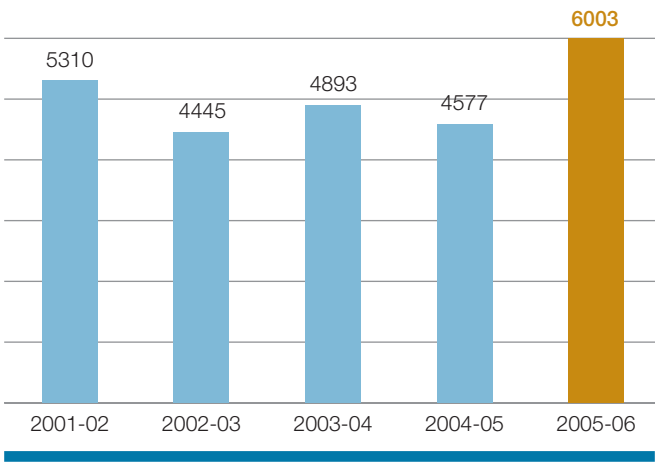
HEALTH CARE COMPLAINTS COMMISSION

ANNUAL REPORT 2005–06

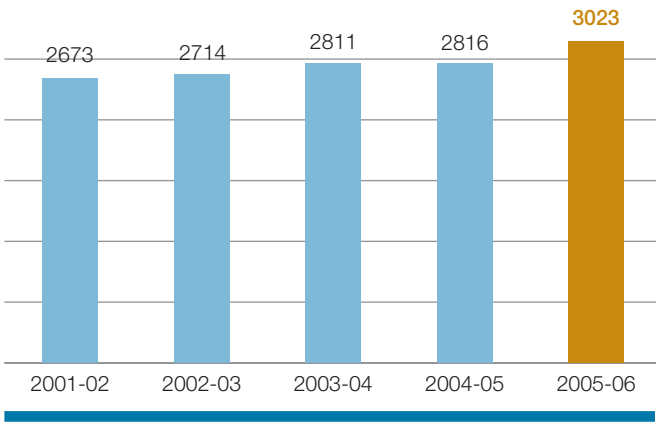
HEALTH CARE COMPLAINTS COMMISSION

FIVE YEARS AT A GLANCE

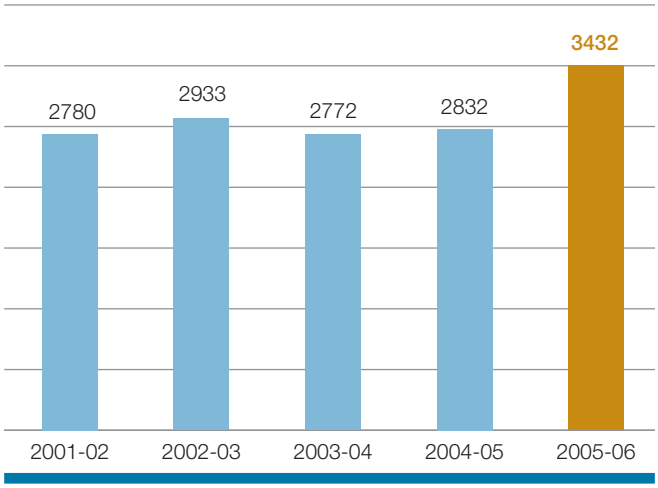
NUMBER OF TELEPHONE INQUIRIES RECEIVED



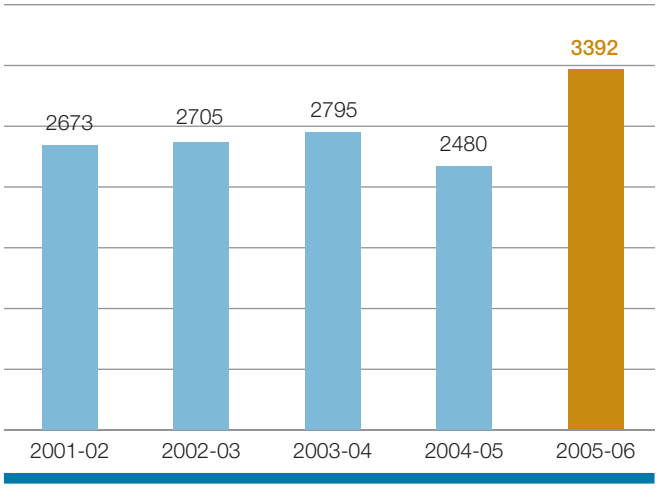
NUMBER OF COMPLAINTS RECEIVED



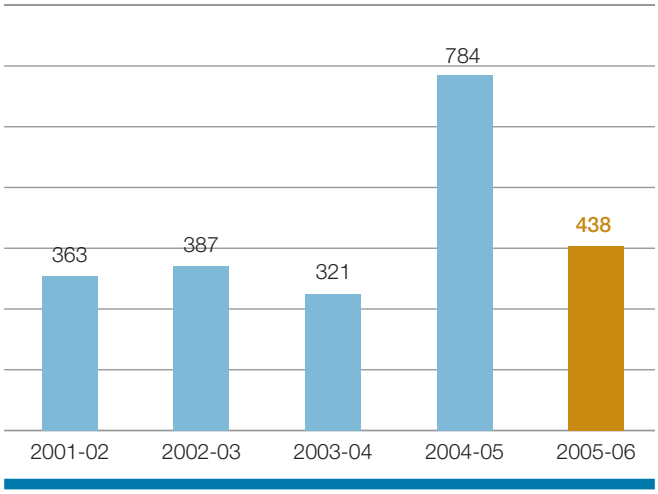
NUMBER OF COMPLAINTS FINALISED



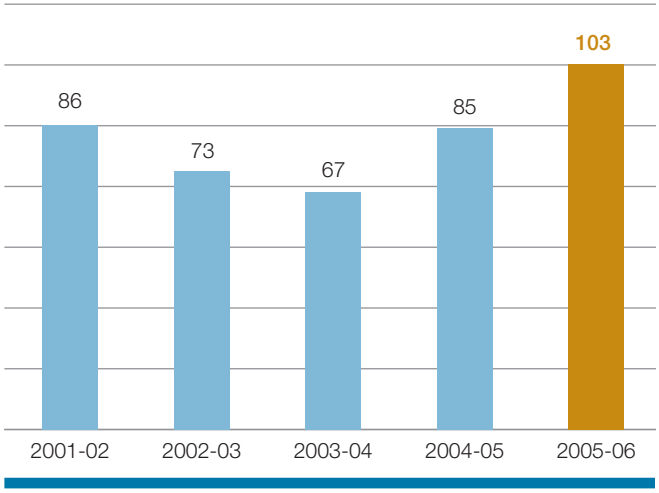
NUMBER OF ASSESSMENTS FINALISED



NUMBER OF INVESTIGATIONS FINALISED



NUMBER OF DISCIPLINARY ACTIONS FINALISED



For an explanation of the matters included in complaint numbers please see Section 7.0 Complaint Numbers, Trends and Issues on page 18

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HEALTH CARE COMPLAINTS COMMISSION

The Hon. John Hatzistergos, MLC
Minister for Health
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Minister

Report of activities for the year ended 30 June 2006

I am pleased to provide the Annual Report and financial statements of the Health Care Complaints Commission and the Office of the Health Care Complaints Commission for the financial year ended 30 June 2006 for presentation to the Parliament of NSW.

The report has been prepared and produced in accordance with the provisions of the *Annual Reports (Statutory Bodies) Act 1984, the Public Finance and Audit Act 1983* and the *Health Care Complaints Act 1993.*

Yours sincerely

Kieran Pehm
Commissioner

2.0 ABOUT THE COMMISSION

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Vision

The Health Care Complaints Commission acts in the public interest by resolving, investigating and prosecuting complaints about health care to protect the health and safety of the public.

Charter

The Commission's role is to:

- receive and assess complaints relating to health services and health service providers in NSW
- resolve or assist in the resolution of complaints
- investigate and assess whether any such complaint is serious and if so, whether it should be prosecuted
- prosecute serious complaints.

In exercising its functions under the Health Care Complaints Act the Commission is to have as its primary objective the protection of the health and safety of the public.

The services provided by the Commission include:

- receiving and dealing with complaints concerning the care and treatment provided by health practitioners and health organisations
- resolving complaints with the parties
- providing opportunities and support for people to resolve their complaints and concerns locally
- investigating complaints
- prosecuting cases before disciplinary bodies
- publishing and distributing information about the Commission's work and activities
- advising the Minister and others on trends in complaints.

Stakeholders

- Health consumers
- The diverse communities of NSW
- Parliament of NSW
- NSW Minister for Health
- Parliamentary Joint Committee on the Health Care Complaints Commission
- NSW Department of Health
- Area Health Services
- The Commission's Consumer Consultative Committee
- Health professional registration authorities
- Health practitioners and organisations
- Health professional, educational and industrial organisations
- Other government agencies
- Media.

3.0 COMMISSIONER'S FOREWORD

The year 2005–06 has been a very productive one for the Commission. The Commission has been continuing its program of extensive reform with the focus firmly on complaint handling and improving the quality and timeliness of the Commission's work.

The Commission's Inquiry Service is now staffed by Resolution Officers, who have a greater depth of experience with the health system, and are better able to advise and assist potential complainants about how best to pursue their complaint. The year has also seen the completion of the restructure of the Commission's Assessment Branch. The assessment process is now much more engaged with both complainants and health service providers, produces a more extensive and accurate assessment of complaints, and better informs decisions about how complaints should be handled. Although some delays in the assessment process were experienced through the year, these delays were a consequence of the reforms, as staff adapted to new ways of working. The Assessment Branch is now running effectively and will continue to improve.

Only the most serious complaints are formally investigated, and the various options for resolution between the parties are being explored to a greater degree. I expect the Commission will continue to expand and develop its capacity to assist complainants in resolving complaints to their satisfaction. The Commission has absorbed the functions of the Health Conciliation Registry and, together with its Resolution Officers, now has greater ability to promote dispute resolution.

The large backlog of complaints under investigation has been cleared and the timeliness of the investigation process continues to improve. Closer case management within the Investigations Division is also ensuring greater consistency and a higher quality of decision-making. The proportion of complaints substantiated at the end of investigation is increasing as the assessment process ensures that only the more serious matters are investigated. The Commission is also developing its capacity to contribute to the improvement of health service delivery generally through monitoring of implementation of the recommendations arising from investigations.

The Commission's Legal Division has also undergone significant change. The Director of Proceedings now makes decisions regarding prosecution independently and the division has recently been restructured to provide more supervision and better case management.

Supporting these reforms is the continued development of the Commission's electronic case management system, which was introduced in March 2005 and underwent further development throughout the year.

It has not been an easy year for the staff of the Commission. Complaints regarding health services are often highly emotionally charged and can involve inherently difficult and complex issues. The reforms to work practices have required greater personal interaction with the parties to complaints and more rigorous procedures and analysis of information and evidence. While there has been some staff turnover as a result, the majority have responded well to the challenges. I would like to thank all staff and particularly the Commission's senior management for their hard work and dedication throughout the year.

4.0 EXECUTIVE SUMMARY

Following an extended period of change, 2005–06 has been a year of consolidation for the Health Care Complaints Commission.

2004–05 was a period of major reform throughout the Commission, with all aspects of the Commission's work affected. These reforms included:

- conclusion of the investigations conducted into Camden and Campbelltown Hospitals
- organisational change through the establishment of a new structure
- inclusion of Health Conciliation Registry in the Commission
- introduction of a new electronic case management system (Casemate)
- changes to legislation in March 2005, including the formalisation of the Resolution Service and the creation of the position of Director of Proceedings.

In furthering these reforms, more improvements in the Commission and its practices have been implemented this year, including:

- the change in responsibility for the Telephone Inquiry Service
- refinements made to Casemate
- introduction of a performance management system
- establishment of the Senior Management Group.

All the divisions within the Commission have shown an outstanding improvement in their handling of complaints.

Complaints received

The Commission received 3023 written complaints in 2005–06, an increase of 7.4% on the 2816 complaints received in 2004–05.

In preparing this Annual Report the Commission identified discrepancies in the way complaints had been counted in previous years. To ensure consistency in complaint data, the counting and reporting of complaints has been revised. Complaint numbers and outcomes for the last four years have been amended on this basis. These revised numbers are reflected throughout this report.

During 2005–06 changes were made to the Telephone Inquiry Service with telephone inquiries now handled by the Commission's Resolution Officers. These officers previously dealt with complex inquiries as Patient Support Officers and have a depth of experience that allows them to respond to inquiries more effectively. These changed procedures have resulted in an increase in the count of inquiries received.

The Resolution Officers offer callers a number of different mechanisms to address their concerns. Advice may include referring them to a more suitable body that can deal with their concerns more appropriately or discussing strategies to assist in resolving their concerns.

Analysis of complaints received

One of the functions of the Commission is to provide information on trends in complaints to the Minister for Health, health service providers and professional and educational bodies.

As part of this year's Annual Report the Commission undertook a review of complaints during 2005–06. The review resulted in a more detailed profile of complaints received by the Commission than had been completed in previous years. The review analysing numbers, trends and issues is set out in Chapter 7.0

Complaint handling performance

The Commission assessed 3392 complaints in 2005–06, considerably more than the 3023 complaints received in the same period.

Improvements to the assessment process have continued throughout 2005–06. Significant modifications were made to Casemate to address performance and workflow related issues. New procedures have been introduced and complaints are assessed more comprehensively than in recent years.

As a general rule Assessment Officers now clarify the complaint as much as possible prior to assessment. This includes:

- contacting the complainant
- notifying the provider and seeking a response to the complaint
- accessing health records, and in some cases
- seeking clinical advice.

The changes to Casemate and introduction of new procedures have influenced the time taken to assess complaints. During the reporting period 55.6% of assessments were completed within the statutory 60-day timeframe. However, from 1 April 2006, the Assessment Branch has been achieving a rate of 80% of assessments being finalised within 60 days.

The Resolution Service finalised 601 complaints during the 2005–06 year. A total of 593 complaints were referred for assisted resolution; 73.2% of complaints finalised by the Resolution Service were either resolved or partially resolved.

During 2005–06, 186 complaints were assessed as suitable for referral to the Health Conciliation Registry, and 149 complaints were closed. Of those complaints where conciliation was consented to, 94.2% reached an agreement either during conciliation or prior to conciliation being held. The Health Conciliation Registry has introduced a number of measures to increase the consent rate for conciliation and will continue to monitor this area.

A total of 373 complaints were assessed for investigation during 2005–06 and 438 investigations were finalised during 2005–06. Of the investigations finalised, 92 were regarding health organisations and 346 regarding health practitioners.

The average number of days taken to complete investigations continued to improve during 2005–06. The average number

of days to complete investigations in 2005–06 was 352 compared to 595 days to complete investigations in 2004–05 and 938 days in 2003–04.

2005–06 has seen an increase in the proportion of investigations referred for disciplinary outcomes, in the case of individual health practitioners from 50.8% in 2004–05 to 57.5% in 2005–06. Similarly, in the case of health organisations, the proportion of investigations finalised where the Commission made comments and recommendations has also increased from 21.8% in 2004–05 to 54.3% in 2005–06.

Correspondingly the number of investigations finalised without further action has decreased in 2005–06. This is an outcome of the more thorough and rigorous assessment process.

A growing area of focus for the Commission is the making of comments or recommendations at the end of an investigation into a health organisation. It is through comments and recommendations to health organisations that the Commission is able to address systemic issues uncovered during an investigation.

During 2005–06, 50 investigations resulted in the making of comments or recommendations. This is twice the number from 2004–05 and over three times the number from 2003–04. During 2005–06 the Commission introduced new processes to monitor the implementation of recommendations made to health organisations.

Following the finalisation of the backlog of complaints in 2004–05, this year saw a reduction in the number of complaints referred to the Legal Division.

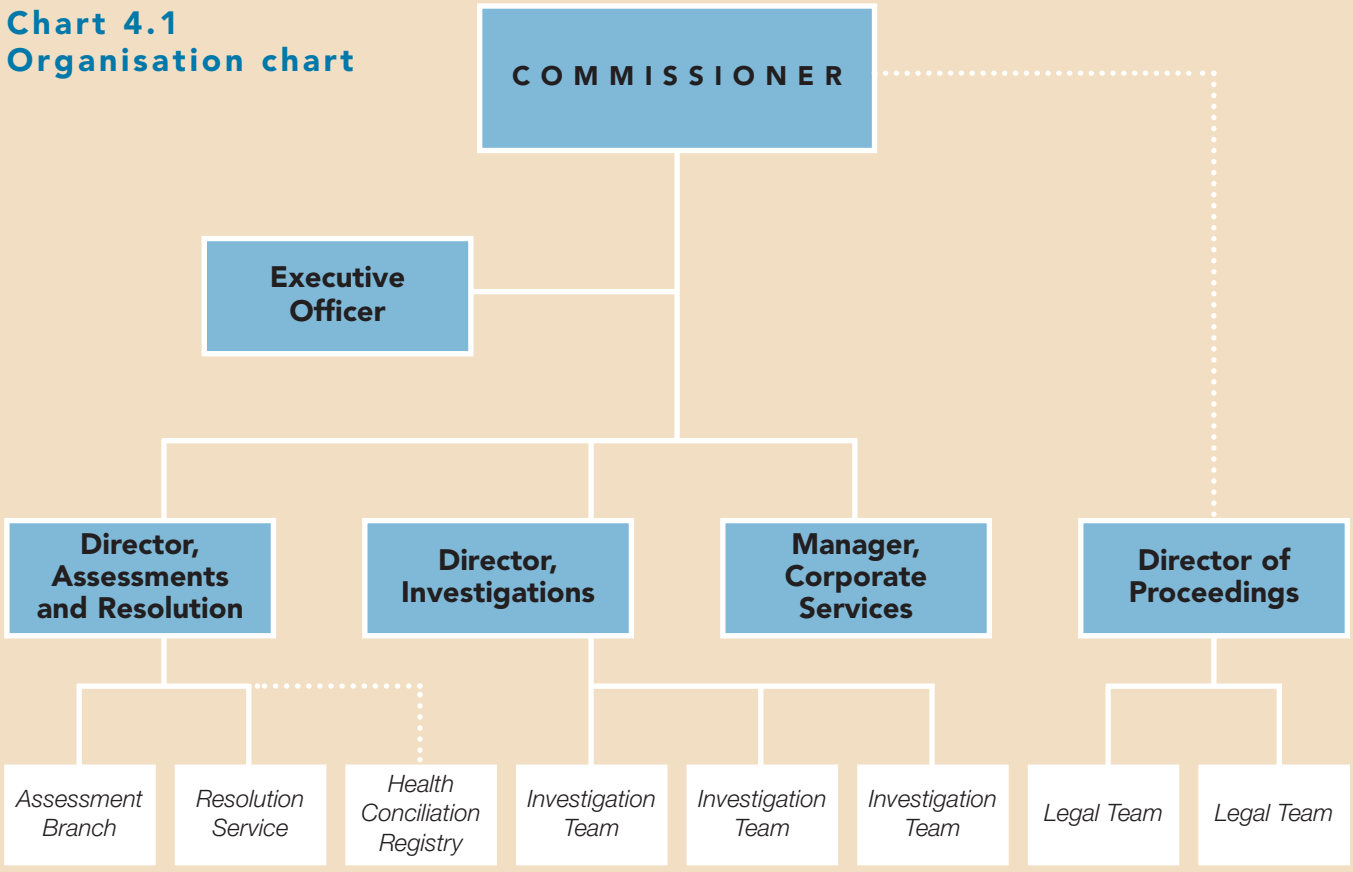
One hundred and three cases were finalised by the Legal Division in 2005–06, a significant increase in the 85 cases finalised in 2004–05.

Corporate reform

Some highlights of the Commission's achievements in corporate reform include:

- an independent review of the Commission's records practices and changes in records management procedures across the Commission
- establishment of an Internal Audit Committee
- implementation of a performance management system
- range of training activities including training in complaint handling processes, investigations and legal practices as well as training on Commission-wide issues such as EEO and diversity, job evaluation and merit selection techniques
- the development of an Information and Communication Technology (ICT) Strategic Plan 2005–08 and establishment of an ICT Steering Committee to monitor progress of key ICT projects
- establishment of a Senior Management Group to promote leadership across the Commission through participation in organisational development issues.

Chart 4.1
Organisation chart



Goal 1: Comprehensive and responsive complaint handling

1.1 Efficient and timely processing and assessment of complaints

Strategy: Employ best practice complaint handling processes by: ■ improving assessment briefing format and assessment guidelines ■ contacting complainant, respondent and clinical advisor to maximise opportunity for less serious complaints to be mutually resolved ■ timely communication of assessment processes and outcomes.	**Measure:** 1.1.1 Number of complaint assessments finalised.	The Commission assessed 3392 complaints in 2005–06. This represents a 36.8% increase on the 2480 complaints assessed in 2004–05.
	Measure: 1.1.2 Percentage of complaints assessed with 60 days.	During the reporting period 55.6% of assessments were completed within the statutory 60-day timeframe. However, from 1 April 2006, the Assessment Branch has been achieving a rate of 80% of assessments being finalised within 60 days.
	Measure: 1.1.3 Percentage of complaints assessed subject to a request for review.	The Commission received 393 requests for review of assessment decision. This represents 11.5% of assessments finalised.
	Measure: 1.1.4 Percentage of complaints where outcome is coded "resolution between parties".	During the 2005–06 period 150 complaints were resolved during the assessment process. This represented 4.4% of all complaints received, and was an increase on the previous year when 45 complaints (1.8%) were resolved during the assessment process.
	Measure: 1.1.5 Percentage of matters referred for investigation.	11.0% (373) of complaints were referred for investigation. The years 2003–04 and 2004–05 had unusually high rates of referral for investigation due to Campbelltown and Camden matters and re-assessment of old complaints.
Strategy: Maintain and improve capability of Casemate as a case management and decision-making support tool.	**Measure:** 1.1.6 Improved performance reporting within Casemate system for performance and trend analysis.	The Commission has reviewed and implemented new Casemate processes for assessments, investigations and legal.
	Measure: 1.1.7 Complete business analysis and design specification for next phase of Casemate development.	In addition to employing an Application Systems Manager in February 2006 the following enhancements were made to Casemate in the last financial year: ■ upgrade of investigations process for monitoring recommendations made to health organisations ■ improvements made to the legal process to enhance process outcome related functionality ■ new team security was implemented to enhance overall security of Casemate via a team-based access ■ all Casemate reports were enhanced and moved to the Intranet for wider access ■ Casemate was re-engineered to enhance assessment process and related functionality to address performance and workflow related issues ■ Casemate was migrated to a faster server and upgraded version of Casemate software along with SQL server 2005 to address performance related issues.

1.2 Promote greater use of and increased confidence in formal and informal complaint resolution

Strategies:	Measure:	
1. Develop assessment criteria that identify those matters that may benefit most from assisted resolution. 2. Resolution assistance plans (RMP) developed for assisted resolutions.	1.2.1 Percentage of matters resolved or partially resolved by Resolution Service.	17.5% of all complaints assessed during 2005–06 were referred to the Resolution Service. Of the complaints finalised by the Resolution Service 73.2% were resolved or partially resolved.

1.3 Promote complaint resolution services provided to people in rural and regional NSW by the Resolution Service and Health Conciliation Registry

Strategy: Resolution Officers meet with local and regional community and support groups to promote Commission activities.	**Measure:** 1.3.1 Number (percentage) of complaints resolved by regional Resolution Officers.	115 complaints were resolved or partly resolved by regional Resolution Officers. This represents 29.2% of the 394 complaints resolved or partly resolved by the Resolution Service. It is not possible to compare this information to the 2004–05 period due to the change to the role of the Resolution Officers after March 2005.
Strategy: Health Conciliation Registrar monitors conduct of conciliation ensuring professional behaviour, informed decisions and engagement of parties without undue pressure or influence.	**Measure:** 1.3.2 Number of conciliation matters referred to Health Conciliation Registry.	186 complaints were referred to the Health Conciliation Registry in 2005–06. Again, previous years' complaints are anomalous due to changes operating after March 2005.
Strategy: Develop improved community and public sector information reporting of case performance and information.	**Measure:** 1.3.3 Percentage of Health Conciliation Registry matters where agreement/partial agreement reached.	Of the 69 complaints where consent for conciliation was received in 2005–06, 65 (94.2%) reached agreement or partial agreement.

1.4 Promote public awareness of the assessment and resolution of complaints about health care

Strategy: Implement an external communications strategy including updated promotional materials.	**Measure:** 1.4.1 Number of new/redesigned publications.	The Commission published two new documents in 2005–06: the Annual Report 2004–05 and the Corporate Plan 2006–07. Four Commission publications were redesigned in 2005–06: Information about the Commission; Resolution Service; Complaint Form; and How to Write a Complaint to the Health Care Complaints Commission.
Strategy: Resolution Service officers meet with community and support groups to promote Commission activities.	**Measure:** 1.4.2 Website publications/materials updated.	The Commission's website was updated in November 2005 with new information on the Assessment Process and How to make a complaint.
	Measure: 1.4.3 Number of community groups and extent of networking.	During the reporting period the Commission's Resolution Officers participated in 36 presentation and networking events. These were presented to a variety of community groups. See full list at Table 14.30.

Goal 2: Investigate and prosecute serious complaints

2.1 Ensure a best practice approach for the conduct of investigations

Strategy: Apply a comprehensive approach to investigations and inquiries using a range of appropriate investigative techniques including development and approval of investigation plans and implementation of risk management practices for conducting investigations.	**Measure:** 2.1.1 Number of investigations completed.	The Commission finalised 438 investigations. Whilst this is a significant reduction on the 785 investigations finalised in 2004–05, which were a result of the backlog of Camden and Campbelltown matters, it is an increase in the number of investigations finalised in 2002–03 and 2003–04.
	Measure: 2.1.2 Number of Investigations open.	There were 322 investigations open at 30 June 2006. This compares favourably to the 385 investigations open at 30 June 2005, and the 718 investigations open at 30 June 2004.
Strategy: Develop a consistent approach to the application of expert medical advice.	**Measure:** 2.1.3 Guidelines implemented.	Updated guidelines were sent to all accepted expert peer reviewers in May 2006.
Strategy: Monitoring investigations to ensure statutory compliance, timeliness, re-assessment of issues including status reports to Investigations Reporting Group.	**Measure:** 2.1.4 Reduce average number of days taken to complete investigations.	The average number of days to complete investigations in 2005–06 was 352. This is a considerable reduction on the average of 595 days to complete investigations in 2004–05.
Strategy: Establish a training program for investigators.	**Measure:** 2.1.5 Training program implemented.	A training needs analysis was completed in 2005–06. Training was received in relation to the compilation of 'briefs of evidence' for file handover to the Legal Division. The training needs analysis identified a need to improve the analytical capacity of investigators. A facilitator will be sourced to provide this training during 2006–07.
Strategy: Upgrade Investigations Manual including: procedures in line with new investigatory techniques; compliance with standards; and improved case management.	**Measure:** 2.1.6 Investigations Manual re-issued.	During 2005–06 the Commission completed the bulk of the planning for the Investigations Manual. New procedures relating to the legislative amendments and changes are currently being finalised and it is expected that the manual will be completed in 2006–07.
Strategy: Develop procedures/protocol for the handover of cases to Legal Division for prosecution.	**Measure:** 2.1.7 Number of referrals for consideration of disciplinary action.	In 2005–06 the Commission referred 66 matters to the Director of Proceedings for consideration of disciplinary action.

2.2 Successful prosecution and exposure of serious cases of unsatisfactory health care in a fair and timely manner

Strategy: Timely and high quality legal advice provided throughout investigations.	**Measure:** 2.2.1 Percentage of legal responses provided within 21 days.	Formal processes for requesting legal advice introduced. All legal advice provided within requested timeframes.
Strategy: Implement a quality review program for the management of investigations.	**Measure:** 2.2.2 Recommendations to improve investigation/legal processes implemented and manual updated.	The Director of Proceedings and Director, Investigations have reviewed a variety of prosecutions to identify any issues that may have a negative impact on the success of a prosecution. A 'brief of evidence' protocol has been introduced to improve the file handover between investigations and legal.
Strategy: Timely determinations made to prosecute.	**Measure:** 2.2.3 Percentage of matters determined within 3 months of referral (80%).	66% of matters were considered within 3 months of referral. This can be attributed to a very high number of matters being referred to the Director of Proceedings in 2004–05 and 2005–06, including matters that had not been referred for prosecution as at 1 March 2005 and a large number of backlog matters. It is anticipated that the percentage of matters considered within three months of referral will significantly increase in 2006–07.
Strategy: Compliance with Health Care Complaints Act and other legal requirements for determination of prosecution action.	**Measure:** 2.2.4 No successful legal challenges.	There were no successful challenges to the Commission's procedures. For all other details on appeals see section 10.0 Legal Division and the Director or Proceedings.
Strategy: Further development of Casemate to cover the conduct of legal proceedings.	**Measure:** 2.2.5 Business analysis completed and system specifications prepared.	During 2005–06 improvements were made to the legal process in Casemate to enhance process outcome related functionality.
Strategies: 1. Ensure compliance with directions given by Professional Standards Committees, Tribunals, Boards of Inquiry and courts. 2. Timely listing of matters for hearing.	**Measure:** 2.2.6 Percentage of compliance with deadlines (80%).	This information is not currently captured by the Casemate system. This will form part of the review of the Casemate system to be undertaken with the Legal Division in 2006–07.

2.3 Improve health care systems through recommendations from investigations

Strategy: Ensure practical recommendations are made to improve health care systems.	**Measure:** 2.3.1 Percentage of recommendations implemented.	Of the 57 recommendations made to health organisations in 2005–06, 26 recommendations have been implemented. It is expected that the percentage of recommendations implemented will improve over time as complex recommendations often have lengthy timeframes for implementation.

Goal 3: Accountability

3.1 Provide timely, accurate and relevant reporting to the Minister and NSW Joint Parliamentary Committee (JPC)

Strategy: Monthly reporting on progress of reform program and major issues to Minister.	**Measure:** 3.1.1 Positive response to reports by Minister.	In addition to Quarterly Performance Reports submitted to the Minister for Health the Commission provides regular updates on any reforms or major issues to the Minister. The Minister has indicated he is happy with the provision of these reports.
Strategy: Develop and maintain open and meaningful communication with the JPC.	**Measure:** 3.1.2 JPC consulted about options to improve Commission responses to JPC inquiries.	The Commission liaises with the JPC on a regular basis and provides copies of its Quarterly Performance Reports.
	Measure: 3.1.3 Effectiveness and efficiency of response framework monitored.	No concerns expressed by the Minister or JPC with the Commission's reporting and communication.

3.2 Ensure all business activity complies with all regulatory requirements and standards requirements

Strategy: Ensure appropriate compliance strategies for all aspects of the Commission's operations.	**Measure:** 3.2.1 Policies upgraded and procedures for the management of records in line with State Records and privacy requirements completed.	The Commission commenced its Records Management Program during 2005–06. This included an independent review of the Commission's records practices, the appointment of a full-time officer for the management of the records process and the development of a Records Management Policy.
Strategy: All regulatory requirements (for the Commission and agencies with which we work) included in business plans.	**Measure:** 3.2.2 No breaches of regulatory requirements and central agency reports completed on time.	The Commission is not aware of any breaches of regulatory requirements or of any central agency reports not completed on time.

3.3 Report publicly about the work of the Commission

Strategy: Annual Report reflects the key business and operational results for the year and fully complies with legislative requirements.	**Measure:** 3.3.1 Annual report prepared and tabled in Parliament by 31 October.	In compliance with statutory requirements, the 2004–05 Annual Report was presented to the Minister in October 2005 and was tabled in both Houses of Parliament on the 24 November 2005. It is expected that the 2005–06 Annual Report will be presented to the Minister by the end of October 2006 and tabled in parliament by the end of November 2006.
	Measure: 3.3.2 Clean audit certificate achieved for annual financial statements.	A clean audit certificate was provided for the year's financial statements.
	Measure: 3.3.3 No major deficiencies identified during JPC hearing.	The JPC in its report in relation to the Inquiry into Review of the 2004–05 Annual Report of the Health Care Complaints Commission complimented the Commission on some significant improvements which had been accomplished during the 2004–05 year. It also indicated there were a number of further issues it would like to see addressed.
Strategy: Provide various communication channels for promoting and reinforcing Commission messages: ■ Website ■ Annual Report ■ Media liaison.	**Measure:** 3.3.4 Number of new publications.	See 1.4.1.
	Measure: 3.3.5 Number of website visitors.	Information on website visitors not available for 2005–06. The Commission's website is hosted by the NSW Department of Health. The Department recently introduced new software that allows the Commission to access details regarding number of visits to its website. This information will be collected from July 2006.

Goal 4: Our Organisation

4.1 Continue to develop as a learning organisation that embraces a culture of continuous improvement, excellence and sharing of knowledge

Strategy: Implement staff performance management system including staff learning and development plans that address technical and management skills.	**Measure:** 4.1.1 Each performance agreement demonstrates a direct link to corporate/divisional business plans and/or position accountabilities.	Training on the new performance management procedures system was provided to all managers and the system was trialed in 2005–06 with all managers and selected staff preparing performance agreements relating to their position responsibilities.
	Measure: 4.1.2 Comprehensive learning plans implemented that include training in core competencies and management and leadership skills.	The Commission provided a diverse range of training activities for 2005–06 that included training in core competencies in complaint-handling processes, investigations and legal practices as well as training on Commission-wide issues such as EEO and Diversity, Job Evaluation and Merit Selection Techniques.
Strategy: Develop the organisation's skills capability to meet expected performance requirements.	**Measure:** 4.1.3 Management and supervisory training structured to develop leadership potential.	Training in Commission-wide issues such as EEO and Diversity and performance management included specific management streams. Also a Senior Management Group was established during the year to promote leadership across the Commission through participation in organisational development issues.
Strategy: Foster a culture of supportive leadership across the organisation and regular use of cross-divisional teams for all types of investigations and corporate projects.	**Measure:** 4.1.4 Upgrade induction program to provide greater coverage of business systems and processes.	During 2005–06 an eight-week induction and orientation program was developed for all new Assessment Branch staff. The training occurs for two 2-hour periods each week over two months. The induction program covers issues such as overview and orientation to the Commission, understanding Casemate, preparing briefs, being organised, team building, letter writing, understanding the other divisions of the Commission, understanding the legislative requirements of complaint management, communication strategies, performance agreements, board consultations and the Commission's code of conduct.
	Measure: 4.1.5 Wide cross-section of staff from all divisions participate in the preparation of annual business planning.	Divisional business planning includes extensive participation by staff.

4.2 Provide a safe, equitable, productive and satisfying workplace

Strategy: Develop and maintain an organisational culture which promotes equity, diversity and safety.	**Measure:** 4.2.1 Risk assessment plans developed for offsite investigations.	Each investigation is assessed for risks and appropriate plan implemented.
	Measure: 4.2.2 OH&S plan developed and monitored.	A three-year OH&S and Risk Management plan was developed for the Commission and OH&S Committee was established.
	Measure: 4.2.3 EEO and disability plans developed and improvement measures monitored closely.	An EEO Management Plan and a three-year Disability Action Plan were developed during the year. The details of these plans are set out in Sections 11.0 and 12.0 of this report.
Strategy: Provide information and records systems that actively support and improve business processes.	**Measure:** 4.2.4 Effective implementation of the ICT Strategic Plan.	An Information and Communication Technology (ICT) Strategic Plan 2005–08 was developed and an ICT Steering Committee established to monitor progress of key ICT projects.
	Measure: 4.2.5 Review of records management requirements completed.	An independent review of the Commission records practices was completed and a full-time officer appointed to administer and implement the changes in records management procedures across the Commission.
	Measure: 4.2.6 Policies upgraded and procedures for the management of records in line with State Records and privacy requirements completed.	See 3.2.1.
	Measure: 4.2.7 Achieve compliance with information security standards.	As a precursor to seeking certification of information-security compliance the computer room needed to be upgraded to ensure property security and safety standards are in place. Compliance with ISO 27001 Standards for Information Security including business continuity planning will be undertaken in 2006–07.
	Measure: 4.2.8 Develop business continuity plans.	See 4.2.7.
Strategy: Improve levels and timeliness of internal communication throughout the organisation.	**Measure:** 4.2.9 Regular general staff briefings on events, outcomes, activities, changes, significant organisational changes etc.	The Commission holds staff meetings on a monthly basis. These meetings provide an opportunity for briefings and information sharing across the Commission.
	Measure: 4.2.10 Regular briefings by Directors to direct reports, who conduct subsequent team briefings.	Each division has its own program of structured meetings and briefings ensuring all staff are aware of Commission strategies and programs.
	Measure: 4.2.11 Copies of key corporate documents distributed to all staff and/or included on the intranet.	Copies of key corporate documents are available on the Commission's intranet site.

4.3 Be a lead agency in our governance and corporate infrastructure

Strategy: Establish internal management groups to plan, review and monitor performance ■ Executive Management Group ■ Investigations Reporting Group ■ ICT Steering Committee ■ OH&S Committee ■ Divisional meetings.	**Measure:** 4.3.1 Regular meetings held, performance monitored and recommended business improvements implemented.	The following internal management groups continued to meet in 2005–06: ■ Executive Management Group ■ Investigations Reporting Group ■ ICT Steering Committee. The following internal management groups were established in 2005–06: ■ OH&S Committee ■ Internal Audit Committee ■ Senior Management Group. These governance mechanisms combine to monitor and improve performance.
Strategy: Implement a strategic planning process that integrates all planning activities, budget preparation and regular performance reporting.	**Measure:** 4.3.2 Annual cycle for strategic planning process completed for corporate and divisional levels.	The Commission Strategic Plan, Corporate Plan and divisional plans were prepared for 2005–06. Also prepared for 2005–06 were the Commission's EAPS Forward Plan and EEO Management Plan.
	Measure: 4.3.3 Quarterly business reports to the executive on business performance showing achievement of business plan targets/results.	Quarterly Performance Reports were completed based on performance results obtained from the operational divisions.

4.4 Monitor our performance to ensure work quality and effective resource management

Strategy: Review/develop/monitor key performance measures for efficiency and effectiveness.	**Measure:** 4.4.1 Monthly financial management and staffing reports showing projects and activities achieved on time and within budget.	During 2005–06 regular monthly financial and staff reports were submitted to the Executive Management Group.
Strategy: Implement financial and business management policies and procedures and regular performance review and reporting.	**Measure:** 4.4.2 Quarterly business reports to the executive on business performance showing achievement of business plan targets and performance results.	See 4.3.3.
Strategy: Staff performance management system.	**Measure:** 4.4.3 Performance agreements developed for all staff.	See 4.1.1.

Receiving complaints

The Commission is responsible for receiving and dealing with complaints:

- relating to the professional conduct of individual health practitioners
- concerning the clinical management or care of individual clients by health service providers, including both individual practitioners and organisations, such as hospitals.

Complaints against individual health practitioners involve different procedures from those made against health organisations. This is indicated in the two process flowcharts illustrated at Chart 6.1 and 6.2.

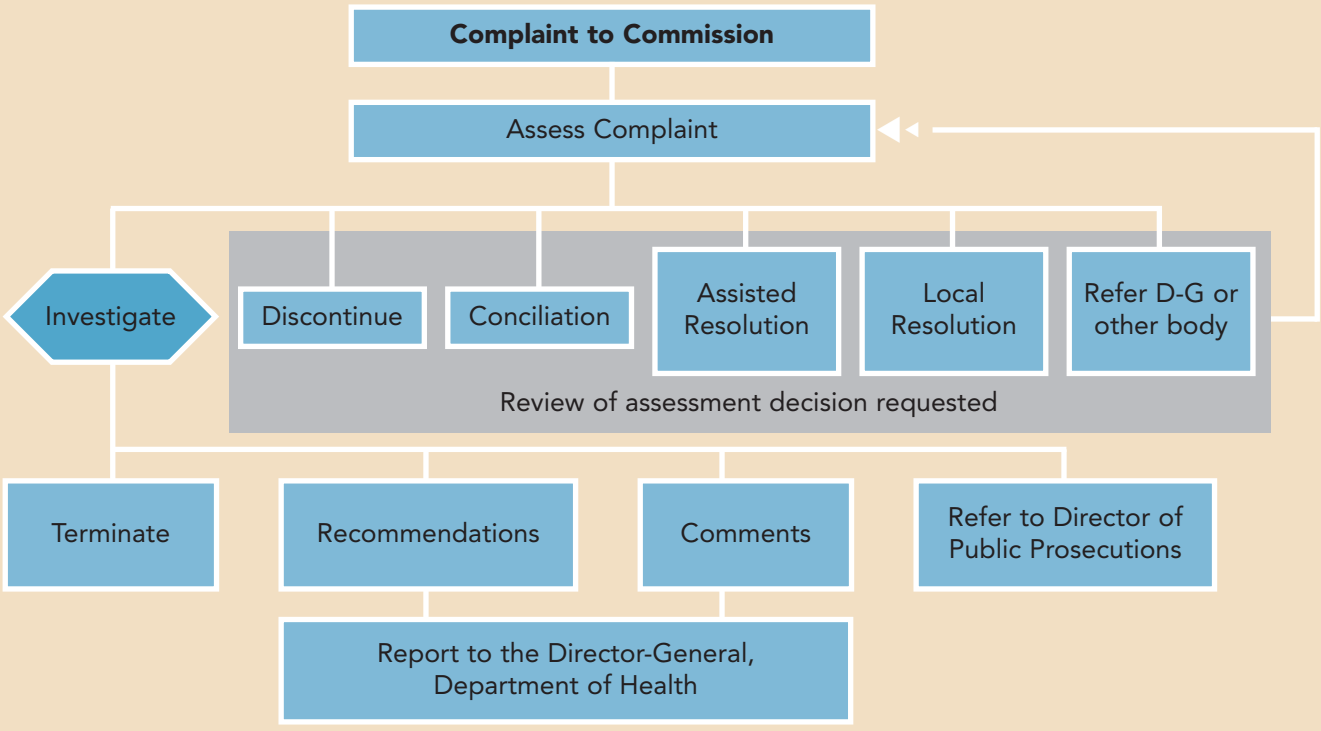
Once a complaint is received the Commission will assess the complaint for the purpose of deciding whether the Commission will:

- discontinue dealing with the complaint
- refer the complaint for local resolution, where the health service provider is a public organisation and consents to try to resolve the matter directly with the complainant
- refer the complaint for assisted resolution where a Commission Resolution Officer will attempt to resolve the complaint between the persons concerned
- refer the complaint for conciliation by the Health Conciliation Registry
- refer the complaint to the applicable health registration authority for attention under its Act
- refer the matter to another more appropriate agency for attention, or
- investigate the complaint.

Depending on the nature of the complaint, some of the key steps involved in assessing a complaint are:

1. **Initial Assessment** by the Manager, Assessment Branch and the Director, Assessments and Resolution Division.
2. Contacting the complainant to **clarify the complaint** and to ensure that the Commission has a proper understanding of their concerns.
3. **Notifying the provider** and seeking a response to the complaint. A copy of the complaint is usually sent to the provider or providers so that they can address the matters of concern.
4. **Accessing health records.** The Commission may request a copy of relevant health records or clinical notes to assist its assessment in cases where the complaint raises concerns about clinical issues.
5. **Seeking clinical advice.** The Commission has nursing and medical advice available to assess the appropriateness of the health care or treatment provided to the subject of the complaint.
6. **Assessment.** All of the relevant information, including any expert advice, is compiled into an assessment brief which, together with the file, is presented to an assessment committee, chaired by the Commissioner.
7. The Commission is required to **consult with the relevant registration authority** as part of the assessment process in the case of a complaint against an individual health practitioner who is registered in NSW.
8. **Notifying the complainant and provider** of the assessment decision. Reasons are given for any decision made and complainants are advised of their statutory right to request a review of the assessment decision, except where the complaint has been referred for investigation.

Chart 6.1 Process for complaints against health organisations



Assessment of complaints

The outcomes of assessment are:

Conciliation

Where a matter is assessed as being appropriate for conciliation it is referred to the Health Conciliation Registry ("the Registry"). The Registry maintains a panel of independent expert conciliators who can facilitate a meeting of the parties to the complaint and guide them in seeking a resolution of the issues that underlie the complaint. Conciliation is a voluntary and confidential process.

Assisted resolution

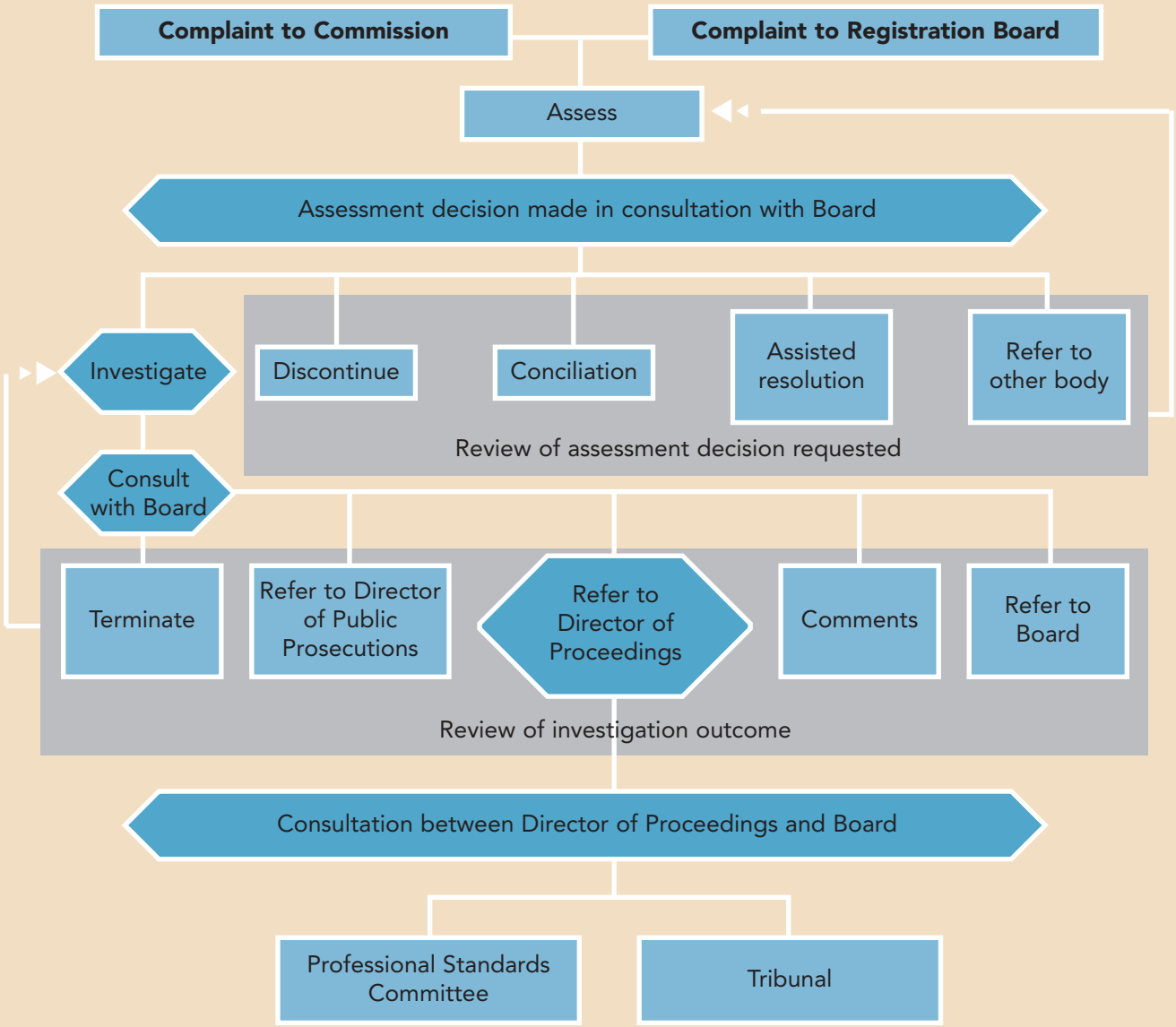
Often a complaint may be resolved with the assistance of one of the Commission's Resolution Officers. This is called assisted resolution. Where a complaint is assessed as being appropriate for assisted resolution a Resolution Officer is available to discuss with the complainant how the complaint may best be resolved.

Resolution Officers can arrange meetings with health service providers and assist the complainant to prepare for those meetings. Resolution Officers are officers of the Commission and they remain neutral in the assisted resolution process. It is their role to help all parties resolve the complaint. Participation in assisted resolution is voluntary.

Local resolution

The Commission can refer the complaint to the health service provider for them to resolve directly with the complainant. This can only be done where the health service provider that has been complained about is a public health organisation such as a hospital or clinic operated by an Area Health Service. The provider must agree before a referral for local resolution is made.

Chart 6.2 Process for complaints against health practitioners



Referral to a health registration authority or another body

In some instances it is appropriate that a complaint be referred to another body to be dealt with by them. There are some instances where referral to one of the registration authorities, such as the Dental Board or the Physiotherapists Board might be appropriate. This kind of referral can be made by the Commission where the relevant Board has specialist expertise and is better able to talk to the practitioner about the way in which they may have dealt with the complainant or the person on whose behalf the complaint was made.

Discontinuing a complaint

The Commission can discontinue dealing with a complaint for many reasons including the age of the matter complained of or that it might be better dealt with by some alternative means of redress. Complaints which are not serious enough to require investigation and where the parties are not willing to participate in a resolution process are also discontinued.

Investigation

Complaints are subject to formal investigation by the Commission where they raise a significant question about public health or safety or about the appropriate care or treatment of an individual or where, if substantiated, the complaint would provide grounds for disciplinary action or would involve gross negligence on the part of a practitioner.

The focus for investigations is on the protection of public health and safety rather than trying to obtain redress for an individual complainant.

Review of assessment decision

If the complainant disagrees with the Commission's assessment decision they may seek a review, except where the complaint has been referred for investigation. If the request is made within 28 days the Commission must review the decision and may review it if the request is received later.

Investigating a complaint

The purpose of an investigation is to obtain information so that the Commission can objectively determine the most appropriate action (if any) to take. The Commission does not act for the complainant when investigating a complaint and must remain impartial.

Once a complaint has been assessed as suitable for investigation, the process includes interviewing witnesses, analysing medical records, and seeking advice from the Commission's Internal Medical Advisors. When investigating a health practitioner the Commission may seek the opinion of an expert advisor who practices in the same field as the health practitioner under investigation. The Commission has an extensive panel of these advisors whose advice is drawn upon during investigations.

The Commission must consult with the appropriate registration authority before making a decision about an investigation concerning a health practitioner. Usually, the Commission will provide an investigation report and supporting documentation such as submissions from the health practitioner and copies of any expert reports.

If the Commission proposes to make comments, refer the complaint to a registration authority, and/or refer if for consideration of disciplinary proceedings, it must first inform the practitioner of the substance of the grounds for its proposed action.

At the end of an investigation into a registered health practitioner, the Commission may:

- refer the complaint to the Commission's Director of Proceedings to consider whether to prosecute the matter before a disciplinary body
- refer the complaint to the appropriate registration authority to take action under the relevant health registration Act. In some cases, the health registration authority may have the power to refer the practitioner for performance or impairment assessment. Most often, the health registration authority may decide to counsel the practitioner about the conduct which is the subject of the complaint
- make comments to the health practitioner
- take no further action
- refer the complaint to the Director of Public Prosecutions for consideration of criminal charges.

At the end of an investigation into a health organisation (such as a hospital), the Commission may:

- make comments to the health organisation (comments made to a health organisation are a statement that adverse care or treatment was provided.)
- make recommendations to the health organisation (recommendations are made where an investigation discloses poor health service delivery and identifies improvements that could be made to practices)
- take no further action
- refer the subject matter of the complaint to the Director of Public Prosecutions.

Referral to the Director of Proceedings

The Director of Proceedings determines whether a complaint should be prosecuted before a disciplinary body. The Director of Proceedings makes decisions independently from the Commissioner and the assessment and investigation processes. To ensure that the co-regulatory nature of the system is preserved, the Director of Proceedings is required to consult with the relevant registration authority about its views prior to determining whether or not to institute disciplinary proceedings.

7.0 COMPLAINT NUMBERS, TRENDS AND ISSUES

Counting complaints

There are a number of possible ways to count complaints received by the Commission. These are:

By case

On receiving a new complaint the Commission creates a file and allocates a unique case number. Each case may involve multiple complainants and/or health service providers.

By complainant

Most complaints received by the Commission are from a single complainant, however the Commission occasionally receives complaints from more than one complainant about the same matter. This is most often in cases where parents are jointly complaining about the care provided to their child, or separate family members are complaining about the care provided to another family member.

By health service provider

Some complaints received by the Commission involve more than one provider. An example of this would be complaints received about care provided in a hospital. The complaint may identify the hospital, a nurse, an anaesthetist and a surgeon. For the purposes of counting by provider this would be considered as four separate complaints.

By issue raised in the complaint

A number of complaints received by the Commission raise more than one issue. When receiving and clarifying a complaint the Commission may identify multiple issues regarding each provider in the complaint.

These different methods result in significant variance when counting complaints as illustrated in Charts 7.1 to 7.4, which show complaints received from 2002–03 to 2005–06.

The different counting techniques can be demonstrated in the following hypothetical example:

> *A mother and father jointly complain about the care provided to their son when he had his surgery at a local hospital. Their complaint raises issues of inadequate treatment, competence and delay in admission and identifies a hospital, a nurse and a surgeon as providers. This example would be counted as one case, with two complainants, three providers and three issues.*

The case management system used by the Commission in the past did not allow the recording of more than one issue per provider. Following the introduction of a new case management system, Casemate, in March 2005, the Commission is now able to record multiple issues per provider.

The Commission has traditionally counted complaints by provider when reporting on the performance of the Commission. The reasoning behind this is that the end result of an investigation process relates to each individual provider and the outcome can be different for each of the providers involved. When attempting to analyse the kinds of things people complain about, however, it makes sense to count by issue, even though a single matter may raise a number of issues. Each table or chart appearing in this report will give details on the methodology used.

Chart 7.1 Number of complaints received (by case)

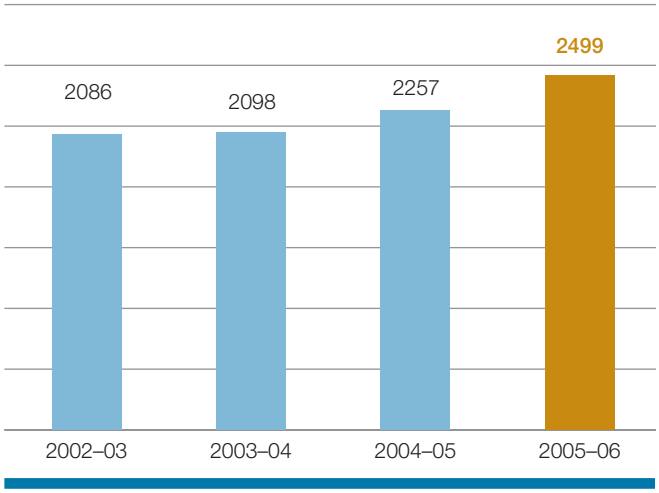


Chart 7.2 Number of complaints received (by complainant)

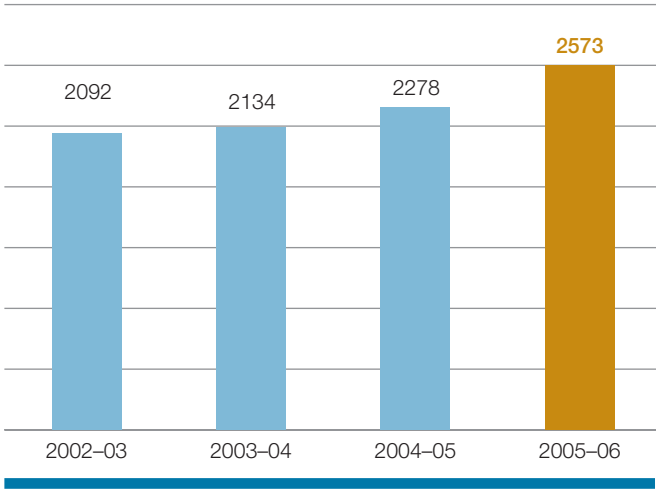


Chart 7.3 Number of complaints received (by provider)

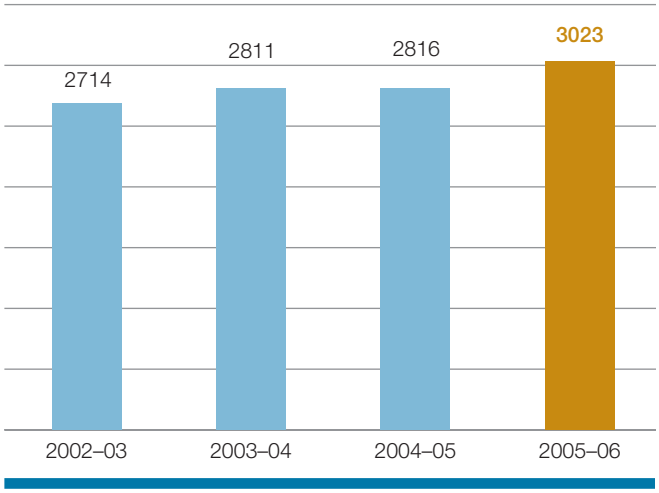
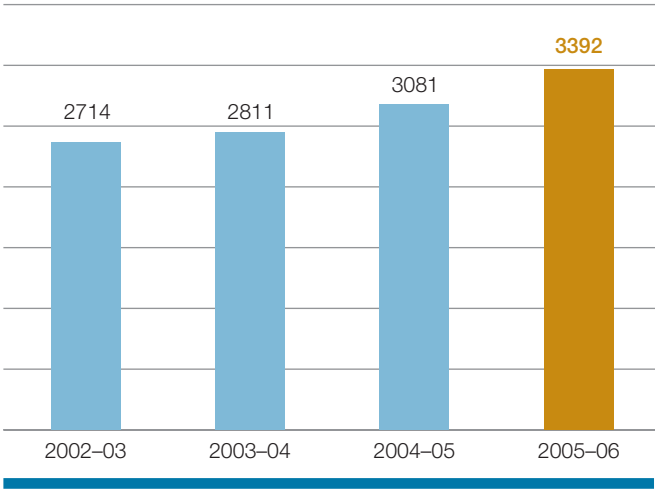


Chart 7.4 Number of complaints received (by issue)



Matters excluded from the counting of complaints

Some matters have been excluded from the general figures provided about complaints. These are matters:

- where the Commission has no jurisdiction
- regarding the failure of nurses to complete annual declarations, and
- that are notifications of conduct for the Commission's interest, but not legally a complaint under the Act.

As the Commission's responsibility in relation to these matters varies from simply recording and acknowledging receipt to minor administrative inquiries they do not compare with the work involved with the usual type of complaint. The Commission therefore has not included these matters in its figures. This provides a more accurate reflection of Commission performance in handling complaints and provides for better comparison with previous years.

Complaints against nurses regarding the failure to complete annual declarations

The addition of section 42A to the Nurses and Midwives Act from 1 August 2004 resulted in a new requirement for nurses to complete and return an annual declaration form to the Nurses and Midwives Board. Failure to return the declaration is deemed grounds for a complaint.

In 2005–06 the Commission received 617 complaints from the Nurses and Midwives Board regarding the non-return of annual declaration forms.

Of these 617 complaints, 551 were either discontinued or resolved during the assessment process. The Commission resolved these matters by sending the nurses a further request for the annual declaration form and in some cases contacting the nurses by telephone. Eighteen matters were referred to the Nurses and Midwives Board. Some of those referred were cases where the nurses said they had already returned the forms to the Nurses and Midwives Board; these were referred to the Board to further check their records.

Forty-eight complaints were referred to the Investigations Division, where further steps were taken to contact the nurses, including a search of the electoral roll and sending letters by registered mail.

In February 2006 the Commission met with the Nurses and Midwives Board to discuss more efficient ways of dealing with these matters. The Commission has not received any complaints of this kind from the Board since December 2005. The Board is looking into alternative ways of dealing with these matters. Although these matters are technically "complaints" as defined by the Health Care Complaints Act, they have been removed from the general count for this and the past year.

Notifications

These are matters where people want to bring things to the Commission's attention but do not intend to make a complaint. They can include notice of misconduct findings against practitioners in other jurisdictions, expressions of general concern about health services or advice from health registration authorities about action under their Acts that may concern individual practitioners.

Amendments to the count of complaints

As a consequence of the Commission excluding these matters from complaint numbers, and to provide a more appropriate and effective comparison to previous years, some complaint numbers reported in last year's Annual Report are reported differently in this report.

The Commission's 2004–05 Annual Report noted 3239 complaints received for that year. Due to complexities during the migration of complaint data to the new case management system in March 2005, this figure was incorrectly calculated. The corrected number of complaints received in 2004–05 using a count by provider is 3131. Of these complaints, the Commission received:

- 98 complaints where it did not have jurisdiction
- 213 complaints concerning failures by nurses to return annual declaration forms, and
- four matters that were notifications only.

Deducting these, so that the figures are comparable to 2005–06, the number of complaints received in 2004–05 is 2816.

Complaint numbers

It is clear enough that complaints have increased over the past four years. There are a number of reasons, set out in more detail below, why a simple conclusion that more complaints means health services are getting worse is not reliable.

Trends and Issues

Among the statutory functions of the Commission are "to monitor, identify and advise the Minister on trends in complaints" (section 80(1)(e) of the Health Care Complaints Act) and "to provide information to health service providers and professional and educational bodies concerning complaints, including trends in complaints" (section 80(1)(g)).

The analysis of complaints about the delivery of health services should be a useful tool to inform both government and health service providers about potential areas of concern and where the delivery of health services in general might be improved.

In practice, however, there are considerable difficulties in drawing meaningful conclusions about the general delivery of health services from the Commission's complaints data.

Factors which complicate simple deductions include the problem that there is no effective measurement of the extent of awareness of health consumers about how to make a complaint. It may be that health consumers are increasingly educated about complaint mechanisms and avenues of complaint and if this is the case, the number of complaints would be expected to increase.

On the other hand, both the public and private sectors are placing increased emphasis on internal complaint handling, and are investing more resources in this area. Assuming that health service providers are dealing with complaints more effectively at the source, this could result in a reduction in complaint numbers to the Commission.

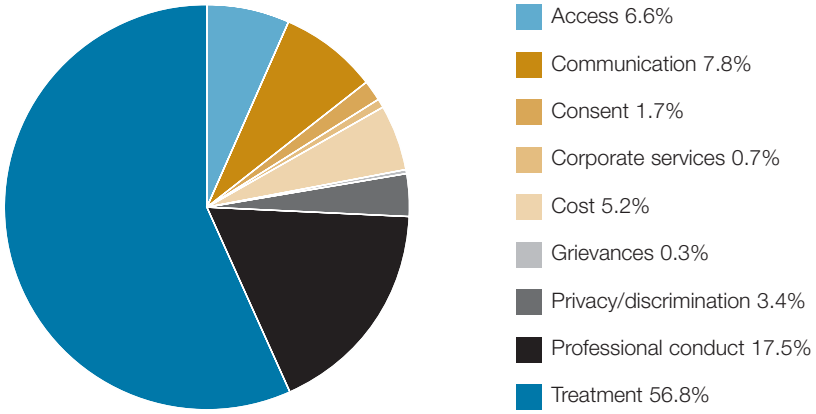
It should also be understood that the number of complaints to the Commission, compared to the number of occasions on which health services are provided, is very small. For example, the Commission received 1227 complaints against medical practitioners in 2005–06. There are 27,918 medical practitioners registered in NSW and Medicare reports over 31 million General Practitioner attendances in NSW in 2005–06.

Similarly, with respect to Emergency Departments in public hospitals, the Commission received 107 complaints in 2005–06. There were over 2 million Emergency Department attendances in NSW in the same period.

Further, it is evident from the analysis undertaken for this year's report that there are subjective elements to the Commission's recording of the issues raised in complaints. These processes will be addressed during the 2006–07 year, to ensure that the identification of issues raised in complaints becomes more comprehensive and consistent.

Nevertheless, with all these limitations in mind, the Commission attempts in this section of its report to provide some information on the issues raised by complainants, the kinds of health service providers complained about, and any trends that can be discerned from the Commission's data.

Chart 7.5 Issues raised in all complaints received



Trends and issues

The following material extracts and analyses data relating to:

- trends in numbers of complaints against health practitioners
- issues and trends in issues raised in complaints against health practitioners
- trends in numbers of complaints against health organisations
- issues raised in complaints against health organisations
- trends in issues raised in complaints by area of practice.

Issues raised in complaints

When a complaint is received, the Commission identifies the issues raised. These issues are broadly classified into the following categories:

- **access**, including complaints regarding delays in admission or treatment, and refusal to admit or treat
- **communication**, including complaints regarding attitude
- **consent**
- **corporate services**, including administration, cleaning and accommodation
- **cost**, including complaints regarding billing practices
- **grievances**, including failure to respond to concerns, and employment issues
- **privacy/discrimination**
- **professional conduct**, including complaints regarding competence, certificates/reports, sexual misconduct and and illegal practices (e.g. assault, fraud)
- **treatment**, including complaints regarding inadequate treatment, medication and diagnosis

Chart 7.5 shows the issues raised in all complaints received by the Commission in 2005–06.

The greatest number of issues raised in complaints received by the Commission in 2005–06 was in the area of treatment, with over half of the complaints received (56.8%) raising this as an issue. This was followed by professional conduct with 17.5% of complaints then:

- communication (7.8%)
- access (6.6%)
- cost (5.2%)
- privacy/discrimination (3.4%)
- consent (1.7%)
- corporate services (0.7%)
- grievances (0.3%).

A full list of the issues raised in complaints assessed in 2005–06 is included in Appendix B at Tables 14.1 and 14.2. Table 14.2 also provides further detail on the issue categories listed above.

Trends in numbers of complaints against health practitioners

Health practitioners can be classified into two categories. These are:

- Registered health practitioners
  such as medical practitioners, nurses, dentists, chiropractors, osteopaths etc.
- Unregistered health practitioners
  including acupuncturists, counsellor/therapists, naturopaths, radiographers, and practitioners of traditional Chinese medicine.

The Commission received 1788 complaints against individual health practitioners in 2005–06. The vast majority of these complaints (1710 or 95.6%) were against registered health practitioners with only 52 complaints (2.9%) relating to unregistered health practitioners.

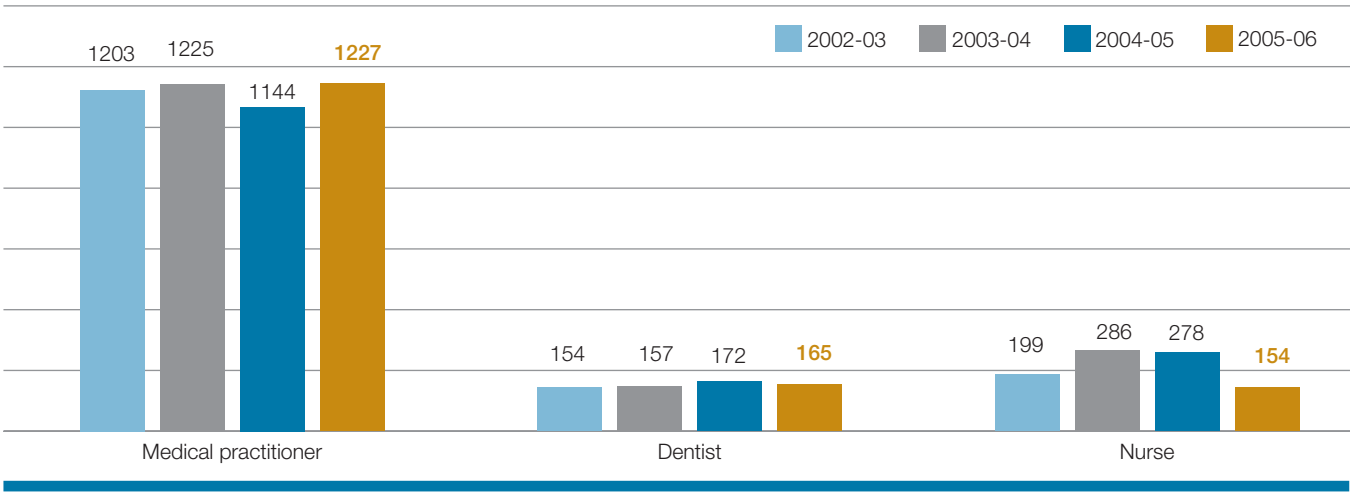
In addition there were 26 complaints (1.5%) received where the provider was not identified by the complainant.

Of complaints made against individual health practitioners in 2005–06, the largest proportion concerned medical practitioners, with 68.6% (1227) of complaints. This was followed by dentists with 9.2% (165) and nurses with 8.6% (154). This is shown in Chart 7.6.

A breakdown, by profession, of complaints received from 2002–03 to 2005–06 is included at Appendix B at Table 14.3.

Tables 14.4 and 14.5 also include a breakdown by profession and professional categories of the issues raised in complaints received during 2005–06.

Chart 7.6 Complaints received against health practitioners 2002–03 to 2005–06



Issues raised in complaints against health practitioners

The Commission has analysed the types of issues raised in complaints against the three kinds of health practitioners with the greatest number of complaints (i.e. medical practitioners, dentists, nurses). In addition, this section also looks at the trend in issues raised in complaints against medical practitioners over four years.

Trends in issues raised in complaints against medical practitioners

Chart 7.7 shows the breakdown of types of issues raised in complaints against medical practitioners that were received in 2005–06.

The issues raised in complaints against medical practitioners are broadly consistent with the issues raised generally against health service providers.

Looking at the trends in complaints received against medical practitioners over the last four reporting periods as shown in Chart 7.8 we see that the proportion of issues concerning communication and consent appears to be getting smaller, while concerns about treatment are increasing.

Chart 7.7 Issues raised in complaints received against medical practitioners

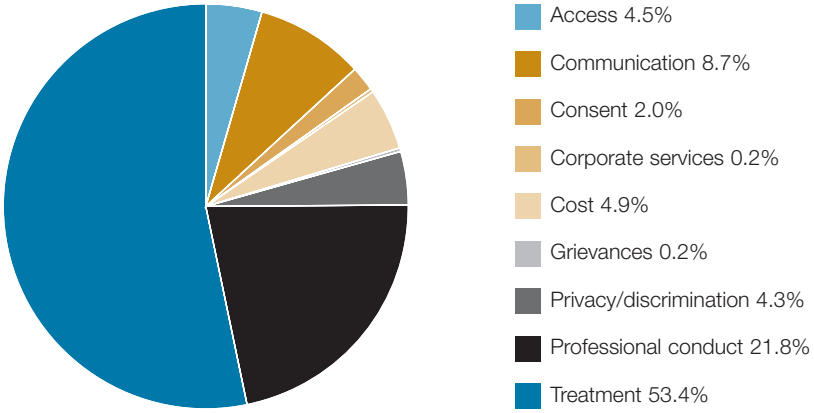
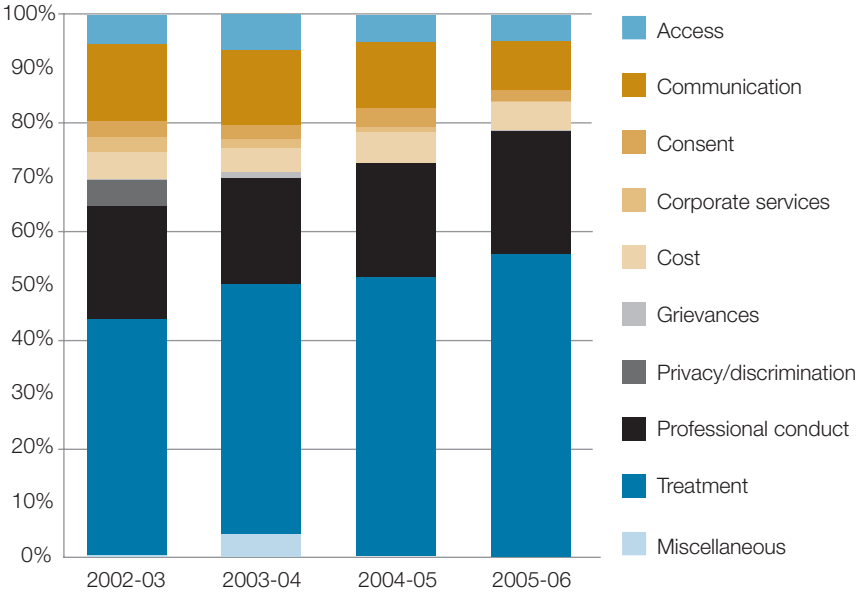


Chart 7.8 Issues raised in complaints received against medical practitioners 2002–03 to 2005–06



Issues raised in complaints against dentists

Chart 7.9 shows the breakdown of types of issues raised in complaints against dentists that were received in 2005–06.

No complaints were received against dentists in 2005–06 in the issue categories of grievances or corporate services.

The proportion of issues raised concerning cost is significantly higher than for other areas. Issues of professional conduct, including competence and improper conduct are lower.

Issues raised in complaints against nurses

Chart 7.10 shows the breakdown of types of issues raised in complaints against nurses that were received in 2005–06.

No complaints were received against nurses in 2005–06 in the issue categories of grievances, corporate services or cost.

Relatively few complaints are received directly against nurses. Many complaints against nurses are identified by the Commission in the course of inquiries regarding treatment of patients in hospitals. Consequently, complaints against nurses reflect a much higher proportion of issues relating to professional conduct including competence.

Chart 7.9 Issues raised in complaints received against dentists

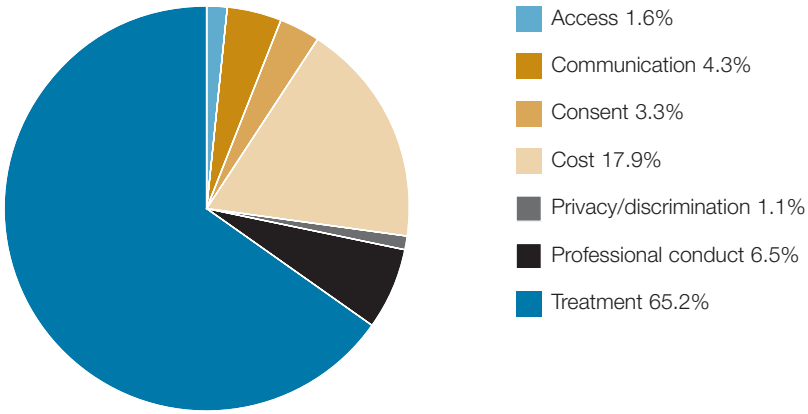
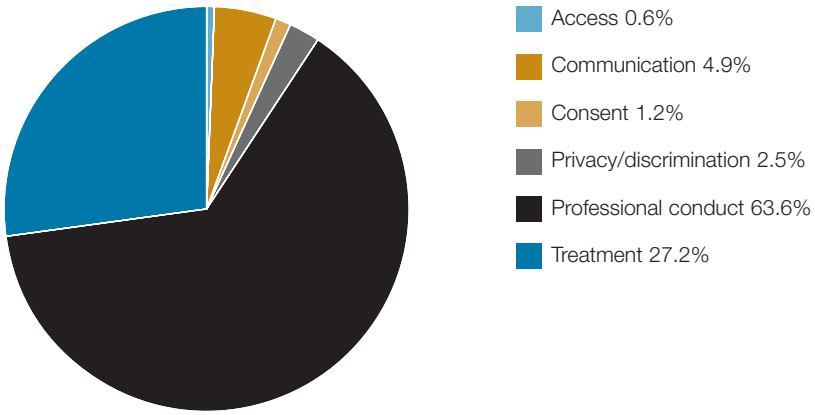


Chart 7.10 Issues raised in complaints received against nurses



Trends in numbers and issues raised in complaints against health organisations

The Commission has analysed the types of issues raised in complaints against health organisations and the trend in complaint numbers over four years.

Four-year trends in complaint numbers

Charts 7.11 and 7.12 show the complaints received against health organisations, concentrating on the types of facilities with the highest complaint numbers. A full breakdown of complaints received against health organisations in 2005–06 is included in Appendix B at Table 14.7.

The number of complaints received about public hospitals increased significantly over the four-year period. As a percentage of all complaints received against health organisations the number decreased, from 51.6% in 2003–04 to 43.4% in 2005–06.

The greatest proportion of complaints against health organisations concerns public hospitals, which is to be expected. The next biggest area of complaint, over this four-year period, concerns private hospitals. Charts 7.13 and 7.14 illustrate the issues raised in relation to public and private hospitals.

Chart 7.11 Complaints received about health organisations 2002–03 to 2005–06 (by number)

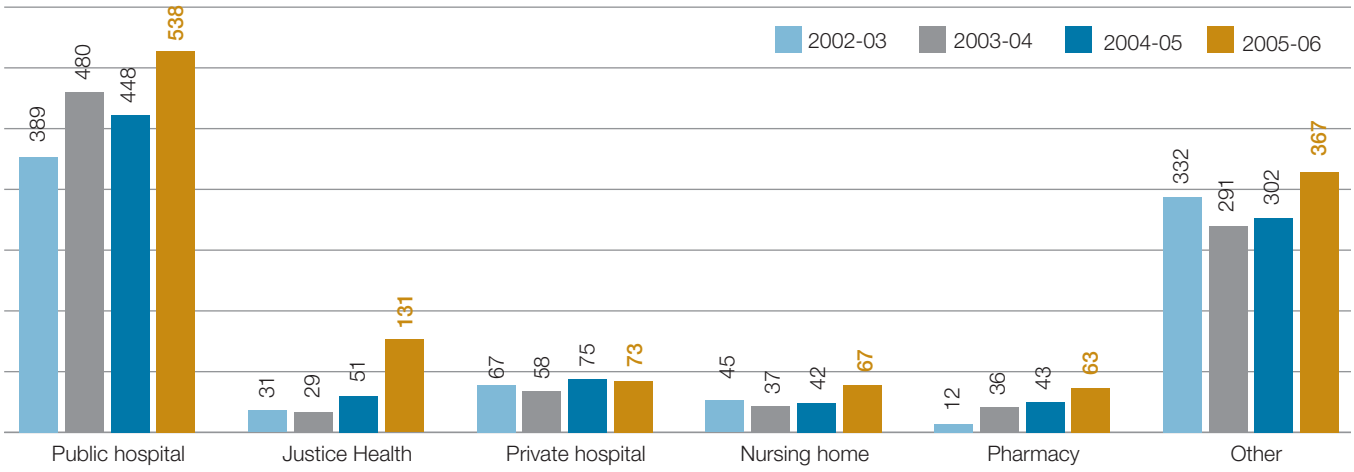
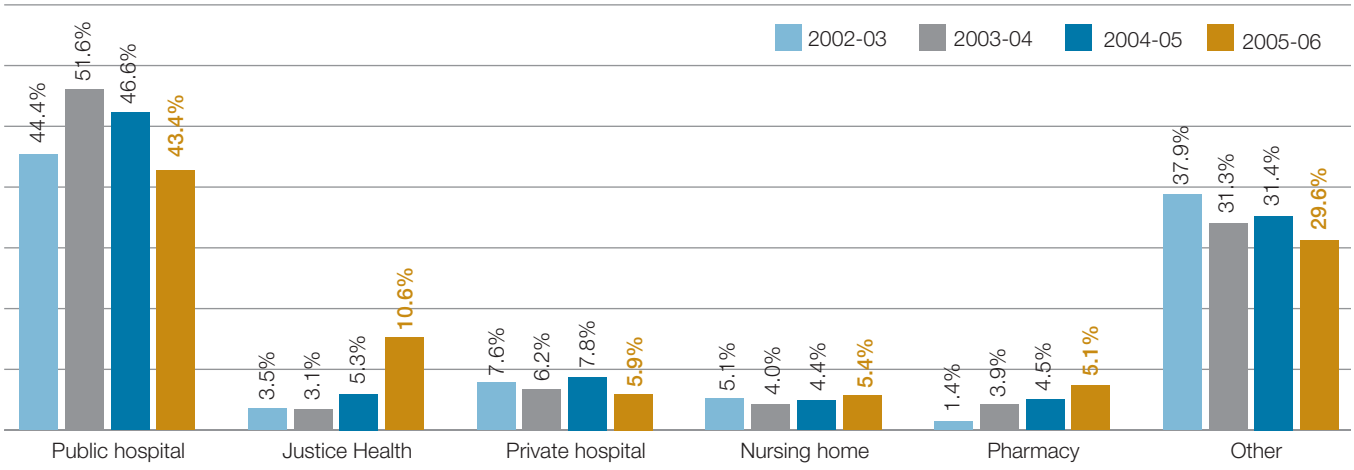


Chart 7.12 Complaints received about health organisations 2002–03 to 2005–06 (as a percentage of all complaints against health organisations)



Issues raised in complaints against public hospitals

Chart 7.13 shows the breakdown of types of issues raised in all complaints received against public hospitals during 2005–06.

Apart from issues of treatment (by far the highest issue category identified in complaints), issues of access to services in public hospitals are higher than the proportion of access issues raised in relation to health services providers generally.

Issues raised in complaints against private hospitals

Chart 7.14 shows the breakdown of types of issues raised in all complaints received against private hospitals during 2005–06.

Issues of access are comparatively small in complaints against private hospitals. Issues of cost and corporate services (primarily the quality of accommodation) are substantially higher than for complaints generally or for complaints against public hospitals.

Chart 7.13 Issues raised in complaints received against public hospitals

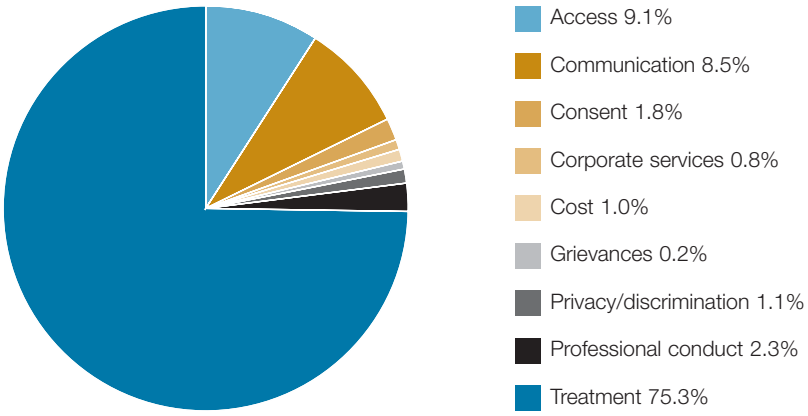
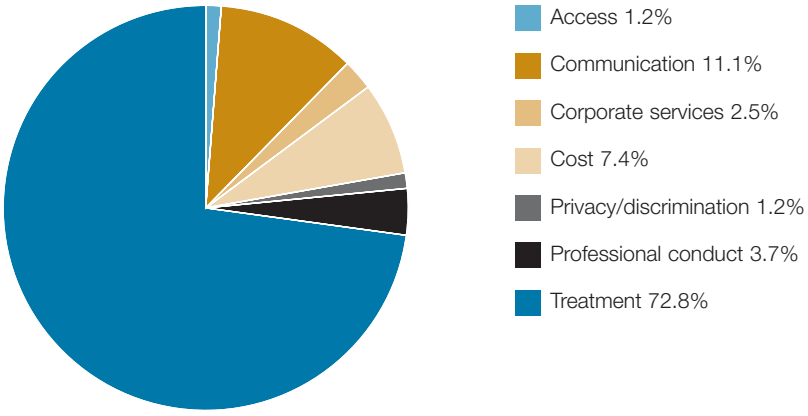


Chart 7.14 Issues raised in complaints received against private hospitals



Trends in issues raised in complaints by area of practice

The Commission has also analysed the types of issues raised in complaints by area of practice. Chart 7.15 shows the issues raised in complaints received, looking at those areas of practice with the highest complaint numbers. A full breakdown of complaints received in 2005–06 by area of practice is included in Appendix B at Table 14.11.

Treatment is the dominant issue raised in complaints regarding all areas of practice except general practice where issues of professional conduct are proportionally higher. Access issues are relatively high in accident and emergency and very high in Justice Health complaints.

Broadly, the issues raised in complaints about areas of practice reflect the particular nature of the area concerned.

Chart 7.15 Issues raised in complaints received by area of practice

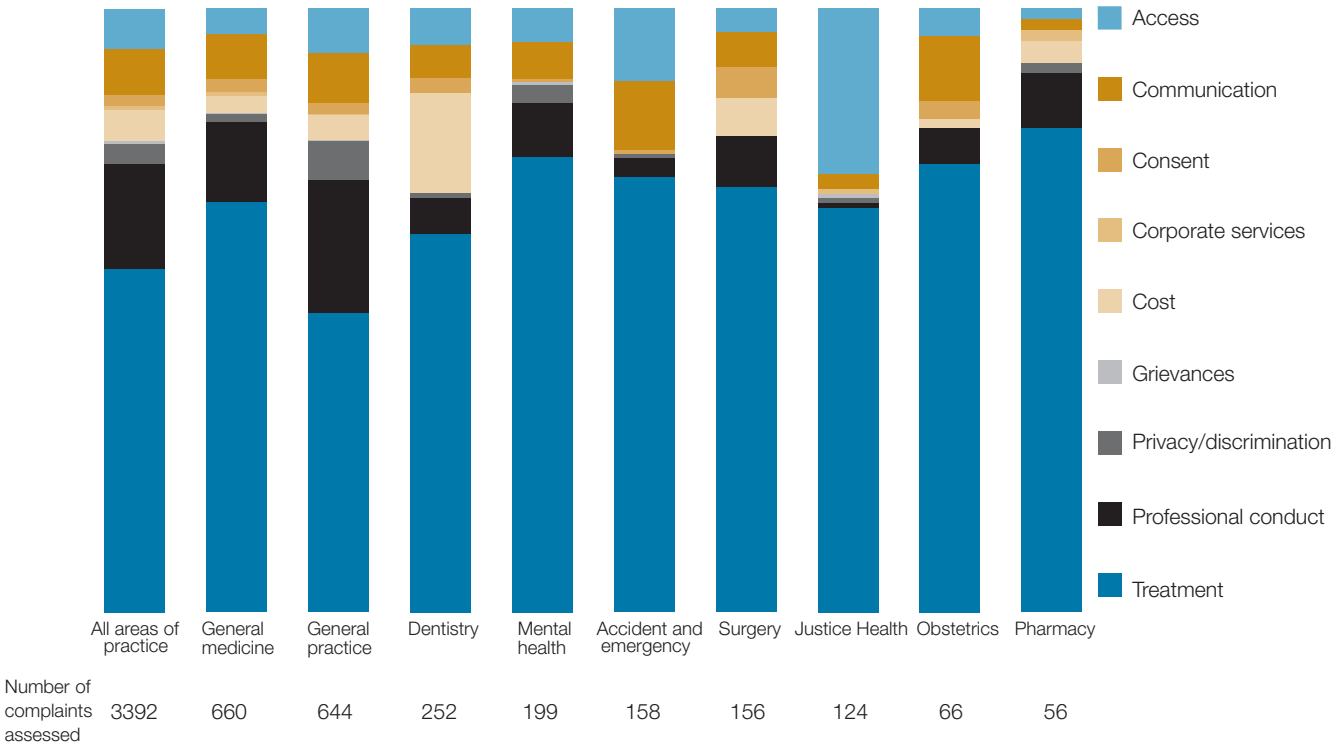


Chart 7.16 Issues raised in all complaints assessed

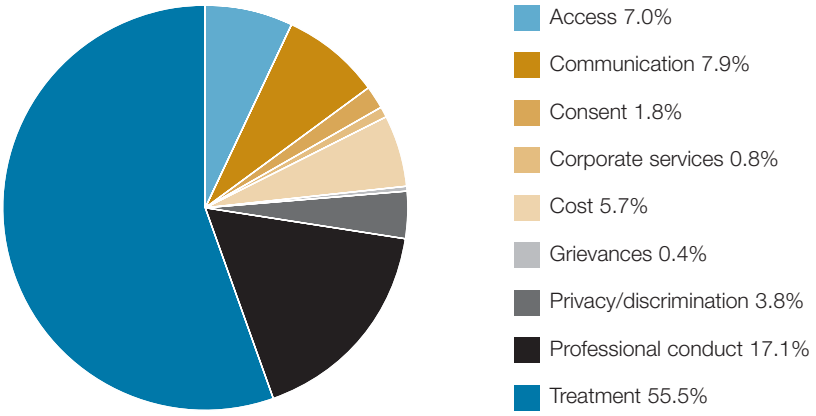


Chart 7.17 Issues raised in discontinued complaints

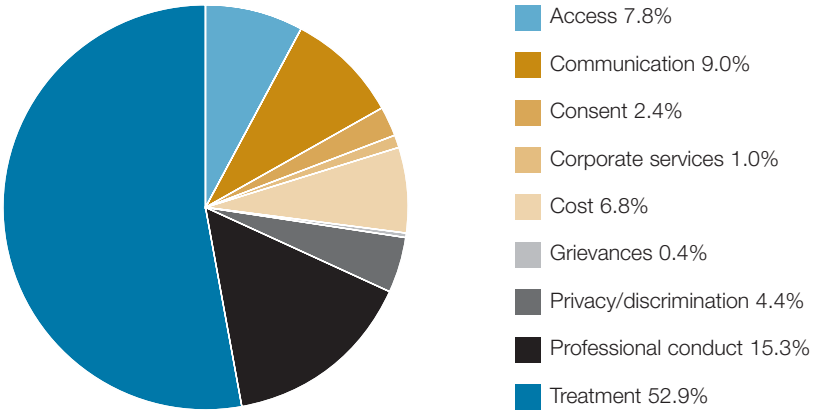
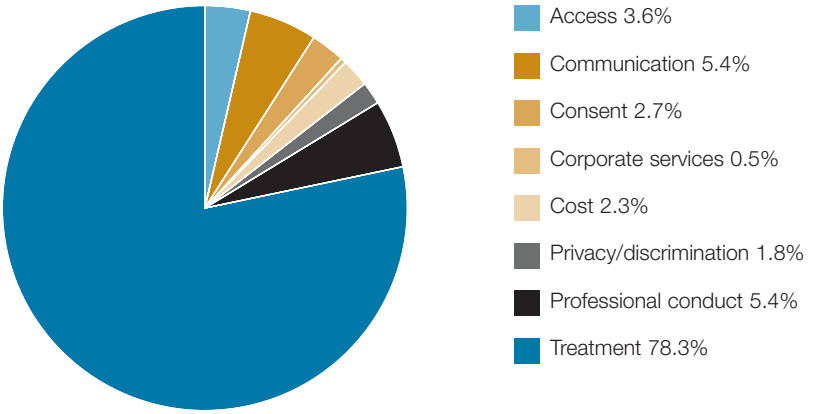


Chart 7.18 Issues raised in complaints assessed for conciliation



How the issues raised in complaints impact the way complaints are handled

In addition to an analysis of complaints received the Commission has also undertaken a review of the complaints assessed, with a view to reporting on how the issues raised in complaints affected the way the complaints were assessed by the Commission. For an explanation of the assessment process and outcomes of assessment see Section 6 The Complaints Process on page 15.

Chart 7.16 shows the breakdown of types of issues raised in all complaints assessed during 2005–06. The results of this chart are similar to Chart 7.5 which shows the issues raised in complaints received in 2005–06, with only minor differences.

A full list of the issues raised in complaints assessed during 2005–06 is included in Appendix B at Table 14.14.

Assessment decisions in relation to issues raised

Complaints discontinued

Chart 7.17 shows the breakdown of types of issues raised in all complaints discontinued during 2005–06.

The proportions of issues in discontinued complaints broadly reflect the proportions of issues raised in the complaints assessed. Issues of treatment and professional conduct have lower rates of discontinuation compared to other areas, where adverse outcomes are less serious and evidence tends to be less specific.

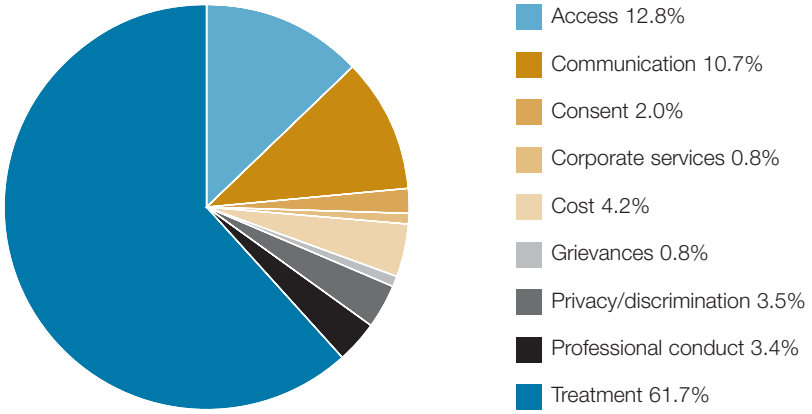
Complaints assessed for conciliation

Chart 7.18 shows the breakdown of types of issues raised in all complaints assessed for conciliation during 2005–06.

The most significant differences in comparing the complaints assessed for conciliation to all complaints assessed during 2005–06 are the decrease in the percentage of complaints raising issues of professional conduct from 17.1% to 5.4% and the increase in the percentage of complaints raising treatment as an issue from 55.5% to 78.3%.

Complaints about treatment that were assessed for conciliation did not include serious cases of alleged mistreatment; they generally concerned areas where there are misunderstandings and extensive explanation is required to address the grievance. Issues of professional conduct often go to a practitioner's competence and illegal or otherwise improper conduct, so are less suitable for conciliation.

Chart 7.19 Issues raised in complaints assessed for resolution

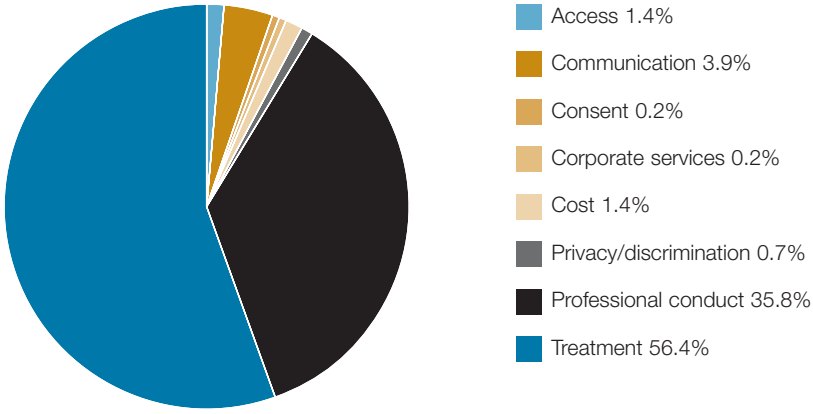


Complaints assessed for local or assisted resolution

Chart 7.19 shows the breakdown of types of issues raised in all complaints assessed for local or assisted resolution during 2005–06.

The assessment of complaints about treatment for resolution will concern less serious cases. Again, as with conciliation, the proportion of professional conduct issues assessed for resolution is small. Access and communication issues are assessed for resolution in higher proportions than received, as they are generally more suited to resolution between the parties.

Chart 7.20 Issues raised in complaints assessed for investigation

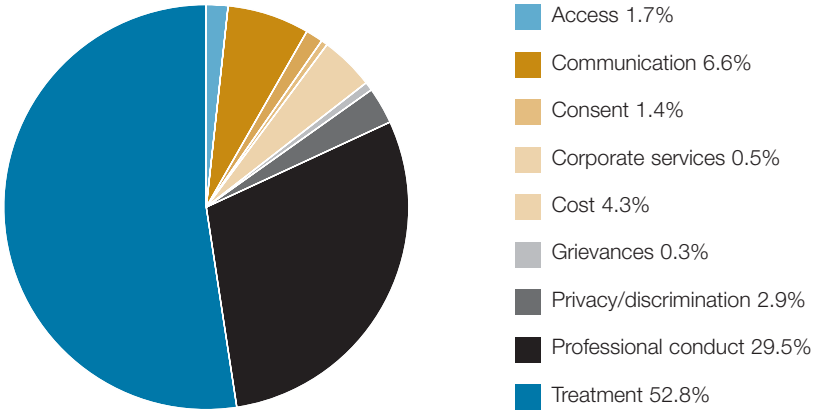


Complaints assessed for investigation

Chart 7.20 shows the breakdown of types of issues raised in all complaints assessed for investigation during 2005–06.

While the proportion of issues concerning treatment is similar to that for all complaints assessed (as shown in Chart 7.16), double the proportion of complaints raise issues of professional conduct. This reflects the more serious nature of issues of professional practice going to both clinical competence and seriously improper conduct.

Chart 7.21 Issues raised in complaints assessed for referral to a registration authority



Complaints assessed for referral to registration authorities

Chart 7.21 shows the breakdown of types of issues raised in all complaints assessed for referral to the registration authority during 2005–06.

The larger proportion of issues relating to professional conduct than for all complaints assessed (17.1% as shown in Chart 7.16) reflects the capacity of the registration authorities to evaluate the general competence of practitioners.

Assessment decisions in relation to the most common issues raised

The ten most common issues raised in complaints are listed below in Chart 7.22. These issues make up 80.8% (3140) of the 3884 complaints assessed when counted by issue.

Chart 7.22 also provides detail on the assessment decisions in relation to the ten most common issues raised in complaints. The breakdown of assessment decisions for all issues raised in complaints is provided for comparison purposes. A full list of assessment decisions in relation to issues raised in complaints is included in Appendix B at Table 14.14.

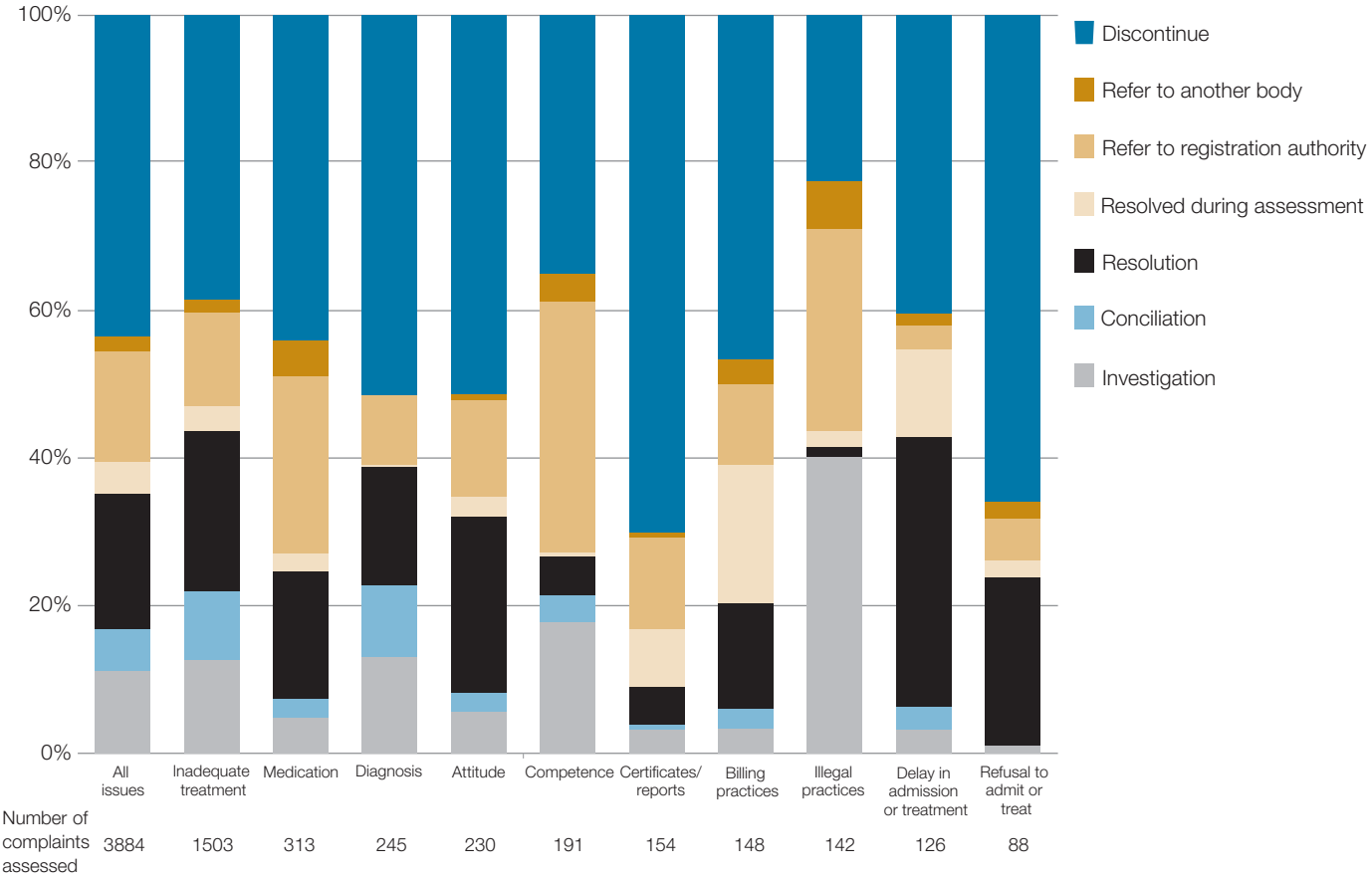
Where complaints raise issues regarding competence or illegal practices these are more likely to be either investigated by the Commission or referred to the relevant registration authority. As shown in Chart 7.22 (and in Table 14.14), 67.6% of complaints raising illegal practices and 51.8% of complaints raising competence were either investigated by the Commission or referred to the relevant registration authority, compared to a total of 26.2% of all complaints. Often these complaints involve allegations going to the capacity of the practitioner or serious misconduct issues which, if substantiated, would result in disciplinary proceedings.

A greater proportion of complaints raising the issues of delay in admission or treatment, refusal to admit or treat, and attitude are assessed as suitable for resolution. There is generally an ongoing relationship between the complainant and the health service provider in these types of complaints and the complainant's need for further treatment can be best worked out with the assistance of the Commission's Resolution Service.

In addition Chart 7.22 shows a greater portion of complaints raising issues of diagnosis and inadequate treatment are referred for conciliation. As shown in Chart 7.22 (and in Table 14.14), 9.8% of complaints raising diagnosis and 9.2% of complaints raising inadequate treatment were referred for conciliation, compared to a total of 5.7% of all complaints. These issues often involve complaints of inadequate service and/or insufficient explanation of negative outcomes and are generally best resolved through a formal and confidential conciliation process allowing parties to speak as openly as possible.

The chart also illustrates the likelihood of the Commission to discontinue complaints raising the issue of certificates and/or reports. These complaints are generally linked to compensation claims or other legal processes where the complainant alleges that a health practitioner, often working for an insurer or as an independent court appointed expert, has not provided a proper or accurate report, or that the consultation with the practitioner was inadequate. Complaints in this area include inadequate examinations, rudeness, attitude and provision of an unfavourable report. The Commission takes the view that unless the complaint is serious, the issues are best left to be determined through the relevant legal process for which the report or certificate was completed.

Chart 7.22 Assessment decisions for the ten most common issues raised in complaints



Assessment decisions in relation to areas of practice

Another area of analysis conducted for this report was a review of the area of practice identified in all complaints assessed. Some of the most common areas of practice are shown in Chart 7.23. These areas of practice made up 68.8% (2672) of all the 3884 complaints assessed.

Chart 7.23 also shows the assessment decisions for common areas of practice during 2005–06.

The high level of referrals to both the Pharmacy and Dental Boards reflects the special expertise and investment of resources by these authorities in the handling of complaints.

Accident and emergency, obstetrics and surgery all show high proportions of complaints being investigated, reflecting the high incidence of adverse patient outcomes in these areas. These areas also show high levels of complaints referred for conciliation, again reflecting complainant concern about adverse outcomes but where assessment does not identify serious issues of unprofessional conduct or competence.

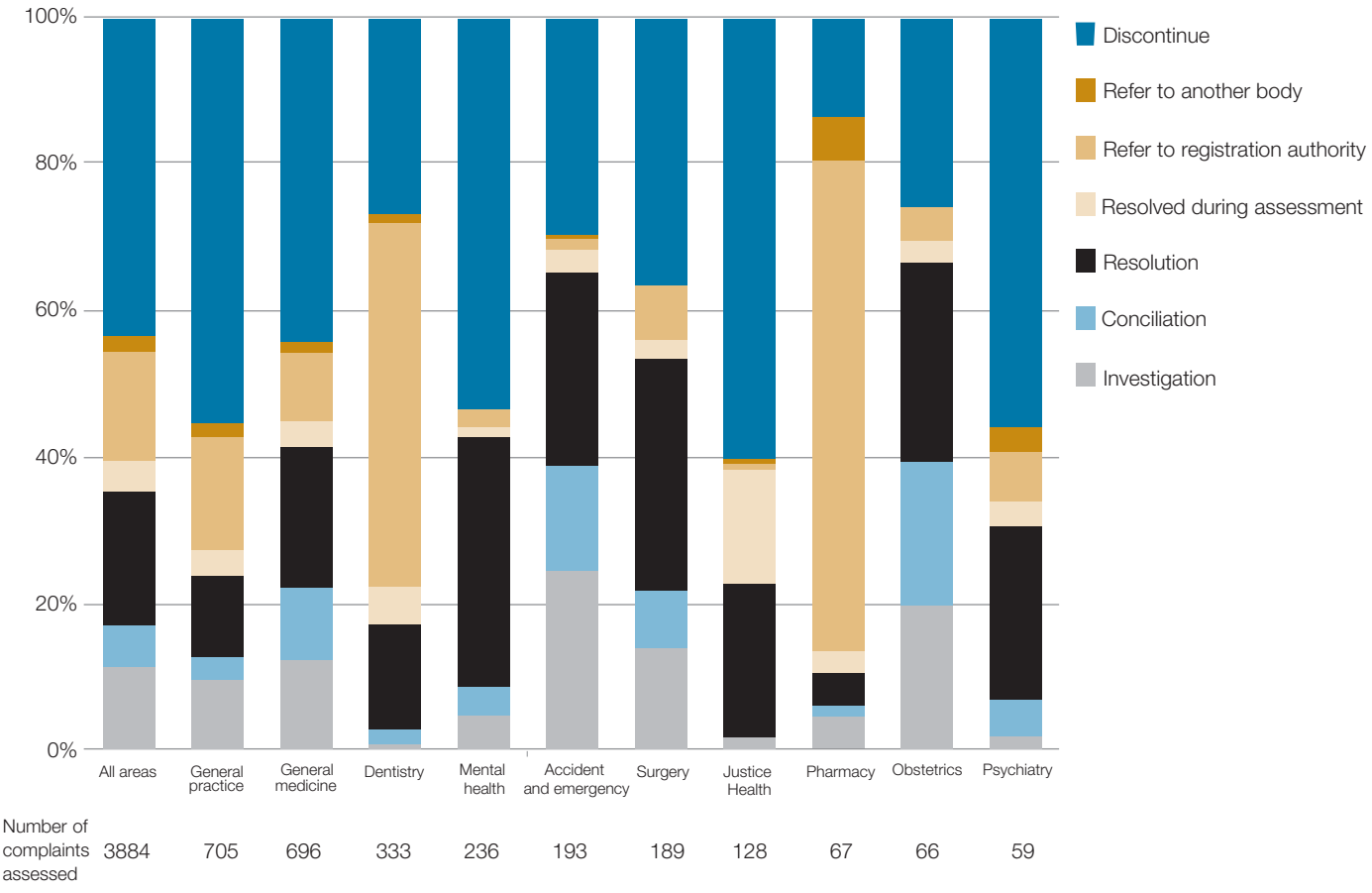
The Mental Health area shows a high level of complaints discontinued because many complaints in this area concern issues regulated through the Mental Health Act and the Mental Health Review Tribunal, such as compulsory treatment orders and involuntary detention. This area also has a high proportion of complaints referred for resolution, as generally there is a need for patients and families to re-establish good relationships with health service providers.

A full breakdown of assessment decisions in relation to areas of practice is included in Appendix B at Table 14.23.

Further information

The data shown in these charts is included in detailed tables in Appendix B which can be referred to for further information.

Chart 7.23 Assessment decisions for common areas of practice



8.0 ASSESSMENTS AND RESOLUTION DIVISION

Overview

The Assessments and Resolution Division is made up of the Assessment Branch, the Resolution Service (including the Inquiry Service) and the Health Conciliation Registry.

Inquiry Service

Inquiries received by telephone and e-mail about making complaints were previously split between officers within the Assessment Branch and Resolution Service. Assessment staff dealt with simple inquiries, while more complex inquiries were referred to Resolution Officers.

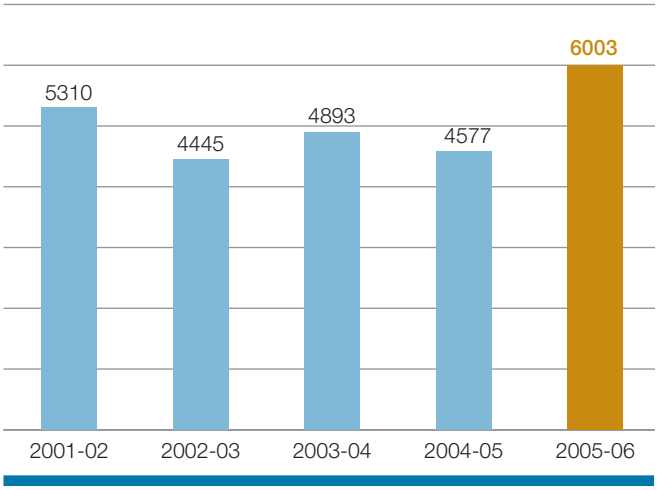
A review of the Inquiry Service during the year determined that all of the inquiry work would be handled more effectively and efficiently if it were combined. It was determined that the role would be best performed by the Commission's Resolution Service. Resolution Officers are more senior and better equipped to assist complainants to both clarify and articulate their complaints and refer them to other suitable means of redress when appropriate. Consequently, from 1 April 2006, the Inquiry Service became the entire responsibility of Commission officers in the Resolution Service.

The role of the Inquiry Service is to clarify issues raised by potential complainants. The officers staffing the Inquiry Service now take a greater role in clearly identifying the cause for complaint before a formal written complaint is made. In some cases, inquiry officers are able to refer potential complainants to a more suitable avenue of redress or give them the information they need to address their concerns more directly with health service providers where they feel this would be preferable to lodging a complaint.

Performance of the Inquiry Service

Chart 8.1 shows the number of inquiries received by the Commission for the 2005–06 year compared to previous years. Although there is an apparent increase on previous years, this reflects the movement of inquiries into a single service and the corresponding decrease in the more complex inquiry matters previously referred to and dealt with by the Resolution Service and counted as part of the work of that area.

Chart 8.1 Number of telephone inquiries received



Assessment Branch

Last year's annual report detailed the major changes undertaken in the complaint assessment process. The principal objective of the changes is to ensure a more thorough assessment of new written complaints so that the best decision can be made on how to handle the complaint. During the reporting year, the Commission continued to develop both the structure of its Assessment Branch and the processes under which assessments are made.

Structure

The Assessment Branch comprises two teams of four Assessment Officers reporting to a Team Leader. The Team Leaders in turn report to the Manager of the Branch. The structure has been implemented to foster a team approach and allows the Team Leaders and Manager to effectively support and supervise staff. It provides for better and more timely case management and allows delays and problems to be identified and acted upon before they become significant. Together with clerical support staff, the Assessment Branch currently employs 14.2 full-time equivalent positions.

Casemate

The Commission's electronic case management system has also been developed through the year. By the end of the reporting year the Casemate process for assessments had been substantially redesigned and simplified to reflect assessment processes.

Assessment process

On receiving a written complaint each complaint is considered by the Director of the division and Manager of the Assessment Branch, an assessment plan is created and the complaint entered into Casemate. The complaint is then acknowledged, providing the complainant with a file number and the name of the Assessment Officer to whom the matter has been allocated for action. The Assessment Officer will generally contact the complainant at this stage to clarify the nature of the complaint and explain the Commission's process in handling their complaint.

In most cases the health service provider(s) identified in the complaint will be sent a copy of the complaint and given the opportunity to provide a response. In more complex matters it may be necessary to obtain responses from multiple providers, information from other parties, copies of medical records and/or other medical test results.

Where the complaint is complex and concerns clinical treatment, the Commission may also ask its Internal Medical and Nursing Advisors to review the information and records. The Medical or Nursing Advisors will be asked to provide an opinion on whether the conduct in question constitutes a

significant departure from acceptable standards of care. In areas where expert advice is required, the Commission's medical advisors may also consult with specialists regarding the complaint.

All of the relevant information, including any expert advice, is then compiled into an assessment brief, which together with the file, is presented to an assessment committee, chaired by the Commissioner. Where the complaint is about the conduct of an individual health practitioner, the Commission must also consult with the health registration authority that governs that practitioner. There are 13 different registration authorities, the NSW Medical Board and the NSW Nurses and Midwives Board being the two most regularly consulted by the Commission.

At the end of the assessment process, a decision is made on how the complaint will be dealt with in line with the options provided by the Act. These are:

- discontinue dealing with the complaint
- refer the complaint for local resolution where the health service provider is a public organisation and consents to try to resolve the matter directly with the complainant
- refer the complaint for assisted resolution where a Commission Resolution Officer will attempt to resolve the complaint between the persons concerned
- refer the complaint for conciliation by the Health Conciliation Registry
- refer the complaint to the applicable health registration authority for attention under its Act
- refer the matter to another more appropriate agency for attention, or
- investigate the complaint.

The parties to the complaint are then notified by the Commission of the outcome of the assessment process. Reasons are given for any decision made and complainants are advised of their statutory right to request a review of the assessment decision, except where the complaint has been referred for investigation.

Outcomes of the assessment process

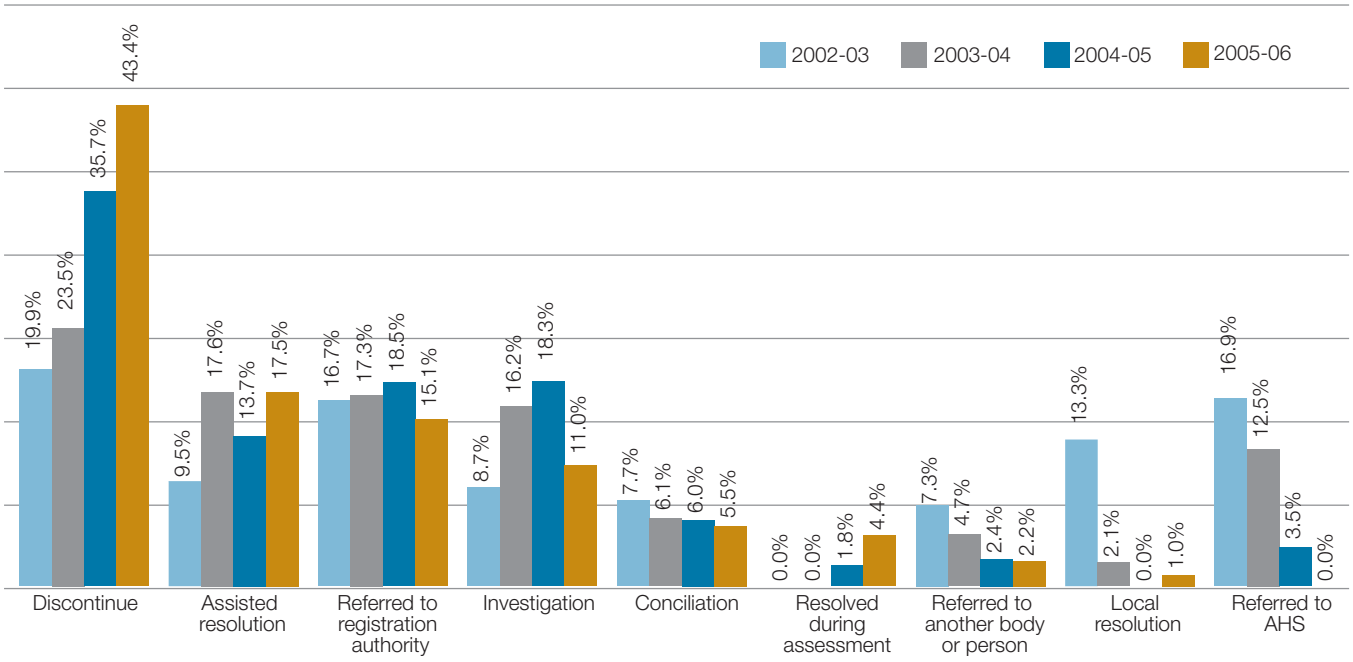
Chart 8.2 compares the outcomes of the 3392 assessment decisions made during the reporting year to previous years.

The proportion of complaints discontinued after the assessment process has increased again on last year's figure. This is to be expected given the more rigorous assessment process. The number of complaints referred for investigation is less than the previous two years, as these years reflect unusually high numbers due to the impact of the complaints arising from Camden/Campbelltown hospitals and reviews of previous Commission complaints that were re-assessed for investigation.

The referral of complaints back to health organisations for investigation or resolution has effectively ceased. In past years the Commission referred numerous complaints back to hospitals to investigate. In March 2005, amendments to the Act came into force making it clear that this was not an option available to the Commission. A small number of more minor matters were referred to health organisations for local resolution.

The 2005–06 year has also seen an increase in the number of complaints resolved during assessment. Although this is not a formal outcome of the assessments process provided by the Act, there are occasions where, in the process of clarifying the nature of a complaint or conducting the inquiries

Chart 8.2 Assessment decisions 2002–03 to 2005–06



necessary for an assessment, the complaint is effectively resolved between the parties. These matters are referred to in Chart 8.2 as "resolved during assessment". Assessment staff are being encouraged, and educated, to explore opportunities for informal alternate dispute resolution where appropriate. This was not an initiative prior to 2004. During the 2005–06 period 150 complaints were resolved during this assessment process. This represented 4.4% of all complaints received, and was an increase on the previous year when 45 complaints (or 1.8%) were resolved during the assessment process.

Performance of the Assessment Branch

There were 3023 written complaints received by the Commission during the reporting year and 3392 assessment decisions made. The area is more than keeping pace with the incoming complaints.

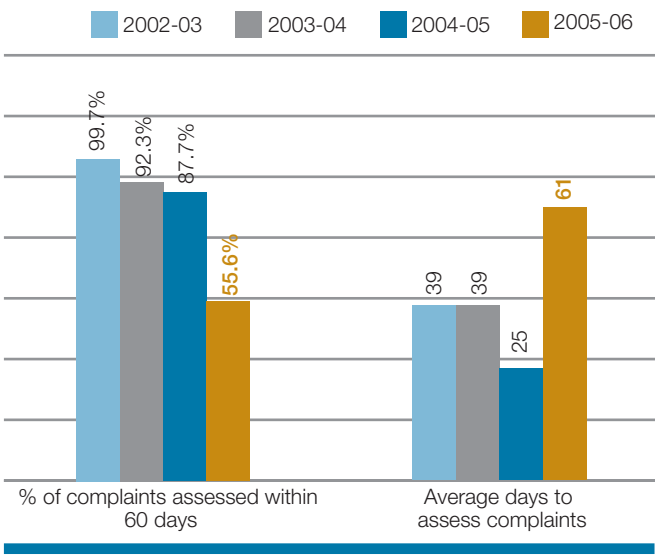
In the restructuring of the Assessment Branch, involving a more rigorous assessment process and the introduction of new computerised database case management system, there were significant problems with the timeliness of assessments during the year. Chart 8.3 shows that 55.6% of assessments were completed within the statutory 60-day timeframe compared to 87.7% the previous year and higher figures earlier. The extra time taken during this year is in part a reflection of the much more extensive process now undertaken. It also reflects an initial lack of clarity around the new procedures, inexperience of the staff of the Branch in conducting a more extensive and analytical assessment and initial incapacity of the case management system to effectively monitor and report on the progress of cases.

These issues have now been substantially addressed. There has been substantial turnover of staff in the area and more focussed training has been provided to existing and new staff. The re-engineering and improvement of case management systems has provided for improved tracking of the progress of cases. The removal of the Inquiry Service from the Assessment Branch has allowed staff to concentrate on their core function of assessing complaints. From 1 April 2006, the Assessment Branch has been achieving a rate of 80% of assessments being finalised within 60 days.

Although improvements to internal procedures and processing times will continue, some matters will continue to exceed the 60 day timeframe. Complaints received by the Commission regarding health care range from the simple to the extremely complex. In complex matters, there will always be cases where a thorough and responsible assessment of the complaint will take time even allowing for good case management and the receipt of relevant material within reasonable timeframes. Measurements of effectiveness in this area should not be determined by a "one size fits all" time limit set in statute that has little regard to the nature of particular complaints.

The Commission will be developing and implementing a range of performance indicators for the new assessments process during the 2006–07 year. These will be reported on in next year's annual report.

Chart 8.3 Time taken to assess complaints



Assessment Branch Case Study

The complainant had hip replacement surgery at a private hospital and was not satisfied with the care he received post surgery.

The complaint concerned rough handling by a wards person who, in giving the complainant a backwash, nearly rolled him out of his bed. At that time he complained to both the wards person and the Nursing Unit Manager, but didn't receive a response. The second issue related to a nurse not returning for seven hours to assist him back into bed after toileting. A complaint was lodged to the nurse and to the Nursing Control Desk, but he received no feedback.

After the Commission brought this matter to the attention of the hospital, the hospital responded to the concerns raised by the complainant. Regarding the incorrect movement of the complainant, the wards man was counselled and additional education has been provided to all wards persons. Regarding the wait for assistance by the night nurse, the Nurse Manager relayed an apology to the complainant, and the private hospital also apologised to him. The acknowledgment made by the hospital and the action they had taken, resolved all of this complainant's concerns.

More case studies can be found in Appendix A

8.0 ASSESSMENTS AND RESOLUTION DIVISION

Assessment Branch Case Study

The complainant's physiotherapist suggested that the complainant have some x-rays taken at the medical centre where her general practitioner practiced.

The medical centre would not provide the complainant with all of the reports from the required x-rays. The complainant was so dissatisfied she was also considering changing doctors.

When the medical centre became aware of this complaint via the Commission the general practitioner from the medical centre initiated a meeting with the complainant and explained that she was happy to provide a copy of the x-ray report. The complainant was pleased with the meeting and the provision of the report, and she then considered the matter resolved.

More case studies can be found in Appendix A

Assessment Branch Case Study

The complainant sought a consultation with a general practitioner following an eye injury that was associated with a workers compensation claim.

Discussion between the complainant and the doctor regarding fees associated with this consultation (as it was a workers compensation matter) left the complainant with the understanding that neither she nor her children would receive service from this doctor in the future. This was of great concern to the complainant as she lives quite a long distance away from another medical practice and it would inconvenience her a great deal if she had to find another family doctor.

Contact by the Commission with the general practitioner resulted in an assurance to the Commission and the complainant that the doctor would continue to provide care to the complainant's children. The complainant was pleased with this assurance, and she considered the matter resolved.

More case studies can be found in Appendix A

Reviews of assessment decisions

The Act requires the Commission to notify the parties of an assessment decision and to advise the complainant of their statutory right to request a review of that decision. The Commission must review an assessment decision where the request for review is made within 28 days and may review the decision where the request takes longer.

To ensure the independence of the review process, reviews are conducted by Commission Resolution Officers who have no role in the assessments process.

During the 2005–06 year the Commission received 393 requests for review and finalised 384 assessment reviews.

Chart 8.4 shows the requests for review of assessment received by the Commission from 2002–03 to 2005–06.

Of the 384 reviews finalised in 2005–06, 89.8% of decisions were confirmed while 10.2% were re-assessed for other complaint handling options. The outcomes of assessment reviews are detailed at Chart 8.5.

Chart 8.4 Assessment review requests

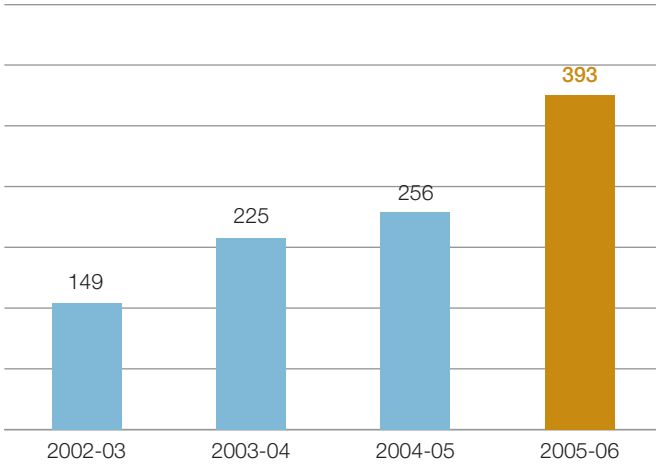
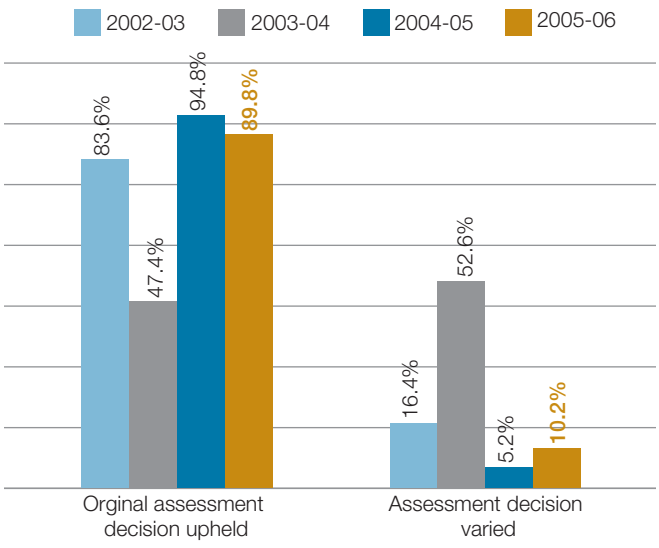


Chart 8.5 Outcome of assessment reviews



Resolution Service

In March 2005, the previously informal service provided by Patient Support Officers was brought under the Act and renamed the Commission's Resolution Service.

The objectives of this means of complaint handling are set out in Division 9 of the *Health Care Complaints Act 1993.* The objectives of the Commission under this Division are as follows:

- to provide an alternate and neutral means of resolving complaints that is independent of the investigative processes of the Commission
- to facilitate the resolution of complaints, including determining the most appropriate means of resolution having regard to the nature of the complaint and the expectations of the parties to the complaint, and
- to provide information to health service providers and members of the public on the complaints resolution functions of the Commission under this Part.

The Resolution Service helps health service consumers and providers resolve complaints that have been assessed for assisted resolution by the Commission. There are currently 11 Resolution Officers employed by the Commission; ten are out-posted (six in the Sydney metropolitan area with four regionally based in Newcastle, Wollongong, Lismore and Dubbo).

The aims of the Resolution Service are to:

- assist in the timely, efficient and effective resolution of health care complaints
- assist consumers and providers to understand approaches to local resolution of health complaints
- equip consumers to take a positive and active role in their health care and to resolve their own concerns in future.

When a complaint is referred to the service it is allocated to a Resolution Officer, who contacts the complainant and health service provider to explain how the service might assist both parties. The service makes it clear that participation is voluntary and that the Resolution Service is impartial.

At this initial stage the Resolution Officers help people:

- generate ideas for resolving the issues that gave rise to the complaint
- gain a broader understanding of the other person's point of view
- communicate with each other
- understand the outcomes that might be achieved, and
- find general information about the health system.

There are many different resolution strategies possible depending on the complaint and what the complainant wants to achieve as a result of making the complaint. When the strategies have been discussed and the preferred options put to the parties, the Resolution Officers develop a Resolution Management Plan specific to the complaint. Appropriate timeframes are set and approved by the Manager of the service.

Some complainants will want to meet with the health service provider to discuss their concerns. Others will not want direct contact with the service provider and may request a written response to their complaint. There is no set way for a resolution to occur.

Resolution Officers will often:

- arrange meetings, help people prepare for meetings and facilitate and/or attend meetings between the people involved
- help follow up the agreements made at those meetings
- negotiate between the parties, if they do not want direct contact, and
- help in obtaining appropriate written responses.

Resolution Service Case Study

Accessing support to continue care at home

A man complained to the Commission when his application for a portable ventilator was rejected. The man has muscular dystrophy and uses assisted ventilation twenty-four hours a day. The home ventilator is powered by electricity. With the support of his respiratory physician and treating team the man requested a portable ventilator through the PADP scheme. The reason for the application was two-fold. The portable ventilator would provide backup in case of a power failure at home and would also allow the man to leave the house for medical and recreational reasons. The application was denied as the Area Health Service said one ventilator had already been supplied.

The complaint was referred for assisted resolution. The Resolution Officer spoke with the man who explained he had pursued a portable ventilator through other avenues but had not been successful. He was keen for the Resolution Officer to negotiate with the health organisation to reconsider his application for a portable ventilator. The man remains at home as his family provides full-time care and his condition continues to deteriorate. The provision of a portable ventilator would enhance his quality of life and support the family to care for him at home rather than seek the costly alternative of residential care.

The Resolution Officer discussed the situation with the health organisation. The organisation acknowledged the need for a portable ventilator and agreed to supply one.

More case studies can be found in Appendix A

Outcomes

The 2005–06 reporting year was the first full year that the Resolution Service dealt with complaints referred by the Commission through its assessment process. During the year, 676 complaints were referred for assisted resolution.

The Resolution Service finalised 537 complaints through its assisted resolution process during the 2005–06 year, as well as 64 processes that remained from its patient support cases at the start of the reporting year. There were 155 complaints open with the Resolution Service at 30 June 2006.

The outcomes of the 537 resolution process finalised during the reporting year are shown in Chart 8.6.

When a complaint is resolved possible outcomes of the process can include:

- an apology
- acknowledgment of distress
- explanations about what happened
- agreements about preventing adverse consequences happening again
- continuation of health care where a relationship had become strained
- improved communication between patient and provider
- refunds or additional services.

Chart 8.6 Resolution Service outcomes

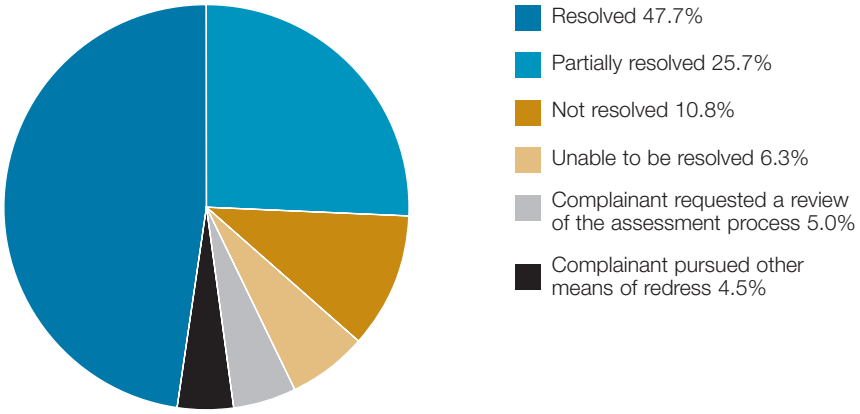
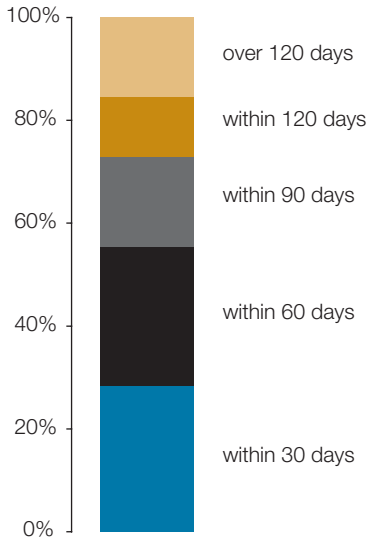


Chart 8.7 Average time taken to finalise complaints referred to the Resolution Service



Timeliness of the Resolution Service

Resolution Officers offer a responsive service that is able to progress at the pace desired by the client. Grief, for example, can require that issues progress slowly whereas incidents demanding immediate response can be dealt with speedily. Sometimes when written responses are sought from health service providers the resolution process can be lengthened.

Chart 8.7 indicates how long it took to finalise complaints referred to the Resolution Service in 2005–06.

Of the complaints finalised, 28.3% of cases were completed within 30 days, 73.0% within 90 days and 100.0% within a year. The small number of cases (5.2%) that took more than six months to a year to finalise were delayed because of various reasons, including: the complexity of the issues and the multiple activities required before completion; difficulties in contacting and getting responses from providers; time taken by clients to decide when/how to proceed.

Results of the Resolution Service satisfaction survey 2005–06

The Resolution Service seeks feedback from complainants and providers with whom there has been significant contact during the resolution process. Satisfaction surveys are posted to the parties with a reply-paid envelope. The survey includes questions about helpfulness in generating resolution options, fairness and whether the Resolution Officer's involvement was useful.

Surveys were sent to 252 complainants and 117 responses were received (46.4% response rate). Surveys were sent to 183 health providers and 62 responses were received (33.8% response rate).

Key results include:

- 83% thought Resolution Officers understood their concerns
- 77% found Resolution Officers helpful in generating resolution options
- 80% thought the Resolution Officer was fair
- 75% felt that the involvement of the Resolution Officer was helpful.

Community liaison and education role

The Commission also provides information to the community and to health service providers about the complaint resolution functions of the Commission. Resolution Officers conducted 36 presentations to health organisations and community groups during the reporting period. They also developed information material on the Commission: How to write a complaint to the Health Care Complaints Commission and the Resolution Service. Further fact sheets and brochures will be developed in the coming year.

A list of the presentations by Resolution Officers through the year can be found at Table 14.30 in Appendix B.

Resolution Service Case Study

Effective communication with carers

A woman's adult son with a long-term mental illness and problems with substance use was admitted to a mental health unit in a public hospital. During the admission the son told staff that he did not want to talk with his mother and so she was given minimal information on his progress. The woman respected that her son did not want her involved at this time although she thought she could provide important information to the treating team to assist in the process of determining the most effective plan for him.

The woman received a phone call from one of the doctors to say her son was being discharged into her care. She requested a meeting with the treating team to discuss the discharge arrangements and was informed that her son was on his way to her place in a taxi. There was difficulty in accessing community mental health support at home and the following day the son took a serious overdose and needed a long hospital admission.

The woman wrote to the Commission raising issues about discharge planning, communication with carers, leave arrangements for an acutely ill person in a mental health unit and other treatment matters. The complaint was assessed for assisted resolution. The mental health service provided a written response to the Commission and this was forwarded to the complainant. The response indicated that everything was done in accordance with policy.

When the Resolution Officer contacted the woman her son was again in hospital and very unwell. There were a number of concerns about his current treatment. The woman did not feel the concerns in her complaint had been addressed in the response and requested a meeting be arranged to discuss her outstanding questions and concerns.

The Resolution Officer facilitated a meeting between the woman, the Mental Health Service Manager and the Medical Superintendent who was the treating psychiatrist. A list of questions were prepared with the woman before the meeting and forwarded to the Manager. The psychiatrist indicated the son had agreed for the treating team to talk to his mother.

At the meeting, it was acknowledged that the previous discharge arrangements were inadequate and that there had been a communication breakdown between the psychiatrist and her registrar. An apology was provided for the error. It was acknowledged that when a patient has agreed to family being involved, discharge to a family home should involve a meeting with family members before the discharge takes place. The failure to refer for community mental health support was also acknowledged.

Regarding the current admission, the psychiatrist acknowledged the complainant's concerns and explained current diagnostic issues, treatment plans and discharge options. A plan was implemented for ongoing consultation between the treating team and the complainant. She was satisfied with the information provided and the plans for further consultation. She was pleased there was an apology and acknowledgment of the issues in her complaint.

More case studies can be found in Appendix A

8.0 ASSESSMENTS AND RESOLUTION DIVISION

Health Conciliation Registry

Conciliation is one of the dispute resolution processes available for the Commission to use where a complaint does not warrant investigation. Where the Commission decides that conciliation is the preferred option for resolving a complaint, the Commission can refer it to the Health Conciliation Registry (the Registry). The Commission must consult with the Registrar prior to referring a complaint for conciliation.

Conciliation is a voluntary and formal process in which a conciliator, independent of the Commission, facilitates a meeting between the parties and assists them to agree on ways to resolve the complaint. At the outset of conciliation, the Registry endeavours to accommodate the specific needs of the parties and is flexible in its approach to conciliation of complaints. The focus of conciliation is usually a formal meeting, however conciliation may also include informal meetings, the provision of further written information by a provider and shuttle telephone discussions with the parties by the Registry. Irrespective of the way in which conciliation of a complaint may ultimately proceed, there is no compulsion for the parties to participate if they choose not to do so.

The Act provides that conciliation is confidential. This means that anything said or documents created for or shared during the conciliation process, cannot be used as evidence if a matter subsequently proceeds to any court, tribunal or other body. The only exception to this is when all of the parties who attended the conciliation, or who were named during the conciliation, consent to the use of any such evidence being used elsewhere. This protection exists to encourage parties to speak to each other as freely as they are able, with a view to resolving a complaint. This confidentiality provision also provides an opportunity for parties to resolve complaints on the basis of refunds or other financial compensation if that is appropriate.

The types of complaints that the Commission can assess as suitable for conciliation are likely to meet at least one of the following criteria:

- a breakdown in communication between the parties
- insufficient information provided to the complainant
- inadequate explanation for poor outcome or an adverse event
- inadequate service
- a complainant is seeking an improvement in the quality of health service, or
- a complainant is seeking a refund or financial compensation as an outcome.

A complaint will not be assessed as suitable for conciliation if:

- the complainant has indicated that they do not want to meet or interact with the provider again, and do not see this as a means to resolve the complaint
- it is apparent that the issue may be resolved more efficiently or less formally by another process
- a complainant has a particular support need which may require a less formal approach to resolution, e.g. a person with ongoing mental health issues or an ongoing patient/provider relationship, or
- it is unlikely the complaint will be resolved.

Conciliators and conciliation

The Minister appoints the conciliators who facilitate conciliations for the Registry. The conciliators are appointed to a panel and work on a sessional basis. They are appointed for terms of up to three years and the recruitment process is publicly advertised and competitive. The conciliators who are on the current panel are highly experienced and skilled in conciliation and other dispute resolution processes.

Since 1 March 2005, the Registry has been integrated into the Commission, although it retains independence from the Commission with respect to the decisions made in managing individual complaints.

The Registry is responsible for obtaining the consent of parties to participate in conciliation and the parties are requested to advise the Registry of their intentions within a designated twenty-one day period. Both parties are encouraged to bring a support person to conciliation and the conciliation meeting is held in a location that is convenient to the parties. Conciliation meetings can be held at the Registry, however the majority occur outside the Commission in the Sydney metropolitan area and regional NSW.

The Registry works with all the parties prior to a conciliation meeting to assist with preparation. This may include identifying the issues for discussion and questions that a complainant would like to have answered, or anything else that a complainant is seeking to resolve their complaint. Most common outcomes from conciliation involve things such as providing information, a verbal and/or written apology and agreed ways of providing safer and better health care. If a complainant wants to seek a financial outcome, the Registry will request details of this some time prior to the conciliation meeting so that a provider is in a position to discuss and possibly resolve a claim at the conciliation meeting.

Performance of the Health Conciliation Registry

During 2005–06 186 matters were referred to the Health Conciliation Registry and 149 matters were closed.

Of the 69 complaints where parties consented to participate in conciliation; 65 (94.2%) reached an agreement and in 4 complaints (5.8%) there was no agreement reached.

Of those complaints where agreement was reached, 16 complaints were resolved due to the assistance provided by the Registry and the parties did not participate in a formal conciliation meeting. This is indicated in Chart 8.8.

Of the 149 complaints closed, 80 (53.7%) did not proceed to conciliation. The most common reason for this was the parties not consenting to conciliation. Moreover, it is apparent that the rate of non-consent by complainants far exceeded that of providers with 52 complainants declining to consent to conciliation, 15 providers declining to consent, in 3 matters one of the parties withdrew their consent and in one matter neither party consented. Nine did not proceed to conciliation for other reasons. This is shown in Chart 8.9.

The Registry has introduced a number of measures to curb the rates of non-consent to conciliation by expanding the range of flexible conciliation options available to the parties. In circumstances where either party has indicated they do not wish to participate in conciliation, the Registry will contact the party to ascertain their concerns regarding conciliation. Depending upon the nature of the complaint and the needs of the parties, the Registry may offer an alternative conciliation process tailored to meet the particular circumstances. This can include dispensing with a formal meeting or alternatively, requesting further information from a provider if it is likely that the provision of such information might assist with resolution.

Chart 8.8 Outcomes of conciliation

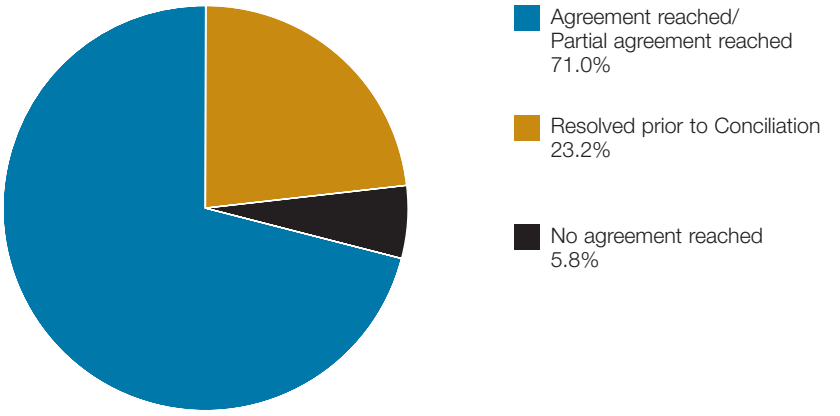
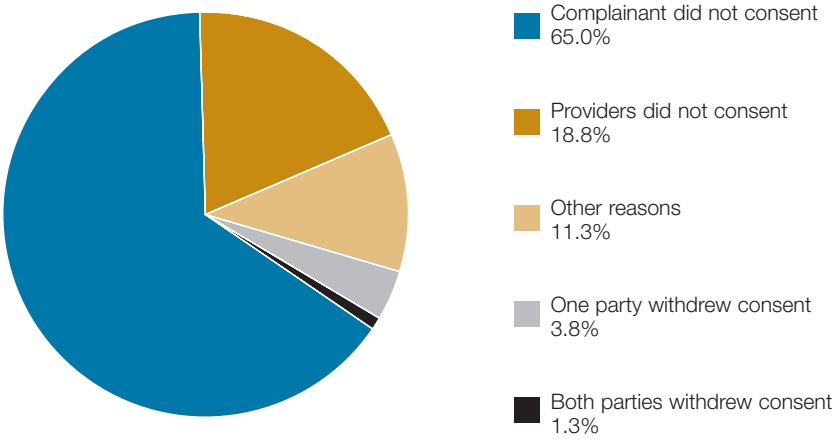


Chart 8.9 Reasons for conciliations not proceeding



9.0 INVESTIGATIONS DIVISION

Overview

The Investigations Division is separated into three teams, each led by an Investigation Manager who supervises a team of approximately five Investigaton Officers.

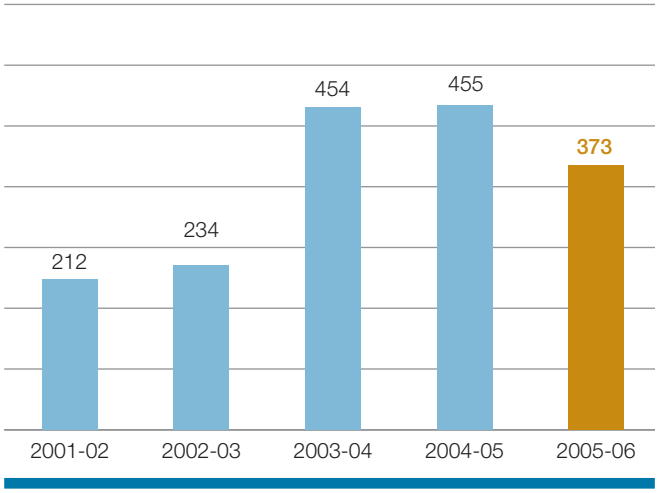
The managers engage in close supervision of each of their team members to ensure that individual investigations remain on track, and on target to be completed within a reasonable time frame. Each manager has a scheduled review with each investigation officer every fortnight. The managers also undertake their own more complicated investigations and review tasks.

Investigation of complaints

During the financial year 2005–06 the Commission assessed 3392 complaints. Of these, 373 were assessed as requiring investigation. This represented 11.0% of the total number of assessment decisions. As shown in Chart 9.1, 2005–06 saw a drop in complaints assessed for investigation from the previous year, but an increase over the figures for years prior to 2003–04.

The 2003–04 and 2004–05 years included a large number of investigations arising out of complaints concerning Camden and Campbelltown Hospitals. In addition, following replacement of the senior management of the Commission in late 2003, numerous old complaints were re-assessed and were also referred for investigation.

Chart 9.1 Complaints assessed for investigation 2001–02 to 2005–06



Conducting an investigation

Under section 23 of the *Health Care Complaints Act 1993* the Commission must investigate certain types of complaints. These are complaints which:

- raise significant issues of public health or safety
- raise significant questions as to the appropriate care or treatment of a client by a health service provider
- if proven, would provide grounds for disciplinary action against a health practitioner
- if proven, would involve gross negligence on the part of a health practitioner
- the registration authority (such as the Medical Board or the Nurses and Midwives Board) is of the opinion should be investigated.

In making decisions about whether to investigate a complaint, the primary object of the Act is the protection of the health and safety of the public.

The Commission retains a number of internal medical advisors and nursing advisors for advice on general clinical issues. In addition when conducting investigations, if the subject matter requires it, the Commission obtains a report from a suitably qualified independent expert.

When selecting an expert, the Commission obtains a declaration from that person to ensure there are no financial, personal or other conflicts of interest with any party to the complaint that may influence their decision-making process. It is also Commission practice to ask all prospective experts to indicate if they have ever been the subject of a disciplinary finding in any jurisdiction that may affect their credibility as a witness.

In conducting an investigation, the Commission has certain coercive powers. Those powers are stipulated within the Act and are only used when information is essential to the investigation and requests for the information have been unsuccessful.

If the Commission is investigating a complaint and is of the opinion that a complainant or health service provider is capable of giving information, producing documents (including medical records) or giving evidence that would assist, these powers permit the Commission to give notice in writing requesting the person to:

- give the Commission any such information of which the person has knowledge
- produce any such documents
- provide evidence in writing or orally, at a reasonable time and place.

These powers have proved to be a useful investigative tool in a number of investigations, ensuring all relevant evidence is obtained and investigations are not delayed unnecessarily.

Outcomes of investigations

During the year the Commission finalised 438 investigations. This figure is made up of 346 investigations into individual health practitioners and 92 investigations into health organisations. This is shown in Chart 9.2.

Investigations Case Study

The complainant gave birth to her third child at a hospital in 2003. She had had a normal pregnancy, during which she had attended the hospital's antenatal clinic on a regular basis.

She was admitted to the hospital's maternity unit in labour at around 3:40am on the morning of the delivery. The attending midwives subsequently noted evidence of foetal distress and contacted the on-call obstetrician.

The doctor arrived at around 6:00am and proceeded to deliver the baby vaginally, through thick meconium, about an hour later. There was no paediatrician present for the delivery.

The baby was apnoeic and asystolic at birth, with no spontaneous movements. The umbilical cord was wrapped tightly around her neck several times. She was subsequently resuscitated, but died five days later.

The Commission investigated the management of the complainant's labour and delivery; the intrapartum and post-partum care provided by a number of midwives; and the overall management of the pregnancy.

The investigation resulted in a referral to the Director of Proceedings to consider professional disciplinary proceedings against the doctor and one midwife and referral of another midwife to the Nurses and Midwives Board for counselling. The Commission also made recommendations to the hospital concerning its systems for responding to phone calls from maternity patients and the revision of existing guidelines for post-partum management of maternity patients.

Outcomes of investigations into health practitioners

At the end of an investigation into a registered health practitioner, the Commission may:

- refer the complaint to the Commission's Director of Proceedings
- refer the complaint to the appropriate registration authority to take action under the relevant health registration Act. In some cases, the health registration authority may have the power to refer the practitioner for performance or impairment assessment. Most often, the health registration authority may decide to counsel the practitioner about the conduct which is the subject of the complaint
- make comments to the health practitioner. Such comments are kept on the record at the Commission and with the relevant health registration authority
- take no further action
- refer the complaint to the Director of Public Prosecutions for consideration of criminal charges.

Chart 9.3 shows the outcomes of finalised investigations into health practitioners from 2002–03 to 2005–06.

Chart 9.2 Investigations finalised 2002–03 to 2005–06

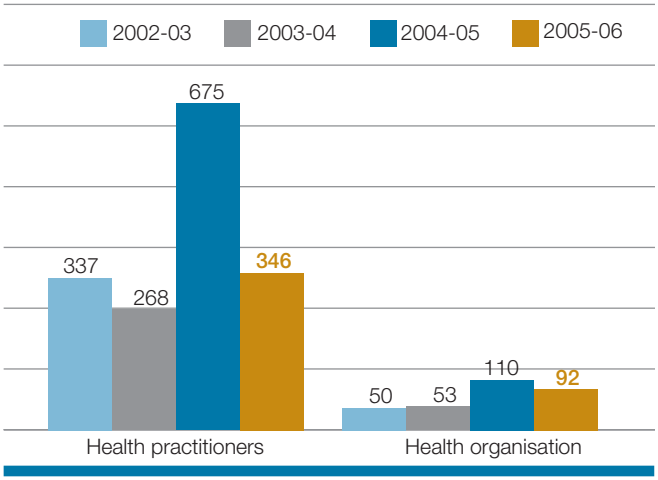
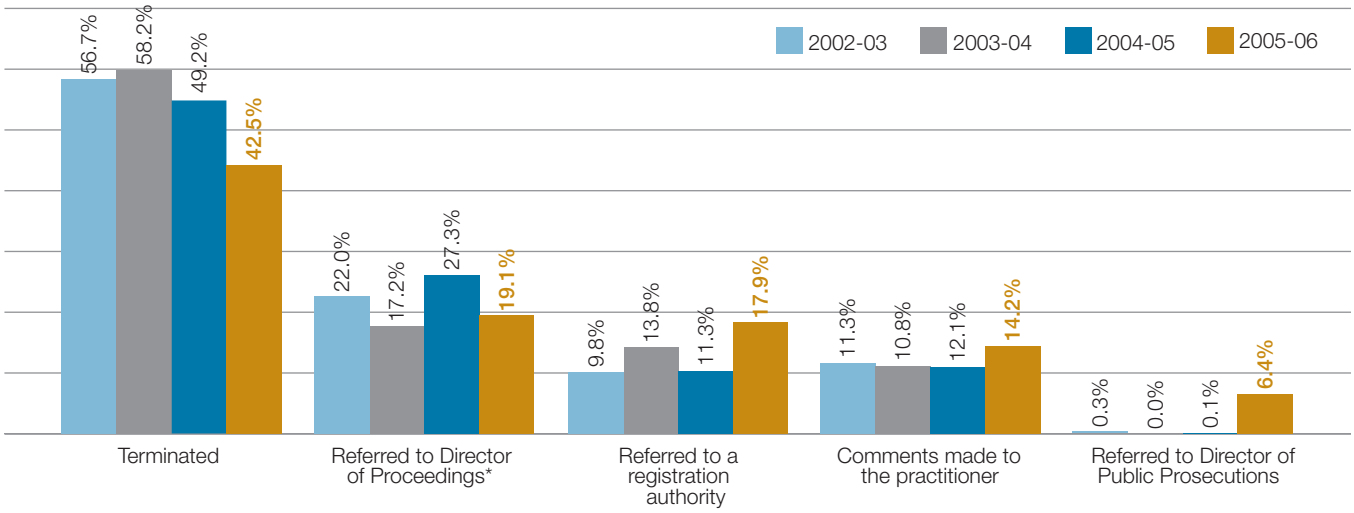


Chart 9.3 Outcomes of investigations into health practitioners 2002–03 to 2005–06



**Prior to 1 March 2005 complaints were referred for prosecution before a disciplinary body rather than to the Director of Proceedings.*

As a result of the more thorough and rigorous assessment processes, ensuring that only the most serious matters are referred for investigation, the proportion of investigations finalised without an adverse outcome for the practitioner is decreasing.

Where the practitioner is not registered with a registration authority (such as a naturopath, an acupuncturist or an alternative health provider), the Commission at the conclusion of the investigation is able to make comments to the practitioner, or refer the matter to the Director of Public Prosecutions if criminal conduct is involved.

The relatively high proportion of matters referred to the Director of Public Prosecutions during 2005–06 is due to the Commission having received numerous complaints against a single unregistered health service provider.

Investigation reviews

The Act provides for a review of investigation in respect of an individual practitioner but not in respect of a health organisation. Where the complaint is about an individual practitioner, the complainant can seek a statutory review of the action taken by the Commission if they are dissatisfied. Complainants are advised of their right to request a review and are requested to provide written reasons for their review request. In most cases the Commission will offer the complainant an opportunity to meet with the Investigation Manager, the Investigation Officer and an Internal Medical Advisor, to go through issues contained within an investigation report. Complainant feedback from these meetings indicates they are well received and provide a further forum for the Commission to explain its decision-making process and jurisdiction.

Investigation reviews are conducted by an Investigation Manager who was not involved in the original investigation, and are determined by the Commissioner.

The Commission received 24 requests for review of an investigation outcome in 2005–06. Chart 9.4 details the number of requests received in the years 2002–03 to 2005–06.

Twenty-nine reviews were completed, the outcomes of which are reported in Chart 9.5.

Outcomes of investigations into health organisations

At the end of an investigation into a health organisation (such as a hospital), the Commission may:

- make comments to the health organisation
- make recommendations to the health organisation
- take no further action
- refer the subject matter of the complaint to the Director of Public Prosecutions.

Chart 9.6 shows the outcomes of finalised investigations into health organisations from 2002–03 to 2005–06.

Chart 9.4 Investigation review requests

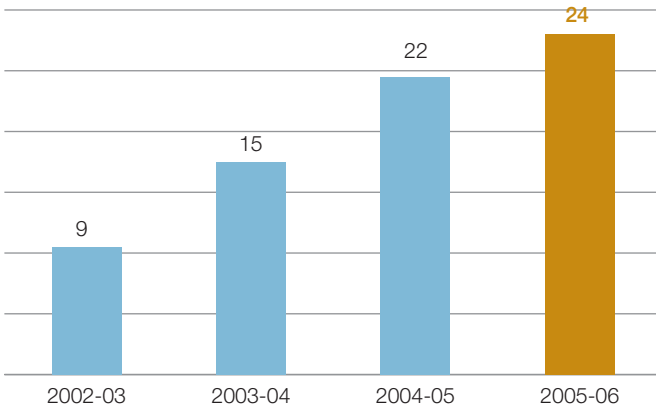


Chart 9.5 Outcome of investigation reviews

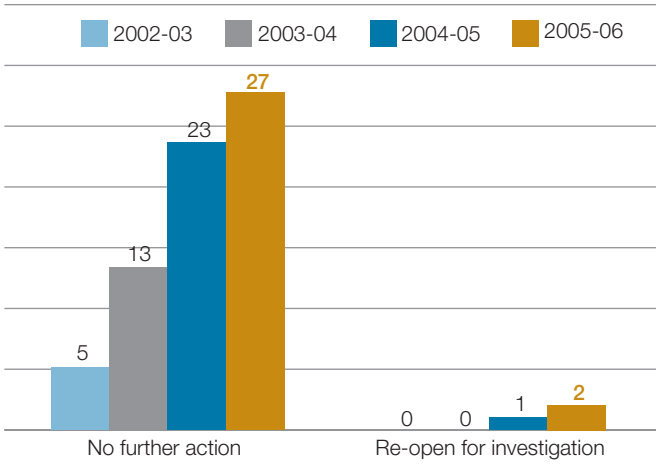
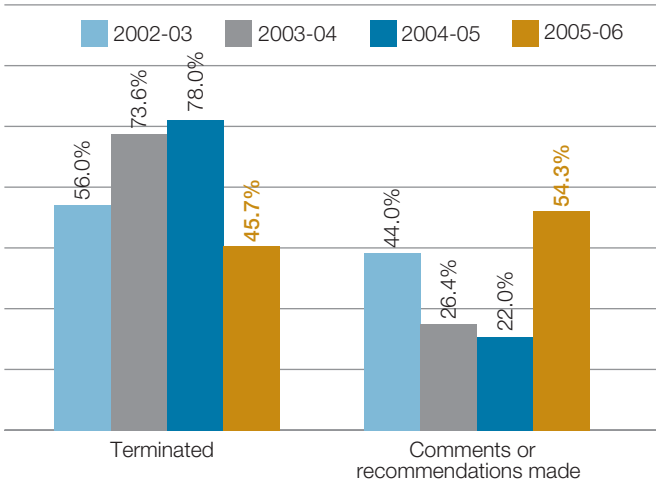


Chart 9.6 Outcomes of investigations into health organisations 2002–03 to 2005–06



Making recommendations or comments to health organisations

An important aspect of the Commission's work in improving health services is the making of recommendations and/or comments to health organisations. A number of investigations reveal that the central issue in a complaint is not the behaviour, competence or conduct of an individual health practitioner, but a systemic issue impacting on the delivery of health services. It is through recommendations and comments made to health organisations that the Commission can address these systemic issues.

Processes involved

If the Commission proposes to make recommendations or comments at the end of the investigation it will notify the health organisation and give the organisation the opportunity to respond to the draft recommendations or comments. This response is required within 28 days. Prior to finalising the investigation any response to the proposed recommendations or comments will be taken into consideration.

At the end of an investigation, if the Commission makes recommendations or comments to a health organisation, a report detailing the recommendations or comments must be provided to the Director-General, NSW Department of Health. The report must include:

- the reasons for its conclusions, and
- the reasons for any action recommended to be taken.

The Commission may request the Director-General to notify it of any action taken or proposed as a consequence of its report. If the Commission is not satisfied that sufficient steps have been taken within a reasonable time as a consequence of its report to the Director-General, it may, after consultation with the Director-General, make a report to the Minister. If the Commission is not satisfied that sufficient steps have been taken within a reasonable time as a consequence of its report to the Minister, it may make a special report on the matter to Parliament. The Commission has not taken this action to date.

During 2005–06 the Commission established procedures to routinely follow up actions taken by an organisation in response to the Commission's recommendations. These procedures are detailed below.

Although the making of recommendations is the result of an individual complaint made against a particular health organisation, there are cases where the recommendations may be applicable not only to that organisation, but to all facilities within the Area Health Service or even across the health system.

Where the Commission suspects that the identified problem is not confined to a single facility or hospital, the Commission may write to the Director-General recommending that consideration be given to the wider application of its recommendations.

During 2005–06 the communication and co-operation between the Commission and the Department of Health has continued to develop. This is primarily the result of regular meetings between the Commissioner and the Director-General, as well as the establishment of designated contacts within both organisations.

Comments

Comments made to a health organisation are intended to act as a record of the adverse care or treatment provided, where the investigation finds inadequate care but there are no wider problems likely to result in further instances of poor care.

The comment below was made in light of a health organisation's response to a draft report, advising that the health organisation had reminded nursing staff of their duties with regard to the making and recording of patient observations:

> *"The Commission's investigation substantiated that the nursing staff at Hospital X failed to properly monitor, treat and care for patient A in that:*
>
> 1. *The nursing staff failed to document appropriate standard observations.*
> 2. *The nursing staff failed to recognise patent A's neurological deterioration between 0230 and 0325 hours."*

During 2005–06 the Commission made comments to health organisations in 26 complaints. The majority of these complaints (21) concerned public hospitals, with three instances of comments being made to nursing homes and two instances of comments being made to private hospitals.

Recommendations

Recommendations are made by the Commission to improve practices, and can vary in nature. They may relate to the adequacy of and adherence to existing training and supervision mechanisms, or may request the facility to undertake a review of policies and practices.

The following is an example of a recommendation made to a health organisation during 2005–06;

> *"That a system be developed whereby photographs of wounds such as ulcers, are taken and incorporated into a patient's file in order for specialists to appropriately assess and manage the wound."*

Chart 9.7 Types of facilities where recommendations were made

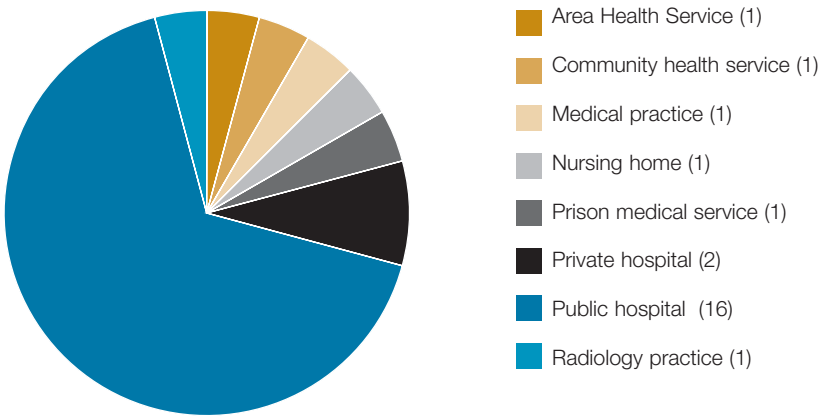


Chart 9.8 Types of recommendations made

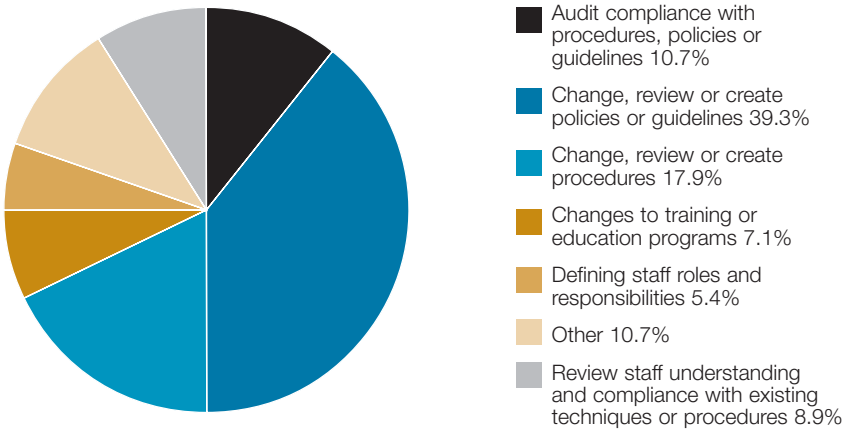
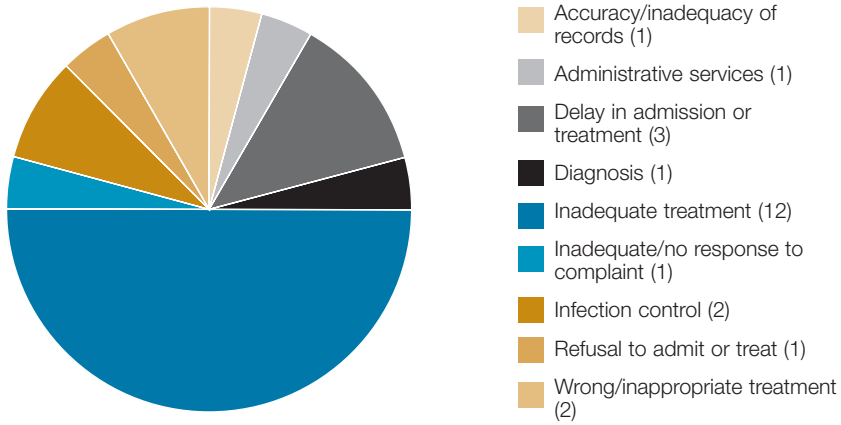


Chart 9.9 Issues raised in complaints resulting in recommendations



Recommendations made during 2005–06

During 2005–06, 24 complaints resulted in the Commission making recommendations to health organisations. Chart 9.7 indicates the types of facilities to whom the Commission made recommendations.

These recommendations were made to a variety of facilities, with 16 instances of recommendations being made to public hospitals, two instances of recommendations being made to a private hospital and one instance of recommendations made to an Area Health Service, a community health service, a medical practice, a nursing home, a prison medical service and a radiology practice.

Whilst there were 24 cases in which the Commission made recommendations to a health organisation, often these cases included more than one recommendation. In total there were 57 recommendations made to health organisations, which can be broadly categorised as recommendations to:

- audit compliance with existing procedures, policies or guidelines
- change, review or create policies or guidelines
- change, review or create procedures
- changes to training or education programs
- defining staff roles and responsibilities
- review staff understanding and compliance with existing techniques or procedures.

As shown in Chart 9.8 almost 60% of recommendations relate to the change, review or creation of policies, guidelines or procedures.

Issues raised in complaints resulting in recommendations

As shown in Chart 9.9 the main issue raised in complaints where the Commission made recommendations to a health organisation was inadequate treatment (50%), followed by delay in admission or treatment (12.5%).

This compares to 27.77% of all finalised investigations where the main issue was inadequate treatment, and 1.41% where the main issue was delay in admission or treatment.

Implementation of recommendations

Once recommendations have been made to a health organisation the Commission monitors the implementation of these recommendations. Of the 57 recommendations made to health organisations, 26 recommendations have been implemented so far.

Progress on the implementation of recommendations will be reported in future annual reports and, if necessary, in the case of failure to implement, by report to Parliament.

In April 2006 a new module was added to Casemate to allow the Commission to monitor the implementation of recommendations made to health organisations.

Performance of the Investigations Division

As indicated in previous reports the Commission's investigation processes have been subject to review due to historical issues of delay. Each investigation undertaken by the division during this reporting period has had a defined written plan. The plan fixes the issues for investigation and guides the information-gathering phase of the investigation.

Complaints are also regularly reviewed by the Investigation Managers. In addition, an Investigations Reporting Group, chaired by the Commissioner, meets fortnightly, to direct the conduct of more serious investigations and investigations that are more than 12 months old.

The implementation of these initiatives has ensured that individual Investigation Officers remain focussed on the defined issues and that their investigations progress in a timely manner. The result of this strategy is best reflected in Chart 9.10 which illustrates that the time taken to complete investigations is decreasing.

A significant performance deficiency previously identified within the division was investigations becoming unnecessarily protracted. As reflected in Chart 9.10 there have been substantial inroads made into the timeliness of investigations. The stated objective of the Commission is for 80% of investigations to be completed within 12 months. Chart 9.10 shows that 61.6% met that standard in this reporting period. This represents an increase from the last reporting period (38.5%). With further refinements of processes and a continuing cultural change within the division, it is anticipated there will be further improvements in the timeliness of investigations.

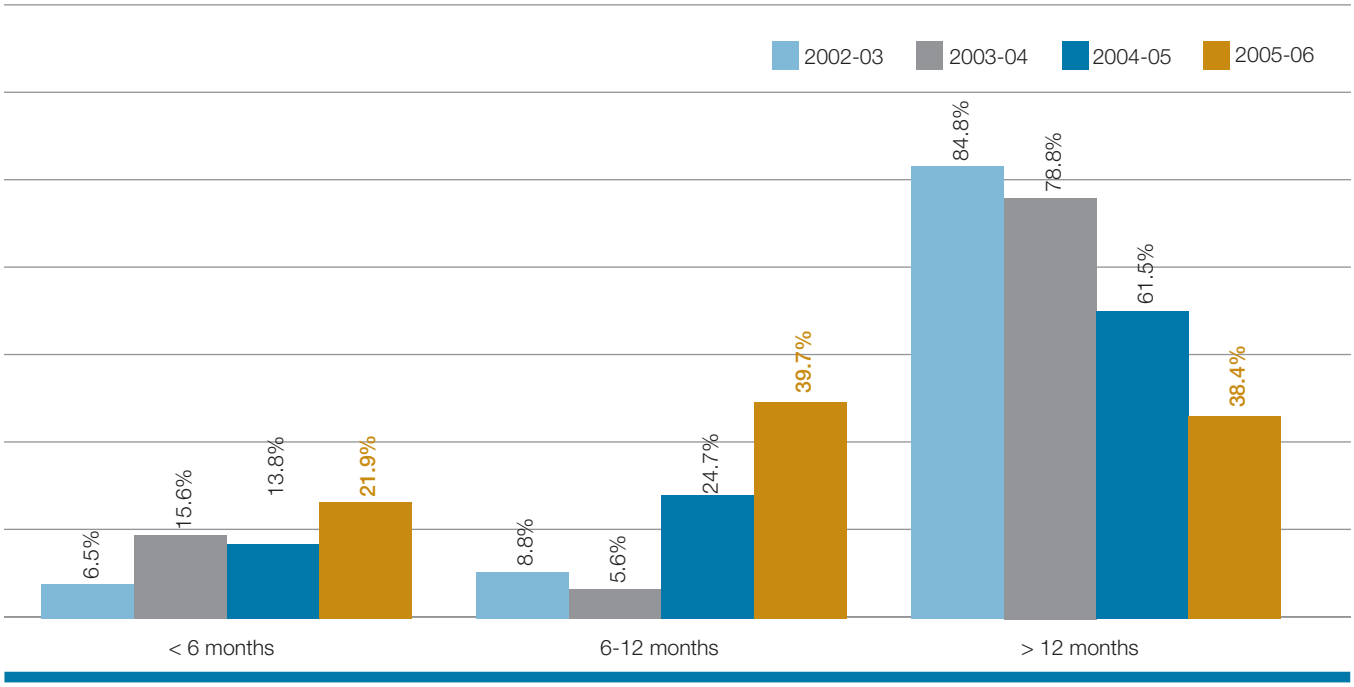
Future directions—improving investigations

As previously reported, the division has undergone substantial changes and improvement in order to ensure that a backlog of investigations does not recur. Investigations processes have been reviewed to ensure that they comply with legislative requirements.

New procedures are being implemented to ensure that investigations are timely and proportionate. As stated above the current target for completing investigations is to ensure that 80% are finalised within 12 months from the assessment decision being made.

The division has had quite a substantial change in personnel during this reporting period. This personnel change has assisted the division in moving towards a more analytical, evidence-based process. There will also be a structured training program implemented in line with the new

Chart 9.10 Time taken to complete investigations 2002–03 to 2005–06



performance management system, to develop analytical capacity and to ensure appropriate resources are utilised.

The division is developing a 'brief of evidence' protocol for file management, which is expected to be implemented in the first quarter of 2006–07. This protocol will provide the Director of Proceedings and Legal Officers with quick access to all the evidence in the possession of the Commission, and potentially lower review times for files referred to the Legal Division, thus lowering legal costs.

Investigations Case Study

The complainant's mother attended a pre-admission clinic, prior to her admittance to hospital for elective gynaecological surgery. During the pre-admission clinic, a chest x-ray was performed and reported on by a radiologist. The x-ray showed a lesion in the patient's right lung, at the time identified as measuring 30mm x 25mm. The x-ray report recommended further investigation. The operation was successfully performed and the patient was subsequently discharged. Information regarding the lesion was recorded on the patient's discharge summary, however she was not given a copy of this document when discharged.

One week after the operation, the patient attended the office of her specialist and was given a clean bill of health, with no mention being made of the abnormal x-ray result. Approximately nine months later, the patient attended her general practitioner complaining of a sore shoulder. An x-ray of the shoulder revealed an inoperable tumour in her right lung. The patient subsequently underwent several rounds of chemotherapy but died of lung cancer approximately seven months later.

The Commission considered that the lack of follow up of the result of the pre-operative chest x-ray by the patient's treating team and the failure of the radiologist to ensure the results of the chest x-ray were delivered to the team, were not issues that warranted adverse findings against any individual practitioners, as there would be an expectation that a hospital would have appropriate systems in place for the communication of pre-admission results prior to surgery. The Commission therefore found that there was a lack of appropriate systems in place within the hospital.

As a result of this case, the Area Health Service had already implemented changes to its referral systems. These improvements facilitate direct communication between radiologists and treating medical teams, however the Commission identified a few additions to these changes that have also now been implemented.

The Chief Executive of the Area Health Service advised the Commission that the hospital had initiated changes in line with the Commission's recommendations. The Chief Executive advised an electronic communication system was now in place for all abnormalities in x-ray reports to be brought to a medical officer's attention. Previous staffing issues had been addressed and policy change had occurred to clarify these amendments.

More case studies can be found in Appendix A

Investigations Case Study

The Commission received a complaint from the daughter of a 77-year-old woman, about the care and treatment her mother received at hospital after sustaining a fractured hip in a fall at home. The patient faced a long delay in the Emergency Department (ED) at hospital. Her hospital admission was complicated by the development of severe pressure ulcers and displacement of the screw used to repair her hip, which required further surgery. The patient did not return home until over four months after her initial ED presentation.

The Commission found that the patient was brought into the ED by ambulance at 6:40pm on a Sunday evening and remained there for 19 hours, of which about seven hours were spent on an ambulance trolley, before being transferred to a bed in the surgical ward. She was triaged to be seen by a doctor within 30 minutes but was not seen until two hours after her presentation. A doctor did not see her again until the following morning, 12 hours after the last review by a doctor. During her overnight stay in the ED, the patient was not re-assessed by a nurse experienced in triage, nor was there any evidence of baseline observations having been taken by nursing staff or the provision of basic nursing care.

At the time of the patient's ED presentation there were no policies in place at the hospital regarding management of elderly patients in the ED.

An expert reviewer was of the opinion that the patient was at high risk of developing pressure areas and her prolonged stay in the ED, without any pressure area prevention intervention or pressure relieving devices such as sheepskins and/or an air mattress, contributed to the breakdown in her skin integrity and the subsequent development of pressure ulcers.

The Commission also noted deficiencies in relation to nursing observations and interventions during the patient's hospital admission.

At the end of the investigation, the Commission made four recommendations to the health organisation regarding the development of policies and procedural guidelines to ensure:

(i) Patients waiting in the ED are re-assessed by a nurse experienced in triage and continue to be observed and receive timely nursing interventions throughout their emergency stay.

(ii) Elderly patients who present to the ED receive prompt medical attention, a planned multidisciplinary approach to care, and early surgical intervention, if medically stable and if clinically warranted.

(iii) Early identification, ongoing re-assessment and early intervention of patients at risk of pressure area development and education for staff regarding prevention and management of pressure areas.

(iv) Patient observations are conducted and documented as often as clinically indicated, and appropriate and timely interventions are instigated when clinically indicated.

More case studies can be found in Appendix A

10.0 LEGAL DIVISION AND THE DIRECTOR OF PROCEEDINGS

Overview

The Legal Division operates under the supervision of the Director of Proceedings. The Director of Proceedings determines whether a complaint should be prosecuted. Complaints may involve allegations of impairment, unsatisfactory professional conduct or professional misconduct.

The Director of Proceedings makes decisions independently from the Commissioner and the assessment and investigation processes. To ensure that the co-regulatory nature of the system is preserved, the Director of Proceedings is required to consult with the relevant registration authority about its views prior to determining whether or not to institute disciplinary proceedings.

The powers of the Director of Proceedings are contained in Part 6A of the Health Care Complaints Act. Section 90B sets out the functions of the Director of Proceedings and also confers the power to prosecute complaints. Section 90C sets out the criteria that the Director of Proceedings must consider when determining whether to prosecute a matter. These criteria are:

- the protection of the health and safety of the public
- the seriousness of the alleged conduct the subject of the complaint
- the likelihood of proving the alleged conduct
- any submissions made under section 40 by the health practitioner concerned.

If the Director of Proceedings considers that a matter does not meet the threshold for prosecution the matter can be terminated, referred back to the Investigations Division to gather further evidence, or referred to the Commissioner to determine the outcome in line with statutory requirements.

The independence of the Director of Proceedings is codified in section 90D. That section provides that:

> *" the Director of Proceedings is not subject to the direction and control of the Commissioner in relation to dealing with any particular complaint that has been referred by the Commission to the Director for consideration".*

Generally, complaints which may lead to a finding of unsatisfactory professional conduct are referred to a Professional Standards Committee (PSC) that is constituted by the relevant registration authority. The practitioner is entitled to be accompanied by either a barrister or solicitor or another advisor or to be represented by a non-lawyer advocate.

A PSC is not empowered to de-register or suspend a practitioner but may issue a caution or reprimand, impose a fine or impose conditions on the registration of the practitioner. PSC hearings are conducted in private and the findings are generally not made public.

Prosecutions for professional misconduct are generally heard before a Tribunal, which has the power to suspend or de-register a practitioner. In certain circumstances a decision may be made that it is in the public interest to have a matter involving unsatisfactory professional conduct heard in a Tribunal as these matters are open to the public. A practitioner is able to be legally represented in such hearings.

Medical Tribunal Case Study

Monier Gad, re-registration application

In March 2006, the Medical Tribunal heard an application by Monier Gad for the return of his name to the Roll of Medical Practitioners. The application was refused.

Mr Gad had appeared before the Tribunal twice before. In 1990, the Tribunal found him guilty of professional misconduct following his convictions in 1986 for making fraudulent claims under the Health Insurance Act, those offences having been committed when he was working in contravention of conditions on his practice. He was suspended and conditions were placed on his practice.

In 2001, he again came before the Medical Tribunal to answer a complaint that he had administered testosterone to a 16-year-old female patient, who developed serious side effects as a result of that inappropriate treatment. On 19 October 2001, the Tribunal found Mr Gad guilty of professional misconduct and ordered that his name be removed from the Register.

When Mr Gad sought re-registration in 2006, he carried the onus of satisfying the Medical Tribunal that the defect in his character, which led to his name being removed from the Register, had been rectified.

Prior to deregistration, Mr Gad had practised as a general practitioner in Firth Street, Arncliffe. At the time of the hearing in 2006, the former practice premises continued to display signage that identified the premises as a medical practice from which Dr Gad operated.

In refusing the application, the Tribunal noted its concern about three aspects of Mr Gad's character: his dealings and association with the Arncliffe practice, his holding himself out as a medical practitioner, and his failure to inform his medical referees of his 1986 convictions and subsequent suspension from practice.

The Tribunal found that Mr Gad had been dishonest in relation to his dealings with the Arncliffe practice and that he had improperly held himself out, to patients of the Arncliffe practice and to professional medical organisations, as a medical practitioner. It also found that he had been deliberately dishonest with his medical referees. The Tribunal ordered that he cannot reapply for re-registration for a period of 3 years from the date of its decision.

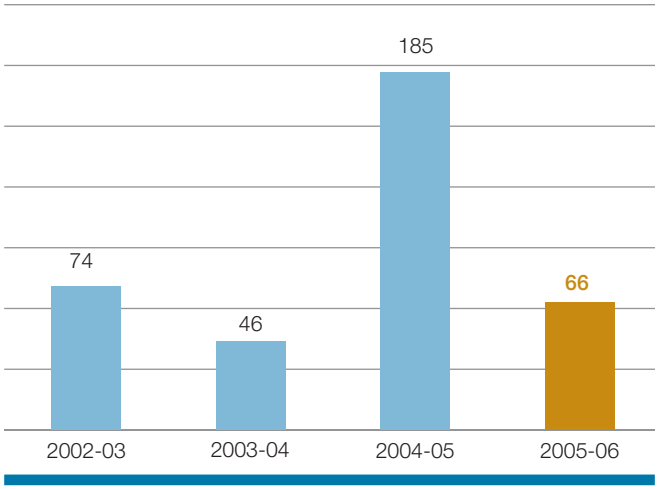
More case studies can be found in Appendix A

10.0 LEGAL DIVISION AND THE DIRECTOR OF PROCEEDINGS

Disciplinary and other legal cases

The 2005–06 year saw a reduction in the number of complaints referred to the Legal Division for consideration of disciplinary proceedings from 185 in 2004–05 to 66. This is shown in Chart 10.1. The 2004–05 figure included a large number of backlog matters whilst the 2005–06 figures are more in keeping with previous years.

Chart 10.1 Complaints referred to Director of Proceedings or for prosecution before a disciplinary body 2002–03 to 2005–06



At the end of 2005–06, the Commission had finalised 103 matters, including 86 disciplinary matters, nine review or re-registration applications and eight appeals and applications. In nine matters, the complaints were withdrawn and inquiries were not held for various reasons including that the practitioner could not be located or was no longer practising. Four matters were dismissed as the disciplinary body was not satisfied that the complaint had been proven. Results are shown in Chart 10.2. There was a 21.2% increase in disciplinary and other matters finalised compared to last year (103 as against 85) which itself was up 32.8% from the 2003–04 year.

The further increase in prosecution numbers over the 2005–06 year is a consequence of the finalisation of a number of the backlog matters referred from Investigations in the 2004–05 year and which took some time to be listed and heard in the various PSCs, Tribunals and Boards of Inquiry. Due to the more informal procedures, PSC matters tend to be listed and heard more quickly than Tribunal matters and this is reflected in the decrease of PSC matters in the 2005–06 year.

The Legal Division will undergo a further change in structure in 2006–07 with the introduction of two new Senior Legal Officer positions. The structure of the Legal Division will now mirror the management structure that currently exists in the Assessments and Resolution Division and Investigations Division and will allow the new Senior Legal Officers to participate in the Commission's Senior Management Committee. It will also assist in the continued roll-out of performance agreements to all Legal Division Officers and allow projects, such as the review and update of the Prosecutions Manual to be implemented.

The outcomes of disciplinary cases determined by Tribunals, Professional Standards Committees and Boards of Inquiry for 2005–06 are shown at Table 10.1.

Chart 10.2 Legal matters finalised 2002–03 to 2005–06

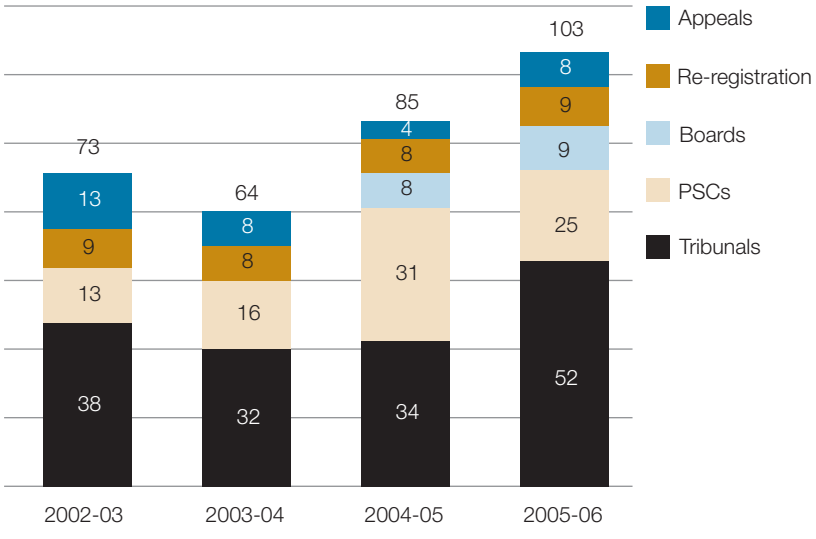


Table 10.1 Outcomes of disciplinary cases determined 2005–06

TRIBUNALS			
Chiropractors Tribunal	Proved	Reprimand (Smith)	1
	Not proved / Inquiry not held		0
Medical Tribunal	Proved	De-registered (Katelaris, Catchlove, Haddad)	3
		Reprimand and conditions (Dinaker, Muller, Kwan, Bastas, Practitioners A and B—names suppressed)	6
		Reprimand (Practitioners C, D and E—names suppressed)	3
		Reprimand, fine and conditions (Stewart, Singh and Whitton)	3
		Reprimand and fine (Guest)	1
		Conditions (Cross, Caladine)	2
	Not proved / Inquiry not held	Heard and dismissed	2
		Withdrawn and dismissed	8
		Withdrawn and referred to PSC	1
Nurses and Midwives Tribunal	Proved	De-registered/Unable to re-register for period (Karaozbek, Burrows, Liu, Noach, Agbinya, Easterbrook, Maher, Yee, Barbary, Ham)	10
		Reprimand and conditions (Szakaly)	1
		Conditions (Sullivan, Maslen, Practitioner F—name suppressed)	3
		Suspension (Barber, Condon)	2
	Not proved / Inquiry not held	Withdrawn and dismissed	1
		Heard and dismissed	1
Optometrists Tribunal	Proved	Suspension (Caristo)	1
	Not proved / Inquiry not held		0
Psychologists Tribunal	Proved	Reprimand and conditions (Smith, McDonald)	2
		De-registered (Mueller)	1
	Not proved / Inquiry not held		0
PROFESSIONAL STANDARDS COMMITTEES			
Medical Professional Standards Committee	Proved	Reprimand	2
		Reprimand and conditions	5
		Conditions	0
		Caution and conditions	1
		Caution	0
	Not proved / Inquiry not held	Heard and dismissed	1
Nurses Professional Standards Committee	Proved	Reprimand	0
		Reprimand and conditions	4
		Conditions	2
		Caution and conditions	2
		Caution	2
	Not proved / Inquiry not held	Terminated and referred to Tribunal	2
Pharmacy Professional Standards Committee	Proved	Reprimand and conditions (Angelis, Metlege, Sawan, Ho)	4
	Not proved / Inquiry not held		0
BOARDS OF INQUIRY			
Pharmacy Board of Inquiry	Proved	Reprimand	0
		Reprimand and conditions (Leftakis, Chiotis)	2
		Reprimand, fine and conditions (Waskin, Gibson, Leros, Mesiti, Pahos)	5
	Not proved / Inquiry not held		0
Psychologists Board of Inquiry	Proved	Caution	1
		Caution and conditions	1
	Not proved / Inquiry not held		0
TOTAL			**86**

The outcomes of appeal cases for 2005–06 are shown at Table 10.2.

Table 10.2 Outcomes of appeal cases and other applications completed 2005–06

APPEALS	OUTCOME	NO.
Court Of Appeal		
Appeal from Medical Tribunal by practitioner	Appeal allowed in part (Lindsay) Appeal dismissed (Prakash)	1 1
Supreme Court		
Application by practitioner	Dismissed (Cheng)	1
Administrative Decisions Tribunal		
Appeal against privacy determination	Dismissed	1
Medical Tribunal		
Appeal by practitioner against PSC conditions	Appeal allowed and conditions varied	2
Appeal by practitioner against interlocutory decision of PSC	Appeal withdrawn by consent	1
Nurses Tribunal		
Appeal by practitioner against PSC conditions	Appeal allowed. Complaint dismissed	1
TOTAL		**8**

The outcomes of re-registration/review application cases for 2005–06 are shown at Table 10.3.

Table 10.3 Outcomes of re-registration/review application cases completed 2005–06

RE-REGISTRATION/REVIEW APPLICATION	NO.
Medical Tribunal	
Re-registered with conditions (Anderson, Matter)	2
Heard and dismissed (Gad, Ferguson)	2
Review of conditions dismissed	0
Review of conditions allowed	1
Nurses and Midwives Tribunal	
Re-registered with conditions	1
Dismissed (Agbinya)	1
Withdrawn and dismissed	2
TOTAL	**9**

Disability Action Plan

The Commission is committed to minimising and, where possible, eliminating discriminatory practices and increasing access to services and premises for people with disabilities. As part of this commitment and to help guide the Commission in a planned approach to realising this objective, the Commission developed and endorsed a three-year Disability Action Plan in line with the NSW Government's Disability Policy Framework and Section 9 of the *NSW Disability Services Act 1993.*

During 2005–06 the following outcomes were achieved:

- development of an Employment of People with a Disability policy
- various workplace and other reasonable adjustments were undertaken to support staff with disabilities to continue their work in the Commission
- engagement of an external provider to prepare and co-ordinate return-to-work plans for staff with temporary disabilities and/or work-related injuries
- purchase of ergonomic equipment recommended by an external advisor to assist staff in workplace adjustment to enhance the performance of their work
- all staff undertook EEO/Grievance/Diversity refresher training
- identified staff undertook merit selection training or merit selection refresher training conducted by an external consultant
- engagement of an expert provider to undertake an access audit of the Commission's premises (audit occurred in July 2006).

Chart 11.1 Staff with disabilities (by level)

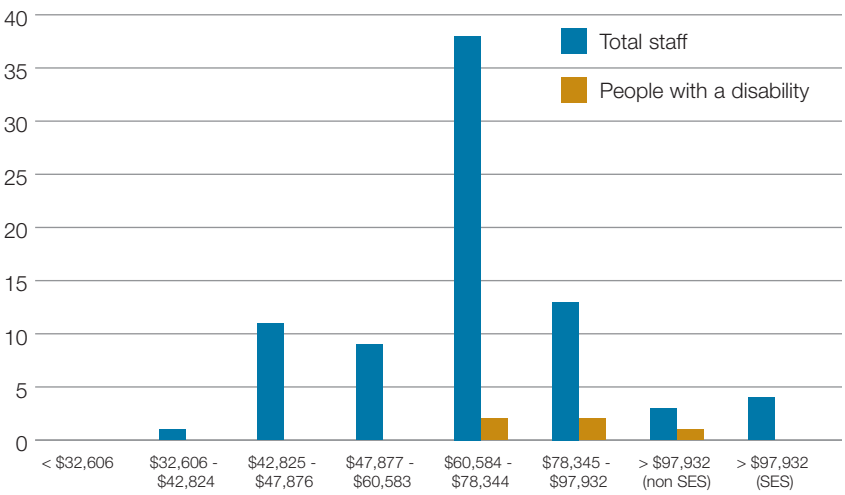
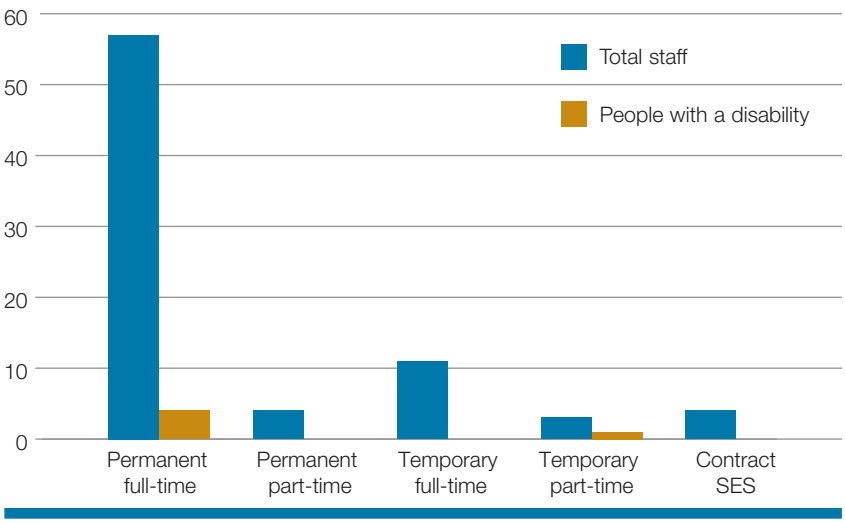


Chart 11.2 Staff with disabilities (by employment basis)



Ethnic Affairs Priorities Statement

The Commission recognises its legislated obligations and upholds the principles of multiculturalism. It is committed to the ongoing support of these principles for both staff and our clients who are from culturally and linguistically diverse backgrounds and who are Australian citizens or permanent residents.

During the reporting period the Commission developed its 2005–06 Ethnic Affairs Priorities Statement (EAPS) and Management plan in accordance with the NSW Government's principles of multiculturalism, as defined in the *Community Relations Commission and Principles of Multiculturalism Act (2000).*

During the year the Commission achieved the following outcomes against its EAPS strategies for 2005–06:

- developed an intranet page listing the days of religious significance for multicultural NSW in 2006
- promoted the community language allowance scheme (CLAS) to staff
- engaged accredited interpreters when required for assisting in the conduct of Commission business
- engaged an external provider from the Centre for Community Welfare Training (CCWT) to deliver Cultural and Linguistic Diversity training to all Commission staff and managers. Training occurred in July 2006.
- developed a Contact Information Package for members of the public to assist them in accessing the appropriate Commission Division

Chart 11.3 Staff whose first language is other than English (by level)

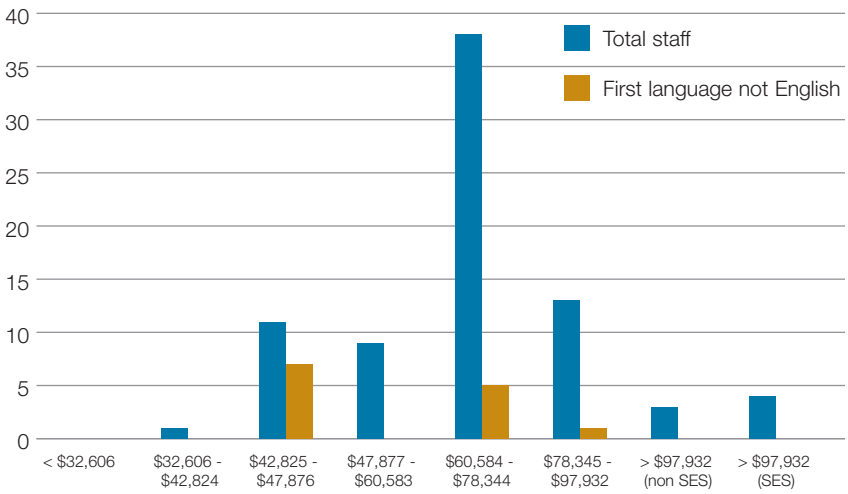
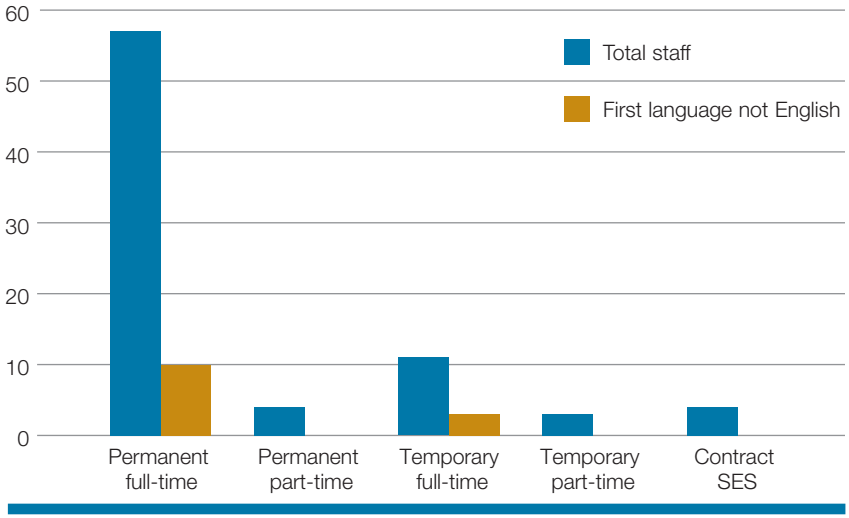


Chart 11.4 Staff whose first language is other than English (by employment basis)



- developed language signage and language cards for non–English speaking members of the public
- provided an external Telephone Interpreter Service; Commission staff are aware of services which are available to assist them when dealing with members of Cultural and Linguistic Diverse (CALD) communities
- had CALD representation on the Commission's Consumer Consultative Committee (see note later under Committees).

The Commission's 2006–07 EAPS plan will also focus on the following EAPS strategies:

- development of a policy and procedure on using bilingual staff to improve internal arrangements for receiving complaints from people of CALD backgrounds, including translation and interpreting
- signage for the Commission's public areas developed to assist CALD clients
- Commission services and resources promoted to a range of CALD communities through a targeted community radio campaign.

Electronic service delivery

Within the past two years, the Commission has carried out significant changes to the look, feel and navigation of both the internet and the intranet websites. The content of both websites is under constant review and is updated regularly. This has allowed both Commission staff and the general public to access the most current information available in an easier manner.

The implementation of a new helpdesk system has allowed Commission staff to lodge and monitor helpdesk requests online through the intranet.

All Casemate reports have been published on the intranet for easy and secure access by all Commission staff.

The Commission also enhanced its internet-based remote access facility by implementing RSA secure tokens and additional firewalls to the Commission's network. Commission staff are now able to securely access the Commission's systems and network using wired or unwired (mobile) broadband internet from any external location.

Freedom of Information (FOI)

As at 1 March 2005 the Health Care Complaints Commission became an exempt body under Schedule 2 of the *Freedom of Information Act 1989* (section 9) in relation to its complaint handling, investigative, complaints resolution and reporting functions (including any functions exercised by the Health Conciliation Registry).

Tables 11.1 to 11.11 set out the FOI requests received by the Commission during 2005–06.

Table 11.1 Number of new FOI requests

FOI REQUESTS	PERSONAL *		OTHER#		TOTAL	
	2004–05	2005–06	2004–05	2005–06	2004–05	2005–06
New	47	1	1	0	48	1
Brought forward	0	0	0	0	0	0
Total to be processed	47	1	1	0	48	1
Completed	47	1	1	0	48	1
Transferred out	0	0	0	0	0	0
Withdrawn	3	0	0	0	3	0
Total processed	44	1	1	0	45	1
Unfinished (carried forward)	0	0	0	0	0	0

* Personal requests are those made by individuals
\# Other requests are those made by organisations

Table 11.2 What happened to completed requests

RESULTS OF FOI	PERSONAL		OTHER	
	2004–05	2005–06	2004–05	2005–06
Granted in full	12	0	1	1
Granted in part	22	0	0	0
Refused	13	0	0	0
Deferred	0	0	0	0
Completed	47	0	1	0

Ministerial certificates

No Ministerial certificates issued during this or the previous reporting period.

Table 11.3 Formal consultations – number of requests requiring consultations (issued) and total number of FORMAL consultations for the period

	ISSUED		TOTAL	
	2004–05	2005–06	2004–05	2005–06
Number of requests requiring formal consultations	5	0	5	0

Amendment of personal records

No requests for notation were made during this or the previous reporting period.

Table 11.4 Amendment of agency records—number of requests for amendment processed during the period (s.43)

RESULTS OF REQUESTS	2004–05	2005–06
Agreed	1	0
Refused	0	0
Total	**1**	**0**

Notation of personal records

No requests were made for notation during this or the previous period.

Table 11.5 FOI requests granted in part or refused. Basis of disallowing access – number of times each reason cited in relation to completed requests which were granted in part or refused

BASIS OF ALLOWING OR RESTRICTING ACCESS	PERSONAL		OTHER	
	2004–05	2005–06	2004–05	2005–06
S19 (application incomplete, wrongly directed)	0	0	0	0
S22 (deposit not paid)	1	0	0	0
S25 (1) (a1) (diversion of resources)	0	0	0	0
S25 (1) (a) (exempt)	0	0	0	0
S25 (1) (b), (c), (d) (otherwise available)	0	0	0	0
S28 (1) (b) (documents not held)	25	0	0	0
S 24 (2) (deemed refused, over 21 days)	0	0	0	0
S 31 (4) (released to medical practitioner)	0	0	0	0
Schedule 2 (complaint being processed by the Commission)	2	0	0	0
Section 9 (exemption from operation of FOI Act.)	7	3	0	0
Totals	35	3	0	0

Note: Section 9 of Schedule 2 of the FOI Act relating to the Health Care Complaints Commission was amended effective from 1 March 2005.

Table 11.6 Costs and fees of requests processed during period

	ASSESSED COSTS		FOI FEES RECEIVED	
	2004–05	2005–06	2004–05	2005–06
All completed requests	$1,036	$0	$1,036	$30

Table 11.7 Discounts allowed

TYPE OF DISCOUNT ALLOWED	PERSONAL		OTHER	
	2004–05	2005–06	2004–05	2005–06
Public interest	0	0	0	0
Financial hardship—pensioner / child	10	0	0	0
Financial hardship—non-profit organisation	0	0	0	0
Totals	10	0	0	0
Significant correction of personal records	0	0	0	0

Table 11.8 Days to process				
ELAPSED TIME	PERSONAL		OTHER	
	2004–05	2005–06	2004–05	2005–06
0–21 days	30	0	1	0
22–35 days	8	0	0	0
Over 35 days	9	1	0	0
Totals	**47**	**1**	**1**	**0**

Table 11.9 Processing time				
PROCESSING HOURS	PERSONAL		OTHER	
	2004–05	2005–06	2004–05	2005–06
0–10 hours	41	1	1	0
11–20 hours	6	0	0	0
21–40 hours	0	0	0	0
Over 40 hours	0	0	0	0
Totals	**47**	**1**	**1**	**0**

Table 11.10 Reviews and appeals—number finalised during period		
	2004–05	2005–06
Number of internal reviews finalised	1	0
Number of Ombudsman reviews finalised	1	0
Number of District Court reviews finalised	0	0
Number of ADT appeals finalised	0	0

Bases of internal review

Table 11.11 Grounds on which internal review requested								
	PERSONAL				OTHER			
	UPHELD		VARIED		UPHELD		VARIED	
	2004–05	2005–06	2004–05	2005–06	2004–05	2005–06	2004–05	2005–06
Access refused	0	0	0	0	0	0	0	0
Deferred	0	0	0	0	0	0	0	0
Exempt matter	0	0	1	0	0	0	0	0
Unreasonable charges	0	0	0	0	0	0	0	0
Charge unreasonably incurred	0	0	0	0	0	0	0	0
Amendment refused	0	0	0	0	0	0	0	0
Totals	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**

Privacy Management Plan

The Commission is subject to provisions of the *Privacy and Personal Information Protection Act 1998* and the *Health Records and Information Privacy Act 2002* which impose obligations on public sector agencies as to how they handle personal information.

The Commission's Privacy Management Plan describes how the Commission will manage our obligations as we collect, use, disclose, secure and retain personal information.

The Plan also describes how the Commission will provide individuals with a right of access to, and correction of, personal information held about them, and explains the various exemptions that apply as we undertake:

- the collection of information for research purposes
- the use of information for investigative purposes
- some information transfers between public sector agencies.

The Plan will be reviewed in 2006–07 and, if necessary, updated to ensure the Commission continues to meet privacy obligations in a changing business environment.

There were no privacy requests received in 2005–06. There was one Administrative Decisions Tribunal (ADT) hearing arising out of a privacy request in 2004–05 in respect of certain conduct of the Commission. The application was dismissed by the ADT but an appeal against this decision has subsequently been lodged.

Inquiries regarding the Commission's Privacy Management Plan should be directed to the Privacy Contact Officer privacy@hccc.nsw.gov.au

Promotion

Publications

Commission publications in 2005–06:

- Annual Report 2005–06
- Information about the Commission
- Resolution Service
- Complaint Form
- How to write a complaint to the Health Care Complaints Commission.

These publications are available on the Commission's website www.hccc.nsw.gov.au

Commission policy documents

The Commission's policy documents are:

- Consumer Consultative Committee—Terms of Reference and Code of Conduct
- Guidelines for Professional Reviewers and Advisors
- Privacy Management Plan.

Commission fact and information sheets

The Commission is updating a range of information and fact sheets to inform members of the public about the Commission's services. Some publications will be produced in languages other than English. These will be available on the Commission's website www.hccc.nsw.gov.au

Complaints by consumers

When a complainant is dissatisfied with a decision of the Commission in relation to either an assessment or investigation outcome he or she is entitled to seek a review of the matter. Assessment reviews are undertaken pursuant to section 28 of the *Health Care Complaints Act 1993.* Reviews of investigation outcomes concerning individual practitioners are undertaken pursuant to section 41. The numbers are reported elsewhere in this report.

Consumers are entitled to complain to the NSW Ombudsman and the Independent Commission Against Corruption about the Health Care Complaints Commission. For the reporting year the Ombudsman received three Freedom of Information complaints about the Commission, two were declined at the outset and preliminary inquiries were made on the third. Twenty-two general complaints were received, eight were declined at the outset and preliminary inquiries were made on 14. No matters were formally investigated.

The Commission

The Commission consists of a Commissioner appointed by the Governor for a period of five years. The Commissioner, Kieran Pehm, BA, LLB, LLM, was appointed on 29 June 2005.

Senior Executive Service

In the 2005–06 reporting period the Commission had four SES positions. The positions and their incumbents are:

Commissioner, SES Level 6—Kieran Pehm, BA, LLB, LLM

Director of Proceedings, SES Level 2—Karen Mobbs, BA, LLB

Director of Investigations, SES Level 2—Scott Schaudin, Diploma in Law, Graduate Diploma in Legal Practice

Director of Assessments and Resolution, SES Level 1—Ian Thurgood, qualifications in nursing and alternative dispute resolution

Two of the above positions were filled during the reporting period due to the resignations of the previous occupants. The current incumbent of the position of Director of Investigations commenced on 14 November 2005 and the current incumbent of the position of Director of Assessments and Resolution commenced on 19 December 2005.

Table 12.1 Senior Executive Service

	2004–05	2005–06
Number of female executive officers	2	1
Number of executive positions		
SES Level 6	1	1
SES Level 5	1	
SES Level 4		
SES Level 2	2	2
SES Level 1	1	1

Performance of the Commissioner

Annual reporting legislation requires a report on the performance of any SES officers at level 5 or above.

Mr Kieran Pehm, the Commissioner throughout 2005–06 was the only senior officer in this category. The Commissioner is responsible to the Minister for Health for the management and performance of the Commission. The Minister advised that he considers the Commissioner's performance during the 2005–06 financial year to be of satisfactory standard.

The total remuneration package (inclusive of superannuation contributions) for Mr Pehm is currently $237,801.

Commission staff

At 30 June 2006 there were 79 staff employed by the Commission in a range of permanent and temporary full-time and part-time positions. Since its restructure, the Commission consists of an Executive Unit and four Divisions: Investigations Division, Legal Division, Assessments and Resolution Division and Corporate Services Division. Currently, there are four Senior Executive Service (SES) officers employed on contract and of the remaining 75 staff members, 61 staff were employed on a permanent basis and 14 staff were employed on a temporary basis. Ninety-one percent of the Commission's employees are full-time and nine percent of staff are currently on a part-time work arrangement.

Table 12.2 Number of staff by salary level

	2003–04		2004–05		2005–06	
Level	**Men**	**Women**	**Men**	**Women**	**Men**	**Women**
< $31,352	0	0	0	0	0	0
$31,352 - $41,177	1	0	1	0	1	0
$41,178 - $46,035	1	8	1	9	1	10
$46,036 - $58,253	4	5	4	4	1	8
$58,254 - $75,331	14	31	11	32	11	27
$75,332 - $94,165	5	6	5	4	4	9
> $94,165 (non SES)	1	3	0	6	0	3
> $94,165 (SES)	1	2	2	2	3	1
Sub Total	27	55	24	57	21	58
Total	**82**		**81**		**79**	

Table 12.3 below sets out the average full-time equivalent staffing levels for the last four years and provides a more accurate indication of staff trends.

Table 12.3 Average full-time equivalent staffing 2002–03 to 2005–06

2002–03	2003–04	2004–05	2005–06
No.	**No.**	**No.**	**No.**
76	91	90	74.9

The Commission's average number of full-time equivalent employees (FTE) during 2005–06 was 74.9, a decrease of 15.1 FTEs from the previous year. The attrition of staff was mainly attributed to the release of a number of temporary staff engaged in 2004–05 to undertake the Macarthur Investigation and clear the backlog of outstanding investigation cases as well as staff resignations, re-deployments and voluntary redundancies following the restructuring of the Commission. The following table provides a breakdown of staff attrition by division for 2005–06.

Table 12.4 Staff attrition 2005–06

DIVISION	NUMBER SEPARATING	REASON							
		Transferred to another Public Sector agency	Medical retirement	Seconded out to another agency	Secondment ending	Retirement	Resignation/ Termination	Voluntary redundancy	**TOTAL**
EXECUTIVE	Permanent employee			1			1		**2**
	Temporary employee								
CORPORATE SERVICES	Permanent employee							2	**2**
	Temporary employee								
ASSESSMENTS AND RESOLUTION	Permanent employee					1	2	1	**4**
	Temporary employee				1		1		**2**
LEGAL	Permanent employee						1		**1**
	Temporary employee	1					1		**2**
INVESTIGATIONS	Permanent employee	2	2				2		**6**
	Temporary employee				1		1		**2**
TOTAL		**3**	**2**	**1**	**2**	**1**	**9**	**3**	**21**

Conditions of employment and movement in salaries and allowances

Commission staff are either members of the Senior Executive Service or officers appointed under the *Public Sector Employment and Management Act 2002*. Officer's salaries are set by awards and agreements. The majority of the Commission staff's salaries are determined by the Crown Employees (Public Sector – Salaries 2004) Award. The Commission's Medical Advisors are employed under the Crown Employees (Health Care Complaints Commission, Medical Advisers) Award 2005.

Commission staff who were employed under the Crown Employees (Public Sector – Salaries 2004) Award received a further 4% salary increase effective from the first full pay period after 1 July 2005.

The Statutory and Other Offices Remuneration Tribunal (SOORT) determined a performance-based increase of 4% for SES officers, effective 1 October 2005.

Conditions of employment are principally set by the *Public Sector Employment and Management Act 2002* and for the majority of staff, the Crown Employees (Public Service Conditions of Employment) Reviewed Award 2006. Employees' conditions and entitlements are managed according to the guidelines set by the Premier's Department in the NSW Personnel Handbook. During the reporting period all employees received enhancements to parental leave conditions as a result of the flow-on effect of the passing of the Parental Leave Provisions Test Case. These provisions were administered from the date of the IRC's decision on 19 December 2005 and included:

- an obligation for the employer to communicate with an employee on parental leave about their position
- the right to request up to 2 years unpaid parental leave
- the right to request up to 8 weeks simultaneous unpaid parental leave
- the right to request to return to part-time work until the child reaches school age.

Consultants

During the reporting period consultants were engaged at a total cost of $173,130. Table 12.5 sets out the type of consultants used by the Commission and the cost for their services.

Table 12.5 Consultants

CATEGORY OF CONSULTANCY	NO. OF ENGAGEMENTS	TOTAL COST
Clinical advice on complaints	360	$155,952
Review of records management practices	1	$17,178

Committees

The Commission held three meetings with the Consumer Consultative Committee during the year. The Committee is made up of the following members:

- Kath Brewster, Council on the Ageing
- Elizabeth Buchanan, People With Disabilities NSW Inc.
- Ann Cutler, Association for the Welfare of Child Health
- Samantha Edmonds, NCOSS
- Jodie Little, People Living With HIV/AIDS
- Ann MacLochlainn, Mental Health Coordinating Council
- Tim Marchant, Carers NSW
- Susan Mitchell, Rural and Remote Health Consumers of Australia
- Helena O'Connell, NSW Council for Intellectual Disability
- Barbara Wright, Combined Pensioners and Superannuants Association
- Sam Choucair, CALD representative.

The Committee represents the interests of consumers and provides valuable advice and feedback to the Commission. Issues discussed include consumer complaints about health services generally, standards of health service delivery, issues that raise public interest concerns, and policy issues raised by the Commission.

Equal Employment Opportunity Program

The Commission continued to promote the principles of equity and equal employment opportunity (EEO) during 2005–06 and has in its employ staff from diverse cultural backgrounds. The NSW Government has established benchmarks as employment indicators for people from identified EEO groups. Measurement against these Government employment targets provides an indication of how well the Commission's EEO Management Plan, EAPS Plan and broader EEO and Diversity Program are achieving their objectives.

Table 12.6 shows the percentage of Commission staff in relation to the various EEO employment groups against the established NSW Government benchmarks.

Table 12.6 Trends in the representation of EEO groups

EEO GROUP	% of Total staff				
	Benchmark or target	2003	2004	2005	2006
Women	50%	67%	69%	70%	73%
Aboriginal people and Torres Strait Islanders	2%	1%	2.7%	1.3%	0%
People whose first language was not English	20%	14%	15%	15%	16%
People with a disability	12%	9%	3%	8%	6%
People with a disability requiring work-related adjustment	7%				Not recorded

Trends in the distribution of EEO groups

The distribution index for women employed by the Commission as at 30 June 2006 is 93. A distribution index of 100 indicates that the distribution of the EEO group across salary levels is equivalent to that of other staff. Values less than 100 mean that the EEO group tends to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be. In some cases the index may be more than 100, indicating that the EEO group is less concentrated at lower salary levels.

The distribution index is automatically calculated by data obtained from the Commission's Annual Workforce Profile report submitted to the Premier's Department. The distribution index is not calculated where EEO group or non-EEO group numbers are less than 20. Women are the only EEO group employed in the Commission with more than 20 members. Last year the index was 99.

Table 12.7 shows the trends in the distribution of Commission staff in relation to the various EEO employment groups.

Table 12.7 Trends in the distribution of EEO groups

EEO GROUP	Distribution index				
	Benchmark or target	2003	2004	2005	2006
Women	100	98	96	99	93
Aboriginal people and Torres Strait Islanders	100				
People whose first language was not English	100		*Not calculated as EEO*		
People with a disability	100		*group numbers are less than 20*		
People with a disability requiring work-related adjustment	100				

Notes:
1. Staff numbers are as at 30 June.
2. Excludes casual staff

Tables 12.8 and 12.9 show the EEO group representation of staff in relation to salary level and the basis of employment.

Table 12.8 Staff numbers by EEO group and salary levels

LEVEL	TOTAL STAFF	Respondents	Men	Women	Aboriginal people and Torres Strait Islanders	People from racial, ethnic, ethno-religious minority groups	People whose first language was not English	People with a disability	People with a disability requiring work-related adjustment
< $32,606		0	0	0	0	0	0	0	0
$32,606 - $42,824	1	1	1	0	0	0	0	0	0
$42,825 - $47,876	11	11	1	10	0	5	7	0	0
$47,877 - $60,583	9	9	1	8	0	0	0	0	0
$60,584 - $78,344	38	38	11	27	0	8	5	2	0
$78,345 - $97,932	13	13	4	9	0	1	1	2	0
> $97,932 (non SES)	3	3	0	3	0	0	0	1	0
> $97,932 (SES)	4	4	3	1	0	0	0	0	0
Total	**79**	**79**	**21**	**58**		**14**	**13**	**5**	

Table 12.9 Staff numbers by EEO group and basis of employment

EMPLOYMENT BASIS	TOTAL STAFF	Respondents	Men	Women	Aboriginal people and Torres Strait Islanders	People from racial, ethnic, ethno-religious minority groups	People whose first language was not English	People with a disability	People with a disability requiring work-related adjustment
Permanent full-time	57	57	15	42	0	10	10	4	0
Permanent part-time	4	4	1	3	0	0	0	0	0
Temporary full-time	11	11	2	9	0	4	3	0	0
Temporary part-time	3	3	0	3	0	0	0	1	0
Contract – SES	4	4	3	1	0	0	0	0	0
Contract – Non SES		0	0	0	0	0	0	0	0
Training positions		0	0	0	0	0	0	0	0
Retained staff		0	0	0	0	0	0	0	0
Casual		0	0	0	0	0	0	0	0
Total	**79**	**79**	**21**	**58**	**0**	**14**	**13**	**5**	**0**
SUBTOTALS									
Permanent	61	61	16	45		10	10	4	0
Temporary	14	14	2	12		4	3	1	
Contract	4	4	3	1					
Full-time	68	68	17	51		14	13	4	
Part-time	7	7	1	6				1	

Industrial relations

The Commission, its officers and the Public Service Association of NSW (PSA) have maintained a strong commitment to joint consultation. The Commission has a Workplace Agreement, which provides details relating to flexible working hours as well as a Workplace Consultative Committee (WCC) to provide a formal framework for the conduct of co-operative industrial relations. The WCC ensures that workplace issues, policies and procedures and organisational changes are discussed and resolved quickly and effectively.

Workplace Consultative Committee Representatives for the period 2005–06

The WCC is the primary instrument for enabling the Commission Executive, staff of the Commission and the PSA to consult on policy and issues relating to conditions of employment that may arise in the workplace during the year. The Committee is responsible for consulting with staff on intended changes to existing policies and procedures as well as the introduction of new policies, procedures and corporate plans. The WCC also provides an official avenue for staff to raise any issues that may relate to employment conditions, policy or procedure. The WCC meets on a monthly basis and approves new and revised policies and procedures that affect staff conditions of employment prior to them being put forward for endorsement by the Commissioner. During the reporting period eleven meetings were held.

Commission Representatives

- Director, Investigations, Scott Schaudin
- Director of Proceedings, Karen Mobbs
- Manager, Corporate Services, Lance Favelle
- Director, Assessments and Resolution Division, Ian Thurgood.

Public Service Association Representatives

- Industrial Officers, Rachel O'Shea and Dylan Smith.

Representatives nominated by PSA members on the Commission staff

- Robyn Clark, Legal Division
- Bernadette Liston, Assessments and Resolution Division
- Jessie Choy, Investigations Division
- Denis Smith, Corporate Services.

Other representatives were Virginia Tinson representing Human Resources and Suzanne Ellis, Executive Officer of the Committee.

No industrial disputes involving the Commission arose during the reporting period.

Personnel policies and practices

Although the Commission refers to the guidelines set out in the Premier's Department Personnel Handbook, the Commission has developed a number of its own policies and procedures to help staff understand and administer conditions of employment, EEO, occupational health and safety issues and operational requirements. All of the Commission's policies are displayed on the Commission's intranet to enable easy access by staff.

During the reporting period the following policies were either reviewed or developed:

- Recruitment and Selection Policy
- Email Policy
- Study and Examination Leave
- Flexible Work Arrangements
- Flexible Working Hours
- Manual Handling
- Adoption Leave Policy
- Maternity Leave Policy
- Other Parent Leave Policy
- Employment of People With Disabilities
- Bullying and Harassment Prevention Policy
- Job Evaluation Policy
- Risk Management Policy and Toolkit
- Grievance Policy
- EEO and Discrimination Prevention Policy
- Records Management Policy.

Staff education and development

Learning and development continues to be a priority for the Commission so we can build our knowledge base. The Commission encourages all staff to participate in a range of learning and development activities that include attendance at forums, seminars, conferences, performing higher duties and undertaking external training courses. Two staff members were seconded to other Public Sector agencies during the reporting period. Secondment opportunities contribute to individual and organisational capability.

The Commission also encourages staff to undertake further study to enhance their skills and provides assistance in the form of study and examination leave. During 2005–06 four staff were granted leave of this kind.

During 2005–06 Commission staff attended training activities that included:

- EEO and Diversity Training for all Commission staff
- Fire Warden training
- Senior First Aid Officers Course
- UNIFEM breakfast for International Women's Day
- Merit Selection Techniques Training full day course and Merit Selection Techniques Refresher Training

- Mercer's Job Evaluation training
- Microsoft Word and Excel—introduction and intermediate/advanced
- Specialised IT courses
- TTY – Telephone Typewriter Training
- Introduction To Return To Work Coordination
- OH&S Committee training
- Alternative Dispute Resolution for the 21st Century
- Records Management Fundamentals
- Grievance Management Skills Handling Course
- Essential Drafting Techniques
- Mediation
- Skills Training for Contact Officers

Legal Staff attended the following seminars:

- Legal Professional Regulations Clause 142
- Legal Professional Regulations Clause 176
- Medical and Health Law Update
- Government Lawyers CLE
- Lawyers Guide To Dealing With Distressed Clients
- Expert Evidence in Health Law
- Fundamental Guide To The Uniform Civil Procedure
- Civil Trial Preparation
- Medical Negligence
- Solicitor Advocate Skills Workshop
- Health Law – NSW State Legal Conference

Assessment and Resolution Officers attended courses specifically developed for the Commission and run internally:

- Internal report writing course
- Conducting investigations course
- Amendments to the HCC Act (Legal Officers also attended).

Performance management

The Commission has developed a performance management system that requires staff to prepare an annual performance agreement that links the Commission's objectives with individual performance targets. The performance agreement includes a tailored learning and development plan that covers training and personal development opportunities for the staff member.

Training on the new performance management procedures system was provided to all managers and the system was trialled in 2005–06 with all managers and selected staff preparing performance agreements relating to their position responsibilities.

Over the next year the performance management system will be extended to all staff of the Commission.

Access and equity

The Commission's 2005–06 EEO Management Plan ensures that the Commission has indicators in place, with appropriate associated strategies, to enable the Commission to realise the aims of its EEO Program. Relevant Commission policies are continually being developed, revised or improved to address areas where further action needs to be taken in order to achieve EEO outcomes.

During 2005–06 the following outcomes were achieved:

Grievance Contact Officers

The Commission sought nominations from staff to become Grievance Contact Officers. Two staff were nominated and consequently underwent training provided by the Anti-Discrimination Board.

Flexible work arrangements

The Commission actively promotes its flexible work practices and supports applications from staff to undertake temporary part-time work, take carers leave or work from home on a short-term basis to balance work and family responsibilities. The Commission has specifically developed a policy to assist staff in applying for flexible work arrangements.

EEO and diversity-related training

A strategy of the Commission's 2005–06 EEO Management Plan is for all Commission staff to receive training in EEO and Diversity. This training is considered mandatory by the Commission and during January, February and March of this year, staff and managers underwent a training session facilitated in-house by an external provider. The training included an outline of the Commission's policies and procedures on EEO and discrimination, harassment and bullying, grievances and the Code of Conduct.

The Commission also provided the opportunity for all managers to attend either a full or refresher course in Merit Selection Techniques training.

Employee Assistance Program

The Commission renegotiated a further one-year agreement with an external agency to provide professional and confidential counselling services for staff and their families.

Accommodating the requirements of staff with (temporary or permanent) disabilities

The Commission employs an accredited rehabilitation provider to ergonomically assess and make recommendations for specific equipment and workstation adjustments to assist staff with disabilities.

TTY Services

Continuation of a TTY telephone service for the hearing impaired and provision of training to reception and support staff in the use of TTY.

EEO related Policies developed

- Grievance Policy
- EEO and Discrimination Prevention Policy
- Bullying and Harassment Prevention Policy.

NSW Government Action Plan for Women

The NSW Government Action Plan for Women is a whole-of-government approach to improving the economic and social participation of women in NSW society. The Action Plan provides a comprehensive picture of the work being done by government for the women of NSW. The Commission through its internal equity and occupational health and safety related policies and plans ensures that it promotes the NSW Government's strategies relating to women.

The Commission has ensured that it has a skilled and diverse workforce with women comprising 73.4% of total staff, of which 70% earn in excess of $60,000 per year and 7% earn in excess of $97,932 per annum. This is shown in Chart 12.1.

The Commission also contributes to the Action Plan's objective to promote workplaces that are responsive to all aspects of women's lives by ensuring that it has development opportunities and programs in place specifically targeted to assist its female employees. Seven female employees attended the UNIFEM breakfast seminar organised as part of International Women's Day.

Chart 12.1 EEO for women (by level)

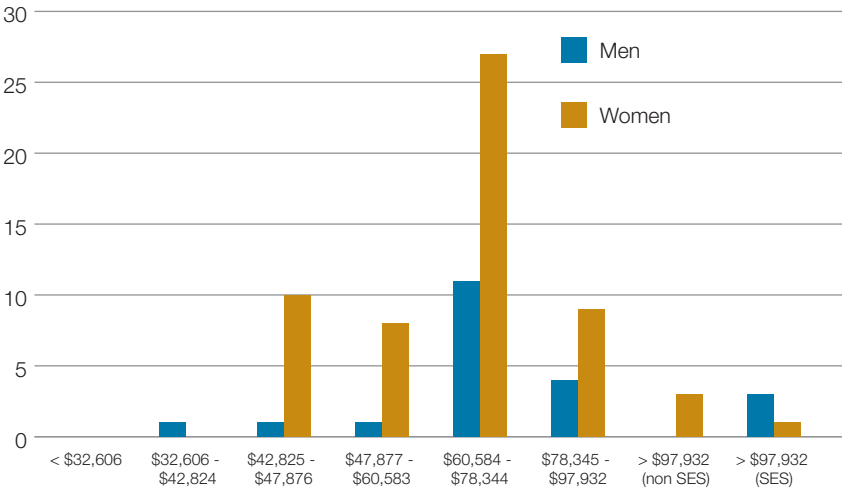
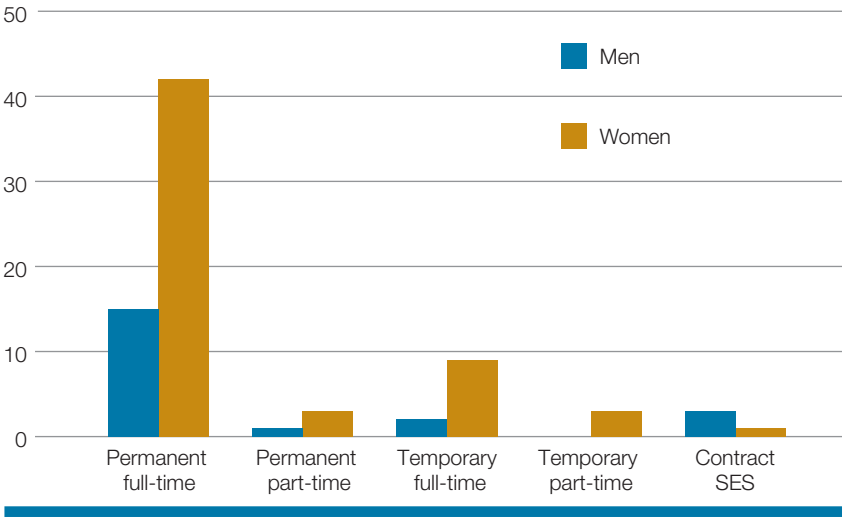


Chart 12.2 EEO for women (by employment basis)



Waste Reduction and Purchasing Policy

The Commission continued its commitment to the Government's Waste Reduction and Purchasing Policy during the reporting period.

- the Commission returns all toner cartridges used in its printers, photocopiers and facsimile machines for recycling
- of the 2,800 reams of paper purchased during the year (1,250 reams less than 2004–05), 2,000 reams had 35% recycled content and 800 had 50% recycled content. All future purchases will have 50% recycled content
- the Commission's Annual Report is printed on recycled paper
- the Commission sent 12 tonnes of used paper for recycling during the year.

Energy management

The Commission continues its commitment to the NSW Government Energy Management Policy as part of the National Greenhouse Strategy.

The Central Square premises occupied by the Commission have obtained a four-star accredited Australian Building Greenhouse Rating by the Department of Energy, Utilities and Sustainability.

Energy data for 2005–06 is shown below at Table 12.10.

Table 12.10 Energy use

	2004–05			2005–06		
Energy use	**Office**	**Cars**	**CO2**	**Office**	**Cars**	**CO2**
Electricity (kWh)	304,432		291	168,173		161
Greenpower (kWh)	19,340			9,999		
Petrol (L)		4,060	9		2441	6
Normalisation factors	**2004–05**			**2005–06**		
Occupancy (no. of people)	79			73		
Area (m^2)	1,790			1,854*		
Distance travelled (km)	35,152			21,995		
	2004–05			**2005–06**		
Energy utilisation index	**Office**		**Cars**	**Office**		**Cars**
Mj / person / annum	14,754			8,787		
Mj / M^2 / annum	651			346		
Mj / Km			4			3.8

*Floor area was re-calculated for 2005–06.

Outline budget

Over the past five years, total expenses have increased from $6.9 million to $10.3 million reflecting the government's commitment to investigating and prosecuting serious complaints of health care treatment. This included additional funding provided to the Commission in 2003–04 and 2004–05 to reform the Commission's operations and clear the backlog of investigation cases and finalise the investigation of complaints against the Macarthur Area Health Service.

Table 13.1 Comparison of finances 2002–06

ACTUAL	2001–02	2002–03	2003–04	2004–05	2005–06
	$000	$000	$000	$000	$000
Total expenses	6,872	9,183	10,416	11,080	10,306
Total retained revenue	1,538	1,114	865	373	323
Gain/(loss) on sale of non-current assets	-	(23)	-	-	(24)
NET COST OF SERVICES	5,334	8,092	9,551	10,707	10,007

For 2005–06 the financial statements have been prepared in line with the requirements of the full adoption of the Australian equivalents to international financial reporting standards (AIFRS). Only minor changes in financial reporting have been necessary in preparing the Commission's financial statements for 2005–06 under AIFRS, such as the disclosure of computer software as intangible assets. The financial statements also comply with the new reporting entity requirements arising from the *Public Sector Employment Legislation Amendment Act 2006* that designate the newly formed 'Office of the Health Care Complaints Commission' as the employer of Commission staff. As a consequence, the financial statements disclose the Health Care Complaints Commission as a reporting entity comprised of the Office of the Health Care Complaints Commission and the Health Care Complaints Commission.

A detailed budget for the reporting period is given in the following audited financial statements. The Commission ends the year in a strong financial position. No significant issues were raised by the Auditor General regarding the Commission's finances. No after-balance-date events occurred which will have a significant effect in the succeeding year on the Commission's operations or clients.

Table 13.2 Outline budget for 2006–07 financial year

OPERATING STATEMENT	2006–07
	$000
Expenses	
Operating expenses	
Employee related	7,138
Other operating expenses	2,845
Depreciation and amortisation	370
Total expenses	**10,353**
Less	
Retained revenue	
Sales of goods and services	5
Investment income	46
Other revenue	185
Total retained revenue	**236**
NET COST OF SERVICES	**10,117**

Account payment performance

The processing of accounts for payment and the recording of the Commission financial data is incorporated into the Sun finance system which is maintained by the Office of Liquor, Gaming and Racing as part of the Commission's shared corporate service arrangement.

The payment performance analysis is as follows:

Table 13.3 Aged analysis at end of each quarter

Quarter	Current (i.e. within due date) $	Less than 30 days overdue $	Between 30 and 60 days overdue $	Between 60 and 90 days overdue $	More than 90 days overdue $
September	699,645	17,294	10,875	6,322	1,290
December	1,153,749	30,918	28,869	5,302	9,114
March	839,227	30,582	9,020	265	4,346
June	935,553	68,529	12,265	2,358	24,422

Table 13.4 Accounts paid on time within each quarter

	TOTAL ACCOUNTS PAID ON TIME			TOTAL AMOUNT PAID
Quarter	Target %	Actual %	$	$
September	85	95.13	699,645	735,425
December	85	93.96	1,153,749	1,227,951
March	85	95.00	839,227	883,441
June	85	89.69	935,533	1,043,127

The format is in accordance with the requirements of Treasury Circular TC 01/12. No interest was paid on overdue amounts.

Occupational health and safety

The Commission is committed to providing a safe working environment to its staff as well as clients and visitors accessing its premises. A three-year Occupational Health, Safety and Risk Management (OHS&RM) Plan has been developed for the period 2006–09 and endorsed by the Commissioner. This plan addresses the NSW Government's *Working Together: Public Sector OHS and Injury Management Strategy 2005-2008* and has incorporated its five performance targets into the Action section of the plan. The OHS&RM Plan provides for the integration of the risk management process into the Commission's operations, practices and planning strategies.

During 2005–06 the Commission achieved the following outcomes:

- workstations of relevant staff were ergonomically assessed by an accredited occupational therapist
- several individual workplace assessments were undertaken by an accredited rehabilitation provider in response to notification of potentially work-related incidents
- nominations sought from staff for membership of the OH&S Committee for a two-year term and OH&S Committee training attended or organised
- appointment and training of three new first aid officers
- new fire wardens appointed
- emergency procedures updated and distributed to work areas
- OH&S site established on Commission's intranet.

Table 13.5 Occupational health and safety incidents, injuries and claims 2005–06

	2004–05	2005–06
Number of new claims	2	6
Number of workers compensation claims accepted	2	6
Fall, trip, slip outside workplace	1	3
Work practice/setup related	1	0
Total injuries	2	9

OH&S Committee

An OH&S Committee was formed towards the end of the year with membership from staff representing various work groups of the Commission. The Committee is scheduled to meet quarterly. The purpose of the Committee is to review OH&S policies and practices, conduct regular workplace inspections, facilitate the resolution of safety issues and assist in mitigating reported hazards.

The OH&S Committee membership comprises:

- Bernadette Liston, Assessments and Resolution Division
- Robyn Clark, Legal Division
- Denis Smith, Corporate Services Division
- Marianne Weaver, Corporate Services Division

The Senior Management representative is Lance Favelle, Manager, Corporate Services. Virginia Tinson represents Human Resources and Suzanne Ellis is the Committee's Executive Officer.

Risk management and insurance activities

Reviewing key business risks ensures the Commission effectively manages the risks associated with its business activities and makes best use of opportunities. An annual business risk assessment is undertaken each year as part of the Commission's corporate planning process that identifies the key risk areas of the Commission. Strategies and treatments for these risks are included in divisional business plans.

During the year a Risk Management Policy and Risk Management Framework and Toolkit were developed to assist managers in identifying and managing risks associated with their operations. Also a three-year Occupational Health, Safety and Risk Management (OHS&RM) Plan has been developed for the period 2006–09. The OH&S Committee was formed towards the end of the year to ensure OH&S issues are being addressed and to assist in mitigating reported hazards.

The NSW Treasury Managed Fund (TMF) provides insurance cover for workers compensation, motor vehicles, public liability, property and miscellaneous items. Workers compensation insurance is provided by Allianz Australia Insurance Ltd with GIO General Ltd providing insurance cover for the remaining categories.

The Commission's claims management for fund year 2005–06 is reflected in the deposit premiums for 2006–07. The Commission achieved reduction in workers compensation premium for 2006–07 (24%), public liability (20%), property (16%) and miscellaneous insurance (31%). Motor vehicle insurance costs increased by $220 (+10%) for 2006–07.

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDIT REPORT

HEALTH CARE COMPLAINTS COMMISSION

To Members of the New South Wales Parliament

Audit Opinion

In my opinion, the financial report of the Health Care Complaints Commission (the Commission):

- presents fairly the Commission's financial position as at 30 June 2006 and its performance for the year ended on that date, in accordance with Accounting Standards and other mandatory financial reporting requirements in Australia, and
- complies with section 41B of the *Public Finance and Audit Act 1983* (the Act) and the *Public Finance and Audit Regulation 2005*.

My opinion should be read in conjunction with the rest of this report.

Scope

The Financial Report and the Commissioner's Responsibility

The financial report comprises the balance sheet, operating statement, statement of changes in equity, cash flow statement and accompanying notes to the financial statements for the Commission, for the year ended 30 June 2006.

The Commissioner is responsible for the preparation and true and fair presentation of the financial report in accordance with the Act. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report.

Audit Approach

I conducted an independent audit in order to express an opinion on the financial report. My audit provides *reasonable assurance* to Members of the New South Wales Parliament that the financial report is free of *material* misstatement.

My audit accorded with Australian Auditing Standards and statutory requirements, and I:

- assessed the appropriateness of the accounting policies and disclosures used and the reasonableness of significant accounting estimates made by the Commissioner in preparing the financial report, and
- examined a sample of evidence that supports the amounts and disclosures in the financial report.

An audit does *not* guarantee that every amount and disclosure in the financial report is error free. The terms 'reasonable assurance' and 'material' recognise that an audit does not examine all evidence and transactions. However, the audit procedures used should identify errors or omissions significant enough to adversely affect decisions made by users of the financial report or indicate that the Commissioner had not fulfilled their reporting obligations.

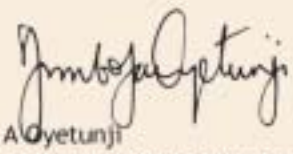
My opinion does *not* provide assurance:

- about the future viability of the Commission,
- that it has carried out its activities effectively, efficiently and economically, or
- about the effectiveness of its internal controls.

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office are not compromised in their role by the possibility of losing clients or income.



A Oyetunji
Director, Financial Audit Services

SYDNEY
20 October 2006

HEALTH CARE COMPLAINTS COMMISSION

FINANCIAL REPORT FOR THE YEAR ENDED 30 JUNE 2006

CERTIFICATE OF ACCOUNTS

Pursuant to Section 41C(1B) of the *Public Finance and Audit Act 1983*, I declare on behalf of the Health Care Complaints Commission that:

(i) the financial report of the Health Care Complaints Commission for the year ended 30 June 2006 has been prepared in accordance with applicable Australian Accounting Standards (which includes Australian equivalents to International Financial Reporting Standards (AIFRS)), other authoritative pronouncements of the Australian Accounting Standards Board (AASB) and the Urgent Issues Group (UIG) Interpretations, the requirements of the *Public Finance and Audit Act 1983* and the *Public Finance and Audit Regulation 2005*, the Financial Reporting Code for Budget Dependent General Government Sector Agencies and Treasurer's Directions.

(ii) the financial report exhibits a true and fair view of the financial position of the Health Care Complaints Commission as at 30 June 2006 and the operations for the year ended.

(iii) there are no circumstances which would render any particulars in the financial report to be misleading or inaccurate.

Kieran Pehm
Commissioner

Date: 19 / 10 /2006

Operating Statement for the Year ended 30 June 2006

	Notes	Parent			Consolidated		
		Actual 2006 $'000	Budget 2006 $'000	Actual 2005 $'000	Actual 2006 $'000	Budget 2006 $'000	Actual 2005 $'000
Expenses excluding losses							
Operating Expenses							
Employee Related	2(a)	–	–	–	6,992	7,084	8,179
Personnel Services		6,992	7,084	8,179	–	–	–
Other Operating Expenses	2(b)	3,043	3,047	2,778	3,043	3,047	2,778
Depreciation and Amortisation	2(c)	271	339	123	271	339	123
Total Expenses Excluding Losses		10,306	10,470	11,080	10,306	10,470	11,080
Less:							
Retained Revenue							
Sale of Goods and Services	3(a)	–	16	1	–	16	1
Investment Revenue	3(b)	75	42	54	75	42	54
Other Revenue	3(c)	248	279	318	248	279	318
Total Retained Revenue		323	337	373	323	337	373
Gain / (loss) on disposal	4	(24)	–	–	(24)	–	–
Net Cost of Services	19	10,007	10,133	10,707	10,007	10,133	10,707
Government Contributions							
Recurrent Appropriations	5	9,423	9,423	10,418	9,423	9,423	10,418
Capital Appropriation	5	118	118	691	118	118	691
Acceptance by the Crown Entity of employee benefits and other liabilities	6	362	326	952	362	326	952
Total Government Contributions		9,903	9,867	12,061	9,903	9,867	12,061
SURPLUS/(DEFICIT) FOR THE YEAR		(104)	(266)	1,354	(104)	(266)	1,354

The accompanying notes form part of these statements

Statement of Changes in Equity for the Year ended 30 June 2006

	Notes	Parent			Consolidated		
		Actual 2006 $'000	Budget 2006 $'000	Actual 2005 $'000	Actual 2006 $'000	Budget 2006 $'000	Actual 2005 $'000
TOTAL INCOME AND EXPENSES RECOGNISED DIRECTLY IN EQUITY		–	–	–	–	–	–
Surplus/(Deficit) for the Year		(104)	(266)	1,354	(104)	(266)	1,354
TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR	14	(104)	(266)	1,354	(104)	(266)	1,354

The accompanying notes form part of these statements

Balance Sheet as at 30 June 2006

	Notes	Parent			Consolidated		
		Actual 2006 $'000	Budget 2006 $'000	Actual 2005 $'000	Actual 2006 $'000	Budget 2006 $'000	Actual 2005 $'000
ASSETS							
Current Assets							
Cash and Cash Equivalents	8	2,044	1,747	1,712	2,044	1,747	1,712
Receivables	9	141	325	348	141	325	348
Other		38	109	109	38	109	109
Total Current Assets		2,223	2,181	2,169	2,223	2,181	2,169
Non-Current Assets							
Plant and Equipment	10	640	381	602	640	381	602
Intangible Assets	11	409	494	494	409	494	494
Total Non-Current Assets		1,049	875	1,096	1,049	875	1,096
Total Assets		3,272	3,056	3,265	3,272	3,056	3,265
LIABILITIES							
Current Liabilities							
Payables	12	234	226	171	234	226	171
Provisions	13	631	494	577	631	494	577
Total Current Liabilities		865	720	748	865	720	748
Non-Current Liabilities							
Provisions	13	4	95	10	4	95	10
Total Non-Current Liabilities		4	95	10	4	95	10
Total Liabilities		869	815	758	869	815	758
Net Assets		2,403	2,241	2,507	2,403	2,241	2,507
EQUITY							
Accumulated Funds	14	2,403	2,241	2,507	2,403	2,241	2,507
Total Equity		2,403	2,241	2,507	2,403	2,241	2,507

The accompanying notes form part of these statements

Cash Flow Statement for the Year ended 30 June 2006

	Notes	Parent			Consolidated		
		Actual 2006 $'000	Budget 2006 $'000	Actual 2005 $'000	Actual 2006 $'000	Budget 2006 $'000	Actual 2005 $'000
CASH FLOWS FROM OPERATING ACTIVITIES							
Payments							
Employee Related		–	–	–	(6,565)	(6,621)	(7,671)
Personnel Services		(6,565)	(6,621)	(7,671)	–	–	–
Other		(2,900)	(3,289)	(3,032)	(2,900)	(3,289)	(3,032)
Total Payments		(9,465)	(9,910)	(10,703)	(9,465)	(9,910)	(10,703)
Receipts							
Sale of Goods and Services		115	16	83	115	16	83
Interest Received		66	47	36	66	47	36
Other		340	459	246	340	459	246
Total Receipts		521	522	365	521	522	365
Cash Flows from Government							
Recurrent Appropriation		9,423	9,423	10,418	9,423	9,423	10,418
Capital Appropriation		118	118	691	118	118	691
Cash Reimbursements from Crown Entity		–	–	404	–	–	404
Net Cash Flows from Government		9,541	9,541	11,513	9,541	9,541	11,513
NET CASH FROM OPERATING ACTIVITIES	19	597	153	1,175	597	153	1,175
CASH FLOWS FROM INVESTING ACTIVITIES							
Proceeds from sale of Plant and equipment		7	–	–	7	–	–
Purchase of Plant and Equipment		(272)	(118)	(833)	(272)	(118)	(833)
NET CASH FLOWS FROM INVESTING ACTIVITIES		(265)	(118)	(833)	(265)	(118)	(833)
NET INCREASE IN CASH		332	35	342	332	35	342
Opening Cash and Cash Equivalents		1,712	1,712	1,370	1,712	1,712	1,370
CLOSING CASH AND CASH EQUIVALENTS	8	2,044	1,747	1,712	2,044	1,747	1,712

The accompanying notes form part of these statements

Summary of Compliance with Financial Directives for the year ended 30 June 2006

	2006				2005			
	Recurrent		Capital		Recurrent		Capital	
	Recurrent Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Capital Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Recurrent Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Capital Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000
ORIGINAL BUDGET APPROPRIATION/ EXPENDITURE								
Appropriation Act	9,423	9,423	118	118	10,569	10,346	–	–
Additional Appropriations	–	–	–	–	–	–	–	–
s21A PF&AA – special appropriations	–	–	–	–	–	–	–	–
s24 PF&AA – transfer of functions between departments	–	–	–	–	–	–	–	–
s26 PF&AA – Commonwealth specific purpose payments	–	–	–	–	–	–	–	–
	9,423	9,423	118	118	10,569	10,346	–	–
OTHER APPROPRIATIONS/ EXPENDITURES								
Treasurer's Advance	–	–	–	–	–	–	428	428
Section 22 – expenditure for certain works and services	–	–	–	–	–	–	–	–
Transfers to/from another agency (s28 of the Appropriation Act)	–	–	–	–	72	72	263	263
	–	–	–	–	72	72	691	691
Total Appropriations/ Expenditure/Net Claim on Consolidated Fund (includes transfer payments)	9,423	9,423	118	118	10,641	10,418	691	691
Amount drawn down against Appropriation		9,423		118		10,418		691
Liability to Consolidated Fund		–		–		–		–

Notes to and forming part of the financial statements for the year ended 30 June 2006

1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) Reporting Entity

The Health Care Complaints Commission, as a reporting entity, comprises all the entities under its control, namely the Office of the Health Care Complaints Commission and the Health Care Complaints Commission.

In the process of preparing the consolidated financial report for the economic entity consisting of the controlling and controlled entities, all inter-entity transactions and balances have been eliminated.

The Health Care Complaints Commission (HCCC) is a NSW Government agency, responsible for protecting the public from substandard health services and incompetent and unethical health practitioners. The HCCC is a not-for-profit entity (as profit is not its principal objective) and it has no cash generating units.

The HCCC was established as a body corporate under Section 75 of the *Health Care Complaints Act 1993* and is a separate reporting entity under Schedule 2 of the *Public Finance and Audit Act 1983*, outside the control of the NSW Department of Health.

The reporting entity is consolidated as part of NSW Total State Sector Accounts.

This consolidated financial report for the year ended 30 June 2006 has been authorised for issue by the Commissioner on 19 October 2006.

(b) Basis of Preparation

The Commission's financial statements are a general purpose financial report, which has been prepared in accordance with:

- applicable Australian Accounting Standards (which include Australian equivalents to International Financial Reporting Standards (AIFRS))
- the requirements of the Public Finance and Audit Act and Regulations, and
- the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer.

Property, plant and equipment are measured at fair value. Other financial report items are prepared in accordance with the historical cost convention.

Judgments, key assumptions and estimations management has made are disclosed in the relevant notes to the financial statements.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

(c) Statement of Compliance

The consolidated and parent entity financial statements and notes comply with Australian Accounting Standards, which include AIFRS.

This is the first financial report prepared based on AIFRS and comparatives for the year ended 30 June 2005 have been restated accordingly, except as stated below.

In accordance with AASB 1 *First-time Adoption of Australian Equivalents to International Financial Reporting Standards* and Treasury Mandates, the date of transition to AASB 132 *Financial Instruments: Disclosure and Presentation* and AASB 139 *Financial Instruments: Recognition and Measurement* has been deferred to 1 July 2005. As a result, comparative information for these two Standards is presented under the previous Australian Accounting Standards which applied to the year ended 30 June 2005.

Reconciliations of AIFRS equity and surplus or deficit for 30 June 2005 to the balances reported in the 30 June 2005 financial report are detailed in Note 21.

(d) Income Recognition

Income is measured at the fair value of the consideration or contributions or received or receivable. Additional comments regarding the accounting policies for the recognition of income are discussed below.

(i) Parliamentary appropriation and contributions

Parliamentary appropriations and contributions from other bodies (including grants and donations) are generally recognised as income when the HCCC obtains control over the assets comprising the appropriations/contributions. Control over appropriations and contributions is normally obtained upon the receipt of cash.

(ii) Sale of Goods

Revenue from the sale of goods is recognised as revenue when the agency transfers the significant risks and rewards of ownership of the assets.

(ii) Rendering of Services

Revenue is recognised when the service is provided.

(iv) Investment Revenue

Interest revenue is recognised using the effective interest method as set out in AASB139 *Financial Instruments: Recognition and Measurement.*

(e) Employee Benefits and Other Provisions

(i) Salaries and Wages, Annual Leave, Sick Leave and On-Costs

Liabilities for salaries and wages (including non-monetary benefits), annual leave and paid sick leave that fall due wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of payroll tax, workers compensation insurance premiums and fringe benefits tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

(ii) Long Service Leave and Superannuation

The HCCC's liabilities for long service leave and defined benefit superannuation are assumed by the Crown Entity. The HCCC accounts for the liability as having been extinguished, resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of employee benefits and other liabilities". Prior to 2005–06 the Crown Entity also assumed the defined contribution superannuation liability.

Long service leave is measured at present value in accordance with AASB119 *Employee Benefits*. This is based on the application of certain factors (specified in NSWTC 06/09) to employees with 5 or more years of service, using current rates of pay. These factors were determined based on a actuarial review to approximate present value.

The superannuation expense for the financial year is determined by using the formulae specified in the Treasurer's Directions. The expense for certain superannuation schemes (ie Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For other superannuation schemes (ie. State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

(f) Insurance

The HCCC's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self insurance for Government agencies. The expense (premium) is determined by Fund Manager based on past claim experience.

(g) Accounting for the Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST, except where:

- the amount of GST incurred by the HCCC as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the cost of acquisition of an asset or as part of an item of expense.
- receivables and payables are stated with the amount of GST included.

(h) Acquisitions of Assets

The cost method of accounting is used for the initial recording of all acquisition of assets controlled by the HCCC. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or construction or, where applicable, the amount attributed to that asset when initially recognised in accordance with the requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised at their fair value at the date of acquisition.

Fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction.

(i) Capitalisation Thresholds

Plant and Equipment and intangible assets costing $5,000 and above individually (or forming part of a network costing more than $5,000) are capitalised.

(j) Revaluation of Plant and Equipment

Physical non-current assets are valued in accordance with the "Valuation of Physical Non-Current Assets at Fair Value" (TPP 05–03). This policy adopts fair value in accordance with AASB 116 *Property, Plant and Equipment.*

Property, plant and equipment is measured on an existing use basis, where there are no feasible alternative uses in the existing natural, legal, financial and socio-political environment. However, in the limited circumstances where there are feasible alternative uses, assets are valued at their highest and best use.

Fair value of property, plant and equipment is determined based on the best available market evidence, including current market selling prices for the same or similar assets. Where there is no market evidence, the asset's fair value is measured at its market its market buying price, the best indicator of which is depreciated replacement cost.

The HCCC holds non-specialised assets with short useful lives and these are measured at depreciated historical cost, as a surrogate for fair value.

Notes to and forming part of the financial statements for the year ended 30 June 2006 (continued)

(k) Impairment of Plant and Equipment

As a not-for-profit entity with no cash generating units, the Commission is effectively exempted from AASB136 *Impairment of Assets* and impairment testing. This is because AASB 136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, for an asset already measured at fair value, impairment can only arise if selling costs are material. Selling costs are regarded as immaterial.

(l) Depreciation of Plant and Equipment

Depreciation is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the HCCC.

All material separately identifiable components of assets are depreciated over their shorter useful lives. The useful life of the various categories of non-current assets is as follows:

Asset category	Depreciation life in years
Computer Hardware	5
Plant and equipment	10
Leasehold improvements	5

(m) Maintenance

Day-to-day servicing costs or maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset, in which case the costs are capitalised and depreciated.

(n) Leased assets

Operating lease payments are charged to the Operating Statement in the periods in which they are incurred.

(o) Intangible Assets

The HCCC recognises intangible assets only if it is probable that future economic benefits will flow to the HCCC and the costs of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition.

All research costs are expensed. Development costs are only capitalised when certain criteria are met.

The useful lives of intangible assets are assessed to be finite.

Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the HCCC's intangible assets, the assets are carried at cost less any accumulated amortisation.

The HCCC's intangible assets, computer software, are amortised using the straight line method over a period of 5 years.

In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity with no cash generating units, the HCCC is effectively exempted from impairment testing (refer para (k)).

(p) Loans and Receivables – Year ended 30 June 2006 (refer Note 1(s) for 2004/05 policy)

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the Operating Statement when impaired, derecognised or through the amortisation process.

Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

(q) Payables – Year ended 30 June 2006 (refer Note 1(s) for 2004/05 policy)

These amounts represent liabilities for goods and services provided to the HCCC and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-tem payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

(r) Budgeted amounts

The budgeted amounts are drawn from the budgets as formulated at the beginning of the financial year and with any adjustments for the effects of additional appropriations under s 21A, s 24 and/or s 26 of the *Public Finance and Audit Act 1983.*

The budgeted amounts in the Operating Statement and the Cash Flow Statement are generally based on the amounts disclosed in the NSW Budget Papers (as adjusted above). However, in the Balance Sheet, the amounts vary from the Budget Papers, as the opening balances of the budgeted amounts are based on carried forward actual amounts; i.e. per the audited financial report (rather than carried forward estimates).

(s) Financial instruments accounting policy for 2004/05 comparative period

Investment income
Interest revenue is recognised as it accrues.

Receivables
Receivables are recognised and carried at cost, based on the original invoice amount less a provision for any uncollectible debts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off as incurred.

Payables
These amounts represent liabilities for goods and services provided to the HCCC and other amounts, including interest. Interest is accrued over the period it becomes due.

(t) Comparative Information

Comparative figures have been restated based on AIFRS with the exception of financial instruments information, which has been prepared under the previous AGAAP Standard (AAS 33) as permitted by AASB 1.36A (refer Note 1 (s)). The transition date to AIFRS for financial instruments was 1 July 2005. The impact of adopting AASB 132 / 139 is further discussed in Note 21.

2 EXPENSES EXCLUDING LOSSES

	Parent		Consolidated	
	2006 $'000	2005 $'000	2006 $'000	2005 $'000
(a) Employee related expenses				
Salaries & Wages (including recreation leave)	–	–	5,906	6,775
Superannuation – Defined Benefits Plans	–	–	144	158
Superannuation – Defined Contributions Plans	–	–	318	403
Workers Compensation Insurance	–	–	44	32
Long Service Leave	–	–	209	358
Payroll Tax & Fringe Benefits Tax	–	–	371	453
	–	–	6,992	8,179
(b) Other operating expenses				
Auditors Remuneration – Audit or Review of Financial Reports	12	17	12	17
Bad and Doubtful Debts	5	–	5	–
Consultancy	188	234	188	234
Equipment and plant	47	59	47	59
Equipment leasing	68	112	68	112
Fees for Services Rendered	521	693	521	693
Legal fees and adverse costs*	1,050	399	1,050	399
Maintenance	46	11	46	11
Other	60	62	60	62
Printing	14	14	14	14
Rental Expenses relating to operating Leases	765	836	765	836
Stores	94	131	94	131
Telephone, postal and internet	128	148	128	148
Travelling	45	62	45	62
	3,043	2,778	3,043	2,778
** 2005 Includes an amount of $364,402.35 which represented a reversal of a prior year accrual*				
(c) Depreciation and amortisation expense				
Plant & Equipment – Depreciation	172	123	172	123
Intangible Assets – Amortisation	99	–	99	–
	271	123	271	123

3 REVENUE

	Parent		Consolidated	
	2006 $'000	2005 $'000	2006 $'000	2005 $'000
(a) Sale of goods and services				
Rendering of services	–	1	–	1
	–	1	–	1
(b) Investment revenue				
Interest	75	54	75	54
	75	54	75	54
(c) Other revenue				
Legal cost recoveries	248	318	248	318
	248	318	248	318

4 GAIN / (LOSS) ON DISPOSAL

Gain/(loss)on disposal of plant and equipment				
Proceeds from sale	7	–	7	–
Written down value of assets disposed	(31)	–	(31)	–
Net gain/(loss) on disposal of plant and equipment	(24)	–	(24)	–

5 APPROPRIATIONS

Recurrent Appropriations				
Total recurrent drawdowns from NSW Treasury (per summary of Compliance)	9,423	10,346	9,423	10,346
s28 of the Appropriation Act	-	72	-	72
	9,423	10,418	9,423	10,418
Capital Appropriations				
Total capital drawdowns from NSW Treasury (per summary of Compliance)	118	691	118	691
	118	691	118	691

6 ACCEPTANCE BY THE CROWN ENTITY OF EMPLOYEE BENEFITS AND OTHER LIABILITIES

Payroll tax on superannuation	8	33	8	33
Superannuation	144	561	144	561
Long Service Leave	210	358	210	358
TOTAL:	362	952	362	952

7 PROGRAM INFORMATION

Program 40.1.1 - Health Care Complaints

Program Objective(s):
To investigate, monitor, review and resolve complaints about health care services in New South Wales. To work with stakeholders to improve the safety and quality of health care services and and to ensure that professional standards are met by health care providers.

8 CURRENT ASSETS – CASH AND CASH EQUIVALENTS

	Parent		Consolidated	
	2006 $'000	2005 $'000	2006 $'000	2005 $'000
Cash at Bank and on hand	2,044	1,712	2,044	1,712
TOTAL:	2,044	1,712	2,044	1,712
For the purpose of the Cash Flow Statement, cash and cash equivalents includes cash on hand and cash at bank.				
Cash and cash equivalent assets recognised in the Balance Sheet are reconciled at the end of the financial year to the Cash Flow Statement as follows:-				
Cash and Cash Equivalents (per Balance Sheet)	2,044	1,712	2,044	1,712
Closing Cash and Cash Equivalents (Per Cash Flow Statement)	2,044	1,712	2,044	1,712

9 CURRENT ASSETS – RECEIVABLES

Other revenue	286	495	286	495
Less Allowance for impairment	(145)	(147)	(145)	(147)
	141	348	141	348

10 NON CURRENT ASSETS – PLANT AND EQUIPMENT

	Parent	Consolidated
	Plant & Equipment $'000	Plant & Equipment $'000
At 1 July 2005		
Gross carrying amount	944	944
Accumulated depreciation	(342)	(342)
Net carrying amount at fair value	602	602
At 30 June 2006		
Gross carrying amount	1,077	1,077
Accumulated depreciation	(437)	(437)
Net carrying amount at fair value	640	640

Reconciliation

A Reconciliation of the carrying amount of plant and equipment at the beginning and end of the current reporting period is set out below:-

Year ended 30 June 2006		
Net carrying amount at start of year	602	602
Additions	247	247
Disposals	(37)	(37)
Depreciation expense	(172)	(172)
Net carrying amount at end of year at fair value	640	640
At 1 July 2004		
Gross carrying amount	587	587
Accumulated depreciation	(219)	(219)
Net carrying amount at fair value	368	368
At 30 June 2005		
Gross carrying amount	944	944
Accumulated depreciation	(342)	(342)
Net carrying amount at fair value	602	602

Reconciliation

A Reconciliation of the carrying amount of plant and equipment at the beginning and end of the previous reporting period is set out below:-

Year ended 30 June 2005		
Net carrying amount at start of year	368	368
Additions	357	357
Depreciation expense	(123)	(123)
Net carrying amount at end of year at fair value	602	602

11 INTANGIBLE ASSETS

	Parent	Consolidated
	Software $'000	Software $'000
At 1 July 2005		
Gross carrying amount	494	494
Net carrying amount at fair value	494	494
At 30 June 2006		
Gross carrying amount	508	508
Accumulated amortisation and impairment	(99)	(99)
Net carrying amount at fair value	409	409
Year ended 30 June 2006		
Net carrying amount at start of year	494	494
Additions (acquired separately)	14	14
Amortisation (recognised in "depreciation and amortisation")	(99)	(99)
Net carrying amount at end of year at fair value	409	409
At 1 July 2004		
Gross carrying amount	4	4
Net carrying amount at fair value	4	4
At 30 June 2005		
Gross carrying amount	494	494
Net carrying amount at fair value	494	494
Year ended 30 June 2005		
Net carrying amount at start of year	4	4
Additions (acquired separately)	490	490
Net carrying amount at end of year at fair value	494	494

12 CURRENT LIABILITIES – PAYABLES

	Parent		Consolidated	
	2006 $'000	2005 $'000	2006 $'000	2005 $'000
Accrued salaries, wages and on-costs	–	–	72	51
Payable for personnel services	72	51	–	–
Creditors	115	106	115	106
Other	47	14	47	14
	234	171	234	171

13 CURRENT/NON CURRENT LAIBILITIES – PROVISIONS

Employee benefit and related on-costs				
Recreation leave	–	–	532	482
Payroll tax on long service leave	–	–	68	67
Long service leave on-costs	–	–	35	38
Provision for personnel services	635	587	–	–
Total	635	587	635	587
Aggregate employee benefits and related on-costs				
Provisions – Current	–	–	631	577
Provisions – Non-current	-	–	4	10
Provision for personnel services – Current	631	577	–	–
Provision for personnel services – Non-current	4	10		
Accrued salaries, wages and on-costs (Note 12)	–	–	72	51
Payable for personnel services	72	51	–	–
	707	638	707	638

14 CHANGES IN EQUITY

	Parent		Consolidated	
	2006 $'000	2005 $'000	2006 $'000	2005 $'000
Accumulated Funds				
Balance at the beginning of the financial year	2,507	1,153	2,507	1,153
Surplus/(deficit) for the year from ordinary activities	(104)	1,354	(104)	1,354
Balance at the end of the financial year	2,403	2,507	2,403	2,507

15 COMMITMENTS FOR EXPENDITURE

(a) Other Expenditure Commitments
Aggregate other expenditure for the acquisition of stationery contracted for at balance date and not provided for:

Not later than one year	–	5	–	5
Total (including GST)	–	5	–	5

(b) Operating Lease Commitments
Future non-cancellable operating lease rentals not provided for and payable:

Not later than one year	878	1,139	878	1,139
Later than one year not later than 5 years	3,431	3,420	3,431	3,420
Later than five years	–	828	–	828
Total (including GST)	4,309	5,387	4,309	5,387

Total Commitments above included input tax credits of $391,707 (2004–05 $489,721) that are expected to be recovered from the Australian Taxation Office.

16 CONTINGENT ASSETS

These are legal costs awarded in favour of the HCCC arising from prosecution of serious cases of complaints of health care where the respondents have been found to be negligent.

The amounts are subject to negotiation and determination and total $927,578 (2004–05 $808,506).

17 CONTINGENT LIABILITIES

Adverse costs awarded against the HCCC, across a range of cases, are estimated to be $246,495 at 30 June 2006 (2004–05 $492,265), estimates have been provided by the HCCC's Chief Legal Officer.

18 BUDGET REVIEW

Net Cost of Services
The Net Cost of Services was lower than Budget by $126,000. This mainly reflects slightly lower than expected employee related and depreciation expenses.

Assets and Liabilities
Non-Current assets were $174,000 above budget. The HCCC received approval to expend from its cash balances on computer room facilities and the conciliation registry.

Cash Flows
Cash Flows were above budget by $297,000. This reflects lower cash outflows on employee costs and other operating expenses.

19 RECONCILIATION OF NET CASH FLOWS FROM FROM ACTIVITIES TO NET COST OF SERVICES

	Parent		Consolidated	
	2006 $'000	2005 $'000	2006 $'000	2005 $'000
Net cash used on operating activites	597	1,175	597	1,175
Depreciation	(271)	(122)	(271)	(122)
Increase/(decrease) in provisions	(48)	22	(48)	22
Acceptance by the Crown Entity of employee benefits and other liabilities	(362)	(952)	(362)	(952)
Cash flows from Government/Appropriations	(9,541)	(11,109)	(9,541)	(11,109)
Increase/(decrease) in receivables and other	(278)	7	(278)	7
Decrease/(Increase) in creditors	(80)	272	(80)	272
Net gain/(loss) on sale of plant and equipment	(24)	–	(24)	–
Net Cost of Services	(10,007)	(10,707)	(10,007)	(10,707)

20 FINANCIAL INSTRUMENTS

The HCCC's principal financial instruments are outlined below. These financial instruments arise directly from the HCCC's operations or are required to finance the HCCC's operations.

The HCCC does not enter into or trade financial instruments for speculative purposes. The HCCC does not use financial derivatives.

Cash
Cash comprises cash on hand and bank balances within the NSW Treasury Banking System. Interest is earned on daily bank balances at the monthly average NSW Treasury Corporation (Tcorp) 11am unofficial cash rate, adjusted for a management fee to Treasury.
Terms and Conditions – Monies on deposit attract an average interest rate of approximately 4.33%.

Receivables
All trade debtors are recognised as amounts receivable at balance date. Collectability of trade debtors is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect all amounts due. The credit risk is the carrying amount (net of any allowance for impairment).
No interest is earned on trade debtors. The carrying amount approximates fair value. Sales are made on 30 day terms.

Trade Creditors and Accruals
The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set out in Treasurer's Directions 219.01. If trade terms are not specified, payment is made no later than the end of the month following in which an invoice or a statement is received.
Treasurer's Direction 219.01 allows the Minister to award interest for late payment. The rate of interest applied during the year was nil (2005 – nil).

21 IMPACT OF ADOPTION OF AIFRS

The HCCC has determined the key areas where changes in accounting policies are likely to impact the financial reports.
Some of these impacts arise because AIFRS requirements are different from existing AASB requirements (AGAAP). Other impacts are likely to arise from options in AIFRS. To ensure consistency at the whole of government level, NSW Treasury has advised agencies of options it has mandated for the NSW Public Sector.

The HCCC does not anticipate any material impacts on its cash flows.

No change has been made to the Opening AIFRS Balance Sheet as there are no changes of a material nature in the accounting policies arising from the adoption of AIFRS.

22 AFTER BALANCE DATE EVENTS

No after balance date events have occurred.

END OF AUDITED FINANCIAL REPORT

GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDIT REPORT

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

To Members of the New South Wales Parliament

Audit Opinion

In my opinion, the financial report of the Office of the Health Care Complaints Commission (the Office):

- presents fairly the Office's financial position as at 30 June 2006 and its performance for the year ended on that date, in accordance with Accounting Standards and other mandatory financial reporting requirements in Australia, and
- complies with section 41B of the *Public Finance and Audit Act 1983* (the Act) and the *Public Finance and Audit Regulation 2005*.

My opinion should be read in conjunction with the rest of this report.

Scope

The Financial Report and the Commissioner's Responsibility

The financial report comprises the balance sheet, operating statement, statement of changes in equity, cash flow statement and accompanying notes to the financial statements for the Office, for the year ended 30 June 2006.

The Commissioner is responsible for the preparation and true and fair presentation of the financial report in accordance with the Act. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report.

Audit Approach

I conducted an independent audit in order to express an opinion on the financial report. My audit provides *reasonable assurance* to Members of the New South Wales Parliament that the financial report is free of *material* misstatement.

My audit accorded with Australian Auditing Standards and statutory requirements, and I:

- assessed the appropriateness of the accounting policies and disclosures used and the reasonableness of significant accounting estimates made by the Commissioner in preparing the financial report, and
- examined a sample of evidence that supports the amounts and disclosures in the financial report.

An audit does *not* guarantee that every amount and disclosure in the financial report is error free. The terms 'reasonable assurance' and 'material' recognise that an audit does not examine all evidence and transactions. However, the audit procedures used should identify errors or omissions significant enough to adversely affect decisions made by users of the financial report or indicate that the Commissioner had not fulfilled their reporting obligations.

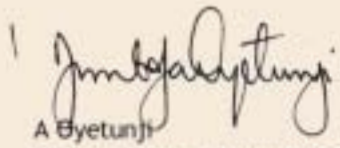
My opinion does *not* provide assurance:

- about the future viability of the Office,
- that it has carried out its activities effectively, efficiently and economically, or
- about the effectiveness of its internal controls.

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office are not compromised in their role by the possibility of losing clients or income.



A Gyetunji
Director, Financial Audit Services

SYDNEY
20 October 2006

OFFICE OF THE HEALTH CARE COMPLAINTS COMMISSION

FINANCIAL REPORT FOR THE YEAR ENDED 30 JUNE 2006

CERTIFICATE OF ACCOUNTS

Pursuant to Section 41C(1B) of the *Public Finance and Audit Act 1983*, I declare on behalf of the Office of the Health Care Complaints Commission that:

(i) the financial report of the Office of the Health Care Complaints Commission for the year ended 30 June 2006 has been prepared in accordance with applicable Australian Accounting Standards (which includes Australian equivalents to International Financial Reporting Standards (AIFRS)), other authoritative pronouncements of the Australian Accounting Standards Board (AASB) and the Urgent Issues Group (UIG) Interpretations, the requirements of the *Public Finance and Audit Act 1983* and the *Public Finance and Audit Regulation 2005*, the Financial Reporting Code for Budget Dependent General Government Sector Agencies and Treasurer's Directions.

(ii) the financial report exhibits a true and fair view of the financial position of the Office of the Health Care Complaints Commission as at 30 June 2006 and the operations for the year ended.

(iii) there are no circumstances which would render any particulars in the financial report to be misleading or inaccurate.

Kieran Pehm
Commissioner

Date: 19 / 10 /2006

Operating Statement for the Year ended 30 June 2006

	Notes	Actual 2006 $'000	Actual 2005 $'000
Expenses excluding losses			
Operating Expenses			
Employee Related	2	6,992	8,179
Total Expenses Excluding Losses		6,992	8,179
Less:			
Revenue			
Personnel Services	3	6,992	8,179
Total Retained Revenue		6,992	8,179
SURPLUS/(DEFICIT) FOR THE YEAR		–	–

The accompanying notes form part of these statements

Statement of Changes in Equity for the Year ended 30 June 2006

	Notes	Actual 2006 $'000	Actual 2005 $'000
TOTAL INCOME AND EXPENSES RECOGNISED DIRECTLY IN EQUITY		–	–
Surplus/(Deficit) for the Year		–	–
TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR		–	–

The accompanying notes form part of these statements

Balance Sheet as at 30 June 2006

	Notes	Actual 2006 $'000	Actual 2005 $'000
ASSETS			
Current Assets			
Receivables	4	703	628
Total Current Assets		703	628
Non-Current Assets			
Receivables	4	4	10
Total Non-Current Assets		4	10
Total Assets		707	638
LIABILITIES			
Current Liabilities			
Payables	5	72	51
Provisions	6	631	577
Total Current Liabilities		703	628
Non-Current Liabilities			
Provisions	6	4	10
Total Non-Current Liabilities		4	10
Total Liabilities		707	638
Net Assets		–	–
EQUITY			
Accumulated Funds		–	–
Total Equity		–	–

The accompanying notes form part of these statements

Cash Flow Statement for the Year ended 30 June 2006

	Notes	Actual 2006 $'000	Actual 2005 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee Related		–	–
Other		–	–
Total Payments		–	–
Receipts			
Sale of Goods and Services		–	–
Interest Received		–	–
Other		–	–
Total Receipts		–	–
Cash Flows from Government			
Recurrent Appropriation		–	–
Capital Appropriation		–	–
Cash Reimbursements from Crown Entity		–	–
Net Cash Flows from Government		–	–
NET CASH FROM OPERATING ACTIVITIES		–	–
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Plant and Equipment		–	–
NET CASH FLOWS FROM INVESTING ACTIVITIES		–	–
NET INCREASE IN CASH		–	–
Opening Cash and Cash Equivalents		–	–
CLOSING CASH AND CASH EQUIVALENTS		–	–

The accompanying notes form part of these statements

Summary of Compliance with Financial Directives for the year ended 30 June 2006

	2006				2005			
	Recurrent		Capital		Recurrent		Capital	
	Recurrent Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Capital Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Recurrent Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000	Capital Appropriation $'000	Expenditure/ Net Claim on Consolidated Fund $'000
ORIGINAL BUDGET APPROPRIATION/ EXPENDITURE								
Appropriation Act	–	–	–	–	–	–	–	–
Additional Appropriations	–	–	–	–	–	–	–	–
s21A PF&AA – special appropriations	–	–	–	–	–	–	–	–
s24 PF&AA – transfer of functions between departments	–	–	–	–	–	–	–	–
s26 PF&AA – Commonwealth specific purpose payments	–	–	–	–	–	–	–	–
	–	–	–	–	–	–	–	–
OTHER APPROPRIATIONS/ EXPENDITURES								
Treasurer's Advance	–	–	–	–	–	–	–	–
Section 22 – expenditure for certain works and services	–	–	–	–	–	–	–	–
	–	–	–	–	–	–	–	–
Transfers to/from another agency (s28 of the Appropriation Act)	–	–	–	–	–	–	–	–
	–	–	–	–	–	–	–	–
Total Appropriations/ Expenditure/Net Claim on Consolidated Fund (includes transfer payments)	–	–	–	–	–	–	–	–
Amount drawn down against Appropriation	–	–	–	–	–	–	–	–
Liability to Consolidated Fund	–	–	–	–	–	–	–	–

Notes to and forming part of the financial statements for the year ended 30 June 2006

1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

(a) Reporting Entity

The Office of the Health Care Complaints Commission (OHCCC) is a Division of the Government Service, established pursuant to Part 1 of Schedule 1 to the *Public Sector Employment and Management Act 2002.* It is a not-for-profit entity as profit is not its principal objective. It is consolidated as part of NSW Total State Sector Accounts.

The OHCCC's objective is to provide personnel services to the Health Care Complaints Commission.

(b) Basis of Preparation

The OHCCC's financial statements are a general purpose financial report, which have been prepared in accordance with:

- applicable Australian Accounting Standards (which include Australian equivalents to International Financial Reporting Standards (AIFRS))
- the requirements of the *Public Finance and Audit Act* and Regulations, and
- the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer.

Judgments, key assumptions and estimations management has made are disclosed in the relevant notes to the financial statements.

The financial statements are prepared in accordance with the historical cost convention. All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

(c) Statement of Compliance

The financial statements and notes comply with Australian Accounting Standards, which include AIFRS.

This is the first financial report prepared based on AIFRS and comparatives for the year ended 30 June 2005 have been restated accordingly, except as stated below.

In accordance with AASB 1 *First-time Adoption of Australian Equivalents to International Financial Reporting Standards* and Treasury Mandates, the date of transition to AASB 132 *Financial Instruments: Disclosure and Presentation* and AASB 139 *Financial Instruments: Recognition and Measurement* has been deferred to 1 July 2005. As a result, comparative information for these two Standards is presented under the previous Australian Accounting Standards which applied to the year ended 30 June 2005.

(d) Income Recognition

Income is measured at the fair value of the consideration received or receivable. Revenue from the rendering of personnel services is recognised when the service is provided and only to the extent that the associated recoverable expenses are recognised.

(e) Employee Benefits and Other Provisions

(i) Salaries and Wages, Annual Leave, Sick Leave and On-Costs

Liabilities for salaries and wages (including non-monetary benefits), annual leave and paid sick leave that fall due wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of payroll tax, workers compensation insurance premiums and fringe benefits tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

(ii) Long Service Leave and Superannuation

The OHCCC's liabilities for long service leave and defined benefit superannuation are assumed by the Crown Entity. The OHCCC accounts for the liability as having been extinguished.

(f) Insurance

The OHCCC's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self insurance for Government agencies. The expense (premium) is determined by Fund Manager based on past claim experience.

(g) Receivables

A receivable is recognised when it is probable that the future cash inflows associated with it will be realised and it has a value that can be measured reliably. It is derecognised when the contractual or other rights to future cash flows from it are transferred.

(h) Payables

Payables include accrued wages, salaries, and related on costs (such as payroll tax, fringe benefits tax and workers compensation insurance) where there is certainty as to the amount and timing of settlement.

2 EXPENSES EXCLUDING LOSSES

	2006 $'000	2005 $'000
Employee related expenses		
Salaries & Wages (including recreation leave)	5,906	6,775
Superannuation – Defined Benefits Plans	144	158
Superannuation – Defined Contributions Plans	318	403
Workers Compensation Insurance	44	32
Long Service Leave	209	358
Payroll Tax & Fringe Benefits Tax	371	453
	6,992	8,179

3 REVENUE

Rendering of personnel services	6,992	8,179
	6,992	8,179

4 CURRENT/NON-CURRENT ASSETS – RECEIVABLES

Personnel Services – Current	703	628
Personnel Services – Non-Current	4	10
	707	638

5 CURRENT LIABILITIES – PAYABLES

Accrued salaries, wages and oncosts	72	51
	72	51

6 CURRENT/NON CURRENT LAIBILITIES – PROVISIONS

Employee benefit and related oncosts		
Recreation leave	532	482
Payroll tax on long service leave	68	67
Long service leave oncosts	35	38
Total	635	587
Aggregate employee benefits and related on-costs		
Provisions – Current	631	577
Provisions – Non current	4	10
Accrued salaries, wages and oncosts (Note 5)	72	51
	707	638

7 CONTINGENT LIABILITIES AND CONTINGENT ASSETS

There are no contingent liabilities or contingent assets at 30 June 2006 (2005:NIL)

8 THE IMPACT OF ADOPTING AUSTRALIAN EQUIVALENT TO AIFRS

There is not likely to be any material effect on the Office's financial statements as a result of the implementation of AIFRS.

9 AFTER BALANCE DATE EVENTS

No after balance date events have occurred.

END OF AUDITED FINANCIAL REPORT

APPENDICES

APPENDIX A

Case studies

Assessment Branch Case Study

Vulnerable patient

The complainant was an elderly woman (with limitations on her mobility) who was an inpatient at a small regional hospital. She was transferred by hospital transport to a larger regional hospital to be reviewed by a heart specialist.

The complainant was discharged from the regional hospital without her clothing, money or any consideration given to transport to her home, which was approximately 110km away. After organising for a taxi from her own town to collect her and drive her home, the complainant was told to wait in the outpatients waiting area for her taxi. She felt embarrassed, vulnerable and distressed as she was in her nightgown and had no money for any sustenance.

The Area Health Service investigated the issues raised and wrote to the complainant acknowledging her distress, and indicating that staff had been instructed to be conscious for similar situations that may occur. Staff were also reminded of their obligation to patients. Also, the Area Health Service advised of changes introduced in relation to the discharge and transport of patients. The complainant was satisfied with the actions taken and considered the matter resolved.

Resolution Service Case Study

Enhancing communication

A young woman complained to the Commission about the continued prescription of antidepressant medication to her mother by a general practitioner (GP) and psychiatrist. The daughter believed her mother told the doctors she was in pain to obtain medication. The daughter reported her mother slept most of the time, didn't do the housework and at times was unable to attend to her school-aged children. A lengthy list of medications that were kept in the home was included with the complaint.

The complaint was referred for assisted resolution. The Resolution Officer phoned the daughter and clarified her concerns. The daughter said she was worried her mother was addicted to the medication and she was unsure what to do.

The Resolution Officer spoke to the GP who confirmed that the mother had chronic neck and lower back pain from an injury. The woman was also being treated for depression. The GP was willing to meet with the mother and daughter to review the medications and explained that she had already spoken with the treating psychiatrist about which medications to continue prescribing.

The mother agreed to go with her older children to see the GP. In preparation for this visit the Resolution Officer assisted the daughter in deciding what she wanted to say, the questions she would ask and how to gather additional information about the medications her mother was taking.

The doctor listened to the concerns of the eldest daughter and her siblings and was able to give them some understanding of their mother's health problems. The current medications were discussed and the GP offered to dispose of the old medications that were in the home. One of the older children is now helping the mother manage her medication each day. The daughter told the Resolution Officer that she now knows to approach the GP if she is worried her mother's condition is getting worse and feels the family and doctor are working together to help her mother.

Resolution Service Case Study

An error acknowledged

Following admission to a public hospital for an arthroscopy and cortisone injection in her ankle a woman awoke from an anaesthetic to find her left ankle was painful. The injection was planned for the right ankle. Prior to discharge the woman overheard staff saying that the injection had been given in the wrong ankle but there was no discussion with the woman about the procedure performed or what had happened.

As instructed the woman tried to make an appointment to see the surgeon within a week. The surgeon phoned the woman acknowledging the error but the woman was left feeling that the surgeon blamed her in some way for the mistake. The hospital sent letters and made calls to the woman saying a meeting would be organised but this did not happen. The woman said she left messages and her calls were not returned and although the admission office rang with a date for a further procedure the woman declined as she was no longer comfortable returning to the hospital. The woman sought legal advice and then made a complaint to the Commission.

The matter was referred for assisted resolution. The woman told the Resolution Officer she simply wanted the original injury to her right foot fixed. Her right foot was painful and she was unable to walk except for a short distance. This stopped her from doing many activities. The woman injured her foot over two years ago and had waited thirteen months on the waiting list for the arthroscopy. The woman clearly remembered her right foot being marked at the hospital prior to the surgery. She felt disillusioned by what had happened.

The Resolution Officer arranged a meeting with the hospital. In this meeting the surgeon explained the results of the arthroscopy and the mistake of injecting the wrong ankle was admitted. An apology was offered for this error, the poor communication that followed and the delay in resolving the matter. A second opinion regarding further treatment was organised. The woman felt this was a step forward in achieving some improvement in her condition.

The woman was satisfied with the treatment by the specialist who provided the second opinion. A scan was done, another injection ordered and after two weeks of wearing a soft removable cast the woman told the Resolution Officer she was pain free, had been on holidays and had been doing a lot of walking. This specialist charged the Medicare rebate only so there were no out of pocket expenses. The woman thanked the Resolution Officer for the assistance given to resolve her complaint and said she felt she "had her life back".

Resolution Service Case Study

Not in vain

An elderly woman died in a regional public hospital after developing peritonitis. Prior to her death the woman received food via a PEG feeding tube. When this tube became dislodged it was temporarily replaced with a Foley's catheter whilst awaiting delivery of the correct size PEG tube. Securing the correct tube took four weeks. The woman's daughter made a complaint to the Commission; she believed the extended use of the Foley's catheter caused the overwhelming infection.

The hospital advised the Commission that while prolonged use of the catheter may have contributed to a greater risk of infection, it was not possible to determine whether this caused the woman's death. A Commission Internal Medical Advisor reviewed the matter and was of the opinion that the care and treatment provided by the hospital did not raise any significant issues of concern requiring investigation by the Commission. The matter was referred for assisted resolution.

Following contact from the Resolution Officer the daughter and the hospital agreed to meet to discuss the issues in detail and for the hospital to outline changes in practice that were developed as a result of this incident. There were some significant discrepancies between the complainant's understanding of what occurred and what was contained in the written response from the hospital.

In the meeting the daughter had the opportunity to fully explain her concerns to senior hospital staff. The hospital representatives expressed their sincere regret about what had happened and acknowledged it had taken too long to source the correct PEG tube. The changes to hospital protocols were explained and a copy of the revised protocol was given to the daughter.

At the conclusion of the meeting the daughter was confident her complaint had been taken seriously, that significant changes had taken place and felt that some good had come out of her mother's death.

APPENDIX A

Case studies

Resolution Service Case Study

Re-establishing relationships

A woman complained that two general practitioners (GPs) failed to provide adequate care during the final hours of her father's life. The treating GP had agreed to supervise the father's care so that he could die at home. The father's condition deteriorated but the family were unable to contact the treating GP as he was on a scheduled day off. The family phoned asking for the other doctor in the practice to visit the home, as they were concerned their father was in pain. The family were distressed when their call for help was refused. The family were told the doctor was booked to see patients all morning. The father died a few hours later.

The treating doctor provided a written explanation to the Commission and both matters were referred for assisted resolution. The family were disappointed at the loss of the relationship with the treating GP. The family wanted an explanation of what had happened and didn't want it to happen to someone else.

In relation to the treating GP the complainant decided she would like to see the GP's response. The doctor agreed enthusiastically as he wanted to write directly to the family in the first instance but was advised by his insurer to wait for the Commission to progress the complaint. The doctor's response included a sincere apology and acknowledgment that the community team were not ready for the sudden deterioration in the father's condition. He suggested a change in the way the community palliative care team and treating doctor worked together in providing palliative care to patients who wish to die at home. Palliative care nurses, in future, will initiate a visit from the doctor in the early stages of community palliative care rather than waiting until a change in condition or crisis occurs.

The Resolution Officer forwarded a copy of the response to the complainant. Before the Resolution Officer was able to speak with the complainant, the GP phoned to say the complainant's mother had turned up to the surgery to see him. The family had responded very positively to his letter and the woman had come to re-establish her relationship with him as her own treating doctor.

The family's concerns about the other GP not attending to their father at home were satisfied when they received an explanation that the doctor had not been in breach of the Medical Practice Act. On the day of the request the GP had offered to speak to the family over the phone after he concluded seeing his patient. The alternative of having the father transported to hospital by ambulance to receive urgent medical attention if required was also offered.

Resolution Service Case Study

Working together for resolution

While fishing, a seven-year-old boy cut his hand on an oyster shell and was taken to the Emergency Department at a public hospital. The injury was treated and the boy went home. The mother was given a letter for the family general practitioner (GP) that recorded details about another patient. The mother was concerned about confidentiality and wrote to the Commission. Following assessment the complaint was referred for assisted resolution.

The Resolution Officer spoke with the mother and established that the boy's hand had not healed. In order to seek prompt medical assessment for the boy the Resolution Officer contacted the hospital's Patient Representative who liaised with a hand specialist at the hospital. The boy's GP was asked to arrange a scan and write a referral to the hand specialist.

An urgent appointment was set up with the hand specialist who confirmed there was residual shell in the wound. The hospital ensured theatre time was made available for surgery to remove the shell and the hospital met both the initial consultation fee with the hand specialist and all costs relating to the surgery.

The Resolution Officer and the Patient Representative worked together to ensure timely resolution of this complaint. The boy's hand healed quickly and the family were able to go on their planned overseas holiday.

In relation to the initial issue of confidentiality the Emergency Department doctor realised her mistake and had corrected the file on the day of the presentation. The doctor apologised that she did not contact the family and explain what had happened. The mother was satisfied that her son's records were accurate.

Resolution Service Case Study

Trust restored

A middle-aged man was presenting frequently to the Emergency Department at two local hospitals requesting treatment and pain relief. The man was involved in a car accident ten years ago and continued to suffer pain and seizures. On earlier presentations he was given medication and referred for scans but recently the man was refused treatment. The man complained to the Commission saying the treatment was inadequate.

The Commission sought a response from the Area Health Service. The service indicated that the man had a complex pain disorder and appeared to exhibit drug seeking behaviour. The matter was referred for assisted resolution.

The Resolution Officer phoned the man and learned that he had been on the methadone program but had reduced his dose to 1 mg, which could explain why he had been seeking pain relief.

The Resolution Officer facilitated a meeting between the man, the Director of Emergency and the Liaison Officer at the hospital. An apology for occasions of poor service was given and the Director of Emergency provided an explanation about Emergency services and chronic pain issues. A management plan was developed to give Emergency staff an understanding of the man's health concerns so that he would not be dismissed as seeking drugs when he presented to Emergency.

The man informed the Resolution Officer that he had been well treated at the next presentation to Emergency. He felt that he had a better relationship with both his general practitioner and the hospital and that he was receiving more appropriate treatment.

Resolution Service Case Study

Rebuilding confidence

Approximately a year after his wife died from lung cancer an older man wrote to the Commission. Comments made by the specialist who treated his wife left the man believing the general practitioner (GP) missed diagnosing the cancer at an early stage. The GP provided a written response and medical records to the Commission. The Commission assessed the complaint and referred it for assisted resolution.

When the Resolution Officer contacted the man he was angry and grieving the death of his wife. He talked about the pain and suffering his wife endured and how he felt the GP had let his wife down. The GP had treated the man, his wife and their adult children for many years.

The Resolution Officer explained the Internal Medical Advisor at the Commission found no evidence that the GP could have made the diagnosis any earlier. The man's wife did not present with symptoms that could be reasonably attributed to lung cancer until a visit when the doctor noticed she had lost a significant amount of weight. The GP acted promptly in organising appropriate investigations when the woman lost weight and made an urgent referral to a specialist when the cancer was diagnosed. The man was satisfied that an independent doctor had reviewed his wife's treatment.

The Resolution Officer phoned the GP who was upset to learn that the man had lost confidence in the GP's care of his wife. The doctor decided to call the man and express his regret. After hearing from the doctor the man called the Resolution Officer to say he was very pleased the rift and misunderstanding had been resolved.

APPENDIX A

Case studies

Investigations Case Study

Inappropriate comments

A 25-year-old female consulted a general practitioner (GP) in a medical centre for bleeding from the anus and constipation. The patient alleged the GP made repeated inappropriate personal remarks during the consultation, which made her feel very uncomfortable particularly during an anal examination. Examples of the alleged inappropriate comments were about the patient's beauty, her anus, her diet and her figure. She also complained that the GP provided an inadequate assessment of her problems and failed to address her pain, bleeding and long-term problems of constipation.

The patient wrote to the NSW Medical Board regarding her complaint and the matter was referred to the Commission for investigation. Following receipt of the complaint, the GP phoned the patient in distress a number of times. He apologised to her and allegedly appealed to her to withdraw her complaint.

As a result the Commission wrote to the GP and drew to his attention section 98 of the Health Care Complaints Act 1993*, which states that it is an offence to intimidate or harass, persuade or attempt to persuade another person not to continue with a complaint.*

In his response to the Commission, the GP extended his apologies to the patient and stated that he did not realise that he had made the patient so uncomfortable. He denied several of the comments, however agreed he had made several remarks regarding her figure and diet.

The expert reviewer stated that if the GP used the language and made the comments described by the patient then he would be severely critical of his conduct. The comments would be inappropriate in the context of a male practitioner seeing a female patient for the first time, and in particular noted them to be condescending, sexist, overfamiliar, vulgar, inappropriate and inaccurate. The expert stated that if the GP used the language and comments described in his response to the complaint then he would be mildly critical of his conduct.

As there was no further information available to corroborate which particular phrases were used by the GP, it was concluded that the GP used inappropriate comments whether the patient's or the GP's version of events were accepted.

The investigation also concluded that aspects of the consultation were considered to be inadequate and inappropriate by the expert reviewer, including the GP:

- *failing to address the various diagnostic possibilities such as irritable bowel syndrome, coeliac disease, or inflammatory bowel disease*
- *failing to deal with the patient's concerns about the cause for her problems*
- *possibly casually recommending referral to a gastroenterologist, and*
- *the comments the GP made about diet were incorrect.*

The expert expressed criticism of the GP for trying to contact the patient a second time after she had made it clear she did not want to speak to him. The expert stated that the patient had troubling and significant symptoms for which she sought advice, and the GP was responsible for managing these not only to his satisfaction but also to the patient's.

The GP was referred to the NSW Medical Board for counselling pursuant to section 39 (1)(c) of the Health Care Complaints Act 1993 *in relation to the expert's concerns. Counselling included:*

- *exploration of use of appropriate language and communication skills, especially when conducting intimate examinations and/or dealing with intimate and/or embarrassing health issues*
- *addressing the concerns of a patient during consultation*
- *the expert's criticisms and comments.*

Investigations Case Study

Systemic change

A patient undergoing radiation treatment for cancer received 70Gy instead of 45Gy (56% higher dose) to her right breast between December 2003 and February 2004, due to a calculation error during the treatment planning phase. This error constituted a breach of Radiation Control Regulation 2003, Section 26(2)(c), as it differed by more that 10 per cent from the prescribed treatment dose.

The matter was referred by the NSW Department of Environment and Conservation due to the seriousness and magnitude of the error. The Commission investigated the matter and made the following findings:

- *Staff made a serious error during the radiotherapy planning phase, resulting in the patient receiving 56% more radiation than the prescribed dose over the 25 fractions between December 2003 and February 2004. This error resulted in significant morbidity for the patient.*
- *This error was made when 16 was entered as the number of fractions into the treatment system, instead of 25. This happened during the manual transcription into the treatment system. The error was not detected during the normal quality assurance checks as staff either incorrectly checked the original prescription, or did not refer back to the original prescription.*

The Commission made the following recommendations:

- *All four mandatory checkpoints should include verification of the original prescription and dosimetry. The forms should be modified to include a checkbox indicating the checker has referred back to the original prescription and checked the dosimetry and number of fractions.*
- *Any future computerised record and verification systems should incorporate adequate checks and balances to prevent errors, since computerised systems are still dependent on human data entry.*

In October 2005, the Commission provided a report to the Director-General of the NSW Department of Health (DOH), pursuant to s.42 (2) of the Act and sought the advice from the Director-General as to the statewide applicability of the recommendations.

The Director-General wrote to the Commission in January 2006, stating an expert group of public and private sector Radiation Therapists, Medical Physicists and Radiation Oncologists had been convened during 2005 to review a better practice document released in 1996 by the DOH. This document is a core list of data components to be incorporated in radiotherapy prescription, and treatment sheets of megavoltage, superficial and orthovoltage radiation therapy, as well as the radiotherapy planning checklist. Staff at two public Radiation Oncology Therapy Centres (ROTCs), not involved in the group, also assessed the documentation and provided feedback. The expert group reconvened and it was agreed that the Commission's recommendations would be included in the revised documentation to be released as a policy to all Area Health Services.

The Acting Director-General of DOH stated in a letter dated July 2006 that the recent NSW Department of Health policy directive "Development of Prescription and Treatment Sheets for NSW Health Radiation Therapy Facilities" incorporates the Commission's recommendations. The Acting Director-General advised that the policy was issued on 13 June 2006 to the NSW public health system, health professional associations and related organisations, the DOH, public hospitals, private hospitals and day procedure centres.

The Acting Director-General also advised that correspondence would be addressed to NSW Public and Private ROTCs, drawing their attention to the policy. While the policy applies to public ROTCs, the Department recommends that as a better practice document, that private ROTCs also adhere to the policy.

The policy prescribes the mandatory data to be collected and verified by NSW ROTCs during the prescription, planning and treatment stages for megavoltage, superficial and orthovoltage radiation therapy. The policy also includes principles for developing radiation therapy prescription and treatment sheets, as well as a checklist for critical activities conducted during the planning and delivery of radiation therapy treatment, which must be checked to avoid errors. It requires Area Health Services to conduct regular audits of ROTC's processes to verify compliance with the policy.

The Director-General also advised that information briefings for ROTCs will also form part of the release process.

APPENDIX A

Case studies

Medical Tribunal Case Study

Dr X, clinical matter

In January 2003, it was discovered that Patient A was suffering from Burkitt's lymphoma, an aggressive cancer with a poor prognosis.

Also in January 2003, Dr X commenced as a radiology registrar at a Sydney hospital. On 17 January 2003, Patient A was admitted to the hospital to commence a chemotherapy regime, which involved several cycles of chemotherapeutic drugs. Different drugs were administered on different occasions. Because of Patient A's size, when a chemotherapeutic drug required intrathecal injection, the injection was administered in the Radiology Department, where imaging could be used to guide the lumbar puncture. On four occasions prior to March 2003, it was Dr X who placed Patient A's lumbar puncture and administered his chemotherapeutic drugs.

On an occasion in March 2003, Patient A was taken to the Radiology Department. Contrary to the usual practice, he was not accompanied by his medication. An orderly was sent to obtain the drugs and returned with two sealed bags each containing a drug-filled syringe and two medication charts.

One of the syringes contained methotrexate, a drug which is administered intrathecally. The medication chart stated that the administration route was intrathecal. The second syringe, contained vincristine, a drug which is administered intravenously and which when administered intrathecally, is generally fatal. The medication chart for the vincristine stated that the administration route was intravenous. Affixed to the syringe was a label, which said "Intravenous…Vincristine…Avoid Extravasation FATAL IF GIVEN INTRATHECALLY". In the bag was a second label, which included the notation "Avoid Extravasation FATAL IF GIVE". Extravasation is the leakage of a chemotherapeutic drug from a blood vessel into the surrounding tissue.

There was a change in nursing shift and a new nurse began to assist Dr X just before the patient's procedure began. The Tribunal accepted Dr X's evidence that he looked at the medication chart and the syringe labels and checked the patient's name against the drugs. Dr X knew almost nothing about the drugs involved.

Dr X failed to ascertain the correct administration route for each drug and assumed that each drug was to be administered intrathecally and because, "usually, only chemotherapeutic drugs designed for intrathecal administration were sent to the Radiology Department, because he appeared to be repeating a procedure with a patient whom he knew and, perhaps, because of his subordinate status within the hospital, he "went on autopilot". *Dr X administered both drugs intrathecally. After the procedure, he signed a procedure report, failing to note the "FATAL IF GIVE" sticker, which had been affixed before he signed. It was not until four days later that the error was discovered and Patient A died about one month later.*

The Tribunal noted that this incident was similar to one in January 2001 in Nottingham in the United Kingdom. An inquiry into the Nottingham incident identified 13 prior cases where patients had died or been paralysed by maladministered spinal injections. In April 2001, the UK Department of Health published recommendations for the prevention of intrathecal medication errors. The hospital responded to the March 2003 incident by introducing protocols, which resemble the 2001 UK recommendations. Vincristine is now prepared in a syringe which is obviously too large for intrathecal administration, and is now accompanied by a large yellow warning sign cautioning "For intravenous use only. Fatal if given by other routes. Do not remove preparation from the bag until immediately before administration."

Dr X admitted he was guilty of unsatisfactory professional conduct and the Tribunal made such a finding. Having observed Dr X giving evidence and having read his references, the Tribunal considered Dr X had accepted responsibility for his conduct and is now "fastidious in his attention to proper procedure. The Tribunal is convinced that the conduct will not be repeated". *The Tribunal considered that the appropriate order in this case was a reprimand and orders that ensured that those responsible for Dr X's training during the remainder of his period as a registrar are aware of the conduct.*

The Tribunal noted that:

"although the complaint proceeded as a complaint of unsatisfactory professional conduct, rather than professional misconduct, and the complainant did not seek the suspension or de-registration of the doctor, the Tribunal considers that it was appropriate for the matter to be brought before it. The case raises matters of public interest. First, it is desirable that the profession be reminded of the need to adhere to elementary procedural principles. Second the context of institutional failure disorder in which the conduct occurred is a matter of public interest.

Finally, it was appropriate that the proceedings be held in a public forum because the individual and systemic faults which have been aired in the proceedings resulted in a man's death. The Tribunal acknowledges the grief of Patient A's family, sympathises with the family and, hopes that these proceedings will bring some sense of closure to the family and they will assist to prevent the future occurrence in Australia of such a tragic incident."

Psychologists Tribunal Case Study

Charles Smith, financial relationship

A complaint alleged that Mr Smith, a psychologist, was guilty of professional misconduct on the basis that he had discussions about forming a financial relationship and/or commenced and maintained a financial relationship with Client A at the time or soon after he terminated a therapeutic relationship with Client A in 2002. In addition, he failed to seek advice from a senior colleague prior to having those discussions and or commencing that financial relationship.

Client A was suffering from a depressive illness, which he considered to be work related. He received treatment from Mr Smith on a regular basis from August 2000 to July 2002. Mr Smith provided a report for Client A's workers compensation matter. During the counselling sessions Client A would discuss his real estate investing activities, which Mr Smith considered to be a useful indicator of the progress of Client A.

Mr Smith continued to meet with Client A after July 2002 in his professional rooms to discuss Client A's real estate investment activity and appointments were occasionally written on his business cards.

In around July 2002, Client A became part of a real estate development syndicate. He discussed this with Mr Smith. The syndicate was involved with the purchase of 30 apartments at a discounted price. Mr Smith subsequently exchanged contracts for the purchase of two of these apartments at the discounted price. He later decided that he not wish to participate in the syndicate.

In November 2002, Client A discussed purchasing a property in Bowral with Mr Smith. A contract was signed by both of them and Mr Smith paid a deposit. Mr Smith and Client A became directors of a company together. In the end the contract was not completed, as finance could not be obtained.

Client A stated that he felt that the relationship between them had changed to be like a business colleague and friend rather than Mr Smith being his psychologist.

At the commencement of the hearing Mr Smith admitted that his conduct amounted to professional misconduct.

The Tribunal stated "that the conduct made out is of such a serious nature that it would warrant the removal of the Respondents' name from the register and a finding of professional misconduct is made. The Tribunal has considered what orders are appropriate in the circumstances of this case and has decided this is one in which appropriate conditions will allow the public safely to be protected and the reputation of the profession to remain intact…The Respondent has displayed a co-operative attitude and has responded to the Commission in a professional fashion. There was a measure of insight displayed by the Respondent in his evidence. He acknowledges that he did not interpret the Code of Ethical Conduct correctly and sincerely agrees that he requires further education in this area to allow him to develop a greater understanding of ethical matters particularly boundary issues."

The Tribunal found Mr Smith guilty of professional misconduct and the Tribunal reprimanded Mr Smith and imposed a number of conditions on his registration including that he complete a professional ethics course and that a senior psychologist supervise him.

Medical Professional Standards Committee Case Study

Dr M, failure to provide medical assistance

The Commission made a complaint against Dr M of unsatisfactory professional conduct in relation to his failure, without reasonable cause, to provide medical assistance to a person in urgent need of such assistance, within a reasonable period of time despite repeated requests to do so.

Dr M was a sole general practitioner (GP) in a regional practice. Patient F was an elderly gentleman with multiple medical problems. He attended Dr M's practice weekly for monitoring of these conditions. Following the consultation, Patient F, accompanied by his partner, walked to a local café, estimated to be several minutes away from Dr M's surgery. Whilst sitting in the café Patient F collapsed. The Committee heard evidence that three people on three separate occasions, including Patient F's partner, approached Dr M's surgery requesting assistance. Dr M refused to leave his surgery advising an ambulance was on its way and there was nothing he could do.

Bystanders commenced CPR and continued with this treatment until the ambulance arrived. Dr M attended the scene some 15 minutes after the initial request but by this time Patient F was motionless and cyanotic with dilated pupils. He advised those assisting the patient that further CPR was useless. Upon arrival the ambulance found the patient to be in ventricular fibrillation and administered electric shocks. At this time Dr M informed Patient F's partner that the patient had died.

Prior to the hearing Dr M admitted the complaint and that his failure to render assistance to a person in urgent need of medical assistance amounted to unsatisfactory professional conduct. Following evidence at the inquiry, the Committee expressed concern that Dr M had failed to maintain his skills in the area of CPR, that he failed to recognise that trust is the foundation of the relationship between a doctor, patient and the community, and, that he breached this position of trust. The Committee were also concerned that Dr M failed to recognise the important role a medical practitioner can play in the provision of psychological support in an emergency situation.

The Committee found the complaint of unsatisfactory professional conduct was proven and reprimanded the practitioner. The Committee also ordered Dr M undertake educational courses in the areas of Emergency Life Support and medical ethics.

APPENDIX A

Case studies

Medical Professional Standards Committee Case Study

Dr Y, failure to conduct a physical examination

The Commission's first prosecution of a complaint pursuant to the current statutory definition of "unsatisfactory professional conduct" was against Dr Y in a Professional Standards Committee.

Patient A, a 28-year-old male, became ill at work around lunchtime on 21 April 2004. Early that evening, after work, he presented to Dr Y at a medical centre near his home, accompanied by his mother. Patient A gave a history of feeling hot and cold, sweaty and nauseous and of aching in his arms, legs and back. Dr Y took the patient's temperature, diagnosed viral influenza and prescribed Tamiflu and Panadol. His parents took the patient home and his condition deteriorated overnight. He was taken back to the medical centre the following morning and was seen by another practitioner. By this time, he had developed a number of red marks on his body and face. Ambulance transfer to hospital was arranged for emergency treatment. The patient was subsequently transferred to another hospital, where he died in ICU on 23 April 2004, after several cardiac arrests. The cause of death was meningococcal sepsis.

The Commission's complaint against Dr Y alleged that he failed to physically examine Patient A, failed to take a sufficiently detailed history from Patient A and failed to give sufficient instructions to Patient A should his condition change or worsen. The complaint alleged that these failures demonstrated that the knowledge, skill or judgment possessed, or care exercised by Dr Y in the practice of medicine, was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

The Committee found that Dr Y was a well-trained and experienced general practitioner. It found that the physical examination of an acutely unwell patient presenting with a high fever and no localising symptoms involves more than merely taking the patient's temperature. It considered that Dr Y had failed to physically examine Patient A and determined on the evidence before it that this was typical of his practice at the time. The Committee determined that this failure constituted unsatisfactory professional conduct.

The Committee found that the history taken from Patient A and the notes recorded by Dr Y were insufficiently detailed, but that while Dr Y had failed to meet optimum standards in this respect, it was not a sufficiently significant departure from accepted standards to amount to unsatisfactory professional conduct. The Committee considered that while it would have been optimum practice for Dr Y to give more detailed advice to Patient A at the end of the consultation, it could not be comfortably satisfied that Dr Y's failure to give more specific instructions constituted a sufficiently significant departure from accepted standards to amount to unsatisfactory professional conduct.

Whilst the complaints relating to Dr Y's note-taking and failure to give specific instructions to the patient were not found to have been proved, Dr Y's failure to physically examine the patient was proved. This was sufficient to result in a finding of unsatisfactory professional conduct being made. The Committee reprimanded the practitioner and recommended that he continue to meet regularly with his long standing general practitioner (GP) mentor and together consider ways in which Dr Y could implement improvements in his practice as a result of the Committee's decision.

NSW Pharmacy Board of Inquiry Case Study

Mamdouh Waskin, supply of pseudoephedrine tablets

A Pharmacy Board of Inquiry found Mr Waskin guilty of professional misconduct.

In 1999 and 2000 Mr Waskin purchased large quantities of single ingredient pseudoephedrine tablets contrary to professional guidelines, which recommend the keeping of pseudoephedrine stock to a minimum and supplied on various occasions multiple boxes of single ingredient pseudoephedrine tablets from his Pharmacy to a customer.

The Board found that the supply was in circumstances where Mr Waskin could not be satisfied that each supply was in a quantity and for a purpose in accordance with recognised therapeutic standards (contrary to the Poisons and Therapeutic Goods Regulation); he knew or ought to have known that pseudoephedrine is the primary precursor substance used in the illicit manufacture of amphetamines; and he knew or ought to have known that the pseudoephedrine supplied by him to the customer was likely to be used in the illicit manufacture of amphetamines.

The Board of Inquiry also found that Mr Waskin had been convicted in the District Court in 2002 of the offence of of influencing a witness to give false evidence.

Mr Waskin had been sentenced to 18 months periodic detention for the offence.

Mr Waskin admitted having lied to police about giving the customer the drugs and admitted having tried to cover up with a staff member who had been involved in the matter. Mr Waskin admitted the particulars of the complaint except that he knew or ought to have known that the pseudoephedrine supplied by him to the customer was likely to be used in the illicit manufacture of amphetamines.

The Board of Inquiry found all particulars of the complaint proved. The Board found that Mr Waskin had not accepted his culpability nor acknowledged his wrongdoing for the offence although he had made some admissions. The Board found that Mr Waskin did not impress it as a person truly contrite nor accepting of his transgressions in relation to his conduct in supplying pseudoephedrine. In determining the appropriate protective orders the Board had regard to the fact that Mr Waskin sold the pharmacies he owned, was now working as a locum pharmacist and had stated that he had no intention or desire to own or run a pharmacy again.

Mr Waskin was reprimanded, fined $4,000 and had a number of conditions placed on his registration.

APPENDIX B

Statistics

Table 14.1 Summary of complaints received by category 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Issue Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	1100	40.5%	1154	41.1%	1422	46.2%	1924	56.7%
Professional conduct	432	15.9%	456	16.2%	621	20.2%	595	17.5%
Communication	315	11.6%	294	10.5%	304	9.9%	265	7.8%
Access	210	7.7%	247	8.8%	203	6.6%	224	6.6%
Cost	123	4.5%	123	4.4%	174	5.6%	178	5.2%
Privacy/discrimination	93	3.4%	73	2.6%	110	3.6%	115	3.4%
Consent	75	2.8%	62	2.2%	81	2.6%	56	1.7%
Corporate services	333	12.3%	252	9.0%	118	3.8%	24	0.7%
Grievances	16	0.6%	34	1.2%	17	0.6%	11	0.3%
Miscellaneous	17	0.6%	116	4.1%	31	1.0%	0	0.0%
Total	**2714**	**100.0%**	**2811**	**100.0%**	**3081**	**100.0%**	**3392**	**100.0%**

**Counted by issues raised in complaint*

Table 14.2 Breakdown of category of complaints received 2005–06*

ISSUE CATEGORY	ISSUE NAME	TOTAL	%
Access	Attendance	8	0.2%
	Delay in admission or treatment	100	2.9%
	Discharge or transfer arrangements	14	0.4%
	Referral	3	0.1%
	Refusal to admit or treat	79	2.3%
	Service availability	17	0.5%
	Waiting lists	3	0.1%
Access Total		**224**	**6.6%**
Communication	Attitude	200	5.9%
	Inadequate information	36	1.1%
	Interpreter/special needs services	1	0.0%
	Wrong/misleading information	26	0.8%
Communication Total		**263**	**7.8%**
Consent	Consent invalid	7	0.2%
	Consent not informed/failure to warn	22	0.6%
	Consent not obtained	23	0.7%
	Failure to consult consumer	3	0.1%
	Involuntary admission	1	0.0%
Consent Total		**56**	**1.7%**
Corporate services	Administrative services	9	0.3%
	Hotel services	5	0.1%
	Hygiene/environmental standards	10	0.3%
Corporate services Total		**24**	**0.7%**
Cost	Billing Practices	124	3.7%
	Government subsidies	1	0.0%
	Information on costs	42	1.2%
	Overcharging	10	0.3%
	Private health insurance	1	0.0%
Cost Total		**178**	**5.2%**
Grievances	Inadequate/No response to complaint	8	0.2%
	Reprisal/retaliation	3	0.1%
Grievances Total		**11**	**0.3%**
Privacy/discrimination	Access to records	45	1.3%
	Discrimination	3	0.1%
	Discrimination public/private	2	0.1%
	Inconsiderate service	2	0.1%
	Privacy/confidentiality	63	1.9%
Privacy/discrimination Total		**115**	**3.4%**

Table 14.2 Breakdown of category of complaints received 2005–06 (continued)*			
ISSUE CATEGORY	**ISSUE NAME**	**TOTAL**	**%**
Professional conduct	Accuracy/inadequacy of records	13	0.4%
	Assault	12	0.4%
	Bad character (Legacy Code)	1	0.0%
	Breach of conditions	17	0.5%
	Certificates/reports	131	3.9%
	Competence	174	5.1%
	Financial fraud	17	0.5%
	Illegal practices	140	4.1%
	Impairment	35	1.0%
	Sexual misconduct	53	1.6%
Professional conduct Total		**593**	**17.5%**
Treatment	Co-ordination of treatment	4	0.1%
	Diagnosis	233	6.9%
	Inadequate treatment	1356	40.0%
	Infection control	33	1.0%
	Medication	281	8.3%
	Negligent treatment	4	0.1%
	Rough/painful treatment	6	0.2%
	Withdrawal/denial of treatment	2	0.1%
	Wrong/inappropriate treatment	9	0.3%
Treatment Total		**1928**	**56.8%**
Grand Total		**3392**	**100.0%**

**Counted by issues raised in complaint*

Table 14.3 Complaints received about registered and non-registered health care providers 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Health practitioner	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Medical practitioner	1203	65.5%	1225	65.2%	1144	61.7%	1227	68.6%
Dentist	154	8.4%	157	8.4%	172	9.3%	165	9.2%
Nurse	199	10.8%	286	15.2%	278	15.0%	154	8.6%
Psychologist	48	2.6%	43	2.3%	67	3.6%	70	3.9%
Other/unknown	82	4.5%	31	1.6%	61	3.3%	30	1.7%
Dental technician and prosthetist	16	0.9%	16	0.9%	17	0.9%	24	1.3%
Physiotherapist	16	0.9%	21	1.1%	13	0.7%	19	1.1%
Alternative health provider	0	0.0%	0	0.0%	0	0.0%	17	1.0%
Chiropractor	14	0.8%	21	1.1%	16	0.9%	17	1.0%
Pharmacist	28	1.5%	13	0.7%	21	1.1%	17	1.0%
Podiatrist	5	0.3%	10	0.5%	10	0.5%	10	0.6%
Traditional Chinese medicine	3	0.2%	5	0.3%	2	0.1%	8	0.4%
Counsellor/therapist	10	0.5%	5	0.3%	1	0.1%	7	0.4%
Optometrist	18	1.0%	7	0.4%	12	0.6%	6	0.3%
Natural therapist	3	0.2%	2	0.1%	8	0.4%	4	0.2%
Administration/clerical staff	8	0.4%	11	0.6%	0	0.0%	2	0.1%
Assistant in nursing	1	0.1%	2	0.1%	6	0.3%	2	0.1%
Naturopath	2	0.1%	3	0.2%	2	0.1%	2	0.1%
Psychotherapist	0	0.0%	0	0.0%	2	0.1%	2	0.1%
Acupuncturist	1	0.1%	4	0.2%	1	0.1%	1	0.1%
Occupational therapist	2	0.1%	1	0.1%	1	0.1%	1	0.1%
Osteopath	3	0.2%	1	0.1%	4	0.2%	1	0.1%
Previously registered medical practitioner	0	0.0%	1	0.1%	3	0.2%	1	0.1%
Social worker	9	0.5%	8	0.4%	4	0.2%	1	0.1%
Ambulance personnel	3	0.2%	1	0.1%	0	0.0%	0	0.0%
Dietitian/nutritionist	1	0.1%	0	0.0%	1	0.1%	0	0.0%
Health education officer	0	0.0%	0	0.0%	2	0.1%	0	0.0%
Optometrical dispenser	1	0.1%	0	0.0%	1	0.1%	0	0.0%
Radiographer	1	0.1%	4	0.2%	3	0.2%	0	0.0%
Residential care worker	4	0.2%	1	0.1%	2	0.1%	0	0.0%
Speech pathologist	2	0.1%	1	0.1%	0	0.0%	0	0.0%
Welfare officer	1	0.1%	0	0.0%	1	0.1%	0	0.0%
Total	**1838**	**100.0%**	**1880**	**100.0%**	**1855**	**100.0%**	**1788**	**100.0%**

**Counted by provider identified in complaint*

Table 14.4 Complaints received about registered professions by category 2005–06*

Category	Medical practitioner	Dentist	Nurse	Psychologist	Dental technician and prosthetist	Physiotherapist	Pharmacist	Chiropractor	Podiatrist	Optometrist	Osteopath	Optical dispenser
	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.
Access	63	3	1								1	
Communication	122	8	8	4	2	1		2				
Consent	28	6	2						1			
Corporate services	3							3				
Cost	69	33		1	7	3	1	2	2			
Grievances	3			1								
Privacy/discrimination	60	2	4	10				2				
Professional conduct	307	12	103	44	1	11	8	4	5	1		
Treatment	751	121	44	15	16	4	8	4	4	5		
Total	**1406**	**185**	**162**	**75**	**26**	**19**	**17**	**17**	**12**	**6**	**1**	**0**
Total practitioners registered in NSW as at 30.6.2006	**27,918**	**4,358**	**99,806**	**9,052**	**1,195**	**6,617**	**7,814**	**1,346**	**804**	**1,664**	**541**	**1,482**

**Counted by issues raised in complaint*

Table 14.5 Complaints received about non-registered professions by category 2005–06*

Category	Other/ Unknown	Alternative health provider	Traditional Chinese medicine	Counsellor/ therapist	Naturopath	Natural therapist	Psychotherapist	Acupuncturist	Administration/ clerical staff	Assistant in nursing	Occupational therapist	Previously reg'd medical practitioner	Social worker
	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.
Access	5												
Communication	2		1	2	1						1		
Consent													
Corporate services	1			1									
Cost	3			1									
Grievances	1												
Privacy/discrimination	2		7	1			1		2				
Professional conduct	6	17		2	2	3	1	1		2			1
Treatment	11			1	1	1	1	1			1	1	
Total	**31**	**17**	**8**	**8**	**4**	**4**	**3**	**2**	**2**	**2**	**2**	**1**	**1**

**Counted by issues raised in complaint*

Table 14.6 Issues raised in complaints received about health practitioners 2002–03 to 2005–06 (Medical practitioners/Nurses/Dentists)*

	2002–03		2003–04		2004–05		2005–06	
Medical practitioner	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Access	65	5.4%	77	6.3%	59	4.7%	63	4.5%
Communication	173	14.4%	164	13.4%	148	11.8%	122	8.7%
Consent	36	3.0%	30	2.4%	40	3.2%	28	2.0%
Corporate services	34	2.8%	20	1.6%	12	1.0%	3	0.2%
Cost	60	5.0%	54	4.4%	67	5.4%	69	4.9%
Grievances	2	0.2%	12	1.0%	2	0.2%	3	0.2%
Miscellaneous	4	0.3%	50	4.1%	2	0.2%	0	0.0%
Privacy/discrimination	46	3.8%	37	3.0%	50	4.0%	60	4.3%
Professional conduct	252	20.9%	233	19.0%	251	20.1%	307	21.8%
Treatment	531	44.1%	548	44.7%	618	49.5%	751	53.4%
Total	**1203**	**100.0%**	**1225**	**100.0%**	**1249**	**100.0%**	**1406**	**100.0%**

	2002–03		2003–04		2004–05		2005–06	
Dentist	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Access	2	1.3%	5	3.2%	4	2.1%	3	1.6%
Communication	8	5.1%	9	5.7%	18	9.4%	8	4.3%
Consent	2	1.3%	3	1.9%	8	4.2%	6	3.3%
Corporate services	3	1.9%	2	1.3%	2	1.0%	0	0.0%
Cost	20	12.8%	26	16.6%	32	16.7%	33	17.9%
Grievances	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Miscellaneous	0	0.0%	10	6.4%	8	4.2%	0	0.0%
Privacy/discrimination	0	0.0%	2	1.3%	1	0.5%	2	1.1%
Professional conduct	5	3.2%	5	3.2%	20	10.4%	12	6.5%
Treatment	116	74.4%	95	60.5%	99	51.6%	121	65.2%
Total	**156**	**100.0%**	**157**	**100.0%**	**192**	**100.0%**	**185**	**100.0%**

	2002–03		2003–04		2004–05		2005–06	
Nurse	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Access	12	5.6%	15	5.2%	6	2.1%	1	0.6%
Communication	26	12.2%	15	5.2%	12	4.2%	8	4.9%
Consent	2	0.9%	4	1.4%	3	1.0%	2	1.2%
Corporate services	25	11.7%	10	3.5%	2	0.7%	0	0.0%
Cost	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Grievances	1	0.5%	3	1.0%	2	0.7%	0	0.0%
Miscellaneous	1	0.5%	17	5.9%	9	3.1%	0	0.0%
Privacy/discrimination	5	2.3%	6	2.1%	6	2.1%	4	2.5%
Professional conduct	72	33.8%	101	35.3%	173	60.3%	103	63.6%
Treatment	69	32.4%	115	40.2%	74	25.8%	44	27.2%
Total	**213**	**100.0%**	**286**	**100.0%**	**287**	**100.0%**	**162**	**100.0%**

**Counted by issues raised in complaint*

Table 14.7 Complaints received about health organisations 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Facility	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Public hospital	389	44.4%	480	51.6%	448	46.6%	538	43.4%
Justice Health	31	3.5%	29	3.1%	51	5.3%	131	10.6%
Private hospital	67	7.6%	58	6.2%	75	7.8%	73	5.9%
Nursing home	45	5.1%	37	4.0%	42	4.4%	67	5.4%
Pharmacy	12	1.4%	36	3.9%	43	4.5%	63	5.1%
Area Health Service	24	2.7%	19	2.0%	31	3.2%	61	4.9%
Medical centre	33	3.8%	39	4.2%	32	3.3%	61	4.9%
Community health service	30	3.4%	33	3.5%	42	4.4%	40	3.2%
Other	47	5.4%	26	2.8%	52	5.4%	34	2.7%
Dental unit, public	8	0.9%	7	0.8%	14	1.5%	30	2.4%
Radiology practice	16	1.8%	14	1.5%	14	1.5%	24	1.9%
Ambulance service	17	1.9%	15	1.6%	14	1.5%	22	1.8%
Private medical practice	9	1.0%	7	0.8%	25	2.6%	19	1.5%
Pathology centres/labs	18	2.1%	13	1.4%	6	0.6%	18	1.5%
Dental surgery, private	0	0.0%	2	0.2%	10	1.0%	12	1.0%
Optometrist practice	5	0.6%	3	0.3%	15	1.6%	8	0.6%
Psychiatric hospital	62	7.1%	34	3.7%	5	0.5%	8	0.6%
Physiotherapy clinic	2	0.2%	1	0.1%	2	0.2%	5	0.4%
Group home, mental health	1	0.1%	1	0.1%	2	0.2%	4	0.3%
College/Association	0	0.0%	0	0.0%	1	0.1%	3	0.2%
Hostel, aged	7	0.8%	6	0.6%	1	0.1%	3	0.2%
Day procedure centre	13	1.5%	9	1.0%	2	0.2%	2	0.2%
Methadone clinic	5	0.6%	1	0.1%	2	0.2%	2	0.2%
Public developmental disability hospital	0	0.0%	0	0.0%	1	0.1%	2	0.2%
Tribunal	0	0.0%	0	0.0%	1	0.1%	2	0.2%
Women's health centre	2	0.2%	1	0.1%	3	0.3%	2	0.2%
Alternative health service	2	0.2%	1	0.1%	2	0.2%	1	0.1%
Chiropractic practice	1	0.1%	0	0.0%	1	0.1%	1	0.1%
Drug and alcohol service	1	0.1%	2	0.2%	6	0.6%	1	0.1%
Group home, developmental disability	0	0.0%	0	0.0%	1	0.1%	1	0.1%
Health fund, public	1	0.1%	11	1.2%	0	0.0%	1	0.1%
Blood bank	0	0.0%	0	0.0%	2	0.2%	0	0.0%
Boarding house	2	0.2%	1	0.1%	1	0.1%	0	0.0%
Department of Health	8	0.9%	29	3.1%	0	0.0%	0	0.0%
Domestic residence	1	0.1%	0	0.0%	0	0.0%	0	0.0%
Early childhood clinic	2	0.2%	0	0.0%	1	0.1%	0	0.0%
Family planning clinic	1	0.1%	1	0.1%	0	0.0%	0	0.0%
Health fund, private	1	0.1%	3	0.3%	6	0.6%	0	0.0%
Hostel, other	2	0.2%	2	0.2%	0	0.0%	0	0.0%
Men's health clinic	3	0.3%	6	0.6%	0	0.0%	0	0.0%
Multi purpose service	0	0.0%	0	0.0%	1	0.1%	0	0.0%
Nursing agency, district/community	4	0.5%	0	0.0%	4	0.4%	0	0.0%
Private psychiatric hospital	2	0.2%	4	0.4%	0	0.0%	0	0.0%
Registration authorities	0	0.0%	0	0.0%	1	0.1%	0	0.0%
Sexual assault	1	0.1%	0	0.0%	1	0.1%	0	0.0%
Waiting lists	1	0.1%	0	0.0%	0	0.0%	0	0.0%
Total	**876**	**100.0%**	**931**	**100.0%**	**961**	**100.0%**	**1239**	**100.0%**

**Counted by provider identified in complaint*

Table 14.8 Complaints received about public and private hospitals analysed by service area 2005–06*

Service Area	Public		Private		Total	
	No.	%	No.	%	No.	%
Accident and emergency	103	18.8%	4	5.5%	107	17.2%
Administration, general	3	0.5%			3	0.5%
Administration, medical records	1	0.2%			1	0.2%
Ambulance	1	0.2%			1	0.2%
Anaesthesia, other	1	0.2%			1	0.2%
Cardiology	3	0.5%	2	2.7%	5	0.8%
Community health	2	0.4%			2	0.3%
Dentistry	1	0.2%			1	0.2%
Drug and alcohol services	1	0.2%	1	1.4%	2	0.3%
Drugs, administration	1	0.2%	1	1.4%	2	0.3%
Drugs, dispensing	2	0.4%			2	0.3%
Gastronenterology	2	0.4%			2	0.3%
General medicine	196	35.8%	28	38.4%	224	36.1%
General practice	3	0.5%			3	0.5%
Gynaecology	1	0.2%	1	1.4%	2	0.3%
Intensive care	5	0.9%	1	1.4%	6	1.0%
Mental health	67	12.2%	3	4.1%	70	11.3%
Midwifery	8	1.5%			8	1.3%
Non health related	9	1.6%	4	5.5%	13	2.1%
Nutrition and dietetics	1	0.2%			1	0.2%
Obstetrics	28	5.1%	3	4.1%	31	5.0%
Oncology, medical	7	1.3%			7	1.1%
Other/unknown	26	4.7%	4	5.5%	30	4.8%
Paediatric medicine	8	1.5%			8	1.3%
Palliative care	5	0.9%	1	1.4%	6	1.0%
Pathology	2	0.4%			2	0.3%
Personal care	1	0.2%	2	2.7%	3	0.5%
Pharmacy	1	0.2%			1	0.2%
Physiotherapy	2	0.4%			2	0.3%
Podiatry			1	1.4%	1	0.2%
Psychiatry	3	0.5%			3	0.5%
Public health	13	2.4%	2	2.7%	15	2.4%
Radiography	1	0.2%	1	1.4%	2	0.3%
Radiology	3	0.5%	1	1.4%	4	0.6%
Renal medicine	1	0.2%			1	0.2%
Sexual assault service	1	0.2%			1	0.2%
Social and welfare service	1	0.2%			1	0.2%
Surgery	31	5.7%	13	17.8%	44	7.1%
Urology	2	0.4%			2	0.3%
Waiting lists	1	0.2%			1	0.2%
Total	**548**	**100.0%**	**73**	**100.0%**	**621**	**100.0%**

**Counted by provider identified in complaint*

Table 14.9 Complaints received about public hospitals by Area Health Service 2002–03 to 2005–06*

Area Health Service	2002-03		2003-04		2004-05		2005-06		2005-06		
	No.	%	No.	%	No.	%	No.	%	Separations	Non-Admitted Patient Services	Emergency Dep't Attendances
Greater Southern	42	9.3%	36	7.0%	17	3.7%	21	3.8%	100,935	2,103,004	248,595
Greater Western	13	2.9%	14	2.7%	35	7.7%	37	6.8%	83,881	1,162,902	220,436
Hunter/New England	27	6.0%	48	9.3%	44	9.7%	61	11.1%	182,593	2,670,854	323,526
Interstate/Other**	2	0.4%	3	0.6%	2	0.4%	1	0.2%	N/A	N/A	N/A
North Coast	44	9.8%	41	8.0%	41	9.0%	50	9.1%	136,970	1,847,543	276,952
Northern Sydney/Central Coast	59	13.1%	77	15.0%	63	13.9%	72	13.1%	188,876	3,038,435	221,823
South Eastern Sydney/Illawarra	102	22.6%	79	15.4%	91	20.0%	104	19.0%	276,933	4,825,626	341,808
Sydney South West	78	17.3%	131	25.5%	86	18.9%	106	19.3%	281,065	4,142,227	298,203
Sydney West	84	18.6%	85	16.5%	75	16.5%	96	17.5%	228,133	4,072,994	263,772
Total	**451**	**100.0%**	**514**	**100.0%**	**454**	**100.0%**	**548**	**100.0%**	**1,479,386**	**23,863,584**	**2,195,115**

Includes Public Developmental Disability hospitals and Psychiatric hospitals.
**Counted by provider identified in complaint*

Table 14.10 Issues raised in complaints received about public and private health organisations by facility type 2005–06*

Facility Type	Health Organisation	Access	Communication	Consent	Corporate Services	Cost	Grievances	Privacy/ Discrimination	Professional Conduct	Treatment	Grand Total
Private	Alternative health service								1		1
	Chiropractic practice									1	1
	College/association								1		1
	Day procedure centre			1		1					2
	Dental surgery, private	2				6			1	3	12
	Drug and alcohol service									1	1
	Hostel, aged									3	3
	Medical centre	10	2	2	1	7		10	6	17	55
	Medical practice	1	1			5		1	2	9	19
	Nursing home	2	7	1	3	1	2	1	2	50	69
	Optometrist practice	1	1			1				6	9
	Pathology centres/labs		2			6				8	16
	Pharmacy	2	2		2	2		1		55	64
	Physiotherapy clinic				1	3			1		5
	Private hospital	1	9		2	6		1	3	59	81
	Radiology practice		4			6		2	8	5	25
	Women's health centre							1			1
Private Total		**19**	**28**	**4**	**9**	**44**	**2**	**17**	**25**	**217**	**365**
Public	Ambulance service	6	3			2			1	10	22
	Area Health Service	8	5	1		2	1	5	6	41	69
	College/association								3	2	5
	Community health service	8	4	1					1	31	45
	Dental unit, public	7	6						1	17	31
	Group home, developmental disablility									2	2
	Group home, mental health	1								4	5
	Health fund					1					1
	Medical centre	3	1		1				1	3	9
	Medical practice			1						2	3
	Methadone clinic									2	2
	Nursing home			1					3	6	10
	Pathology centres/labs							1			1
	Prison medical service	40	4		1		1			92	138
	Psychiatric hospital	1					1			7	9
	Public developmental disability hospital									2	2
	Public hospital	56	52	11	5	6	1	7	14	463	615
	Radiology practice					1				1	2
	Tribunal									2	2
	Women's health centre									1	1
Public Total		**130**	**75**	**15**	**7**	**12**	**4**	**13**	**30**	**688**	**974**
Grand Total		**149**	**103**	**19**	**16**	**56**	**6**	**30**	**55**	**905**	**1339**

**Counted by issues raised in complaint*

Table 14.11 Issues raised in all complaints received by area of practice*

Service Area	Access	Communication	Consent	Corporate services	Cost	Grievances	Privacy/ discrimination	Professional conduct	Treatment	Grand Total	
Accident and emergency	19	18	1				1	5	114	158	4.66%
Administration, general	2	1			5		3		1	12	0.35%
Administration, medical records							2	3		5	0.15%
Alternative health		1						28	3	32	0.94%
Ambulance	4	3			1			1	10	19	0.56%
Anaesthesia, other		1			5			3	11	20	0.59%
Cardiology		1			1			3	13	18	0.53%
Chiropractic		1	1	3	3		2	4	5	19	0.56%
Community health	6	2		1				8	20	37	1.09%
Counselling		1			1		1	1	1	5	0.15%
Dentistry	15	14	6		42		2	15	158	252	7.43%
Dermatology	1	6						4	11	22	0.65%
Developmental disability								1		1	0.03%
Drug and alcohol services	1	1			1				5	8	0.24%
Drugs, administration		1						2	4	7	0.21%
Drugs, dispensing								1	26	27	0.80%
Drugs, prescribing								5	13	18	0.53%
Endocrinology									1	1	0.03%
Gastroenterology		1							7	8	0.24%
General medicine	28	49	14	4	19	1	9	87	449	660	19.46%
General practice (including medical centre)	47	54	11	1	27	1	41	142	320	644	18.99%
Gerontology		1						1	1	3	0.09%
Gynaecology	1	3					2		16	22	0.65%
Haematology (clinical)		1							1	2	0.06%
Immunology (clinical), allergy									1	1	0.03%
Immunology (clinical), other								1		1	0.03%
Intensive care			1						7	8	0.24%
Justice Health	34	3		1		1	1	1	83	124	3.66%
Mental health	11	12	1			1	6	18	150	199	5.87%
Midwifery		6					1	1	11	19	0.56%
Neurology								1	6	7	0.21%
Neurophysiology									1	1	0.03%
Non health related	4	10	1	5	21		4	66	17	128	3.77%
Nutrition and dietetics									1	1	0.03%
Obstetrics	3	7	2		1			4	49	66	1.95%
Occupational therapy		1							1	2	0.06%
Oncology, medical		2			1				12	15	0.44%
Oncology, radiation			1						1	2	0.06%
Opthalmology		1						2	8	11	0.32%
Optometry	1	1			1			2	9	14	0.41%

*Counted by issues raised in complaint

Table 14.11 Issues raised in all complaints received by area of practice (continued)*

Service Area	Access	Communication	Consent	Corporate services	Cost	Grievances	Privacy/ discrimination	Professional conduct	Treatment	Grand Total	
Osteopathy	1							1		2	0.06%
Other	20	29	5	5	16	6	16	89	85	271	7.99%
Paediatric medicine	2	4	1	1				1	12	21	0.62%
Palliative care	3	2	1				1	2	21	30	0.88%
Pathology	1				2		1	1	10	15	0.44%
Personal care		1					1		6	8	0.24%
Pharmacy	1	1		1	2		1	5	45	56	1.65%
Physiotherapy	1	2		1	5			12	3	24	0.71%
Podiatry	1				2			1	3	7	0.21%
Private practice					1				3	4	0.12%
Prosthetics and orthotics		1						1	5	7	0.21%
Psychiatry	2	1					7	8	21	39	1.15%
Psychogeriatrics								1	1	2	0.06%
Psychology		2				1	9	32	10	54	1.59%
Psychotherapy							1	1	2	4	0.12%
Public health	2			1	1			1	12	17	0.50%
Radiography		1			1		2	1	1	6	0.18%
Radiology	1	5	1		6		1	7	18	39	1.15%
Renal medicine									1	1	0.03%
Respiratory									1	1	0.03%
Rheumatology								1		1	0.03%
Sexual assault service								1	1	2	0.06%
Sexual health					1				3	4	0.12%
Social and welfare work		1						2		3	0.09%
Surgery	6	9	8	0	10	0	0	13	110	156	4.60%
Therapy					1			1	1	3	0.09%
Urology	2	1	1		1			1	6	12	0.35%
Waiting lists	4									4	0.12%
Grand Total	**224**	**263**	**56**	**24**	**178**	**11**	**115**	**593**	**1928**	**3392**	**100.00%**

**Counted by issues raised in complaint*

Table 14.12 Source of complaints 2002–03 to 2005–06*								
	2002–03		2003–04		2004–05		2005–06	
Source	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Consumer	1131	54.1%	1041	48.8%	1085	47.6%	1256	48.8%
Family or friend	245	11.7%	311	14.6%	439	19.3%	563	21.9%
Registration authority	443	21.2%	458	21.5%	463	20.3%	486	18.9%
Health professional	24	1.1%	29	1.4%	54	2.4%	66	2.6%
Parliament/Minister	41	2.0%	49	2.3%	44	1.9%	39	1.5%
Department of Health (C'wlth/State)	67	3.2%	132	6.2%	57	2.5%	42	1.6%
Legal representative	29	1.4%	21	1.0%	19	0.8%	30	1.2%
Government department	61	2.9%	46	2.2%	45	2.0%	25	1.0%
Other	11	0.5%	26	1.2%	38	1.7%	23	0.9%
Consumer organisation	21	1.0%	9	0.4%	16	0.7%	19	0.7%
Courts	7	0.3%	6	0.3%	14	0.6%	15	0.6%
Professional association	2	0.1%	1	0.0%	4	0.2%	7	0.3%
Non-government organisation	10	0.5%	5	0.2%	0	0.0%	2	0.1%
Total	**2092**	**100.0%**	**2134**	**100.0%**	**2278**	**100.0%**	**2573**	**100.0%**

**Counted by complainant*

Table 14.13 Assessment decision of complaints finalised 2002–03 to 2005–06*								
	2002–03		2003–04		2004–05		2005–06	
Assessment decision	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Discontinue	539	19.9%	656	23.5%	886	35.7%	1471	43.4%
Assisted Resolution	256	9.5%	493	17.6%	340	13.7%	593	17.5%
Referred to Registration authority	453	16.7%	483	17.3%	459	18.5%	512	15.1%
Investigation by Commission	234	8.7%	454	16.2%	455	18.3%	373	11.0%
Referred for conciliation	208	7.7%	171	6.1%	150	6.0%	186	5.5%
Resolved during assessment	0	0.0%	0	0.0%	45	1.8%	150	4.4%
Refer to another body or person	197	7.3%	132	4.7%	59	2.4%	74	2.2%
Local Resolution	360	13.3%	58	2.1%	0	0.0%	33	1.0%
Referred to AHS/District	458	16.9%	348	12.5%	86	3.5%	0	0.0%
Total	**2705**	**100.0%**	**2795**	**100.0%**	**2480**	**100.0%**	**3392**	**100.0%**

**Counted by provider identified in complaint*

Table 14.14 Outcome of complaints assessed and issues identified in complaint*

Category	Issue name	Conciliation No.	Discontinue No.	Investigation No.	Refer to another body No.	Refer to registration authority No.	Resolution No.	Resolved during assessment process No.	Grand Total No.	Grand Total %
Access	Attendance	1	6			1	1		9	0.23%
	Delay in admission or treatment	4	51	4	2	4	46	15	126	3.24%
	Discharge or transfer arrangements	3	3		1		7	1	15	0.39%
	Referral		4				2		6	0.15%
	Refusal to admit or treat		58	1	2	5	20	2	88	2.27%
	Service availability		9				13	2	24	0.62%
	Waiting lists		1	1			2		4	0.10%
Access Total		**8**	**132**	**6**	**5**	**10**	**91**	**20**	**272**	**7.00%**
Communication	Attitude	6	118	13	2	30	55	6	230	5.92%
	Inadequate information	3	16	2		4	17	3	45	1.16%
	Interpreter/special needs services		1						1	0.03%
	Wrong/misleading information	3	17	2	1	4	4		31	0.80%
Communication Total		**12**	**152**	**17**	**3**	**38**	**76**	**9**	**307**	**7.90%**
Consent	Consent Invalid		8				2		10	0.26%
	Consent not informed/failure to warn	3	10	1		2	4	1	21	0.54%
	Consent not obtained	2	19			5	7	1	34	0.88%
	Failure to consult consumer	1	1			1			3	0.08%
	Involuntary admission		2				1		3	0.08%
Consent Total		**6**	**40**	**1**		**8**	**14**	**2**	**71**	**1.83%**
Corporate services	Administrative services		4		1	2	4	1	12	0.31%
	Hotel services		6		1		1	1	9	0.23%
	Hygiene/environmental standards	1	7	1		1	1	1	12	0.31%
Corporate services Total		**1**	**17**	**1**	**2**	**3**	**6**	**3**	**33**	**0.85%**
Cost	Billing practices	4	69	5	5	16	21	28	148	3.81%
	Government subsidies		1						1	0.03%
	Information on costs		30	1		6	8	6	51	1.31%
	Overcharging	1	14			3		1	19	0.49%
	Private health insurance		1				1		2	0.05%
	Public/private election							1	1	0.03%
Cost Total		**5**	**115**	**6**	**5**	**25**	**30**	**36**	**222**	**5.72%**
Grievances	Inadequate/no response to complaint		3		1	1	6		11	0.28%
	Reprisal/retaliation		3			1			4	0.10%
Grievances Total			**6**		**1**	**2**	**6**		**15**	**0.39%**

**Counted by issues raised in complaint*

Table 14.14 Outcome of complaints assessed and issues identified in complaint (continued)*

Category	Issue name	Conciliation No.	Discontinue No.	Investigation No.	Refer to another body No.	Refer to registration authority No.	Resolution No.	Resolved during assessment process No.	Grand Total No.	Grand Total %
Privacy/discrimination	Access to records		25	1	1	3	15	18	63	1.62%
	Discrimination		4	1		1			6	0.15%
	Discrimination public/private		1				1		2	0.05%
	Inconsiderate service		3						3	0.08%
	Privacy/confidentiality	4	42	1	1	13	9	2	72	1.85%
Privacy/discrimination Total		**4**	**75**	**3**	**2**	**17**	**25**	**20**	**146**	**3.76%**
Professional conduct	Accuracy/inadequacy of records	2	15	1		2	1	1	22	0.57%
	Assault	2	10	1	1	3	3		20	0.51%
	Breach of conditions		6	4		4	14			
	Certificates/reports	1	108	5	1	19	8	12	154	3.96%
	Competence	7	67	34	7	65	10	1	191	4.92%
	Financial fraud		7	3	1	7			18	0.46%
	Illegal practices		32	57	9	39	2	3	142	3.66%
	Impairment		1	11	6	28			46	1.18%
	Sexual misconduct		12	40		4		1	57	1.47%
Professional conduct Total		**12**	**258**	**156**	**25**	**171**	**24**	**18**	**664**	**17.10%**
Treatment	Co-ordination of treatment		3	3			2		8	0.21%
	Diagnosis	24	126	32		23	39	1	245	6.31%
	Inadequate treatment	138	580	191	25	191	328	50	1503	38.70%
	Infection control	2	26			5	8		41	1.06%
	Medication	8	138	15	15	75	54	8	313	8.06%
	Negligent treatment		1	1					2	0.05%
	Rough/painful treatment		7			6			13	0.33%
	Withdrawal/denial of treatment						3		3	0.08%
	Wrong/inappropriate treatment	1	11	4		6	4		26	0.67%
Treatment Total		**173**	**892**	**246**	**40**	**306**	**438**	**59**	**2154**	**55.46%**
Grand Total		**221**	**1687**	**436**	**83**	**580**	**710**	**167**	**3884**	**100.00%**

**Counted by issues raised in complaint*

Table 14.15 Category of complaints assessed and discontinued 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	171	31.7%	181	27.6%	365	40.1%	892	52.9%
Professional conduct	147	27.3%	148	22.6%	163	17.9%	258	15.3%
Communication	69	12.8%	79	12.0%	117	12.9%	152	9.0%
Access	20	3.7%	48	7.3%	59	6.5%	132	7.8%
Cost	35	6.5%	40	6.1%	68	7.5%	115	6.8%
Privacy/discrimination	27	5.0%	22	3.4%	41	4.5%	75	4.4%
Consent	6	1.1%	16	2.4%	23	2.5%	40	2.4%
Corporate services	53	9.8%	65	9.9%	59	6.5%	17	1.0%
Grievances	8	1.5%	16	2.4%	6	0.7%	6	0.4%
Miscellaneous	3	0.6%	41	6.3%	9	1.0%	0	0.0%
Total	**539**	**100.0%**	**656**	**100.0%**	**910**	**100.0%**	**1687**	**100.0%**

**Counted by issues raised in complaint*

Table 14.16 Category of complaints assessed for assisted resolution 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	85	33.2%	163	33.1%	186	44.8%	419	62.0%
Access	27	10.5%	73	14.8%	50	12.0%	87	12.9%
Communication	53	20.7%	78	15.8%	44	10.6%	70	10.4%
Cost	26	10.2%	38	7.7%	36	8.7%	28	4.1%
Professional conduct	17	6.6%	41	8.3%	31	7.5%	24	3.6%
Privacy/discrimination	16	6.3%	22	4.5%	22	5.3%	24	3.6%
Consent	6	2.3%	13	2.6%	17	4.1%	14	2.1%
Grievances	3	1.2%	9	1.8%	6	1.4%	6	0.9%
Corporate services	22	8.6%	41	8.3%	18	4.3%	4	0.6%
Miscellaneous	1	0.4%	15	3.0%	5	1.2%	0	0.0%
Total	**256**	**100.0%**	**493**	**100.0%**	**415**	**100.0%**	**676**	**100.0%**

**Counted by issues raised in complaint*

Table 14.17 Category of complaints referred to another body or person for action 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	468	42.8%	433	45.0%	297	0.5%	346	52.2%
Professional Conduct	149	13.7%	143	14.8%	151	0.2%	196	29.6%
Communication	101	9.2%	91	9.4%	68	0.1%	41	6.2%
Cost	20	1.8%	33	3.4%	26	0.0%	30	4.5%
Privacy/Discrimination	30	2.7%	23	2.4%	16	0.0%	19	2.9%
Access	104	9.5%	87	9.0%	20	0.0%	15	2.3%
Consent	35	3.2%	22	2.3%	10	0.0%	8	1.2%
Corporate Services	182	16.3%	90	9.3%	29	0.0%	5	0.8%
Grievances	1	0.1%	6	0.6%	1	0.0%	3	0.5%
Miscellaneous	7	0.6%	35	3.6%	12	0.0%	0	0.0%
Total	**1097**	**100.0%**	**963**	**100.0%**	**630**	**100.0%**	**663**	**100.0%**

**Counted by issues raised in complaint*

Table 14.18 Category of complaints assessed for investigation 2002–03 to 2005–06*								
	2002–03		2003–04		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	85	36.3%	264	58.1%	195	48.6%	246	56.4%
Professional conduct	94	40.2%	119	26.2%	170	42.4%	156	35.8%
Communication	7	3.0%	9	2.0%	6	1.5%	17	3.9%
Cost	2	0.9%	3	0.7%	0	0.0%	6	1.4%
Access	12	5.1%	18	4.0%	13	3.2%	6	1.4%
Privacy/discrimination	1	0.4%	4	0.9%	2	0.5%	3	0.7%
Consent	6	2.6%	6	1.3%	0	0.0%	1	0.2%
Corporate services	22	9.4%	26	5.7%	11	2.7%	1	0.2%
Miscellaneous	5	2.1%	4	0.9%	4	1.0%	0	0.0%
Grievances	0	0.0%	1	0.2%	0	0.0%	0	0.0%
Total	**234**	**100.0%**	**454**	**100.0%**	**401**	**100.0%**	**436**	**100.0%**

**Counted by issues raised in complaint*

Table 14.19 Category of complaints assessed for conciliation 2002–03 to 2005–06*								
	2002–03		2003–04		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	119	57.2%	87	50.9%	90	55.2%	173	78.3%
Communication	25	12.0%	27	15.8%	25	15.3%	12	5.4%
Professional conduct	2	1.0%	4	2.3%	10	6.1%	12	5.4%
Access	17	8.2%	15	8.8%	15	9.2%	8	3.6%
Consent	7	3.4%	4	2.3%	8	4.9%	6	2.7%
Cost	5	2.4%	1	0.6%	2	1.2%	5	2.3%
Privacy/discrimination	5	2.4%	0	0.0%	0	0.0%	4	1.8%
Corporate services	28	13.5%	20	11.7%	11	6.7%	1	0.5%
Grievances	0	0.0%	2	1.2%	0	0.0%	0	0.0%
Miscellaneous	0	0.0%	11	6.4%	2	1.2%	0	0.0%
Total	**208**	**100.0%**	**171**	**100.0%**	**163**	**100.0%**	**221**	**100.0%**

**Counted by issues raised in complaint*

Table 14.20 Category of complaints resolved during assessment process 2005–06*

	2002–03**		2003–04**		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	N/A		N/A		24	47.1%	59	35.3%
Cost					4	7.8%	36	21.6%
Access					7	13.7%	20	12.0%
Privacy/Discrimination					1	2.0%	20	12.0%
Professional Conduct					2	3.9%	18	10.8%
Communication					6	11.8%	9	5.4%
Corporate Services					3	5.9%	3	1.8%
Consent					2	3.9%	2	1.2%
Grievances					2	3.9%	0	0.0%
Total					**51**	**100.0%**	**167**	**100.0%**

**Counted by issues raised in complaint*
***Figures are not available prior to 2004–05 as this was not an initative prior to 2004*

Table 14.21 Category of complaints assessed for direct and assisted resolution 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	245	39.8%	163	33.1%	120	38.0%	438	61.7%
Access	57	9.3%	73	14.8%	42	13.3%	91	12.8%
Communication	113	18.4%	78	15.8%	39	12.3%	76	10.7%
Cost	61	9.9%	38	7.7%	29	9.2%	30	4.2%
Privacy/discrimination	29	4.7%	22	4.5%	22	7.0%	25	3.5%
Professional conduct	35	5.7%	41	8.3%	26	8.2%	24	3.4%
Consent	20	3.3%	13	2.6%	17	5.4%	14	2.0%
Corporate services	46	7.5%	41	8.3%	16	5.1%	6	0.8%
Grievances	7	1.1%	9	1.8%	1	0.3%	6	0.8%
Miscellaneous	2	0.3%	15	3.0%	4	1.3%	0	0.0%
Total	**615**	**100.0%**	**493**	**100.0%**	**316**	**100.0%**	**710**	**100.0%**

**Counted by issues raised in complaint*

Table 14.22 Complaints referred to another body 2002–03 to 2005–06 by the type of body referred to*								
	2002–03		2003–04		2004–05		2005–06	
Body referred to	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Registration Board	453	41.3%	483	50.2%	482	76.5%	580	87.5%
Other body	63	5.7%	66	6.9%	22	3.5%	37	5.6%
Other Commonwealth government body	8	0.7%	13	1.3%	8	1.3%	24	3.6%
Other government department	99	9.0%	40	4.2%	4	0.6%	22	3.3%
AHS	458	41.8%	348	36.1%	94	14.9%	0	0.0%
Director-General	6	0.5%	7	0.7%	19	3.0%	0	0.0%
Private Health Insurance Commission	8	0.7%	5	0.5%	0	0.0%	0	0.0%
Private health provider	2	0.2%	1	0.1%	1	0.2%	0	0.0%
Total	**1097**	**100.0%**	**963**	**100.0%**	**630**	**100.0%**	**663**	**100.0%**

**Counted by issues raised in complaint*

APPENDIX B

Statistics

Table 14.23 Outcome of complaints assessed and by area of practice*

Service Area	Investigation No.	Conciliation No.	Resolution No.	Resolved during assessment No.	Refer to registration authority No.	Refer to another body No.	Discontinue No.	Grand Total No.	Grand Total %
Accident and emergency	39	23	44	5	2	1	49	163	4.81%
Administration, general			5	1		2	5	13	0.38%
Administration, medical records				1	1		7	9	0.27%
Alternative health	26	1			1		6	34	1.00%
Ambulance		2	7	4			9	22	0.65%
Anaesthesia, other	1	1	4	1	1		10	18	0.53%
Autopsy							1	1	0.03%
Cardiology	8	3	2	1	1		7	22	0.65%
Chiropractic	3	2		2	9	1	5	22	0.65%
Community health	2	2	11	4		2	18	39	1.15%
Counselling					2		7	9	0.27%
Dentistry	1	6	41	15	130	4	77	274	8.08%
Dermatology	5				4		8	17	0.50%
Developmental disability	1				3			4	0.12%
Drug and alcohol services	2		4			1	4	11	0.32%
Drugs, administration	2		1		1			4	0.12%
Drugs, dispensing	2		2		17	1	3	25	0.74%
Drugs, prescribing	2		1		1	3	6	13	0.38%
Endocrinology							1	1	0.03%
Gastroenterology	4	1	3				1	9	0.27%
General medicine	73	56	119	20	60	8	277	613	18.07%
General practice (inc. Medical centre)	53	20	70	24	98	12	339	616	18.16%
Gerontology			3	1		2	8	14	0.41%
Gynaecology	1		7		2		12	22	0.65%
Haematology (clinical)			1				2	3	0.09%
Immunology (clinical), allergy			1					1	0.03%
Immunology (clinical), other					1			1	0.03%
Infectious diseases							2	2	0.06%
Intensive care	6	2	2				1	11	0.32%
Justice Health	1		27	18	1	1	73	121	3.57%
Mental health	10	9	72	3	6		107	207	6.10%
Midwifery	4	2	5		2		6	19	0.56%
Neurology	3		8				6	17	0.50%
Non health related	10	1	9	4	36	5	49	114	3.36%
Nutrition and dietetics			1					1	0.03%
Obstetrics	12	10	18	2	2		13	57	1.68%
Occupational health					1			1	0.03%
Occupational therapy							1	1	0.03%

*Counted by provider identified in complaint

Table 14.23 Outcome of complaints assessed and by area of practice (continued)*

Service Area	Investigation No.	Conciliation No.	Resolution No.	Resolved during assessment No.	Refer to registration authority No.	Refer to another body No.	Discontinue No.	Grand Total No.	Grand Total %
Oncology, medical	1	4	5		1		8	19	0.56%
Oncology, radiation	1						2	3	0.09%
Opthalmology	2	1	1		2		8	14	0.41%
Optometry			5	1	4		3	13	0.38%
Osteopathy					1		1	2	0.06%
Other	23	5	32	10	33	20	115	238	7.02%
Paediatric medicine	6	4	3	1			6	20	0.59%
Palliative care	4	3	9	1		1	12	30	0.88%
Pathology	2	2	2	2			8	16	0.47%
Personal care	1	1	2				4	8	0.24%
Pharmacology (clinical)		1						1	0.03%
Pharmacy	3	1	3	2	45	4	6	64	1.89%
Physiotherapy	5		3	2	3		17	30	0.88%
Podiatry		1	2	1			3	7	0.21%
Private practice	2		1	1			4	8	0.24%
Prosthetics and orthotics			3		2	1	1	7	0.21%
Psychiatry	1	2	11	2	3	1	31	51	1.50%
Psychogeriatrics	1					1	1	3	0.09%
Psychology	10		1		24	1	16	52	1.53%
Psychotherapy		1			1		2	4	0.12%
Public health	4	4	6	2		1	8	25	0.74%
Radiography			4	2		1	4	11	0.32%
Radiology	6		8	9			14	37	1.09%
Rehabilitation medicine			1				3	4	0.12%
Renal medicine	1							1	0.03%
Reproductive medicine	1							1	0.03%
Respiratory							1	1	0.03%
Rheumatology							1	1	0.03%
Sexual assault service		1					1	2	0.06%
Sexual health	3			2			2	7	0.21%
Social and welfare work	1			1			2	4	0.12%
Surgery	23	13	51	5	11		57	160	4.72%
Therapy		1					3	4	0.12%
Urology	1		2				6	9	0.27%
Waiting lists			3				1	4	0.12%
Grand Total	**373**	**186**	**626**	**150**	**512**	**74**	**1471**	**3392**	**100.00%**

**Counted by provider identified in complaint*

Table 14.24 Complaint assessment performance*

	2002–03	2003–04	2004–05	2005–06
Percentage of complaints assessed within 60 days	99.7%	92.3%	87.7%	55.6%
Average days to finalise non-investigation complaints	39 days	39 days	25 days	61 days

**Counted by provider identified in complaint*

Table 14.25 Requests for assessment reviews 2002–03 to 2005–06*

	2002–03	2003–04	2004–05	2005–06
	No.	No.	No.	No.
Requests for review	149	225	256	393
Total	**149**	**225**	**256**	**393**

**Counted by provider identified in complaint*

Table 14.26 Outcome of assessment reviews 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Review result	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Orginal assessment decision upheld	122	83.6%	54	47.4%	293	94.8%	345	89.8%
Assessment decision varied	24	16.4%	60	52.6%	16	5.2%	39	10.2%
Total	**146**	**100.0%**	**114**	**100.0%**	**309**	**100.0%**	**384**	**100.0%**

**Counted by provider identified in complaint*

Table 14.27 Resolution Service outcomes 2005–06*

	2005–06	
Outcome	**Count**	**%**
Resolved	256	47.7%
Partially resolved	138	25.7%
Not resolved	58	10.8%
Unable to be resolved	34	6.3%
Complainant pursued with Commission's assessment/review process	27	5.0%
Complainant pursued with legal advisor	9	1.7%
Complainant pursued with other	7	1.3%
Complainant pursued with other government body	7	1.3%
Complainant pursued with health facility/provider	1	0.2%
Total	**537**	**100.0%**

**Counted by issues raised in complaint*

Table 14.28 Timeliness of Resolution Service 2005–06*						
	2005–06					
Time taken to complete	Count	%	Health Practitioner		Health Service	
Same Day	2	0.4%	0	0.0%	2	0.6%
1-30 days	150	27.9%	74	37.9%	76	22.2%
>1 month	145	27.0%	52	26.7%	93	27.2%
>2 months	95	17.7%	25	12.8%	70	20.5%
>3 months	62	11.5%	18	9.2%	44	12.9%
4-6 months	55	10.2%	20	10.3%	35	10.2%
6-12 months	28	5.2%	6	3.1%	22	6.4%
>12 months	0	0.0%	0	0.0%	0	0.0%
Total	**537**	**100.0%**	**195**	**100.0%**	**342**	**100.0%**

**Counted by provider identified in complaint*

Table 14.29 Complaints finalised by the Resolution Service by AHS 2005–06*												
	Greater Southern AHS	Greater Western AHS	Hunter/New England AHS	Interstate	Justice Health	North Coast AHS	Northern Sydney/ Central Coast AHS	Other/Unknown	South Eastern Sydney/ Illawarra AHS	Sydney South West AHS	Sydney West AHS	Grand Total
Complaints referred to the Resolution Service												
Resolved	22	12	22	2	9	26	49	2	44	39	29	256
Partially resolved	4	3	8		1	18	17		41	28	18	138
Not resolved	1		5	1	1	3	7		12	17	11	58
Unable to be resolved	1		4		3	2	6		7	4	7	34
Complainant pursued with Commission's assessment/ review process	1	1	3			6	3		11	2		27
Complainant pursued with another body	1		5			3	3	2	5	2	3	24
Total	**30**	**16**	**47**	**3**	**14**	**58**	**85**	**4**	**120**	**92**	**68**	**537**
Complaints referred to the Patient Support Service												
Incomplete resolution		1	1			1	2		4	12	3	24
Resolved			2		1	2	2		4	7	4	22
Client pursued with another body			1			1	3		3		1	9
Not resolved			2			1	1		3	1		8
No contact									1			1
Total		**1**	**6**		**1**	**5**	**8**		**15**	**20**	**8**	**64**
Grand Total	**30**	**17**	**53**	**3**	**15**	**63**	**93**	**4**	**135**	**112**	**76**	**601**

**Counted by provider identified in complaint*

Table 14.30 Resolution Service presentation and networking report 2005–06

Date	Agency/Group Name	AHS	Target Group	No	Topic	Issues raised
1 July 2005	Arabic Aged Group	Sydney West	Aged	25	The role of the Commission Health rights	▮ need for Arabic pamphlets ▮ seeking further treatment/second opinion
3 July 2005	Greek Schizophrenia Support Group	Sydney South West	Carers and community members	20	The role of the Commission. How to make a complaint.	Changed Commission practice.
4 July 2005	Mixed Aged Day Care Group	Sydney West	Aged	20	The role of the Commission. Health rights	Nursing home issues
8 July 2005	Mixed Aged Day Care	Sydney West	Aged	20	The role of the Commission. Health rights	▮ confidentiality and decision-making ▮ inappropriate care of older patients in hospital
12 July 2005	Consumer Advocates, Macquarie Hosp.	Northern Sydney/ Central Coast	Health advocates	2	The Commission and the role of the Resolution Service	Interest in how the advocates can approach the Resolution Service
15 July 2005	Indigenous Group	Sydney West	Mixed group	25	The role of the Commission. Health rights	Carers/guardianship and access to medical records
15 July 2005	Sydney West Joint Patient Reps meeting	Sydney West	Complaints managers	3	Working co-operatively with shared clients	▮ Changing role of Resolution Officers ▮ new AHS Clinical Governance Units ▮ complaints handling
18 July 2005	Mulgoa Seniors	Sydney West	Mixed aged	25	The role of the Commission. Health rights	Waiting list for elective surgery
26 July 2005	Dunedoo Health Organisation	Greater Western	All staff	10	Introduction to Commission	Access to Services and restraints on complaining
3 August 2005	HIV Aids Legal Centre	South Eastern Sydney/ Illawarra	Staff and consumers	30	The Commission and the role of the Resolution Service. Complaints	Complaints processes
4 August 2005	Orange Community Care HACC Forum	Greater Western	HACC workers	20	Health Rights and Responsibilities	
16 August 2005	HACC workers Meeting	Sydney West	Aged workers	12	The role of the Commission. Health rights	Assisting older people with health concerns
16 August 2005	Meeting with Health Organisation Manager and DON	Sydney West	Health Organisation Providers	2	The Commission and the role of the Resolution Service	
19 August 2005	Aids Council Regional Directors	South Eastern Sydney/ Illawarra	Staff	6	The Commission and the role of the Resolution Service.	Regional issues around the complaints
1 September 2005	Wellness Group	Greater Western	Older people	30	Getting the best out of your health system	
7 September 2005	Hearing Expo	Greater Western	Hearing impaired	100	Commission and the role of the Resolution Service	Need for advocacy and support groups for hearing impaired
8 September 2005	Patient Representatives Sydney South West	Sydney South West	Staff	15	Changes to Commission legislation and practices	Commission processes
8 September 2005	Patient Liaison Officers Meeting SSydney West	Sydney South West	Patient Liaison Officers	15	Changes to Commission legislation and practices	Changes in procedures of Commission
13 September 2005	Aged Care Workers	Sydney West	Aged care workers	25	The Commission and the role of the Resolution Service. Health rights	Complaints Resolution
20 September 2005	Dubbo Diabetes Group	Greater Western	Diabetics	30	Getting the best out of your health system	
18 October 2005	Methadone Liaison Group		Methadone workers	10	Changes to Commission legislation and practices	
20 October 2005	WEA	Hunter/ New England	Trainee Practice Managers	12	Commission and the role of the Resolution Service	
27 October 2005	Schizophrenia Fellowship. Depression group, Curl Curl	Northern Sydney/ Central Coast	Carers and people with depression	4	Roles and responsibilities, Commission and Resolution Service	Concerns relating to lack of rights under Mental Health Act
27 October 2005	Northern Beaches Refugee Working Group	Northern Sydney/ Central Coast	Workers and community members	35	Commission and the role of the Resolution Service	Spoke with people who work with refugees in the resettlement program.
20 February 2006	New Interns at Liverpool Hospital	Sydney South West	Interns	30	Commission and the role of the Resolution Service	
21 February 2006	Bosnian Welfare Centre	Sydney West	CALD welfare centre staff	2	Commission complaints handling	▮ how to lodge complaints ▮ use of interpreters, cultural sensitivity ▮ resource development ▮ Commission brochure translations
23 February 2006	Clinical School	Greater Western	Medical students	12	Confidentiality and Privacy	
9 March 2006	Bosnian Welfare Centre	Sydney West	Bosnian community	50–100	Commission complaints process	Encouraging CALD target group to contact Commission with complaints
10 March 2006	Alcohol and Drug Information Service (ADIS)	South Eastern Sydney/ Illawarra	Staff of ADIS and MACS	8	Commission complaints process	Complaint management

Table 14.30 Resolution Service presentation and networking report 2005–06 (continued)

Date	Agency/Group Name	AHS	Target Group	No	Topic	Issues raised
10 March 2006	Chinese Seniors Group Greenfield Park	Sydney South West	Chinese Seniors	10	Commission and the role of the Resolution Service	
5 April 2006	Bosnian Welfare Centre	Sydney West	Bosnian community	25–50	Complaints process	▮ patient rights ▮ problems with interpreters ▮ how to write letters to doctors.
20 April 2006	Christodelphian Nursing Home Padstow Heights	Sydney South West	Nursing Home Staff	6	Commission complaints process	
6 June 2006	Mental Health Consumer Network	South Eastern Sydney/ Illawarra	Mental Health Consumer Advocates	4	Complaints process	▮ Mental health complaint issues ▮ assisting people to negotiate at a local level
Monthly	Clinical Governance Unit Complaints Management Meeting	Northern Sydney/ Central Coast	Complaints staff and patient Representatives	16	Resolution Service and the Commission	Changes in Commission practice and updates
24, 30 August and 23, 28 September 2005	Community Participation and Community Representatives Network	Sydney South West	Health consumers		The Commission and the role of the Resolution Service. Privacy.	▮ changes in Commission ▮ privacy issues regarding community representatives being involved in complaint handling.

Table 14.31 Results of conciliations held during the year 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Outcome	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Agreement reached/Partial agreement reached	133	78.7%	113	83.7%	85	84.2%	49	71.0%
Resolved prior to conciliation	0	0.0%	3	2.2%	3	3.0%	16	23.2%
No agreement reached	36	21.3%	19	14.1%	16	15.8%	4	5.8%
Total	**169**	**100.0%**	**135**	**100.0%**	**101**	**100.0%**	**69**	**100.0%**

**Counted by provider identified in complaint*

Table 14.32 Reasons for conciliations not proceeding during the year 2005–06*

	2005–06	
Reasons for conciliations not held	**No.**	**%**
Complainant did not consent	52	65.0%
Providers did not consent	15	18.8%
Other reasons	9	11.3%
One party withdrew consent	3	3.8%
Both parties did not consent	1	1.3%
Total	**80**	**100.0%**

**Counted by provider identified in complaint*

Table 14.33 Outcomes of investigations 2002–03 to 2005–06*

		2002–03		2003–04		2004–05		2005–06	
Investigation result		**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Health organisation	Terminated by the Commission	28	56.0%	39	73.6%	86	78.2%	42	45.7%
	Make comment or recommendation	22	44.0%	14	26.4%	24	21.8%	50	54.3%
	Health organisation Total	**50**	**100.0%**	**53**	**100.0%**	**110**	**100.0%**	**92**	**100.0%**
Health practitioner	Terminated by the Commission	191	56.7%	156	58.2%	332	49.2%	147	42.5%
	Refer to Director of Proceedings	0	0.0%	0	0.0%	54	8.0%	66	19.1%
	Make comments to the practitioner	38	11.3%	29	10.8%	81	12.0%	49	14.2%
	Refer to a registration authority	33	9.8%	37	13.8%	76	11.3%	62	17.9%
	Refer to Director of Public Prosecutions	1	0.3%	0	0.0%	1	0.1%	22	6.4%
	Prosecute a complaint before a disciplinary body	74	22.0%	46	17.2%	131	19.4%	0	0.0%
	Health practitioner Total	**337**	**100.0%**	**268**	**100.0%**	**675**	**100.0%**	**346**	**100.0%**
Total		**387**	**100.0%**	**321**	**100.0%**	**785**	**100.0%**	**438**	**100.0%**

**Counted by provider identified in complaint*

Table 14.34 Investigations finalised into health practitioner and health organisation 2002–03 to 2005–06*

		2002–03		2003–04		2004–05		2005–06	
	Description	No.	%	No.	%	No.	%	No.	%
HEALTH ORGANISATIONS	Public hospital	37	74.0%	37	69.8%	85	77.3%	65	70.7%
	Private hospital	4	8.0%	3	5.7%	4	3.6%	10	10.9%
	Nursing home	6	12.0%	3	5.7%	7	6.4%	5	5.4%
	Medical centre, private	1	2.0%	1	1.9%	0	0.0%	4	4.3%
	Drug and alcohol service	0	0.0%	0	0.0%	0	0.0%	2	2.2%
	Prison medical service	0	0.0%	0	0.0%	3	2.7%	2	2.2%
	Ambulance service	0	0.0%	0	0.0%	1	0.9%	1	1.1%
	Area Health Service	0	0.0%	0	0.0%	1	0.9%	1	1.1%
	Community health organisation	0	0.0%	2	3.8%	0	0.0%	1	1.1%
	Radiology practice	0	0.0%	0	0.0%	1	0.9%	1	1.1%
	Hostel	1	2.0%	0	0.0%	0	0.0%	0	0.0%
	Multi purpose service	0	0.0%	0	0.0%	1	0.9%	0	0.0%
	Optometrist practice	0	0.0%	1	1.9%	0	0.0%	0	0.0%
	Other	0	0.0%	2	3.8%	2	1.8%	0	0.0%
	Pathology centres	0	0.0%	1	1.9%	0	0.0%	0	0.0%
	Private medical practice	0	0.0%	1	1.9%	3	2.7%	0	0.0%
	Psychiatric hospital	1	2.0%	2	3.8%	0	0.0%	0	0.0%
	Women's health centre	0	0.0%	0	0.0%	2	1.8%	0	0.0%
	Health organisation Total	**50**	**100.0%**	**53**	**100.0%**	**110**	**100.0%**	**92**	**100.0%**
HEALTH PRACTITIONERS	Medical practitioner	216	64.1%	148	55.2%	340	50.4%	191	55.2%
	Nurse	80	23.7%	73	27.2%	260	38.5%	113	32.7%
	Alternative health provider	1	0.3%	0	0.0%	2	0.3%	17	4.9%
	Psychologist	15	4.5%	7	2.6%	16	2.4%	9	2.6%
	Chiropractor	4	1.2%	6	2.2%	2	0.3%	3	0.9%
	Chiropodist/podiatrist	1	0.3%	6	2.2%	1	0.1%	2	0.6%
	Dentist	1	0.3%	4	1.5%	15	2.2%	2	0.6%
	Pharmacist	2	0.6%	4	1.5%	19	2.8%	2	0.6%
	Physiotherapist	8	2.4%	5	1.9%	7	1.0%	2	0.6%
	Acupuncturist	0	0.0%	0	0.0%	2	0.3%	1	0.3%
	Assistant in nursing	0	0.0%	1	0.4%	0	0.0%	1	0.3%
	Dental technician and prosthetist	4	1.2%	0	0.0%	2	0.3%	1	0.3%
	Social worker	1	0.3%	0	0.0%	1	0.1%	1	0.3%
	Optometrist	1	0.3%	7	2.6%	0	0.0%	1	0.3%
	Administrative or clerical Staff	0	0.0%	1	0.4%	0	0.0%	0	0.0%
	Health practitioner de-registered	2	0.6%	0	0.0%	0	0.0%	0	0.0%
	Natural therapist	0	0.0%	2	0.7%	0	0.0%	0	0.0%
	Naturopath	0	0.0%	2	0.7%	0	0.0%	0	0.0%
	Osteopath	1	0.3%	0	0.0%	3	0.4%	0	0.0%
	Radiographer	0	0.0%	0	0.0%	3	0.4%	0	0.0%
	Traditional medicine	0	0.0%	1	0.4%	2	0.3%	0	0.0%
	Counsellor/therapist	0	0.0%	1	0.4%	0	0.0%	0	0.0%
	Health practitioner Total	**337**	**100.0%**	**268**	**100.0%**	**675**	**100.0%**	**346**	**100.0%**
	Grand Total	**387**	**100.0%**	**321**	**100.0%**	**785**	**100.0%**	**438**	**100.0%**

*Counted by provider identified in complaint

Table 14.35 Category of investigations finalised 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment	177	45.7%	123	38.3%	438	0.5%	297	52.5%
Professional conduct	138	35.7%	130	40.5%	287	0.3%	203	35.9%
Access	16	4.1%	15	4.7%	39	0.0%	22	3.9%
Corporate services	17	4.4%	27	8.4%	38	0.0%	8	1.4%
Miscellaneous§	11	2.8%	2	0.6%	13	0.0%	5	0.9%
Communication	7	1.8%	3	0.9%	34	0.0%	15	2.7%
Cost	3	0.8%	5	1.6%	2	0.0%	6	1.1%
Consent	9	2.3%	7	2.2%	11	0.0%	4	0.7%
Privacy/discrimination	8	2.1%	9	2.8%	4	0.0%	4	0.7%
Grievances	1	0.3%	0	0.0%	1	0.0%	2	0.4%
Total	**387**	**100.0%**	**321**	**100.0%**	**867**	**100.0%**	**566**	**100.0%**

** Counted by issues raised in complaint*

§ Miscellaneous: other unethical/improper conduct 4; other 1

Table 14.36 Outcome of investigations finalised by profession and facility type 2005–06*

Health practitioner	Medical practitioner	Nurse	Other	Psychologist	Chiropractor	Physiotherapist	Dentist	Pharmacist	Chiropodist/podiatrist	Social Worker	Optometrist	Assistant in nursing	Acupuncturist	Dental technician and prosthetis	Grand Total
Referred to the Director of Public Prosecutions	4	1	16				1								22
Referred to the Director of Proceedings	34	25		3		2			1		1				66
Referred to registration authority	35	23		3										1	62
Comments	26	20		1						1		1			49
No further action	92	44	1	2	3		1	2	1				1		147
Health practitioner Total	**191**	**113**	**17**	**9**	**3**	**2**	**2**	**2**	**2**	**1**	**1**	**1**	**1**	**1**	**346**

Health organisation	Public hospital	Private hospital	Nursing home	Medical practice	Drug and alcohol service	Radiology practice	Community health organisation	Prison medical service	Area Health Service	Ambulance service	Grand Total
Recommendations	16	2	1	1		1	1	1	1		24
Comments	21	2	3								26
No further action	28	6	1	3	2			1		1	42
Health organisation Total	**65**	**10**	**5**	**4**	**2**	**1**	**1**	**2**	**1**	**1**	**92**
Grand Total											**438**

**Counted by provider identified in complaint*

Table 14.37 Request for investigation reviews 2002–03 to 2005–06*

	2002–03	2003–04	2004–05	2005–06
	No.	No.	No.	No.
Review of investigations received	9	15	22	24
Total	**9**	**15**	**22**	**24**

**Counted by provider identified in complaint*

Table 14.38 Outcome of investigation reviews 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Outcome	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
No further action	5	100.0%	13	100.0%	23	95.8%	27	93.1%
Reopen for investigation	0	0.0%	0	0.0%	1	4.2%	2	6.9%
Total	**5**	**100.0%**	**13**	**100.0%**	**24**	**100.0%**	**29**	**100.0%**

**Counted by provider identified in complaint*

Table 14.39 Time taken to complete investigations 2002–03 to 2005–06*

	2002–03		2003–04		2004–05		2005–06	
Timeframe	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
< 6 months	25	6.5%	50	15.6%	108	13.8%	96	21.9%
6-12 months	34	8.8%	18	5.6%	194	24.7%	174	39.7%
12-18 months	40	10.3%	40	12.5%	143	18.2%	76	17.4%
18-24 months	74	19.1%	29	9.0%	86	11.0%	65	14.8%
24-30 months	66	17.1%	34	10.6%	75	9.6%	18	4.1%
30-36 months	56	14.5%	37	11.5%	65	8.3%	7	1.6%
36 months +	92	23.8%	113	35.2%	114	14.5%	2	0.5%
Total	**387**	**100.0%**	**321**	**100.0%**	**785**	**100.0%**	**438**	**100.0%**

**Counted by provider identified in complaint*

Table 14.40 Complaints not finally dealt with at 30 June 2006*

	2002–03		2003–04		2004–05		2005–06	
Category	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Open assessments	279	25.86%	173	15.99%	506	39.32%	334	28.55%
Open assessment reviews	25	2.32%	45	4.16%	91	7.07%	82	7.01%
Open resolutions	32	2.97%	12	1.11%	66	5.13%	155	13.25%
Open conciliations	91	8.43%	57	5.27%	52	4.04%	98	8.38%
Open investigations	589	54.59%	718	66.36%	385	29.91%	322	27.52%
Open investigation reviews	4	0.37%	11	1.02%	6	0.47%	8	0.68%
Open legal	59	5.47%	66	6.10%	181	14.06%	171	14.62%
Total	**1079**	**100.00%**	**1082**	**100.00%**	**1287**	**100.00%**	**1170**	**100.00%**

**Counted by provider identified in complaint*

APPENDIX C

List of expert advisors as at 30 June 2006

Adler, Professor Robert
Alexander, Dr Ion
Alexander, Dr John
Allen, Dr Hugh
Allnutt, Dr Stephen
Anker, Dr Anthony
Arnaudon, Dr Peter
Arnold, Dr Mark
Baker, Professor Arthur
Baker, Mr John
Banks, Dr Gary
Banks, Mrs Susan
Barnes, Professor David
Barr, Mrs Jeanne
Barraclough, Dr Bruce
Barrington, Mr Glen
Bekhor, Dr Philip
Bell, Professor James
Bellamy, Dr Lynette
Bencsik, Dr Albert
Benson, Dr Warwick
Berton, Dr Peter
Bertouch, Dr Jim
Besser, Professor Michael
Billings, Ms Robin
Black, Dr Jules
Bland, Dr Peter
Bokey, Professor Elie
Borenstein, Mr Sam
Bowers, Dr David
Brazier, Dr David
Brew, Professor Bruce
Bridger, Dr George
Brodaty, Professor Henry
Brodie, Dr Geoffrey
Brodie, Professor Pat
Brooks, Dr Andrew
Browne, Ms Elspeth
Bryant, Professor Richard
Bunker, Dr Jeremy
Burns, Dr Richard
Caldwell, Mrs J
Capizzi, Ms Jann
Champion, Dr Harry
Chapman, Mr Ian
Chard, Professor Richard
Cherry, Mrs Lesley
Child, Dr Andrew
Childs, Dr Clive
Christie, Dr Louis
Chung, Dr Ian
Chung, Dr Rhoderic
Church, Dr David
Cleasby, Mr Peter
Cleghorn, Professor Geoffrey
Colditz, Professor Paul
Coleiro, Mr Albert
Coleman, Mr Mark
Collits, Dr Brian
Commens, Professor Christopher
Cooke, Mrs Helen
Cooper, Ms Anne
Cummins, Ms Allison
Currie, Dr Jon
Davies, Professor David
Davis, Mr John
Day, Dr Robert
Derkenne, Mr Christopher
Dickson, Professor Hugh
Dobson, Ms Pauline
Dore, Dr Glenys
Duncan, Dr Geraldine
Dunlop, Dr Iain
Edgtton-Winn, Ms Maureen
Ehrlich, Dr Frederick
Eisinger, Dr David
Eizenberg, Dr David
Elder, Dr Ian
Eldridge, Ms Jeanette
Elison, Dr Barry
Ellard, Dr John
Engel, Mr Roger
England, Dr John
Evans, Ms Ellen
Eyers, Dr Anthony
Farlow, Dr Diana
Farnsworth, Dr Alan
Farnsworth, Dr Annabelle
Ferrier, Dr Alan
Fletcher, Professor John
Fulde, Professor Gordian
Ghabrial, Dr Rafat
Gibbons, Dr Margaret
Giblin, Dr Michael
Gibson, Dr William
Gillett, Professor David
Gillis, Dr Jonathan
Goldberg, Mrs Greta
Goldstone, Dr Philip
Goodfellow, Mrs Alison
Gordon, Ms Amanda
Gottlieb, Professor David
Goulston, Professor Kerrie
Greenwood, Professor James
Greig, Mrs Sue
Greive, Ms Ann
Gruenewald, Dr Simon
Hamilton, Dr Neal
Handelsman, Professor David
Hanna, Mr Christopher
Harding, Dr Michael
Hartman, Dr Keith
Hayek, Dr Ray
Hazell, Dr Phillip
Heithersay, Dr Geoffrey
Hendel, Dr Paul
Henderson, Mr Chris
Higgins, Dr Ralph
Hobbs, Dr Anthony
Hoekstra, Dr Margaretha
Hogg, Dr John
Holman, Dr Peter
Hore, Dr Craig
Hume, Dr Kenneth
Hungerford, Dr Carole
Isbister, Professor James
James, Dr Allan
Jane, Dr Elizabeth
Jansen, Professor Robert
Jeremy, Professor Richmond
Johnson, Dr Ian
Jones, Ms Maren
Jordan, Ms Andrea
Joseph, Dr Anthony
Jurd, Dr Stephen
Kairies, Ms Blanche
Keir, Dr Jeffrey
Kendall, Ms Fiona
Keogh, Dr Timothy
Khatri, Dr Suresh
Khoury, Mr Raymond
Kinchington, Mr Michael
Kirby, Ms Narelle
Kitching, Mr David
Kleinman, Dr Leon
Klug, Dr Peter
Knox, Dr David
Knudson, Ms Penelope
Kotze, Dr Beth
Kovac, Dr Paul
Kramer, Ms Wendy
Kurtberg, Professor Joanne
Langcake, Dr Mary
Lau, Dr Kit
Lele, Mr Vinoo
Lenehan, Dr John
Leslie, Dr Garth
Loughman, Dr Edward
Lucas, Mr Ashton
Lukersmith, Ms Sue
Lye, Dr Peter
Lyneham, Dr Robert
Mackey, Dr Kenneth
Macleod, Dr Colin
MacQueen, Dr Andrew
Marsh, Ms Elizabeth Ann
Marshall, Professor Donald
Mayhew, Ms Susan
McCarthy, Professor William
McConkey, Professor Kevin
McGee-Collett, Dr Martin
McGuigan, Dr Louis
McMahon, Dr Christopher
McNair, Mr Bernard
Meltzer, Dr Michele
Middleton, Ms Rebekkah
Mill, Ms Colleen
Moore, Mr Peter
Morse, Dr Peter
Mowbray, Dr Joy
Mullins, Dr Raymond
Nelson, Dr Gregory
Newman, Mr Frank
Newman, Dr Louise
Nye, Mr Daryl
O'Connor, Dr Nicholas
O'Dey, Dr Wendy
O'Meara, Dr Matthew
Oates, Mrs Rosemary
Oliver, Professor Lyn Douglas
Parmegiani, Dr Julian
Patrick, Dr Gordon
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