints management process;
- Ensuring that complaint information is considered as part of District quality improvement and risk management processes;
- Managing and reviewing outcomes and investigations;
- Coordinating staff training on complaint management.

The handbook contains some common examples of the types of complaints relating to health service delivery such as:

- dissatisfaction with the type or level of treatment provided to a user (for example, at a public hospital) such as unsuitable care, misdiagnosis, communication issues, non-consent to procedures;
- general dissatisfaction with the health care or services received such as waiting lists or inappropriate diet;
- concerns that relate to unsatisfactory conduct of HSPs;
- limited or no access to personal records, disrespectful behaviour, lack of privacy, and/or confidentiality breaches.

The handbook also links risk management with complaints management. In other words, all complaints are also to be assessed to determine whether the level of risk for a specific complaint is acceptable or not. It provides a matrix for use in trying to determine the level of risk. QH's Integrated Risk Management Policy provides that each District, Branch or other accountable area is required to maintain a register of all risks to the organisation.

In June 2004, QH also introduced an *Incident Management Policy* (23360) which directs that Managers are required to report and manage sentinel events[32] and events with very high and extreme risk ratings. The policy was introduced to enable QH to learn from underlying causes of incidents and near misses and to improve systems to reduce the likelihood of recurrence.

The handbook outlines the timeframes for handling complaints. Basically, complaints should be acknowledged, or referred to external agencies for handling, within 3 working days of being received, or the need being identified. Relevant staff should

[32] Sentinel events are rare events that lead to catastrophic patient outcomes. The ACSQHC has endorsed a national list of sentinel events that includes, for example, retained instruments or other material after surgery requiring re-operation or further surgical procedure.

endeavour to resolve complaints within a 28 day timeframe, otherwise complainants are to be advised of progress of the complaint every 28 days until the complaint is resolved.

A health service may decide to undertake an investigation of any matter. Those complaints that cannot be resolved at the point of service, or those that are of a more serious nature (namely, those categorised as moderate, major or extreme), will usually be investigated.

Depending on the degree of seriousness of the matter being investigated, investigations may be conducted internally by a number of nominated QH employees including the line manager, the complaints coordinator, a senior member of the health care team or an investigator appointed by the Queensland Audit and Operational Review Branch. Complaints may also be referred to and investigated by an external agency like the HRC, MBQ or QNC.

The Director-General of QH may appoint a person as an auditor or investigator pursuant to s.52 of the *Health Services Act* (HSA). The functions of an investigator are to investigate and report to the Director-General on any matters relating to the management, administration or delivery of "public sector health services" (that is, a health service provided by the State), for example, matters relating to clinical practices and standards of health care in the delivery of public sector health services[33].

There is no requirement for QH to consult with the HRC or any of the registration boards at any time during the complaints process. However, QH may refer a complainant to an external entity at the end of the internal complaint process. For example, a complaint about a registered health practitioner may be referred to the relevant health professional registration body if it raises competence concerns because of a series of errors, or a pattern of behaviour demonstrating a lack of knowledge, skill or ability, and/or poor judgment based on problems with assessment, analysis or decision-making. The District Manager (or delegate) is responsible for such a referral.

QH recognises that many "minor" complaints can be resolved through the provision of information, or an explanation of why things happened the way they did, together with an apology and recognition of the effect the situation had on the complainant.

With more complex complaints, resolution may be achieved with the assistance of a trained mediator or conciliator, or by a process of facilitation. Facilitation is utilised when a group or parties with divergent views want to reach a goal or complete a task to their mutual satisfaction. A facilitator assists in defining issues, and in assisting and taking steps to encourage the parties to reach consensus.

3.1.2 Assessment of QH's Complaints Management Policy and Procedures

In March 2003, my Office initiated a project called the Complaints Management Project (CMP), which involved my staff giving assistance to 11 State and local government agencies to implement complaint handling systems that meet recognised national and international standards. For the purposes of the project, my Office produced several publications, including fact sheets explaining the essential components of a best practice complaints management system, and a template to

[33] s.55 HSA

follow when drafting complaints management policies and procedures. These documents are available on our website[34].

At the time our project commenced, QH, which was one of the agencies participating in the project, had recently finalised a new policy and procedures for managing complaints received from members of the public.

Each of the agencies involved in the project, including QH, carried out a self-assessment of their current complaints management systems using an audit and assessment checklist which my Office designed for that purpose.

The QH complaints management system is based on QH's Complaints Management Policy (No 15184 approved on 23 July 2002). The Policy relates to complaints made "by or on behalf of a consumer or a group of consumers regarding the provision of a health service". A complaint can be made orally or in writing.

The Policy does not apply to complaints made by QH employees that involve PIDs or that relate to staff grievances or other staff concerns. Nor does it apply to complaints made to QH about public health issues (for example, complaints about food outlets).

QH's policy on Whistleblowers is IRM 3.1-4, *Policy and Procedures for the Management of Public Interest Disclosures – In Accordance with the Whistleblowers Protection Act 1994.* Its policy for handling staff complaints is Policy IRM3.5, *Grievance Resolution* and EB5 *Grievance Settling; and Industrial Disputes.* We did not review those documents as part of our CMP because the focus of the CMP is on complaints from members of the public.

My officers reviewed a copy of the completed audit and assessment checklist provided by QH. Based on their review of the checklist and other information relating to QH's complaint management process, my officers prepared a report of their assessment, which I provided to the Director-General of QH on 8 March 2004.

Particulars of the QH complaints management process have been explained earlier[35]:

Our report concluded that the QH system (assuming QH complied with its complaint policies and procedures) "compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management."

However, we considered that the system could be improved. In particular, we recommended that QH:

- Develop and establish a central or common complaint database to enable complaints data across all Districts to be collated and analysed.

- Improve awareness of the QH complaints management system on the part of QH staff across all Districts.

Our first recommendation was based on the fact that QH did not have a centralised database for recording complaints data across all Health Service Districts. In our view,

[34] www.ombudsman.qld.gov.au
[35] at 3.1.1

this is an essential component of an effective complaint system. The existing systems within the Districts had limited compatibility which meant there was little capacity to:

- identify significant complaint issues, complaint trends or improvement strategies, or
- ensure an appropriate level of consistency in the management of complaints across all districts.

The second recommendation resulted from our assessment that there was no program in place to ensure consistent staff awareness across Health Service Districts concerning the complaints management system. For the system to operate effectively, we considered it essential that QH staff, especially those who deal directly with the public, be aware of the system.

Although the Policy specified that "all staff receive training on complaints handling within six months of commencement and at least every 3 years thereafter", information that we received indicated that training was conducted on an *ad hoc* basis within and across Districts and hence there was no guarantee that consumer complaints were being dealt with in accordance with the process. We suggested that QH should conduct surveys of staff awareness of the system.

In relation to training for QH officers who deal with complaints, we made no recommendation because of advice from QH that it had a comprehensive training regime for complaints staff, as outlined in its complaints management handbook. QH also advised that complaints coordinators are selected and trained in accordance with the principles outlined in QH's policy and handbook and all undergo a two day training session.

We have not conducted any audit to determine whether QH is providing such training as this is not part of the current phase of our CMP.

In the course of the project, we made several other suggestions to improve QH's complaints management system one of which resulted in the QH website being amended to include a dedicated section on consumer complaints.

Following receipt of our report, QH commenced work to develop a State-wide consumer feedback information system/database for the management and tracking of consumer complaints as well as for receiving information concerning critical incidents and for risk management purposes.

QH also advised that, in accordance with our recommendation, it planned to provide further training to staff to raise awareness of its complaints management process and that this training would be provided in conjunction with training associated with the implementation of the new database.

I am informed that the database has been developed and is currently undergoing testing in a Health Service District.

I am also informed that the database is not intended to capture information concerning PIDs under the WPA. Under current QH procedures, details of PIDs are provided to the Audit and Operational Review Branch of QH which is responsible for:

- ensuring that proper recording processes are in place for filing and receiving PIDs, and
- maintaining confidential files on disclosures.

It needs to be understood that the purpose of the CMP is to assist agencies, including QH, to implement complaints management procedures and systems that meet recognised standards. The project does not involve auditing whether agencies are complying with those procedures. For example, QH's complaints system imposes various responsibilities on the complaints coordinator in each District. However, it is noted that QH's Initial Submission to the Inquiry dated 16 May 2005 (p.38) stated that the Bundaberg Health Service District "has had no dedicated Complaint Coordinator".

Based on the evidence presented to the BHCI, I believe further action needs to be taken by QH to improve its current complaints management. In formulating these proposals, we have also had regard to QH's publication "Issues Paper for Bundaberg Hospital Commission of Inquiry – Complaints Management, July 2005".

3.1.3 Proposals for further improving QH's complaints management system

I propose that:

- QH develop a central Complaints Management Unit that will be responsible for:
    - overall internal complaints management including devising, implementing, reviewing and improving complaints systems;
    - providing advice and training to all complaints staff about both patient and staff complaints;
    - monitoring and reviewing local complaints handling to ensure that all complaints are actioned in a timely and appropriate manner;
    - investigating, or monitoring the investigation (at the local level) of, all complaints categorised as moderate, major or extreme;
    - liaising with the external complaint agency, where an unresolved complaint is escalated by the complainant to external review;
    - the collection and analysis of consumer feedback on QH health services;
    - benchmarking, conduct of complaint trend analysis, and auditing of complaints processes in the districts;
    - providing regular analysis reports about internal complaints management back to health districts and to senior management; and
    - liaison with the Patient Safety Centre to provide inputs, from analysis of patient complaints data, into strategies for quality improvement initiatives/activities.
- All Health Service Districts should have a dedicated complaints coordinator (CC) appointed at the level of A05 – A07 (depending on the size of the relevant

District/Branch), to ensure that CCs have an appropriate skill level, and sufficient seniority in the organisation, to credibly manage complex patient complaints. CCs should be accredited in complaints handling. There should be one State-wide position description (PD) as opposed to each District having its own PD for the role. It is acknowledged that some of the smaller health districts that do not receive many complaints may only require a part-time CC. The CC should report directly to the District/Branch Manager (or in large Districts, to an appropriate manager at senior executive level). The CC needs to have the standing and influence to ensure that serious attempts are made to resolve complaints at the local level wherever possible, and that issues warranting closer examination by management are escalated appropriately.

- All staff responsible for the receipt, referral and actioning of complaints should be adequately trained in respect of QH's Complaints Management Policy and Handbook.

Coordination of health data management systems

One of the important issues exposed during the hearings of the BHCI was the need for health services to maintain well integrated data management systems. In the case of Bundaberg (and potentially elsewhere), it is understood that the local patient complaints register and the adverse events and sentinel events records were not reconciled or integrated in any way, which significantly impeded capacity to identify systemic issues relevant to patient safety and delayed effective intervention.

Furthermore, a scan of the QH data management practices revealed a number of instances where data relevant to patient safety and quality improvement activities is collected via more than one source, eg. as part of preparations for accreditation surveys and for measured quality improvement activities. This duplication of effort in data collection and reporting requirements wastes resources and is understandably a source of frustration for staff.

It is also significant to note that several witnesses at hearings of the BHCI gave evidence that they seldom, if ever, received any feedback on the outcome of data collection and reporting activity.

The following proposals are made to address these deficiencies:

i) QH should finalise the implementation of its web-based complaints database as a matter of priority.

ii) Consideration should be given to amending the Health Act to establish a new statutory data collection of adverse events and complaints relevant to patient safety for public and private health care facilities. This database would be maintained by the QH Information Centre.

iii) Steps should be taken to improve and streamline coordination of data collection practices within QH to minimise duplication of effort.

iv) Feedback should be given at appropriate intervals (quarterly or biannually) to all services providing data for quality improvement or accreditation purposes.

Enhancing research on patient complaints and patient safety matters

At present, there is considerable scope for QH to enhance the scope and transparency of its patient complaints and patient safety data management practices. Without reliable quantitative data, performance management and quality improvement activity are hampered.

In view of the recent events at QH, the public will soon be seeking reassurance that the circumstances leading to these events have been addressed and that the situation has significantly improved. Developing the capacity to undertake research of reliable data will assist QH to demonstrate that the problems in the existing system are being addressed.

If, as proposed, QH implements improved data management practices as a priority then it would be possible to commence a range of research activity aimed at identifying the factors that could lead to improvements in patient safety and reduce the incidence of complaints. Good data would enable health care facilities to identify the most significant factors influencing public confidence in the health care system. Funding for such research could be provided to monitor the public health care system only (for example, through enhanced funding to the Patient Safety Centre in QH) or alternatively to capture data on the entire health sector in Queensland (through enhanced funding to a remodelled HRC to undertake research specifically on consumer complaints and patient safety issues within both the public and private sectors).

3.2 Complaints management by the HRC

If a complainant is unable to resolve a complaint with the service provider or is dissatisfied with the outcome or response provided, the complainant can seek the assistance of the HRC in resolving the complaint. If a complaint or serious allegation is about a registered health practitioner or registered nurse/midwife, the complainant may also take the complaint direct to the relevant health practitioner registration board or the QNC.

Part 5 of the HRCA outlines the types of complaints which can be made to the HRC, the assessment process, and what action can be taken if the HRC accepts a complaint.

Complaints may be made about any aspect of care or treatment provided anywhere in Queensland by any health service or health care practitioner, whether operating in the public or private sector. However, complaints must be raised with the HRC within 12 months of knowledge of the cause for complaint.

Only a person prescribed by s.59 of the HRCA may make a complaint to the HRC, that is:

- the user of the health service or his/her representative;
- someone with sufficient interest to act on behalf of the user if the user cannot choose a representative;
- if the user has impaired capacity, an appropriate attorney or the Adult Guardian or other guardian;
- the Minister for Health;

- anyone else the Commissioner considers should be permitted to make the complaint in the public interest.

If a complainant is not a prescribed person under s.59, the HRC does not have jurisdiction to assess or investigate the complaint. In these cases, the HRC may refer the complainant to the relevant registrant's board or other body.

3.2.1. Assessment process

Upon receipt of a complaint, the HRC undertakes a formal assessment and acts as an impartial link between the complainant and the HSP to resolve the complaint. The HRC may elect to facilitate resolution of a complaint even before formal assessment of the complaint has been undertaken.

Where the complaint is retained by the HRC for assessment, the Commissioner may invite submissions from the complainant and/or the provider and must invite a submission from the registration board.

Before deciding to accept a complaint for action, the HRC must be satisfied that, if at all practicable, the complainant has taken all reasonable steps to resolve the complaint with the provider[36].

The HRC endeavours wherever possible to take an informal and conciliatory approach to resolution of health complaints as the HRCA specifically refers to proceedings being conducted with "*as little formality and technicality, and with as much expedition, as practicable*[37]."

From commencement of an assessment, the Commissioner has a statutory time limit of sixty (60) days in which to assess the complaint. This period, however, may be extended by a further thirty (30) days in certain circumstances, for instance, if the complaint is too complex to assess in 60 days or the Commissioner considers the complaint can be satisfactorily resolved[38].

Upon assessing a complaint, the Commissioner must decide whether to take any action[39]. If the complaint is about a registered provider, the Commissioner must consult with the Board prior to taking action[40].

If the HRC decides to accept for action a complaint about a provider (other than a registered provider), the HRC may[41]:

- conciliate the complaint (under Part 6 HRCA);
- investigate the complaint (under Part 7 HRCA); or
- refer the complaint to another entity (s.73 HRCA).

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[36] s.71 HRCA
[37] s.30(1)(a) HRCA
[38] s.76 HRCA
[39] s.71(1) HRCA
[40] s.71(3) HRCA
[41] s.73(2) HRCA

3.2.2 Complaint about registered provider

Generally, the Commissioner must immediately assess a health service complaint[42]. However, where the complaint is about a registered provider, the Commissioner must refer it to the registered provider's registration board without assessment and not take any further action in relation to the complaint if:

- the Commissioner considers it is in the public interest for the complaint to be immediately referred to the registered provider's registration board; and
- after consulting with the registration board about the complaint, the board agrees it is in the public interest for the board to immediately deal with the complaint[43].

In addition, if the Commissioner believes:

- the registered provider poses an imminent threat to the life, physical or psychological health, safety or welfare of users of the provider's services, or another person or class of person, or the registered provider; and
- immediate action to suspend, or impose conditions on, the registered provider's registration appears necessary to protect the person or persons,

the Commissioner must immediately refer the complaint to the registration board[44].

The HRC meets regularly with representatives from the health registration boards for the purpose of discussing complaints received and determining how best those complaints should be handled.

The Commissioner must not take any action about the complaint until the first of the following happens:

- the Commissioner receives the registration board's comments (usually to be provided within 14 days of the Commissioner consulting with the board)[45]; or
- the registration board advises the Commissioner that the board does not intend to give any comments; or
- the time for providing comments ends[46].

The Commissioner must have regard to any comments made by the registration board in making the decision[47]. If the registration board has advised the Commissioner it considers the complaint warrants investigation or other action by the board, the Commissioner must not decline to take action on the complaint, but must refer the complaint to the board[48].

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[42] s.67 HRCA
[43] s.68 HRCA
[44] s.77 HRCA
[45] s.71(5)(a) HRCA
[46] s.71(6)(a) HRCA
[47] s.71(6)(b) HRCA
[48] s.71(7) HRCA

3.2.3 Conciliation

Conciliation under the HRCA is a relatively formal process, that is accorded a number of statutory protections, in contrast to informal methods of dispute resolution that may be undertaken at the Intake or Assessment stage.

On accepting a complaint about an HSP, the Commissioner has a primary obligation to try to resolve the complaint by conciliation if the Commissioner considers it can be resolved in that way[49]. A decision to conciliate a complaint must take into account the public interest[50].

Conciliation is a flexible process which focuses on helping people to resolve their complaint about an HSP, through discussion and negotiation. Both the complainant and the HSP must agree to a matter proceeding to conciliation. The Conciliator acts impartially in the process and tries to encourage settlement of the complaint in a way that is acceptable to both parties. Some examples of the possible outcomes of conciliation include:

- an explanation of what happened;
- an apology;
- financial settlement;
- quality assurance changes;
- change in health care provision.

If no satisfactory outcome has been reached, the complainant still retains the right to commence civil action[51]. The Commissioner may also decide to commence an investigation into the complaint. However, any information gathered for the purposes of conciliation or anything said or admitted during conciliation cannot be used by the Commissioner as a ground for investigation or inquiry[52] and is not admissible as evidence in a proceeding before a court, tribunal or disciplinary body.

3.2.4 Investigation process

Investigation is a formal process whereby the Commissioner gathers and analyses information concerning a complaint, and then forms a view as to the reasonableness or otherwise of the action being investigated. The Commissioner has substantial powers to obtain information and records, and to interview relevant parties. A report may be issued at the end of an investigation with recommendations to appropriate persons/organisations.

However, the Commissioner has no power to investigate a registered provider.

Where the complaint is about a registered provider and the Commissioner and the registration board have agreed that the complaint requires investigation or other action

[49] s.73 (3) & s. 74 (4) HRCA
[50] s.73(4) & s. 74(5) HRCA
[51] Any civil action must be commenced within a period of three years from the incident that led to the complaint.
[52] s.91 HRCA

by the board, the Commissioner must immediately refer the complaint to the board[53]. If the Commissioner and the board cannot agree, the Minister will decide[54].

3.3 Complaints management by the registration boards

The Health Practitioner Registration Boards (the boards) have a legislative duty to protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way. The boards must also aim to uphold the standards of practice within the health care professions and to maintain public confidence in their profession.

Each board is responsible for the determination of professional standards, assessment of applications for registration and investigation of complaints. If a board reasonably believes at any time, whether on the basis of a complaint or otherwise, that a registrant poses an imminent risk to the health or safety of others, the board has authority to suspend, or impose conditions on, the registrant's registration[55].

The boards may institute disciplinary action against their registrants for "unsatisfactory professional conduct", a term defined in the Schedule Dictionary to the HPPSA.

3.3.1 Complaint handling by the boards

If users of health services are unable to resolve their complaint directly with the registered provider, they may lodge a complaint with the HRC or the appropriate registration board. As mentioned earlier, the HRC and the boards consult regularly about complaints.

A complaint about a registrant may be made to the registrant's board about any aspect of the registrant's conduct or practice, or another matter relating to the registrant, that appears to provide a ground for disciplinary action against the registrant[56]. Also, a complaint may be made to a board about a matter for which a complaint may be made under the HRCA[57].

While most complaints are dealt with by the HRC in the first instance, the boards will deal with certain types of complaint, for example:

- complaints about compromised standards of practice;
- sexual misconduct;
- complaints made by one practitioner about another practitioner; and
- complaints about medico-legal reports.

A registration board must investigate the registrant:

(a) if directed by the Minister ;
(b) where the registration board and the Commissioner have agreed the board is to investigate the complaint; or

[53] s.74 HRCA
[54] s.74(7) HRCA
[55] s.59 HPPSA
[56] s.48(1) HPPSA
[57] s.48 HPPSA

(c) where the board has suspended or imposed conditions on the registrant's registration.

In addition, a board may investigate a registrant of its own motion (that is, without a complaint being received) if it reasonably believes that an aspect of the registrant's conduct or practice, or another matter relating to the registrant, may provide a ground for disciplinary action against the registrant[58].

An investigation is commenced by the appointment of an investigator or investigative committee. The HPPSA provides for who may be appointed as an investigator, including a member of a board, the Executive Officer of a board, a member of the board's staff (with the consent of the Executive Officer) or other person considered by the board to have the necessary expertise or experience to be an investigator[59].

The registration boards have similar investigative powers to the HRC (Part 5 Division 5 of the HPPSA). However, unlike the HRC, the boards have power to compel a registrant to respond to a complaint and provide stated information within a reasonable time. A penalty can be imposed for failure to provide the requested information[60].

Upon finalisation of an investigation, a preliminary report and/or a final report is prepared by the board, including the findings and proposed action to be taken by the board[61]. A copy of the report is provided to the Commissioner who may provide comments about the report within 14 days after receiving the report or such longer period as agreed to by the board[62].

After providing the Commissioner with a copy of the report, the board must not take any action on the complaint until one of the following happens:

a) the board receives the Commissioner's comments about the report and considers the comments;
b) the board receives advice that the Commissioner does not intend to give any comments;
c) the period for the Commissioner to give comments about the report ends. [63]

Section 118 of the HPPSA outlines the types of action the board may take upon finalisation of the investigation. For example, the board may decide to refer a disciplinary matter for hearing by a panel or by the Health Practitioners Tribunal (the Tribunal) or start proceedings to prosecute the registrant for an offence. Where appropriate, the board may also decide to enter into an undertaking with the registrant, with the registrant's agreement, about the registrant's professional conduct or practice. This will be recorded in the board's register for the term of the undertaking.

As soon as practicable after deciding what action to take under s.118, the board must give written notice about its decision to the registrant, the complainant, and the Commissioner[64] and then proceed with the relevant action.

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[58] s.63 HPPSA
[59] s.73 HPPSA
[60] ss.78 & 79 HPPSA
[61] ss.114 & 115 HPPSA
[62] s.116 HPPSA
[63] s.116 HPSA
[64] s.120(1) HPPSA

The HPPSA provides that the purposes of disciplinary proceedings and disciplinary action against registrants are:

(a) to protect the public;
(b) to uphold standards of practice within the health professions; and
(c) to maintain public confidence in the health profession[65].

There are a number of grounds outlined in the HPPSA[66] that the registration boards can rely on when commencing disciplinary action against a registrant, including:

- the registrant has behaved in a way that constitutes unsatisfactory professional conduct;
- the registrant has failed to comply with a condition on practice imposed under that Act or the Health Practitioner Registration Act under which the registrant is registered, or an undertaking entered into under the HPPSA.

The term "unsatisfactory professional conduct" is defined in the Schedule to the HPPSA. It includes professional conduct that is of a lesser standard than that which might reasonably be expected of the registrant by the public or the registrant's professional peers. It also includes professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgment or care, in the practice of the registrant's profession. This definition gives a wider scope to "unsatisfactory professional conduct" than "conduct discreditable to the profession" or "professional misconduct" as previously understood and applied, because the concept embraces public and peer group perceptions of what is acceptable conduct.

A registrant's board may start disciplinary proceedings against a registrant if it reasonably believes a disciplinary matter exists in relation to the registrant. This may be in response to a single complaint received about the registrant or a number of complaints which may suggest a pattern of conduct or practice.

Part 6 of the HPPSA provides a three level disciplinary framework to which the MBQ may refer disciplinary matters. The three levels are:

- Disciplinary proceedings conducted by the MBQ (in the form of a hearing or by correspondence);
- Professional Conduct Review Panel;
- Health Practitioners Tribunal (the Tribunal).

The three levels differ in the constitution of the disciplinary body, and in the severity of the sanction which may be imposed if allegations against the registrant are proven.

The QNC is governed by the provisions of the Nursing Act, and has similar functions and disciplinary powers and procedures as the boards, but in respect of registered nurses and midwifes. It also meets regularly with the HRC for the purpose of discussing the management of complaints about registered nurses/midwives received by either itself or the HRC.

[65] s.123 HPPSA
[66] s.124

3.4 Development of Queensland's current health complaint mechanisms

Queensland experienced a significant health reform process in the 1990s. The establishment of the HRC in 1992 followed the inquiry into Ward 10B of the Townsville General Hospital during the 1980s.

3.4.1 The previous scheme

When it was established in 1992, the HRC had jurisdiction to investigate complaints against registered health providers. If it was decided that a complaint warranted action, the HRC had the power to retain the complaint for conciliation or investigation, or it could refer the complaint to whichever of the registration boards it determined had the most appropriate functions and powers to deal with the case[67].

The ability of a board to investigate complaints about its own registrants was somewhat hampered, for a number of reasons:

- a board was required to refer any complaint it received to the HRC (even though there was no reciprocal requirement for the HRC to refer a complaint to the board);
- there was no legislative provision to enable boards to require the HRC to refer to a board complaints on which the board wished to take action;
- except for the MBQ, the boards lacked investigative powers.

Under this scheme, the HRC was the primary agency for investigating and resolving health service complaints, with the boards mostly responsible for addressing disciplinary issues arising from health care complaints. However, under this scheme, the HRC did experience some operational problems. The disciplinary provisions of the health practitioner registration Acts did not dovetail with the HRCA, and this created the potential for delay and an increased risk that professional standards issues could be overlooked.

During the consultation stage of the reform process, a number of concerns about the old scheme were raised, including:

- the absence of parallel jurisdiction to the HRC to accept and investigate complaints;
- doubts about the admissibility of the HRC's investigation reports in disciplinary proceedings before the boards;
- inadequate powers of the boards to investigate disciplinary matters;
- deficiencies in the statutory consultation requirements (for example, the Commissioner was not required to consult a board before making an assessment decision and a board was not required to advise the Commissioner when disciplinary proceedings were being commenced);
- inability of the Commissioner to refer complaints to a board without going through the assessment process, which was causing delays in disciplinary matters being addressed.

[67] refer s.121 of the *Health Rights Commission Act,* as then in force

3.4.2 The current scheme

In the late 1990s, 13 Acts relating to health care were passed which substantially addressed these concerns and reformed the existing health complaints system. The most notable of these was the HPPSA which had been under discussion and consultation for six years before it became law in 1999.

The operations of the HRC were affected by the passing of the HPPSA, because it removed the HRC's powers to investigate complaints against registered providers and placed them instead in the hands of Queensland's health practitioner registration boards. This shift in power to the boards represented a judgment that complaints against individual registered practitioners should be primarily assessed and actioned on the basis of peer review.

The then Commissioner expressed strong concerns about this change during the proposal stage of the Act. In the HRC's Annual Report 1999-2000 at p.4, he said: *"If the investigation of complaints is to be seen to be undertaken in an open and accountable manner this can best be achieved by an independent and impartial agency."* Many did not see the registration boards as meeting these criteria. As a consequence of their protests, the proposed legislation was amended to give the HRC a role in monitoring complaints referred to a board for investigation, with the board being required to provide its investigation reports to the HRC for comment.

Under the new legislative scheme, the HRC was left with its existing jurisdiction to investigate complaints against:

- non-registered practitioners; and
- institutions/organisations providing a health service, including both public and private hospitals.

The intention of the reforms was to better protect the public by:

- enabling the boards to investigate complaints about their own registrants and initiate disciplinary proceedings for unsatisfactory professional conduct; and
- freeing up the HRC to more readily carry out its statutory function of overseeing, reviewing and improving the health system.

It was anticipated that this model would allow the HRC to continue to oversee the handling of complaints about health services, through monitoring complaint handling by the boards thereby promoting consistent approaches by the different boards.

Provisions were introduced into the respective Acts to require the boards and the QNC to keep the HRC informed of all matters relating to an investigation, and to forward to the Commissioner a copy of the reports on an investigation prior to taking action on the matter.

In considering the reports, the boards and the QNC are required to have regard to the comments of the Commissioner. There is no statutory requirement for boards and the QNC to comply with comments made by the Commissioner. However, the Commissioner in his 2003-2004 Annual Report, stated that, where he had commented

on or raised issues requiring further attention by a board, the board had taken those comments into account before making a final decision.

If the Commissioner considers a board has not taken appropriate action in response to his comments, he may give a report to the Minister.[68]

3.4.3 Weaknesses in the current jurisdiction and powers of the HRC

A comparative study of the HRCA and corresponding legislation in other states and territories in Australia and New Zealand indicates that the HRC's jurisdiction and powers in respect of health service complaints are limited in comparison to its counterparts, in particular, with respect to:

(i) the limited category of persons who may complain to the HRC;
(ii) the HRC's lack of power to compel a registered provider to respond to a complaint;
(iii) the HRC's lack of jurisdiction to formally investigate complaints about registered providers, or to initiate "own motion" investigations on matters that may be in the public interest;
(iv) the HRC's lack of power to impose any formal sanction on HSPs (particularly unregistered providers who are not subject to any prosecutorial or disciplinary action by another body), and limited involvement (that is, commenting on action proposed by a registration board) in decisions about disciplinary action against registered HSPs.

Who may complain to the HRC

Section 59 of the HRCA provides that a complaint may be made to the HRC by:

- the user of the health service or his/her representative;
- someone with sufficient interest to act on behalf of the user if the user cannot choose a representative;
- the Legal Friend or Adult Guardian;
- the Minister for Health; and
- anyone else the Commissioner may accept a complaint from in the public interest.

Section 59 effectively excludes complaints from non-users of a health service (for example, another HSP, clinical or administrative staff of an organisation providing health services, or whistleblowers) unless accepted by the Commissioner as a complaint concerning a health service which should be accepted in the public interest.

The New South Wales Health Care Complaints Act (HCCA) provides that "any person" may make a complaint[69]. This is considered preferable in that it enables independent external review of complaints from both users of a health service, and other potential complainants of the kinds indicated above.

[68] s.126 HCRA
[69] s.8 of the *Health Care Complaints Act 1993* (NSW)

The HRC's lack of power to compel a registered provider to respond to a complaint

When the HRC receives a complaint about a registered provider, the Commissioner is to assess the complaint to determine whether or not to accept it for action. However, while the HRC has power to require a non-registered provider, or an organisation, to respond to a complaint and to provide information, it has no power to make the same requirement of a registered provider. Rather, the HRC can only invite a response from a registered provider[70]. A refusal by a registered provider to co-operate with the HRC's enquiries can lead to unnecessary delay in the complaint being progressed.

This often leads to the HRC having no other option but to refer the matter to the relevant board, which does have the power to compel a registered provider's co-operation with a board's investigation of a complaint (although the board will only investigate complaints that raise issues sufficiently serious as to potentially involve "unsatisfactory professional conduct" as defined in the Schedule to the HPPSA).

The Commissioner in his 2003-2004 annual report (p.9) noted that one way around the above problem would be for the HRC to be given the power to obtain relevant information and to require providers to respond to a complaint. This would bring the HRC into line with interstate Commissions that currently have this power.[71]

The HRC's lack of jurisdiction to formally investigate complaints about registered providers or to initiate "own motion" investigations

The HRC is the only Commission in Australia that does not have jurisdiction to investigate a complaint about a registered provider. All other interstate Commissions have a discretionary power to investigate such complaints.

In Victoria, if a complaint relating to a registered provider is received by the Commission, it must refer the complaint to the appropriate registration board if, after consultation with the provider's registration board, the Commissioner considers that the board has the power to resolve or deal with the matter and the matter is not suitable for conciliation[72].

In other jurisdictions, the Commissioner's view prevails in respect of more serious complaints, for example, complaints involving issues of a systemic nature or complaints relating to professional conduct, or complaints raising concerns about public health or safety or the public interest[73]. In other words, in these jurisdictions the Commission may exercise a discretion to investigate in the interests of public health or safety, or if the complaint raises significant issues as to the provider's practice.

One of the flaws in the HCRA is that, although the HRC must refer all complaints about registered providers to the relevant registration board, the boards are not compelled to accept a complaint for action, and will only do so if they consider the

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[70] s.70 HRCA. The only obligation on a registered provider is to advise the HRC whether or not he/she intends to make a submission.

[71] s.28 of the *Health and Community Services Complaints Act 2003* (NT); s.30 of the *Health and Community Services Complaints Act 2004* (SA)

[72] s.19(6) *Health Services (Conciliation and Review) Act 1987* Vic.

[73] *s.48 Health and Community Services Complaints Act 1998* (NT); *s.40 Community and Health Services Complaints Act 1993* (ACT); *s.26 Health Care Complaints Act 1993* (NSW); *s.43 Health and Community Services Complaints Act 2004* (SA); *s.46 Health Services (Conciliation and Review) Act 1995)* WA.

complaint is sufficiently serious to warrant their intervention because it may involve unsatisfactory professional conduct (as defined in the Schedule to the HPPSA) by a registered provider.

This creates a hiatus for complaints against a registered provider which have substance, but which the board considers are not sufficiently serious for it to take action (because they would not reach the standard for disciplinary action, that is, "unsatisfactory professional conduct", as defined). The HRC has no power to investigate such complaints against a registered provider (unless specific permission is obtained from the Minister on 'case by case basis'). In these circumstances, the complainant may well have no avenue for independent review.

The Neville complaint provides an example of the difficulties that can arise when a board declines to accept a complaint for further action (on the basis that the conduct complained of does not appear to provide a ground for disciplinary action). After the MBQ declined to accept the Nevilles' complaint about the Executive Director, the Commissioner sought the Minister's approval for the HRC to investigate the matter. The Minister refused on the basis that QH had appointed an external investigator to investigate this aspect of the Nevilles' complaint. In my view, the external investigator did not adequately address this issue, with the result that this aspect of the Nevilles' complaint has never been adequately investigated. This situation could have been avoided if the HRC had the power to investigate aspects of a complaint that relate to the conduct of a registered HSP.

The HRCA does not empower the HRC to conduct "own motion" investigations. The Health and Disability Commission in New Zealand and a number of interstate Commissions have the power to initiate investigations[74] on their own motion, as does the newly formed Legal Services Commission in regulating the legal profession in Queensland, and my Office.

<u>The HRC's lack of power to impose any formal sanction on HSPs (particularly unregistered providers who are not subject to any prosecutorial or disciplinary action by another body), and limited involvement in decisions about disciplinary action against registered HSPs</u>

The HRC is able to accept for investigation complaints about non-registered providers (primarily, organisations such as hospitals, hostels or nursing homes and a number of alternative therapists not subject to professional registration requirements). However, in instances of unsatisfactory service (no matter how egregious) it is unable to impose any formal sanction or initiate any disciplinary action against that provider, and there is no other disciplinary body able to take on this role.

The boards and the QNC are empowered to take disciplinary action against registered providers before established disciplinary bodies. While the Commissioner is unable to initiate, or direct a board or the QNC to initiate, disciplinary action, the Commissioner does have some limited input into the process. Where the Commissioner has requested a board or the QNC to provide him with reasonable reports during an investigation, the board /QNC must give the Commissioner a report about the findings of the investigation and the action taken or proposed to be taken (including any

[74] e.g. s.59 HCCA; s. 40 *Community and Health Services Complaints Act 1993*(ACT); s. 43 *Health and Community Services Complaints Act 2004* (SA); s.48 *Health and Community Services Complaints Act 2003*(NT)

proposed disciplinary action to be taken against the registrant the subject of the investigation). The Commissioner may then make comment or recommendations to the board/QNC about any proposed disciplinary action to be taken. The HRCA also makes provision for the Commissioner to intervene in a proceeding against a registered provider before a disciplinary body at any time during the proceedings[75].

The only jurisdictions in which the Commissions are empowered to prosecute cases against individual registrants before disciplinary bodies are New South Wales and New Zealand. In both jurisdictions, the decision whether to take any disciplinary action is made by a Director of Proceedings, who is a senior lawyer employed by the Commission (see Appendix 4 for more detail).

Some commentators believe that a Commission having a prosecutorial role is inimical to obtaining co-operation by registered HSPs for the resolution of complaints through negotiation and formal conciliation, which should be the primary emphasis of a health complaints body[76]. The contrary view is that decisions on possible disciplinary action should not be left in the hands of registration boards comprised mostly of members of the relevant health care profession.

In Queensland, we have a precedent for the prosecutorial model in the recently established Legal Services Commission, which may indicate a legislative preference for removing control of professional regulation and discipline from bodies comprising members of the relevant profession.

The Legal Services Commission currently initiates disciplinary proceedings against legal practitioners if, after investigation, there is a "reasonable likelihood of a finding by a disciplinary body of unsatisfactory professional conduct or professional misconduct" and "it is in the public interest to do so". When the evidence warrants it, the Legal Services Commissioner prosecutes legal practitioners before the Legal Practice Committee or, for more serious matters, the Legal Practice Tribunal. Accordingly, there is an established precedent in Queensland for an independent complaints agency that investigates, or monitors the investigation of, complaints about the provision of professional services, and makes decisions about whether or not to initiate disciplinary proceedings.

[75] s.130 HRCA.
[76] D.Thomas (ed.). *Medicine called to Account: Health Complaints Mechanisms in Australia, UNSW Press, 2002 p.8*

4. Health complaints models interstate and overseas

4.1 Australia and New Zealand

The various bodies established in Australian States and Territories and in New Zealand for receiving and investigating health care complaints (called "Commissions" here for the sake of brevity) differ in their jurisdiction and powers. In general though, they all have jurisdiction to:

- receive health care complaints;
- attempt to resolve complaints, primarily through a process of mediation or conciliation between the service provider and the complainant; and
- oversee, review and improve the overall health system.

The Commissions are also, to varying degrees, empowered to investigate "systemic" issues. The New Zealand Health and Disability Commissioner is among those offices which have a wider brief, with the ability to investigate and prosecute private and public providers, orthodox and alternative therapists and, importantly, to initiate "own motion" investigations.

The complaints mechanisms set up in all Australian States and Territories, other than in New South Wales, are based on a conciliation approach. The New South Wales Health Care Complaints Commission is the only Australian Commission that, like the New Zealand Health and Disability Commissioner, is empowered to prosecute health practitioners before registration boards, tribunals and professional standards committees. However, conciliation has been introduced in New South Wales as an alternative to the Commission's predominantly prosecutorial approach.

The proponents of the conciliation approach argue that, when medical errors or misadventures occur, the best way to deal with them is through non-legal conflict resolution measures. Furthermore, the conciliation approach enables those who have suffered medical misadventure to obtain financial compensation. They also argue that an adversarial, legalistic approach is not the best way to promote efficiency and effectiveness in the health care area, or to deal with situations in which human error rather than intentional misconduct has resulted in adverse events.

Until March 2005, the New South Wales Health Care Complaints Commission provided an advocacy role for complainants. On that date, it lost that role and took on a role as an impartial body for alternative complaints resolution. This provides a less formal option to the conciliation approach and is completely independent of the investigative processes of the Commission. The New Zealand Commission is now the only jurisdiction that has an advocacy role for complainants.

While there are some subtle differences, the individual processes of the Commissions are very similar.

The following table summarises the key processes of the Commissions in each State/Territory and New Zealand.

	QLD	NSW	VIC	NT	WA	ACT	TAS	SA	NZ
Health Commission	x	x	x	x	x	x	x	#	x
Formal Investigative role	x	x	x	x	x	x	x		x
Formal Conciliation role	x	*	x	x	x	x	x		x
Advocacy role									x
Legislation includes services for aged				x		x			
Legislation includes services for disabled				x		x			x
Consult with Boards	x	x	x	x	x	x	x		x
Prosecutorial function		x							x
Assessment timeframe	x	x	x	x	x		x		
Extension of Assessment option	x	x	x						
Code of Health Rights & Responsibilities				x			x		x
Act recently reviewed/under review		x		x	x	x	x	x	

*In New South Wales the conciliation function is carried out by the Health Conciliation Registry. This was previously a separate body within the New South Wales Department of Health. However, on 1 March 2005, the Registry was integrated with the New South Wales Health Care Complaints Commission (HCCC) so that the existing conciliation service could be better utilised and all alternative dispute resolution functions could be performed efficiently under the auspices of the HCCC. It has retained its independence, in that it is not subject to the direction or control of the Commissioner when carrying out its conciliation function.

Since 1 March, the HCCC also has a complaints resolution role (refer to Division 9 of the *Health Care Complaints Act 1993* as amended).

#Currently, the SA Ombudsman considers health complaints, but only those relating to public providers. The SA Parliament has passed legislation to establish a Health and Community Services Complaints Commissioner. The Act is expected to operate from mid to late 2005.

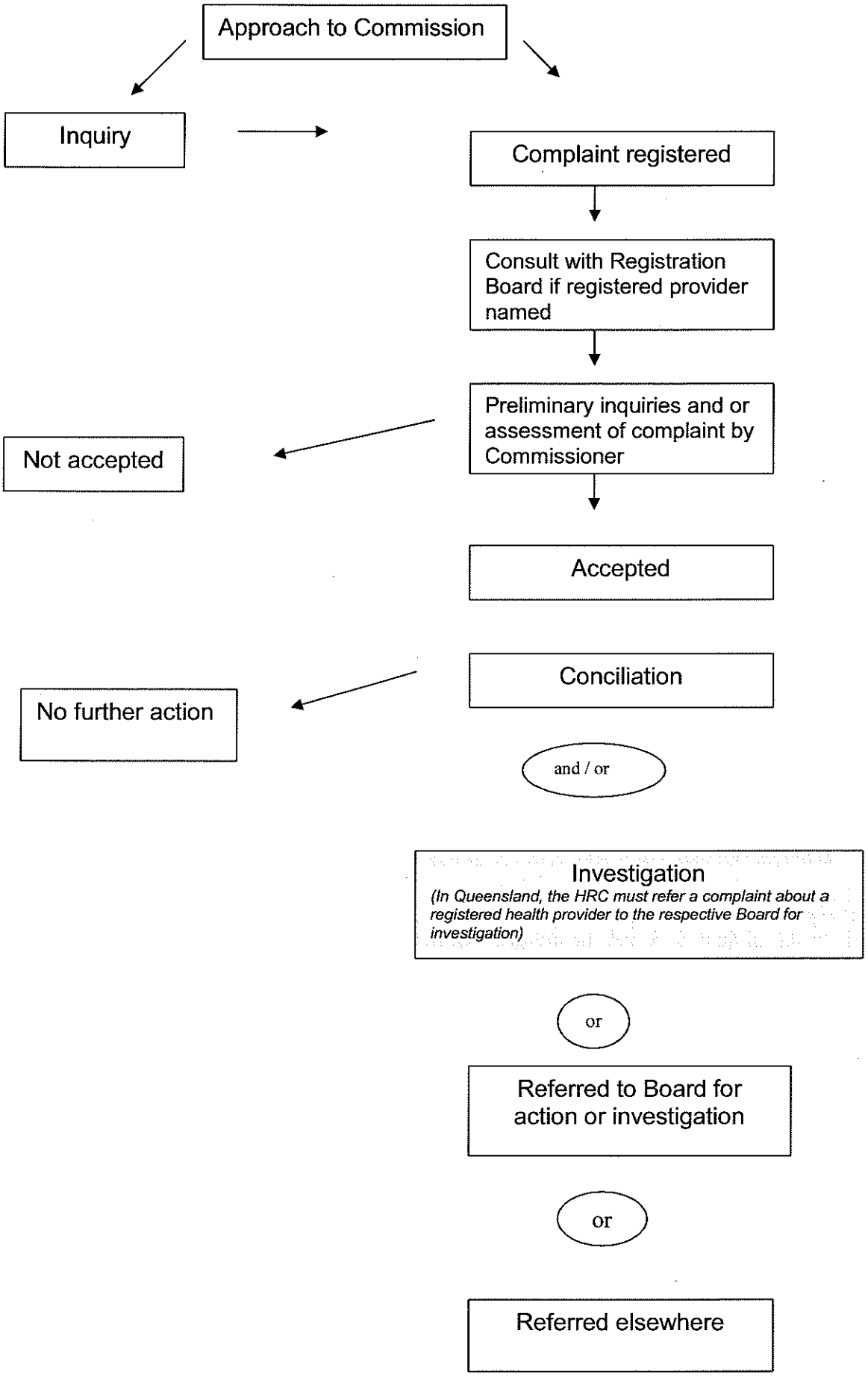
4.1.1 Relationships between the Commissions and the registration authorities

In Australia, the respective Commissions and registration boards generally have a statutory obligation to report complaints about registered providers to each other, and consult on the best way to manage the complaint. A complaint may be referred to the board if the Commission considers the board has power to deal with it, or if the complaint is not suitable for conciliation. There is a requirement for written protocols to ensure consultation occurs and, where the legislation is silent, on how disagreements regarding management of a complaint are to be resolved.

Except in Western Australia, there is no requirement for a Commission to obtain the complainant's consent before referring a complaint received about a registered provider to a registration board for action. In Western Australia, the Office of Health Review has a statutory obligation to obtain the written consent of the complainant before referring the complaint to the registration board for action[77].

The following flowchart represents the standard processing of complaints by the Commissions (with the exception of New South Wales):

[77] *s.31 Health Services (Conciliation and Review) Act 1995* WA.


Approach to Commission
Inquiry
Complaint registered
Consult with Registration Board if registered provider named
Preliminary inquiries and or assessment of complaint by Commissioner
Not accepted
Accepted
Conciliation
No further action
and / or
Investigation
(In Queensland, the HRC must refer a complaint about a registered health provider to the respective Board for investigation)
or
Referred to Board for action or investigation
or
Referred elsewhere

4.2 New Zealand

In New Zealand, the complaint mechanism established by the *Health and Disability Commissioner Act 1994* NZ is the primary method for dealing with complaints about the quality of health care and disability services.

The New Zealand model employs a code, entitled the *Code of Health and Disability Services Consumer's Rights* (the Code), that has a binding effect on all providers of health and disability services. The Code sets out ten rights, including the right to be treated with respect, to be free from discrimination or exploitation, to dignity and independence, to services of an appropriate standard, to give informed consent, and to complain.

The role of the Commissioner is to protect the rights of consumers of health and disability services, and facilitate the fair, simple, speedy and efficient resolution of complaints. There is a national network of independent advocates (free service) under the Director of Advocacy. There is also an officer called the Director of Proceedings who is an employee of the Commissioner's office but who acts independently of the Commission in exercising the powers and performing the duties and functions of the position[78]. The objectives of the Act are achieved through the Code, the establishment of a complaints process to ensure enforcement of the rights in the Code, and the ongoing education of providers and consumers.

The Commissioner is also able to undertake investigations on his/her own initiative. This enables the Commissioner to fulfil the role of "consumer watchdog" and to ensure public safety.

All complaints made to the registration boards must be referred to the Commissioner. Once this occurs, no disciplinary action can be taken by the registration board until the Commissioner, or the Director of Proceedings, has dealt with the matter and decided to take no further action. Only at that point can the registration board take up the matter.

However, referral of a complaint to the Commissioner does not preclude a registration board from considering a member's fitness to practice for reasons other than discipline, namely health or disability or competence to practice.

The Commissioner's options in respect of complaints are to take no further action, to investigate, or to refer the complaint to formal mediation or to advocacy. Advocates can assist a consumer in resolving a complaint with a provider. The advocate, after hearing the complaint, can provide free advice about the rights of the complainant and provide support in deciding what course of action to take.

If the Commissioner decides to investigate a complaint, an investigator is appointed. Once all relevant information has been gathered, the Commissioner may ask an expert in the area to review the information and advise whether the services provided met the appropriate professional standards. Taking into account the expert advice and other relevant evidence, the Commissioner determines whether the rights in the Code have been breached.

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[78] s.15 *Health and Disability Commissioner Act 1994* (NZ)

If the Commissioner forms an opinion that a provider has breached the Code, the respective parties are notified and the provider will be given an opportunity to make a written submission. In reporting the final decision, the Commissioner may refer the matter to the Director of Proceedings, who may bring disciplinary and/or other proceedings. On referral to the Director of Proceedings, the principal avenues of redress are a claim before the Human Rights Review Tribunal, or disciplinary proceedings before a health professional disciplinary body. The Director may decide to take action in both forums. If the Director of Proceedings decides to take no action, an individual is able to take his or her own case to the Human Rights Review Tribunal.

The Commissioner does not have any power to award compensation. Examples of recommendations that may be made where a provider has not met the obligations under the Code include:

- an apology;
- a refund of some or all of the money a consumer has paid for services that are found to be below expected standards;
- a change in the way the provider does things, or changes to organisational policies.

The Commissioner can also ask the Minister for Health to take steps to improve a service if an investigation reveals a problem, or if new rules are needed to protect consumers.

4.3. United Kingdom (UK)- National Health Service

In 1999, a national evaluation of the National Health System (NHS) complaints procedure revealed that the public considered the procedure was not sufficiently independent. A further report released in 2003 found the complaints system was perceived as inconsistent, and that complaints took too long to be processed.

As a result, the UK Department of Health decided that a new complaints system should be set up, incorporating a second level of review by an independent organisation, the Healthcare Commission (HCC). The HCC is an independent inspection body for both the NHS and private and voluntary healthcare. The aim of the HCC is to increase patient confidence in the NHS complaints procedure, and to improve services in the NHS by pinpointing where things are going wrong in an independent, fair, consistent and timely manner. The HCC has the power to charge the NHS Trusts[79] for reviewing complaints made against them.

[79] Trusts are public bodies that provide health services.

An outline of the changes to the complaints process is summarised below:

	Old Process (est. 1996)	New Process (July 2004)
Stage 1 - Local Resolution	Patient, or someone acting on their behalf, complains to the organisation or practitioner concerned.	(Unchanged)
Stage 2 - Independent review	If the patient was unhappy with the response obtained at stage 1, they could apply for an independent review overseen by an NHS convener - usually a non-executive Director of the Trust to which the complaint was made. If the individual was unhappy with the convener's initial response, a panel consisting of the convener, a chair nominated by the strategic health authority, and one other, would be established to hear the complaint.	If the patient is unhappy with the response obtained at stage 1, they can apply to the HCC for an independent review. Trusts can also refer complaints to the HCC with the patient's consent. If the individual is still unhappy after the initial review and investigation by the case manager, they have the option of having their case heard by an independent panel. There are set timescales and phases the HCC works to in handling these requests.
Stage 3 - Health Service Ombudsman	If a patient was unhappy, the complaint could be referred to the Health Service Ombudsman.	If a patient is still unhappy, complaint can still be referred to the Health Service Ombudsman and, in some circumstances, the HCC will refer complainants directly to the Ombudsman.

The success of the new NHS complaints procedure depends on good complaints handling locally, by the service provider. The HCC works with the Department of Health to identify best practice complaints handling and to promote good clinical practice.

Under the new system, an individual needs to bring a complaint to the HCC within two months (60 days) of receiving a formal written response from the trust or health practice concerned. The only exception to this is if the complaint has been with the trust or practitioner for more than six months without a formal response, in which case the HCC can be asked to investigate.

All requests for an independent review by the HCC are acknowledged within two days. A member of the complaints team then conducts an initial review of the case, with the help of expert advice if necessary, to determine whether further investigation is needed. To ensure consistency, a team leader reviews any recommended course of action by the case manager. Both the complainant and organisation/practitioner complained about are advised of the decision and any recommendations within 20 days. The following table summarises the complaints process and the timeframes involved.

ACTION	TIME
Acknowledge complaint	Within two days of receipt
Obtain consent forms (obtain medical records)	Up to 5 days
Call for papers, including views of organisation complained against on the complaint	Up to 20 days
Expert advice identified and received	Up to 30 days
Decision on what will happen to the case	Up to 10 days
Communication to all parties	Immediately following decision on what is to happen to the case
If investigation agreed, terms of reference drafted	Two days
Comments from parties	Up to 10 days
Identify and secure experts	Up to 20 days
Arrange interviews, call for further papers, write report, quality assurance	Must be completed within 90 days of decision to investigate unless there is good reason
Request from complainant or organisation complained against for hearing by a panel	Within 40 days of report
Panel established	Within 48 days of the receipt of the request
Draft report for checking by parties for factual accuracy	Within 10 days of panel hearing
Receipt of comments and checks for quality	Within 10 days of deadline for comments
Issue report	

N.B. Some of the timeframes may be concurrent.

The HCC investigates allegations of, or information suggesting, serious failings that have a negative impact on the safety of patients, clinical effectiveness or responsiveness to patients such as:

- a higher than anticipated number of unexplained deaths;
- serious injury or permanent harm, whether physical, psychological or emotional;
- events that put at risk public confidence in the healthcare provided, or public confidence in the NHS generally;
- a pattern of adverse events or other evidence of high risk activity;
- a pattern of failures in services or teams, or concerns about these;
- allegations of abuse, neglect or discrimination against patients.

Other failings with less serious effects on patient safety may be subject to review by the HCC.

If the decision is made to carry out further investigation, the investigation's terms of reference are agreed upon with both the complainant and the organisation/practitioner. Even if a complaint has been made to a statutory professional regulatory body, an investigation by the HCC and full report of the investigation findings are provided to both parties at the end of the investigation.

If individuals are unhappy with the outcome of the investigation, they have a right to request an independent panel be established to hear their concerns. The panel consists of three members of the public, who are not connected to the NHS but who have been specially trained to deal with NHS complaints. The panel will hear both sides of the complaint. They will also make recommendations for resolution and/or for improving services where appropriate. In the majority of cases, the whole process should take no longer than six months.

The panel is not adversarial, but must uphold the principles of fairness and consistency. The standard of proof is the civil standard of "balance of probabilities". The majority view prevails.

Accurate records approved by the panel members are kept of conclusions and recommendations, and the reasons for reaching the conclusions. The panel makes two sets of recommendations: one concerned with redress for the individual and the other regarding improvement of the services (where appropriate). A full report is available to the parties and an anonymised report is published and available on the HCC website. At every stage of the procedure, anonymised information is fed into the HCC's baseline information systems on the organisations complained against, to facilitate analysis of patterns or trends.

The boards of the relevant NHS trusts are responsible for putting into operation the recommendations (if any) in the investigation and panel reports. The HCC expects NHS bodies to be able to demonstrate how they have improved systems as a result of information from complaints. This involves the NHS service providers producing action plans based on recommendations from the HCC investigations, panel hearings and reports.

One of the problems faced by review panels under the old system was that they often had incomplete information on which to make a judgment. Under the new system the panel will have a full investigation report and so will not need to reinvestigate issues that have been established.

An individual can expect that the HCC will pursue an explanation and acknowledgement of what went wrong, and action to put the matter right. Where warranted, the HCC seeks an apology for the patient and can also recommend the healthcare provider change the way it works so that similar things don't happen again and that lessons are learnt from what went wrong. The HCC is unable to seek compensation for the complainant/patient.

Where complaints involve different aspects of care, such as a GP service and a hospital for acute care, the HCC can look at the whole of the patient's experience. The HCC works with other agencies to ensure that the complaint investigation covers the whole of the patient's experience, rather than separate investigations for different elements of a complaint. In this way it helps to avoid duplication of investigation for healthcare organisations and makes it easier for the relevant bodies to learn from complaints.

By carrying out its responsibilities for inspection and audit of healthcare, the HCC is in a position to ensure that information from complaints is used by local organisations to improve services.

Clear cases of negligence are referred to the General Medical Council.

The HCC also shares information obtained from complaints with the National Patient Safety Agency (NPSA). The NPSA is a special health authority created in July 2001 to establish a national system for identifying adverse events and near misses in healthcare by:

- gathering information on causes; and
- acting to reduce risk and prevent similar events occurring in the future.

The NPSA was established to help address the estimated 900,000 incidents (at that time) either harming or nearly harming NHS hospital inpatients in the UK each year.

As well as making sure errors are reported in the first place, the NPSA promotes an open and fair culture in the NHS and encourages the reporting of incidents and "near misses" without undue fear of personal reprimand in the knowledge that, by sharing their mistakes, others will be able to learn lessons and improve patient safety. It proactively works to develop national solutions to prevent incidents that affect patient safety and aims to discover why things go wrong, rectify incorrect actions and make it harder to do the wrong thing.

The NPSA's areas of work originate from a number of sources including individual patients, patient groups, clinical experts, healthcare professionals and coroners. Issues are also identified by a National reporting and learning system and data from other organisations in the UK and abroad.

When the NPSA identifies an issue, it builds up a complete picture using information from a number of sources. Solutions are designed in partnership with clinical experts and patients, and then piloted in NHS organisations to assess their impact. The NPSA undertakes risk assessments at every stage, evaluates the effectiveness of solutions and learns from the results. The following summarises the different stages of the NPSA process:

- understand the patient safety issue
- identify areas for solution development
- explore possible solutions
- test and refine solutions and
- monitor solutions and track progress.

5. Proposals for a new health complaints system

5.1 Shortcomings of the existing health complaints system in Queensland

The Neville investigation demonstrates a number of significant shortcomings and problems with the current health complaints system in Queensland. The system is difficult for many complainants to access and navigate. This is illustrated by the difficulties Dr Neville experienced in trying to obtain timely and appropriate outcomes from the system. Dr Neville is a medical practitioner (although his field is medical research), with highly developed research skills, and as a senior QH official, had a good understanding of the relevant systems. His travails highlight the difficulties liable to be experienced by others who attempt to use the current system without the advantages Dr Neville possessed.

The shortcomings of the current system can be summarised as follows:

- A fragmented health complaints system, involving several health complaint agencies, each with limited jurisdiction, but whose jurisdictions can overlap to varying degrees and are not well integrated. This results in:
    - inability of one agency to investigate all aspects of a complaint (for example, if the HRC investigates a complaint against a hospital it has to stop at the point where clinical competence of a registered provider becomes an issue);
    - complainants having to decide on the most appropriate agency to which to direct their complaint, or whether separate aspects of the one complaint may need to be referred to another agency or agencies for assessment, investigation and/or other action;
    - potential for duplication where a complaint has been split and a number of agencies are investigating different issues arising from the same incident;
    - annoyance for the complainant and witnesses when different agencies seek different kinds of information (relevant to the issues they have jurisdiction to investigate) at different times;
    - inability to produce one coordinated response following investigation of a complaint which has been split because different agencies have sole jurisdiction to deal with particular issues.
- A system that is not consumer-focused or user-friendly, principally because of the fragmentation referred to above, but also through:
    - lack of information by HSPs about their complaint processes;
    - a "culture" that does not welcome complaints thereby discouraging complainants for fear of reprisal;
    - "open disclosure" principles[80] not being broadly implemented;
    - lack of readily available support and advice for complainants who may require assistance in presenting and resolving their complaints with HSPs (for example, complaints coordinators in each QH Health Service District or an independent patient advocacy service).

[80] See section 5.9.2 below

- The system itself tends to foster delay through requirements for cross-referral and consultation between agencies with overlapping jurisdiction (or gaps in their jurisdiction), and because of the HRC's inability to compel a registered provider to respond to a complaint during the assessment phase. With regard to the latter, the HRC may frequently have no option but to refer a complaint to the relevant registration board (which does have coercive powers), but the registration board will only take action if it believes the matter may involve unsatisfactory professional conduct. This has a relatively high threshold test which would not be met in many instances of unsatisfactory service by HSPs.

- There is a perceived or potential lack of impartiality in registration boards, comprised of members of the relevant profession, conducting an investigation, and undertaking disciplinary action, against 'one of their own' (*cf.* recent moves to have an independent Legal Services Commissioner, rather than the Queensland Law Society Inc, take responsibility for supervision of complaints and disciplinary matters involving the legal profession).

- There is currently no provision for the centralised collection of complaints data, that could be analysed to reveal recurring problems and trends, as a basis for quality improvement measures.

5.2 Key features of a better health complaints system

A quality complaints system should be:

- accessible and user friendly to everyone, including those with special needs;
- fair and impartial in its processes;
- timely and efficient in dealing with complaints;
- committed to achieving fair remedies and promoting systemic improvements;
- accountable and transparent in its operations;
- committed to best practice and continuous improvement;
- cost effective;
- subject to periodic review.

A comprehensive coordinated system is needed for handling health complaints in Queensland. The primary means of dealing with such complaints should be the internal complaint management processes of the HSPs themselves. Each HSP should be required to implement a complaint handling procedure that complies with the Australian Standard.

In the case of QH, its internal complaint process should be enhanced as proposed at section 3.1.3 in Part 2 of this submission. That process also needs to be supplemented by appropriate procedures for encouraging and acting on PIDs and providing safeguards for those who make them, as recommended in Part 1 of this submission.

An independent body is also needed with overriding responsibility for all complaints (referred to here as "external complaints") that cannot be resolved by the relevant HSP or that are not appropriate to be resolved by the HSP. That body would deal with external complaints itself or ensure they are appropriately dealt with by another body.

In summary, this body should:

- receive and assess all external complaints about health service provision in both the public and private sectors, including complaints about registered providers, as well as non-registered providers;
- wherever possible, attempt early informal resolution of complaints, and where that is not successful, provide access to mediation and conciliation;
- investigate all aspects of the more serious complaints, including complaints about registered providers;
- refer cases warranting disciplinary action to a new disciplinary body (that would deal with disciplinary issues currently dealt with by the boards/QNC) or, in more serious cases of unsatisfactory professional conduct, to the Health Practitioners Tribunal (as is currently the position);
- be empowered to order minor remedial action for breaches by HSPs of a Code of Health Rights and Responsibilities;
- centralise the recording, collation and analysis of complaint data, so that complaint trends can be identified enabling complaint reduction measures and service delivery improvements; and
- be funded independently of QH, and report to Parliament and not to a Minister.

The focus of both internal and external complaint management should, wherever practicable, be more consumer focussed by providing complainants with ready access to informal complaint resolution processes and explanations for the causes of complaints. Furthermore, the system should focus not only on redressing the effect of poor decisions and service, but also on identifying and addressing the cause of recurring complaints and systemic failure.

Specific details of the recommended new health complaints system are set out in section 5.4, followed by reference to some other issues which should be considered in order to improve current arrangements.

5.3 Response to the BHCI proposals for a "One Stop Shop"

The BHCI has suggested that the best approach to dealing with the deficiencies in the existing public sector health complaints environment is to establish a "one stop shop" such as a Health Sector Ombudsman.

It is considered that a "one stop shop" is an appropriate model for external complaints resolution. However, the primary emphasis should be on local complaints resolution, with independent investigation, oversight and review where the matter cannot be satisfactorily resolved directly with the relevant HSP.

There should also be strong emphasis on non-adversarial complaints resolution processes, and on learning from patient complaints information to improve patient safety outcomes.

Within QH, a State-wide network of adequately resourced complaints coordinators would assist other measures referred to above for improving systems for, and outcomes from, local complaint resolution.

Local complaint resolution should be complemented by a remodelled HRC to provide a comprehensive health complaints system. Legislative amendment will be required to

empower the HRC to take a more effective and central role in resolution of complaints that cannot be resolved locally with the HSP, in improving standards of health service provision, and in professional disciplinary matters. The HRC will need additional funding if it is to perform these responsibilities effectively.

The BHCI Discussion Paper made the recommendations numbered 1-5 below in relation to the role of the Health Sector Ombudsman, and I have made comments below about those proposed functions.

1. Receive complaints from any interested party, including patients, clinical staff, administrative staff, and the general public

Adopting the approach proposed in the BHCI Discussion Paper potentially adds a further layer or step in the complaints resolution process by requiring all complaints to go first through a central bureaucracy (which would have to be substantial given the number of complaints that are currently made each year) rather than encouraging direct local resolution wherever possible in the first instance.

It is considered preferable that, as the initial response, the local complaints coordinator work with the complainant to resolve the complaint with the HSP at the local level. Part of the receipt and referral function would involve facilitating access to alternative dispute resolution mechanisms where appropriate. The matter would be escalated to the appropriate entity where necessary.

Broadening the scope of persons eligible to complain would be better dealt with by an administrative policy within public sector health services and an amendment to the HRCA that entitles health practitioners to complain.

2. Refer complaints to the appropriate authority, whether it be the hospital administration, QH, the HRC, or the MBQ

Having a Health Sector Ombudsman screen and refer complaints would require substantial resources that could be better directed to enhancing the capacity of service providers to deal effectively with complaints at the local service delivery level and for better resourcing a remodelled HRC to undertake expanded functions and to achieve better performance in terms of timeliness.

3. Monitor the investigation and handling of complaints, to ensure that they are addressed and dealt with, both fully and expeditiously

The vast majority of complaints do not require monitoring because they should be resolved quickly and easily at the local level. For those matters which cannot be resolved, a remodelled HRC should take responsibility for timely complaint resolution, and providing more resources to that body would be more a effective allocation of resources.

Public sector health complaints could be centrally monitored directly via the web based complaints management system that is currently being trialled by QH. A similar and linked system could be established by the HRC to capture complaints from the public and private health sectors that are escalated for independent investigation.

To ensure that complaints related to patient safety are appropriately monitored and investigated, another option would be to establish a statutory data collection integrating all complaints related to patient safety, as well as serious adverse and sentinel events reports. *The Health Act 1937* could be amended to create a duty for such matters to be reported by public and private health care providers and complaints management entities to the QH Information Centre. This data would then be available for research and intervention focussed on quality improvement and patient safety.

4. **Where necessary, ensure the investigation of the complaint is escalated to the appropriate level if it cannot be resolved at a lower level; and**

5. **Ensure that the complainant receives feedback regarding the outcome of the complaint**

The model proposed in this submission should satisfy recommendations 4 and 5 through reform or enhancement of existing entities, without establishing a further agency or duplicating existing systems.

These requirements could become part of an operational protocol or administrative instruction to staff employed in complaints management at the local level. In the case of both public and private sector health service organisations, the escalation of unresolved complaints could be facilitated by ensuring that complaints coordinators report directly to the Senior Manager at the health facility. In the public sector this could be monitored by the complaints management unit in QH via the web-based complaints system.

It is reasonable to expect a complainant, who is dissatisfied with the relevant HSP's attempts at local resolution, to directly refer the complaint to a remodelled HRC for independent external review. The referral process should be straightforward because the HRC would be, in effect, a 'one stop shop' at the external review stage.

In keeping with adopting a non-adversarial approach to complaints management, it is proposed that following the HRC's assessment of a matter, an attempt should be made to conciliate the complaint provided it is considered suitable for conciliation. The most recent HRC Annual Report suggests that there is already a heavy demand on these services and an associated backlog of cases, so it may not be possible to extend the availability of formal conciliation without additional resources.

Furthermore, the HRC's current practice of trying to informally resolve complaints prior to finalising its formal assessment should be continued as it is less resource intensive than conciliation under the HRCA.

5.4 Outline of the proposed health complaints system

The following outline is provided of the key features of the proposed new health complaints system.

5.4.1 In relation to QH and public sector HSPs, the system will involve a three stage complaints process, as is presently the case:

- Stage 1 - Delegated staff will resolve minor complaints at the point of service wherever possible.
- Stage 2 - More serious complaints and any unresolved minor complaints will be referred to the complaints coordinator within each Health Service District for resolution, but with monitoring and review by a central Complaints Management Unit[81].
- Stage 3 – Independent external review by a remodelled HRC, which for the purposes of this submission, is referred to as the Independent Health Services Commission (IHSC).

In addition, the Queensland Ombudsman will retain jurisdiction to review administrative action of public sector health agencies, including the IHSC, and investigate systemic issues.

5.4.2 Private sector HSPs should adopt a similar complaint management system with any necessary modifications and be subject to review by the IHSC.

5.4.3 The complaint resolution process of each HSP should be based on the current Australian Standard for Complaints Handling 4269:1995 (or as revised). This could be made a condition of their registration/licensing.

5.4.4 A "Code of Health Rights and Responsibilities" (the Code) should be developed similar to codes presently in existence in the Northern Territory, Tasmania, and New Zealand (copies provided at Appendix 3). The main function of the Code is to establish standards to assess the conduct of HSPs. The Code will provide for the consumer's right to complain about breaches of the Code.

5.4.5 To emphasis its independence, the IHSC should be accountable directly to Parliament rather than to the Health Minister and should be independent of QH in its operations and funding.

5.4.6 The jurisdiction of the IHSC should be broader than that of the HRC, particularly in the areas of assessment and investigation. The IHSC should have coercive powers to compel registered and non-registered providers to provide information and documents, at the assessment and investigation stages.

5.4.7 The IHSC should provide complainants with a "one stop shop" in that it should have jurisdiction to deal with all aspects of complaints in relation to both registered and non-registered providers, and in both the public and private sectors.

5.4.8 The IHSC should be able to accept complaints from any person, that is, not only recipients or users of health services (or their representatives), but other registered providers, including employee health practitioners complaining about health service provision by an organisation that employs them. The current measures in the HRCA[82] aimed at protecting complainants from reprisals, should be retained for the expanded class of prospective complainants.

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[81] See section 3.1.3 of Part 2
[82] For example, s.64, s.142

5.4.9 Following the initial intake of a complaint, the IHSC should, in all appropriate cases, attempt early informal resolution of the complaint (that is, without detailed assessment or investigation), before a matter is assessed as to whether it is suitable for conciliation or should be referred for investigation.

5.4.10 The IHSC should have a discretion to decline to accept a complaint, or decline to take further action on a complaint, if legal proceedings have been commenced. However, the IHSC may retain the complaint if it is in the public interest to do so, for example, if the complaint raises systemic issues or the possibility of unsatisfactory professional conduct by the HSP.

5.4.11 The initial objective of the IHSC in most cases will be to attempt to resolve complaints primarily through a process of informal resolution or conciliation.

5.4.12 Where informal resolution or conciliation is not successful, the IHSC will be empowered to investigate the complaint, or to refer the investigation of less serious matters to the relevant HSP (such as a hospital with a substantial investigative capacity) or to the relevant registration board/QNC. The HSP or the board would be obliged to investigate the referral, and report to the IHSC on the investigation.

5.4.13 The IHSC should be able to undertake investigations on its own initiative.

5.4.14 Where the Commissioner, after investigation, is satisfied that a breach of the Code has occurred, the Commissioner should be able to order that simple remedies be provided, for example:

- that an explanation or apology be given;
- that the HSP take remedial action to improve systems or procedures;
- that the consumer be provided with a refund for an unsatisfactory service;
- that restitution be made for additional expenses.

5.4.15 When assessing or investigating a complaint, the IHSC should have access to relevant professional advice from a panel of clinical experts, or to legal advice.

5.4.16 The grounds for taking disciplinary action should be the same as at present, namely, conduct by a registered HSP that is "unsatisfactory professional conduct", according to the current definition in the HPPSA.

5.4.17 The Commissioner should be able to initiate disciplinary proceedings for less serious instances of unsatisfactory professional conduct before a Health Practitioners Disciplinary Committee which would be able to impose a range of sanctions on registered HSPs, including conditions or undertakings, reprimands and fines.

5.4.18 For more serious instances of unsatisfactory professional conduct, the Commissioner should be able to initiate proceedings before the Health Practitioners Tribunal which would be able to impose the same range of sanctions as the proposed Health Practitioners Disciplinary Committee with the additional power to suspend or cancel an HSP's registration, and make orders as to costs of the proceedings.

Code

The proposed model calls for a Code of Health Rights and Responsibilities to be developed, published, and given practical effect and enforceability through empowering the IHSC to investigate breaches of the Code, and, in appropriate cases, award minor remedies where a breach of the Code is established. The provisions of the Code should also provide a reference point for complaint resolution at the local level.

It is notable that ss.37-39 of the HRCA already provide for the Health Rights Commissioner to develop a Code for consideration by the Minister, although the Act is silent on what the Minister is to do after considering the proposed Code.

My inquiries have disclosed that a draft Code was developed and submitted to the then Minister for Health in 1994, but I am not aware of any further action being taken in respect of it (although I note that QH currently has a Public Patient Charter which sets out a number of specific rights and responsibilities for the benefit of public patients).

5.5 Complaint resolution by HSPs (local complaints resolution process)

It has already been noted that, under the existing scheme, a complainant must have taken all reasonable steps to resolve a complaint with the relevant HSP before the HRC will decide to take any further action. This should also be a feature of the proposed model.

Experience indicates that it is generally good practice to resolve complaints locally at the "point of service" [83]. This approach helps HSPs to maintain good relationships with their customers and encourages HSPs to take responsibility for dealing with sub-optimal service and to take an open and improvement-focused approach to customer feedback. It also recognises that many people do not want to formally complain to an external body but simply want some action taken so that "the same thing does not happen to someone else".

Local resolution involves the service provider attempting to resolve a complaint as directly and as quickly as possible, with the primary aim of addressing the complainant's concerns. Data from the UK reveals that the local resolution stage in the NHS complaints process is effective in dealing with the vast majority of health related complaints. In fact, between 96 and 98% of written complaints do not proceed beyond the local stage.[84]

Current information from QH indicates that a lesser rate of approximately 85% of complaints are resolved by frontline complaint handling. Implementation of the proposals in this submission is likely to substantially increase the incidence of local resolution of complaints.

[83] Ombudsmen commonly define complaints as "any expression of dissatisfaction". Others draw a distinction between complaints and concerns or complaints and service delivery issues.
[84] "Achieving local resolution" ICAS Resources for the Complaints Journey www.icasresources.com

Management and resolution of complaints at the point of service delivery are important elements of quality management and require an HSP to have an effective complaint handling system in place. A benefit of such a system is the identification of areas for improvement to raise the quality of service provided to the community.

An effective complaint handling system should also provide for the receipt of complaints from staff. Staff are in the best position to identify potential risks or existing problems with the quality of health services being provided. Therefore they should be able to raise these with their employer in the knowledge that they will be appropriately acted upon. This is a key aspect of quality management (see section 5 of Part 1 of this submission for proposals on enhancing protections for whistleblowers).

If a complainant is dissatisfied with the outcome provided at the local level or "point of service", then the HSP's complaints system should provide for internal review (this may not be practicable with small health practices). If an HSP does not have the capacity, or any process, for internal review, the complainant should have the right to take the complaint to the IHSC. Furthermore, an HSP should have an obligation to advise the complainant of their right to seek external review, and how to do so, where the complainant expresses dissatisfaction with:

- the outcome of local resolution and the HSP has no internal review process; or
- the outcome of internal review.

5.6 Details of proposed IHSC's process

5.6.1 Intake/Early Resolution

Where a complaint is received by the IHSC, as part of the intake process, the complainant should generally be required to demonstrate that they have attempted to resolve the matter with the HSP. There should be exceptions to this, for example, where there is an immediate risk to the health or safety of a user or consumers, or where a complaint is made by a staff member of the relevant HSP who is fearful of reprisal.

Wherever appropriate, staff of the IHSC should encourage complainants to employ alternative dispute resolution mechanisms, or directly facilitate resolution of the complaint at the local level to promote early resolution of the complaint.

The IHSC should be able to receive complaints from any person, including employees of QH or a HSP.

This jurisdiction is significantly wider than that of the HRC. It is submitted that creating an independent body capable of considering health service complaints from both consumers and persons "in the system" will enhance public confidence in the health system.

5.6.2 Assessment

The IHSC should undertake an assessment of all external complaints. This is a departure from the current process which also enables the boards to assess complaints received about their registrants.

The IHSC should give written notice of the making of a complaint, the nature of the complaint and the identity of the complainant, to the person against whom the complaint is made. However, the IHSC should have a discretion to withhold provision of the notice, or some details that would normally go in a notice, if disclosure would be likely to:

- prejudice the investigation of the complaint; or
- place the health or safety of a person at risk; or
- place the complainant or another person at risk of reprisal.

The IHSC may also seek a response/submission from the person complained about.

In certain circumstances it will also be appropriate for the IHSC to provide details of the complaint to the relevant board/QNC and invite a submission.

If, at any time, the Commissioner suspects that a complaint involves or may involve official misconduct, the Commissioner will be obliged to refer the matter to the CMC.

The Commissioner should also refer to the Ombudsman matters involving maladministration of a kind more appropriate for the Ombudsman to deal with, in accordance with protocols to be developed with the Ombudsman.

The Commissioner should have power to recommend interim action against an HSP during or immediately following assessment. For example, if the IHSC has concerns that a registrant poses a risk to patients or the public, it may recommend that the relevant registration board consider suspending, or imposing conditions on, the registrant's registration. If the board refuses to impose the recommended restrictions, the Commissioner should be empowered to apply to the Health Practitioners Disciplinary Committee for an order imposing interim conditions or suspension.

Under the existing system, the HRC has no power to recommend to a board that it take interim action against a registrant.

5.6.3 Conciliation

With the consent of both parties, matters may be referred for conciliation if considered appropriate after initial assessment by the IHSC. The HRC currently has the same power.

However, in a recent meeting with my officers, the current Commissioner adverted to a flaw in the current conciliation process in that he has no power to take action against an HSP if, during the conciliation process, it becomes evident that the HSP has been guilty of conduct that would normally attract some form of disciplinary action. This problem may be difficult to address in that, while there is a public interest in disciplinary action being taken in appropriate cases, there is also a public interest in having a conciliation process that encourages open disclosure in a confidential setting with a view to reaching a mutually acceptable outcome.

5.6.4 Investigation

The IHSC should undertake, monitor or review, the investigation of all external complaints whether the complaint relates to a registered or non-registered provider, in

a public or private health service. This will provide complainants with one centralised independent complaints body.

The registration boards would no longer conduct investigations of complaints about their own registrants, except by arrangement with the Commissioner, and subject to monitoring and review by the Commissioner. This should remove any potential or perceived "conflict of interest". This is a significant change from the existing system.

Examples of matters that would be investigated by the IHSC include:

- complaints where conciliation is not agreed to by both parties or has been unsuccessful;
- complaints raising matters of public interest or concerns about policies/practices that have broader implications for public health care;
- complaints that are not of an isolated nature but may reflect systemic problems;
- complaints that may involve cause for taking disciplinary action.

The IHSC should be able to conduct investigations informally or by exercising coercive investigative powers.

Investigators should have a mix of skills. Some should have a clinical background. Furthermore, the IHSC should engage (on sessional rates of pay) a variety of clinicians to form a panel of experts from which the IHSC may seek advice on clinical or technical issues during the assessment or investigation process.

If a report of the IHSC includes any recommendations for specific action by the HSP, the HSP should be obliged to submit advice to the IHSC outlining a plan for the implementation of the recommendations and an associated timeframe.

The IHSC should be given power to make recommendations about, or to impose some minor remedies for, breaches of the Code, for example, an apology; order to improve systems or procedures, order for restitution or a refund; an explanation to the complainant as to what went wrong and what has been done by the HSP to ensure it doesn't happen again. It may be appropriate to also provide that:

- where an investigation has resulted in disciplinary action against an HSP, the IHSC's proposed jurisdiction to award a compensatory remedy should not be exercised until after disciplinary proceedings have been finalised; and
- where a complainant commences a civil action for damages against an HSP, there should be, in any award of damages made by a court, a set-off for any compensatory award made by the IHSC.

The IHSC should be able to provide a report to a registrant's board if the Commissioner has concerns about an aspect of a registrant's conduct, although that conduct may not amount to "unsatisfactory professional conduct" (for example, unsatisfactory service attributable to impairment).

If, as a result of an investigation, the IHSC considers that disciplinary action should be taken for unsatisfactory professional conduct, such action would be taken in accordance with the disciplinary process discussed below.

The Commissioner may also wish to consult with a member of the panel of experts (or obtain other specialist advice) or seek legal advice, before making a final decision as to whether a matter should be referred for disciplinary action.

As an alternative to initiating disciplinary action before the Health Practitioners Disciplinary Committee in less serious instances of unsatisfactory professional conduct, the Commissioner should have a discretion, in appropriate cases, to accept an undertaking from an HSP (for example, to undertake additional skills training, or to perform certain health services only under qualified supervision) if the Commissioner considers that that course of action will afford satisfactory protection to consumers of health services. The Commissioner would make arrangements with the relevant registration board to supervise compliance with the undertaking(s). Breach of an undertaking should itself be a sufficient ground for disciplinary action.

5.6.5 Disciplinary action

Under the proposed scheme, the Commissioner would take over the existing role of the boards/QNC of determining whether disciplinary action should be initiated against a registered HSP.

Another model operates in New South Wales and New Zealand where the decision about whether disciplinary action should be instituted is made by a senior lawyer called the Director of Proceedings, employed by the relevant complaints commission. A summary of the role of that officer in New South Wales and New Zealand is provided in Appendix 4. It is an option that could be considered for Queensland, if it is considered that there are advantages in having the Commissioner recommend disciplinary action to a semi-independent legal expert, who would assess the available evidence, decide whether it warranted the laying of disciplinary charges, and prosecute the proceedings.

It is proposed that disciplinary proceedings be heard by:

(1) the Health Practitioners Disciplinary Committee, chaired by a legal practitioner of 10 years standing, assisted by a member of the relevant registration board, and a community representative appointed from a panel; or
(2) the Health Practitioners Tribunal chaired (as now) by a District Court judge, assisted by the Chair of the relevant registration board, and a community representative appointed from a panel.

The Health Practitioners Disciplinary Committee would hear less serious cases of unsatisfactory professional conduct. It would have power to:

- order the imposition of conditions (including limited registration or enrolment);
- obtain an undertaking from the registrant;
- impose fines (to a monetary limit or penalty units); or
- reprimand.

This Committee would also be able to impose interim suspension, or interim conditions, on a registrant pending the outcome of an investigation.

The Health Practitioners Tribunal would hear more serious matters of unsatisfactory professional conduct and have power to impose all of the above sanctions, as well as the power to:

- suspend or cancel a registrant's registration;
- make orders as to costs.

The proposed scheme does not contemplate a continued role for the Nursing Tribunal, which in 2003-2004 dealt with only eight cases (according to the QNC's Annual Report for that financial year). Its functions can be performed by the Health Practitioners Tribunal.

5.6.6 Role of the registration boards

Unless the Commissioner considers a matter is more appropriately investigated by a board, the board would not investigate a complaint against one of its registrants.

Furthermore, the board would no longer have the responsibility for making decisions about disciplinary action to be taken against their registrants. However, it is proposed that the boards would continue to undertake the balance of their existing functions, for example:

- registration and maintaining a roll of registrants;
- promoting continuing education;
- competitive regulation;
- managing impaired and self reported practitioners with health concerns;
- supervising/overseeing compliance with conditions/undertakings or other disciplinary sanctions ordered by the Health Practitioners Disciplinary Committee and Health Practitioners Tribunal, or undertakings by an HSP that are accepted by the IHSC as a suitable alternative to initiating disciplinary action before the Health Practitioners Disciplinary Committee.

5.7 Independent Patient Advocacy Services

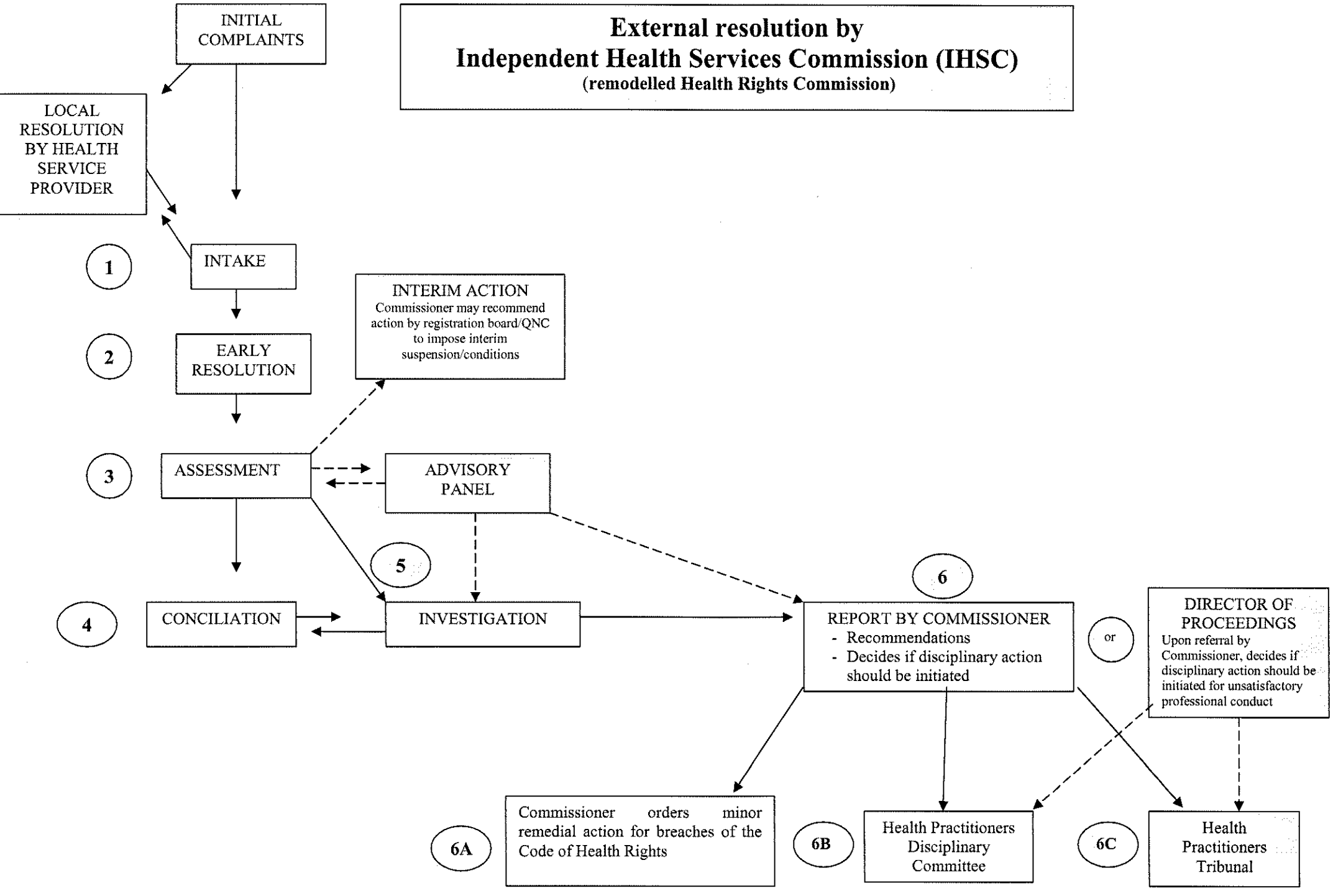
Appendix 5 contains information about the independent patient advocacy services that operate in the UK and New Zealand. Those services assists complainants through all stages of the complaints process, and provide information about consumer rights to consumers and HSPs. It is recommended that consideration be given to whether the likely benefits of establishing an independent patient advocacy service (including whether it will facilitate high levels of complaint resolution at the local level) will outweigh the costs of establishing and maintaining such a service. In the context of the recommendations made in this submission for an improved health complaints system, a patient advocacy service should be viewed as an optional extra rather than as an essential component of the system.

5.8 Flow chart

The steps of the complaint process under the proposed new system are shown in the flow chart on the following page.

External resolution by Independent Health Services Commission (IHSC)

(remodelled Health Rights Commission)



5.9 Other issues

5.9.1 Lack of a uniform health complaints system

There is presently no uniform system of patient complaints management across the private and public health sectors within Queensland. The *Private Health Facilities Act 1999* enables the Chief Health Officer to make standards on a wide range of matters for the protection of the health and wellbeing of patients receiving health services at private health facilities. However, the Chief Health Officer does not have authority to require private health facilities to establish patient complaints processes.

If all health consumers in Queensland are to be guaranteed access to patient complaints systems which focus on processes for local resolution, this issue will need to be addressed by legislative amendments.

Consideration should be given to amending s.12(2) of the *Private Health Facilities Act 1999* to empower the Chief Health Officer to make standards with respect to patient complaints management systems within the private health sector in order to guarantee all patients access to complaints processes that meet recognised standards.

5.9.2 Open disclosure and protection from civil liability

In July 2003, the Australian Council for Safety and Quality in Health Care (ACSQHC) introduced a National "Open Disclosure" Standard, which was endorsed by all Australian Health Ministers at the time. The Standard promotes a clear and consistent approach by Australian hospitals to open communication with patients and their nominated support person following an adverse event. "Open Disclosure" refers to open communication when things go wrong in health care. The elements include:

- an expression of regret;
- a factual explanation of what happened;
- consequences of the event; and
- steps being taken to manage the event and prevent a recurrence.

QH's *Incident Management Policy* (introduced in June 2004) states that the ACSQHC Standard on Open Disclosure is to be followed as part of the incident management of adverse events.

QH has advised that a structured piloting plan of the Open Disclosure Standard within QH is currently under development by the Safety Improvement Unit, Patient Safety Centre. In January 2005, the Australian Health Ministers reaffirmed their commitment to piloting this Standard with pilot reviews to be assessed at the Australian Health Ministers Conference in December 2006 prior to full implementation.

Queensland Health currently has five Health Service Districts that are pilot sites participating in the national pilot (Townsville, Rockhampton, Princess Alexandra, QE11, and The Royal Brisbane and Women's Hospital), with two more under negotiation.

One of the impediments to open disclosure by HSPs and individual registrants is concern about civil liability. However, in many cases, people who raise concerns about provision of health services simply want an explanation and an apology.

To encourage HSPs to provide explanations and apologies in the interests of resolving health service complaints, it is proposed that the legislation for an IHSC should include provisions making it clear that an apology provided by an HSP to a person who has (including through an agent) made a complaint directly to the HSP, or to the IHSC, does not constitute an express or implied admission of fault or liability by the HSP, and is not relevant to the determination of fault or liability in any civil proceeding brought against the HSP. Evidence of an apology should not be admissible in any civil proceedings as evidence of fault or liability of the HSP who provided the apology. The *Civil Liability Act 2002* NSW affords an appropriate model in that regard: see s.67(1), s.68(definition of apology), s.69.

It is considered that ss.69-72 of the *Civil Liability Act 2003* Qld are too restricted, compared to the New South Wales provisions. The Queensland provisions protect from admissibility in a civil proceeding only an expression of regret "to the extent that it does not contain an admission of liability on the part of the individual or someone else".

It may be preferable to amend the general provisions in ss.69-72 of the *Civil Liability Act 2003* Qld, to correspond with the aforementioned New South Wales provisions. There is no reason for limiting these recommended changes to health service complaints, as the desirability of encouraging apologies in appropriate cases is just as relevant in many other areas. However, if that does not occur, specific provisions relating to HSPs are considered necessary for the proposed new health complaints system to work efficiently and effectively.

Appendix 1: Statutory objectives of the HRC

Purpose

The purpose of the *Health Rights Commission Act 1991* is to provide independent review and conciliation with respect to services provided by health service providers to health service users and for improvements to those services.

Objectives (section 4)

The principal objectives of this Act are –

(a) to provide for oversight, review and improvement of health services by establishing an accessible, independent facility that will –
  (i) preserve and promote health rights; and
  (ii) receive and resolve health service complaints; and
  (iii) enable users and providers to contribute to the review and improvement of health services; and
  (iv) provide education and advice in relation to health rights and responsibilities and the resolution of complaints about health services, whether or not made under this Act; and
  (v) assist users and providers to resolve health service complaints; and

(b) to provide for the development of a Code of Health Rights and Responsibilities; and
(c) to provide for the appointment, functions and powers of a Health Rights Commissioner; and
(d) to provide for the establishment, functions and operation of a Health Rights Advisory Council.

Commissioner's Functions (section 10)

The functions of the commissioner are –

(a) to identify and review issues arising out of health service complaints; and
(b) to suggest ways of improving health services and of preserving and increasing health rights; and
(c) to provide information, education and advice in relation to –
  (i) health rights and responsibilities; and
  (ii) procedures for resolving health service complaints; and
(d) to receive, assess and resolve health service complaints; and
(e) to encourage and assist users to resolve health service complaints directly with providers; and
(f) to assist providers to develop procedures to effectively resolve health service complaints; and
(g) to conciliate or investigate health service complaints; and
(h) to inquire into any matter relating to health services at the Minister's request; and
(i) to advise and report to the Minister on any matter relating to health services or the administration of this Act; and
(j) to provide advice to the Council; and
(k) to provide information, advice and reports to registration boards; and
(l) to perform functions and exercise powers conferred on the commissioner under any Act.

Appendix 2: Findings and recommendations by Professor Stokes

Findings

- In January 2002 there were no protocols in place at the hospital giving guidelines on the management of paediatric head injury and neither was there in April 2004 when the Investigator visited the ED.

- It was inappropriate for a junior doctor to be working unsupervised and without proper protocols in the ED.

- The hours of work were also inappropriate for the doctor in the ED.

- The confusion by the staff over the admission or otherwise of children for observation was a major factor in the outcome of this case and the issue needs a very complete investigation by QH.

- The [Executive Director's] report was not an investigative report as no investigation was carried out nor was he asked to. Rather it was simply an "incident report".

- Sadly QH have never conducted a formal investigation into the events leading to the death of Elise nor has it conducted a "root cause" analysis. In this manner Dr and Mrs Neville have been badly served.

- QH have not responded in an appropriate manner to Elise's parents in so much that no attempt would appear to have been made to discuss with the parents issues of systems which may have failed or been inadequate.

- "Open disclosure" was difficult because of the legal framework set up to protect QH from liability and because no formal investigation was ever conducted.

- Some system improvements have been made including:

    - the appointment of a senior medical officer to the ED at Caloundra who is working on developing protocols for the management of clinical states and the training of junior staff;
    - Director of Nursing is developing training programmes for nurses in triage and has increased nursing numbers.

Recommendations

- Attempts be made to clarify with Dr and Mrs Neville the type of report the [Executive Director] wrote.

- Dr and Mrs Neville be interviewed again by the Director-General of QH for the purpose of discussing the process issues that would appear to have contributed to Elise's death and to outline the steps taken to rectify these issues in the hope of minimising risk of such a future event.

- There be an urgent review of the district ED arrangements including management and supervision of clinical care.

- QH should urgently develop and promulgate guidelines on the assessment and treatment of head injury (specifically paediatric) and ensure that education programmes are put in place for these across the health districts.

- Clinical staffing in the ED at Caloundra Hospital to be consistent, drawing resources from Nambour hospital on a rotational basis.

- The ED should be staffed by experienced 3rd or 4th year post graduate doctors who have received training in the ED before going to Caloundra.

- The district should develop clinical policies for Caloundra Hospital and medical education activities, especially for the ED staff.

- ED staff should be competent in intubation and resuscitation, especially when left without senior supervision after hours.

- A firm and stable communicative link for doctors be established between Caloundra and Nambour hospitals on a 24hr basis seven days a week. A telemedicine network would also assist with this.

- Nursing training and competency programmes should continue.

- When staffing issues become critical it may be wise to close down the ED and refer patients to Nambour Hospital.

- Consideration be given to the possibility of one of the two privately owned CT scanners in the Caloundra area to be relocated to the Caloundra Hospital.

- Current work being done to define the emergency medical systems should be expedited.

- The current retrieval systems should be enhanced by overall regional coordination.

Appendix 3: Northern Territory, New Zealand and Tasmanian Code of Health Rights

1. Northern Territory

CODE OF HEALTH RIGHTS AND RESPONSIBILITIES

INTRODUCTION TO THE CODE

The Code confers a number of rights and responsibilities on all users and providers of health and community services in the Northern Territory.

The rights and responsibilities set out in the Code are not absolute. The obligation imposed on users and providers is to take reasonable action in all circumstances to give effect to the Code.

When a complaint is made, the Commission will consider the reasonableness of the action taken by the provider, in light of the circumstances. The circumstances in a particular case may include the user's state of health or well-being and any resource constraints operating at the time.

The Code does not override duties which are set out in Territory or Commonwealth legislation.

Principle 1: Standards of Service

1. Users have a right to:
    a. timely access to care and treatment which is provided with reasonable skill and care ;
    b. care and treatment which maintains their personal privacy and dignity;
    c. care and treatment free from intimidation, coercion, harassment, exploitation, abuse or assault;
    d. care and treatment that takes into account their cultural or ethnic background;
    e. providers who seek assistance and information on matters outside their area of expertise or qualification;
    f. services provided in accordance with ethical and professional standards, and relevant legislation;
    g. services which are physically accessible and appropriate to the needs arising from an impairment or disability; and
    h. services provided without discrimination, as set out in relevant Territory and Commonwealth legislation.

Principle 2: Communication and the Provision of Information

1. Providers have a responsibility to:
    a. provide accurate and up to date information responsive to the user's needs and concerns, which promotes health and well-being;
    b. explain the user's care, treatment and condition in a culturally sensitive manner, and in a language and format they can understand. This includes the responsibility to make all reasonable efforts to access a trained interpreter;
    c. answer questions honestly and accurately;
    d. provide information about other services, and as appropriate, how to access

these services;
e. provide prompt and appropriate referrals to other services, including referral for the purpose of seeking a second opinion; and
f. provide the user with a written version or summary of information, if requested.

3. Users have a responsibility, to the best of their ability, to:

a. provide accurate and timely information, about their past care and treatment and issues affecting their condition; and
b. inform the provider of issues that might interfere with participation in care or treatment recommended by the provider.

Principle 3: Decision Making

1. Subject to any legal duties imposed on providers, users have a right to:
    a. make informed choices and give informed consent to care and treatment;
    b. seek a second opinion;
    c. refuse care and treatment, against the advice of the provider;
    d. withdraw their consent to care and treatment, which includes the right to discontinue treatment at any time, against the advice of a provider;
    e. make an informed decision about body parts or substances removed or obtained during a health procedure. This includes the right to consent or refuse consent to the storage, preservation or use of these body parts or substances; and
2. In non-emergency situations, providers have a responsibility to seek informed consent from users before providing care and treatment by:
    a. seeking consent specific to the care and treatment proposed, rather than a generalised consent;
    b. discussing the material risks, complications or outcomes associated with each care or treatment option;
    c. ensuring the user understands the material risks, complications or outcomes of choosing or refusing a care or treatment option;
    d. where relevant, explaining the legal duties imposed on providers which prevent users from refusing a type of care or treatment, such as those imposed by the Mental Health and Related Services Act and the Notifiable Diseases Act;
    e. providing users with appropriate opportunities to consider their options before making a decision;
    f. informing users they can change their decision if they wish;
    g. accepting the user's decision; and
    h. documenting the user's consent, including the issues discussed and the information provided to the user in reaching this decision.
3. Providers have a right to treat without the user's consent where:
    a. treatment is provided in a life threatening emergency or to remove the threat of permanent disability and it is impossible to obtain the consent of the user or the user's personal representative; or
    b. treatment is authorised or required under Territory or Commonwealth legislation.
4. Where a provider reasonably considers that a user has diminished capacity to consent, the user still has a right to give informed consent to a level appropriate to their capacity.
5. Where a provider considers a user lacks the capacity to give informed consent, a provider must, except under specific legal circumstances, seek consent from a person who has obtained that legal capacity under the Adult Guardianship Act or other relevant legislation.

Principle 4: Personal Information

1. Users have a right to information about their health, care and treatment. However, they do not have an automatic right of access to their care or treatment records.
2. Providers may prevent users from accessing their records where:
    a. legislative provisions restrict the right to access information; or
    b. the provider has reasonable grounds to consider access to the information would be prejudicial to the user's physical or mental health.
3. Providers have a responsibility to protect the confidentiality and privacy of users by:
    a. ensuring that the user's information held by them is not made available to a third party unless:
        - the user gives written authorisation for the release;
        - subject to subpoena or pursuant to legislation; or
        - it is essential to the provision of good care and treatment and the provider obtains the user's consent. This may take the form of consent to share information between a treating team.
    b. providing appropriate surroundings to enable confidential consultations and discussions to take place;
    c. having policies and procedures in place, including policies relating to the storage of information, and ensuring all staff are aware of these;
    d. communicating with the user and other providers involved in their care and treatment in an appropriate manner and environment.

Principle 5: The Relationship between User and Provider

1. Both users and providers have a responsibility to treat each other with respect and consideration.
2. Providers have a responsibility to:
    a. make clear the standards of behaviour and language acceptable in the relationship between user and provider;
    b. make clear the circumstances under which they will restrict or withdraw the services they provide;
    c. advise users if and why they are unable to provide a service the user has requested; and
    d. subject to those responsibilities regarding emergency treatment, remove, or seek the removal of any person whose behaviour is considered dangerous to the provider or service users.
3. Users have a responsibility to ensure they do not endanger or deliberately put the safety of the provider or other service users at risk.
   This responsibility is extended to the user's family members, friends, carers and advocates in their interactions with the provider.
4. Providers have a right to be able to provide care and treatment free from intimidation, coercion, harassment, exploitation, abuse and assault.

Principle 6: Involvement of Family, Friends, Carers and Advocates

1. Users have a right to:
    a. involve their family, friends, carer or advocate in their care and treatment;
    b. withhold information from family members, friends and carers on their care and treatment, or request the provider do so;
    c. seek help from an advocate if required.
2. Providers have a responsibility to:
    a. respect the role family members, friends, carers and advocates may have in the user's care and treatment, and the user's right to withhold information from them; and
    b. recognise the carer's knowledge of the user and of the impact care and

treatment options may have on the user's health and well-being.

Principle 7: Research, Experiments and Teaching Exercises

1. Providers have a responsibility to:
    a. inform users if the care or treatment offered to them is experimental or part of a teaching or research exercise, of its functions and aims, and of their avenues for complaint;
    b. inform users they can withdraw from the research, experiment or teaching exercise at any stage; and
    c. accept the user's refusal to take part in research, experiments and teaching exercises.

Principle 8: Complaints and Feedback

1. Providers have a responsibility to:
    a. provide a mechanism for users to give feedback or make complaints about their care and treatment;
    b. inform users of the complaint process and of how to make a complaint;
    c. ensure that complaints are dealt with in an open, fair, effective and prompt manner, and without reprisal or penalty; and
    d. provide users with information about external complaint resolution mechanisms and advocates.
2. Users and providers have a responsibility to be fair, truthful and accurate when making or responding to a complaint.

2. New Zealand

The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996

1. Consumers have rights and providers have duties

1) Every consumer has the rights in this Code.
2) Every provider is subject to the duties in this Code.
3) Every provider must take action to -
   a) Inform consumers of their rights; and
   b) Enable consumers to exercise their rights.

2. Rights of consumers and duties of providers

The rights of consumers and the duties of providers under this Code are as follows:

RIGHT 1
Right to be Treated with Respect

1) Every consumer has the right to be treated with respect.
2) Every consumer has the right to have his or her privacy respected.
3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 3
Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5

Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

RIGHT 6

Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
   c) Advice of the estimated time within which the services will be provided; and
   d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
   e) Any other information required by legal, professional, ethical, and other relevant standards; and
   f) The results of tests; and
   g) The results of procedures.
2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.
3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about -
   a) The identity and qualifications of the provider; and
   b) The recommendation of the provider; and
   c) How to obtain an opinion from another provider; and
   d) The results of research.
4) Every consumer has the right to receive, on request, a written summary of information provided.

RIGHT 7

Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.
2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.
3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.
4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -
   a) It is in the best interests of the consumer; and
   b) Reasonable steps have been taken to ascertain the views of the consumer; and
   c) Either, -
      i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the

services is consistent with the informed choice the consumer would make if he or she were competent; or

ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

5) Every consumer may use an advance directive in accordance with the common law.

6) Where informed consent to a health care procedure is required, it must be in writing if -
   a) The consumer is to participate in any research; or
   b) The procedure is experimental; or
   c) The consumer will be under general anaesthetic; or
   d) There is a significant risk of adverse effects on the consumer.

7) Every consumer has the right to refuse services and to withdraw consent to services.

8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.

9) Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.

10) No body part or bodily substance removed or obtained in the course of a health care procedure may be stored, preserved, or used otherwise than
   (a) with the informed consent of the consumer; or
   (b) for the purposes of research that has received the approval of an ethics committee; or
   (c) for the purposes of 1 or more of the following activities, being activities that are each undertaken to assure or improve the quality of services:
      (i) a professionally recognised quality assurance programme:
      (ii) an external audit of services:
      (iii) an external evaluation of services.

RIGHT 8
Right to Support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.

RIGHT 9
Rights in Respect of Teaching or Research

The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

RIGHT 10
Right to Complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

2) Every consumer may make a complaint to -
   a) The individual or individuals who provided the services complained of; and
   b) Any person authorised to receive complaints about that provider; and
   c) Any other appropriate person, including -
      i. An independent advocate provided under the Health and Disability Commissioner Act 1994; and
      ii. The Health and Disability Commissioner.

3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

4) Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.

5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.
6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -
   a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and
   b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of -
      i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and
      ii. The Health and Disability Commissioner; and
   c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and
   d) The consumer receives all information held by the provider that is or may be relevant to the complaint.
7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, -
   a) Decide whether the provider -
      i. Accepts that the complaint is justified; or
      ii. Does not accept that the complaint is justified; or
   b) If it decides that more time is needed to investigate the complaint, -
      i. Determine how much additional time is needed; and
      ii. If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.
8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of -
   a) The reasons for the decision; and
   b) Any actions the provider proposes to take; and
   c) Any appeal procedure the provider has in place.

3. Provider Compliance

A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

The onus is on the provider to prove it took reasonable actions.

For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

4. Definitions

In this Code, "**Advance directive**" means a written or oral directive:

(a) By which a consumer makes a choice about a possible future health care procedure; and
(b) That is intended to be effective only when he or she is not competent.

"**Choice**" means a decision:

(a) To receive services.
(b) To refuse services.
(c) To withdraw consent to services.

"**Consumer**" means a health consumer or a disability services consumer; and, for the purposes of rights 5, 6, 7(1), 7(7) to 7(10), and 10, includes a person entitled to give consent on behalf of that consumer.

"**Discrimination**" means discrimination that is unlawful by virtue of Part II of the *Human Rights Act 1993*.

"**Duties**" includes duties and obligations corresponding to the rights in this Code.

"**Ethics committee**" means an ethics committee :

(a) established by, or appointed under, an enactment; or
(b) approved by the Director-General of Health.

"**Exploitation**" includes any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence.

"**Optimise the quality of life**" means to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances.

"**Privacy**" means all matters of privacy in respect of the consumer, other than matters of privacy that may be the subject of a complaint under Part VII or Part VIII of the Privacy Act 1993 or matters to which Part X of that Act relates.

"**Provider**" means a health care provider or disability services provider.

"**Research**" means health research or disability research.

"**Rights**" includes rights corresponding to the duties in this Code.

"**Services**" means health services, or disability services, or both; and includes health care procedures.

"**Teaching**" includes training of providers.

5. Other Enactments

Nothing in this Code shall require a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment.

6. Other Rights

An existing right is not overridden or restricted simply because the right is not included in this Code or is included only in part.

2. The Tasmanian Charter of the Rights & Responsibilities of Health Service Users and Providers (currently under review)

Charter of the Rights and Responsibilities of Health Service Users and Providers

The Charter of Health Rights and Responsibilities has been developed following consultation with health service users, referred to as consumers in this Charter, and health service providers.

When viewed as a partnership, the relationship between the health service consumer and the health service provider is more likely to benefit the health outcomes of the service consumer. While the health service provider has a responsibility to meet certain rights of the health service consumer, the consumer in turn, should also assume some responsibility for their own health care.

This Charter is intended to be used as a guideline to maintain the balance of rights and responsibilities, and strengthen the relationship between, health service users and health service providers.

Who is covered by the Charter?

The Charter is in place for any person who gives or receives a health service including those who are under age or whose capacity to be self determining is limited. Under the Health Complaints Act 1995, someone who is not yet 14 years of age is considered to be under age.

The parent or guardian of a child who has not attained the age of 14 years, claims the rights and responsibilities listed in this Charter on behalf of that child. Similarly, if the carer of a person with limited capacity has guardianship in the area of health care, they too can claim the rights and responsibilities listed in this Charter on behalf of that person.

Do the rights described in the Charter always apply?

Sometimes health service providers may not be able to meet all of the rights of the health service consumer. Similarly, consumers may not always be in a position to meet all of the rights of the provider. However, both providers and consumers should always do what they reasonably can under the circumstances.

What services are covered by the Charter?

The *Health Complaints Act 1995* sets out the requirement for a Charter of Health Rights. Under Schedule 1, Part 1 the Act also describes services that are recognised as health services for the purpose of the Act. These services are covered by the Charter.

1. A service provided at a hospital, health institution or nursing home.

2. A medical, dental, pharmaceutical, mental health, community health, environmental health or specialised health service or a service related to such a service.

3. A service provided in association with the use of premises for the care, treatment or accommodation of persons who are aged or have a physical disability or mental dysfunction.

4. A laboratory service provided in support of a health service.

5. A laundry, dry cleaning, catering or other support service provided to a hospital, health institution, nursing home or premises referred to in item 3, if the service affects the care or treatment of a patient or resident.

6. A social work, welfare, recreational or leisure service, if provided as part of a health service.

7. An ambulance service.

8. Any other service provided by a provider, for or purportedly for, the care or treatment of another person.

9. A service provided by any of the following:

    - audiologist;
    - audiometrist;
    - optical dispenser;
    - dietitian;
    - prosthetist;
    - physiotherapist;
    - dental prosthetist;
    - psychotherapist;
    - radiographer;
    - podiatrist;
    - therapeutic counsellor; or

    any other service of a professional or technical nature provided for, or purportedly for, the care or treatment of another person or in support of a health service.

10. A service provided by a practitioner of massage, naturopathy or acupuncture or in another natural or alternative health care or diagnostic field.

11. The provision of information relating to the promotion or provision of health care or to health education.

12. Any other service provided by a person registered by a registration board.

RIGHT 1: ACTIVE PARTICIPATION IN HEALTH CARE

The Rights of the Health Service Consumer

The health service consumer has the right to take an active role in his/her own health care. This role includes making decisions about his/her own health care and being responsible for those decisions.

- The health service consumer has the right to choose a health service provider subject to several conditions including the treatment required and whether the consumer is a public or private patient.

- The right to be provided with information enables the consumer to make informed decisions about his/her own health care. This information might include:

  - diagnosis, the possible nature of the illness or disease;
  - test results and their implications;
  - the approach to proposed treatment or further investigation as well as,
    a) what that entails;
    b) the expected benefits;
    c) any likely side effects that may occur;
    d) any recognised risks associated with that investigation and/or treatment;
  - other options for investigation and/or treatment;
  - the likely consequences of any treatment option available;
  - the likely consequences of not having any particular treatment or procedure;
  - an estimate of the costs of any particular treatment or procedure or other health service fees; and
  - advice regarding additional services, facilities and support groups.

  This information should be presented in a way to best ensure the consumer's understanding. The information should be simple and straightforward. If necessary diagrams, models or other visual aids should be used.

  Those with physical or intellectual limitations such as visual, auditory or verbal difficulties and those who have other difficulties with language or communication have the right to be offered alternative means of information dissemination. These alternatives may include, among others, interpreters and/or translation services, large print or audio tapes. In theses cases and where a health service consumer has limited capacity, information can be provided to a guardian or person authorised by the consumer.

- The right to feel comfortable and at ease and be encouraged to take an active role in his/her own health care in being consulted about options and by participating in decisions.

- The right to take notes, ask questions and expect honest, comprehensive and direct answers in order to clarify information provided by health service providers.

- The right to take sufficient time to absorb and consider information, seek advice and additional information from other sources, and discuss issues with family, friends and supporters.

  It may not always be possible to fully exercise this right particularly in emergency situations where there is often little time to consult and consider.

- The right to not only be informed by the provider about his/her condition and options, but to offer suggestions and feedback and discuss these with the provider.

- The right to choose any treatment option available and have the provider respect that decision, even if they prefer a different option.

  It is important to note that the provider is not required to provide any treatment with which he/she does not agree and has the right to withdraw from the provision of treatment.

- The right to grant, withhold or withdraw consent for treatment or performance of a procedure at any time.

The Rights of the Health Service Provider

- The provider has the right to inquire about all aspects of the health of the consumer so that he/she is able to provide the highest level of quality health care possible. The information about which the provider might inquire includes:

  - condition, symptoms and health history;
  - outside factors that may impact on health care provision such as work, sport, family, home life and life style choices;
  - changes to circumstances;
  - expectations of the provider;
  - outcomes for health and well-being; and
  - the level of involvement the consumer wants in making decisions about his/her own health care.

  The provider has the right to have this information presented openly, with honesty and in a straightforward manner.

- The right to be told if the consumer does not understand the information provided or if he/she would like more information.

- The right to be informed if the consumer is consulting, or receiving treatment from, another health care provider.

- The right to be informed if the consumer is unable or unwilling to proceed with any care or treatment.

- The right to express any concerns if he/she does not agree with a decision made by the consumer about his/her health care, and have those concerns acknowledged.

- The right to withdraw from the provision of care if the consumer elects to proceed with an option for health care about which the provider expresses concerns.

- The right to be given notice if the consumer is unable to attend an appointment.

RIGHT 2: INDIVIDUALISED SERVICE THAT IS FREE FROM DISCRIMINATION

Discrimination generally refers to unfair or less favourable treatment of a person based on a range of personal attributes or criteria that might include gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation, political belief or activity, cultural belief or activity, situation, circumstance, economic or social status.

The Rights of the Health Service Consumer

- The health service consumer has the right to receive health services regardless of gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation,

political belief or activity, cultural belief or activity, situation, circumstance, economic or social status.

- The right to receive health services where the values and beliefs and associated judgements, attitudes, opinions and behaviours of the provider in relation to the areas listed above, do not impact on the provision of care.

- The right to receive health services free from any harassment, exploitation, abuse, deception, assault or fraud.

- The right to receive health services free from physical intimacy unrelated to the health service or medical treatment and free from unwarranted attention of a sexual nature.

- The right to be treated with dignity, courtesy and respect.

- The right to receive health services where the needs, wishes and background of the consumer are known, and considered in the provision of his/her health care.

- The right to withdraw from service provision if the provider behaves in an unacceptable way or places the consumer under duress.

The Rights of the Health Service Provider

- The provider has the right to request information about the consumer's background, needs and wishes so that he/she can consider the impact of these on the provision of health care, for example:

    - if the consumer feels that his/her gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation, political belief or activity, cultural belief or activity, situation, circumstance, economic or social status will have an impact on his/her health or provision of care, the consumer should inform the provider.

- The right to be informed if the needs or wishes of the consumer are not being met or if the provider has been intrusive, insensitive or inconsiderate of the background of the consumer.

- The right to be informed if the consumer wishes to seek a second opinion.

- The right to expect reasonable courtesy and respect from the consumer.

- The right to provide health services free from any harassment, exploitation, abuse, deception, assault or fraud.

- The right to refuse to provide a health service if he/she has a conscientious or other objection.

  In these circumstances the provider should refer the consumer to another provider who may be able to provide the service or to a support group or organisation who can assist the consumer in seeking appropriate service provision.

- The right to refuse service if the consumer behaves in a threatening or unacceptable way or places the provider or those working with the provider under duress.

RIGHT 3: CONFIDENTIALITY, PRIVACY AND SECURITY

The Rights of the Health Service Consumer

- The health service consumer has the right to have his/her personal health information and any matters of a sensitive nature kept confidential.

  No identifying information about the consumer, his/her condition or treatment may be disclosed without his/her consent unless the disclosure is required or authorised by law.

  In some cases, the provider is legally required to disclose health issues under mandatory reporting requirements or in the public interest.

- The right to be informed if the provider is required to disclose information about his/her health due to mandatory reporting requirements or in the public interest.

- The right to know who may have access to his/her personal health record, within the bounds of confidentiality.

- The right to know what sort of information is kept on his/her health record.

- The right to nominate another person who may receive information about the consumer's health status and care. This person does not necessarily have to be a next of kin.

- The right to have information about his/her health status and care passed on to another provider, at his/her request.

- The right to expect that staff of health service facilities are bound by confidentiality agreements, and will be disciplined if these agreements are breached.

- The right to health service facilities which ensure his/her privacy when receiving health care.

- The right to be treated with sensitivity as regards his/her confidentiality and privacy.

- The right to expect that information about his/her health is kept securely and cannot be easily accessed by unauthorised persons.

  Any record that contains personal information about the consumer's health should not be left in reception areas or treatment rooms. When the provider or another authorised person does not have a file, it should be stored securely. The same applies to computer or electronic records.

  Similarly, health service providers should not talk about consumer's health or care where other unauthorised persons can overhear them.

The Rights of the Health Service Provider

- The provider has the right to discuss the health care and treatment of a consumer with other providers for advice and support, in the best interest of the consumer's health and well-being.

RIGHT 4: ACCESS TO COMPLAINTS MECHANISMS

The Rights of the Health Service Consumer

- The health service consumer has the right to complain about health services and health service providers if he/she has reason to be dissatisfied with the service that he/she has received.

- The right to be informed about complaints procedures.

  Complaints procedures might be internal to the health service that the consumer has been using or external like the Registration Boards or The Health Complaints Commissioner.

- The right to access complaints procedures that are easy to use.

- The right to have his/her complaint dealt with promptly, fairly and without any adverse effect or discrimination arising as a consequence of having made a complaint.

The Rights of the Health Service Provider

- The provider has the right to be made aware of complaints about him/her or the service provided.

- The right to have a complaint against him/her, lodged with the appropriate authority in accordance with established complaints procedures with supporting documentation as required.

  An appropriate complaints procedure might be internal to the health service or a Registration Board, or the Office of the Health Complaints Commissioner.

- The right to be made aware of the outcomes the consumer would like to achieve in making his/her complaint.

RIGHT 5: CARERS

The Rights of Carers

The relationship between the health service consumer and the provider is the primary relationship. While those who provide care for health service consumers have rights and responsibilities as part of their role as carer, their rights are secondary to the rights of the health service user in the consumer/provider relationship. However, carers have the right to be treated with respect.

The parent/s of a child under 14 years of age is not considered to be a carer. However, the carer of a person with limited capacity for self determination does possess the rights listed in this section.

- Carers have the right to have their particular knowledge about the person in care considered and included in the health service provision for the person in care.

- Carers have the right to be involved in care planning and delivery, especially where it impacts on their role as carer.

- Carers have the right to information about the care of the health service user, support services and equipment, including support services and training for themselves as carers.

The Rights of the Health Service Provider

- The provider has the right to be informed when changes in the health status, circumstances, needs or treatment outcomes of the consumer impact on his/her health or treatment.

RIGHT 6: THE CONTRIBUTION OF THE HEALTH SERVICE PROVIDER

The Rights of the Health Service Provider

- The provider has the right to be acknowledged for their contribution to health care and their commitment to providing quality care.

- The right to recognition and respect for the level of training undertaken by providers and for the knowledge, skills and experience providers bring to the provision of consumer's health care.

- The right to expect that the advice provided and the treatment he/she dispenses will be considered and followed, and if this is not possible or does not occur, he/she will be informed.

- The right to feedback on the health services provided including positive and negative comment where appropriate or necessary.

  This might include participating in evaluation exercises or questionnaires about services.

- The right to reasonable expectations from consumers about the level of care and treatment that can be provided.

  Consumers should realise and acknowledge the limitations of health services and health service providers. For example, consumers may have to wait to receive service, attend a different provider or be referred.

- The right to expect consumers to pay accounts promptly or if there is any difficulty in doing so, to discuss the matter with the provider.

Appendix 4: Director of Proceedings

New South Wales Model

The function of determining whether a complaint should be prosecuted before a disciplinary body and by whom (that is, by the Commission or some other person or body for prosecution) is undertaken by the **Director of Proceedings** (s.90B HCCA). If the Director determines that a complaint should be prosecuted before a disciplinary body by the Commission, the Director will prosecute the complaint. The Director does not exercise any other function of the Commission other than this function and is not subject to the direction and control of the Commissioner in dealing with any particular complaint that has been referred by the Commissioner to the Director for consideration. Criteria for determinations of the Director include:

- the protection of the health and safety of the public;
- seriousness of the alleged conduct the subject of the complaint;
- the likelihood of proving the alleged conduct;
- any submissions by the HSP.

New Zealand Model

Director of Proceedings is an independent statutory officer appointed under the *Health and Disability Commissioner Act 1994* and is a lawyer. Although the Director may provide representation or assistance to complainants in any forum (for example, a court, tribunal, inquiry), the primary focus is on disciplinary proceedings or proceedings before the Human Rights Review Tribunal.

In certain circumstances where the Commissioner forms the opinion that a breach of a consumer's rights has occurred, the Commissioner may refer the case to the Director of Proceedings. The Director reviews the Commission's file and makes an independent decision whether or not to take any further action. The Director can lay a disciplinary charge before the Health Practitioners Disciplinary Tribunal, issue proceedings before the Human Rights Review Tribunal or both. A team of lawyers and assistants work with the Director in reviewing files and prosecuting cases.

Appendix 5: The Independent Patient Advocacy System in the UK and New Zealand

The Patient Advocacy System as it operates in other jurisdictions such as the UK and New Zealand, functions as an independent service funded via grants from the National Health Service (NHS) to existing community based organisations or, as in the case of New Zealand, via staff contracted by the Health and Disability Commissioner (HDC). In New Zealand, there is a total of 26 equivalent full-time staff working throughout the country, and in the UK, there is a total of 180 full time equivalent staff. In both instances, independent Patient Advocates operate in *tandem* with the network of Complaints Coordinators employed by health service providers.

The rationale for establishing these services was to intervene to resolve complaints as early as possible, address the perceived power imbalance which exists between health service providers and complainants and to ensure that the public have access to an independent support service to assist them through all stages of the complaints process.

Both the UK and the New Zealand systems are premised upon the assumption that local complaint resolution is always the preferred approach and should be achieved wherever possible. In the UK, data indicates that approximately 97% of health complaints do not proceed beyond the stage of local resolution.[85] In New Zealand, the HDC reported that in 2004 approximately 85% of complaints were resolved locally with advocacy assistance, or as a result of the consumer's own action after advocacy, and on average only 4% were escalated to formal complaints with the HDC.[86]

In both countries presently using this model, the Patient Advocate requires that in the first instance, complainants who are able to, must take up their complaint directly with the service provider in order to attempt to sort out their concern. Only if complaints are unable to be resolved locally with the HSP, do complaints proceed to external review. Patient Advocates help clients identify the options for taking forward their complaints. This may include coaching consumers to handle the issue themselves (where appropriate), an option that a number of consumers appreciate. Many say that once they have the options explained to them, they are able to "get on with it". Patient Advocates also make sure lessons from users' experiences arising from the complaint are fed back into the service and to those responsible for scrutinising the delivery of health care services.

UK Patient Advocates do not assist clients who want to commence, or who are already involved in, litigation against a HSP, nor do they directly investigate complaints.

Patient Advocates in the UK encourage local complaint resolution in order to provide prompt investigation and resolution of the complaint at local level, aiming to satisfy the complainant and be fair to staff. A verbal response or explanation from the HSP is often the best way of resolving concerns quickly. An advocate may assist a complainant by meeting with or writing to HSPs, accessing medical records or other information related to the health service, or formulating a formal complaint.

In the UK, the NHS complaints reforms aim to change attitudes to complaints so they are integral to clinical governance and service improvement. There, Patient Advocates attempt to differentiate at the outset between complaints which are relatively minor in nature and relate to purely "personal grievance" matters and those which have a relevance to "clinical governance", that is, those that might indicate that a health professional has placed a patient at risk or has delivered a poor standard of care.

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[85] ICAS Resources for the Complaints Journey http://www.icasresources.com/reviewoptions2.html
[86] NZ HDC 2004 Annual Report p.13. http://www.hdc.org.nz/files/pagepublications/report2004.pdf

Patient Advocates generally attempt to ensure "personal grievance" complaints are addressed by way of conciliation and mediation to restore, if possible, the relationship of trust between the health professional and the complainant. However Patient Advocates are likely to encourage more formal consideration of "clinical governance" complaints, so that the health service concerned can address the issues raised as part of its clinical governance responsibilities.

In the UK, when Patient Advocates consider that there is a serious risk to patient safety or there is clear evidence of malpractice, the advocate, with the advice of their line manager, will work with the complainant to identify how the complaint can be dealt with as promptly and thoroughly as possible, preferably via more formal processes.

Those who support the Patient Advocate concept argue that the Patient Advocate plays an important role in making the system more accessible, enhancing public confidence in the fairness of the process and improving trust in the complaints resolution system. Citing the results of its 2004 survey of complainants who used its investigation services, the New Zealand HDC observed that only 46% of complainants were satisfied overall with the fairness of the process (in contrast to 80% of providers), although interestingly in the HDC's 2003 evaluation of customer satisfaction the parties surveyed who had experienced advocacy, reported much higher levels of satisfaction (over 86% of complainants *and* providers).[87]

In its 2004 Annual Report, the New Zealand HDC observed that the number of new complaints remained fairly static (1,142 compared to 1,159 in the previous year), but the Office made considerable progress in clearing the backlog of open files. The HDC considered this progress could be attributed to the "greater use of advocacy and intervention by HDC's complaints assessors, improving the speedy low-level resolution of complaints." Therefore, despite concerns that patient advocacy systems entrench adversarial processes, are unpopular with HSPs and unnecessarily complicate health complaints resolution systems, the New Zealand experience suggests that this may not be correct.

Should a similar independent patient advocacy model to the New Zealand or UK systems be adopted in Queensland with a comparable level of service provision, it is estimated that 28 EFT (A06) Patient Advocates would be required State-wide plus a State-wide coordinator (A08) and administrative support officer (A03).

As mentioned earlier, until March 2005, the New South Wales Health Care Complaints Commission provided an advocacy role for complainants but lost that role when it took on its alternative complaints resolution role.

[87] NZ HDC 2004 Annual Report p.1 http://www.hdc.org.nz/files/pagepublications/report2004.pdf