The Office of the Health Complaints Commissioner Tasmania

Annual Report

2022–23

Independence
Impartiality
Fairness
Respect

Health
Complaints
Commissioner
Tasmania

The Honourable President
of the Legislative Council

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 Office of the Health Complaints Commissioner for 2022–23.

Yours sincerely

Richard Connock

HEALTH COMPLAINTS COMMISSIONER
10 November 2023

About this Report

This report describes the functions and operations of the Office of the Health Complaints Commissioner Tasmania for the year ending 30 June 2023.

It is available in print or electronic viewing format (visit https://www.healthcomplaints.tas.gov.au/publications) to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with a disability. Requests should be directed to the Executive Officer at 1800 001 170 or Health.Complaints@healthcomplaints.tas.gov.au.

Acknowledgment of Country

In recognition of the deep history and culture of this Island, we would like to pay our respects to all Tasmanian Aboriginal people, the past and present Custodians of the Land.

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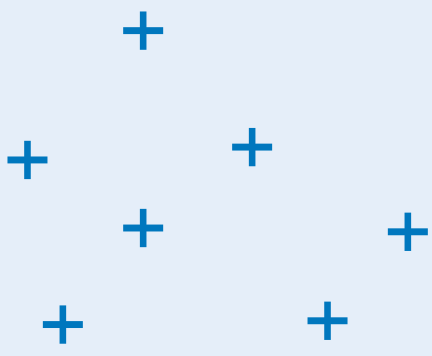

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Message from the Health Complaints Commissioner

The year in review has brought significant positive changes to my Office.

As mentioned in my report last year, my Office received a welcome increase to recurrent funding which has allowed me to recruit staff on a permanent basis to positions that had been vacant for many years. Accordingly, this year we have focused on the key enabler for strengthening the role of my Office in the community: our people and their capability.

Continuous improvement in the health system is dependent on capable complaint handlers who are essential for identifying gaps in service provision and helping health service providers to use complaints to inform their continuous improvement cycle.

My staff increased from 3.8 full-time equivalents (FTEs) in December 2022 to 5.6 FTEs by the end of June 2023. This increase in staff ensures that my Office is able to deliver on the services for which we exist – the resolution of health complaints and the improvement of the Tasmanian health system – in a more timely way.

"Increased staffing has enhanced our level of activity in the second half of the reporting period."

Increased staffing has enhanced our level of activity in the second half of the reporting period and we have been able to address the extensive backlog of complaints with which we started the year. As the data bears out, we have significantly reduced the complaints carried forward by almost 40%.

In 2021-22 there was an unprecedented number of cases (1,310) and significant differences in the profile of complaints, largely related to the COVID-19 pandemic. In 2022–23 there was an 11% decrease in the number of complaints and enquiries received (1,178).

My Office closed 12 conciliations in the last reporting year, making some excellent improvements through that process. We commenced one own-motion investigation into allegedly serious issues of public interest, which is still underway.

Significantly, I was called upon to represent my Office before, and respond to questions from, the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (the Commission of Inquiry) on a number of occasions in the reporting year. This work was demanding on my staff but nothing compared to that undertaken by the Child Abuse Royal Commission Response Unit and the Office of the Solicitor-General. I would like to acknowledge the work of all staff involved in the Tasmanian Government's response to the Commission and the positive changes that have occurred as a result of their work.

Once again, I would like to thank my staff for the quality of their work, for their dedication and professionalism and for sustaining their remarkable levels of activity over what has been a particularly challenging year.

Our people

My dedicated staff are at the heart of all the achievements we are able to make in the improvement of the delivery of health services through complaint resolution, education and training. My staff remain committed to their work and the goals of the OHCC but, due to low staffing levels in previous years, we have not always reached the standard that we had hoped to achieve.

During the reporting year we undertook several recruitment processes. Similar to other agencies, these processes were not always successful. The job market for employers was very competitive following the COVID-19 pandemic, and prospective employees enjoyed a great deal of choice. On two occasions we had staff accept positions, only to decline at the last moment.

Nonetheless by the end of June 2023 we had successfully appointed four new highly skilled staff members: two senior investigation officers, an investigation officer and an intake and assessment officer.

The new team members have come from diverse backgrounds, including law, nursing, policing and industrial relations. This varied expertise is underpinning some excellent outcomes for complainants. Officers successfully tackled the daunting task of reducing the backlog of complaints that had developed as a result of historically low staffing levels.

My staff have always been supported by an excellent business and administration team, without whom we could not provide our services.

Snapshot Staff profile at 30 June 2023

Position	Male	Female	Total
Commissioner	0.2	0.0	0.2
Principal Officer (Band 8)	0.0	1.0	1.0
Senior Conciliation Officer (Band7)	0.0	0.6	0.6
Senior Investigation Officer (Band 6)	0.0	1.8	1.8
Investigation Officer (Band 5)	1.0	0.0	1.0
Intake and Assessment Officer (Band 4)	1.0	0.0	1.0
Total	2.2	3.4	5.6

“I would like to thank my staff for the quality of their work, for their dedication and professionalism and for sustaining their remarkable levels of activity over what has been a particularly challenging year.”

Our work

Snapshot Restoring relationships

A critical role we serve is restoring relationships between parties where the provision of health care has either not met expectations or has fallen short of good practice. The patient experience from previous health presentations may impact on future patient experiences. It is therefore vital that relationships are rebuilt when they have broken down, as the consumer may need to receive ongoing care and treatment from the same health practitioner in the future. Through our resolution and conciliation processes my staff are skilled in rebuilding relationships that are critical to the success of patient-centred care.

The *Health Complaints Act 1995* (the Act) established the Office of the Health Complaints Commissioner (OHCC), which was first filled in 1997. The major functions of the Office are to:

- receive, assess and resolve complaints from health service users;
- assist health service providers in developing procedures to resolve complaints;
- encourage health service users to resolve complaints directly with health service providers; and
- identify and review issues arising out of complaints and suggest ways of improving health services.

The Commissioner is an independent statutory officer who does not represent the interests of, nor act as an advocate for, either party to a complaint. The functions of the Commissioner are performed independently, impartially and in the public interest. It is not the role of the Commissioner to attribute fault or blame, but to seek improvements in the delivery of health services in Tasmania and, where possible, resolve complaints between the parties through conciliation.

It has been the practice since the commencement of the Act for the appointments of Ombudsman and Health Complaints Commissioner to be held by the same person.

How we do our work

The primary function of the Office is to provide an accessible, impartial and confidential service for the resolution of health complaints. In this section, we provide information about complaint management, statistics, trends and outcomes.

Snapshot 'Overview of the complaints process'

Enquiry

The intake team provides information on:

- The complaint process
- Raising a complaint with the service provider
- Referral to a more appropriate agency
- Other complaint resolution options.

Assessment

Complaints are assessed to ensure they meet a range of threshold criteria, including whether they relate to:

- The provision of health services
- Services provided in Tasmania
- An incident occurring in the past two years
- An incident that has already been raised with the service provider.

In some circumstances where the person making the complaint has not tried to resolve the matter directly with the provider, a facilitated referral for early resolution of the matter may be initiated.

Complaint resolution

Complaints can be resolved in the following way:

Early resolution

We assist with the exchange of information to reach an outcome which is often acceptable to both parties.

Conciliation

Encourages resolution by facilitating discussions between the parties to assist in reaching an agreement.

Investigation

This is normally only undertaken if a complaint raises a serious systemic or public interest issue.

Referral

A complaint may also be resolved through referral to another agency such as the Australian Health Practitioner Regulation Agency.

Outcomes

The Office is able to achieve a range of outcomes for both the person who made the complaint and for improved service delivery.

These include provision of explanations by service providers, apologies, refunds, reduction or waiver of fees and facilitating access to services.

We also attempt to address gaps in service provision by suggesting further staff training, changes to processes and procedures, introduction of new policies and/or procedures.

We may also be able to assist in the obtaining of compensation.

Closed

Once the complaint resolution process is complete, the parties are informed of the outcome by letter or a report containing details of any outcome of the complaint.

Our performance
Year at a glance

1,178 **Approaches (enquiries and complaints)**

Complaints
*excluding Notifications from AHPRA

628
complaints
opened

739
complaints
closed

Time taken

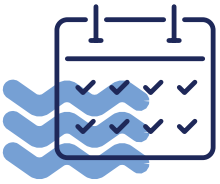
210
complaints
closed in
30 days

254
complaints
closed in
6 months

157
complaints
closed in more
than 6 months

Enquiries

550
opened



549
closed

*Notifications from the Australian Health Practitioner Regulation Agency (AHPRA)

66
received

69
closed

Complaint and enquiry activity

Data about our complaint activity is collected in our case management system, RESOLVE. All cases received by the OHCC are initially recorded as enquiries. They then proceed through different workflows in the system, according to how they are managed, and data is collected at various points through those workflows. Cases are either closed as an enquiry or they progress to a complaint or notification.

For the purpose of the statistics which follow:

- An ***enquiry*** is a case where a person or organisation is either seeking information from, or providing information to, the OHCC.
- A ***complaint*** is a case where it is obvious that the person wants to make a complaint, rather than just seek or provide information, and where we undertake some form of assessment under the Act – even if that is only as to jurisdictional and threshold issues – or if we refer them to another agency. For the purposes of this report, enquiries and complaints have largely been grouped together as 'cases' or 'complaints'.
- A ***notification*** is a case where a person lodges a notification with the Australian Health Practitioner Regulation Agency (AHPRA) which, following consultation with this Office as to which is the preferred entity to deal with the matter, it is agreed that AHPRA should retain the matter.

Table 1 Summary of cases received and closed in the reporting year, 2022–23

Case type	Received	Closed
Enquiries	550	549
Complaints	628	739
Notifications	66	69
Total	1,244	1,357

Table 2 Overall case activity – excluding AHPRA notifications

Total cases	2021–22	2022–23	Variance
Cases carried forward from 1 July	80	290	263%
Cases received	1,310	1,178	-11%
Cases closed	1,100	1,288	15%
Cases active at 30 June	290	180	-38%

How we manage complaints

All our complaints and notifications are put through an 'assessment process'

Assessment is the stage under the Act at which a determination must be made as to whether a complaint should be referred to another entity, referred to conciliation, referred to investigation, a combination of any of these, or dismissed.

This determination is meant to occur within 45 days of the complaint being received, but this period can be extended to 90 days, or longer if the Commissioner is waiting for information. This is also the stage at which attempts are made at early resolution.

This year 739 of the complaints we received were closed following assessment. Table 9 in 'Complaint and enquiry summaries' later in this report provides full details about the outcomes of assessment.

Preliminary assessment

All complaints undergo a preliminary assessment to ascertain whether or not we have jurisdiction to deal with them.

The Act sets out a number of criteria to be satisfied before we can accept a complaint. If these criteria are not met, or if there is another organisation or person better equipped to deal with the complaint, then it is either dismissed or referred to the other entity as required.

Quick resolution

These cases are managed as informally as possible and usually involve obtaining information from the provider, or other entity, and sharing this with the complainant.

Alternatively, they involve speaking with the parties and negotiating outcomes, such as a refund or waiver of fees or the provision of a service. Most cases about Correctional Primary Health Services – our largest cohort – fall into this category. These cases are recorded as having been closed in assessment on the basis that a reasonable explanation has been provided or that the complaint has been resolved.

> **"The formal assessment process involves making preliminary enquiries, including obtaining formal written responses from the provider; receiving and reviewing medical records and identifying and reviewing relevant clinical standards."**

Referral to registration boards

The relationship between this Office and Australian Health Practitioner Regulation Agency (AHPRA) is governed by the *Health Practitioner Regulation National Law Act 2009* (the National Law).

A memorandum of understanding (MoU) is in place between AHPRA and the various health complaints entities. When a complaint concerning a registered practitioner is made to the OHCC, we are required to advise and consult with AHPRA as to whether any aspects of the complaint should be referred to AHPRA.

Formal assessment

All remaining complaints, including those ultimately referred to AHPRA or to conciliation or investigation, undergo a more formal assessment process.

The formal assessment process involves making preliminary enquiries, including obtaining formal written responses from the provider; receiving and reviewing medical records and identifying and reviewing relevant clinical standards. It also involves, where necessary, consulting with AHPRA in relation to registered health practitioners involved in the episode of care.

These cases are in effect "mini investigations" or informal conciliations, and the closure reasons do not reflect the complexity or extent of the work undertaken. These cases represent a large percentage of the cases carried forward at the end of the reporting year.

Conciliation

When there is an adverse outcome from an episode of care, most complainants want to understand what happened, and why it happened, and are often seeking an apology, ongoing care and/or compensation. They also want to know what can be done to prevent what happened to them happening to someone else.

Conciliation under Part 5 of the Act is confidential and privileged, and provides a safe forum where the parties can have open and honest discussions about these issues.

In previous years, conciliation has been used extensively and with great success in resolving complaints, and as a vehicle for exploring and bringing about systemic change.

As reported in last year's annual report, the recruitment of a permanent part-time (0.6 FTE) conciliator in March 2022 enabled us to resume our conciliation service. However, changes in both governance arrangements within the Department of Health (DoH) and in senior management roles within the Tasmanian Health Service (THS) following hearings by the Commission of Inquiry resulted in significant delays in progressing and finalising a number of complex matters. These delays are particularly pronounced in cases where compensation is being sought.

As these new arrangements bed down, and as new staff in both THS and the Department become more familiar with the OHCC conciliation process and aware of the benefits of resolving matters through a collaborative and restorative approach (rather than a medico legal/defensive/adversarial approach), it is hoped that conciliation will once again gain acceptance and be regarded not only as a useful adjunct to open disclosure and model litigant policies but as the preferred way in which to resolve complaints.

My Office hopes to be able consult with the relevant departments about progressing this in the near future.

Twelve cases were closed within conciliation this year (with another six on the cusp of finalisation). Of the matters closed:

- four resulted in an offer of compensation to the complainant;
- two resulted in a commitment to ongoing care or rectification services;
- four resulted in significant quality improvements being implemented within the provider organisation; and
- two did not proceed to conciliation due to earlier delays associated with COVID-19 and the need to progress matters through litigation due to limitation periods.

In almost all cases, including those that did not result in any tangible outcome, the complainant received an acknowledgement and a genuine apology for the events that occurred giving rise to the complaint.

Investigations

A decision was made some years ago that formal investigations would only be conducted into complaints which give rise to a matter of public interest, and that conciliation would be used more extensively. One of the reasons for this was that, in many cases, by the time the matter is brought to our attention, the provider has already engaged in a root cause analysis, and this has led to the identification and implementation of systemic changes necessary to prevent a recurrence of the subject incident. These changes are then shared with the complainant at conciliation. The matters referred to investigation have tended to be those that affect vulnerable groups. As mentioned above, my Office is currently undertaking one own-motion investigation.

Issues raised by complainants

Consistent with previous reports, the recurring issues raised in complaints related to concerns about treatment, access to services, poor communication and medication.

Tables showing comparative data for three years, including all issues and breakdowns, can be found at 'Complaint and enquiry summaries' later in this report.

Snapshot Top common issues overall

Issue	2022–23
Treatment	492
Access	174
Communication/information	153
Medication	127
Fees and costs	47
Professional conduct	36

*Most complaints raise more than one issue.

Most common treatment concerns

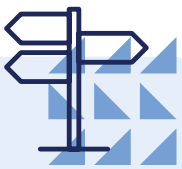
93 Delay in treatment

92 Inadequate care

90 Inadequate treatment

61 Unexpected treatment outcome or complications

44 Coordination of treatment



Snapshot Out-of-jurisdiction complaints

While most complaints were about health services delivered in Tasmania, the Office also received a number of complaints that were out of jurisdiction: these are complaints that do not relate to the provision of health services in Tasmania. In these circumstances, staff provide information about an alternative agency that may assist the individual with their concerns. Staff also provide information about the support available to assist the individual such as advocacy or legal services.

Table 3 Complaints about health service organisations

Organisation	2021–22	2022–23	Variance
Correctional Primary Health	262	228	-13%
Public Hospitals	132	114	-14%
Medical Practices/ Clinics	84	60	-28%
Private Hospitals	17	14	-18%

Issues raised about health service organisations

I am happy to report that my Office maintains excellent relations with the main health service providers in Tasmania and that genuine goodwill and patient-centred care are the prime factors in both complaint resolution and system improvement.

As in previous years, the main source of complaints about health organisations came from prisoners in the Tasmanian Prison Service and related to Correctional Primary Health Services. This was followed by complaints about public hospitals and then medical practices.

Correctional Primary Health Services (CPHS)

The Health team continues to receive large numbers of complaints from prisoners and remandees who have access to my Office by way of a direct telephone line at no cost to the detainees. We received a total of 228 complaints, which was a -13% decrease on complaints from the previous financial year.

We have always maintained strong links with the CPHS and have recently implemented regular meetings with the Clinical Director of the CPHS and his medical team in order to be informed about developments and the means of addressing ongoing challenges.

Examples of the health issues raised with my Office by prisoners include access to the opioid replacement therapy program, access to restricted medications, access to specialist care and oral health service wait times.

Delays in receiving treatment caused by lockdowns have been on ongoing problem in the last few years and were particularly prevalent during COVID-19. Complaints about lockdowns and the incumbent limitations on the delivery of health care were less of a problem towards the end of the reporting period. However, at different times throughout the year inmates have complained about severe spikes in lack of clinics due to the number of lockdowns.

Table 4 Main issues arising from complaints about CPHS

Issue	2020–21	2021–22	2022–23
Treatment	49	145	132
Access	116	72	108
Medication	131	100	85
Communication/ information	13	18	12

During the reporting year, the CPHS introduced a new method of responding with my Office about complaints. Our regular method of communication was that we would request a response from the CPHS to a prisoner's concerns and the CPHS would respond to us. We now forward all complaints from prisoners to the Statewide Mental Health Service (SMHS) who obtain a response to the prisoner's concerns from the CPHS which the SMHS then forwards to us. There were the usual teething troubles at the beginning of this change, but that is to be expected, and it now seems to be working quite well.

My Office enjoys a positive relationship with the CPHS which promptly responds to the health concerns which prisoners raise with us.

Tasmanian Health Service

We closed 114 complaints about public hospitals in the reporting year. Consistent with previous years, public hospitals were the subject of the next highest number of complaints closed this financial year. This total represents a 14% decrease in the number of complaints closed about public hospitals in the last financial year, down from 132. The likely reason for this relative decrease is the high number of complaints we received last year due to COVID-19.

As in previous years, the main issues raised in relation to hospitals were treatment and communication.

"My Office enjoys a positive relationship with the CPHS which promptly responds to the health concerns which prisoners raise with us."

Table 5 Main issues arising from complaints about public hospitals

Issue	2020–21	2021-22	2022–23
Treatment	44	98	131
Communication/ information	30	38	38
Access	23	20	19
Grievance processes	3	6	12
Medication	9	7	10
Professional conduct	1	13	8

Table 6 Main issues arising from complaints about individual providers

Issue	2022–23
Treatment	24
Fees and costs	24
Access	22
Communication/ information	18

Individual providers

We received 119 complaints about individual health service providers this year. This is in addition to 66 notifications received from AHPRA. This is a reduction on complaints from last year when we received 143 complaints (largely due to COVID-19) and 57 notifications.

The majority of complaints and notifications we received about individual providers related to medical practitioners. As noted in previous reports, this is attributable to there being more doctors than other individual health providers who practise in their own right. Complaints about nurses, for example, are usually incorporated into complaints about hospitals. There was an 18% decrease in the number of complaints about medical practitioners received this year, from 69 down to 56.

Private hospitals

There was a decrease of -18% in complaints about private hospitals in the reporting year, from 17 last year to 14 this year.

Table 7 Main issues arising from complaints about private hospitals

Issue	2020–21	2021-22	2022–23
Treatment	13	10	18
Communication/ information	8	7	2
Medical records	0	1	2

Topical issues during 2022–23

Outreach and education

My staff continually provide information to both complainants and providers on how they can make and respond to complaints most effectively. However, as this year my Office was focused on recruitment and reducing the backlog of complaints, we have not delivered any training in this regard in the reporting year. In 2023 I participated in an information forum with the Australian Health Practitioner Regulation Agency (AHPRA) representatives, arranged on the initiative of Health Consumers Tasmania (HCT).

Code of Conduct for Unregistered Health Care Workers

I have reported previously regarding the establishment and implementation of a National Code of Conduct for Unregistered Health Care Workers (the Code) such as naturopaths, social workers and counsellors. The Code is to be administered by the health complaints entities in each jurisdiction and, as reported last year, the Tasmanian legislation to implement the Code had passed through Parliament but has not yet been proclaimed. This situation has not changed.

As in previous years we received complaints and enquiries about unregistered health care workers in the cosmetic industry that we were unable to accept. There is no regulatory body currently accepting complaints about services such as the use of injectables (like botox) and other cosmetic therapies provided by unregistered practitioners.

The other health complaints entities that have adopted a Code of Conduct report high levels of regulatory action in regard to services provided by massage therapists.

In the last year we received one complaint about a massage therapist that we referred to Tasmania Police.

As more interstate prohibition orders are brought to my attention, it is apparent that due to the lack of a nationally consistent definition of a health service for the purposes of the Code, I would not be able to enforce an interstate prohibition order in Tasmania in respect of a health service that does not fall within the Tasmanian definition. As interstate recognition was one of the main objectives, that will require further amendment to the Act.

As previously reported, it is not possible to say how many complaints we might receive relating to possible breaches of the Code. The trend interstate indicates it will be high, but any complaints will mean an added strain on resources; existing resources will not be sufficient to deal with them. There will also need to be extensive modifications to our case management system to accommodate workflows related to the administration of the Code.

I remain concerned that, without additional resources and funding, we will not be able to perform this new function adequately.

Stakeholder engagement

The Department of Health (the Department), particularly through its services at the Royal Hobart Hospital, the Launceston General Hospital, the North West Regional Hospital and the Latrobe Mersey Hospital, has frequent interaction with my Office due to the understandably high numbers of complaints and enquiries emanating from these four sites. My Office has always experienced a highly productive relationship with these service providers.

Towards the end of the reporting year, the Department created a new system for managing complaints in response to the findings of the Commission of Inquiry.

In the past we attempted to resolve complaints directly with the regional Consumer Liaison Units within the Tasmanian Health Service, but with the implementation of the Statewide Complaints Management Oversight Unit (SCMOU) we now refer all complaints to that unit, which sits within the Office of the Secretary of the Department. The role of the SCMOU is to provide oversight and governance for monitoring and managing complaints across the entire Department.

This system is as yet untried, but we are hopeful of developing similarly good relationships with the SCMOU as we had with the local authorities.

During the year, my Office also maintained strong links with staff of Equal Opportunity Tasmania, the Australian Health Practitioner Regulation Agency, Health Consumers Tasmania, the Radiation Protection Unit and the Correctional Primary Health Service.

Strategic planning

By increasing our staffing profile we have fulfilled on one of the most important targets of the current Strategic Plan. The other objectives should be easier to achieve now that we have staff to undertake some of the overdue projects that I have referred to in my previous reports. These include seeking amendments to the *Health Complaints Act 1995* to help streamline our resolution processes, and a revision of the *Charter of Health Rights* is also overdue and is mandated for my Office to undertake.

Snapshot Capacity building

As well as extensive in-house training, my staff undertook a number of capacity building courses in the last financial year. The most significant of these were:

'Managing unreasonable conduct by a complainant' delivered by Ombudsman NSW.

Unreasonable conduct by a complainant can take up a lot of time and resources in the workplace. This workshop was undertaken to help the Health team:

- identify and manage unreasonable conduct;
- deliver effective prevention and resolution policies and strategies; and
- support staff members and colleagues impacted by complainant behaviour.

In March 2023, the Health team attended a two-day investigation training workshop with the Workplace Institute from Toronto, Canada called 'As a matter of fact – Best Investigative Practices Workshop'.

Children and young people

The safety and wellbeing of children and young people have been at the fore in Tasmania for the last two years with the establishment of the Commission of Inquiry. The Commission sought information and input from my Office, which involved a considerable amount of work for my staff, and I was called on as a witness on a number of occasions in my capacity as Ombudsman, Health Complaints Commissioner and Custodial Inspector.

The process of responding to the Commission has highlighted areas for improvement in how my Office interacts with young people, and we anticipate that the report will identify more.

The focus on the safety and wellbeing of young people has prompted us to review how our Office operates and staff have undertaken training in safeguarding children. We have produced a series of promotional materials to send out to Ashley Youth Detention Centre, schools, doctors' surgeries and hospitals.

I have organised for an external review of my Office to be undertaken to ensure that it is child safe and child friendly. Children and young people are under-represented in the cohort of people using my Office, so we are also focusing on promoting our various services to them.

Closure of St Helen's Private Hospital

St Helen's Private Hospital was a private mental health facility in Hobart that closed on 23 June 2023. The hospital also provided services for mothers and babies by way of a residential unit.

Following the closure, hospital services were ceased, and the building was put up for sale in July 2023.

The closure of the hospital created a challenge for people who had been receiving care there. However, the Tasmanian Government advised that it was working closely with both public and private services across the state to make sure that the health system continues to meet community needs. The OHCC did not receive complaints about the closure of the hospital.

North West Maternity Services handed back to the THS

Following the report of the *Review of the Quality and Safety of Maternity Services delivered in the North West of Tasmania* published in 2021, the Tasmanian Government determined to make changes to bring birthing services back under a public model (a one-governance structure) similar to Launceston and Hobart. This change will coincide with the end of the current contract with the North West Private Hospital (NWPH). This means that the new service can begin in December 2023. Our Office has received a number of complaints about maternity services provided under the private model. We are hopeful that this change will assist families living in the north west of the State to experience safer birthing arrangements.

Time taken to assess and finalise complaints

Time taken to assess complaints

The Act requires that a complaint be assessed within 45 days. This can be extended to 90 days, and longer in some cases. There are a number of circumstances, described in past annual reports and referred to earlier in this report, that are beyond our control and have an impact on this Office's ability to meet these statutory periods.

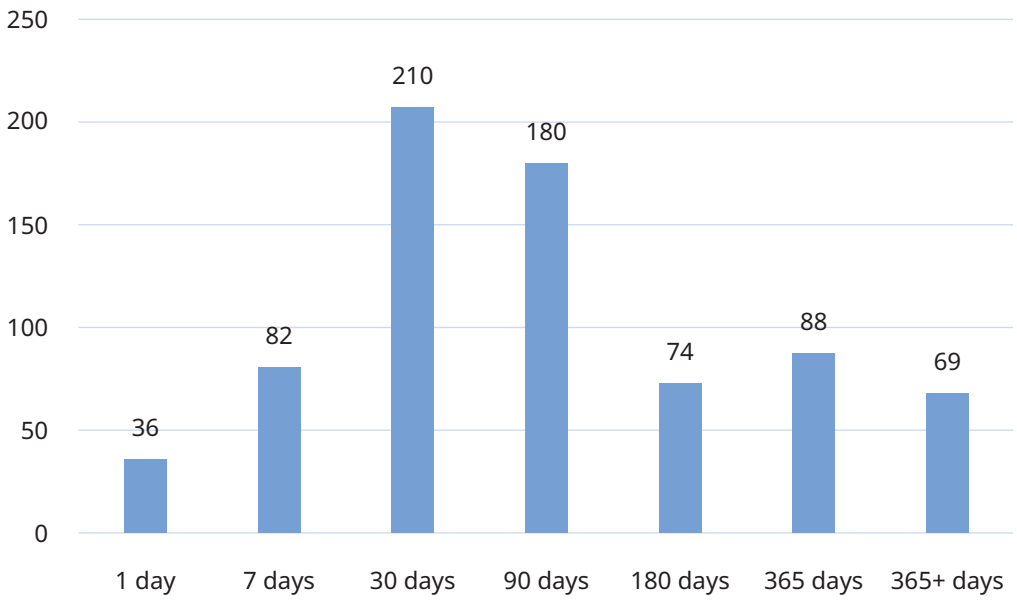
Time taken to finalise complaints

Table 8 and Figure 1 below show the time it takes to finalise complaints. As previously noted, the less complex complaints were generally resolved within three months and made up around 69% of all complaints received. The remaining 31% tended to be more complex and required more formal assessment processes (see page 10).

Table 8 Time taken to finalise complaints

Timeframe	Number	%
1 week or under	118	16%
8 to 30 days	210	29%
1 to 6 months	254	34%
More than 6 months	157	21%

Figure 1 Time taken to finalise complaints



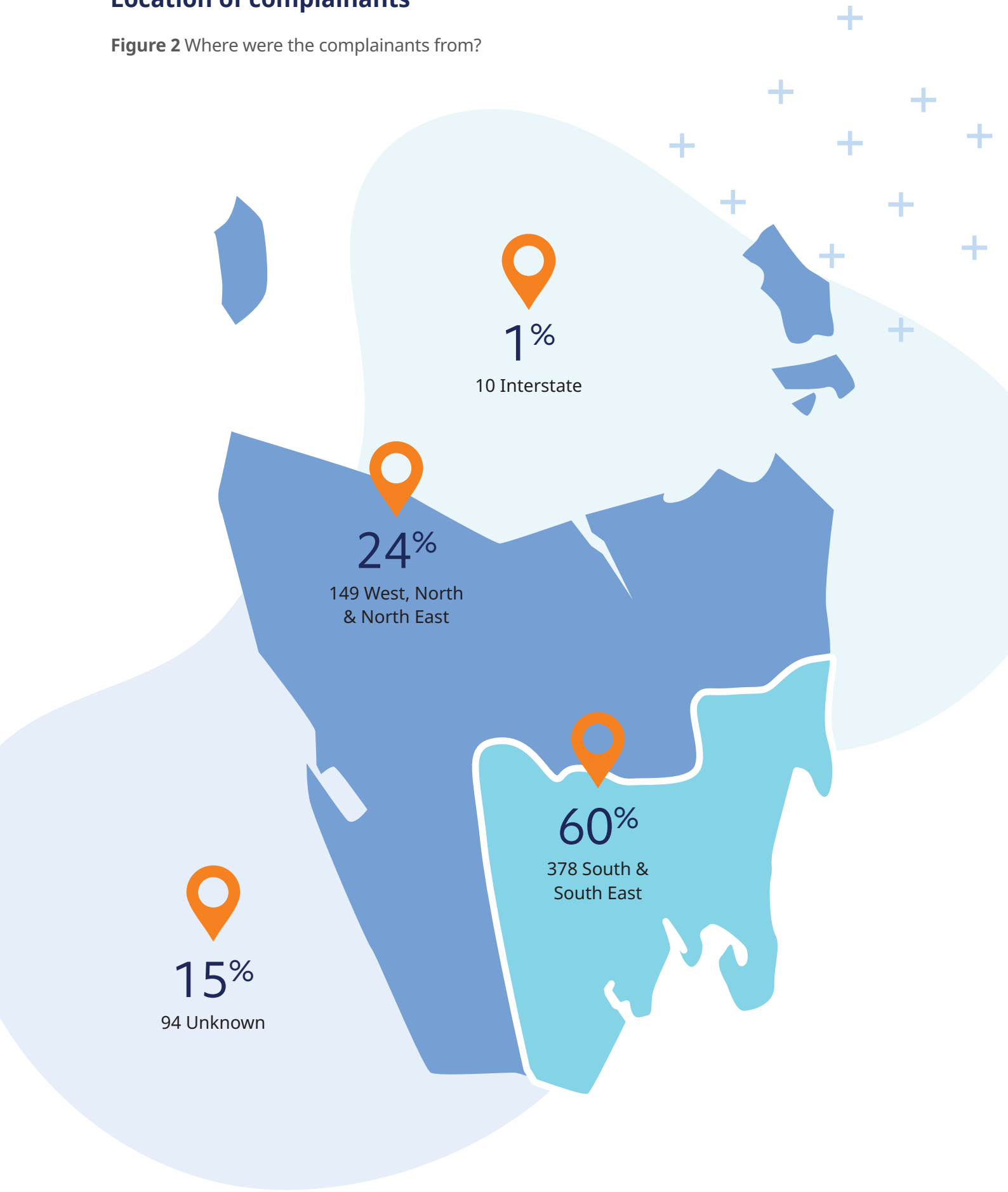
How complaints and notifications were resolved

Table 9 Reasons for closure
*including notifications from AHPRA

Reason	2020–21	2021–22	2022–23
Dismiss – Section 25(5)(a) Complainant not a person entitled under section 22	6	10	7
Dismiss – Section 25(5)(b) Complaint does not disclose a subject matter referred to in section 23	13	29	11
Dismiss – Section 25(5)(c) Complainant became aware of the circumstance more than 2 years ago	9	10	4
Dismiss – Section 25(5)(d) Complainant has not attempted direct resolution	61	168	255
Dismiss – Section 25(5)(e) Issues adjudicated by court or tribunal	0	2	3
Dismiss – Section 25(5)(g) Complainant has been given reasonable explanation and information	259	231	283
Dismiss – Section 25(5)(h) The complaint lacks substance	0	8	18
Dismiss – Section 25(5)(i) The complaint is frivolous, vexatious or not made in good faith	5	0	0
Dismiss – Section 25(5)(j) Complaint has been resolved	44	112	74
Dismiss – Section 25(7) Complainant has failed to provide information under section 24	0	1	0
Section 30(1) The complaint has been withdrawn in writing	8	12	29
Other	2	3	12
Out of jurisdiction	0	4	13
Section 25(1)(a) Complaint referred to the Ombudsman or another person	45	18	14
Referred to AHPRA pursuant to MoU	22	23	5
Retained by AHPRA pursuant to MoU	53	57	69
Closed in conciliation	12	0	11
Closed in investigation	1	0	0
Total	540	688	808

Location of complainants

Figure 2 Where were the complainants from?



Complaint case summaries

Facilities

Improvements made in post-fall treatment

We received a complaint from an elderly patient who had had a fall from his bed during an admission to a public hospital, which had exacerbated the issues for which he had been admitted.

Of concern to the patient was that he had not received appropriate investigations after the fall and that his deterioration post-fall was not responded to in a timely or reasonable manner.

My Office sought a number of responses from the Tasmania Health Service (THS) to the patient's concerns and consulted with AHPRA about the conduct of the practitioners involved in his care.

As a result of our inquiries and a recognition by the THS that improvements were required to mitigate the risk of a similar adverse event occurring, the following improvements were adopted by the THS

- It is now mandatory for the on-call registrar to attend and review patients post-fall.
- The trialling of 'Post Fall Safety Huddles' – a person-centred open-disclosure conversation with the patient and their family or carer. The conversation is guided and recorded on a 'Post Fall Safety Huddle Form'.
- Proper documentation in rounds to be discussed with all doctors in the team, including each new rotation of residents and interns.
- Improved communication with patients to address their concerns and expectations, including discussion of the reasons for decisions involving investigations and continuation of care on the ward.

Improvements in patient-centred care

Following surgery for a hip replacement, a patient complained to us that he had received ageist and unhelpful comments from his surgeon regarding his rehabilitation. The concerns raised reinforced the importance of person-centred care in order to maintain the therapeutic relationship between patient and practitioner.

We consulted with AHPRA about the complaint, and it considered that no further action was required. However, to enhance the possibility of the practitioner improving her practice we provided information from the Australian Commission on Safety and Quality in Healthcare on 'Person-centred care in practice', which detailed the conversational cornerstones of patient-centred care to improve clinician communication.

A protocol review

A patient attended a public hospital clinic for wound management. An acetic acid (vinegar) wash was used on the patient's wound. The patient experienced a 'burning' sensation and considered their ongoing pain to be connected to the acetic acid. The patient complained about the appropriateness of the use of the acetic acid and the process of obtaining informed consent for this treatment.

My Office gathered information about the treatment, including the dilution of acetic acid and policies for wound and topical treatments. There was no evidence to suggest that the use of or dilution of the acetic acid was contrary to accepted standards, and it was identified that the protocol for wound treatment included a comprehensive assessment of the individual and their healing environment, including previous wound treatments and their therapeutic outcome.

However, the patient's medical records revealed that the patient had received ongoing wound care for some time and had experienced sensitivities to various wound treatments in the past. Accordingly, my Office suggested that the wound management protocol be reviewed and that, in circumstances where the patient has demonstrated sensitivities or intolerances to other topical treatments, consideration be given to including the performance of a "patch test" before proceeding with the full treatment. This approach would contribute to the information available to the patient when consenting to the treatment. At the time of writing, the Wound Management protocol was in the final stages of review and stakeholder feedback.

The current *draft* version has had the addition of the following:

> Initial and ongoing wound assessment should include documented evidence of:
>
> (...)
>
> - Allergies/sensitivities to topical agents and/or wound products; if indicated, attend a 'patch-test' before proceeding with new treatments.

Explanation obtained

A patient underwent a surgery and experienced complications with the anaesthetic treatment received. The patient complained about the symptoms she experienced following the anaesthetic treatment and had concerns about the lack of explanation or communication she received about the treatment.

We contacted the treating anaesthetist and requested a response to the concerns raised. The anaesthetist provided a detailed response which explained the complications and the treatment outcomes. The anaesthetist apologised for the patient's experience and noted that an explanation was provided during recovery, but had they been advised of the patient's ongoing concerns they would have made contact sooner. The patient was happy to have received a sincere apology and detailed explanation of their treatment.

Delayed ambulance

A complaint was received from a son about the extensive delay in receiving treatment/transport from Ambulance Tasmania which his father had experienced. The patient was suffering extreme pain and discomfort. The complainant had attempted to resolve his concerns with Ambulance Tasmania but this had been unsuccessful.

The initial response from Ambulance Tasmania appeared rushed and did not adequately empathise with the concerns raised by the complainant. Subsequent follow-up responses from Ambulance Tasmania demonstrated more empathy and understanding.

The OHCC identified that the complainant was only seeking confirmation that policies and procedures would be implemented/changed to prevent similar events occurring in the future.

The OHCC made contact with the operations manager who was able to supply the OHCC with draft material about protocol changes. This was explained to the individual who was pleased with this outcome.

General practice

Improvements to emergency care in a general practice

A complainant alleged that a regional medical practice had failed to provide emergency medical assistance. We requested a response to the concerns raised by the complainant who was seeking an improvement in the delivery of care by the practice.

The practice apologised for the distress the episode had caused the complainant and confirmed that his concerns had been registered and that reception staff had received updated triage training.

In addition we provided de-escalation resources to be considered at the next practice meeting. The complainant was satisfied with the outcome, which went some way to addressing his frustration with the practice.

Patient banned from practice

A complaint was received from a person who had been banned from her local GP clinic. The complainant claimed that the ban was unfair, as she had not exhibited any behaviour that was contrary to the clinic's policy on behaviour and conduct. The complainant alleged that the therapeutic relationship had been terminated without consideration being given to her medical needs, and she had been denied natural justice in appealing the decisions made by the practice manager.

The OHCC made extensive enquiries with the practice manager, obtained the relevant patient clinical notes and discussed the complaint at length with the complainant's advocate. The OHCC requested the records that documented the substance of the complaint and a history of the complainant's behaviour and conduct warnings.

The OHCC identified that the complainant had previously been openly disparaging towards the doctors at the practice and made claims that the treatment she was receiving was inadequate. A doctor at the clinic had spoken with the complainant about her conduct, explaining that trust is the cornerstone of an effective therapeutic relationship; however, this did not deter further negative behaviour by the complainant.

The practice manager produced a copy of the letter advising of the termination of her care, which advised that her final appointments would be honoured, her patient records would be transferred to a new clinic upon request, and in an emergency situation she would be treated at the clinic.

The OHCC identified the following deficiencies:

> *there was not a dedicated incident report system; and*
>
> *no informed consent obtained from patients when they commenced with the clinic in relation to adhering to the codes of conduct and behaviour policy.*

The OHCC made suggestions that were welcomed by the practice manager. The OHCC suggested the implementation of an incident reporting system. It was also suggested that the clinic's new patient registration form include a signed acknowledgement to abide by the practice's conduct and behaviour policy. This would prevent confusion for the patient and allow the practice manager to clearly articulate how the patient had breached the behaviour and conduct policy.

Conflict between GP and patient

An elderly gentleman complained that he had received rude and distressing verbal treatment by a GP about which he approached the OHCC, seeking an apology. The OHCC obtained a response from the GP and consulted with AHPRA about the GP's conduct which appeared to be a departure from best practice as described in the Code of Conduct. The GP failed to apologise to the patient and became openly adversarial with the OHCC.

The Medical Board of Australia imposed a caution on the GP's registration as a result of this complaint.

Other health services

The OHCC helps in obtaining a prosthesis

The complainant contacted the OHCC regarding delays she was experiencing in receiving her prosthesis following surgery. She had been waiting three months for follow-up appointments, and she had been trying unsuccessfully to resolve the issue with the provider.

Following a series of telephone calls between our Office and the parties, the matter was promptly resolved. Some five days after contacting our Office the complainant had an appointment for the prosthetic fitting.

The OHCC spoke with the complainant a week following the fitting and we were advised that she now had her prosthesis fitted. The complainant thanked the OHCC for our assistance and support to reach this resolution.

Lack of social media policies causes confusion in a health service

A complaint was received regarding restricted access to services within a community health service. The complainant was denied access to the service on the grounds that she had posted negative information on a social platform. The complainant alleged that she had been denied natural justice as she had been banned from the facility without an opportunity to appeal the process.

The OHCC made extensive enquiries with the provider and complainant. At the conclusion of the assessment the OHCC suggested that the provider obtain informed consent from all new and existing patients regarding the standard of behaviour required. We also suggested that the provider should update their policies to include social media and the relevant agreed standards of behaviour, with posters displayed to the public.

The suggestions were welcomed by the provider. The provider gave the OHCC a copy of their updated Charter of Rights, which included a section for the patients to sign and acknowledge their obligations to abide by the Charter. The provider also updated its closed social media groups with agreed standards of behaviour.

Improvements made during consultation with AHPRA

A new mother complained that she had been provided with incorrect information by her GP about breastfeeding. The GP denied the patient's allegations, explaining that he had provided appropriate information about breastfeeding in the context of his concerns about his patient's health.

The OHCC consulted with the Medical Board of Australia and was satisfied that the complaint was appropriately resolved, in that

Snapshot A refund for painful orthotics

We received a complaint about orthotic devices that caused a woman pain and bruising, and in relation to which, further adjustment was not successful.

Without accepting that the treatment or orthotic devices provided to her were substandard, the provider agreed to refund approximately 75% of the cost of the orthotics. The complainant was pleased with this outcome.

the GP provided a number of undertakings to make sure he was fully informed about best practice with regard to providing information about breastfeeding.

The complainant was seeking a change in policy and procedure and a quality improvement as outcomes of the complaint. It is arguable that these outcomes were achieved.

Unregistered providers

Burns from *Cool Slimming* treatment

A treatment called *Cool Slimming* was provided to a woman at a cosmetic business. She complained that she had received the treatment on her stomach and incurred extensive painful burns such that she was unable to attend her workplace for over a week and had to attend her GP for treatment.

The complainant was advised that the OHCC was unable to accept her complaint, as the service she received does not constitute a health service under the *Health Complaints Act 1995*.

She was referred to a number of regulators for assistance but was also advised that there is no specific regulator overseeing this sort of service.

Sexual assault during a massage

The complainant attended a booked appointment at a massage clinic in the north of the state.

She alleged that during the massage she was sexually assaulted and extremely traumatised. We obtained permission from the complainant to refer the matter to Tasmania Police.

Complaint about IPL treatment

A complaint was received from a client of a laser clinic who had attended a number of sessions for pigment treatment, claiming that the treatment had made his pigment issue worse.

He sought a refund from the clinic and improvements to the clinic's consent process.

The OHCC attempted to resolve the issues on the grounds that correction of a problematic skin pigmentation could be considered a health service. We sought a response from the clinic and requested a refund on behalf of the complainant.

The clinic refused to refund the cost of the services and produced a document signed by the complainant that demonstrated he had apparently understood that laser treatments can produce negative outcomes for some clients.

The OHCC contacted the Radiation Protection Unit at the Department of Health, which advised it was unable to accept complaints about individual treatments.

The complainant was dissatisfied with this outcome.

Cases closed in conciliation

Plaster cast removal – learnings

A young girl presented to hospital with a fracture of her lower arm. The bone was realigned and a cast applied. On review a week later, it was identified that the bone was not properly aligned and surgery would be required to achieve this. The patient was anaesthetised, the cast was removed, the bone was realigned and a back-slab was placed on her arm.

Three weeks later, on experiencing an unusual level of discomfort during the removal of the back-slab, it was identified that the patient had suffered burns from the saw used to remove the earlier cast. These burns had not been identified at the time and had adhered to the back-slab. When that was removed, the scabs that had formed were torn off causing significant pain and leaving scars along the length of the patient's arm.

Although staff at the hospital apologised when the back-slab was removed, the patient's parents raised their concerns with the OHCC. They wanted to understand how the injury had occurred in the first place, why more steps hadn't been taken to prevent it at the time, and what was being done by the hospital to make sure it didn't happen to someone else in the future.

The complaint was referred to conciliation. As part of that process, the parents met with representatives from the hospital and told their story. They had the opportunity to give details of the impact of the injury on their daughter (and them) and to be involved in discussions about the types of interventions that might be implemented to prevent a similar occurrence in the future. The hospital had the opportunity to provide an explanation as to what happened and why, and the impact which the incident had had on the staff involved.

The end result was that the hospital:

- offered the patient and her parents a heartfelt apology;
- advised that a saw blade exchange program had been implemented;
- advised that plaster saws were now vacuum extracted (which keeps the blades cooler);
- committed to expanding the orthopaedic orientation manual to include learnings from this particular case; and
- committed to developing a pictorial warning, to be attached to plaster saws in the theatre suite, warning of the risk of cast saw burns and outlining the process to be used.

Complication from skin graft harvesting

A woman presented to hospital with an injury to her thigh. The injury required a skin graft. The usual dermatome instrument for harvesting the skin graft was not available on the day. The doctor performing the procedure used a different technique using a Watson knife. This was unsuccessful, resulting in a full thickness laceration. A further two attempts (using a different Watson knife on each occasion) were made but each caused a full thickness laceration. The fourth attempt was successful. The lacerations were repaired with sutures.

The woman made a complaint to the OHCC. She was concerned that the doctor had continued to use an instrument that was not working properly. She was seeking an explanation, apology and compensation, and she also wanted steps to be taken to prevent a similar occurrence in the future.

The hospital provided a response acknowledging the woman's concerns, apologising and explaining that the usual dermatome instrument had not been available on the day as it was undergoing repairs. The hospital explained that the doctor performing the procedure had been trained in the use of the Watson knife, but, on closer inspection after the incident, it was identified that some Watson knives had warped, probably during the sterilisation process. The hospital advised that as a consequence Watson knives had been withdrawn from use. It offered to meet with the complainant in conciliation to discuss her concerns and her request for compensation.

The complaint was referred to conciliation. Unfortunately, delays occurred throughout COVID and the woman moved interstate. The complaint was successfully resolved through a shuttle process.

The hospital reiterated that Watson knives had been withdrawn from use and staff had been advised of the ability to borrow a dermatome from one of the private hospitals.

Delay in diagnosis of elderly patient

An elderly, yet previously very active, man presented to hospital with concerns about sudden deterioration in his mobility. He underwent neurological examinations and a CT scan of his lumbar spine, which identified spinal stenosis. He was sent home with advice to see his GP.

He re-presented a few days later with worsening mobility and increased numbness and was admitted to hospital. He was reviewed by a neurologist and underwent various tests. He was identified as possibly having Guillain-Barré syndrome (GBS) for which he received a course of treatment over several days. He continued to deteriorate and was started on another course of treatment for GBS.

He continued to deteriorate. The neurologist by this time was no longer working at the hospital. The man was ultimately seen by a gerontologist who ordered further CT scans. He was diagnosed as having a thoracic spinal synovial cyst, which was placing pressure on his spinal cord. He underwent urgent spinal surgery but did not recover his premorbid level of functioning, being no longer able to drive or walk unassisted.

He made a complaint directly to the hospital. The hospital responded, acknowledging his concerns, outlining the steps taken to diagnose and treat his condition and inviting him to make a complaint to the OHCC, which he did. A further response from the hospital conceded that there had been a delay in diagnosis of the cyst but said that there was no indication that this had an impact on the outcome and that he had made a good recovery given his age.

The OHCC undertook an internal review of the medical records and identified that there were symptoms described in the medical records – the presence of a

Babinski sign when testing the plantar reflex – that should have led to an earlier diagnosis of a spinal lesion.[1]

The complaint was referred to and resolved in conciliation. In the process the man had the opportunity to tell, and have acknowledged, his feelings of despair and frustration lying in a hospital bed with no one listening to him, the feeling that he was too old for treatment and the impact on his previously very active life.

Refund for orthodontic treatment

The complainant signed up, and paid in advance, for a five-year course of orthodontic treatment with a dentist. He moved interstate before completing the treatment. He attended a different dentist interstate and was told the initial treatment had not been appropriate. He incurred further costs undergoing rectification procedures. He wrote to the original dentist seeking a refund of the fees he had paid. The dentist initially agreed, but despite a number of requests, the payment did not eventuate.

The complainant made a complaint to the OHCC. The complaint was referred to and resolved in conciliation.

1 The plantar reflex is a reflex elicited when the sole of the foot is stimulated with a blunt instrument. The reflex can take one of two forms. In healthy adults, the plantar reflex causes a downward response of the big toe (flexion). An upward response (extension) of the big toe is known as the Babinski response or Babinski sign, named after the neurologist Joseph Babinski. The presence of the Babinski sign can identify disease of the spinal cord and brain in adults.

Refund for endodontic treatment

A woman attended a dentist complaining of tooth pain. She required root canal treatment.

The dentist commenced this treatment but when it became complicated referred her to a more experienced dentist in the same practice. The second dentist attempted to complete the treatment but in the process perforated the apical tip of the tooth.

The woman attended an endodontist who advised that the tooth would need to be extracted and that, had the woman been referred to an endodontist initially, it was likely they would have been able to save the tooth. She was referred to a dental surgeon who undertook an extraction under general anaesthetic.

The woman lodged a complaint with the OHCC about the second dentist. She complained that she should have been referred to the endodontist earlier and was seeking reimbursement of the expenses incurred in treating and removing the tooth. She was also seeking compensation for pain and suffering and the costs associated with replacing the tooth with an implant.

The second dentist responded, apologising to the woman and explaining that they had only been trying to help the woman when they proceeded with the root canal treatment. Further, they would in future assess complex cases more thoroughly and refer to an endodontist sooner.

The complaint was referred to and resolved in conciliation.

Complaint and enquiry summaries

Summary of issues by category

Table 10 Summary of issues by category

Issue	2020–21	2021–22	2022–23
Access	166	144	174
Communication/information	124	149	153
Consent	19	18	6
Discharge/transfer arrangements	10	14	6
Environment/management of facilities	31	56	10
Fees and costs	20	26	47
Grievance processes	21	16	19
Inquiry service	17	21	22
Medical records	8	16	19
Medication	172	136	127
Professional conduct	27	47	36
Reports/certificates	20	23	9
Treatment	214	382	492
Total	849	1,069	1,120

Breakdown of issues by category

Table 11 Access

Issue	2020–21	2021–22	2022–23
Access to facility	2	5	3
Access to subsidies	3	1	0
Refusal to admit or treat	18	36	25
Remoteness of service	2	2	1
Service availability	122	80	121
Waiting lists	19	20	24
Total	166	144	174

Table 12 Communication and information

Issue	2020–21	2021–22	2022–23
Attitude/manner	66	68	68
Inadequate information provided	25	42	39
Incorrect/misleading information provided	26	27	32
Special needs not accommodated	7	12	14
Total	124	149	153

Table 13 Consent

Issue	2020–21	2021–22	2022–23
Consent not obtained or inadequate	8	12	6
Involuntary admission or treatment	10	4	0
Uninformed consent	1	2	0
Total	19	18	6

Table 14 Discharge and transfer arrangements

Issue	2020–21	2021–22	2022–23
Delay	1	2	2
Inadequate discharge	7	9	4
Mode of transport	0	1	0
Patient not reviewed	2	2	0
Total	10	14	6

Table 15 Environment/management of facilities

Issue	2020–21	2021–22	2022–23
Administrative processes	20	44	3
Cleanliness/hygiene of facility	1	4	1
Physical environment of facility	7	7	4
Staffing and rostering	2	1	2
Statutory obligations/accreditation standards not met	1	0	0
Total	31	56	10

Table 16 Fees and costs

Issue	2020–21	2021–22	2022–23
Billing practices	12	17	31
Cost of treatment	1	3	14
Financial consent	7	6	2
Total	20	26	47

Table 17 Grievance processes

Issue	2020–21	2021–22	2022–23
Inadequate/no response to complaint	18	14	14
Information about complaints procedures not provided	3	1	1
Reprisal/retaliation as a result of complaint lodged	0	1	4
Total	21	16	19

Table 18 Inquiry service

Issue	2020–21	2021–22	2022–23
Request for information – Health Service	4	3	2
Request for information – Other	4	2	4
Request for Information – Commission	0	6	10
Request for information – Complaint mechanisms	9	10	5
Request review	0	0	1
Total	17	21	22

Table 19 Medical records

Issue	2020–21	2021–22	2022–23
Access to/transfer of records	5	14	13
Record keeping	2	1	5
Records management	1	1	1
Total	8	16	19

Table 20 Medication

Issue	2020–21	2021–22	2022–23
Administering medication	4	9	12
Dispensing medication	3	4	6
Prescribing medication	164	122	89
Supply/security/storage of medication	1	1	20
Total	172	136	127

Table 21 Professional conduct

Issue	2020–21	2021–22	2022–23
Assault	2	0	1
Boundary violation	1	3	6
Breach of condition	0	0	1
Competence	9	13	15
Discriminatory conduct	0	10	5
Emergency treatment not provided	1	0	0
Financial fraud	3	1	0
Illegal practice	3	2	1
Impairment	0	0	3
Inappropriate disclosure of information	8	14	3
Misrepresentation of qualifications	0	2	1
Sexual misconduct	0	2	0
Total	27	47	36

Table 22 Reports and certificates

Issue	2020–21	2021–22	2022–23
Accuracy of report/certificate	7	5	4
Cost of report/certificate	1	0	1
Refusal to provide report/certificate	9	9	2
Report written with inadequate or no consultation	2	2	1
Timeliness of report/certificate	1	7	1
Total	20	23	9

Table 23 Treatment

Issue	2020–21	2021–22	2022–23
Attendance	0	1	2
Coordination of treatment	26	52	44
Delay in treatment	34	75	93
Diagnosis	24	27	21
Excessive treatment	2	6	5
Experimental treatment	1	1	3
Inadequate care	32	48	92
Inadequate consultation	9	10	15
Inadequate prosthetic equipment	4	4	4
Inadequate treatment	22	64	90
Infection control	1	1	3
No/inappropriate referral	7	11	13
Rough and painful treatment	6	6	13
Unexpected treatment outcome/complications	36	43	61

Table 23 Treatment

Issue	2020–21	2021–22	2022–23
Withdrawal of treatment	2	15	17
Wrong/inappropriate treatment	8	18	16
Total	214	382	492

Summary of outcomes of complaints

Table 24 Outcomes from cases closed in assessment stage

Outcomes	2020–21	2021–22	2022–23
Apology given	38	44	28
Change in policy	10	10	8
Change in procedure	14	9	9
Compensation received	0	1	4
Concern registered	149	213	420
Declined/referred	6	17	24
Dismissed (no other outcome)	14	0	0
Explanation given	177	204	207
Fees/costs – refunded, waived or reduced	7	11	7
Information obtained	257	267	242
Quality improvement	14	22	14
Service obtained	85	148	86
Total	771	949	1,049

Enquiries about this annual report should be directed to:

Health Complaints Commissioner
Level 6, 86 Collins Street
Hobart, Tasmania 7000

Telephone: 1800 001 170

Email: health.complaints@healthcomplaints.tas.gov.au

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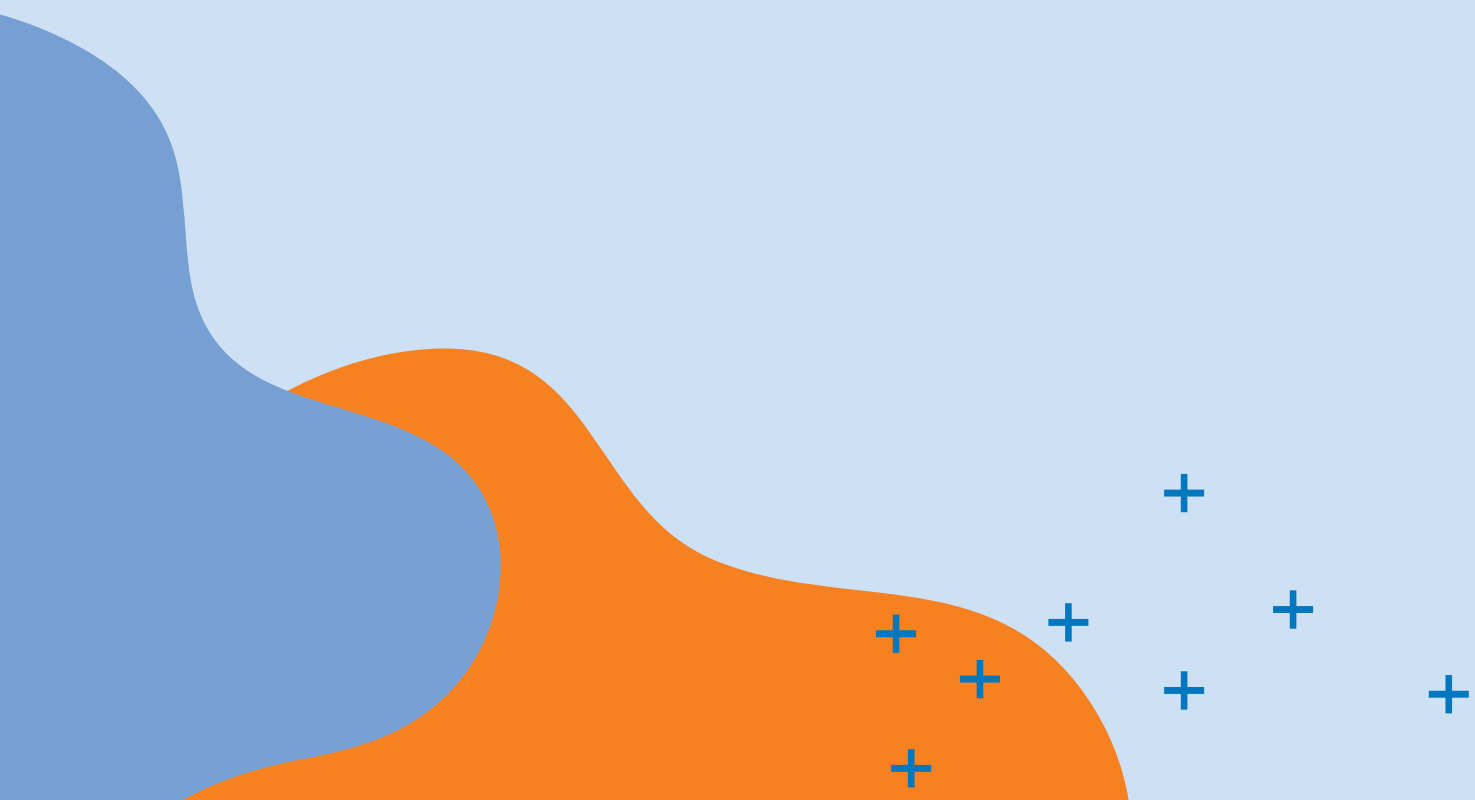

The Office of the Health Complaints Commissioner Tasmania