

**HEALTH COMPLAINTS COMMISSIONER**  
TASMANIA

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**Annual Report 2006 – 2007**

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To

**The Honourable the President of the Legislative Council**

and

**The Speaker of the House of Assembly**

Pursuant to section 12 of the *Health Complaints Act* 1995, I present to the Parliament the annual report of the Health Complaints Commissioner Tasmania for 2006-07.

Yours faithfully

A handwritten signature in grey ink, appearing to read 'Simon Allston', is written over the typed name.

**SIMON ALLSTON**  
**HEALTH COMPLAINTS COMMISSIONER.**

October 2007

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## FROM THE COMMISSIONER

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This is the eleventh Annual Report of the Health Complaints Commissioner, and my second such report.

This has been a very productive year for the staff who assist me as Health Complaints Commissioner. I note in particular that 26 investigations under Part 6 of the *Health Complaints Act* 1995 have been completed, compared with 9 in 2005/6. Investigations vary in the complexity of the issues that need to be considered, and in the amount of evidence that needs to be collected. Some of those completed this year were particularly complex - for instance one into the changed model of care for the delivery of mental health services in the State, one relating to the future of the Huntington's Disease Register presently in the custody of the Mental Health Services branch of the Department of Health and Human Services, and one which concerned adverse consequences for a patient from the use of derma filler in a cosmetic procedure. Details of the investigations conducted during the year are to be found later in this report. I wish to especially recognise the work of Robyn Hopcroft, Principal Officer - Health Complaints, in carrying out many of these investigations, and in guiding the work of others in those which she did not carry out herself.

The year was also a productive one for the two conciliation officers who assist me in this jurisdiction. Thirty-seven matters were closed, in comparison to 29 in the previous year. Some of these were complex matters, which might otherwise have resulted in protracted litigation. Some also resulted in agreement on the payment of substantial awards of compensation. One of the main policy purposes behind the *Health Complaints Act* is to reduce the amount of litigation arising from medical misadventure, and conciliation is a very effective tool in this regard.

In late 2006, we adopted complaint handling standards for the work of the Office of the Health Complaints Commissioner, which drew upon similar standards for equivalent offices in the ACT and the Northern Territory. Central to these is the objective of making sure that, so far as is reasonably possible, we meet the requirement in s 25 of the *Health Complaints Act* that a complaint be assessed within 45 days of receipt - a period which can if necessary be extended by another 45 days. Maximising the number of cases in which we meet these time limits is one of the annual performance measures for the Office.

The work of the Office occurs in close conjunction with that of the 11 health profession registration boards listed in Schedule 2 to the Act. During the reporting year I agreed with each of the boards a single set of protocols, to elucidate the relationship between the Commissioner and a board, and in particular the circumstances under which a complaint should be dealt with by the Commissioner or by a board. The protocols will be reviewed after they have been in operation for a year, and periodically thereafter. Present indications are that they provide a very useful foundation for the interaction between the Commissioner and the boards.

As in previous years we have had the benefit of advice from numerous expert practitioners, many of whom assist us at a reduced fee or on a *pro bono* basis. Usually we select these practitioners on a case-by-case basis, but we have a special

arrangement with the Dental Board of Tasmania, under which advice is given to us on dental cases by two dental surgeons nominated by the Board, who volunteer their services for this work. This has been extremely beneficial to us, and I wish to thank the Board for this arrangement, and to thank these two practitioners for their assistance.

The *Health Complaints Act* provides for a Charter of Health Rights, and amongst the grounds upon which a complaint may be made under the Act is the fact that a health provider has acted in a manner which is inconsistent with the Charter. The present Charter came into existence shortly after the Act commenced, and has remained unchanged since then. I propose to review the Charter during the forthcoming year, and to engage in public consultation in doing so.

I hold an appointment as Ombudsman in conjunction with my appointment as Health Complaints Commissioner, and the staff who assist me in each of these roles are located in the one office. This report should be read with my Annual Report as Ombudsman, which details a number of changes and management initiatives which have affected or will in the future affect the Office as a whole. These include –

- going to tender for a new case management database, which we expect to start commissioning later this year;
- developing an intranet site for the Office;
- publishing all significant reports on our websites;
- creating the opportunity for prison inmates and detainees to make complaints to the Office by telephone;
- renovating communal spaces within the Office; and
- achieving a situation in which all but one member of staff in the Office is permanently employed.

The Ombudsman's Annual Report can be viewed at [www.ombudsman.tas.gov.au](http://www.ombudsman.tas.gov.au).

I close by thanking all of my staff for their hard work and support during the year.

**SIMON ALLSTON**  
**HEALTH COMPLAINTS COMMISSIONER**

October 2007

## **COMMUNITY OUTREACH AND STAFF PROFESSIONAL DEVELOPMENT**

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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 2006***

- The Principal Officer attended a consultation session on reforms to Mental Health in Tasmania.

### ***August 2006***

- The Principal Officer gave a talk to U3A on the health complaints system.

### ***September 2006***

- The Principal Officer and Senior Investigation Officers attended the opening of the new prison at Risdon and inspected the Risdon Prison hospital annex.

### ***October 2006***

- A presentation was given in Launceston on all jurisdictions of the Office of the Ombudsman and Health Complaints Commissioner, as part of a seminar on Complaint Management delivered by the Office.

### ***November 2006***

- The Commissioner and Principal Officer met with the representatives of the Commonwealth Department of Health and Ageing to be briefed on proposed changes to the Aged Care Complaints Resolution Scheme including the role of the Commissioner and the Office of Aged Care Quality and Compliance.
- The Commissioner, Principal Officer and Senior Conciliator attended the 2006 Australian Health Conference.

### ***December 2006***

- The Principal Officer met with Mr Russell McGowan, the Consumer Surveyor at the Launceston General Hospital, as part of the LGH 4 year accreditation process.

### ***February 2007***

- The Principal Officer gave a talk on the health complaints system to the Department of Veterans Affairs – Treatment Monitoring Committee.
- The Commissioner, Principal Officer and staff met with Dr Wake and Dr Henderson of Correctional Health Services to discuss the complaints process.

### ***March 2007***

- The Principal Officer gave a talk on the health complaints system to Rotary at Claremont.

### ***May 2007***

- Agfest attendance to promote all jurisdictions
- The Principal Officer gave a talk to the North Hobart Probus group on the jurisdictions of the Office of the Ombudsman and Health Complaints Commissioner.
- Dr John Crawshaw and Dr Adrian Reynolds from DHHS, gave an information session to staff on the proposed changes to the Pharmacotherapy Program.

### ***June 2007***

- The Principal Officer gave a talk to the War Widows Guild at Legacy House on the jurisdictions of the Office of the Ombudsman and Health Complaints Commissioner.
- The Commissioner and Principal Officer met with Associate Professor Des Graham, Martin Gibson and Karen Payne to discuss the Mental Health Act Review.

## **Professional Development**

The Office of the Health Complaints Commissioner (OHCC) has a commitment to professional development. In March 2007 staff from all jurisdictions and allied agencies attended a training day presented by representatives from the Office of the NSW Ombudsman on 'Managing Unreasonable Conduct'.

Other professional development sessions included attendance at the RHH Research Foundation breakfasts, an information session presented by Professor George Williams on "A Charter of Human Rights for Tasmania", the launch of the Mental Health Services (MHS) Professional Services Unit, the inaugural Red Cross Oration at UTAS, titled "The Challenge of Bioethics in a Globalised World," and a presentation by Stephen Escourt QC at the Supreme Court on "Pro Bono Schemes – Is Tasmania ready for One?"

Officers attended various training courses, both intrastate and interstate, including an Advanced Investigations Training program in Melbourne, a Critical Reasoning Analysis and Decision Making course, an HIV/AIDS course in Launceston, the "Stop Bullying and Harassment" course commissioned by the Department of Justice, a Writing Letters and Emails course and a course on Word 2000 Introduction and Intermediate Training.

## **Work Experience**

This Office is receptive to providing work experience at a secondary, tertiary and postgraduate level. In August 2006, a Grade 10 work experience student was hosted in the Launceston Office and in September a postgraduate law student commenced an 8-week placement with the Office as part of her ANU Legal Practice Course. An approved work program was developed by the Principal Officer to ensure that the student had an opportunity to develop a range of skills including participating in an investigation, analyzing evidence, conducting interviews and undertaking research into legislation with provisions similar to s 4 of the *Health Act 1997* (Tas).

## **COMPLAINT HANDLING**

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The OHCC handles complaints in accordance with the *Health Complaints Act 1995* (the Act), and the Tasmanian *Charter of Health Rights and Responsibilities*. Under the Act, the Commissioner is required to act independently, impartially and in the public interest and seeks to do so in a manner consistent with recognised dispute resolution standards.

Complaints handling is based on the dispute resolution principles mentioned in the relevant Australian Standard (AS 4369-1995), which promote effective complaint handling. The objective of the AS is to ensure that matters are dealt with in a timely and efficient manner and that the principles of procedural fairness are applied to the complaints process.

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 Principal Officer, in consultation with staff developed Complaints Handling Standards based on work undertaken in the ACT and NT. Every complaint is audited on the basis of these standards and the results are reported at the monthly Managers' Meetings. The Complaint Handling Standards were signed off by the Commissioner and will be adapted for use in all jurisdictions within the Office.

The Complaint Handling Standards incorporate definitions of complexity, and require each stage of the complaint to be completed within a stipulated time. Timeliness is one of the benchmarks. Effective complaint handling requires complaints to be dealt with in the shortest possible time, having regard to accuracy and fairness. The process begins when the complaint is lodged. The emphasis is on the early resolution of complaints by negotiation, but if the matter does not resolve and is not dismissed for any reason provided for under s 25(5) of the Act, then assessment (as to the most appropriate action or actions to be taken) must be completed within 45 days. This 45-day period is a statutory requirement, but there is provision under the Act to extend the assessment period for a further 45 days, making a total of 90 days.

### **Auditing complaint handling – timeliness**

In some instances this Office is unable to complete the assessment in accordance with the statutory time limit or complaints handling standards. The assessment period might be longer if a timely response is not made for a variety of reasons. For instance, the provider may question whether they can lawfully provide the Commissioner with sensitive personal information if the complainant is not the health consumer but a third party. Alternatively, the provider might be absent, or medical records may be required from multiple health service providers.

The assessment might be delayed when providers seek advice from their indemnity insurers. In most cases the outcomes sought by the complainant do not raise matters that could be the subject of a claim and the provider appears to be seeking advice both as assurance that their response to the complaint is not jeopardising their indemnity cover, and for assistance in formulating their response. In most instances indemnity insurers appear to now focus on expediting resolution and, as in most jurisdictions, an

apology under s 7 the Tasmanian *Civil Liability Act 2002* does not constitute an admission of liability –

*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.”*

As a consequence, the provider’s approach is often more conciliatory and they appear willing to explain and apologise for any problems that may have arisen.

In the reporting year 52.63 % (70) complaints were assessed within 45 days and 37.59% (50) complaints were assessed in over 45 but fewer than 90 days. In 9.77 % (13) of cases, the statutory assessment time was exceeded. This is a significant improvement by comparison with previous years.

### **Protocols for expediting responses**

During the reporting year, a protocol was developed between this Office and the Department of Health and Human Services (DHHS) where the Secretary is notified of all complaints about health services administered by DHHS via email to Executive and Portfolio Services (EPS). EPS email the complaint to the DHHS officer required to respond, with a copy sent back to this Office. For the most part this has improved response times, but in some instances there are still unwarranted delays. Hospitals and Emergency Services do not fall within the protocol and the CEO or division head will compile a response having collected information from a number of sources, but may elect to respond through the Secretary. In some instances a personal response from an individual provider is necessary, irrespective of whether the State might be vicariously liable for the actions of its employee, or of whether it is more convenient for hospital administration to respond on an individual’s behalf.

### **Fairness and impartiality**

The Charter and the complaints handling standards of this Office are designed to ensure that the complaints handling system is effective and that the outcomes are fair. The complaints handling procedures within this Office are aimed at ensuring the quality of the work undertaken. Officers draft assessment reports recommending the most appropriate action to be taken and both the Principal Officer and the Commissioner sign off on the recommended action. Experts are commissioned to review complex cases and Registration Boards sometimes nominate health providers who assist in assessing complaints.

The establishment of a health complaints system in every State and Territory has also provided an alternative dispute resolution mechanism, through the conciliation and investigation process. The health complaints system provides a conduit to the Registration Boards regulating health providers. The Commissioner determines whether a matter will be referred to or retained by a Registration Board but does this after consultation and in accordance with protocols. These protocols help define what matters should be dealt with by the Registration Boards or by this Office, or split between each jurisdiction or in some instances the subject of a joint investigation. The aim is to seek a qualitative outcome and to take the most appropriate action given the nature of the complaint.

## **Managing unreasonable conduct**

A common theme in complaints jurisdictions such as Ombudsman and Health Complaints is the inordinate amount of time involved in managing those few complaints where the complainant's conduct is unreasonable. The Principal Officer conducted a professional development session on managing unreasonable conduct for this Office during the year. Subsequently, and as part of a national project funded by the Commonwealth government and supported by all Ombudsmen, representatives from the NSW Ombudsman presented a comprehensive professional development session for this Office and other complaints handling jurisdictions, outlining strategies for dealing with such conduct.

## **Website and intranet**

During the reporting year a decision was made to place Case Notes on the website. At the conclusion of a matter, case summaries are uploaded onto the health complaints website. Health provider organisations are not de-identified but the complainant is, and in most instances the identity of an individual health provider does not appear. The exception is when the matter has already become a matter of public notoriety. The website address is [www.healthcomplaints.tas.gov.au](http://www.healthcomplaints.tas.gov.au).

During the reporting year material, including the OHCC procedural manual, has been reviewed and placed on the newly installed intranet.

## **CASES CLOSED IN THE REPORTING YEAR**

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There were 536 complaints and enquiries closed during the reporting year, of which 238 were complaints. As indicated in Table 3, the majority of complaints are closed at the assessment stage and the complaint dismissed under s 25 (5) of the Act. Of the 132 closed at the assessment stage, 22 were resolved and an additional six were resolved at the *early resolution* stage. The focus is on expediting complaint resolution and increasing the number closed at an early stage. Sixty-eight complaints were closed on the basis that the complainant had been given reasonable explanations and information. Of the remaining complaints, 37 were closed in conciliation under Part 5 of the Act and 26 were closed in investigation under Part 6. Ten complaints were referred to a Registration Board under s 25(1A) of the Act and 24 ‘*grievances*’ which are matters which can constitute a complaint under the Act were, with the agreement of the Commissioner, retained by Registration Boards under s 57 (1)(c).

### **The complaint issues**

Many complaints made to this Office are genuine but misconceived. An appropriate explanation and conciliatory approach generally resolves these matters at the outset. Other complaints are well founded and cover a range of concerns about health services and health service providers. Some reflect consumer difficulties in accessing public health services within a reasonable time. Table 4 reports the resolved complaint issues in this reporting year and compares this with the previous reporting year.

This Office categorises complaints according to the following issues: access, treatment, information, cost, decision-making, grievances, privacy, professional conduct, and other issues. One complaint may give rise to multiple issues of equal importance to the consumer and hence the number of issues exceeds the number of complaints lodged.

The most common issues raised by complaints in this reporting year related to *treatment*. Of the 485 issues recorded in all complaints closed during the reporting year a total of 281 (or 57.94%) related to *treatment*. Of the 10 sub-categories recording complaint issues the largest number related to inadequate treatment (80 issues or 16.49%), followed by negligent treatment (74, or 15.26%), adverse outcomes (29, or 5.98%) and unskilful and/or incomplete treatment (24, or 4.95%).

The second highest category related to *access*, representing 53 of the issues raised in complaints. This was a slight increase in complaints relating to access from 82 (12.95%) in the previous reporting year to 53 (or 10.92%) in this reporting year. In the access category 21 related to either no service or an inadequate service, 14 to delays in treatment and 8 to refusal of admission or treatment.

The third highest category related to *professional conduct*. Forty-eight (or 9.89%) of the issues related to professional conduct.

Other notable statistics from this reporting year are as follows –

- Issues in relation to *cost* (38 or 7.83%) – unsatisfactory billing practices, inadequate information on costs and overcharging.
- *Information* (22 or 4.53%) – the greatest number of complaint issues related to a failure to pass on information or inadequate access to records.
- *Privacy* (21 or 4.32%) – the greatest number of complaint issues related to a failure to ensure privacy.
- Other issues (10 or 2.06%) – of which half related to public health issues and the balance administrative practices, with one relating to illegal practice.
- Grievances (7 or 1.45%) – the greatest number of complaint issues related to inadequate access to records and inadequate information on diagnosis, prognosis and treatment options.
- Decision-making issues (5 or 1.03%) – primarily an inadequate response, or no response to a complaint. A further breakdown of category types is set out in Table 4.

### **The health service providers**

As indicated in Table 2, in this reporting year there was a reduction in the number of complaints lodged under the Act from 269 to 224, and any comparison with numbers of complaints in previous reporting years needs to have regard to the overall reduction in complaints. A numerical comparison can be simplistic as there may in any one year be fewer complaints, but a greater percentage of those complaints may be significant and involve serious issues.

As indicated in Table 5, there were 41 complaints against public hospitals and seven against private hospitals, representing a decrease since the previous reporting year where there were 62 complaints against public hospitals and 16 against private hospitals.

During the past three reporting years there has been an increase in complaints against Mental Health Services (MHS) (14, 19 & 23) though this is not necessarily reflected in the statistics. An increase in complaints against an organisational provider may simply reflect increased community awareness of this Office or may reflect concerns about changes to services or an expectation of change following an investigation. This is reflected in the case of Ward 1E, at the Launceston General Hospital, where despite substantial progress, problems continue to emerge.

In this reporting year there were 7 complaints against MHS which represents a decrease, but these statistics need to be put in context as multiple complaints on the same issue have sometimes been aggregated into a single complaint. There was controversy surrounding the actions taken in relation to the Huntington's Disease Register and in relation to the impact of the change in the model of care on former clients of the Mobile Intensive Support Team (MIST) in southern Tasmania. These matters are reported under the Investigations and Health Services sections of this report.

In the case of Correctional Health Services, there were 13 complaints compared to 20 in the previous reporting year. This Office is on the whole, very satisfied with the delivery of health services to prisoners given the transition to the new Risdon Prison and the better provision of oral health and other primary care services. An increase in the number of complaints might in future result from an increase in the number of prisoners and better access as inmates may now lodge a complaint to this Office by telephone. The changes in the delivery of Correctional Health Services are reported under the Health Services section of this report.

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. Table 6 gives a breakdown of the 61 complaints about medical practitioners.

Over the past three reporting years the complaint numbers against individual providers have dropped slightly (220, 198, 180). Of the 252 complaints closed in this reporting year, 61 were against medical practitioners, 21 against nurses and six 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**

A comparison between Table 1 and Table 2 shows that in this reporting year there were 297 enquiries. The approach adopted in this reporting year has been to separate complaints from enquiries to better distinguish between the enquiries and complaints handling functions. Some enquiries are recorded on the Raemoc complaints database though no written complaint has been lodged. This occurs if the information raises potentially serious issues or allegations and needs to be recorded, or where work has been undertaken.

252 complaints were closed during the reporting year. One complaint was excluded under Part 2 of Schedule 1 of the Act as being out of jurisdiction, but the transfer of the file to a Registration Board was facilitated with the authorisation of the person who lodged the complaint.

Of the remaining 251 complaints, 24 were assessed as appropriately retained by Registration Boards, pursuant to s 57(1)(c)(ii) of the Act, for actions under its legislation, leaving 227 complaints to be dealt with by this Office. Of those, 10 were referred to a Registration Board under s 25(1A) of the Act.

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

Section 25(5) of the 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 dismissed in accordance with that provision of the Act –

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

In this reporting year 8 complaints were rejected on the basis that the complainant was not a person entitled to make a complaint. However, in some instances the

Commissioner allowed a person other than the consumer to join in making the complaint, or allowed the complaint to be made on behalf of the consumer providing that the consumer signed the authorisation on the complaint form. In some instances the Commissioner initiated an investigation on his own motion, as the circumstances of the complaint raised questions of public interest and/or public safety, and in other instances accepted a third party complaint.

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

The Commissioner received three written complaints that did not disclose any ground upon which a complaint could be made under the Act. The grounds are specified in s 23 of the Act.

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. In some instances, the Commissioner sought the assistance of Official Visitors under the *Mental Health Act 1996*, MHS, the Public Guardian, Correctional Health Services or others to assist in clarifying whether there was a substantive matter which could constitute grounds of complaint requiring further action. This assistance is appreciated. These complaints are in the most part without substance and the providers often exhibit a great degree of tolerance and compassion in attempting to resolve these matters with the consumer.

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

No complaints were dismissed on the basis that the complainant became aware of the circumstances that gave rise to their complaint more than two years before the complaint was made. The Commissioner, if satisfied that the complainant had good reason for not making the complaint within that two-year period, may accept a complaint which otherwise would be outside the time limit.

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

Two complaints were dismissed on the basis that the complainant made no attempt at direct resolution. Complainants are required to take reasonable steps to resolve their complaints directly with their health service provider unless they can show that there is a good reason why they should not be required to do so. In some instances complainants do attempt to resolve their grievances directly with their service provider but encounter an impenetrable barrier at reception. The provider is often unaware that a patient or health service user has raised a concern until correspondence is received from this Office. However, in many instances staff and providers are consumer-orientated and regard complaints resolution as part of their business and as part of a quality assurance process.

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

Only one matter was dismissed on the basis that the issues had been adjudicated by a court or tribunal. Such cases often involve a complainant wanting to use the health complaints system to contest the conditions in orders made by the Mental Health Tribunal or the Guardianship and Administration Board.

***Court has commenced hearing (s 25 (5)(f))***

One matter was dismissed in this category.

***The complainant was given reasonable explanations (s 25 (5)(g))***

The Commissioner is required 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. A total of 68 complaints was dismissed on this basis in this reporting year.

A significant amount of the work of this Office involves information gathering and examining the factual circumstances surrounding each complaint. Medical records, reports and expert opinions may be obtained to assist the assessment process. In each case discretion needs to be exercised as to the seriousness of the case, whether it involves systemic, ethical or professional conduct issues and what action would be the most appropriate in the circumstances. Having undertaken those tasks within the statutory assessment period, it is possible to provide many complainants with sufficient explanations and information to satisfy this requirement.

Technically the complaint is *dismissed* under these circumstances, but securing and providing an explanation is a significant and important part of complaints resolution and the work of this Office. 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. This dialogue between the provider and consumer is a valuable means of resolving the complaint. Many complaints arise out of a communication gap between the information the provider believes they have imparted to the consumer and what that person comprehends.

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. Early resolution, clear explanations and a conciliatory approach assist in complaint resolution, and conversely a defensive or aggressive approach hinders resolution and makes the complainant less likely to accept that an explanation is reasonable. In some instances, even though the service provider has provided a reasonable explanation, 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 they have suffered a wrong can make such complaints difficult to handle.

This Office can, through the explanations and information provided, monitor the quality of the service given by health service providers and the actions taken by the provider to redress the problem and prevent a recurrence. The process of obtaining responses also allows the Commissioner, through consultation with the regulatory bodies, to determine whether it is appropriate to dismiss the matter. The complaint, response and any reply are forwarded to the Registration Boards with any accompanying documentation before a decision is made as to whether the matter should be dismissed.

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

In this reporting year 18 complaints were dismissed on the basis that they lacked substance. It is not always possible to come to that conclusion without making preliminary enquiries. In some instances the provider believes that there is no substance to the person's complaint and is aggrieved that enquiries are being made

rather than the matter being dismissed outright. In other instances the provider is quite clearly aware that the complainant is confused and makes attempts to ameliorate the situation even though the complaint lacks substance. As there is a requirement under the Act to notify the Registration Boards of complaints against registered providers, it was suggested to the Medical Council that it make a specific notation when a complaint lacks substance.

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

Two complaints were dismissed under this section, a statistic that is consistent with the general experience of this Office. While many complainants are genuine, some of their complaints are misconceived.

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

Six matters have been *dismissed* on the basis that they have been resolved during the assessment process. As indicated above, elements of resolution are present in those matters closed on the basis that a reasonable explanation has been given and no further action is necessary.

***Other grounds for dismissing a complaint (s 24 (1) & 25 (7))***

No complaints 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 complaint processes. In some instances notices were sent cautioning complainants that their complaint would be dismissed or an investigation would be terminated if they failed to provide information or, exceptionally, if they refused to engage in a process of review by a specialist, which might provide evidence to support or refute their claim.

**Summary**

In summary, those matters dismissed on the basis that a reasonable explanation has been given or that the matter has been resolved, constitute a significant and valuable part of the work of this Office. In many cases, where medical records or a response from a specialist in a complex matter is required, assessing the most appropriate action within the statutory 45 days time frame is problematic.

Occasionally a matter is moved to investigation in conformity with a policy decision to adhere strictly to the initial 45-day assessment period, with a single 45-day extension period, but this did not occur during this reporting year. In some instances matters are moved into investigation only because substantive facts in dispute need to be established by investigation before there is a proper basis for making a decision as to whether there is benefit in referring the matter to conciliation.

The guiding principle is that all complaints are dealt with by the most appropriate body and by the actions most appropriate to the circumstances of each particular case. Given that the majority of cases lodged can be resolved at the initial assessment stage, the preference is to establish the critical facts in issue and to achieve an early resolution consistent with fairness to all the parties involved.

Complaints that are not dismissed at assessment may proceed to investigation, to conciliation or be referred to a Registration Board or other statutory body. In some

instances more than one action may be taken to deal with different aspects of the complaint. In one matter during the reporting year, the provider was referred to a Registration Board, an investigation was conducted under Part 6 of the Act to establish the substantive facts and at the conclusion, the matter was referred to conciliation under Part 5 of the Act where it was resolved by a negotiated financial settlement. Where appropriate, a recommendation is made at the conclusion of an investigation that the matter be referred to conciliation.

### **Conciliation**

There were 37 matters closed at conciliation of which 21 were resolved. Sixteen were unresolved, of which 13 were ended by the Commissioner. Of the 21 matters resolved, 9 involved a financial settlement or refund of costs. A full report on conciliations is in the section of the report on “Conciliations under Part 5”.

### **Investigation**

There were 26 matters closed following investigation, as indicated in Table 3. A full report is in the section of the report on “Investigations under Part 6”.

## **CONCILIATIONS UNDER PART 5**

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Thirty-nine matters were referred to conciliation under Part 5 of the Act during this reporting year. This was seven less than the previous year.

Thirty-seven matters were closed in conciliation this year. Of these, 21 were resolved and 16 unresolved. Of the matters that were resolved, nine resulted in the payment of compensation or a refund or waiver of fees. However, as with previous years, the main focus for complainants was to gain a better understanding of what had happened and why and, where appropriate, to have providers acknowledge their experience and concerns, and if necessary to implement quality improvements. As such the remaining 12 matters were resolved either as a consequence of being provided with explanations (from either the provider or an independent expert), expressions of regret or quality assurances.

The term unresolved in this report is used to describe a situation where either one or other of the parties withdrew from the conciliation process or where the complainant was not satisfied with the outcome. In the latter case this should not be taken as meaning that the conciliation was wholly unsuccessful. For example it is often difficult for complainants to understand that although they may have suffered an adverse outcome, this is unlikely to give rise to a payment of compensation in the absence of negligence on the part of the provider. In nine of the unresolved matters, meetings and discussions were held between the parties, explanations were sought and provided, and expressions of regret were made. However, because the complainants' belief that they should receive compensation was not shared by the providers, these matters cannot be said to be resolved.

In three matters it became clear following preliminary meetings with the parties that conciliation would be unlikely to resolve the complaint, and in a further four, delays in bringing the parties together resulted in their withdrawing from the process.

The statistics referred to above do not however present a full picture of the conciliation work undertaken within this Office during the year. As at 30 June 2007, 38 matters remained open in conciliation, many of which were drawing very close to being finalised.

Several of these ongoing matters involve extremely complex personal injuries claims where the complainants have chosen to pursue their quest for compensation through the conciliation process offered by this Office, as opposed to litigation. Perhaps one of the major reasons for this has been, until recently, the lack of legal aid available to fund civil litigation, but another significant reason is no doubt because conciliation is widely regarded as a more therapeutic means of resolving medical misadventures.

Conciliation provides opportunities to discuss concerns about communication, and recommendations for changes in policies, procedures and personal behaviour, as well as the opportunity to explore questions of legal liability. It therefore enables the parties to discuss a wider range of issues than if the matter was litigated, and can therefore offer greater potential for closure for the aggrieved party than litigation. This is one of the great benefits provided by the Act.

## **INVESTIGATIONS UNDER PART 6**

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A complaint may be investigated under Part 6 of the Act if there are substantive facts in dispute which are central to the complaint, or the complaint involves systemic issues which impact on the quality and safety of health care. The implementation of recommendations made by the Commissioner may require monitoring over a period of years and represents a significant component of the investigative work of this Office. In some instances the Commissioner will initiate an investigation at his 'own motion' to monitor on-going matters. These are reported below in the Report on Health Services.

A decision was made during the reporting year to place Case Notes on the website at the conclusion of an investigation. The address is [www.healthcomplaints.tas.gov.au](http://www.healthcomplaints.tas.gov.au)

Twenty-six investigations were concluded and one matter was referred to conciliation at the conclusion of the investigation. Although the number of complaints lodged in the reporting year decreased to 224 complaints compared to 269 in the previous year, the number of investigations increased from nine to 26, as did the seriousness and complexity of those investigations. This has occurred although the number of equivalent full time staff has decreased, and is indicative of significant productivity achievements by those officers investigating complaints.

In undertaking such investigations and in determining whether a complaint should be investigated or conciliated, this Office 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, and constitute a very valuable contribution to the work of this Office.

### **Overview of the Investigations undertaken**

Investigations were undertaken covering public and private health care services and a broad range of health related issues. Twelve related to public and private hospitals, others related to services for which DHHS is administratively responsible (6 to Mental Health Services, 2 to Disability Services, one to Breast Screen Tasmania, one to Orthotic Prosthetic Services Tasmania), one to a hospice and three to individual service providers. The investigations differed in seriousness and complexity, but most raised serious issues and in two cases, tragic outcomes with regard to two infants. One matter subsequently referred to the Coroner involved the issue of whether a medication error had contributed to the death of a woman in a hospice. Another concerned the standard of care at a district hospital and whether an earlier diagnosis and transfer to a tertiary hospital for treatment might have prolonged the patient's life.

Six investigations were conducted into complaints against MHS. One related to the future of the Huntington's Disease Register and associated blood and brain samples, and another encompassed two complaints into the one investigation relating to changes to the model of care and service provision by MHS and the withdrawal of some services from the Peacock Centre. The primary issue was whether the disbanding of the Mobile Intensive Support Team (MIST) serving a cohort of the

most seriously mentally ill in southern Tasmania was to the detriment of those clients and whether the changes to the service still provided an adequate service for this group. Recommendations for a clinical audit of ex-MIST clients and a report on MHS are the subject of a further 'own motion' investigation by the Commissioner. Another investigation related to a suicide while on leave from an acute care facility and another the assault of a patient by a co-patient in an acute care ward. The investigation into Disability Services related to the alleged assault of a client in supported accommodation, and quality of care issues.

In some investigations an adverse outcome followed surgery or cosmetic procedures and raised questions as to whether the surgery had been performed with due skill, and whether the consumer had been informed of the relevant risks. In one matter the complainant had suffered an adverse reaction to Dermalive®, a deep derma filler used in a cosmetic procedure. There is a public interest issue relating to product safety as in order to give valid consent, consumers need to be informed of potential complications, contraindications and risk associated with the product and the cosmetic techniques used. The Commissioner did not publish or table the report in Parliament as it appears that there is probably sufficient information now available throughout Australia and reputable practitioners would no longer use the product or would warn of the potential risks.

The following is a summary of the investigations undertaken during the reporting year.

#### ***Whether problems during resuscitation contributed to a baby's death***

A complaint was lodged against the Mersey Community Hospital, which at the relevant time was operated by a private company, Healthscope Ltd. The hospital is now the Mersey Campus of the North West Regional Hospital (NWRH) and is a public hospital. The complaint related to the death of the complainant's first-born child. It alleged that the NWRH provided poor obstetric care during labour and that the problems encountered during an attempted resuscitation might have contributed to the baby's death.

The complainant was admitted post term for induction of labour. Pethidine was administered during labour. After slow progress in the second stage, an episiotomy was performed. Shortly after, the baby was born in an unexpectedly poor condition with no heartbeat and no breathing efforts. Cardio-pulmonary resuscitation was commenced. Attempts to insert an endotracheal tube down the baby's throat were unsuccessful.

It was concluded that the complainant had some risk factors including post-term gestation, slow progress in the second stage of labour, heavy sedation and the use of pethidine as pain relief. The resuscitation attempts on the baby were not in accordance with the ILCOR Advisory Statement on Resuscitation of the Newly Born Infant as adrenaline was not administered when circumstances clearly indicated it should have been. The investigation established that there were some deficiencies relating to briefings at shift changeovers, and in relation to contemporaneous and relevant documentation in the health care records. Recommendations were made in relation to training in resuscitation. The NWRH provided a comprehensive report on the changes made and it is accepted that these changes will improve the quality and safety of care in the obstetrics unit. It was said by the NWRH that antenatal care had changed as a result of the death of this baby. Patients are encouraged to have a

greater input into their birthing plans and there is a program available for neonatal resuscitation for all staff and not just the midwives. Alternative pain relief is available and there is a new CTG machine, which allows a patient in labour to move around whilst still being continuously monitored. A recommendation was made that the hospital implement all guidelines recommended by the Victorian Council of Obstetric & Paediatric Mortality and Morbidity so that all placentas in cases of foetal death, and where possible in early neonatal death, are sent for pathological examination.

### ***Remote area transfers***

A complaint was made against the Launceston General Hospital (LGH) and the Tasmanian Ambulance Service (TAS). The complainant believed that the delay in TAS transporting her to the LGH, her antenatal care and her care on admission contributed to the stillbirth of her son.

The complainant was transported by TAS, from St Helens to the LGH. There were delays in the transfer such as a request for reassessment by the paramedic, the collection of volunteers, changing of vehicles and other delays of a private nature unrelated to the complainant's needs. During the second stage of labour at LGH, thick meconium was noted, and the foetal heart could not be heard. A stillborn baby was delivered with no discernible heartbeat. Resuscitation was attempted in accordance with the ILCOR Guidelines on Neonatal Resuscitation.

The medical practitioner providing the complainant with antenatal care advised the complainant to move closer to Launceston from 37 weeks gestation until the birth. The complainant did not do so, partly because she not aware that the Patient Travel Assist Scheme (PTAS) could assist and that accommodation in the Spurr Wing of the LGH could be arranged. She regrets not having attended the clinic and hospital when advised.

The conclusion was that although there were delays in the transfer, these delays were not causally related to the adverse outcome. The care provided by the LGH was of an acceptable standard although the foetal monitoring by the midwife during the second stage of labour was less than optimal. This is contrary to the recommendations in the Intrapartum Fetal Surveillance Clinical Guidelines. There was one attempt at auscultation although the LGH submitted that subsequent auscultation did occur but was not recorded. Further, there was a failure by the midwife to contact the RMO on the complainant's arrival, as required by LGH protocol.

The cause of the infant's death could not be clearly established, but had the mother moved closer to the LGH prior to the birth as recommended by the complainant's medical practitioner, then there might have been a better chance of managing any complications arising during labour.

A recommendation was made that information about PTAS and existing LGH accommodation services needs to be more widely disseminated so that pregnant women with a medium to high-risk pregnancy living in remote areas can reside close to a hospital with obstetric facilities. It was also recommended that the DHHS ensure that all public hospitals implement the draft guidelines issued by the Council of Obstetric & Paediatric Mortality and Morbidity for the investigation of unexplained stillbirths, in order to help determine the causes and help prevent recurrences.

### ***Whether a hysterectomy was necessary***

The complainant believed that a hysterectomy performed eight years ago was unnecessary and lodged a complaint against two surgeons practising at the NWRH. The Commissioner exercised the discretion available under the Act to accept the complaint on the basis that the complainant first became aware that the hysterectomy was unnecessary in 2005.

A surgeon had diagnosed endometriosis following a laparoscopy and advised the complainant that the only option was a hysterectomy. The surgeon who performed the hysterectomy informed the complainant that he saw no evidence of endometriosis. The hysterectomy deprived the complainant of having other children before she was ready to relinquish this, and she claimed that as a consequence, she suffered depression and loss of self-esteem.

Expert opinion concluded that it was reasonable for the surgeon to proceed with the hysterectomy in the absence of endometriosis as the complainant had also complained of dyspareunia, dysmenorrhoea and menorrhagia, but the consultant was at a loss to explain the discrepancy between the initial findings at laparoscopy and the findings at hysterectomy because "*spontaneous resolution of active endometriosis...is not likely*" and "*adhesions do not resolve spontaneously.*" The conclusion was that the hysterectomy was not performed unnecessarily and was made to improve the complainant's quality of life based on clinical judgment. On that basis a recommendation for a referral to conciliation was not made, as there was no compensable loss.

### ***Multiple presentations at Emergency***

A complaint was lodged by a woman on behalf of her deceased husband relating to his treatment at the NWRH. The patient had six presentations to the Department of Emergency Medicine (DEM) within a relatively short time frame, three admissions to Surgical West and one admission to Spencer Clinic before it was ascertained that he was seriously ill. Ultimately the outcome would have not altered in that this patient would most likely have died from cholangiocarcinoma. This is a rare condition and based on epidemiology, only four patients a year would be diagnosed in Tasmania. The prognosis is generally poor. Expert opinion is that it is difficult to provide an early diagnosis for this condition but it causes quite serious symptoms, sufficient to warrant a referral to a specialist, where it would usually be discovered. The opinion was that the care and management of the patient at some of the presentations at DEM was "*not up to an expected standard*" and his symptoms "*should have been reviewed by a more senior clinician from DEM or if unavailable an inpatient registrar/consultant*".

The multiple presentations, the failure to refer to test results and the absence of adequate reviews or referrals brought into question the level of experience of the medical practitioners in DEM and whether the arrangements for review by senior medical practitioners were operating effectively. The expert commissioned to assist the investigation suggested that there should be operational guidelines for referral to a more senior staff member. The NWRH agreed to develop guidelines for all category 3 and above patients, with the guidelines to be based on the following principle: "*Triage category 3, multi-system disorder, co-morbidities, should be seen by or the*

*case presented to one of the rostered senior doctors or in their absence an inpatient team”.*

A further issue under investigation was whether the patient’s co-morbidity and his mental state distracted some of his treating medical practitioners from a thorough examination of his physical symptoms. The conclusion was that this patient’s mental state appeared to have prevented the treating doctors from carrying out further diagnostic tests. The expert commented that this is well documented; less experienced doctors are sometime persuaded that the patient’s mental state is responsible for serious symptoms and as a consequence such patients are not investigated as fully as patients without a mental health disorder. There were also deficits in the patient’s nursing care and his transfer to a tertiary institution for review took five days, which was an unacceptable delay in the circumstances.

### ***Deficiencies in care at the George Town District Hospital***

The complainant lodged a complaint on behalf of his deceased wife about the standard of care provided to her by staff at the George Town District Hospital (GTDH). It was claimed that the staff failed to respect her privacy and dignity, exposed her to an infection, and failed to act in a sensitive manner in dealing with her personal belongings after her death. A written apology was made for the failure to afford the woman privacy and for the manner in which her personal belongings were returned.

The complainant’s wife was admitted to the GTDH with possible pneumonia. She was transferred to the LGH [Launceston General Hospital] and diagnosed with advanced stage lung cancer for which she commenced chemotherapy treatment. She was transferred back to the GTDH and then again to the LGH. She was diagnosed with neutropaenic sepsis post chemotherapy and died three days later. The complainant alleged that at the GTDH his wife was transported in a patient sling from her room down the ward passage past patients and visitors to the ward toilet without wearing underwear.

Further issues were whether the complainant’s wife was exposed to infection which contributed to her death, and whether her standard of care was adequate. As a consequence of having undergone chemotherapy treatment, the complainant’s wife was susceptible to infection and had shown early signs of neutropenia. It was found that the nursing observations and documentation at GTDH were inadequate and there were deficiencies in her nursing care. The complaint about cross infection from a patient in the shared ward however was not substantiated. It was clear that the GTDH at that time did not create a satisfactory environment for patient care but as indicated in the section of the report relating to Health Services, action has been taken by DHHS to address these matters.

### ***Delays due to a shortage of Neurologists at the Royal Hobart Hospital***

The complaint concerned alleged delay in the provision of a range of medical services at the Royal Hobart Hospital (RHH) for the treatment of schwannoma (tumour) from the thoracic region. The delays primarily concerned the Neurosurgical and MRI imaging units. The investigation found the complainant had experienced a delay in receiving an MRI scan but that the delay was due to the replacement of the MRI equipment within the unit. The RHH had implemented a temporary procedure to outsource some more urgent MRI appointments during this period but the

complainant at that time did not appear to meet the clinical criteria and was therefore required to wait for the first available appointment within the RHH. The delay was not found to indicate a broader operational deficiency in the provision of MRI services at the RHH.

The complainant had also experienced delays in receiving clinical appointments with the Neurosurgical Unit but it was found that the delays were attributed to the shortage of neurologists during a difficult operating period in 2005. The difficulties were found to be due to staff leaving and the associated challenges of recruiting replacement specialist staff, which is continuing to be addressed. It was concluded that the RHH could have provided more consistent communication through a single point of communication with the complainant during the period he was required to attend various appointments across a range of units.

It was recommended that in the future, when an unusual delay is anticipated in the provision of services, that all staff and patients should be clearly informed of the delay. The appointment of Elective Surgery Liaison Nurses during 2006 provides a single point of communication for the range of medical services to patients and should effectively facilitate the dissemination of this information to staff and patients.

#### ***Whether a gauze swab was left following surgery***

A mother lodged a complaint on behalf of her young son who underwent surgery for the repair of a cleft palate when he was 10 months old.

The mother noticed an increasingly unpleasant odour coming from the infant's mouth and nose and the infant was referred for the examination of both nostrils and the nasal space under anaesthesia. A foreign object was found in the right nostril and removed. The operation report notes that "cotton wool" was found. An independent examination of the foreign object was undertaken by Forensic Science Service Tasmania. The Laboratory Report noted the specimen to be "*clear colourless polyester fibres*". An examination of a sample of the composite sponge that would have been used during surgery was also undertaken. The pathology report noted that "*The morphology of the polyester fibres of the stitching thread of item 2 was different to that of the polyester fibres from the previously submitted item 1 and consequently these fibres could not share a common origin*".

The conclusion was that the foreign object removed from the infant's nostril was not left behind from the operation. The question as to how the foreign object became lodged remains unanswered and is unlikely to be capable of resolution.

The case illustrates that considerable investigative work might be undertaken before it is established that a complaint is not substantiated. However, by utilising the health complaints system the complainant had the benefit of a complex matter being investigated by an independent body at no cost to her, whereas the cost of litigating this matter could have been significant.

#### ***Application for a Guardianship order by the Launceston General Hospital (LGH)***

The complainant was critical of diagnosis, treatment and care she received at the LGH's Department of Emergency Medicine (DEM) during her eight month hospitalisation, and of an application made by the LGH to the Guardianship and Administration Board (G&AB) for a guardian to be appointed in respect of her affairs.

The complainant had presented at DEM on two occasions with left-sided weakness, slurred speech, photophobia, dull headache and neck pain. She was sent home following assessment on both occasions. Two days later she was admitted to a private hospital where she was diagnosed with brain stem infarcts. Six days after her discharge from the private hospital she presented at DEM due to further deterioration and was admitted.

Expert opinion concluded that the incorrect diagnosis was made on the second presentation and it may have been prudent to admit the complainant at that time. However, it was not possible to determine whether her admission would have altered the occurrence of ischaemic infarcts. A review of the hospital medical records revealed that the complainant received the requisite standard of care expected for a person recovering from a stroke.

The hospital made an emergency application to the G&AB when the complainant chose to self-discharge against medical advice. The LGH was in an invidious position as they considered that there was no *responsible person* prepared to care for the complainant, support services had not been put in place, she was an on-going suicide risk and she was impaired in her decision making capacity.

A psychiatrist reviewed the complainant and recorded that she had “*inappropriate effect*”, “*little insight*” and her “*capacity [was] impaired.*” The psychiatrist noted that she was “*not able to appreciate the risks of going home...I am worried about her likely ongoing suicide risk . . . I do not believe that [she] has capacity as she cannot appreciate the consequences of her decisions...A Guardianship Order is necessary to keep her safe and facilitate her placement.*”

The complainant obtained legal representation for the hearing and incurred legal costs. The conclusion was that it was appropriate for the LGH to have applied to the G&AB in the circumstances. However, they should have informed the complainant of the process, and of her rights and relevant advocacy and legal services. The LGH agreed to make an ex gratia payment towards the complainant’s legal costs of \$550, and \$600 towards counselling. It also agreed to appoint a staff member to take a lead role in any applications to the G&AB, receive training in relevant legislation, consult with all involved personnel and provide the person subject to the application with information regarding their rights and details of legal and advocacy services.

### ***Charges on reclassification to non-acute patient care***

The Act provides grounds for a complaint that a health service was not provided *in language and terms understandable to the user, with sufficient information on the treatment and health services available to enable the user to make an informed decision.* The following investigation involved the question of informed financial consent.

The complainant’s husband had been an acute care inpatient at the LGH. When he was re-classified from an acute patient to a non-acute patient, he was transferred to the GTDH where he remained for about three months. He was charged \$3,692 for accommodation as a ‘*nursing home type patient*’. Public hospitals throughout Australia are able to charge bed-day fees to inpatients whose length of stay is greater than 35 days and whose doctor declares the patient to be non-acute. The LGH apparently informed the patient of the change in his patient status. The complainant claimed that she was not advised that there would be a charge for her husband’s accommodation and sought a waiver of payment of the accommodation charges.

The issue under investigation was whether informed financial consent had been obtained. This requires the hospital to inform the consumer or person responsible for paying the account of the cost of that care and how the charges arise. The conclusion was that the patient and his family were not adequately informed about accommodation fees, and hence did not provide informed financial consent. It was recommended that a waiver of the outstanding accommodation fees should occur and that accounting practices alter. This was accepted by the DHHS.

The complainant was also critical of the standard of personal care provided by the nursing staff to her husband at the GTDH and various incidents, largely relating to the patient's incontinence and the attitude of staff, were the basis of complaint to the hospital, to this Office and to the DHHS.

The patient had requested a urine bottle and was told by nursing staff that he should urinate in his nappy. The call bells didn't function during a power blackout, and on another occasion the buzzer used to alert staff was unplugged. Clinical charts were completed irregularly, and it was noted that the medication charts showed that prescribed medication for pain management was withheld or not given when due with no explanation as to why. A diabetic chart had been completed over 5-6 days but with no entry or record to indicate that the patient had diabetes. Care plans were inadequate. A visiting health professional had previously raised concerns about the nursing staff's attitude to aged persons and persons of ethnic background.

The DHHS conducted a comprehensive audit of the GTDH, identifying a number of critical systemic issues that impacted on the quality of care provided. The audit concluded that the nursing care provided to the complainant's husband by GTDH was not of an acceptable standard in many respects and his incontinence was not managed according to contemporary clinical standards. A recommendation was made that the hospital reinforce appropriate methods of patient care and communication and implement a strategy for nursing staff to roster their breaks so that there is always a nurse on duty to ensure client care requests are responded to adequately. The DHHS issued an apology to the complainant, and reported on the actions taken in response to the complaint and the review, which included substantial renovations to the hospital.

### ***Whether compensation follows a suboptimal outcome from surgery***

The Act provides grounds of complaint relating to whether *a health service provider failed to exercise due skill* and whether the health service user was provided *with a reasonable opportunity to make an informed choice of the treatment or services available*.

A complaint was made against a surgeon and a public hospital, which alleged that the complainant was unable to walk properly since the performance of a left bunionectomy to correct a hallux valgus deformity. The complainant submitted that had she been made aware that the functionality of her foot would be compromised, she would not have consented to the operation.

An orthopaedic surgeon commissioned to review the outcome concluded that the surgery was performed with due skill and that the valgus deformity was corrected with a very good cosmetic result and stability of the metatarsophalangeal joint. His opinion was that the complainant had suffered an unfavorable early outcome in terms of functionality, which he said is not uncommon in this condition. He stated that the

functional result was suboptimal due to the presence of pain and difficulty in the complainant loading the left forefoot. He thought she might have some entrapment of the sensory nerve branches in the surgical scar making the area sensitive and painful and that a pre-existing condition may have contributed to the early unfavourable outcome. He was of the opinion that that the function of her left forefoot would increase with the passage of time but a small degree of permanent impairment was likely. He was also of the opinion that the claimed symptoms *“are out of proportion to the objective findings and that there is obviously a psychosomatic condition related to the surgery”*.

On the issue of whether the complainant had given valid consent, it was noted that she had signed a consent form which referred to risks and outcomes. The conclusion is that she was warned of the risks but may not have fully comprehended them. The matter was not referred to conciliation as it could not be established that the surgeon had *failed to exercise due skill* or that the complainant had not been informed of the risks associated with surgery.

### ***Palliative care – quality of care issues***

The Commissioner conducted an ‘own motion’ investigation into a non-government organisation. The matters under investigation related to the circumstances surrounding the death of a patient at a private hospice/palliative care unit, and whether the patient’s death could be attributed to a medication error. The hospice offers specialist care to persons in need of supportive terminal care.

The patient was transferred to the hospice for pain relief and symptom control and died 4 hours and 15 minutes after being administered Clonazepam.

The question under investigation was whether the dose was unusually large and caused or contributed to the timing of the patient’s death. The patient’s death was not reported at the time to the Coroner although s 19 of the *Coroners Act 1995* required such action. Central to the investigation was whether the palliative care service provided was in accordance with accepted palliative care therapeutic practice.

Expert opinion was that the amount of Clonazepam administered to the patient was a very large dose which may have contributed to the timing of death and would have been questioned by a nurse with palliative care experience. The dose was *“substantially higher than usual clinical practice and accepted palliative care therapeutic practice in Australia and internationally”*. The consultant thought that the cause of death was *“inherently more likely to be multifactorial and hard to determine”*. He went on to advise that *“it is normal practice in palliative care to start at the lower end of a prescribed range and titrate upwards, unless there are pressing reasons to the contrary.”*

The sole nurse on duty at the hospice was a nurse with little palliative care experience and no specialist palliative care nursing qualifications. Her only induction to the hospice was two orientation shifts and she had not undergone any professional development during her employment. At the time she was not required to undertake annual drug competency testing and the drug Clonazepam was not a drug she had administered often.

The hospice did not employ nurses with palliative care experience on the night or weekend shifts. The investigation found that this practice was not appropriate and it was recommended that this should cease forthwith. Alternatively, if nurses with

palliative care qualifications were not available, then the hospice should select registered nurses and provide the relative palliative care training or provide resources to train the nurses to attain competency in palliative care.

The consultant considered that the patient's oncological history placed her in a category of '*high risk*' for poor cancer pain control and that specialist palliative medicine inpatient management would normally be regarded as essential. He questioned whether this patient would have been more properly managed in a designated or dedicated palliative care bed at a public hospital, in close proximity to oncology services. On the basis of the consultant's review, the conclusion was that this patient probably required acute hospital care for radiotherapy to improve pain control and that a request for urgent re-assessment and consideration of emergency radiotherapy would have been beneficial.

Another systemic issue that arose during the course of the investigation was the credentialling system for granting medical practitioners the right to admit patients. In this instance the hospice did not follow its own credentialling procedures.

It was concluded that the incident should have been the subject of a comprehensive clinical audit and evaluation, informed by a palliative care specialist and that the matter should have been reported to the Coroner. The hospice has since acted to enhance the palliative care service by appointing a number of well credentialled specialist staff, establishing a Clinical Audit Committee, reviewing their Medical Staff Association Rules and By-Laws, Policies and Regulations and revising a number of their policies and procedures. A Palliative Care Specialist Nurse Manager has been appointed and a Consultant Physician with extensive relevant experience has been appointed as Medical Director. A Medical Advisory Committee has also been established.

### ***An adverse outcome from a dental extraction***

The complainant had her lower right premolar removed and claimed that the dentist applied excessive force which left her with extreme post-operative pain and discomfort. She further claimed that as a result of the difficult extraction, she suffered Temporomandibular Joint Pain Dysfunction (TMJ), otherwise known as "clicky jaw", and continues to suffer a number of on-going physical and psychological conditions. She sought compensation for pain and suffering.

The dentist stated that he was of the view that the matters in the complaint were unrelated to the treatment he provided and that the extraction was dealt with correctly and in line with current treatments. He also claimed that the consent form covered any complications arising out of the surgery.

An independent oral & maxillofacial surgeon examined the complainant and provided an expert report, which suggested that the difficult extraction might have exacerbated pre-existing TMJ. The other physical and psychological conditions complained of would not, in his view, have been caused by the dental surgery. Further, the dry socket and infection which the patient had also complained of, were common complications about which she had been warned. The surgeon advised that the provider dealt with the extraction according to correct and current treatments, but that there were some deficiencies in the records and that they could have been more detailed.

The complainant denied that the TMJ was a pre-existing condition and maintained that she should have been warned of this risk. Expert opinion was that the provider did not need to warn of this particular risk.

The conclusion was that the complaint was not substantiated. The complainant had an abscess which necessitated the extraction. She was in great pain, and it was likely that she would have proceeded with the extraction even if she had been warned of the risk. It was concluded that the dentist needed to be mindful of his responsibilities regarding the making and keeping of clear, accurate, and contemporaneous patient records. The Dental Board of Tasmania was consulted and sought a referral relating to some aspects of the complaint.

### ***An adverse outcome from a cosmetic procedure***

A complaint was made against a medical practitioner by a woman who alleged that she had suffered an adverse reaction to Dermalive®, a deep derma filler used in a cosmetic procedure in 2001.

In or about 2004 the complainant began to experience pain and was aware of lumps having developed in the areas injected during the cosmetic procedure. She sought access to her medical records and information from the doctor about the filler used, without success. A plastics and reconstructive surgeon operated to remove the lumps and advised her that, in his opinion, the lumps were a late-onset granulomatous reaction following the injection of the product Dermalive®. Further lumps emerged and the prognosis is that further surgery will be required.

A plastics and reconstructive surgeon provided an opinion on a *pro bono* basis during the investigation.

The conclusion was that the doctor knew or ought to have known of the risks involved with the use of Dermalive®, and that prospective patients should have been warned of those risks. At the time of the introduction of Dermalive®, it was documented that one of the potential risks was inflammatory granuloma formation and that, although rare, this should be covered in any pre-operative discussion with a patient contemplating the use of the product. The doctor maintained that he knew of the relevant risks, warned the complainant and provided her with the product information. The complainant stated that she did not receive the product information and that she was not informed of the potential risks. This was corroborated by a friend who accompanied her to the appointment. The conclusion reached was that the doctor failed to warn the complainant of potential complications and risks. The matters were resolved at conciliation.

### ***Billing practices in private hospitals***

A complaint was lodged against two private hospitals relating primarily to administrative and billing matters. The complainant, a tourist, was admitted to the first private hospital for the treatment of injuries and was transferred to the second private hospital the same day. The complainant had travel insurance, which included full medical cover and private health international cover, and had the policy documents with him. Neither hospital made a reasonable attempt to contact the complainant's insurer, primarily due to the policy of requiring an up-front payment prior to treatment.

In any insurance cover the insurer needs to be satisfied that the cover is activated and that they are liable to indemnify the insured. In this case, the insurer needed a written report of the injuries requiring treatment before it would confirm liability to meet the cost arising under the policy. The complainant believed that the hospitals ought to have forwarded medical reports to his insurer and arranged for the accounts to be met.

The second hospital stated that at the time of the complainant's admission there had been no confirmation of acceptance of his hospital charges by his health/travel insurer, hence the provision of an interim account. They stated that it is their normal practice to obtain acceptance of liability by an insurer prior to the admission of patients, or acceptance of responsibility for the account by the patient for either the full cost of treatment or any gap costs. For all "nil insured" patients, ie those for whom at the time of admission an insurer has not accepted responsibility for the account, payment for the estimated costs is required prior to admission.

The complainant objected to being presented with an invoice charging for more than the estimated period of admission. The complainant stated that it was estimated that he would require two days hospitalization, but he received an invoice for four nights. It was required to be paid immediately or the surgery would not proceed. The explanation provided by the hospital was that the initial invoice was for an estimate of the costs he would incur whilst an inpatient. The hospital stated that they take their obligation of informed financial consent seriously and that until a procedure has occurred, the final invoice amount is not known. To assist in this process, "quotes" or interim invoices are provided.

A recommendation was made that both hospitals consider adopting the hotel practice of impressing a credit card at reception and later revising the amount charged. If the claim is not accepted prior to discharge then the final account can be debited against the card. This would balance the hospital's need to secure a payment against the need of an injured person who requires an emergency admission. This would have allowed the complainant to be admitted, the medical report to be sent to the insurer, and the charges accepted by the insurer prior to the patient being discharged. If such a practice had been in place the complainant would not have had to meet the charges personally.

### ***BreastScreen Tasmania***

A medical practitioner who self referred to BreastScreen Tasmania (BST) lodged a complaint when BST refused to provide her with her pathology results and insisted that they be provided to a nominated GP.

Routine mammography detected an abnormality and the complainant, a GP who had worked for about two years in Palliative Care Services, had been recalled for further testing. As she had recently moved interstate and anticipated an adverse result, she was reluctant to nominate an unknown GP. The BreastScreen policy was that results must be sent to a GP and not be given to the patient directly. She sought an exception to this policy but was refused. She then nominated her husband, also a medical practitioner, but BST adhered to policy.

Given the complainant's experience and background and her clearly expressed wish to receive the test results directly, it would not have been unreasonable for BST to depart from its policy. The conclusion reached however was that BST had made its

decision in good faith and with regard to the potential long-term psychological impact of a diagnosis of malignancy being communicated without adequate psychosocial support.

There were further concerns relating to BST's communications with the nominated medical practitioner, its failure to forward the mammogram to the complainant's surgeon and its unsatisfactory system for recording calls. The conclusion was that the administrative arrangements within BST in this instance were unsatisfactory and that a message record-keeping system was required. BST has since implemented a system which electronically records and archives incoming phone messages. It was recommended that the report of this investigation be referred to the Cancer Screening and Control Services' Consumer Reference Group and Policy Review and Quality Management Committee as the investigation had revealed systemic problems within BST. A recommended apology to the treating surgeon was not forthcoming.

### ***Audiologist – hearing aid – standard of care***

The issue in this complaint was whether hearing aids supplied to the complainant were fit for their intended purposes and whether the provider's action in retaining part payment was reasonable after the complainant withdrew from treatment and requested a full refund.

The complainant attended a private health provider for testing and treatment for hearing loss. He agreed to the provision of hearing aids and clinical care for a period of twelve months at a cost of \$7000. He paid a deposit of \$4500. During the rehabilitation process the complainant reported the hearing aid changing program by itself and making hissing and squealing noises. He reported similar hissing problems with replacement hearing aids. The hearing aids were tested by the laboratory and the manufacturer but the problems were unable to be verified. After nine months of treatment, the complainant returned the hearing aids. He advised the provider that he was withdrawing from treatment and requested a full refund of the deposit. The provider reported that the clinical services provided to that date were \$2085. The provider retained \$700 as part payment for the clinical time and service provided and refunded \$3800. The complainant believed he was entitled to a full refund, as he had been able to obtain hearing aids through another service that operated effectively.

An independent expert was of the opinion that the level of service provided was thorough and showed good attention to detail. The opinion was also expressed that appropriate techniques had been used to resolve issues, and that appropriate information had been provided on services beyond hearing rehabilitation. It was concluded that the complainant was provided with hearing aids that were reasonably fit for their purpose with a satisfactory level of service, even though it was accepted that he experienced problems with the hearing aid. It was accepted that the provider was generous in its reimbursement of \$3800 to allow the complainant to seek further hearing assistance if he so desired. No recommendations were made.

### ***Huntington's Disease Register***

A complaint was made against Mental Health Services (MHS) which related to its management of the Huntington's Disease Register (the Register) and of associated blood and tissue samples, and to actions contemplated by MHS in relation to the custody of the Register and the samples. The complainant alleged that MHS had not complied with relevant legislation, regulations and best practice in the management of the Register and the samples.

The Register is a record of data in relation to all known Huntington's Disease (HD) affected individuals and families in Tasmania. Confidentiality is paramount. It has over 3,000 entries from 1842 to 1996, representing 10 generations of key Tasmanian families with a history of HD. The Register was used to provide a statistical prediction of HD. HD is a hereditary neurodegenerative disorder without cure or effective therapies, the symptoms of which manifest between 30 and 60 years of age with a progression from onset to death over a period of 15 to 25 years. The Tasmanian incidence is thought to be twice the rate of other Australian states and the approximate number of those affected or at risk in Tasmania is said to be between 600-800. With the identification of the HD gene in 1993 and the development of a direct predictive gene test, the Register became redundant and data collection ceased in 1996. Blood samples and brain tissue were also collected in conjunction with the family histories.

MHS has proposed that the Register be relocated to State Archives once they have formulated strict access guidelines and have had the guidelines approved by a Human Research Ethics Committee. The course of action proposed by MHS is considered appropriate.

Blood samples were located stored in a freezer at the Clinical School at the RHH. The samples were reportedly in poor condition with a number of vials broken and evidence of contamination. Some samples had been accidentally destroyed when a freezer housing some of the samples malfunctioned.

The question arose as to whether there was any clinical or research merit in retaining the blood samples. Genetic experts considered that the samples should be retained in order to do further studies. There was a further suggestion that DNA be extracted from the blood samples, which would provide another option for linking DNA data to the Register. Given the conflict in expert evidence, the conclusion reached was that prior to a final determination regarding the destruction of the samples, MHS should obtain further opinion from genetic experts and clinicians currently working with HD as to the value of retaining the samples. A recommendation was made to that effect.

### ***Mental Health Services – change in the model of care***

In December 2005, a complaint was lodged by an employee of the DHHS about proposed changes to the Medical Health Services' (MHS) model of care. It was alleged that the service then provided by the Mobile Intensive Support Team (MIST) known as Assertive Case Management (ACM) to a discrete group of the seriously mentally ill in southern Tasmania was to cease and MIST disbanded. The complainant considered that the changes would provide a less effective model of care and a diminution of the current service to this discrete group.

The primary issue for investigation was whether the proposed model would continue to provide effective treatment for this discrete group. If the new service with its altered ratio of clinicians to clients was not as effective for this discrete group, was this 'loss' counterbalanced by a greater number of clients receiving services? This raised an issue about equity in the distribution of resources. MHS is engaging in a reform process and acting to implement the Mental Health Services Strategic Plan 2006 – 2011, which reflects the National Mental Health Strategy. In the changed model of care the functions of existing specialist teams are embedded into three new multidisciplinary teams as part of a standardized, comprehensive range of services to be delivered throughout Tasmania. MHS maintained that the changes would result in

a significant distribution of services for a large proportion of the Tasmanian population and that greater access may prevent more serious mental illness developing.

In this investigation, it was clear that the complainant had valid concerns relating to the retention of MIST and the ACM model, and the proposed reforms. The conclusion was that the new model of care had the capacity to provide an improved quality of care, but that during the period of transition it was likely that there would be some adverse effects upon the discrete group of seriously mentally ill clients. The decision to disband the MIST service needed to be balanced against the needs of all clients statewide that require MHS. Historically, there were inequities in access and services between regions, particularly in the North and North West and the revised model and increased funding addressed these inequities. It was likely that the dispersal of the MIST team and the clinicians in the south having an increased client base could be to the detriment of ex-MIST clients. The question posed for investigation was what the cost associated with this approach would be and how it would be measured. Was the suicide rate amongst the seriously mentally ill likely to increase significantly and was this a known quantifiable risk? Was the frequency and duration of hospitalization in acute care psychiatric facilities likely to increase? If so, did these costs offset the costs of maintaining the ACM model and MIST?

In order to ascertain the effect of the changed service on this discrete group, the clinical outcomes of ex-MIST clients needed to be audited. A recommendation was made to that effect. Clinicians are to conduct annual audits of clients of MIST for two years following the introduction of the new model, to ascertain any variation in the outcomes for this group. MHS has accepted that recommendation and this information will be provided by January 2008. The implementation of the recommendation is presently the subject of an 'own motion' investigation by the Commissioner.

Other complaints were lodged about changes to the services currently provided at the Peacock Centre and about the adequacy of communication to clients about those changes. Information was sought as to whether there would be a downgrading of the services currently available, and whether rehabilitation staff and psychologists, and related support facilities such as the activities centre, occupational therapy and kitchen/dining centre would be retained. Having regard to printed information provided to clients and their families in relation to proposed changes, the information is clear and unambiguous. DHHS has advised that some services may eventually be relocated to areas of need or be assessed as to the viability of transfer to the non-government sector.

The genuine concerns expressed by clients and their advocates as to whether services were to be withdrawn illustrate the complexities and political sensitivities of managing change when clients and their families fear the loss of a service they regard as beneficial. It appears the initial information did not adequately address these concerns for some, and others objected to the proposed changes and sought to raise those objections through the media and the complaint process. The conclusion was that adequate information had now been provided, but services previously provided at the Peacock Centre may be altered, relocated or transferred. It was not appropriate that the Commissioner seek to forestall a policy initiative developed by Government, provided that it could be demonstrated that the decision making process was

informed. To monitor service provision, a further recommendation was made that MHS provide a progress report on the implementation of the Strategic Plan and the transition to the new model of care within 12 months of the date of the Commissioner's report.

### ***Mental Health – suicide while on leave from an acute care facility***

This investigation against MHS related to whether a person who was the subject of a Continuing Care Order (CCO) should have been discharged *on leave* from the Spencer Clinic within days of the Mental Health Tribunal (MHT) confirming the CCO for a further six months.

The complainant alleged that his brother was inappropriately discharged from the Spencer Clinic, that MHS did not provide adequate support and monitoring once he had been discharged, and that a copy of a psychiatrist's report for the MHT referring to suicidal and homicidal ideation should not have been provided to his brother.

One issue for investigation was whether it was inconsistent to discharge a patient subject to a CCO so soon after the MHT had confirmed the order in 2000. At the time the *Mental Health Act 1996* did not have a provision whereby those subject to a Community Treatment Order could be compelled to comply with treatment, and a practice had developed regarding those likely to be non-compliant, of obtaining a CCO and then granting leave, rather than making a Community Treatment Order. The *Mental Health Act 1996* has since been amended and there has been considerable effort both within the State and nationally to improve the delivery of mental health services. Significant funding has been allocated for that purpose.

In this instance, given the volatility of the patient's mental condition, the confirmation of the CCO was appropriate. A further issue was whether the discharge planning and follow-up support was appropriate. The follow-up arrangements for this patient were minimal. No finding was made regarding the patient having been provided with the psychiatric report as part of the Tribunal proceedings. The *Mental Health Act 1996* provides that on application some parts of the report can be withheld.

It is envisaged that the implementation of the Mental Health Services Strategic Plan will ensure a more cohesive and supportive transition between different aspects of the service, and in particular between being an in-patient in an acute care facility and being a client of MHS in the community, either having been granted leave or as a person subject to a Community Treatment Order. It is difficult to find the balance between the 'least restrictive alternative' for a person who is mentally ill and the level of care and support required in protecting that person and others from harm.

### ***Mental Health Services – an assault in Ward 1E***

A woman lodged a complaint in which she alleged that, while an inpatient of Ward 1E, she had been assaulted by another patient and as a consequence suffered on-going damage. She alleged that MHS had breached their duty of care, as the perpetrator of the assault was not removed after he had assaulted another patient. MHS apologised and acknowledged that her placement in High Dependency Unit (HDU) when the perpetrator was also there was not ideal and that other options ought to have been explored. MHS stated that the complainant was placed in HDU as she was at risk of absconding and did in fact abscond from Ward 1E.

The complainant was also critical of the actions of nursing staff on night shift in the HDU. She states she awoke about 1am and asked whether she could have a drink and a smoke. She said staff were involved in craft activities and kept telling her to go back to bed. Some time later she attempted to open the door and it was jammed shut as a chair had been placed in front it. A recommendation was made that MHS develop a professional development program for nurses to engage them during such periods during the night shift when direct patient care is not required, and encourage this in preference to personal non-work related activities.

MHS advised that the implementation of a number of the recommendations had already commenced. Shifts are now rotated between day and night, and nurses are required to undertake mandatory skill programs.

### ***Disability Services – treatment of a resident***

The complainant's brother was a resident at a Disability Services (DS) facility and, due to the resident's impairment, the Commissioner accepted the complaint pursuant to s 22(f) of the Act. It was alleged that a DS support worker witnessed a co-worker physically assault the resident and verbally abuse him. Criminal charges were laid. The case went to trial and the charges were dismissed. The issues raised involved the standard of care provided to the resident by DS.

During the course of the investigation, the complainant alleged that the resident was subject to retaliatory conduct by other support workers and that the actions of DS were inadequate. The resident had *special witness* status but when he was taken to court by taxi to determine whether he had the requisite capacity to give evidence, he was accompanied by two witnesses for the defence and was observed to be crying when he alighted from the taxi. Further, a vocal group of support workers who were supporters of the alleged perpetrator were present in court.

The conclusion reached was that while DS acted on the report of the alleged assault once it came to their notice, that action was delayed. The ongoing reports of support worker behaviour at the resident's home and at the trial were illustrative of the poor work culture at the site. It showed that the support workers lacked insight and had little concept of their responsibilities as employees and as carers of persons with disabilities. The resident's needs and interests were not managed appropriately and there was a breach in the standard of care which ought to have been afforded to him having regard to his disability, and the standards set out in the *Disability Services Act*.

KPMG conducted an audit and reported on the standard of care and level of client safety in DHHS homes. The report identified significant systemic problems and recommended changes to service delivery. This coincided with the release of "Living Independently", a government initiative to implement the KPMG report recommendations, including the transfer of DHHS group homes to non-government organisations.

While the government is commended for implementing the recommendations of the KPMG report, the privatisation of supported accommodation services for disabled persons does not obviate the need for accountability in DS and DHHS with respect to service provision. A recommendation was made that following the decision to move management of supported accommodation facilities to the private sector, DHHS

ensure that appropriate funding, accreditation, evaluation and on-going assessment procedures for non-government supported accommodation facilities are in place, that service standards are periodically reviewed by DHHS, and that a system be established to address any breaches of service standards.

DHHS is to provide the Commissioner with evidence of the implementation of the KPMG recommendations in April 2008. A recommendation was made and accepted that DS establish closer links with the Court and Police to ensure that the interests and welfare of DS clients are supported and represented.

### ***Orthotic and Prosthetic Services Tasmania – Prosthetic Limb Replacement***

This complaint relates to services obtained from Orthotic and Prosthetic Services Tasmania (OPST) to manage difficulties the complainant was experiencing with his right below knee prosthesis. The complainant believed that OPST did not provide an adequate service. His expectations were based on the service he had received interstate prior to relocating to Tasmania.

The complainant had a right below-knee amputation following a motor vehicle accident in 1965 and had worn a strap suspension prosthetic leg since that time. When he sought the service of OPST he specifically requested a foot type he had worn for the past 12 years, which he had purchased interstate. OPST did not agree with this request based on clinical grounds, including the need for the complainant to obtain treatment of a neuroma on his stump.

The issues under investigation were whether OPST provided the complainant with an appropriate standard of service and gave him sufficient information about the available treatment and services in order to make informed decisions.

Primary Health convened a Clinical Review Committee (CRC) to investigate the complaint lodged with this Office to identify and correct system weaknesses and to minimise the risk of recurrence. Recommendations made were aimed at addressing the issues raised and at improving service delivery, and were endorsed by the Commissioner.

During the investigation an agreement was reached with the complainant on the progress of clinical intervention and service provision, which was documented in an individual service agreement. OPST made a decision to fully subsidise the requested prosthesis.

The conclusion was that the complainant experienced difficulties with OPST due to his complex needs and as a consequence of the failure to provide a coordinated multidisciplinary approach. The complainant's expectations did not align with the service provided or what was available through OPST. This was due to a number of factors including his expectation that OPST provide a non-standard prosthesis at no cost, inadequate case management and difficulties with communication. OPST took appropriate action in conducting a clinical review of both the complaint and its governance processes, resulting in recommendations to be implemented with a progress report to be provided to the Commissioner.

## **CASES ASSESSED UNDER PART 4**

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The following case studies illustrate the nature of the cases dealt with during the reporting year and the actions taken as part of case resolution. Case Notes have been placed on the Office of the Health Complaints Commissioner (OHCC) website during the reporting year to better inform the public of the work of the OHCC.

A complaint is assessed to determine what is the most appropriate action to take. A number of factors will determine this, such as the seriousness and complexity of the case, whether compensation is sought and whether there are matters of professional misconduct or competency that need to be brought to the attention of a Registration Board. There are four approaches – to refer a matter to a registration board or other statutory body, to conciliate, investigate, or if appropriate to dismiss the complaint. Combinations of these approaches can arise.

The following case summaries are of cases that have either been dismissed or referred. As mentioned in the ‘Complaints Closed’ section of the report, most of the cases dismissed under s 25(5) of the Act were dismissed on the basis that *a reasonable explanation and information had been provided* or that the case had been *resolved*.

In the assessment of complaints this Office consults with the Registration Boards to determine whether a matter or any part of a matter ought to be referred. The regulatory system through the 11 Registration Boards governing individual registered providers exists to address breaches of professional standards and to ensure that providers are practicing ethically and competently. A Registration Board manages the profession through its regulatory and disciplinary powers. If an error has been made then the cause needs to be identified and an appropriate response taken, which may include requiring the provider to undertake further education.

Increasingly, the Registration Boards are working with institutional health services providers such as hospitals to ensure that standards are met by maintaining competency and skills. The Nursing Board of Tasmania (NBT) Care, Assessment, Remediation and Education (CARE) program illustrates this approach. The employer and regulatory authority may be satisfied that the cause of the error has been identified and, if this arises out of a lack of competency in a particular area of practice, then it can be addressed by retraining to acquire competency and a period of supervised practice to ensure that the knowledge and skills acquired in the retraining are being applied in practice. As the following case illustrates, errors can have tragic consequences and it constitutes professional misconduct to disregard systems created to minimise preventable errors.

### ***A matter for the Coroner, Conciliation and the Registration Board***

The following case involved the death of a patient as a consequence of a medication error and was a matter for the Coroner and the Registration Board. It was referred to conciliation for the purpose of negotiating compensation. A complaint lodged against the Royal Hobart Hospital (RHH) and two nurses was accepted as a third party complaint made by the deceased’s sister on behalf of the patient’s four adult children.

A patient in the Neurosurgical Unit of the RHH went into cardiac arrest 4 1/2 hours after being administered 5 times the prescribed dose of Methadone. He was revived and placed on life support, but failed to regain consciousness and died some days later. The complainant met with the RHH where the error was admitted and she was advised to contact this Office.

As a result of this death, the RHH has made changes to its practice, such as the withdrawal of Methadone syrup from all wards throughout the hospital and the placement of large red warning stickers on all high dose narcotics. The Pharmacy Department is to provide in-service education sessions on aspects of medication safety and narcotics for the Neurosurgical Unit.

The NBT dealt with the matters relating to the nurses by laying a charge of professional misconduct, imposing practice restrictions and requiring education and training to be undertaken.

### ***Changes to minimise dispensing errors***

As illustrated in this case, the Registration Boards have a significant role in monitoring and improving standards. This matter was referred to the Pharmacy Board pursuant to s 25 (1A) of the Act. The Pharmacy Board issued the pharmacist with a caution pursuant to s 52 (11) of the *Pharmacist Registration Act 2001* and required that he continue to implement changes in his pharmacy. These changes included the reworking of dispensary procedures, alternate ways of organising staff within the dispensary, the use of dispensary technicians, ensuring the consistent use of scanners and offering staff further training on complaint handling and dispute resolution.

### ***Codes of practice***

Codes of practice and other standards accepted by professional peers as appropriate professional conduct are applied by this Office in assessing whether a complaint ought be referred, and are also applied by Registration Boards. The issues raised in this complaint which concerned inter-personal boundaries, were referred to the Psychologists Registration Board of Tasmania under s 25 (1A) of the Act.

The complainant was contacted by a psychologist on behalf of the psychologist's client, making claims about the complainant's judgment and requesting that she reconsider her decision to end her friendship with the psychologist's client.

Having considered the complaint and oral and written explanations from the psychologist, the Board found that her actions amounted to a transgression of sections 1.1 and 1.7 of the Psychologists Code and that the matter of complaint had been substantiated. The Board required the psychologist to submit to professional supervision and reporting arrangements were put in place.

### ***Sexual relationships with vulnerable patients***

As illustrated by the following case, a sexual relationship between a nurse and a patient will invariably constitute professional misconduct.

In 2002, a nurse engaged in a sexual relationship with a patient at a private psychiatric clinic. At the recommendation of the nurse's employer, he undertook a course of study in legal and ethical issues. In 2005, the nurse engaged in an intimate

relationship with another patient. In this instance his employment was summarily terminated.

The clinic reported the nurse's conduct to the NBT who retained the matter with the consent of the Commissioner, and investigated it pursuant to s 57B(1) of the *Nursing Act 1995*. (Registration Boards are required to notify the Commissioner of all 'grievances' which could constitute a complaint under the Act. After consultation with the Board, and failing agreement, the Commissioner determines whether the matter will be referred to him or retained by the Board.) The NBT determined that the nurse not be permitted to practice in the area of psychiatric nursing.

As in the Ward 1E investigation undertaken by the Commissioner in a previous reporting year, this case should clearly demonstrate to the nursing profession and employers that intimate or sexual relationships with patients, especially those who are vulnerable because of mental illness, will constitute professional misconduct.

### ***Unregulated health providers***

A complaint was lodged against a masseur. The complainant alleged that during a session the masseur had conducted himself in a manner which, if substantiated, would constitute indecent assault. After discussion with the complainant the matter was referred to the police pursuant to s 25(1A)(a) of the Act. The masseur was charged with indecent assault and two charges of assault with indecent intent.

The regulation of alternative health providers was considered in an investigation report which was finalised during the previous reporting year, and tabled in Parliament. The Report recommended that the government consider the introduction of a Code of Conduct to regulate alternative health providers. NSW has since enacted legislation for the regulation of alternative health providers with power to prohibit an alternative provider from practising, and to publish the name of a provider found to have engaged in misconduct. The *Health Legislation Amendment (Unregistered Health Practitioners) Bill 2006* amended the *Health Care Complaints Act 1993* (NSW). The amendments permit the Health Care Complaints Commission to give public warnings about unsafe treatments and practitioners and to make prohibition orders against unregistered health practitioners who pose a risk to members of the public.

### ***Unrealistic expectations of the Tasmanian Ambulance Service (TAS)***

The issue raised by this complaint is whether TAS personnel acted appropriately when they refused to convey the complainant, an elderly woman, from her home to hospital. It transpired that the complainant had called for an ambulance on 16 occasions since January 2006, and had been transported to a hospital on seven of those occasions, but had not been admitted. The complainant was advised that TAS is an emergency service and that she should discuss her health concerns and needs with her GP.

The conclusion was that the refusal to transport the complainant to hospital was reasonable and that the complaint was not substantiated. A secondary issue was that a TAS officer had been rude to the complainant. This particular officer had come under notice before and had been counselled. TAS apologised to the complainant.

### ***Tasmanian Ambulance Service (TAS) unavailability***

The issue in this case was whether TAS should have regarded a terminally ill patient requiring transport to a palliative care ward, as an emergency.

A woman, whose husband was terminally ill, requested that her husband be conveyed to a palliative care ward where a doctor was waiting to admit him. Eighteen hours elapsed before TAS was able to respond. During this time her husband was in a considerable amount of pain and he died the following day.

TAS reported that they were unable to respond to the request on that day because of demand. Since then further funding has been provided to increase ambulance services and TAS are reviewing their procedures for referring non-emergency cases to the Patient Transport Service. The complainant accepted the explanation and apology offered by TAS.

### ***Unrealistic expectations by a consumer***

This complaint concerned the level of services provided by a dentist in 2002 and 2003, and although outside the two-year time limit, it was accepted by the Commissioner pursuant to s 25 (6) of the Act. The complaint related to temporary work done on a tooth and the reuse of an old crown on another tooth. The complainant considered that the crown should not have been reused and would have preferred a new crown instead. However, he consented to the reuse of the crown at the time for financial reasons.

Although a range of options might be available, the best option might not be affordable and a consumer who has given informed consent needs to accept responsibility for the choice made. The complaint was dismissed on the basis that a reasonable explanation had been given.

### ***An allegation of an assault while in hospital***

The complainant alleged that she was assaulted whilst a patient in a hospital and sustained broken ribs, severe bruising, and injuries to her arms and shoulder. The complainant believed that the actions of staff had caused her injuries and that she had been the victim of a criminal assault. Her belief was genuine, but the allegations were unfounded. The hospital responded that the injuries resulted from receiving CPR for a pulmonary embolism, which had saved her life. It was also claimed that the bruising could have resulted from existing kidney and liver problems.

The matter was dismissed on the basis that reasonable explanations and information had been given. Every endeavour was made to establish the facts and provide an explanation which the complainant could understand, to abate her anxiety related to the belief that she had been assaulted. Conciliation was not considered to be of benefit in the circumstances.

### ***Discrimination at an Adult Day Centre***

The complainant's grandmother was denied access to services provided at an Adult Day Centre (ADC). The complainant was told this was because the other residents were very "cliquey" and did not like her grandmother. The complainant felt this constituted discrimination against her grandmother who had been accepted as a client of ADC. The DHHS apologised and stated that the complainant's grandmother

would be welcome back to ADC at any time. Further, they provided the complainant with information about organisations and services that could assist with her grandmother's needs.

The complainant accepted the responses and apologies but stated that her grandmother would not be utilising the ADC's services. As a result of this complaint ADC staff were to receive additional training regarding sensitivity, diversity and conflict resolution, and particular clients were to receive sensitivity sessions. The complaint was dismissed on the basis that the complaint had been resolved.

### ***Financial abuse of a client with a disability***

A man with a physical disability and living alone was being supported by a tenancy support service, Optia Inc (OI). The complaint alleged that a support worker took money from the man's wallet to take him to the doctor but, as he was bulk billed, the money was in effect taken from him.

The support worker denied the allegation. OI advised that as the man was living independently and was only provided with support for part of the week, there was not the same requirement to provide receipts and accounts of spending by support workers as there would be in a group home environment.

It was concluded that there was insufficient evidence to substantiate the claims made and the complaint was dismissed. OI contracted a psychologist to conduct a survey of relevant tenancy support clients and their families. The survey was broad with the aim of flagging any issues of concern that clients or their families had in relation to OI staff and services.

### ***A failed tubal ligation***

The complainant had a tubal ligation performed at a private hospital in 2002. She conceived and gave birth in 2004. The complaint was out of time but accepted by the Commissioner, as the reasons for not lodging the complaint within the time limit included the illness and death of her eldest child and her own ill health. The matter was referred to the Medical Council of Tasmania (MCT) pursuant to s 25 (1A)(a) and it reported that the doctor had "*made an error of judgment and a technical mistake*" in a procedure which has an acknowledged failure rate.

The MCT considered that this appeared to be an isolated incident and not a case where the level of skill and care was so lacking that further intervention was warranted by way of disciplinary proceedings. Accordingly the MCT dismissed the complaint.

The matter was suitable for conciliation. The complainant was willing to attend, but had issued a writ to remain within time under the *Limitations Act*. The doctor was not willing to participate and the matter was settled out of court. In most other jurisdictions it appears that legal practitioners contracted by indemnity insurers to represent insured defendant providers are more receptive to participating in conciliation as an alternative to litigation.

### ***An accidental needle stick injury***

An elderly woman underwent a varicose vein procedure during which she suffered an accidental needle-stick injury. She complained that the medical practitioner failed to provide adequate information about the procedure, that she suffered a complication, namely a clot in her leg, and that she had to obtain and pay for medication to be injected. The medical practitioner provided a reasonable explanation and apology. He stated that he does not supply the injection medication himself, and was of the view that he had explained the procedure in detail. This was consistent with his notes. He apologised for inadvertently pricking the complainant's leg and stated that at the final review there was no evidence of any complications.

In many instances there is a gap between the information the provider believes they have imparted and the information understood by the consumer. One factor in this is that the language used is often technical and the consumer may be receiving the health service or undergoing a procedure for the first time and be unfamiliar with the technical terms. While the complainant did not readily accept the explanation and apology, the case was closed on the basis that a reasonable explanation and apology had been given.

### ***Who is entitled to information?***

The complainant was the legal wife of the deceased but separated from him. As the deceased had named his current partner as his next of kin, the LGH were reluctant to provide information to the complainant regarding his treatment and cause of death. She lodged a complaint countersigned by the deceased's adult son, as they were concerned that the death may have arisen as a consequence of a failure by the LGH to make a correct diagnosis.

The LGH provided a report to this Office with the Coroner's Certificate reporting the provisional cause of death. A copy of the final certificate was provided to the complainant once this had been issued. The complainant accepted the cause of death as reported and was prepared to accept the explanation of treatment provided by the LGH.

Health information is sensitive personal information. While providers are required to respect the specific direction of the patient as to the nominated next of kin, others may also be entitled to such information. In the circumstances, the wife and son of the deceased should have been provided with the information requested.

### ***Sterilisation procedures during orthopaedic surgery***

The complainant believed that she contracted a staphylococcus infection as a consequence of unsatisfactory sterilisation procedures at a private hospital during orthopaedic surgery. She sought compensation for expenses incurred.

The complainant was re-admitted following minor orthopaedic surgery for arthroscopic debridement of her left knee. Culture grown showed a moderate growth of *Staphylococcus aureus*. The complainant required a third admission to undergo a manipulation under anaesthetic of her left knee. She sought compensation to cover expenses such as physiotherapy and medication, and loss of income.

The hospital responded that the surgeon and theatre staff carried out all recommended skin care preparation and precautions, including preparing the operative site in theatre

with 'Betadine' and using sterile equipment and barriers in accordance with standard operating procedures.

Further, it is not common practice to screen for multi-resistant organisms after minor orthopaedic surgery. Infections after such procedures are uncommon, but are an acknowledged risk. Up to 60% of the population might be colonised with *Staphylococcus aureus* at any time. Further, the infection may have occurred at the time of surgery or post discharge from the complainant's own skin.

A further inquiry was made as to whether there had been other staph infections in other patients undergoing surgery at the same theatre on the same day with the same medical team. As no other cases were reported and the sterilisation procedures appeared appropriate, the matter was dismissed on the basis that a reasonable explanation had been given.

#### ***Whether an adverse reaction is attributable to treatment***

Some complaints are lodged in circumstances where the consumer believes that they have suffered an adverse reaction and as a consequence are suffering on-going symptoms. These matters can be difficult to assess, as in some instances the symptoms might relate to the person's condition and not to the treatment received. In the absence of any lack of due skill on the part of the provider and with insufficient evidence that the symptoms are causally related to the treatment, such cases are invariably dismissed.

This complaint concerned a consultation undertaken by a private optometrist and the complainant's belief that he had suffered an adverse reaction from drops placed in his left eye. The provider reported that the ongoing symptoms experienced by the complainant were attributable to symptoms the complainant had failed to rectify through the use of prescription glasses and eye drops and that the complainant had pre-existing injuries to the eye. The Optometrist Registration Board advised they were satisfied with the explanation of the provider and did not seek referral of the complaint. Further testing by the complainant's GP did not identify any clinical matters attributable to the consultation with the optometrist, and the complaint was dismissed on the basis that a reasonable explanation had been given.

#### ***Access to medical records***

A number of complaints to this Office and the Medical Council of Tasmania (MCT) concerned access to medical records. The reasoning in the MCT's decisions form a useful guide to the timeframe in which records should be made available and the costs which might reasonably be charged for providing a summary and photocopying records.

In one of the cases retained by the MCT, there was a delay of 6-8 weeks in providing access to medical records. Although the complaint was dismissed, the MCT indicated that it would encourage medical practitioners to adopt an approach that facilitates timely access to the patient's personal information.

## **REPORT ON HEALTH SERVICES**

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### **Correctional Primary Health Services (CPHS)**

The construction of the new Risdon Prison involved the commissioning of a new Primary Health Centre which, in combination with new policies and procedures, has significantly improved inmate access to clinical care.

In contrast to the old prison environment, nursing staff interactions with prisoners have increased from 300 to 900 per month (200%). This combined with approximately 400 medical appointments per month for a total prison population of approximately 500 gives a good indication of the level of service being provided. Intake screening has been improved to include baseline ECGs, diabetes testing, testing for Blood Borne Viruses, Liver Function Tests, Full Blood Count and testing for Chlamydia and Gonorrhoea. All prisoners were offered the flu vaccine this year with one quarter of prisoners taking up the offer. All female prisoners under the age of 26 are currently being vaccinated with Gardasil.

In previous years there were significant and seemingly intractable problems with the provision of dental services by Oral Health Services Tasmania to the prison population. These problems have been addressed by the actions of Correctional Primary Health Services. An interstate dentist was contracted during the year to address the lack of dental services. Urgent cases are usually seen within two weeks, and the waiting period for non-urgent cases has been reduced to six to seven weeks.

The following services are provided to Inmates –

- Assessment of the medical and mental state of each inmate on entry to the prison system, using the Tier 1 assessment system.
- Management of active health problems, including review of medications, treatment, existing conditions, counselling and drug and alcohol issues.
- Conduct of preventative health programs, including sexual health education, drug and alcohol education, immunisation, and lifestyle assessment and education.
- Care for the frail, disabled and elderly in the Prison environment.
- Inpatient care, including drug and alcohol detoxification and relapse prevention, preoperative and postoperative care, management of infections and trauma.
- Opiate Substitution Program medication provision.
- Outpatient allied health services referrals including forensic mental health, physiotherapy, dental and optometry.
- Support to the Tasmanian Corrections Service - Therapeutic Services psychologists and counselling staff with implementation of the Suicide and Self Harm [SASH] program.

The Clinical Director CPHS is also responsible for conducting quarterly reviews of the public health status of the prison system, under a statutory requirement.

A full review of medication management has led to the implementation of several strategies to improve safety of medication administration and ensure that medication management occurs in accordance with legislative requirements, and that nursing hours previously spent preparing and dispensing medications are focussed on delivery of primary health care.

A pharmacist and a pharmacy technician are employed to manage pharmaceuticals across all locations. A formulary has been developed to reduce off label prescribing and ensure that most medications will be immediately available. The prescribing and administration of emergency drugs has been rationalised and protocols for use changed, to accommodate current guidelines. *Webster* packaging has been implemented which will enable tracking of patient compliance and significantly reduce the risk of drug errors.

### **The Prison Arunta Phone access to the OHCC**

During the reporting year a project was undertaken to introduce phone access for inmates of the Tasmanian Prison Service to the Ombudsman and Health Complaints Commissioner through the Arunta phone system. The initiative was proposed to enable an alternative means for inmates to quickly gain access to information concerning the services available, and to enable simple complaints or enquiries to be more efficiently resolved. The Director of Prison Services and the Director of CPHS supported the initiative.

Phone access through the Arunta phone system is available at no cost to inmates from any Prison Service facility in Tasmania, including Risdon Prison, Hayes Prison Farm and the Hobart and Launceston Reception Prisons. The calls are not monitored and this Office funds the cost. A marketing program to inform inmates of the availability of the service was conducted at the commencement of the service. A report on the outcome of the trial will be included in the next annual report.

### **Ward 1E - The implementation of the recommendations**

An investigation of Ward 1E and Mental Health Services (MHS) matters under Part 6 of the *Health Complaints Act* in a previous reporting year, resulted in 26 recommendations aimed at improving the quality of care and standards in the acute care facility. The then Minister for Health, David Llewellyn, established a task force to implement the recommendations with the intention that substantial progress would be made within a 6-month timeframe. As reported by the Secretary DHHS on 17 July 2007, this implementation process is ongoing with 22 of the 26 recommendations having been implemented and the balance in the process of being implemented.

MHS have commissioned an independent auditor, Mr Peter Santangelo, to audit and review the taskforce recommendations for Ward 1E. The Terms of Reference are to –

1. Undertake an audit of MHS North progress in implementing the 26 recommendations of the Ward 1E Taskforce.

2. Identify all current and potential future issues on the Millbrook Rise Centre site, which impact (or may impact) upon the delivery of safe and quality service.
3. Develop recommendations to address these issues with (possibly) linked strategies, persons responsible and timelines.

A final report on the implementation will be made in the next reporting year.

### **Mental Health Services – the changed model of care**

The Clinical Audit of the former clients of the Mobile Intensive Support Team (MIST) and the review of the impact of the changes to the model of care is on-going as an 'own motion' investigation and will be reported in the next reporting year.

### **The Review of the George Town District Hospital (GTDH)**

The review assessed the quality of the care and service provided by the GTDH against Residential Aged Care Standards as, although the district hospital is not an aged care facility, it does provide a significant amount of care for older persons.

The review was completed in July 2005, and identified that of the 44 standards involved, there were two compliant areas, 37 non-compliant areas and five areas not assessed. A series of recommendations to address the non-compliant areas was made and amounted to a significant and extensive remedial action plan, which required additional resources and a program of ongoing monitoring and support for an extended period of time. The recommendations of the Review of GTDH and the Quality Improvement Plan are endorsed. These recommendations have been implemented. DHHS is to monitor this on an ongoing basis.

In addition, the recommendations from one of the investigations finalised by this Office during the reporting year were that all nursing staff undertake structured training in post-chemotherapy care and that all staff undertake training in maintaining and promoting patient dignity and respect.

The redevelopment of GTDH to provide a new integrated health facility commenced in May 2006.

## COMPLAINT STATISTICS

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### Complaint Activity

Table 1. **Complaint and Enquiry Activity**

Status of Complaints	2003/4	2004/5	2005/6	2006/7
B/Forward from Previous Period	98	86	138	165
Opened in Period	432	464	566	521
Closed in Period	496	440	587	536
Opened & Closed in Period	338	343	444	418
Carried Forward (Still Open)	86	138	165	176

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

Status of Complaints	2003/4	2004/5	2005/6	2006/7
B/Forward from Previous Period	98	86	138	165
Opened in Period	333	320	269	224
Closed in Period	377	282	290	238
Opened & Closed in Period	241	197	177	121
Carried Forward (Still Open)	86	138	165	176

### Complaint resolved by stage

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

Stage of Complaint	2004/5	2005/6	2006/7
Retained by Registration Boards s57 (1)(c)	32	29	24
Enquiries only	158	297	20
Early Resolution s25 (5) (j)	54	49	6
Dismissed (following assessment)	132	142	126
Referred to Registration Boards s25 (1A)(a)	33	24	10
Conciliated	23	29	37
Investigated	4	9	26
Withdrawn	4	6	2
Out of Jurisdiction		2	1
<b>TOTAL</b>	<b>440</b>	<b>587</b>	<b>252</b>

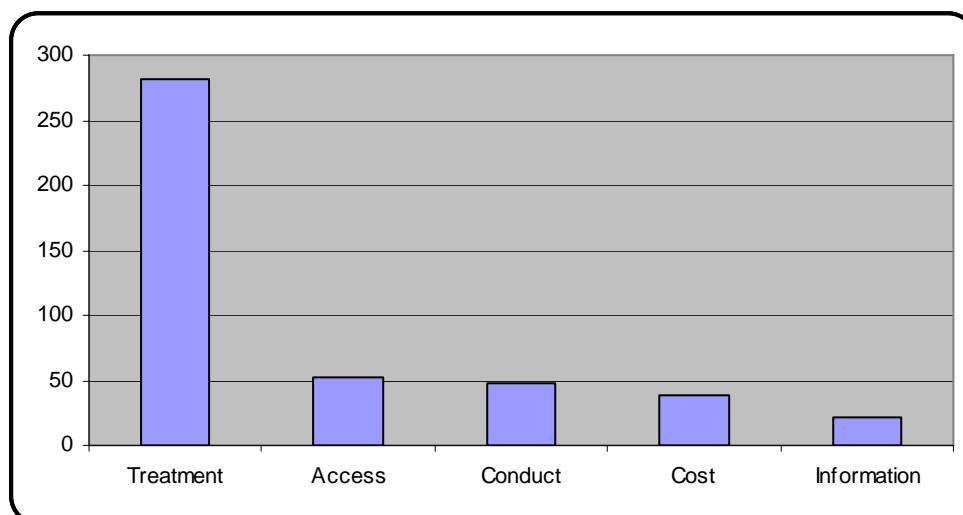
## Complaint issues

Table 4. Resolved Complaint Issues

Category	Issue	2004/5	2005/6	2006/7
Access	Access - waiting list for surgery	8	7	4
	Access discharge/transfer	2	1	1
	Access to transport	4	2	2
	Delay in admission	2	6	2
	Delay in treatment	23	17	14
	Discharge arrangements	2	0	1
	No/inadequate service	34	24	21
	Non attendance	3	0	0
	Refusal to refer	1	2	0
	Refused admission or treatment	12	22	8
	Transfer unsuitable		1	0
	Sub-total		91	82
Cost	Inadequate information on costs	10	23	10
	Fraud		1	1
	MEDICARE schedule fee issue	3	0	3
	Overcharging	13	11	6
	Private health insurance matter	4	0	4
	Unsatisfactory billing practices	20	19	14
	Sub-total	50	54	38
Decision Making	Consent not informed		1	1
	Consent not obtained	1	3	1
	Failure to consult consumer	3	4	1
	Over-servicing/unnecessary treatment	6	0	
	Refusal to treat	6	0	2
	Sub-total	16	8	5
Grievances	Inadequate (or no) response to complaint	8	4	6
	Retaliation following complaint	4	0	1
	Sub-total	12	4	7
Information	Failure to pass on information	8	14	7
	Inadequate access to records	9	11	6
	Inadequate information on diagnosis, prognosis, treatment op	11	6	4
	Inadequate information on services available	5	3	3
	Inadequate records	5	4	2
	Sub-total	38	38	22
Other Issue	Administrative practice	5	10	4
	Illegal practice	3	0	1
	Failure to provide certificate/report	1	5	0
	Policy issue	1	4	0
	Public health issue	1	4	5
	Sub-total	11	23	10

Category	Issue	2004/5	2005/6	2006/7
Privacy	Assault		0	1
	Breach of confidentiality	16	13	4
	Discrimination	3	1	0
	Failure to ensure privacy	6	10	8
	Inconsiderate service	8	6	3
	Unprofessional conduct	11	8	5
	Sub-total	44	38	21
Professional Conduct	Breach of Standard	33	38	24
	Competence/impairment	24	43	8
	Misconduct	58	41	16
	Sub-total	115	122	48
Treatment	Adverse outcome	15	28	29
	Failure to diagnose	10	12	11
	Inadequate diagnosis	22	4	8
	Inadequate treatment	76	71	80
	Medication	47	36	28
	Negligent treatment	81	82	74
	Rough treatment	13	18	21
	Unskilful/incomplete treatment	34	30	24
	Wrong diagnosis	2	4	2
	Wrong treatment	9	7	4
	Sub-total	309	292	281
Not Specified		7		
<b>TOTAL</b>		<b>693</b>	<b>663</b>	<b>485</b>

Figure 1. Most common nature of grievance



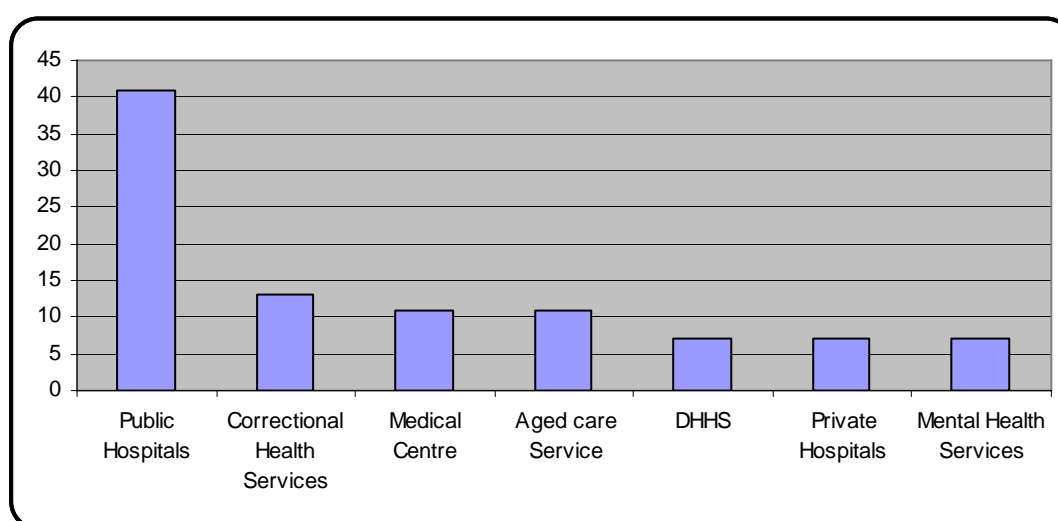
## Profile of Health Service Providers – Organisations

Table 5. Complaints and Enquiries received about Health Service Providers

Organisation	2004/5	2005/6	2006/7
Aged Care	4	8	11
Ambulance	2		3
Community Health	13	6	7
Correctional Health Services	15	20	13
Dental	23	4	3
Department of Health & Human Services (not otherwise specified)	1	14	7
Diagnostic Services		5	0
Disability Services	9	3	4
Medical Practices/Clinics	53	13	11
Mental Health	19	23	7
Other	2	2	0
Optometrist		8	1
Pathology	2	1	1
Pharmacy/Pharmaceutical	8	12	6
Private Hospitals	26	16	7
Physiotherapy	1		0
Public Hospital	87	62	41
Oral Health Services	1		3
<b>TOTAL</b>	<b>266</b>	<b>197</b>	<b>129</b>

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

Figure 2. Breakdown of most complained about Provider



## Profile of Health Service Providers – Medical Practitioners

Table 6. Complaints and Enquiries about medical practitioners

Type	2004/05	2005/6	2006/7
Anaesthetist	5	2	0
Cardiologist	3	2	1
Clinical Psychologist	2	1	0
Dermatologist	1		0
General Practitioner	5	65	40
Gynaecologist/Obstetricians	79	4	1
Neurosurgeon	1		0
Occupational Practitioner	2	1	0
Ophthalmologist	-	4	0
Orthopaedics/Orthotics	-	1	2
Paediatrician	1	2	0
Pain Specialist	-	1	0
Plastic Surgeon	-	8	1
Physician	5	1	0
Psychiatrist	4	5	0
Radiologist	4		2
Specialist (Other)	12	4	0
Surgeon (Other)	4	13	3
Urologist	3	3	0
<b>TOTAL</b>	<b>149</b>	<b>117</b>	<b>61</b>

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

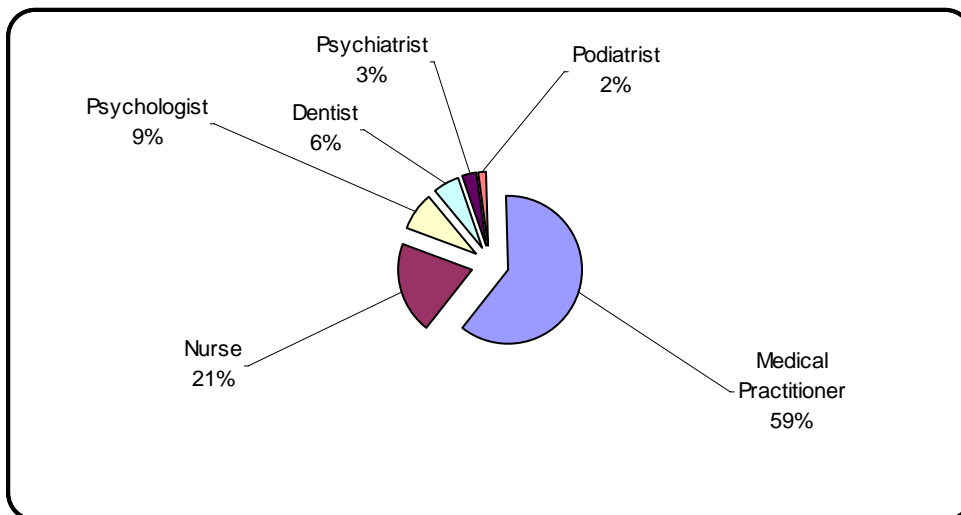
## Profile of Health Service Providers – Individuals

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

Health Provider	2004/5	2005/6	2006/7
Alternative Health	2		1
Chiropractors/Osteopaths	1	4	1
Counsellor		2	1
Dentist	20	17	6
Medical Practitioners	148	117	61
Nurse	19	26	21
Optometrist	2	1	1
Other Services	1	6	0
Pharmacist			1
Physiotherapist	1	1	2
Podiatrist			3
Psychologists	4	6	9
<b>TOTAL</b>	<b>198</b>	<b>180</b>	<b>108</b>

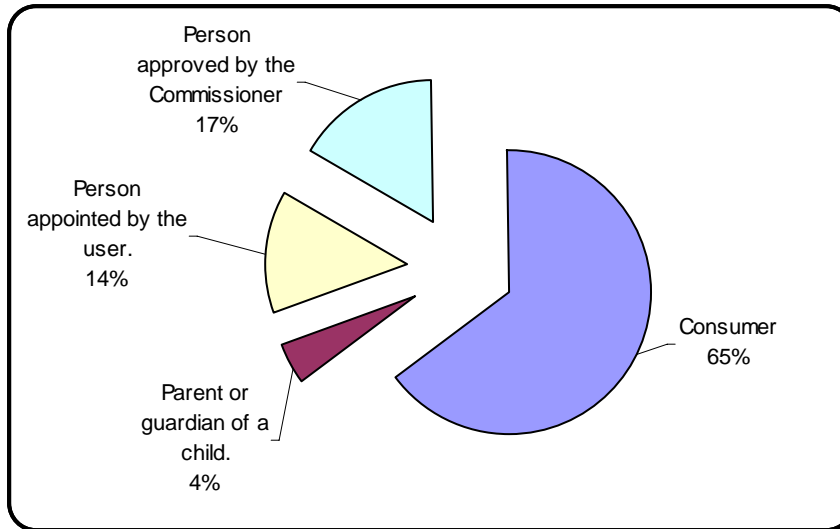
*Note: These figures exclude 2005/6 enquiries that were only recorded in the enquiry database.*

Figure 3. **% Breakdown of most complained about Individual Health providers**



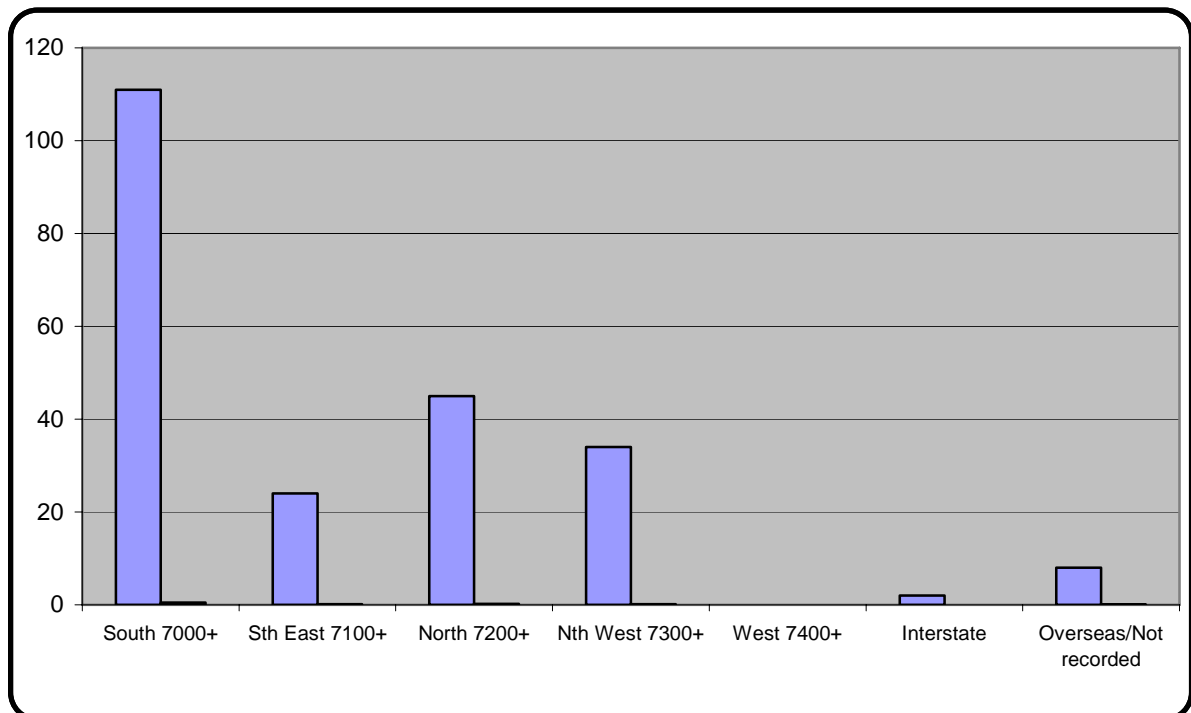
## Profile of Complainants

Figure 4. 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, 65% of complaints lodged are by the person aggrieved.

## Distribution of complaints by postcode region



## Complaint Complexity

Figure 5. Complaints by Complexity

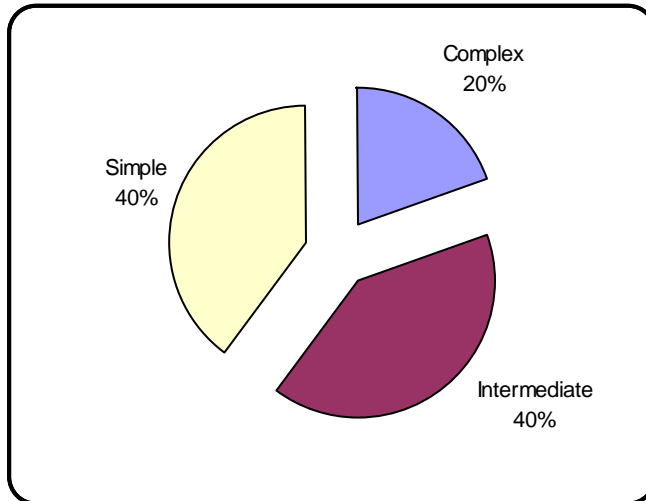
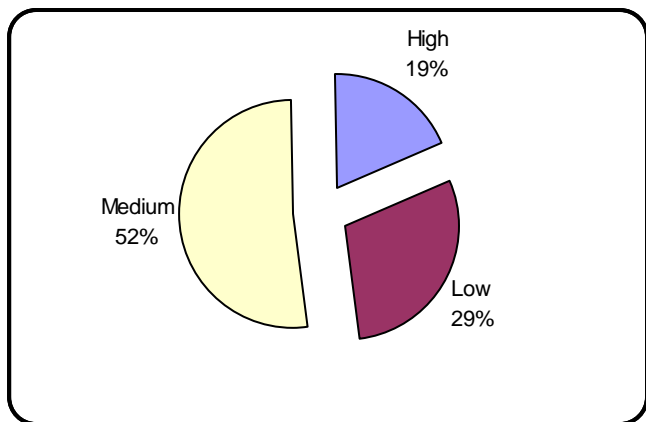


Figure 6. Complaints by Seriousness



## Complaint Details

Table 8. **Complaint and Enquiry Closure Reasons**

<b>Closure Reasons</b>	<b>2004/5</b>	<b>2005/6</b>	<b>2006/7</b>
Enquiry only	158	297	<b>20</b>
Sched 1 Part 2 Excluded as is an opinion/ decision under Workers Compensation	1	2	<b>1</b>
Referred – S. 25 (1A) (a) Complaint referred to relevant Board or person	31	24	<b>10</b>
Dismiss – S. 25 (5) (a) Complainant not a person entitled under s22	3	5	<b>8</b>
Dismiss – S. 25 (5) (b) Complainant does not disclose a subject matter referred to in s23	2	8	<b>3</b>
Dismiss – S. 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago	1	6	<b>2</b>
Dismiss – S. 25 (5) (d) Complainant has not attempted direct resolution		1	<b>2</b>
Dismiss – S. 25 (5) (e) Issues adjudicated by court or tribunal		3	<b>1</b>
Dismiss – S. 25 (5) (g) Complainant has been given reasonable explanation and information	113	105	<b>68</b>
Dismiss – S. 25 (5) (h) The complaint lacks substance	6	14	<b>18</b>
Dismiss – S. 25 (5) (i) The complaint is frivolous vexatious or was not made in good faith	1		<b>2</b>
Dismiss – S. 25 (7) Complainant has failed to provide information under s24	3		<b>22</b>
Early Resolution – S. 25 (5) (j) The complaint has been resolved	54	49	<b>6</b>
Section 30 (1) The complaint has been withdrawn in writing	4	6	<b>2</b>
Conciliation Resolved	19	19	<b>21</b>
Conciliation Unresolved	4	10	<b>16</b>
Section 55 Investigation Report and Recommendation(s)	9	9	<b>26</b>
Section 57 (1) (c) (ii) Retention by the Registration Board	32	29	<b>24</b>
FOI our Records			
<b>TOTAL</b>	<b>440</b>	<b>587</b>	<b>252</b>

*Note:* 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 Health Complaints Office.

Table 9. **Actual Complaint Outcomes**

<b>Outcome %</b>	<b>2004/5</b>	<b>2005/6</b>	<b>2006/7</b>		
Apology given	6.1	3.1	27	<i>Note</i> <sup>1</sup> Many complainants seek outcomes such as compensation in circumstances when this is unwarranted or complainants may have unrealistic expectations.	
Change in policy/procedure effected	2.4	2.1	2		
Compensation received	1.3	0.6	1		
Concern registered	2.0	5.4	7		
Costs refunded	0.9	1.0	2		
Disciplinary action to be taken against provider	6.0	0.8	4		
Enquiry Only		38.9	0		
Explanation given	31.0	19.5	29		
No Jurisdiction	1.7	2.1	2		<i>Note</i> <sup>2</sup> Disciplinary action is primarily a registration board or employer function. There are no disciplinary powers under the Health Complaints Act.
Complaint objective not obtained <sup>1</sup>	28.4	14.6	13		
Part 6 Investigation - Report recommendations	0.2	0.6	0		
S 25(1A)(a) Referral for Registration Board action <sup>2</sup>	5.2	2.9	2		
S 57(1)(c)(ii) Retention by Board <sup>2</sup>	6.1	4.2	3		
S 55(2) (g) Registration Board Action <sup>2</sup>	0.7	0.2	0		
Service obtained	4.8	4.0	7		
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>		

## Referral of Complaints

Complaints referred to Registration Boards or another body as required under s.25 (1A) (a) of the *Health Complaints Act 1995* –

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

<b>Referrals to Other Bodies</b>	<b>2004/5</b>	<b>2005/6</b>	<b>2006/7</b>
Ombudsman		3	1
Tasmania Police	1		1
Medical Council	44	73	16
Psychologists Registration Board	1	5	3
Pharmacy Board	2	1	3
Nursing Board	14	30	1
Dental Board	1	3	
Dental Prosthetists Board	1		
Optometrist Registration Board		2	
Chiropractors Registration Board			1
<b>TOTAL</b>	<b>64</b>	<b>117</b>	<b>26</b>

## Retention of Complaints by Registration Boards

Complaints retained by a Registration Board under s 57(1) (c) (ii) of the *Health Complaints Act 1995* –

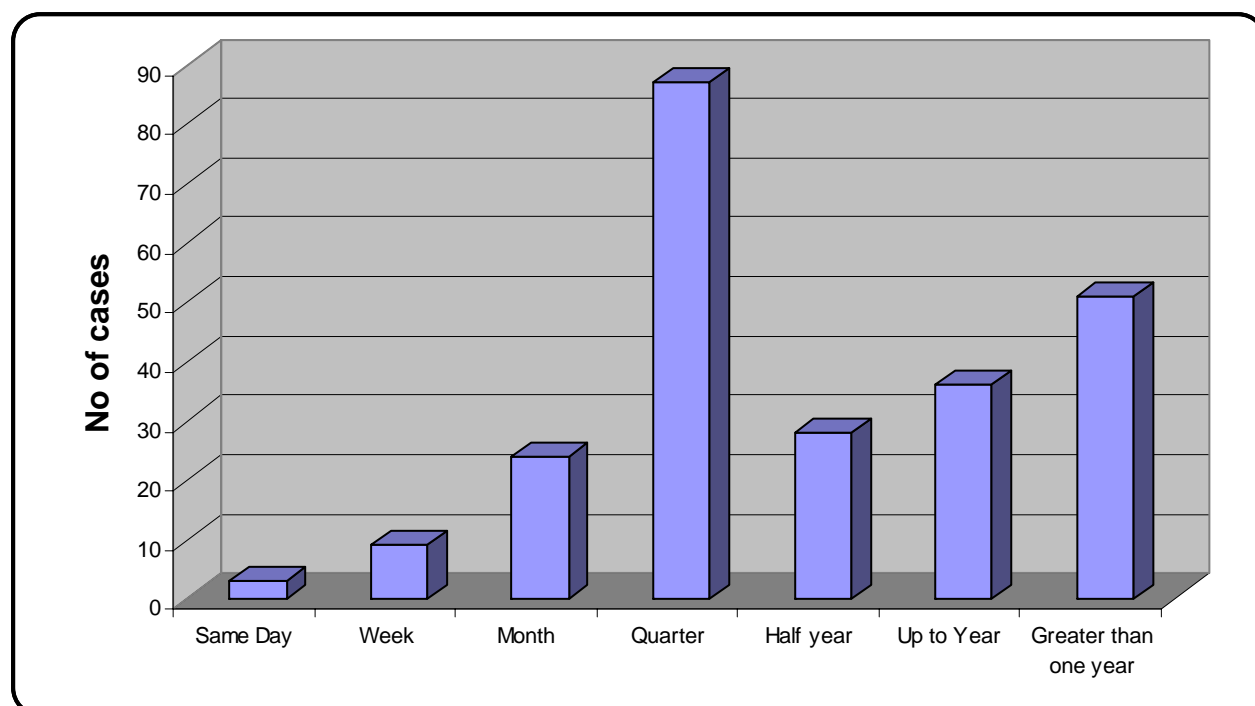
Table 11. **Retention of complaints (opened 1 July to 30 June)**

Complaints Retained by Registration Boards	2004/5	2005/6	2006/7
Chiropractors Registration Board			1
Dental Board			
Medical Council	10	15	22
Medical Radiation Science & Professionals Registration Board			
Nursing Board	19	28	23
Pharmacy Board	1		5
Physiotherapist Registration Board	2	2	
Podiatrists Board			
Psychologists Registration Board		2	7
	<b>32</b>	<b>47</b>	<b>58</b>

*Note:* Tasmania operates as a bipartite system with the 11 registration boards listed in Schedule 2 of the Health Complaints Act 1995 retaining registration, regulatory and disciplinary powers over registered health services providers. 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

## Time taken to finalise Complaints and Enquiries

Figure 7. **Timeliness of complaints' handling**



## APPENDIX A – FINANCIAL STATEMENT

	2004/5	2005/6	2006/7
<b>REVENUE</b>			
Consolidated Revenue	360,698	410,668	640,509
Other Revenue (DHHS)	46,090		
<b>Total Revenue</b>	<b>406,788</b>	<b>410,668</b>	<b>640,509</b>
<b>OPERATING EXPENDITURE</b>			
Salary expenditure	305,891	427,134	507,822
Employee related	1,250	11,009	6,470
<b>Total Salary expenditure</b>	<b>307,141</b>	<b>438,143</b>	<b>514,292</b>
General administration	1,286	14,197	14,902
Information technology	9,596	17,828	13,549
Personnel expenses	849		627
Travel and transport	6,681	13,314	14,244
Property expenses	14,917	43,150	43,665
Operating expenses	19,618	12,955	39,157
Consultants	48,792	1,731	1,171
<b>Total Non-salary expenditure</b>	<b>101,739</b>	<b>103,175</b>	<b>127,314</b>
<b>Total Expenditure</b>	<b>408,880</b>	<b>541,318</b>	<b>641,607</b>

Note: The Consolidated Fund Revenue calculation is based on FTEs in each jurisdiction. This is different to the 2005/06 calculation where Consolidated Fund Revenue was based on salaries.