

Health Complaints Commissioner

Tasmania

Annual Report 2005 – 2006

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To the Honourable Donald George Wing
President of the Legislative Council and the
Honourable Michael Robert Polley Speaker
of the House of Assembly.

I have the honour to submit a report on the
exercise of the Ombudsman's functions
during the year ended 30 June 2006 for
presentation to the Parliament pursuant to
the provisions of Section 12 of the *Health
Complaints Act 1995*.

SIMON ALLSTON
HEALTH COMPLAINTS COMMISSIONER

October 2006

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FROM THE COMMISSIONER

This is the tenth Annual Report of the Health Complaints Commissioner, and my first in the role. I was appointed as Ombudsman and Health Complaints Commissioner on 20 August 2005, for a period of 5 years.

Robyn Hopcroft preceded me as Commissioner, holding the office from 23 May 2005 until the time of my appointment. She therefore held the office for a brief period at the start of this reporting year. Richard Bingham was also Acting Commissioner from 29 November 2005 until 10 July 2006, whilst I was absent on extended sick leave. I wish to acknowledge the excellent work of each of them in guiding the work of the office. I also wish to express my appreciation for Robyn's hard work and dedication in her normal role as Principal Officer (Health Complaints) in my office.

During the reporting year a greater number of staff have been allocated to handle health complaints. At year's end, there were a total of 2.9 FTE's working as investigators, as opposed to 1.8 for 2004/5. There were also 0.9 FTE's working solely in conciliations, as opposed to 0.4 in the previous year. As previously, the investigation staff also has recourse to a full-time administrative assistant. These staffing levels reflect continuing high complaint levels, and my wish and that of Richard Bingham to ensure the timely handling of complaints, the resolution of old matters and the greater and earlier use of conciliation.

The conciliation staff are Pip Whyte (0.6 FTE) and Tony Byard (0.3 FTE). Both operate from Launceston, with frequent visits to Hobart. Compatibly with the requirements of the *Health Complaints Act*, which requires the separation of investigation and conciliation functions, both are directly responsible to me in their conciliation work. As required by s 38 of the Act, the conciliators also have access to a professional mentor, appointed in October 2005, this being Ms Anne Stark. I am grateful to Ms Stark for accepting this appointment.

I am very keen to maintain close contact with the 11 health profession registration boards, to ensure that the work of the Commissioner and that of each of the boards is complementary. Draft protocols have been prepared to elaborate and guide the relationship between the Commissioner and the boards, and I hope to be able to report at this time next year on the adoption of these protocols and how they have performed.

It is to be noted, however, that the Council of Australian Governments (COAG) has agreed to establish by July 2008 a single national registration scheme for health professionals, beginning with the 9 professions currently registered in all jurisdictions. It remains to be seen how this will affect the investigative and disciplinary work of the State boards, and therefore the operation of the *Health Complaints Act*.

Last year's Annual Report records that the second review of the *Health Complaints Act* had commenced, as required by s 76 of the Act. This review has been suspended for the time being, in anticipation of the commencement of the *Justice and Related Legislation (Miscellaneous Amendments) Bill 2006*, by which it is intended to repeal that section and therefore the requirement for the review of the Act at intervals not exceeding 5 years.

In closing this foreword, I wish to thank all of my staff for their support and good work throughout the year. I also wish to thank the health registration boards and their staff for their cooperation, without which the performance of the functions of the Health Complaints Commissioner would be much more difficult. Thanks are also due to those specialist professional practitioners who have provided expert advisory services to the office on a *pro bono* basis. It is frequently necessary for my investigators and conciliators to obtain expert advice, but unfortunately government makes no budgetary allocation to the office for this purpose.

I trust that the readers of this Annual Report, and particularly those who are involved in the provision of health services in the State, find it both informative and educational.

Simon Allston
Health Complaints Commissioner

September 2006

COMMUNITY OUTREACH & STAFF PROFESSIONAL DEVELOPMENT

During the reporting year the Commissioner and staff attended a number of events relating to the health jurisdiction. The following is a précis of outreach, professional development and training events.

July 2005

- Root cause analysis training – 23/24 August in Launceston, attended by Morgen Hughes and Pip Whyte.
- New complaint form designed and trialled.
- 2005 – Consumer Survey – launched, running for three months.
- Royal College of General Practitioners – Article (08/07) written for the RCGP September GP Newsletter.
- Notes on the Office of the Health Complaints Commissioner forwarded to Duncan Kerr for inclusion in *The Denison Report*.

September 2005

- Milda Kaitinis attended the Root Cause Analysis seminar at the Quarantine Centre on 5 September.
- The Health Procedural Manual revised.
- Milda Kaitinis attended the Mental Health Services Strategic Plan 2005-2010 forum.

October 2005

- Simon Allston and Robyn Hopcroft attended the Council of Health Complaints Commissioners Meeting Perth (WA).
- Alanna Perry attended and participated in the “Medical Regulation and Practitioner Health – doctors are human, they get sick too” seminar run by the Medical Council of Tasmania.
- Alanna Perry and Pip Whyte attended the Peter Condliffe workshop “Working with Resistance, Difficult Parties and Persistent Complainers”.
- Alanna Perry attended a consultation session with the Acquired Brain Injury Association of Tasmania, sharing ideas and experiences for acquired brain injury services.
- Milda Kaitinis attended the Training Consortium Workshop – Introduction to Ethical Decision Making and Writing for Government Overview.

November 2005

- Alanna Perry conducted a presentation on the Office of the Health Complaints Commissioner at TAFE for Natural Therapy and Enrolled Nurse students.
- Ann Stark appointed as professional mentor for OHCC conciliators.

January 2006

- Conciliation Survey relating to accreditation and training – responses collated and survey emailed to all jurisdictions.

February 2006

- Milda Kaitinis and Alanna Perry attended the National Breast Cancer Centre – Breast Health Forum.
- Alanna Perry attended Investigation Training at the Victorian Ombudsman's Office.

March 2006

- Richard Bingham, Acting Commissioner, and Robyn Hopcroft met with Bill Turner, President of the Medical Indemnity Protection Society Ltd to discuss the OHCC complaints procedures.
- Alanna Perry attended Administration of Medication Guidelines for People with Disabilities in Community Based Disability Services (DHHS).
- Richard Bingham and Robyn Hopcroft attended the Council of Australian and New Zealand Health Complaints Commissioner in Alice Springs, Northern Territory.

May 2006

- Pip Whyte and Tony Byard attended the 8th National Mediation Conference in Hobart.

June 2006

- Alanna Perry attended a Justice Department Workplace Health and Safety Committee meeting.
- Tony Byard attended AIDS/HIV/HEP C workshop in Launceston.
- Medical Council Information session presented by Dr Hodgson attended by all health staff.
- Alanna Perry and Stuart Wright toured the Correctional Health Services facility at Risdon Prison with Ann Marie Mallett (Manager Correctional Health Services) and Dr Henderson, the prison medical officer.

Work Experience

During the reporting year three people obtained work experience in the OHCC. These were Jessica Childs, Tegan Muskett and Alanna Perry. Their contribution was much appreciated and in the case of Alanna Perry enabled her to experience the jurisdiction before her subsequent appointment, initially on contract then to the permanent staff. Jessica Childs assisted with designing the Consumer Survey and was then engaged on contract for other tasks before resuming her legal studies.

COMPLAINTS HANDLING

The Tasmanian *Charter of Health Rights and Responsibilities*, developed under Part 3 of the *Health Complaints Act 1995*, is intended to provide guidelines for health service users and health service providers as to their respective rights and responsibilities. The Office of the Health Complaints Commissioner (OHCC) handles complaints in accordance with the Act and the Charter, and seeks to do so in a manner consistent with recognised dispute resolution standards.

Under the Act, the Commissioner is required to act independently, impartially and in the public interest.¹ The OHCC has developed standards designed to ensure that the quality of the complaints handling process is efficient, effective and fair and that the health service meets the OHCC Charter. The underlying rationale of the standards is that complaints should be handled in a manner adapted to complaints resolution in the health sector, that the outcomes are just, and that the most appropriate action is taken consistent with the public interest and seriousness of any particular complaint. It is also intended that the complaints handling processes should be transparent and include accountability measures for the parties, registration bodies, and others with an interest in the complaint.

Dispute resolution principles mentioned in the relevant Australian Standard² (AS) promote effective complaint handling. These include: early resolution; accurate communication; the least interventionist approach initially, then staged intervention; time limits for each stage of the process; simplicity; easy access to the complaints process; cost efficiency; fair and reasonable processes which satisfy the parties in the dispute; and promotion of the system complaints process so that potential complainants are aware of how to make a complaint.

The objective of the AS is to ensure that matters are dealt with in a timely and efficient manner. Therefore, there is an emphasis in this AS on timeframes and throughput. Some matters can only be addressed effectively if they are dealt with quickly and in accordance with the early resolution provisions of the Act. The outcomes of a complaints process are equally as important as throughput. It is necessary to ensure that complaints are dealt with thoroughly and fairly, that the concerns of health service consumers are adequately addressed, that opportunities for quality improvement are taken up, that public safety is protected and that the principles of procedural fairness are applied to the complaints process.

Adverse outcomes and systemic errors

Treatments are often complex and sometimes unpredictable. People can suffer an adverse outcome with far worse consequences than the condition for which they sought treatment. While they may have been warned of the risks, many fail to comprehend the consequences of a risk materialising until that happens and almost invariably they believe that it must have been as a result of an error or negligence on the part of the health service provider.

¹ *Health Complaints Act 1995* - s 7

² *Australian Standard AS 4369-1995*. See also the Commonwealth Ombudsman's publication: "*A Good Practice Guide for Effective Complaints Handling*".

Mistakes can be made and accidents can happen for reasons other than that a person was negligent or did not have the necessary competence and capacity to provide that service. Sometimes errors can be described as systemic errors in that the procedures and practices of an organisation are deficient creating an environment conducive to error and poor quality outcomes. In recent years action has been taken to improve patient safety by improving practice in both clinical and non-clinical work environments. “Root Cause Analysis” (RCA) has been implemented to identify and address the actual cause of problems, whether the problem was caused by the actions of an individual, a work unit or the accumulation of systemic inadequacies.

Risk management and quality assurance strategies

Risk management and quality assurance strategies have been developed for the purpose of reducing errors and achieving better outcomes.

Bodies such as the Australian Council for Safety and Quality in Health Care (ACSQHC) were established to develop standards for public and private hospitals.

ACSQHC managed the “Open Disclosure” project which involved conducting information sessions and consultations in all Australian jurisdictions. The purpose of the project was to examine the proposition that it was appropriate, morally and legally, for a health service provider to provide an explanation and an apology to a patient in the event of an unintended adverse outcome. Such “open disclosure” could convey genuine compassion and regret to the patient.

“Open disclosure” was also regarded as an effective “risk management” tool as both anecdotal and other evidence from studies undertaken indicated that an apology and disclosure had brought some resolution to the affected patient and avoided litigation.

In February 2006, the ACSQHC was reconstituted as the Australian Commission for Safety and Quality in Health Care for the purposes of implementing the standards developed by the Council.

In Tasmania, the *Civil Liability Act 2002* provides that an apology does not constitute an admission of liability.³

The establishment of a health complaints system in every State and Territory has also provided an alternative dispute resolution mechanism, through conciliation and investigation, and where appropriate a conduit to the registration boards regulating health providers. The Charter and the complaints handling standards of the OHCC are designed to ensure that the complaints handling system is effective and the outcomes are fair. The OHCC is not an advocate for either party and must be impartial while at the same time achieving just outcomes.

The consumer perspective

Many health service providers now have a system for managing and addressing complaints as part of their quality assurance and risk management programs. There

³ Section 7 - An “apology” means “an expression of sympathy or regret, or of a general sense of benevolence or compassion, in connection with any matter, which does not contain an admission of fault in connection with the matter.”

has been a greater focus on the consumer's perspective including consumer experiences of complaints processes with registration boards.⁴

The OHCC has conducted two complainant surveys – one during the first statutory review of the operation of the *Health Complaints Act*; and the second in the period from July to September 2005 in anticipation of the second statutory review. Some health service providers conduct patient satisfaction surveys and ensure that consumers are aware of the availability of grievance processes. For example, the Hobart Clinic provides its patients with both the *Tasmanian Charter of Health Rights and Responsibilities* and with the *Private Hospital Charter*⁵ and in 2005 agreed to participate in a new initiative, *Consumer Perceptions of Care*, a patient satisfaction model funded by the Commonwealth Government. The Hobart Clinic reported that it is one of eight private psychiatric hospitals in Australia piloting the project along with selected public hospitals in Queensland. Hobart Clinic is also currently trialling another patient satisfaction model at its own expense as part of its continuous improvement plan.

Other public and private hospitals have appointed staff, in some instances optimistically titled “Compliments and Complaints officers”, to resolve grievances at the direct service level. In some States there are also “complaint liaison officers” who can be approached to resolve issues at the point of service by negotiation and mediation. In Australia advocacy services provide a valuable role in assisting those who may wish to express a concern or make a complaint. While these grievance systems assist health service consumers and providers to resolve their differences, the person may be dissatisfied with the result and remain aggrieved.

Factors motivating the making of a complaint

There are some common motivations for making a complaint and these are often reflected in the “outcomes sought” section of the OHCC complaint form. It appears that punishment, disciplinary action or some scrutiny of the provider are motivating factors. Many complainants do not understand that the professional standards of health care providers are regulated by their respective registration boards and that the purpose of that regulation is public protection.

Where there has been an adverse outcome compensation is often sought without any understanding that it will not be paid unless there is a legal obligation to do so. Many people do not understand that a person can make a mistake without having been negligent. An explanation is frequently sought by those contacting the OHCC and a significant part of the work of the OHCC is obtaining a reasonable explanation of what occurred. If an error or mistake has been made then an explanation of how it occurred and how it is to be remedied may defuse the situation. Complainants are frequently altruistic and genuinely wish that others would not experience what they have experienced. However if they have suffered an adverse outcome, or the standard of the health service they received has been less than optimal, and there is no explanation, information or apology then the situation can be exacerbated and anger can fuel a desire for retribution.

⁴ Health Issues Centre & Resolution Resource Network: ‘Bringing in the Consumer Perspective’ Consumer Experiences of Complaints Processes in Victorian Health Practitioner Registration Boards - October 2004

⁵ Hobart Clinic – Andrew Weston 17 June 2005 & 26 July 2006 email re Private Patients Hospital Charter Commonwealth - Department of Health and Ageing

Appropriate responses by providers

Many complaints arise because a health service provider has not provided the consumer with a clear explanation of what occurred and ensured the consumer has understood the explanation, or has not acknowledged that person's concern. A discourteous and dismissive manner can result in a complaint being lodged whereas a concerned and sympathetic manner, and genuine wish to address any substantive issues of concern, can resolve the grievance and satisfy the consumer.

At the conclusion of his article *Angered patients and the medical profession*, author Paul Nisselle stated that: "...A doctor's behaviour after an adverse event, or after receipt of a complaint, is often the major factor determining whether the patient proceeds to litigation or chooses another avenue of complaint or does nothing".⁶ In that same article the author provided the following suggestions on "What to do when an adverse event occurs":

- Inform the patient as soon as possible
- If a letter of complaint is received, forward a reply promptly
- Supply information which is detailed and factual but contains neither positive nor negative "spin"
- Self-flagellation by the doctor or the hospital involved is inappropriate, but so is denial
- Acknowledge the effect ("I appreciate how distressing this is to you")
- Express sincere regret and genuine concern for the patient's welfare ("I'm sorry this has happened to you")
- Do not admit liability ("I'm sorry I did this to you"). It is inappropriate to admit liability in the heat of the moment; calmer reflection, and after seeking advice, may lead to a conclusion that there is no liability.⁷

In many instances, despite a reasonable response by a health service provider the patient may remain aggrieved. If the grievance cannot be resolved unassisted the patient may lodge a complaint under the Health Complaints Act. One of the first actions taken by the OHCC is to consider whether the complaint is one which can be resolved quickly and with an appropriate outcome. This is referred to as "early resolution" and the role of the OHCC is to engage with the parties and facilitate a fair resolution.

Managing unreasonable conduct

The OHCC endeavours to review and adhere to sound complaint-handling standards and to ensure that complaint outcomes are just.

The number of complainants perceived as being difficult has probably remained static in the health complaints jurisdiction. The demographic of complainants includes those with a mental illness, who are frail, aged and/or disabled, have suffered an adverse outcome or who are experiencing difficulties in accessing a service. In relation to access to services, a significant number of Tasmanians are unable to afford private dental health care and rely on public dental services. Although the provision of oral health services is essential for their health and wellbeing such services are not

⁶ Paul Nisselle, *Angered Patients and the Medical Profession*; The Medical Journal of Australia, 1999 Vol 170 pp 576-577. This article is reproduced at <http://www.mja.com.au>

⁷ op. cit.

available at the level required to satisfy community need. Some people express anger and frustration at not being able to access a service they need and the occurrence of these behaviours has probably increased.

A national project on “Managing Unreasonable Conduct” is being developed through the Ombudsman jurisdictions⁸ and the material published to date has relevance for the health complaints jurisdiction. The information on these management strategies will be utilised as part of staff in-service training and professional development.

Administrative and operational actions during the reporting year

Since the commencement of the 2005 amendments to the *Health Complaints Act*, the Procedural Manual and all database template letters have been revised. Conciliation, provider and consumer brochures and business cards have also been revised and printed. The complaints form has been revised and is now printed in-house.

Practice Notes are being developed for those provisions of the *Health Complaints Act* in respect of which legal advice has been required. Practice Notes and Fact Sheets will be available to staff on the intranet when it is operational. The OHCC website is being reviewed.

Fact Sheets have been prepared on: conciliation and financial settlements; the obligation to reimburse bodies such as the Health Insurance Commission, statutory benefit preclusion periods in the event of a financial settlement, complaint issues which recur, such as “informed financial consent”, and whether a consumer, in giving consent, has been informed of a relevant risk. Some issues have arisen as to whether the termination of a health service constitutes retaliation for having lodged a complaint.

Four staff members attended “Root Cause Analysis” training and Investigation Officers attended forums on: *The Right to Die*; *Impaired practitioners*; and *Working with resistance, difficult parties and persistent complainers*.

OHCC did not have a separate planning day during the reporting year. Instead, Ms Di Stow, a Senior Consultant in Human Resources with the Department of Justice, was briefed to review and formulate recommendations in relation to the planning and strategic direction for the Offices of the Ombudsman and the Health Complaints Commissioner.

⁸ The NSW Ombudsman Office is the project co-ordinator and other Ombudsmen are involved along with Dr G Lester and Professor Paul Mullen of the Victorian Institute of Forensic Mental Health.

CLOSED IN THE REPORTING YEAR

The complaint issues

Many complaints made to the OHCC are genuine but misconceived and are able to be quickly resolved by the service provider providing the complainant with an appropriate explanation of the circumstances which gave rise to their grievance, and by apologising to them. Other complaints are well founded. Some reflect structural problems with public health services and access to services. Table 4 reports the resolved complaint issues in this reporting year and compares this with the previous reporting year.

The OHCC categorises complaints according to the following issues: access; cost; decision-making; grievances; information; other issues; privacy; professional conduct; and treatment. The most common issues raised by complaints in this reporting year were: treatment (292); professional conduct (122); and access to health services (82).

Other notable statistics from this reporting year are as follows:

- access to health services (82) - no service or no adequate service; refusal of admission or treatment; and delays in treatment
- issues in relation to costs (54) - inadequate information on costs; unsatisfactory billing practices; and overcharging
- decision-making issues (8) - failure to consult the consumer; and failure to obtain valid consent
- grievances (4) - no response or no adequate response to a complaint
- information (38) - the greatest number of complaints related to a failure to pass on information or inadequate access to records
- other issues (23) - about half related to administrative practices and the balance of complaint issues related to policy or public health issues or a failure to provide a certificate or report
- privacy (38) - the greatest number of complaints related to breach of confidentiality and unprofessional conduct
- professional conduct - competence and/or impairment (43); misconduct (41); and breach of a standard (38). This represented an increase in complaints relating to professional conduct from 115 in the previous reporting year to 122 in this reporting year.
- treatment - the largest number of complaints in the *treatment* category were recorded in the following 4 of the 10 sub-categories: negligent treatment (82); inadequate treatment (71); unskilful and/or incomplete treatment (30); and adverse outcomes (28). This represented a reduction from 309 in the previous reporting year to 292 in this reporting year.

A further breakdown of category types is set out in Table 4.

The health service providers

In this reporting year there were 62 complaints against public hospitals and 16 against private hospitals, representing a decrease since the previous reporting year.

During the past three reporting years there has been a steady increase in complaints against Mental Health Services and Correctional Health Services to 23 and 20 respectively. Those statistics need to be put in context as an increase in complaints may simply reflect increased community awareness of the OHCC or may reflect, in the case of Correctional Health Services, an increase in the number of prisoners.

In the last three reporting years complaints against medical practitioners have decreased overall (163, 149, 117) as have complaints against some categories of medical practitioners, particularly general practitioners and psychiatrists. Complaints against plastic surgeons have increased in the past three reporting years (3, 4, 8). Again while the numbers are so low that they cannot be regarded as statistically significant, this is an area of practice where complainants' expectations of the outcome of surgery may be unrealistic. Table 6 gives a breakdown of complaints about medical practitioners.

Over the past three reporting years the complaint numbers against individual providers have dropped slightly (220, 198, 180). Of the 180 complaints in this reporting year 117 were against medical practitioners, 26 against nurses and 17 against dentists. Table 7 gives a comparison of the complaints against individual health providers as opposed to complaints against organisations providing health services.

Complaint and enquiry numbers

Table 3 records that in this reporting year 587 complaints were closed including 297 that were enquiries requiring no further action other than providing initial information, giving advice and the forwarding of a complaint form and information brochure. Two were excluded as being out of jurisdiction⁹ but the transfer of the file to a professional registration board was facilitated with the consent of the person who lodged the complaint. Of the remaining 288 complaints, 29 were assessed as appropriately retained by registration boards¹⁰ for actions under the board's legislation, leaving 259 complaints to be dealt with by the OHCC. Of those, 24 were referred to professional registration boards as part of the complaints handling process.

Complaints dismissed under section 25(5) of the *Health Complaints Act 1995*

Section 25(5) of the *Health Complaints Act* provides that the Commissioner must dismiss a complaint if satisfied that one of the paragraphs of that section is made out. The following is a summary of the numbers of complaints and examples of the types of complaints which were dismissed in accordance with that provision of the Act.

⁹ Under Part 2 of Schedule 1 of the *Health Complaints Act 1995* which refers to workers compensation matters.

¹⁰ Pursuant to s 57(1)(c)(ii) of the *Health Complaints Act 1995*

The complainant was not entitled to make a complaint (s 25(5)(a))

In this reporting year 5 complaints were rejected on the basis that the complainant was not a person entitled to make a complaint. However, in one instance the Commissioner initiated an investigation on his own motion as the circumstances of the complaint raised questions of public interest and/or public safety.

No grounds (s 25(5)(b))

The Commissioner received 8 written complaints which did not disclose any ground upon which a complaint could be made under the *Health Complaints Act* (see s 23 of the Act where the grounds are specified). In some instances, where complainants were obviously very confused and it appeared that there might be grounds for making a complaint, endeavours were made to assist them to clarify their concerns.

Out of time (s 25(5)(c) and s 25(6))

Six complaints were dismissed on the basis that the complainant became aware of the circumstances that gave rise to their complaint more than 2 years before the complaint was made (see s 25(5)(c)). However, the Commissioner was satisfied in a number of instances that the complainant had good reason for not making the complaint within that 2-year period and those complaints were accepted (see s 25(6)).

No attempt at direct resolution (s 25(5)(d))

Complainants are required to take reasonable steps to resolve their complaints directly with their health service provider (see s 25(5)(d)) unless they can show that there is a good reason why they should not be required to do so. One complaint was dismissed on the basis that the complainant did not have a "good reason" for not attempting direct resolution. In some instances complainants do attempt to resolve their grievances directly with their service provider but encounter an impenetrable barrier at reception behind which the provider remains unaware that there is a concern until correspondence is received from the OHCC. In other practices, staff and providers are consumer-orientated and are interested in resolving any problems rather than taking a defensive approach.

Adjudicated by a court or tribunal (s 25(5)(e))

Three matters were dismissed on the basis that the issues had been adjudicated by a court or tribunal. In most instances, the complainants have wanted to contest conditions of orders made by the Mental Health Tribunal or Guardianship and Administration Board.

In the reporting year a complaint was lodged at the same time an application was made to extend the period under the *Limitations Act 1971* to enable the applicant to commence proceedings against a surgeon at the North West Regional Hospital. The Director of Public Prosecutions contended that the application constituted 'proceedings' for the purposes of s 25(5)(f) and that the Commissioner should dismiss the complaint. An opinion was sought from the Solicitor-General and advice was received that the application under the *Limitations Act 1971* did not constitute proceedings for the purposes of s 25(5)(f).

The complainant was given reasonable explanations and information and there would be no benefit in further entertaining the complaint (s 25(5)(g))

The Commissioner is required by s 25(5)(g) of the *Health Complaints Act* to dismiss a complaint if satisfied that the complainant has been given reasonable explanations and information and there would be no benefit in further entertaining the complaint. On that basis, 105 complaints were dismissed in this reporting year. A significant amount of the work of the OHCC involves information gathering and examining the factual circumstances surrounding each complaint. Having undertaken those tasks it is possible to provide many complainants with sufficient explanations and information to satisfy this statutory requirement.

Such an explanation is frequently accompanied by apologies, acknowledgement that there were issues of concern and assurances that these matters either have been or will be addressed. An explanation, information and opening a dialogue between the provider and consumer is a valuable means of resolving the complaint. The process also allows the OHCC, and through consultation the regulatory bodies, to monitor the quality of care and the actions taken by health service providers to remedy errors which may have arisen.

The complaint lacked substance (s 25(5)(h))

In this reporting year 14 complaints were dismissed on the basis that they lacked substance. It is not always possible to come to that conclusion only on the basis of the information contained in the complaint documentation and in those cases some fact finding work is necessary. In at least 2 of those matters it was necessary for either the OHCC or the provider to undertake such work in order to ascertain whether there was or was not substance to the person's complaint. The following case summary is an example of that kind of situation.

A complainant alleged that his medical practitioner in Tasmania had not provided him with copy of scans following a consultation with a doctor in Victoria. The following information was revealed:

The provider had contacted the practitioner's rooms in Victoria and was advised that although the complainant had consulted the practitioner there was no record of any ultrasound investigation being ordered for the complainant. The provider had also advised the complainant that he had not seen or known of any results from his doctor in Victoria.

The same complainant also alleged that another medical practitioner had failed or refused to provide him with a prescription for epilepsy medication for his use during a trip interstate. It was revealed that the complainant was in error. The doctor against whom this allegation was made had assisted the consulting doctor who had ordered the medication by faxing the script to the pharmacy on his behalf.

The matter was closed as unsubstantiated and all parties including the Medical Council of Tasmania were advised. As there is a requirement under the *Health Complaints Act* to notify the registration boards of complaints against registered providers it was suggested that the Medical Council make a specific notation when a complaint lacks substance.

The complaint was frivolous, vexatious or not made in good faith (s 25(5)(i))

No complaints were dismissed under s 25(5)(i) of the Act, a statistic which is consistent with the general experience of the OHCC. While many complainants are genuine some of their complaints are misconceived.

None were dismissed on the basis that the complainant failed to provide information, though some complainants were selective with the information provided or attempted to manipulate the complaints processes. In some instances notices were sent cautioning complainants that their complaint would be dismissed if information was not provided. Six complaints were withdrawn, some of which because the complainant had resolved the complaint directly with the provider.

The complaint was resolved (s 25(5)(j))

The following matter is an example of a complaint which, although recorded as having been “dismissed” pursuant to s 25(5)(j), was in fact resolved in the “early resolution” process:

The complainant had multiple tooth extractions and new dentures fitted. She asserted that another dentist had advised her that the dentures were incorrectly fitted and would need to be replaced. She also asserted that she could not eat or talk properly with the new dentures. The complaint was resolved when the provider paid the cost of the replacement dentures. However, the provider explained that a re-line is required for dentures fitted immediately after multiple tooth extractions and that an additional cost is incurred for that procedure. He stated that he explained that to the complainant at the outset and when she returned to discuss the relining required. It appeared that this was not clearly understood by the complainant. The provider forwarded a detailed “Consent to treatment” form, which he had drafted and intends to use in future so that patients have a clear understanding of the extent of the costs which are likely to be incurred.

In such cases even though a reasonable explanation is provided by the service provider the complainant is unable to accept that it is reasonable. The complainant’s own state of mind, perception of what occurred, and genuinely held belief that s/he has suffered a wrong, makes such complaints difficult to handle. In such circumstances, the action of dismissing a complaint on the basis that a reasonable explanation was given does not necessarily reflect the complexity and sensitivity of the matter and the degree of difficulty involved in the complaints handling process.

Conciliation

There were 29 matters closed at conciliation of which 19 were resolved and 10 unresolved. Some were ended by the Commissioner.¹¹ The number of matters dealt with in conciliation is comparable with the previous reporting year in that 19 were resolved in each year but the profile is different in that 4 were unresolved compared to 10 unresolved matters in this year. A full report on conciliations is in the section of the report on “Conciliations under Part 5”.

¹¹ Sections 35(1)(a) and (1)(b), s 39, and s 36 respectively.

Investigation

There were nine matters closed at investigation, although some matters were investigated and then referred to conciliation and are therefore not reflected in the investigation statistics in Table 8. A full report on the investigations is in the section of the report on “Investigations under Part 6”.

CONCILIATIONS UNDER PART 5

In this reporting year, 46 new matters were referred to conciliation under Part 5 of the *Health Complaints Act 1995* (an increase of 12 on the previous year) and 29 matters were closed as a result of conciliation.

Of the new matters, 30 were referred in the last half of the year. In response to that sudden increase in demand for conciliation, an existing part-time position (0.6) which was formerly a combined investigation/conciliation officer position is now dedicated solely to conducting conciliation and an existing full-time investigation officer position is dedicated to conciliation duties as 0.3 of a full-time position. There is now the equivalent of nearly one full-time “in-house” conciliation officer. This will contribute significantly to the capacity of the office to meet recently developed case management benchmarks, thus ensuring that matters will be dealt with in a timely and efficient manner.

Of the 29 matters which were closed, 19 were resolved and 10 unresolved compared with 19 and 4, respectively, in the previous reporting year.

For conciliation purposes the term “resolved” means that the parties are substantially satisfied with the outcome. Where litigation is a possibility, resolution may consist of the complainant deciding not to proceed to litigation. Similarly, with matters which are recorded as “unresolved” where the parties seek a court ordered resolution, conciliation should not be interpreted as having been unsuccessful. During the conciliation process, the parties invariably engage in useful dialogue in terms of apologies and explanations and in gaining an understanding of what happened and why it happened. Often the only unresolved issue will be whether liability for damages or compensation exists. The determination of that issue is a matter for a provider’s indemnity insurer and not one which an individual provider can resolve.

In this reporting year, 3 of the 10 unresolved matters proceeded to court for determination. Those 3 matters arose from the same complaint but involved three different providers and related to the death of a patient following surgery. During the conciliation process a number of issues relating to what had been perceived by the deceased’s widow as poor communication following the death of her husband were clarified and apologies (expressions of regret) and explanations were provided. Sadly, this was almost three years after the event and it is likely the delay did little to assuage the widow’s concerns that the adverse event was due to a failure to exercise reasonable care. In another two matters involving the same incident but different complainants, conciliation meetings were held and explanations and undertakings were given in relation to the implementation of system improvements. Issues of compensation were dealt with elsewhere under workers compensation and/or anti-discrimination legislation.

As a result of one complaint made to the OHCC, it became apparent that it could be beneficial to both the OHCC and the office of the Anti-Discrimination Commissioner to develop protocols for cross-jurisdictional consultation in relation to avoiding duplication of processes. The relevant circumstances were that a complainant lodged a complaint with the OHCC and the ADC in relation to the same matter. While the complainant eventually received the apology he was seeking through the ADC process the OHCC had undertaken a lot of groundwork in relation to his complaint.

In a further matter, a provider withdrew from the conciliation process on advice from his indemnity insurer when the complainant commenced proceedings in the Supreme Court. The complainant maintained that she remained keen to explore resolution through conciliation and was simply taking steps to ensure that her right to commence legal proceedings was not defeated by the limitation period.

In relation to three of the unresolved complaints lengthy periods of time elapsed between when the alleged events occurred and when conciliation was attempted. In one such matter the alleged events occurred almost 10 years before the complaint was lodged. The complaint was terminated by the Commissioner. In another, the complaint related to the circumstances surrounding the complainant's involuntary admission to a psychiatric unit five years previously. The provider's recollection of events was confined to what was recorded in the hospital file and the complainant's dispute concerned the content of that record. The third of these matters related to the ongoing care of the complainant's daughter. Although some headway was made, the process was frustrated by difficulties in bringing the relevant clinicians together.

It is apparent that the main focus for complainants is to gain an understanding of what had happened and why it happened and to have their experience and distress acknowledged. Complainants also seek assurances that quality improvements had been implemented to avoid similar occurrences in the future. Explanations were provided in all matters, and apologies and quality assurances were provided in eight. Two matters related solely to the provision of ongoing services. Through the conciliation process the parties not only gained a better understanding of why communication had broken down but they agreed to strategies for maintaining better communication in the future. In three matters, the parties quite simply agreed to disagree. Of the matters that were resolved only six resulted in compensation and/or waiver or refund of fees.

During the reporting year guidelines were developed to assist OHCC officers to identify those matters that might benefit from conciliation. Amongst other things, the guidelines focus on the importance of referring complaints to conciliation in a timely manner, while the events are fresh in the parties' minds and also before the parties become too firmly entrenched in their respective points of view. It is well recognised that the sooner parties are brought together and given the opportunity to discuss an adverse event the more likely it is that they will resolve any issues themselves. If patients perceive that they are not being given an open and honest account of an adverse event they are more likely to resort to adversarial means in order to 'get to the bottom' of what happened.¹²

In recognition of the benefits to the parties of engaging in open and honest discussion following an adverse event and in an attempt to foster trust between health care providers and patients who have suffered an adverse outcome, the Australian Council for Safety and Quality in Health Care (ACSQHC) has developed national standards for "Open Disclosure" which promote open disclosure and honest communication with the patient as early as possible following an adverse event. The standards provide a set of guidelines for providing information to patients and their carers following an

¹² Vincent C, Young M and Phillips A, *Why do people sue doctors? A study of patients and relatives taking legal action*, The Lancet, vol. 343, June 25, 1994.

adverse event. The “Open Disclosure” process does not amount to an admission of legal liability.

Most Australian States, including Tasmania, have legislated that an apology does not constitute an admission of liability (see s 7 of the *Civil Liability Act (Tas) 2002*). Also, under the *Health Complaints Act 1995* all information provided in the conciliation process is confidential and privileged.

It has been suggested that conciliation has limitations as a tool for bringing about quality improvements in the delivery of health care in that it is directed towards meeting only the needs and aspirations of individual complainants as opposed to bringing about significant improvements in the delivery of health services as a whole. That criticism seems to arise partly as a consequence of the confidentiality provisions relating to conciliation. The simple fact however is that quality assurances are frequently sought and obtained through the conciliation process. The real question is whether the only way of bringing about change is through naming and shaming or whether it might not be better in some circumstances to work collaboratively to identify any shortcomings and in developing strategies to avoid them in the future.

INVESTIGATIONS UNDER PART 6

A complaint may be investigated under Part 6 of the *Health Complaints Act 1995* if it is considered the most appropriate way of resolving the complaint. An investigation is undertaken where there are substantive facts in dispute which are central to the complaint. Most complaints are resolved at the preliminary or assessment stage and the majority of those are dismissed on the basis that a reasonable explanation and information has been given to the complainant, or the complaints have been resolved. Complaints that are not dismissed at assessment may proceed to investigation, to conciliation or be referred to a registration board or other statutory body.

Eleven investigations were concluded in this reporting year. Of those, 10 resulted in the complaints being finalised and one was referred to conciliation to resolve some outstanding issues. In undertaking such investigations and in determining whether a complaint should be investigated or conciliated, the OHCC frequently requires expert opinion reports from specialists or suitably qualified and experienced providers. In many instances reports are provided on a *pro bono* or discounted basis, even though a significant amount of work is involved, and had those reports been for medico-legal purposes, a considerable fee could have been charged. In other instances the Dental Board and the Dental Mechanics Registration Board have nominated reputable providers who assist in reviewing records and when required, assessing the complainant and providing a report. The Commissioner and staff are appreciative of this assistance and recognise that the quality of much of the work undertaken by this Office would be diminished without it. We wish to place on record our appreciation of that assistance.

Over the past four reporting years the number of investigations has steadily increased. It is likely that that trend will continue as the complaint numbers increase and also because of a policy decision to adhere strictly to the initial 45 days assessment period. In many cases where medical records or a response from a specialist in a complex matter is required, assessing the most appropriate action within that time frame is problematic.

The focus on early resolution should resolve some matters at the outset, whilst others are best suited to conciliation. Some may be referred to investigation to investigate the substantive facts in issue, after or during which the matter may be referred to the Commissioner. Other cases may be referred to conciliation immediately. Invariably some investigations involve elements of negotiated resolution, particularly where recommendations are formulated which involve changes in a health provider's policy, procedures or models of care.

Overview of the Investigations undertaken

Investigations were undertaken in relation to a range of health care settings and a range of issues. They differed in their seriousness and complexity. Four related to public and private hospitals and two to adverse outcomes of surgical procedures. One investigation was undertaken in relation to complaints concerning each of the following services or issues: a nursing home¹³; privacy issues arising from the preparation of a medical report; billing practices for cancelled appointments; the

¹³ This matter was then referred to conciliation and closed at the conciliation stage.

conduct of an alternative health provider; and one, which was also subject to a coronial inquiry, concerning the suicide of a young woman. Other major or serious investigations continued through the reporting year and are reaching final stages.

Whether alternative health care providers ought be regulated

An investigation was undertaken into allegations of professional misconduct by a massage therapist. The investigation report was tabled in Parliament in order to bring to attention the problems that can arise where traditional or alternative health providers are not required to be registered or otherwise regulated.¹⁴ A recommendation was made that an addendum to the Charter of Health Rights and Responsibilities be developed in the form of a Code of Conduct which applied to all health providers who are not required to be registered.¹⁵ Consideration was given to whether all alternative or traditional health providers ought be registered and made subject to disciplinary and regulatory proceedings. Whilst that was considered to be too onerous at this point in time, if the proposal to create a single disciplinary tribunal for all registered health providers is adopted in Tasmania, that regime could be made to apply to alternative or traditional providers. A summary of this complaint and investigation follows.

The complainant attended appointments with a massage therapist for treatment of neck spasms. The complainant had been sexually abused for a long period of time as a child and described herself as suffering from “selective amnesia” and “repressed memory syndrome”¹⁶ as a consequence. After a number of appointments, the complainant regressed to her childhood and engaged in sexual conduct with the massage therapist. They had a sexual relationship for a period of years in the context of a therapeutic relationship. The complainant became passively dependant on the massage therapist and became “addicted” to the sexual contact between them.

Expert opinion was obtained to the effect that sexual contact as a form of massage therapy has no recognized therapeutic basis. The sexual contact between the parties could be seen as furthering the cycle of abuse. A therapeutic relationship in the circumstances should have been one that was founded on respect for personal boundaries. The sexual contact between the parties would be likely to have caused the complainant psychological harm, including the reinforcing of an excessive emotional dependency on the massage therapist, the distortion of a healthy form of sexuality and intimacy, and the production of shame and mistrust.

There was a significant issue of public safety and a significant question as to the practice of the massage therapist, as vulnerable persons need to be protected from sexual conduct during therapeutic massage treatment.

The Code of Professional Ethics of the Australian Natural Therapists Association and the Code of Practice of the Australian Traditional Medicine Society prohibit its

¹⁴ Other than by criminal and civil law. [These are not forms of “regulation”].

¹⁵ The following recommendations were made:

1. That, pursuant to Part 3 of the *Health Complaints Act 1995*, the Health Complaints Commissioner consult and develop a Code of Professional Conduct as part of a review of the Charter of Health Rights.
2. That the Code of Professional Conduct apply to those alternative health providers or health providers referred to in Schedule 2 of the *Health Complaints Act 1995* who are not by law required to be registered.
3. That Government give consideration to the establishment of a single disciplinary health complaints tribunal governing both registered and unregistered individual health providers.

¹⁶ The term repressed memory syndrome is not used in the DSM-IV manual (Diagnostic and Statistical Manual of Mental Disorders), however it is alluded to under the diagnosis of Dissociative Amnesia.

members from entering into an intimate or sexual relationship with a patient whilst that patient is under their care. Having regard to this ethical standard, it was determined that the conduct of the massage therapist was unprofessional and unethical.

It was further determined that there was no justification for this conduct. The sexual contact between the parties would probably be deemed to be consensual from a legal perspective, but the vulnerability of the complainant should have been apparent to the massage therapist. It was found that the massage therapist's conduct was damaging to the complainant.

The therapist gave an assurance that he had ceased practice.

Investigations into treatment at hospital

Three of the investigations concerned incidents in public and private hospitals, which are referred to in more detail below, and a fourth investigation raised systemic issues relating to the credentialing of surgeons with admitting rights to a public hospital.

Ascorbate therapy

A significant investigation was undertaken into an issue involving a specialist oncologist and the Royal Hobart Hospital. The issue was whether the hospital should provide high dose ascorbate therapy to a terminally ill patient through the public health system. This raised ethical issues relating to medical research, drug trials, new therapies and issues of professional clinical judgment. The complaint also highlighted the pressures experienced by providers working with patients who are terminally ill, and how their care may be compromised by the attitudes and strongly held beliefs of those close to the patient.

The complainant had metastatic malignant melanoma and requested the specialist to administer high-dose intravenous ascorbate (vitamin C) therapy to her at the hospital at a dose recommended by her husband (a retired physician). This request was declined.

The complainant claimed that the specialist recommended a Taxoprexin/ Dacarbazine trial being conducted at the hospital to her but did not conduct a thorough medical evaluation prior to the recommendation. The complainant also asserted that the patient information sheet for the trial was deficient. It was determined upon investigation that the level of information provided in the trial documentation for participants was adequate.

It was established that the specialist and the hospital had considered the complainant's request for treatment in depth and that they were unable to provide this treatment because of the potential harm and insufficient clinical data. The complainant was offered supportive care. The complainant's expectation that the public health system should provide the requested treatment was considered unreasonable. It was also found that the complainant's husband did not treat the specialist and hospital staff with courtesy and respect. While his distress at his wife's condition was understandable it was considered that his conduct was unacceptable.

The conclusion reached was that medical practitioners do have a right to decline treatment not regarded by them as beneficially therapeutic as is outlined in the *Tasmanian Charter of Health Rights and Responsibilities* and the *Australian Medical Association Code of Ethics*. It was deemed appropriate for the specialist to inform the complainant of the availability of the trial and to provide material in relation to it. The fact that the specialist did not examine the complainant at the

20-minute consultation to determine whether she was a suitable candidate for inclusion in the trial was deemed to be reasonable. The specialist appropriately requested that the complainant make another appointment so that she could be examined.

It was determined that the specialist acted professionally, appropriately and compassionately to the complainant, both advising her of an existing trial and approaching other specialists in Tasmania and interstate in order to obtain further information on the requested treatment. Similarly the hospital endeavoured to support the complainant. The complaint was found to be unsubstantiated.

Observations in Accident and Emergency

An investigation was undertaken into actions by the Accident and Emergency Department of Calvary Healthcare Tasmania and the Tasmanian Ambulance Service (TAS). At the conclusion of the investigation, the hospital implemented revised policies and procedures, some of which were under review prior to this particular incident. It also apologised to the complainant. The explanation in relation to TAS was, for the most part, accepted by the complainant.

The complainant's father was admitted to the Accident and Emergency Department at the hospital on 11 March 2005, where he remained for some 5½ hours before being transferred to the St Johns campus. No neurological observations were documented. The complainant believed that her father's condition had deteriorated during the period he was in Accident and Emergency and that he should not have been transferred. She stated that her father was suffering blurred vision, balance problems, an inability to swallow and that he had to be assisted to and from the car. The complainant's father had suffered a brain stem stroke, which was thought to have resolved when the decision was made to transfer him to the St John's campus. He was transferred back to the hospital later that evening by TAS and died the next day.

Incident records were obtained including a summary of attendees at Accident and Emergency on the night. The triage category at the time of admission was reviewed having regard to the Guidelines for Implementation of the Australasia Triage Scale in Emergency Departments. It appeared that the triage category of 4 at the time of admission was appropriate, but may not have been at the time the transfer took place. TAS was responsible for the return of the patient to the hospital. The complainant was critical of a diversion by the ambulance to the RHH but accepted that the delay was brief and did not affect the outcome. The hospital reviewed its policies and procedures where necessary and implemented various initiatives. The complainant accepted both the outcome and a formal apology made by the hospital.

Delays and an inappropriate referral

An investigation was undertaken into a complaint against the Mersey Community Hospital. The complaint concerned the time spent in arranging x-rays, the discharge arrangements, and the referral of the patient to a specialist at the Launceston General Hospital who could not undertake the relevant surgery. The surgeon who eventually undertook the procedure at the North West Regional Hospital provided a report indicating that, apart from pain and discomfort, the time lapse before the procedure was undertaken had not caused the patient any further detriment. As there was no compensable loss, the matter was not referred to conciliation.

The complainant's son presented at the Mersey Community Hospital. He had been assaulted at a nightclub in the early hours of the morning and knocked

unconscious. He was in severe pain with blurred vision, bleeding from the mouth and a suspected broken jaw.

It was alleged that there were delays in the consumer being attended to in Emergency by the medical practitioner, and in obtaining x-rays. The complainant alleged that the reception staff ignored requests for assistance and that when the consumer could no longer remain seated, he lay on the floor, shaking and cold. His friend asked for a pillow but was not assisted promptly or in a considerate manner.

A period of two hours elapsed before the patient was assessed by a doctor and referred for an x-ray. The patient spent a total of 5½ hours in Emergency. It was determined that the referral of the patient to a specialist at the LGH who did not undertake the type of surgery required was inappropriate and ought to have been clarified by the referring medical practitioner at the Mersey Community Hospital.

Concerns about an elderly resident in a nursing home

The complainant's 94-year-old mother was a resident in a secure dementia wing in a Nursing Home. The complainant claimed that her mother's condition had deteriorated since late 2005 and had based this claim on her mother's symptoms of diarrhoea, depression, restlessness, irritability, tension and loss of appetite. On an outing with the complainant, her mother suffered a fall and was taken to hospital by ambulance and admitted. The complainant claimed that the home was reluctant to have her mother return. There were also claims that her mother had suffered another fall at the home, her commode had not been emptied, her bed was made at an inappropriate time, there was 'mismanagement' of her medication, her clothing and a top denture had gone missing, a pair of glasses were broken and a hearing aid was damaged when accidentally put through the laundry.

After investigation, it was found that the complaint relating to the commode and bed was substantiated. The Home offered to compensate the complainant's mother for the damage to her hearing aid, to pay for repairs to her glasses and cover the cost of a dental mechanic to examine the dentures. All the other claims were found to be unsubstantiated.

The conclusion reached was that the parties needed to discuss their concerns and the matter was referred to conciliation.

When a reasonable explanation is not accepted

In the following case, although explanations and information were given to the complainant he was unable to accept what occurred or was unwilling to accept that what occurred was lawful and the actions reasonable in the circumstances.

The complainant attended the Department of Emergency Medicine at the Royal Hobart Hospital pursuant to a court order that he undertake a psychiatric health assessment. It was determined by the hospital psychiatric team that the complainant required medication, which the complainant refused to take. He was placed on an order for admission detention as an involuntary patient under the *Mental Health Act 1996*. The complainant was physically restrained and injected with the prescribed medication.

The issue in this investigation was that the complainant believed that he was not mentally ill at the time and that the restraint and injection of medication constituted an assault.

Upon investigation, it was found that the hospital staff did not act unlawfully and that the order to admit and detain the complainant as an involuntary patient was not outside accepted practices, established protocols or the provisions of the *Mental Health Act 1996*.

Warning of risks

An investigation was undertaken into whether an adverse outcome from surgery occurred as a consequence of the surgeon's impairment and whether the credentialling assessment undertaken by the Credentialling Committee of the Royal Hobart Hospital was adequate in terms of risk assessment, monitoring and clinical audits.

The primary issue under investigation related to whether an adverse outcome from surgery could be attributed to the fact that the surgeon had a diagnosed condition, and whether there was an obligation on him and the hospital to disclose this condition to the patient. Secondary issues were the risk management procedures put in place by the hospital and whether the surgeon, at the date of his annual registration with the Medical Council of Tasmania, was required to disclose his condition. A third issue related to whether the complainant was entitled to be reimbursed by the Patient Travel Assistance Scheme for remedial surgery in Victoria.

The conclusion reached was that the complications experienced during surgery were a recognised risk, which materialised, and that those complications were causally unrelated to the surgeon's condition. The surgeon had disclosed his diagnosed condition to the hospital in his application to the Credentialling and Privileges Committee. His application was approved but limited to a period of one year with the implementation of a risk management strategy. The surgeon believed that he was not required to disclose his diagnosed condition to the Council as, at the relevant time, his condition did not impair his capacity to practice as a surgeon and he had ceased practice of his own volition before this occurred. It was determined that it would have been prudent for the surgeon to make such a disclosure.

The complaint was found to be unsubstantiated. Further, it was found that the complainant was not entitled to be reimbursed by the Patient Travel Assistance Scheme as the surgery could have been undertaken in Tasmania.

Potential risks and whether warnings are adequate?

An investigation was conducted into a complaint that a surgical lap-banding procedure had not had the outcome expected. Independent expert opinions were obtained by OHCC as part of the investigation and the complainant and his wife were provided with opportunities to be interviewed, to obtain advice on the preliminary report and to make further oral and written submissions.

During a lap-banding procedure it was found that the surgical instruments were not long enough to proceed with the planned procedure and it had to be performed as open surgery. A wound infection and an incisional hernia complicated the post-operative period. The lap-band was subsequently removed and the incisional hernia repaired with a mesh hernioplasty.

Two principal issues were examined in this investigation: whether the instruments used in the surgical procedure were unsatisfactory; and whether the surgeon negligently failed to warn the complainant of the material risks of this procedure,

namely the possibility of it being open surgery with the risk of poor wound healing and incisional hernia. An expert opinion was obtained.

The conclusion reached following the investigation was that the instruments used in the surgical procedure were not unsatisfactory as they are the same instruments that are in use today. In relation to whether or not the surgeon warned the complainant of the material risks, there was evidence from both parties that he had. The evidence included a signed consent form and acknowledgment by the complainant of receipt of a Patient Information Booklet which outlined the risk factors. The surgeon stated that he specifically warns patients of the risk of incisional hernia, poor wound healing and infection. The medical records and the surgeon's report to the referring GP provided some support for this statement.

As the complainant sought compensation, it was noted that whilst a doctor has a duty to provide information to patients before the patient agrees to undertake a medical procedure, to succeed in a negligence action for failure to inform, a patient must prove:

- that the doctor failed to take reasonable care by not providing material information
- that he or she has suffered an injury or loss and that the failure to inform has caused the patient's injury or loss
- that if the doctor had given the patient the information in question the patient would not have agreed to the procedure and would not have therefore suffered the injury or loss.

The weight of evidence pointed to a conclusion that it was more likely than not that the surgeon warned the complainant of the specific risks of open surgery, poor wound healing and incisional hernia.

Loss through suicide

The partner of a woman who had committed suicide lodged a complaint regarding her care. He believed that not enough had been done to prevent her suicide and that her psychiatrist, knowing she was suicidal, had not referred her to appropriate services.

The consumer suffered from bi-polar disorder. She attended her psychiatrist for an appointment. The complainant stated that his partner was suicidal at that time and, within days of the appointment, she had committed suicide. The psychiatrist provided a comprehensive review of the consumer's medical records and treatment, and presented the case to a peer review. She had been treating the complainant for a period of approximately six years. The psychiatrist offered to speak to the complainant either by telephone or in person. The complainant was satisfied with this response. Conciliation was offered, but the complainant indicated that he would contact the psychiatrist if he felt he needed to speak with her further.

Privacy

In the following instance, an investigation is undertaken in order to clarify to the consumer the extent of the provider's legal and other obligations.

In 2005 the complainant was required by an insurance company to attend her doctor for an independent assessment of a workplace injury. The complainant signed a privacy statement that she consented to the handling of her information. However, she added a clause restricting the information to be included in the report to that relating to her work place injury. The complainant's doctor subsequently referred in the report to a previous health issue, which was in no way related to her

workplace injury. This was a matter on which the complainant had sought his advice in 1996 and he was of the view that to exclude the information from 1996 would have opened him to claims of providing selective reports, and that the necessity to provide a comprehensive report took priority over any requirements of privacy.

The obligations under the National Privacy Principles contained in the *Privacy Act (Cth) 1988* only relate to information collected after 2001 and therefore did not apply to this complaint. However, it is a generally recognized legal principle that a doctor has an obligation of confidentiality to his patients and that when writing a report for a third party, a doctor should ensure that the patient has provided express consent, and that only necessary information is included in that report.

After the investigation, a recommendation was made that the doctor seek independent legal advice as he was potentially leaving himself open to an adverse determination from the Federal Privacy Commissioner should an aggrieved patient make a complaint, or a civil claim for breach of confidentiality, if the patient suffered an injury or loss as a result of that breach.

Billing for cancelled appointments

This investigation arose out of the complainant's concern that a provider had imposed a 'cancelled appointment charge'. The complainant asserted that she should not have to pay the cancellation charge for several reasons. Firstly, she had notified the provider of her intention to cancel the appointment with 24 hours notice. Secondly, the cancellation was requested on emergency grounds and thirdly, the practice policy was unreasonably restrictive to clients, particularly in relation to the cancellation of appointments on a Monday. The expectation was that this matter would be resolved by early resolution but it proceeded to investigation.

The provider outlined her practice policy and various bodies were contacted to establish whether there were guidelines in relation to billing standards, and to obtain a level of comparison across professions. As a benchmark could not be identified, the reasonableness of the practice policy was considered and recommendations were made.

It was determined that the cancellation charge had been applied unreasonably and should be withdrawn. The debt should be removed from the collection agency and the complainant's name removed from credit reference. The practice policy should be amended to provide equal opportunity for clients to cancel appointments on a Monday. The practice policy should define the term 'emergency' and give detail on how to cancel appointments in an emergency. A secondary phone line or phone number should be installed to separate the provider's business calls from private calls. Alternatively, consideration should be given to moving the practice to a dedicated business address. An answering machine or other service should be connected to the business line to facilitate the effective cancellation of appointments and other emergency calls outside standard practice hours, and the practice policy should be amended to accommodate the changes.

The preferred action in this case would have been that the parties negotiate a resolution through the conciliation process but it seemed that by the time the complaint was lodged the matter had moved beyond compromise. [The OHCC will continue to promote early resolution as a timely and effective means of complaint resolution with the intent that predominantly only complex and serious matters are addressed by investigation.]

CASES ASSESSED UNDER PART 4

The following case studies illustrate the nature of the cases dealt with during the reporting year and the actions taken as part of the case resolution. A complaint is assessed to determine what is the most appropriate action to take in relation to the complaint. A number of factors will determine the most appropriate action, such as the seriousness and complexity of the case, whether compensation is sought and whether there are matters of professional misconduct or competency which need to be brought to the attention of a registration board. There are four approaches – to refer a matter to a registration board, to conciliate, investigate or dismiss the complaint, if appropriate. The following case summaries are of cases which have either been dismissed or referred.

As mentioned in the 'Complaints Closed' section of the report, most of the cases which were dismissed under s 25(5) of the Act were dismissed on the basis that a reasonable explanation and information had been provided. The following cases illustrate the nature of the inquiries conducted at the assessment stage and how a reasonable explanation, an apology or further information can avoid potential litigation or improve services.

There is a 45 day period for assessment of the complaint which can be extended to a further 45 days but may not exceed 90 days. Many cases have exceeded this statutory period, often due to the provider's response being delayed or records being required. The OHCC is moving to ensure that complaints are assessed within the prescribed time. As a consequence matters will be moved to investigation or conciliation within a shorter time but the time taken to complete the complaint and the ultimate outcome is not likely to differ.

Concerns over diagnosis

The following case is an example of a complaint which, although dismissed in accordance with s 25(5)(g), was resolved by the provision of an explanation and information:

The complainant's 8-year-old daughter 'A', was born with a complex congenital heart condition in which there was only one adequate pumping chamber. The condition was realised when 'A' was only 19 days old and the initial diagnosis was a hypoplastic left ventricle with a normal right ventricle. 'A' underwent multiple staged cardiac surgical procedures for this cardiac abnormality at the Royal Children's Hospital in Melbourne. The complainant became aware that 'A's' diagnosis had changed and now read hypoplastic right ventricle. She believed, incorrectly, that the child's diagnosis had been altered by the North West Regional Hospital in Burnie and that this might impact upon 'A's' treatment and care in the future.

To establish whether in fact the change in diagnosis from left ventricle to right ventricle would effect 'A's' treatment and care, an opinion was sought from a cardiologists who had been involved in 'A's' treatment and care. His response was that the slightly varied description used in medical correspondence of 'A's' heart condition is 'immaterial' to her treatments, progress and prognosis to date. 'A' had had successful continuing medical treatments including drug treatments, which were based on her known complete anatomic abnormality. The shortened

descriptions of the cardiac diagnosis used in previous medical correspondence were not technically wrong and had not influenced medical decisions.

The complainant did not accept the cardiologist's report and her concern about 'A's' future treatment and care remained. The OHCC wrote to a cardiac surgeon at the Royal Children's Hospital who had also treated 'A'. The cardiac surgeon responded with a detailed report and advised that it was important to understand that the terminology that is used is simply a form of description. Those names are often somewhat arbitrary, and are simply a means of trying to describe a complex heart. He emphasized that in this condition, where there is only one satisfactory pumping chamber, the treatment would have been no different regardless of the names that were applied to the pumping chambers and any change in the name or label applied to 'A's' heart would have been made through the Royal Children's Hospital. A full copy of the cardiac surgeon's report was provided to the complainant, but again she rejected the advice provided and again she did not provide any specialist medical evidence to refute the two specialist reports.

In that instance the complainant did not, or could not, accept the explanation even though a comprehensive and thorough analysis had been made of the allegations, expert opinion had been obtained and it was established that the complainant's concerns were unfounded. The explanation ought to have assured her that a mistake had not been made and that her daughter's treatment had not been compromised.

Many complaints against medical practitioners arise from the complainant's belief that there has been a misdiagnosis and, as a consequence of not initiating treatment, the patient's condition is worse. Such complaints often involve parents who are anxious about their child's care. A number of them are misconceived and compensation is not warranted, as illustrated in the following case.

The complainant's son developed a limp, initially thought to be an injury. There were three consultations with medical practitioners. The third practitioner arranged an x-ray, which reported that the child had Perthe's Disease, a degenerative disease relatively rare in young children. The records, including the x-ray report and the report of the orthopaedic surgeon were obtained to provide the complainant with a fuller explanation of the child's condition and to assure her that no ongoing or long term damage arose out of the failure to diagnose the child's condition during the relevant consultations. The orthopaedic surgeon reported that the child was currently asymptomatic with regard to his hip joint, that he required no treatment at that point in time and that his prognosis was good.

Warning of risks

Many complaints relate to recognised risks about which the patient has been warned, but where the patient nevertheless consents to the procedure, as illustrated in the following case.

The complainant had breast implants after a mastectomy and suffered a recognised complication of surgery. A further bilateral breast augmentation was undertaken. She believed that she should not bear the additional expenses. She alleged that the surgeon had not warned her of the risk of the complication which had materialised and that he had since refused to see her. A response was sought from the surgeon who stated that there had not been a refusal to review the breast augmentation surgery, but that the surgeon refused to undertake another unrelated cosmetic procedure requested by the complainant and had directed reception staff not to make an appointment relating to this request. He provided his notes and

other evidence from which it was clear that appropriate warnings of risks and complications had been given.

In some instances a provider who elects to resolve a matter by waiving a fee is entitled to claim that fee but is prepared to compromise. The following matter is an example of where the work undertaken was more extensive than the procedure for which the quote had been given.

The complainant asked the provider, a urologist, to provide him with a quote for out of pocket expenses before booking a procedure. The out of pocket expenses actually incurred and billed to the complainant exceeded the quote by \$67.35. The complainant advised that he had spoken to the surgeon and that the matter had been resolved to his satisfaction. Subsequently a letter was received from the urologist indicating that at the operation a rare, solid though benign tumour was discovered (a schwannoma) that could not have been predicted, but which necessitated a bigger and more difficult operation than predicted, a different item number and fee. Nevertheless the urologist had revised his fee.

A valid consent

Some cases involve balancing the rights and legitimate professional concerns of the provider with the rights and interests of the health care consumer. At times, providers may request information about which a consumer is embarrassed or sensitive and which raise questions of privacy and whether consent has been given for a particular use of such information. The following case is an example of how such issues can arise.

The complainant who was in her 80's, objected to a health assessment report on the basis that she did not consent to the assessment and further that it contained inaccuracies. She contacted the provider and a second assessment report issued, which led to the complainant lodging a complaint with the MCT who, pursuant to s. 57(2) of the *Health Complaints Act*, were directed to refer the matter to OHCC. The complainant, who was feisty, vehemently denied that she was in any way incapacitated as stated in the report. She sought an apology and the assessment report destroyed.

There was sufficient evidence indicating that the complainant had consented to the assessment by the nurse and medical practitioner. Central to the complaint was the objection to the assessment of incapacity. The complainant perceived the assessment as erroneous, although in a clinical sense there were conditions which could be regarded as incapacitating. The medical practitioner apologised for any misunderstanding and forwarded the assessment report to the complainant, deleting any record. The case was closed as resolved.

Consent was also an issue in the following case, which was resolved by an apology and led to a policy change being made to ensure that in future written consent was obtained. This case was effectively resolved at the assessment stage without the need for conciliation or investigation.

The complainant underwent an X-ray at the NWRH. The Specialist Radiologist in attendance decided to use an injection of contrast and the complainant queried this as her general practitioner had advised her that an injection would not be required. The radiographer failed to check this with the radiologist and the complainant alleged that the attitude of the attendant towards her was unacceptable. The provider responded to the complaint and explained that it was common for the actual examination that is performed to differ from what the referring doctor may

have envisaged. The provider stated that the Specialist Radiologist in attendance might decide to use an injection of contrast, as it is not always possible to see some anatomical or pathological detail without such an injection.

The complainant subsequently had an anaphylactic reaction to the injection. The provider stated that while reaction to that injection is rare, it is always a possibility and it had always been their policy to obtain verbal consent and explain the procedure to patients prior to the injection. As a result of the complaint, the provider has initiated a policy change with respect to informed consent prior to CT examinations. They now require a consent form to be signed by the patient to ensure that all patients receive adequate information regarding the possible outcomes and the rationale for a CT examination.

In this instance there was a failure to obtain informed consent prior to the injection of dye necessary for the x-ray.

In some cases adverse outcomes are compounded by the complainant's subsequent treatment by staff. The complainant in the above case had an anaphylactic reaction to an injection when having a CT scan. She was taken to the ICU but when subsequently transferred to the Medical Ward, alleges that a nurse spoke to her in a rude and abusive manner and that observations requested by the ICU were not carried out.

The provider apologised and provided the names of all nursing staff on duty at the relevant time. The Director of Nursing indicated that the sequence of observations carried out in the Medical Ward was within an acceptable timeframe and this aspect of the complaint was closed on the basis that the complainant had been given reasonable explanations and information. The complainant wanted an apology from the nurse who allegedly spoke to her in a rude and abusive manner, but the provider was unable to determine who may have been responsible. The complainant was disappointed but accepted that there was no point in pursuing this aspect of the complaint.

An unfortunate outcome

In some instances, although a risk is remote other events occur causing a very poor outcome for the patient, as illustrated in the following case.

The complainant became blind in one eye following a cataract operation. He believed that this complication arose because his medication, Warfarin, had not been stopped prior to the operation and that the surgeon was negligent. The surgeon responded that the bleed had occurred 17 days postoperatively as a result of a combination of a very high INR of 5.2 (which is well outside the therapeutic range of .9 to 1.2) and an episode of vomiting and diarrhoea. The matter was referred to the Medical Council and subsequently dismissed on the basis that there had been no breach of acceptable clinical standards. The decision not to stop Warfarin is well supported by surveys in the medical literature and the INR at the time of the initial surgery was 1.8.

The complainant may not readily accept the explanation but they have the benefit of an independent assessment at no cost to themselves and are not prevented from proceeding to make a common law claim if they do not accept the assessment.

Unhappy with the outcome of surgery

In the following case the outcome of surgery was not as the complainant had expected and further surgery was required. Almost invariably, complaints are made where the complainant believes that the further surgery must be required because the

surgeon did not perform the original operation competently. The complaint assessment allows for explanations to be provided and opinions to be obtained.

The complainant had surgery on her finger for Dupuytren's contracture. She maintained that her finger which had been bent at 30 degrees was now bent at 60 degrees. Further, she complained that she has a scar 3 inches long and that the knuckle is swollen. The complainant sought financial reimbursement for the inconvenience allegedly suffered and for further treatment the complainant believed was required. The surgeon responded that he had given the complainant an information sheet on Dupuytren's contracture outlining the disease process, the tendency of recurrence following surgery and the use of post-operative physiotherapy and splintage and that he had emphasised the need for early and aggressive post-operative physiotherapy. She also complained that the Dupuytren's disease was found to be more widespread than initially thought. Reports of the complainant's consultations with two other plastic surgeons' were considered, one of which stated that "It is also a well recognised fact that surgery (which is another form of injury) can accelerate the progression of Dupuytren's contracture into other parts of the hand" and that the complainant was "likely to have some problems with this for the rest of her life." All three surgeons advised the consumer that further surgery was recommended to correct the contracture of her finger. The complainant accepted the explanation.

Dissatisfied with a cosmetic procedure

In some cases the complainant has had a cosmetic procedure and does not accept the outcome even though the results are reasonable. In such matters the Medical Council assists the OHCC by considering the complaint and the provider's explanation prior to the complaint being dismissed. The OHCC regards this as a means of providing a form of peer review so that a matter that has substance is not dismissed.

The complainant was dissatisfied with plastic surgery on an area surrounding his nose, and underwent further remedial surgery. The complainant was still dissatisfied and the provider refused to conduct any further surgery by way of revision. He reported on the various procedures he had undertaken and maintained that each resulted in an excellent outcome. The Medical Council of Tasmania provided advice and the OHCC dismissed the complaint. The complainant did not accept the explanation.

Dissatisfied with dentures

Dissatisfaction with an outcome is not uncommon when dentures are being replaced and consumers need to be careful when approving the initial work as it is preferable that adjustments be made before the dentures are completed, as illustrated in the following case.

The complainant was dissatisfied with the fit and comfort of an upper denture after having attended a total of 17 appointments and had the denture remade. She sought compensation. An expert opinion was obtained from a specialist, who reported that there was nothing lacking in the workmanship of the upper denture though there was a problem with under-extension of the postdam, which was easily remedied. It was concluded that the amount of appointments attended was reasonable considering that the denture was remade, which required further appointments for adjustments. Approval had also been given for the provider to complete the final denture, which implied that the complainant was satisfied with the comfort level and aesthetics of the denture. The dental prosthetist indicated that he was willing to remake the denture and provide further appointments at no

extra charge and offered to undertake remedial work on the dentures after the complaint had been brought to his attention.

A dry socket as a recognised complication

As illustrated in the following case of a dental service, a complainant may experience a relatively common but unpleasant complication but believe that it was caused by the dentist's negligence and that compensation is warranted.

The dentists reviewing this matter reported that "the sequence of events was unremarkable in that dry sockets occur in about 20% of extractions. They are painful but usually resolve within 7-12 days. It is not uncommon to have to dress twice in a persistent case". Providers need to be more aware that it is this gap between the complainant's understanding of what could occur and the provider's knowledge of complications, which is the genesis of many complaints.

Medical care to residents in aged care facilities

The following case is indicative of on-going problems in some aged care facilities and the need to ensure that resident's health care needs are attended to in a timely and appropriate manner.

Service provisions in Nursing Homes

The complainant claimed that the care provided by a GP and/or the Nursing Home to her elderly mother was inadequate. Her mother was confined to a wheelchair for the last 3 months of her life and the complainant was initially notified by nursing staff that her mother had developed a small pressure sore on her tailbone that was being treated. Several days after being told this, the complainant visited her mother and found her in bed and in a distressed state. She noticed a smell emanating from her mother's bed, and made further enquiries and was told the sore had developed into an ulcer and had become gangrenous.

The complainant immediately requested that her mother's GP be contacted and asked to attend her. The following day, the nursing home advised her that the GP could not attend her mother, as he was ill with the flu. The GP had suggested that a swab be taken of the affected area and sent to pathology. The complainant contacted the GP by telephone and stressed the urgency of the matter. The GP indicated that he would try to attend her mother the same day, did so, and immediately had the elderly resident admitted to hospital (acute care). She was severely dehydrated, unable to fight the gangrene and passed away 9 days later.

Aged Care Complaints were contacted concerning the Nursing Home and they advised that a separate investigation was underway into the quality of care provided at the Nursing Home and not the GP involved. The OHCC assessment then centred upon the GP. A copy of the GP's response was provided to the complainant who accepted that there was no fault on the part of the GP regarding her mother's care and treatment while at the Nursing Home. There had not been any request from the Nursing Home to the GP to see the elderly resident for 10 weeks prior to the complainant contacting him.

This complaint raises a systemic issue referred to in past reports. It relates to the relationship between residents in aged care facilities, the facility and the treating medical practitioner. The arrangement with the medical practitioner may be that he or she will only visit the patient in response to a request from the patient or the patient's family. However a resident may be unable, because of impairments or incapacity

relating to age, illness or disability, to initiate that contact and visiting family members are often unaware that the resident has a condition which requires treatment.

In our view the nursing home has a duty of care commensurate with the needs of its residents and the onus is on the nursing staff, carers and the organisation to be vigilant in their care of residents. This includes arranging for their residents to be provided with health services when such services are required. Some facilities take these obligations seriously and the standard of care is high; others are remiss and adopt the view that the resident or the resident's family unit take responsibility for initiating contact with the medical practitioner.

A further nursing home complaint

The Commonwealth Department of Health and Ageing made a complaint against a medical practitioner on behalf of the family of a deceased woman.

The complaint alleged that the doctor was contacted by staff at the nursing home at noon but delayed his arrival at the home until that evening even though he knew from a previous examination that his patient was seriously ill. While that delay had occurred, the complaint was unsubstantiated and the cause of death was unrelated to the medical practitioner's treatment prior to her transfer to the Royal Hobart Hospital. The Medical Council accepted that the treatment provided was appropriate.

Medical care for an intellectually disabled person

In this case, a client in Disability Services supported accommodation had died from complications associated with a bowel obstruction. The client was intellectually disabled and had challenging behaviours which had remained largely unchanged for about 30 years. This person had been a client of Willow Court and was amongst the last group of clients to be placed in supported accommodation. A complaint was made to the National Disability Abuse and Neglect Hotline, who forwarded an anonymous complaint to the OHCC.

The complaint alleged that when treating and examining the resident, the provider would avoid any physical contact and that the provider could not have made a correct diagnosis without a physical examination. It was said that repeated requests for a referral to a psychologist/psychiatrist had been made but no referral was made. It was said that the assessment could have enhanced the client's quality of life and ensured that she received the appropriate support to deal with her disability.

The provider's response was comprehensive and the substantive allegations were not supported. The provider described the difficulties associated with conducting a physical examination and the need to have two trained staff to physically restrain the client when a physical examination was needed. The clinical care associated with the patient's condition was appropriate and during the provider's absence interstate, a locum had been briefed and introduced to the client and visited her at the request of staff. The patient had also been admitted to and discharged from a hospital prior to her death.

The doctor, OHCC and disability services met to discuss protocols between GPs and disability service clientele and a process whereby carers can either raise grievances or seek information without unnecessarily involving bodies such as the National Abuse Hotline. The development of such protocols was deferred until a broader Disability Services review was underway. The provider, who had demonstrated a

commitment to the care of persons with disabilities and at considerable inconvenience had visited clients at the home over many years, then ceased that part of his practice. This outcome was regrettable.

Respite care

In some instances there is no apparent system for redressing a concern in-house. As in this case involving respite care, the complainant contacted the on-call doctor who then called and spoke to the nurse who was unaware as to why the doctor had been contacted.

The complainant was aggrieved at the treatment provided to her mother when she was in respite in a nursing home. The allegations of the complainant included that responses to her mother's requests for assistance were inadequate, that information was not being relayed at shift change-over and that medication and oxygen was not being provided as requested/required.

A response was received from the provider which outlined the systems in place for assessing patients and providing care, answering call bells and relaying information. However, the response did not address the complainant's concerns. A further response was received identifying that the complainant had contacted the after hours service without informing or discussing the issue with the nursing staff on duty. The RN on duty had responded to a call from the after-hours doctor unaware of the alleged change in the consumer's condition. The complainant's mother had passed away and the complaint was closed with no further action.

A body declined under the body bequest program

The following case also illustrates how programs, in this instance relating to body, organ and tissue donations, could be improved. In this case the complainant accepted the explanation and recommendations were made to the administrator of the program.

The complaint's wife had requested that her body be donated to the University of Tasmania upon her death. The complainant contended that the Hospital had failed to make appropriate arrangements for the donation, creating an emotional and financial burden for him. The hospital had contacted the University immediately following the consumer's death, but the wife's body was declined on the basis that her remains were unsuitable. As a result of this decision responsibility for the disposal of the remains reverted to the wife's estate.

In the course of making inquiries into this complaint, the issue arose of whether there was adequate contemporaneous documentation of the conversations between Hospital staff, the Administrator of the Body Bequest Program at the University of Tasmania, and with the complainant. The complainant accepted the provider's explanation and indicated that he saw no benefit in participating in conciliation. The Commissioner suggested that the Hospital advise and counsel staff involved in this incident with regard to the importance of maintaining contemporaneous documentation. Suggestions were also made to the Administrator of the Body Bequest Program including: that the Administrator converse directly with the next of kin or executor of the donor; that the application form relating to the Body Bequest Program identify conditions which would exclude the individual from being a participant in this program; and a statement that the body is intended for the teaching of human anatomy to medical students not for research purposes. Those suggestions were made to assist in preventing a recurrence of this event.

District Hospitals and restricted services

In some cases people in regional areas do not fully appreciate the limits on the service being provided by community and district hospitals after hours and during weekends.

The complainant presented to the Smithton District Hospital with a suspected broken thumb and was directed by the practitioner to a local clinic. The primary issue arising whether the complainant ought to have been assessed and triaged when he presented at the Hospital. The complainant was in considerable pain with a suspected broken thumb and, not having been assessed at the Smithton District Hospital, then drove to Accident and Emergency Service at the North West Regional Hospital. His thumb was x-rayed, he was required to have his arm in a sling and not use it for a week and pathology tests were undertaken to determine whether the swelling related to an infection. It seems that his condition could have been triaged as having a degree of urgency and ought at least to have been assessed in Smithton.

The signage at the hospital and the Site Manager's response indicates that there is a 24 hour Accident and Emergency Service at the Smithton District Hospital, although there is no resident medical officer. It would seem that the Accident and Emergency service only covers cases triaged as urgent and only these matters receive treatment by an on-call doctor at the Hospital. All non-urgent cases are directed to local general practitioners who charge for their services. In the complainant's case there was no assessment by a registered nurse and, although there was a GP on the premises, the GP refused to assess the complainant and instead directed him to attend the local Clinic which charges and where he practices.

The secondary issue is that no GP's in Smithton bulk bill and once the Hospital directs public patients to a private clinic then the medical treatment is not free. When the complainant presented at the Smithton District Hospital he did not have the funds to utilise the private system. The treatment at the Smithton Hospital was refused and as a consequence he drove to the NWRH where he obtained treatment in a public hospital. The arrangements at the Smithton District Hospital remain unchanged.

The on-call doctor

The complainant in the following case believed that her child's injury would have been less serious had he been assessed and treated by the on-call medical practitioner rather than by a nurse.

The complainant's son, aged 7, lost the tip of his finger in an accident and the family attended the Deloraine District Hospital where the nurse manager telephoned the on-call doctor. She was instructed to strap the child's finger up and that he should be taken to see his GP on Monday. On Monday the wound was cleaned and sutured and the child was referred to a plastic surgeon at the LGH. The complainants alleged that the surgeon said that the finger could have been re-attached if the doctor had told them to go straight to the LGH. This allegation was not substantiated. However, the on-call doctor responded directly to the complaints. He apologised for their concerns but explained that the nurse was experienced and that he relied on her description of the wound and felt conservative treatment and pain relief to be best. He had informed the nurse of the dressing to apply and the options for further treatment/follow up.

The Patient Travel Assist Scheme

Claims relating to the Patient Travel Assist Scheme fall into the category of administrative action, which are within jurisdiction if they are directly related to a health service. The following complaint was determined to be unsubstantiated even though the referral to the specialist in Melbourne was for a procedure not available in Tasmania. The reason for that view was that alternative treatment was available in this State and that the referral had been made by the complainant's GP before any discussion with the specialist in Tasmania. The issue is not a patient's right of choice but whether that choice should be subsidised.

The complainant was aggrieved that his treating surgeon in Tasmania refused to sign the form that would have supported his application for subsidised travel costs under the Patient Travel Assist Scheme (PTAS). The complainant travelled to a specialist in Melbourne for a procedure not available in Tasmania (i.e. robotic assisted laparoscopic prostatectomy). The referral arrangements were made by the complainant's GP without any consultation or discussion with the Tasmanian specialist of the options available in this State.

Alternative and more conventional treatment was available in Tasmania (open prostatectomy or laparoscopic procedures) and the Tasmanian specialist had recommended radiotherapy which he states that in the complainant's age group is often the least morbid mode of treatment for prostatic carcinoma where cure is the ultimate intent.

Communications with family when death is close

When a patient is close to death, appropriate and timely communication with family members can be problematic. Other issues such as those described in the following example can also be more distressing at such times.

Following the death of his mother the complainant was billed for an outstanding account of \$200 even though a notice had appeared in the paper advising creditors that they had until 9 January 2005 to pursue a claim. The hospital's claim, made after this date, had been backdated to give the impression that was within the time specified in the notice. The provider apologised for the clerical error and advised that a process for the debtors clerk to check the death notices had been instituted.

The complaint probably would not have been made had the complainant not been dissatisfied about the treatment his mother received while in the private hospital. He was further aggrieved when he received a call from the hospital to say that his mother was unwell and might not make it through the night, only to find when he arrived at the hospital that she had died prior to the phone call being made. The hospital apologised for this poor communication and indicated that in-service education had been provided regarding customer service, audits were being undertaken with patients to gauge their satisfaction, and next-of-kin notification procedures had been discussed whereby any change of condition of a patient was to result in a call to the next of kin.

Vaccinated in error

The following summary is an example of how the risk of errors can increase if administrative protocols are not adhered to.

The father of an asthma sufferer chose to defer his child's Hepatitis B immunisation until the child had completed a course of asthma medication. Although he did not consent to the child being vaccinated he was vaccinated in

error. The provider apologised to the complainant, stating that the direction from a provider flow chart for “Non-consented children are to be removed from the immunisation area completely” had not been observed. Also the person administering the vaccines had not personally checked before proceeding with the treatment. The provider stated that procedures had been put in place to prevent a recurrence of this type of error.

Informed financial consent

Patients are entitled to be told of all of the costs and other charges which will be incurred in relation to a treatment.

The complainant contended that he was not made aware by either the surgeon or the practitioner assisting of the extra fees which would be incurred for the services of the assisting practitioner. The extra fees were withdrawn, but the provider also stated he would no longer be assisting during surgical procedures as it was uneconomic. It was recommended that the surgeon should advise his patients that other costs would be incurred by those assisting and he agreed to inform patients accordingly.

Gap Payments

Similarly, patients are entitled to be informed of gap payments which will apply. Patients are unlikely to be familiar with the arrangements for separate billing for those assisting with surgical procedures and with the complexities of the gap payment requirements under private health insurance.

The complainant stated that the provider had not told her of the Gap Payment she would be required to pay. The provider questioned the complainant's understanding but was willing to compromise and sent the complainant a cheque via the OHCC.

Billing for cancelled appointments

Billing issues and cancelled appointments can be contentious but complaints can usually be resolved, as they were in the following example:

Before an appointment a complainant phoned her provider's rooms to check whether he was running on time. The receptionist informed the complainant that the provider was running 30 minutes behind schedule. As the complainant had another appointment she cancelled her appointment but was charged a late cancellation fee. Subsequently, she requested a script for medication from a pharmacist to cover her until her next appointment with the provider. However, when the pharmacy contacted the provider the pharmacist was told that the script would not issue until the overdue 'cancellation' fee was paid. Further correspondence with the doctor resulted in the fees being cancelled.

Absent without leave

While providers may not be able to be on time, if they are running late an explanation or apology should be given. In the following case, a patient was attending for a post natal check-up and her baby was fractious.

The complainant was kept waiting for a post-natal and neo-natal check up and pap smear for some 20-30 minutes without any explanation. The doctor showed her into the consulting room, and then received a phone call and stated that he had to go next door and would be back shortly. The complainant's baby became distressed as it was hungry. She checked with the receptionist who did not know

where the doctor was. She left after informing the receptionist. As she was leaving the complainant ascertained that the doctor was still not ready to see them. When some dissatisfaction was expressed, the doctor told them that it would be best for them to find another doctor and he would transfer their records. No reason was given for the delay.

In response to inquiries from the OHCC, the provider explained that he was called away by the registered nurse to see another patient. The provider stated that it was his understanding that he had apologised to the family and explained the need to leave them at the time. He acknowledged that this did not appear to be understood and apologised that he did not clearly explain what was happening. The complainant disputed the accuracy of the practitioner's response, but accepted the apology.

Professional boundaries and personal views

A provider may have strongly held personal or religious values and a distinction needs to be made between adherence to those values and providing professional advice to clients. The following illustrates a failure to maintain that professional boundary:

The complainant is in a same sex relationship. The couple decided they would like to have a child and went to a medical practitioner for a referral to the fertility specialist. The doctor pulled out a copy of the bible and some religious documents and began preaching to the couple. The complainant believed that in this day and age such behaviour was unprofessional and discriminatory. The Medical Council investigated the matter and advised that the doctor accepted the Council's findings and has agreed to act as required by the Council.

Termination of the doctor/patient relationship

In some cases complaints have been made about the patient-doctor relationship being terminated.

In one case the patient contacted the practitioner's rooms on two occasions to ensure that the practitioner was prepared to see her and to undertake surgery. The practitioner agreed but later terminated the doctor/patient relationship. The practitioner made appropriate alternative arrangements for the consumer. While it was disappointing and inconvenient the relationship was terminated in an appropriate manner and the complainant had not suffered any loss as a direct result of the practitioner's action.

There are instances where a provider's reaction to the expression of a legitimate concern by withdrawing a service comes very close to retaliation. This is illustrated in the following case involving the provision of respite care.

A disabled child had Individual Support Package (ISP) funding for weekend respite one weekend a month, and HAC Host Funding for a further weekend respite one weekend a month. The complainant arrived to place the child in respite and expressed concern that there was only one carer to care for 3 highly dependent children overnight. The ISP contract required that there be 2 support workers available for every 3-4 children in respite. The provider's response to the complaint was to advise that the program was not for those in the child's age group and that respite would cease. The contract had some 8 months to run and did not refer to age restrictions. The issue could not be resolved and the provider considered that it would be in the consumer's best interests to discuss her situation with Disability Services and that a more appropriate long term plan be developed for her care. If the complainant wished to stay with the current provider then there would be a change of case manager.

Some cases are not able to be resolved

In the following situation the complainant remained convinced that the provider's conduct was unprofessional and that the regulatory and complaints systems has failed her.

The complainant attended a medical practitioner for her 6 weeks antenatal check. She left the consultation and went immediately to the local police station and was referred to this office. She believed that the practitioner had acted inappropriately in the manner of examining her and that she had been sexually assaulted. The complainant had other children and had undergone previous checkups without incident. The complainant was distressed by what she perceived had occurred and this was exacerbated by the dismissal of the case by the Medical Council.

Identity fraud

Providers need to have appropriate risk management procedures in place to protect themselves, their practices and their bona fide patients from identity fraud particularly in relation to people attempting to access medications from a number of providers:

A complainant became aware that another individual was using her Medicare number when she was billed for consultations she had not attended. She alleged that the person was impersonating her to gain access to Doctors to obtain opioid medication. The provider had not requested proof of identity from this individual who was not then a patient of the practice, and when information was given it was never verified. The complainant had made a complaint about the theft and fraudulent impersonation to Tasmania Police and a criminal investigation is continuing. The matter was informally referred to the Medical Council who accepted the medical practitioner's explanation. Enquiries were made as to the procedures in place at the practice to minimise a recurrence of this problem. The Chief Pharmacist was contacted and he advised of the actions he intended to take to better inform general practitioners about strategies to curb diversion and abuse of prescription opioids.

REPORT ON HEALTH SERVICES

Oral Health Services (OHS)

In this reporting year the capacity of Oral Health Services (OHS) to provide a public dental service deteriorated even further. As a consequence fewer Tasmanians were able to access public dental services within a reasonable timeframe. There is no Medicare rebate applying to dental services, other than the enhanced primary care program,¹⁷ and most dental services are provided by the private sector. Routine and preventative care has all but disappeared from the public dental system and is a serious public health issue.¹⁸

In Australia, approximately 500,000 adults are on a waiting list for non-emergency dental treatment and waiting lists are between eight months and five years¹⁹ long. There is a national shortage of dentists affecting both the public and private dental system.²⁰ In Tasmania approximately 12,000 Tasmanians are waiting for up to five years for a check-up through OHS.²¹ The State Government has allocated \$16 million for oral health services this financial year, an increase of \$3 million for wages and recruitment, in an attempt to improve the capacity of the public dental system.²²

OHS at Risdon Prison

OHS is administered by the Department of Health and Human Services and provides OHS to the inmates at Risdon Prison. Following an earlier investigation, OHS at the Prison had increased to one day a week but effectively ceased in April 2005 when the OHS dentist returned to the United Kingdom.²³ An inmate, supported by other petitioners, lodged a complaint against OHS contending that there was no dentist at the Prison and that the dental service did not meet the standard set by s 29(1)(h) of the *Corrections Act* 1997, which states that prisoners have a right to have access to reasonable dental treatment necessary for the preservation of dental health.

¹⁷ See Australian Government – Department of Health and Ageing “Enhanced Primary Care (EPC) Program www.hic.gov.au/providers/incentives_allowances/medicare_initiatives.htm

¹⁸ Reference - National Advisory Committee on Oral Health - a sub-committee of AHMAC June 2004. According to the national oral health plan, tooth decay is the second most costly diet-related disease in Australia. Poor oral health can have an impact on self-esteem, psychological wellbeing, employment, interpersonal relations and quality of life.

¹⁹ According to ACOSS, the shortest delays are in Queensland and the longest in Tasmania.

²⁰ According to Professor John Spender of the University of Adelaide, Australia faces a shortfall of about 1500 dentists thanks to increases in population, more dentists preferring part-time work, and a lack of university training places.

²¹ Those requiring dentures are waiting many years for treatment and routine care through Oral Health Services (OHS) is becoming problematic, with about half of all care being provided on an emergency basis. Tasmanians are reputed to have the worst dental health in Australia, in that they have the highest rate of complete tooth loss, the greatest number of people with dentures, the highest average number of missing teeth and the greatest number of people who have not seen a dentist in the last five years.

²² The former Minister for Health, Mr David Llewellyn sought to improve OHS by increased funding and measures to attract dentists to the public system stating that: “We have indeed in recent times, through better remuneration for dentists, achieved extra dentists into the system. We've also employed some 20-odd dental assistants as well over the last little while. We are doing quite a lot of work to address this issue which I know isn't good enough and we need to do more”.

²³ We are informed that this dentist will be returning from the UK to Tasmania in October 2006 and will be available to recommence at Risdon Prison.

These concerns were discussed with the State Manager of OHS Tasmania who advised that OHS was attempting to recruit staff including the replacement of a dentist to provide services to Risdon Prison inmates. The complaint was substantiated and the matter was brought to the attention of the Minister for Health and Human Services. The Minister advised that it has not been possible to recruit new staff who were prepared to visit the Prison and that the high level of emergency care required by the general population has kept existing staff fully occupied.²⁴ The Minister and OHS indicated that it is expected that a dentist will recommence dental services at Risdon Prison later this year, but it seems that this is contingent upon the construction of a new dental surgery as part of the prison redevelopment.

In essence, the OHS only operates an emergency service. It is OHS policy that urgent or emergency cases are transferred under escort to the OHS New Town Clinic at Archer Street. In the course of investigating the complaint, OHS advised that since April 2005 there had been a total number of 67 inmates treated.²⁵

The initiative by Correctional Health Services to provide dental care to inmates

As OHS was unable to provide dental services at the Prison, the Health Service Manager of Correctional Health Services (CHS) arranged for a private dentist with previous experience in providing dental services to the Prison to consult with and provide treatment to inmates/detainees on the waiting list and to those who had recently requested dental care. This initiative is to be commended and will be reported on in the next reporting year. The provision of those services has cleared the waiting list and enabled treatment of those most in need. The CHS is considering the options for providing appropriate and effective dental services to prisoners/detainees in the future.

The nature of the dental work undertaken emphasises how critical it is that inmates receive an appropriate level of routine dental care and that they are a high needs population.²⁶

²⁴ Letter of A/Deputy Secretary dated 23 May 2006 to A/Commissioner - There had been discussions between OHST, CHS and NSW Prison Dental Services in relation to the possibility of that service providing dental services to Risdon Prison, however this did not proceed but

²⁵ CHS records indicate that in the 12 months from August 2005 until August 2006 64 visits to Archer St dental clinic were arranged and 2 visits to the Denture clinic. These cases were the most urgent, with active dental disease. - There appears to be some discrepancy in the recorded numbers but this may relate to multiple visits by the same individual.

²⁶ In summary, between 24th July and 9th August 2006, 203 inmates were assessed and 181 seen, with 22 declining an appointment. Dental treatment was provided for 135, and for these patients 240 standard extractions were performed, 115 surgical extractions and 30 fillings. Information was provided that this high number of extractions highlights the deterioration of inmate's dentitions. Many of these teeth were 'wisdom teeth' and extractions were complicated by the gross levels of decay both of the crowns and roots of remaining teeth. Two patients presented for extraction related alveolitis, requiring surgical intervention, and one had to be admitted to the RHH for 5 days following internal bleeding. One patient had 2 bullets surgically removed from the jaw which were preventing prosthesis (denture) fitting. Ten inmates requested prosthetics (dentures) of which nearly 50% were women, who represent less than 5% of the total prison population. It is estimated there are 50 more who would request and require prosthetics if and when a regular service becomes available.

OHS in the community

It is somewhat ironic that, because OHS in the community has become so difficult to access, a complaint from Risdon Prison that OHS fails to provide a service equivalent to community standards²⁷ no longer has the same force. OHS no longer has the capacity to undertake general routine care for the public within a reasonable period of time. Care is usually limited to high levels of emergency care (around 65% of all care) with some general care offered to clients who have been registered on waiting lists.²⁸ The low number of public dentists (about 13 FTE) in Tasmania continues to limit the capacity of the service to provide comprehensive care and priority is given to patients with pain, infection, discharge or those on high levels of analgesia.

There are also some administrative aspects of the service which cause difficulty, as illustrated by the following case.

A pensioner, aged 70, lodged a complaint. Reportedly he was suffering severe pain from a toothache and arrived at the OHS Dental Clinic at 8.20am, without an appointment, seeking urgent treatment. He was told to phone from a public telephone box to make an appointment. After trying two public telephone boxes without being put through, a small business in the local area allowed him the use of a phone. As he was still unable to be connected because of the busy line, he went back to the clinic to explain his problem, but was again sent away. Six months later after unsuccessful attempts to make an appointment he went to a private dentist. He incurred costs of \$300, which caused him financial hardship. This complaint highlights the need for appropriate resources for OHS and flexibility within its policies and procedures to deal with emergency cases.

Children with special needs

One complaint received during the reporting year related to children with disabilities and the inadequacy of oral health services provided to children with special needs. Reference was made to a program said to have operated at the Royal Hobart Hospital (RHH).

In the course of the investigation, the RHH informed OHCC that the issue was a matter for OHS. Further inquiry revealed that if a child's dental care involved hospital care, OHS relied on the RHH and the delay referred to in the complaint was due to the shortage of anaesthetists available at the RHH. The OHCC was informed that since September 2005 the general anaesthetic lists at the RHH have been reduced from two per week to one per week, due to the shortage of anaesthetists. The Manager of OHS discussed the issue with the RHH. The complainant's child received care and the complaint was resolved.

The systemic issue with regard to children was not resolved. OHS responded that:

"The issue of providing care for children with special needs is a major challenge for OHS. Wherever possible Dental Therapists or Dental Officers will attempt to ensure that dental care is provided in the most effective and efficient way in community clinics and under local anaesthesia. Where a local anaesthetic is not appropriate or where the needs of the patient clearly require in-hospital care and support, a referral is made to the relevant major hospital. Once that referral is

²⁷ S. 29(1)(h) of the *Corrections Act 1997* - to paraphrase - states that it is the right of prisoners to have access to reasonable dental treatment necessary for the preservation of dental health equivalent to community standards

²⁸ Currently the service offers dental care for adults from the major sites of Launceston, Burnie, Devonport and Hobart.

made, the OHS has no influence on the length of time that a patient may be required to wait for care. This is explained to the parent or guardian at the time of referral."

The OHS advised that it does endeavour to prioritise those clients with special needs or those who need complex, medically necessary dentistry. It appears that the delays referred to in the complaint were due to the shortage of anaesthetists at the RHH.

In the following case, the complaint related to recognised complications which the complainant believed were attributable to the dentist's lack of skill.

The complainant had a tooth extracted²⁹ and complained of post-operative pain and a dry infected socket. She said that the dentist spent about ½ an hour extracting the tooth and she was in immense pain afterwards.

The matter was referred to a dentist who is engaged by OHCC to assist in assessing complaints. The advice provided included that: the extraction was simple, in that there was no requirement to section the tooth or surgically remove surrounding bone; 45 minutes would be a reasonable time for such an extraction; the presence of bone chips is a common occurrence; post-operative pain after any extraction is inevitable, and normally resolves in about 3 to 5 days. The dentist also advised that if a dry socket ensues, as in this case, then prolonged pain would be experienced. A dry socket can occur in about 20% of extractions, usually between 3 to 7 days after extraction, and the correct treatment is irrigation of the socket and placing a sedative pack within the bony defect. Infected sockets are far less frequent and generally antibiotics are not indicated unless swelling is present. The complainant had a number of predisposing factors for a dry socket including infection, lowered immunity, a difficult extraction and a history of past dry socket problems.

An explanation was provided to the complainant and the complaint was dismissed.

Forensic Mental Health Services

In year 2000, the Ombudsman published a report on Forensic Mental Health Services (FMHS) and the Risdon Prison Hospital. The primary recommendation was that a secure psychiatric unit be established for FMH patients outside the prison system and that it be administered by the Department of Health and Human Services. On 20 February 2006 the *Wilfred Lopes Centre for Forensic Mental Health* was opened. The Wilfred Lopes Centre will accommodate people with acute mental illnesses who require specialist mental health inpatient treatment. FMS patients and others who meet the admission criteria have been transferred from the Risdon Prison Hospital to the Wilfred Lopes Centre.³⁰

²⁹ The records indicated that there had been an attempt to control the developing pulpitis with a pulp capping of Iedermix and a temporary filling. This was not successful and the tooth remained painful. A bacterial infection was present prior to the tooth being removed but this had not advanced to a stage where antibiotic treatment was required. It appears that extraction was the correct treatment.

³⁰ Patients at the Centre will include:

- Prisoners with mental illnesses who require specialist mental health inpatient treatment
- People with mental illnesses appearing in, or remanded from, Magistrate and Supreme Courts and requiring inpatient specialist mental health treatment and/or assessment;
- Those found Not Guilty by Reason of Insanity (NGRI) or Unfit to Plead and placed on a Forensic Order;

In exceptional circumstances, subject to approval by the Clinical Director, the following people may also be admitted to the SMHU

- Young people with mental illnesses from the Ashley Youth Detention Centre who are unable to be adequately treated at Ashley.

The opening of the Wilfred Lopes Centre brings Tasmania in line with other Australian States and international human rights conventions relating to the incarceration and treatment of people with mental illnesses. It enables the most acute mentally ill to be accommodated and treated outside the prison system.³¹

The Forensic Mental Health Services unit is a specialist unit within the Department of Health and Human Services which is also responsible for managing the Community Forensic Mental Health Services (CFMHS), the Wilfred Lopes Centre for Forensic Mental Health and the Court Liaison Service.

Primary mental health services for offenders are provided in all of the facilities managed by Correctional Health Services. A team of mental health nurses, medical officers, CFMHS psychologists and psychiatrists delivers the services.

Correctional Health Services

Tasmania's Correctional Health Services (CHS) provide outpatient and inpatient health services for offenders held in custody in the Tasmanian Prison Service. Health services for prisoners and remandees are provided at all Tasmanian prison facilities³² and are managed by CHS for the Department of Health and Human Services. Some of the services are obtained from private sector health providers.³³

As part of the CHS Renewal Project, a health centre with consulting rooms, a pharmacy and treatment room has been provided within the new prison complex. There are six inpatient beds to accommodate prisoners/detainees with short-term medical and nursing needs.

The improvements in CHS have been marred by problems particularly in Oral Health Services (OHS). As only the most urgent cases receive treatment CHS have needed to address dental pain through pain relief medication. A number of complaints have been made in relation to access to medical staff.

-
- Prisoners with cognitive or intellectual disabilities who require specialist care in a secure hospital unit &
 - Adult non-offenders, who have severe and/or prolonged mental illnesses resulting in significant risk to themselves or others

³¹ The *Wilfred Lopes Centre* is staffed by highly trained specialist mental health nurses, psychiatrists and psychologists, a social worker, an occupational therapist and other staff who have undergone an intensive training program to specifically equip them for work in the *Wilfred Lopes Centre*. Patients will be provided with modern, professional and highly specialised psychiatric care and treatment. Treatment will be based on individually tailored programs designed to support independence and dignity, and minimise the ill effects of long-term care

³² Health services are provided in Hobart and Launceston Reception Centres, Risdon Prison, Mary Hutchinson Women's' Prison and Hayes Prison Farm.

³³ Services provided include:

- Emergency and urgent health care;
- General Practitioner health services;
- Nursing care (including immunisations and medication administration);
- Allied health services (optometry, audiology, physiotherapy, dental, podiatry);
- Alcohol and drug education and counselling;
- Diagnostic services as ordered by the Medical Officer;
- Physical and mental health assessments;
- Health promotion programs; and
- Other essential health services as required.

Alcohol and other drug related problems are overly represented in the prison population. The increase in prisoner numbers and the limited resources within CHS often means that alcohol and drug dependency and other conduct harmful to health is not being addressed during detention. Also, there is no continuity of care between the treatment of drug addiction in the Prison and transfer to Drug and Alcohol Services (D&AS).

The health educator (who left more than a year ago and has not been replaced) is responsible for the management of health promotion, BBV education, vaccination and other important areas relevant to the Prison health.

The demographic profile of the Prison population is changing and there are a number of vulnerable groups who mostly need to have their needs met. There is some concern that this has not been fully appreciated by those designing the new prison. Many inmates are elderly with chronic illnesses including diabetes, respiratory diseases and multiple other health problems including fragility. Many inmates are over 70 years of age and at times are transferred to the RHH for surgical and other interventions. When discharged back to the Prison some of them have special needs including facilities in their cells (such as showers). Currently there are about 26 beds in the Risdon Prison Hospital but in the new prison there will be a primary health unit with a 6-bed in-patient facility. It is thought that that may not be sufficient.

After the move into the new prison facility, everyone received into the prison system will be assessed. Nurses will conduct the initial tier 1 assessment at reception to assess each person's physical and mental health and their potential to self-harm. If the assessment is uncertain, a person may be retained in the new assessment unit for further assessment. The Prison doctor will make a further assessment of all those coming into reception as soon as practicable and the assessment report will assist the Department of Justice in locating the person within the prison system. Some coming through reception will suffer mental ill health but may not fall within the criteria established for admission to the Wilfred Lopes Centre. Others have intellectual disabilities and are not easily accommodated within the prison system. The prison environment is also a harsh environment with its own stressors and many inmates with not enough to do will have little motivation to improve their health. In some interstate prisons cigarettes are sold at full retail price and the funds used to support 'quit' smoking programs.

Complaints against Disability Services

The last year's annual report highlighted complaints against Disability Services (DS) and primarily concerned the conduct of staff assisting clients in residential care. The conclusion reached was that DS needed to address issues arising through the complaints process in order to secure an appropriate standard of care and support for clients and their families.

The Department of Health and Human Services (DHHS) acted promptly by commissioning a consultant to develop a Learning and Development Program for DS and engaged KPMG to conduct an audit of clients with challenging behaviours and complex health needs. The purpose of the consultancy by KPMG was to audit the government-provided Accommodation Support Services (ASS) in Tasmania. This audit covered issues such as governance, service management and business processes in the delivery of ASS. The audit aimed to provide the Department with

recommendations on the standard of care, optimal arrangements for assessments, service coordination, case management and health care support. A reference group was established as part of the KPMG process and the consultation was intensive involving clients of DS, their families and advocates.

The KPMG audit indicated that DS had not uniformly been able to meet appropriate standards of care and community integration. According to KPMG, the current support services approach model did not reflect a contemporary model of social support for people with disabilities. The model was outdated, with examples of institutional practices evidenced in a number of locations. In relation to issues of service management, it was reported that there was a lack of person centred approaches in supporting residents to be active members within their household and within their local community. There was very little evidence to suggest that staff worked in a holistic manner in supporting residents.

The audit also highlighted that there was a need for significant reform of the accommodation support system managed by DHHS. It was reported that at the most fundamental level, there is a need to identify strategies that will redress the institutional practices and move into a more proactive model of support for residents. The audit report identified defects in policy, practice and training, induction, performance management, incident reporting and grievance mechanisms. Such matters diminished the standard of service and created a culture incorporating some of the detrimental features of institutionalised care, which the move to supported accommodation and group homes had sought to remedy. The auditors recommended that accommodation support provision currently provided by the DS Program be transferred to the non-government sector allowing DS the opportunity to focus on its policy, funding, purchasing and monitoring role.

The Government announced '*Living Independently*' in November 2005 as its response to the findings of the KPMG audit. Under *Living Independently*, all DS group homes managed by DHHS will be transferred to non-government organisations during the next three years. DHHS will continue to be responsible for the establishment, funding and monitoring of service standards contained in the *Disability Services Act 1992*. To assist with the transition of group homes, DS established a Reference Group comprised of representatives of government agencies, non-government organisations, families of affected clients and their advocates and in March 2006, DHHS announced that the group home at Lenah Valley would be the first to be transferred to management by the non-government sector.

With the transfer to the private sector, DS will need to ensure that the rights of persons with a disability are maintained and that their legitimate needs are met. In the past reliance on the conditions of a Service Agreement between the NGO and the Crown through DHHS has not been sufficient to ensure compliance when private sector providers have not provided the standard of care expected. DHHS will need to establish appropriate accreditation, evaluation and audits processes with adequate funding to ensure that the standards, principles and objectives of the *Disability Services Act 1992* are met. The OHCC will continue to examine, through the health complaints system, the provision of services for persons with disabilities.

Mental Health Services and Ward 1E

The Ninth Annual Report of the Tasmanian Health Complaints Commissioner reported that the Minister for Health and Human Services had directed the Commissioner to conduct an investigation into complaints concerning Ward 1E, an acute psychiatric unit located in the Launceston General Hospital and administered by Mental Health services (MHS) in the North and Northwest. The investigation was a conjoint investigation with the Nursing Board of Tasmania in accordance with agreed Terms of Reference and the governing legislation. The recommendations made were based on the clinical audit, the findings of the investigation, and the actions recommended by both consultants. 26 recommendations were developed to cover systemic issues within MHS and in particular Ward 1E.³⁴

As an immediate response to the Commissioner's report, the Minister established a high level Taskforce to oversee the implementation and monitoring of the recommendations about the delivery of services to Tasmanians who experience mental illnesses and disorders. The Ward 1E Taskforce, in collaboration with MHS, has actively progressed the implementation of the 26 recommendations arising from the Health Complaints investigation into Ward 1E.

To date, 22 of the 26 recommendations have been implemented and significant infrastructure improvements have been realised. They pertain to policies, procedures, documentation, training and education, articulation of roles and responsibilities, clarification of leadership and governance and improvement in consumer carer and other stakeholder involvement together with improvements to the physical environment of Ward 1E. The remaining 4 recommendations require further implementation and are subject to progression within the broader Mental Health Service Strategic Plan 2006 - 2011.

MHS will need to continue to pursue the maintenance and enhancement of these recommendations to deliver continual improvement in service levels to all stakeholders. Monitoring the successful completion of the outstanding recommendations and actions will continue to be the responsibility of senior MHS staff and key staff on Ward 1E.³⁵

³⁴ These included: Ethical and appropriate workplace conduct, Appropriate Professional Conduct, Incident Reporting, Complaints and grievances, Clinical Supervision and Mentorship, Workplace Harassment, Allocation of nursing rosters, Risk Assessment, Staff development, Quality Improvement, Policy and procedures, Partnership Development, Mental Health Promotion, Documentation Suite, Model of Care, Nursing Resources, Medications, Legal Order, Seclusion, Model of care, Performance Management and Nursing Board notifications.

³⁵ These include.

- The introduction of a Quality Improvement and Quality Register
- Provision of seclusion and restraint training for staff
- Improved management of policies and procedures
- Undertaking regular file audits
- Improved medication management practices
- Enhanced patient care planning
- Improved staff rostering
- Introduction of emergency equipment
- Undertaking regular OH&S workplace safety inspections
- Introduction of a Ward 1E reference library
- Formalised staff orientation and induction procedures
- Undertaking patient information surveys

The OHCC investigation, the “Bridging the Gap” report and Anglicare’s “Thin Ice” report, indicated that further funding was required to improve the quality and safety of mental health services in Tasmania and the government in response committed \$47 million over the next four years.

Conclusion

It would appear that significant achievements have been made on Ward 1E and that many of these could be regarded as a model of best practice for broader mental health service programs across Tasmania. Notwithstanding the achievements and improvements to date, the Taskforce, Mental Health Services and Ward 1E staff will need to continue to actively monitor these developments in service provision to ensure that appropriate standards are maintained within a quality framework.

-
- Increased focus on staff training and development
 - Greater supervision for graduate and under-graduate training programs.

COMPLAINT STATISTICS

Complaint Activity

Complaints and enquiries received for the period 1 July 2005 to 30 June 2006 have increased 22% (7.5% 2004/5) over the previous reporting period (refer table 1). Enquiries have been recorded separately since October 2005, hence the increase in enquiry numbers.

Table 1. **Complaint and Enquiry Activity**

Status of Complaints	2002/3	2003/4	2004/5	2005/06
B/Forward from Previous Period	132	98	86	138
Opened in Period	292	432	464	566
Closed in Period	349	496	440	587
Opened & Closed in Period	210	338	343	444
Carried Forward (Still Open)	98	86	138	165

Table 2. **Complaint Activity (excluding Enquiries)**

Status of Complaints	2002/3	2003/4	2004/5	2005/06
B/Forward from Previous Period	132	98	86	138
Opened in Period	292	333	320	269
Closed in Period	349	377	282	290
Opened & Closed in Period	210	241	197	177
Carried Forward (Still Open)	98	86	138	165

Complaint Resolved by Stage

Early Resolution –

A number of complaints are resolved by the provider reaching an agreement with the person who has made the complaint to the mutual satisfaction of both. These matters are resolved, usually very quickly, through a course of negotiated resolution facilitated by the Health Complaints officer who has carriage of the complaint file. There is no need to refer the matter to investigation or conciliation or to take any further action on the complaints. Although these complaints are then "dismissed", under s 25(5)(j) of the *Health Complaints Act*, they represent an important category of complaints where the outcomes sought by the complainant are often achieved. For this reason they have been recorded, for comparative purposes, as a separate category of "dismissed" complaints and are part of the "early resolution" focus of the Office of the Health Complaints Commissioner.

Table 3. **Complaints & Enquiries resolved / dismissed**

Stage of Complaint	2003/4	2004/5	2005/6
Retained by Registration Boards s57 (1)(c)	43	32	29
Enquiries	140	158	297
Early Resolution s25 (5) (j)	55	54	49
Dismissed (following assessment)	150	132	142
Referred to Registration Boards s25 (1A)(a)	89	33	24
Conciliated	8	23	29
Investigated	5	4	9 #
Withdrawn	5	4	6
FOI our Records	1		
Out of Jurisdiction			2
TOTAL	496	440	587

Note: Some matters are formally referred to Registration Boards or other statutory bodies under s.25(1A)(a). However, the Boards are notified of all complaints relating to registered practitioners. The Boards are consulted as to whether or not a referral is required and the Board's opinion is sought before a matter is dismissed.

There were 9 investigations concluded during the reporting year. Of these 5 investigations were completed during the reporting period and the files closed; 3 investigations were concluded but the files were not closed as there were unresolved matters referred to conciliation; 1 investigation file had been deferred pending a Tribunal hearing and was concluded.

Complaint Issues

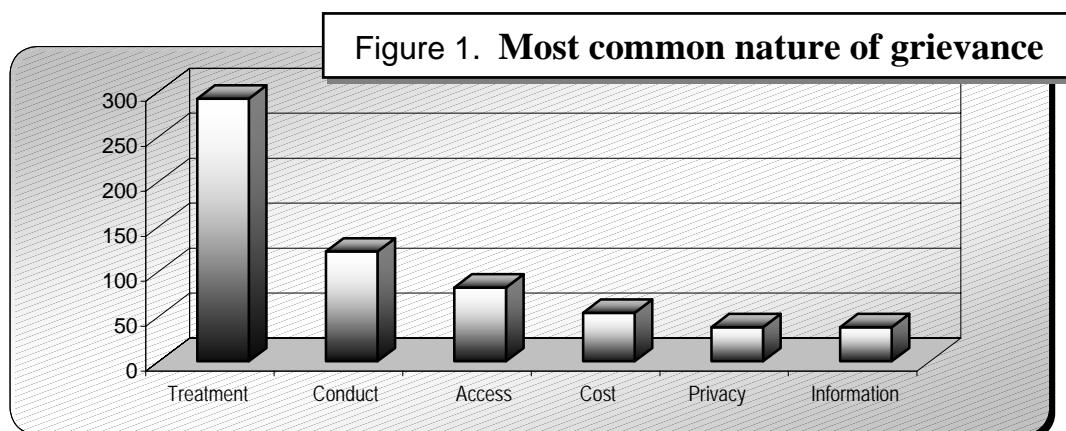
The primary reasons for complaints as stated by consumers are recorded in nine (9) main headings, refer Table 4. As illustrated in Figure 1 the issue 'Treatment' subsumes the majority of complaints, **45%** (33%).

Table 4. **Resolved Complaint Issues**

Category	Issue	2003/4	2004/5	2005/6
Access	Access - waiting list for surgery	5	8	7
	Access discharge/transfer	1	2	1
	Access to transport	4	4	2
	Delay in admission	2	2	6
	Delay in treatment	23	23	17
	Discharge arrangements	2	2	0
	No/inadequate service	34	34	24
	Non attendance	3	3	0
	Refusal to refer	1	1	2
	Refused admission or treatment	12	12	22
	Transfer unsuitable			1
		Sub-total	91	91
Cost	Inadequate information on costs	10	10	23
	Fraud			1
	MEDICARE schedule fee issue		3	0
	Overcharging	10	13	11
	Private health insurance matter	1	4	0
	Unsatisfactory billing practices	37	20	19
	Sub-total	58	50	54
Decision Making	Consent not informed	1		1
	Consent not obtained	3	1	3
	Failure to consult consumer	14	3	4
	Over-servicing/unnecessary treatment	5	6	0
	Refusal to treat	4	6	0
	Sub-total	27	16	8
Grievances	Inadequate (or no) response to complaint	11	8	4
	Retaliation following complaint	6	4	0
	Sub-total	17	12	4
Information	Failure to pass on information	12	8	14
	Inadequate access to records	19	9	11
	Inadequate information on diagnosis, prognosis, treatment op	15	11	6
	Inadequate information on services available	9	5	3
	Inadequate records	1	5	4
	Sub-total	56	38	38
Other Issue	Administrative practice	11	5	10
	Illegal practice		3	0

Category	Issue	2003/4	2004/5	2005/6
	Failure to provide certificate/report		1	5
	Policy issue	5	1	4
	Public health issue	6	1	4
	Sub-total	22	11	23
Privacy	Assault	1		0
	Breach of confidentiality	15	16	13
	Discrimination	1	3	1
	Failure to ensure privacy	6	6	10
	Inconsiderate service	4	8	6
	Unprofessional conduct	5	11	8
	Sub-total	32	44	38
Professional Conduct	Breach of Standard	30	33	38
	Competence/impairment	8	24	43
	Misconduct	34	58	41
	Sub-total	72	115	122
Treatment	Adverse outcome	18	15	28
	Failure to diagnose	18	10	12
	Inadequate diagnosis	12	22	4
	Inadequate treatment	46	76	71
	Medication	30	47	36
	Negligent treatment	14	81	82
	Rough treatment	10	13	18
	Unskilful/incomplete treatment	19	34	30
	Wrong diagnosis	4	2	4
	Wrong treatment	4	9	7
	Sub-total	175	309	292
	Not Specified	16	7	2
	Total	527	693	663¹

Note:¹ Cases recorded only on the enquiry database do not have an issue recorded. Some complaints have more than one issue.



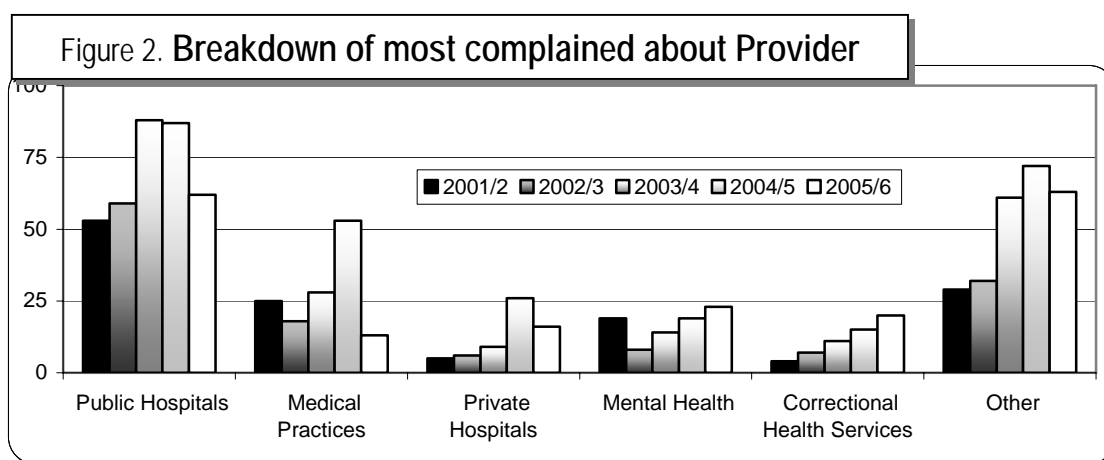
Profile of Health Service Providers - Organisations

In this reporting period (2005/6), there was an increase **22%** (7.4% increase) in the total number of complaints and enquiries recorded against all Health Service Providers (Table 1). 189 of these were recorded in the enquiry database only and are not represented in Tables 5, 6 and 7.

Table 5. Complaints and Enquiries received about Health Service Providers

Organisation	2003/4	2004/5	2005/6
Aged Care	7	4	8
Ambulance	2	2	
Community Health	9	13	6
Correctional Health Services	11	15	20
Dental	25	23	4
Dept. of Health & Human Services (not otherwise specified)		1	14
Diagnostic Services	2		5
Disability Services	6	9	3
Medical Practices/Clinics	28	53	13
Mental Health	14	19	23
Other		2	2
Optometrist			8
Pathology		2	1
Pharmacy/Pharmaceutical	10	8	12
Private Hospitals	9	26	16
Physiotherapy		1	
Public Hospital	88	87	62
Oral Health Services		1	
Total	211	266	197

Note: These figures exclude 2005/6 enquiries that were only recorded in the enquiry database.



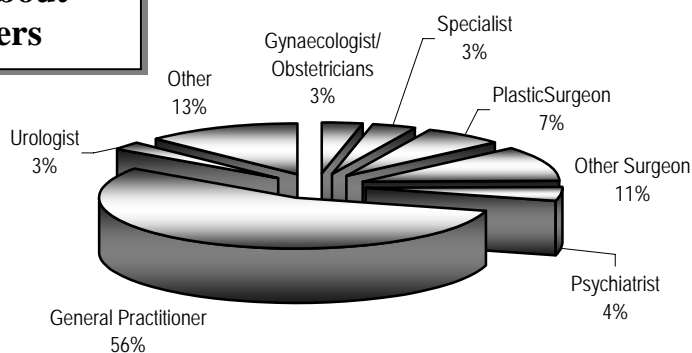
Profile of Health Service Providers – Medical Practitioners

Table 6. **Complaints and Enquiries about medical practitioners**

Type	2003/04	2004/05	2005/6
Anaesthetist	1	5	2
Cardiologist	4	3	2
Clinical Psychologist	2	2	1
Dermatologist	5	1	
Ear, Nose & Throat		5	
General Practitioner	89	79	65
Gastroenterologist		1	
Gynaecologist/Obstetricians	2	2	4
Neurosurgeon	2	-	
Occupational Practitioner	1	-	1
Ophthalmologist	1	1	4
Orthopaedics/Orthotics		-	1
Paediatrician	2	-	2
Pain Specialist	7	5	1
Plastic Surgeon	3	4	8
Physician	2	4	1
Psychiatrist	14	12	5
Radiologist	5	4	
Specialist (Other)	6	3	4
Surgeon (Other)	14	16	13
Urologist	3	1	3
Total	163	149	117

Note: These figures exclude 2005/6 enquiries that were only recorded in the enquiry database.

Figure 3. **% Breakdown of most complained about Medical Practitioners**



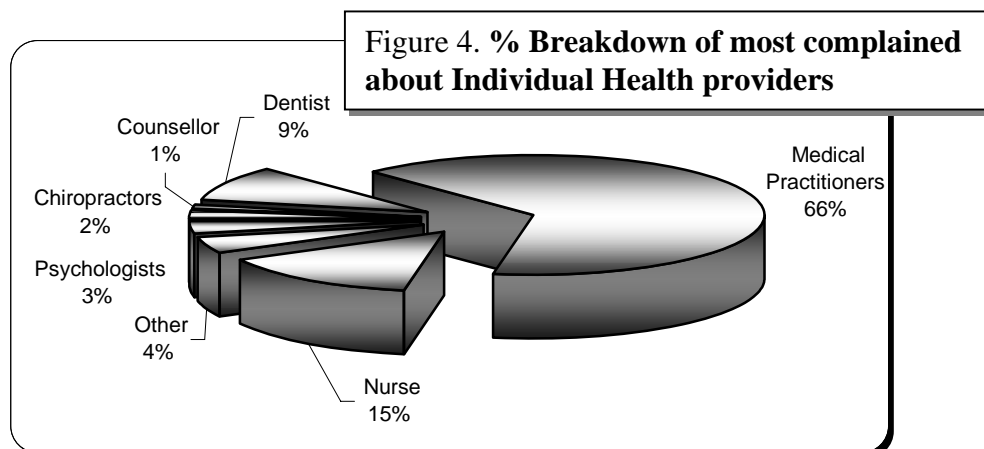
Profile of Health Service Providers – Individuals

Approximately **89% (94%)** of all complaints against individual providers are against Medical Practitioners, Dentists and Nurses. This trend is comparative with previous reporting periods. However, this needs to be put into context: there are significant variations in the number of health service providers registered to practice in Tasmania. For example, the number of medical practitioners registered to practice in the relevant period was 2,250; the number of registered nurses 6214 and 1069 enrolled nurses. By comparison as at 30 June 2005 there were 69 podiatrists registered with the Podiatrists Registration Board". The Dental Prosthetist Registration Board currently has 52 registered dental prosthetists and some other Boards similarly have relatively few registered providers.

Table 7. Complaints and Enquiries received about Individual Health Service Providers

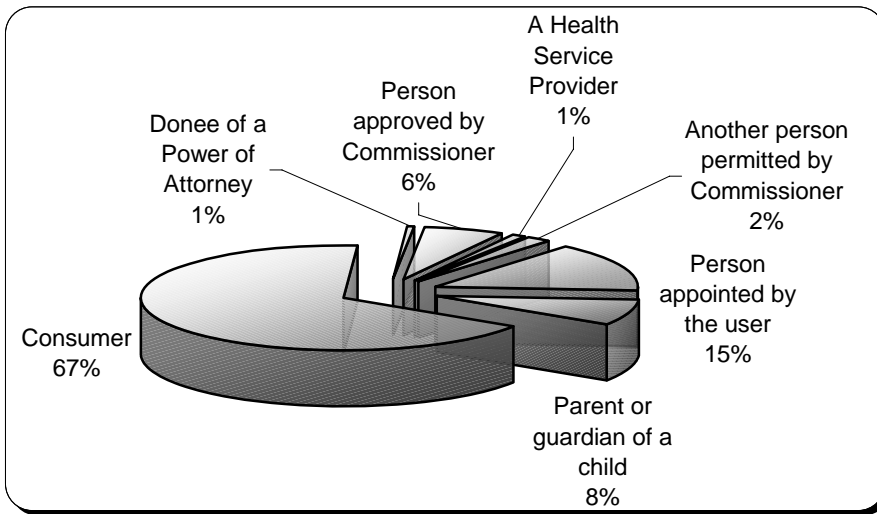
Health Provider	2003/4	2004/5	2005/6
Alternative Health	2	2	
Chiropractors/Osteopaths	1	1	4
Counsellor	1		2
Dentist	26	20	17
Medical Practitioners	163	148	117
Nurse	17	19	26
Optometrist	1	2	1
Other Services		1	6
Pharmacist	7		
Physiotherapist		1	1
Podiatrist			
Psychologists	2	4	6
Total	220	198	180

Note: These figures exclude 2005/6 enquiries that were only recorded in the enquiry database.



Profile of Complainants

Figure 5. Relationship to Consumer



Who is complaining?

As in previous years, the majority of health complaints are made by the Consumer. The *Health Complaints Act 1995* allows the Commissioner to accept complaints from a person other than the consumer. As indicated in Figure 5, **67% (75%)** of complaints lodged are by the person aggrieved.

Figure 6. Consumer Type
In 2005/6 **36% (18%)** of complainants were made by persons representing a number of complainants (Group). This represents an increase of **18%**.

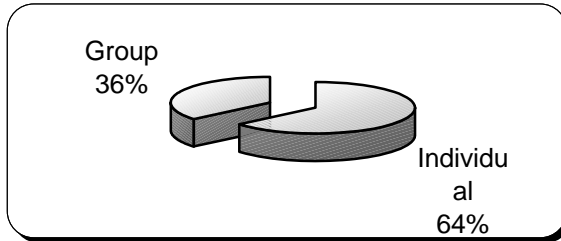
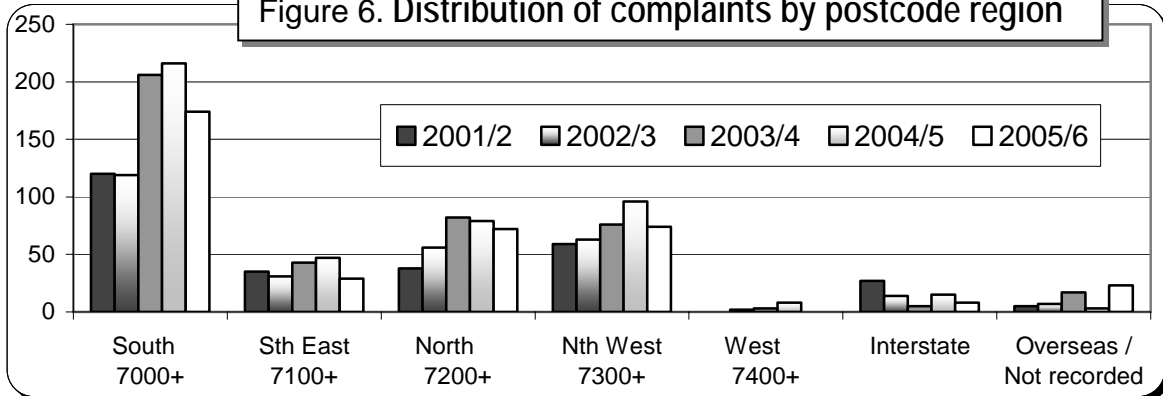


Figure 6. Distribution of complaints by postcode region



Complaint Complexity and Seriousness

Figure 7. Complaints by Complexity

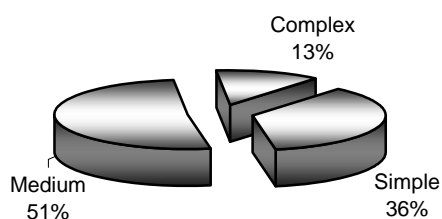
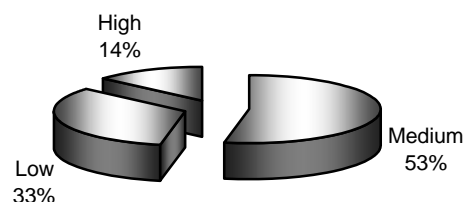


Figure 8. Complaints by Seriousness



Complaint Details

Table 8. Complaint and Enquiry Closure Reasons

Closure Reasons	2003/4	2004/5	2005/6
Enquiry only	140	158	297
Sched 1 Part 2 Excluded as is an opinion/ decision under Workers Compensation		1	2
Referred – S. 25 (1A) (a) Complaint referred to relevant Board or person		31	24
Dismiss – S. 25 (5) (a) Complainant not a person entitled under s22		3	5
Dismiss – S. 25 (5) (b) Complainant does not disclose a subject matter referred to in s23		2	8
Dismiss – S. 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago		1	6
Dismiss – S. 25 (5) (d) Complainant has not attempted direct resolution			1
Dismiss – S. 25 (5) (e) Issues adjudicated by court or tribunal			3
Dismiss – S. 25 (5) (g) Complainant has been given reasonable explanation		113	105
Dismiss – S. 25 (5) (h) The complaint lacks substance		6	14
Dismiss – S. 25 (5) (i) Frivolous, vexatious or was not made in good faith		1	
Dismiss – S. 25 (7) Complainant has failed to provide information under s24	5	3	
Early Resolution – S. 25 (5) (j) The complaint has been resolved	55	54	49
Section 30 (1) The complaint has been withdrawn in writing	5	4	6
Conciliation Resolved	8	19	19
Conciliation Unresolved		4	10
Section 55 Investigation Report and Recommendation(s)	5	9	9
Section 57 (1) (c) (ii) Retention by the Registration Board	43	32	29
FOI our Records	1		
Total	496	440	587

Many complaints in 2003 –2006 are recorded as dismissed complaints under s25, although they may have been substantiated in part or resolved. In particular complaints dismissed under:

- s.25(5)(g) on the basis that the complainant has been given a reasonable explanation and information and
- s.25(5)(j) as resolved

represent categories of complaints where the actions undertaken go beyond an assessment and involve explanations, apologies and negotiated resolution. While not formally referred to conciliation or investigation these complaints represent a significant component of the work of the Office of the Health Complaints Commissioner.

Note: 1. ** Previously these complaints were incorporated into Section 25 (1) (a)

Table 9. **Actual Complaint Outcomes**

Outcome %	2003/4	2004/5	2005/6
Apology given	3.6	6.1	3.1
Change in policy/procedure effected	5.4	2.4	2.1
Compensation received	1.2	1.3	0.6
Concern registered	2.0	2.0	5.4
Costs refunded	2.8	0.9	1.0
Disciplinary action to be taken against provider	0.4	6.0	0.8
Enquiry Only			38.9
Explanation given	24.8	31.0	19.5
No Jurisdiction	3.8	1.7	2.1
Complaint objective not obtained ¹	16.3	28.4	14.6
Part 6 Investigation - Report recommendations	0.2	0.2	0.6
S 25(1A)(a) Referral for Registration Board action ²	9.7	5.2	2.9
S 57(1)(c)(ii) Retention by Board ²	8.3	6.1	4.2
S 55(2) (g) Registration Board Action ²	0.0	0.7	0.2
Service obtained	4.0	4.8	4.0
Total	100%	100%	100%

Note¹:
Many complainants seek outcomes such as compensation in circumstances when this is unwarranted or complainants may have unrealistic expectations.

Note²:
Disciplinary action is primarily a Registration Board or employer function. There are no disciplinary powers under the *Health Complaints Act*.

Referral of Complaints

Complaints referred to Registration Boards or another body in accordance with s 25 (1A) (a) of the *Health Complaints Act* 1995.

Table 10. **Referrals of complaints** (opened between 1 July and 30 June)

Referrals to Other Bodies	2003/4	2004/5	2005/6
Ombudsman	1		3
Tasmania Police		1	
Medical Council	64	44	73
Psychologists Registration Board	3	1	5
Pharmacy Board	8	2	1
Nursing Board	5	14	30
Dental Board	7	1	3
Dental Prosthetists Board	1	1	
Optometrist Registration Board			2
TOTAL	89	64	117

Retention of Complaints by Registration

Complaints retained by a Registration Board under s57(1) (c) (ii) of the *Health Complaints Act 1995*.

Table 11. **Retention of complaints** (retained between 1 July 2005 and 30 June 2006)

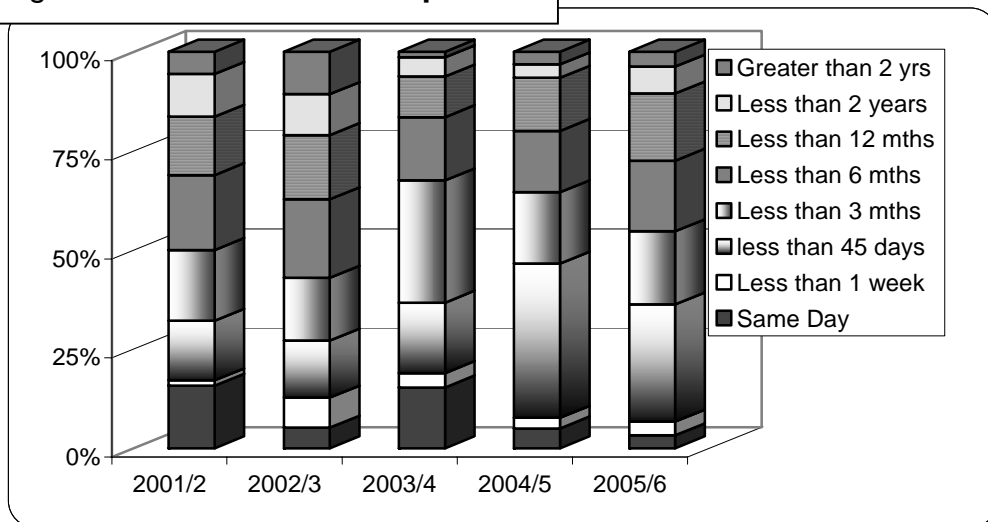
Complaints Retained by Registration Boards	2003/4	2004/5	2005/6
Dental Board	3		
Medical Council	23	10	13
Medical Radiation Science & Professionals Registration Board	1		
Nursing Board	14	19	16
Pharmacy Board	2	1	
Physiotherapist Registration Board		2	
Podiatrists Board			
Psychologists Registration Board			
Note: Tasmania operates as a bipartite system with the 11 Registration Boards listed in Schedule 2 of the <i>Health Complaints Act 1995</i> retaining the registration, regulatory and disciplinary powers over registered health services providers. A number of complaints, referred to in the legislation as grievances, are made directly to the Boards who are required to notify and consult with the Commissioner as to whether the complaint will be retained for action by the Board or referred to the Commissioner.	43	32	29

Time taken to finalise Complaints and Enquiries

The number of complaints and enquiries lodged and finalised on the same day has decreased significantly compared with the 2003/2004 reporting period (**22** compared with 76). However, the total number of complaints and enquiries finalised within the 45 day Assessment Period has increased (**205** compared with 182). This can mainly be attributed to a more considered analysis of the complaint and a focus on “early resolution”.

It is again noteworthy to mention that the number of complaints that had been carried over beyond two years, although a slight increase on 2003/04, has remained relatively low for this period. However, although **411** (465) complaints (including enquiries) were resolved within 12 months, there were **29** (31) cases which exceeded this period. In part this arises out of major investigations, complex conciliations and also reflects problems with staffing levels and staff turn-over.

Figure 9. **Timeliness of Complaints**



APPENDIX A – FINANCIAL STATEMENT

	2003/4	2004/5	2005/6
REVENUE			
Consolidated Revenue	348,131	360,698	410,668
Other Revenue (DHHS)	16,600	46,090 ²	
Total Revenue	364,731	406,788	410,668
OPERATING EXPENDITURE			
Salary expenditure	327,598	305,891	427,134
Employee related	2,320	1,250	11,009
Total Salary expenditure	329,918	307,141	307,141
General administration	1,050	1,286	14,197
Information technology	9,500	9,596	17,828 ¹
Personnel expenses	774	849	
Travel and transport	4,101	6,681	13,314
Property expenses	17,284	14,917	43,150 ¹
Operating expenses	17,273	19,618	12,955
Consultants	17,060	48,792 ²	1,731
Total Non-salary expenditure	67,042	101,739	103,175
Total Expenditure	396,960	408,880	410,316

Notes:

1. Property and IT costs in 2005/6 have been apportioned from the Office of the Ombudsman based on staff salaries. This reflects the actual costs incurred.
2. 2004/5 non-salary expenditure variance is attributed to a major investigation into a Health Service requiring external consultants and expert opinions. Funding for this purpose was provided through the Department of Health and Human Services.