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COMMISSIONS OF INQUIRY ACT 1950

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

STATEMENT OF DAVID ARTHUR KERSLAKE

1. I, **David Arthur Kerslake** of Level 18, 288 Edward Street, Brisbane, am the Health Rights Commissioner for Queensland. I commenced my appointment to this position on 7 August 2002. My formal qualifications are B.A. (Hons.) LL.B. (Hons.) Dip. Ed. The contents of this Statement are true to the best of my knowledge, information and belief.

2. Prior to taking up my current appointment, I held the following positions:

   - January 1998 - July 2002: Director of the Office of Health Review ("Health Complaints Commissioner") for Western Australia;
   - June 1994 - December 1997: Assistant Commissioner, Australian Electoral Commission, Canberra. In this position I had responsibility for managing the conduct of elections for office bearers of industrial (trade union and employer) groups, as well as amalgamation ballots. I also had oversight of the funding and disclosure obligations pertaining to electoral donations to political parties, audit of political party accounts and registration of political parties;
   - February 1993 - June 1994: Director of Investigations, Commonwealth Ombudsman, Canberra. In this role I was responsible for leading the first unit established in an Ombudsman Office in Australia with specific responsibility for the investigation of systemic issues (as distinct from individual complaints). My unit was also responsible for investigating major misconduct allegations against public servants or police;
   - February 1989 - January 1993: Senior Assistant Ombudsman and Deputy Tasmanian Ombudsman. During the course of this appointment I also acted as Tasmanian Ombudsman for a period of approximately 6 weeks.

Statutory Functions of the Health Rights Commission

3. The Health Rights Commission ("HRC") is an independent statutory body established under the *Health Rights Commission Act 1991* ("HRC Act"). Attached hereto and marked **"DK1"** is a copy of the Health Rights Commission's submission to the previous Commission of Inquiry ("the Inquiry") dated 19 May 2005. I was the author of that submission, which provides, inter alia, a comprehensive outline of the statutory powers and functions of the HRC.

4. Through the Medicare Agreements of 1993 and 1997 ("the Agreements") the provision of health funding by the Commonwealth became, and continues to be, conditional in part on all States and Territories maintaining independent health complaints commissions. Under the Agreements, each of these bodies must:

   - be independent of the State's Hospitals and the State's Department of Health;
   - be given powers that would enable it to investigate, conciliate and adjudicate upon complaints received by it; and

- be given a role in recommending improvements in the delivery of hospital services in respect of which the Commonwealth provides financial assistance.

5. The HRC commenced operation in July 1992, meaning that Queensland had, prior to their establishment already satisfied this condition of the Agreements.

6. My main roles as Health Rights Commissioner are to impartially review and resolve complaints about health services provided anywhere in Queensland, across both the public and private health sectors; make suggestions for improvements to health systems and practices by utilising the feedback provided through an analysis of complaints; and to work with health service providers to help them to improve their own complaints management processes. Registration bodies are also required to forward their investigation reports to me for comment.

7. Section 11 of the HRC Act provides that in performing these functions, the Commissioner is to act independently, impartially and in the public interest. The powers of the Minister for Health in relation to the HRC are strictly limited. Pursuant to sections 31 and 32 of the HRC Act, the Minister may give me a written direction to investigate a particular matter or to conduct an Inquiry, but the Minister must then step aside. As Health Rights Commissioner, I am required to form my own views on the matter in question and I have the power, through the Minister, to report to Parliament on matters that I investigate. Accountability and transparency is maintained through the requirement, under section 34 of the HRC Act, for any direction made by the Minister to be published in the HRC's Annual Report.

8. Section 39 of the HRC Act sets out a number of guiding principles to which the Health Rights Commissioner is to have regard when assessing complaints and determining the adequacy of health services. These are that:

(a) an individual should be entitled to participate effectively in decisions about the individual's health;

(b) an individual should be entitled to take an active role in the individual's health care;

(c) an individual should be entitled to be provided with health services in a considerate way that takes into account the individual's background, needs and wishes;

(d) an individual who;

(i) provides a health service; or

(ii) provides care for another individual receiving a health service;

should be given consideration and recognition for the contribution the individual makes to health care;

(e) the confidentiality of information about an individual's health should be preserved;

(f) an individual should be entitled to reasonable access to records concerning the individual's health; and

(g) an individual should be entitled to reasonable access to procedures for the redress of grievances with respect to the provision of health services.

9. One clear and, in my view, significant limitation on my powers as Health Rights Commissioner is that I can only respond to complaints I actually receive. Even if I become aware of apparently serious health issues by means such as media reports, I have no power to intervene unless I actually receive a complaint from someone involved with the particular

health service – for example, a patient or a member of staff at the health service concerned. In other words, under the existing legislative framework I have no power to investigate health care issues of my own initiative, even though the matter reported may raise important issues of public interest, significant systemic issues or serious concerns about a practitioner's competence.

10. The Minister for Health may direct the Health Rights Commissioner to investigate a particular matter or conduct an inquiry and this has occurred on occasions in the past. However, this Ministerial power is in practice, rarely exercised. In fact to my knowledge it has only been exercised in circumstances where the Commissioner of the day has requested a directive from the Minister. This is hardly surprising as the Minister, prior to giving such a direction, will understandably need to have sufficient evidence to justify the exercise of the relevant statutory discretion. On the other hand the Commissioner, in the absence of an actual complaint which founds the exercise of his investigative powers under the HRC Act, will frequently be unable to have gathered sufficient evidence to demonstrate to the Minister that the circumstances are sufficiently compelling to justify the giving of a direction by the Minister to undertake a formal investigation or inquiry.

11. It is my view that the HRC's robustness as an independent body would be reinforced and the protection of the public interest greatly strengthened by affording the Health Rights Commissioner his or her "own motion" powers to initiate an investigation or inquiry where the public interest so requires, along the same lines as those currently held by the Queensland Ombudsman and the New Zealand Health and Disability Commissioner.

12. It is my understanding that the absence of such powers in the legislation at the time of establishment of health complaints commissions across Australia in the early 1990s was contributed to, at least in part, by reservations on the part of practitioner and provider associations as to the manner in which these newly established and evolving bodies would go about their functions. As reported by Mr Peter Forster as part of a review of the HRC in 2001, the legislation was framed in 1992 in a relatively antagonistic environment, where professional groups were wary of the new Commissioner's role, and was claimed by some to be overly prescriptive as a result.

13. However, the health complaints commissions in Queensland and elsewhere have now established their credentials and their integral role in health services complaints review and resolution processes, and such concerns no longer exist. Mr Forster reported that a survey of health service providers, consumers and other stakeholder groups revealed broad support for the HRC's role, and that registration bodies and professional associations had developed an increasing respect for the HRC and its potential for assisting health professionals manage and improve their services

The HRC's Complaints Handling Processes

14. The HRC Act essentially follows the so-called conciliation approach to complaints resolution that has been adopted by all States and Territories other than in New South Wales (NSW). Conciliation is an Alternative Dispute Resolution process widely used in Australia to resolve disputes in areas such as family law, discrimination, aged care and health. In some statutory conciliation programs it is mandatory to attempt conciliation but for health complaints, participation in conciliation is voluntary in all Australian jurisdictions. Unlike mediators, conciliators are empowered to make suggestions or obtain information that might assist in reaching a settlement of the matter in dispute.

15. However, the term "conciliation approach" should not be taken to imply that all, or even most, cases are dealt with by the HRC through a formal conciliation process. Rather, the term reflects a strong emphasis on a *collaborative* approach to resolving medico-legal disputes. The

HRC strives to work cooperatively with all parties to a complaint and wherever possible to help preserve the relationship between them. This contrasts with the more prosecutorial approach to complaints resolution that is reflected in the NSW complaints system, whereby the Health Care Complaints Commission, in addition to its other functions, retains a prosecutorial role.

16. Under the HRC Act, complaints may be dealt with in one of three different ways: through an informal assessment process and, if deemed appropriate or necessary, through more formal conciliation, or investigation. The decision as to which course is pursued may depend upon the complexity of the complaint, whether the complainant is seeking an individual remedy such as compensation, whether the complaint raises broader systemic issues which warrant investigation in the public interest, or whether there is a need to exercise compulsory powers to obtain information. These processes are preceded by the intake, or initial screening stage.

Intake

17. Section 30 of the HRC Act requires that in dealing with complaints the Commissioner should proceed with a minimum of formality. The HRC therefore strives to resolve as many complaints as possible when first received. The Intake Officer receives an initial call or written complaint, and, where appropriate, will provide advice to the complainant or contact the provider to assist resolution of the complaint on an informal basis. The overall emphasis is on resolving less complex cases as expeditiously as possible, and to encourage complainants to take a proactive role in the resolution of their complaints. As the intake area is the first point of contact for most callers or complainants, it is important that it be occupied by experienced staff who can play a positive role in the complaints resolution process.

Assessment

18. Assessment is, in essence, an information gathering process. The health service provider is invited to respond to the complaint and information may be sought from a variety of other sources – copies of patient records, the views of other practitioners who may have treated the patient, or advice on clinical issues from independent experts. The information obtained may be sufficient to prompt the provider to offer a suitable remedy, may identify matters of a systemic nature to be addressed by the provider concerned, or may demonstrate to the complainant that the service they received was reasonable, with the case being closed at that point. The HRC is required to consult with the relevant registration body if professional standards issues are identified.

Conciliation

19. In cases where the information obtained in assessment supports a claim for compensation or some other significant remedy, the matter would quite likely be moved into conciliation, enabling the complaint to be explored further in a privileged and confidential setting. This more formal conciliation process has proven to be a particularly effective alternative to litigation, especially in cases where patients have suffered adverse outcomes. Parties can freely exchange views, assisted by independent expert clinical opinions obtained by the conciliator, without such information being admissible in a court of law. Medical defence bodies, hospital insurers and many law firms have indicated strong support for this process and use this conciliation process to attempt to settle cases thereby saving parties the time, distress and costs that would otherwise be associated with Court action.

20. The conciliator does not have an adjudicating role but does play a pro-active advisory role in making suggestions to help determine whether the level of treatment was adequate or, if found to be sub-optimal, the degree of harm that may have resulted. An experienced conciliator can also assist the parties by suggesting questions that should be put to an independent adviser, or by assisting the parties to reach agreement on such questions. This process may help the

parties to reach agreement on compensation or, alternatively, an understanding as to why compensation is not warranted in the particular circumstances. Under the HRC Act, the parties can reach a legally binding settlement. The HRC's conciliation process has proven to be extremely successful, with a very large proportion of the matters referred to conciliation resulting in outcomes mutually satisfactory to the parties, and some 21% of the complaints conciliated resulting in an agreement that compensation be paid to the complainant.

Investigations and disciplinary action

21. Part 7 of the HRC Act empowers the Commissioner to undertake formal investigation of complaints – for instance, where a complaint raises serious systemic issues that might warrant detailed examination or result in formal recommendations for change. Over the years, investigations conducted by the HRC have resulted in significant improvements to health practices and procedures. For example, investigations into complaints about public hospitals have led to the development of new protocols in relation to the clinical assessment of women at high risk during pregnancy, management of patients at risk of developing pressure sores and the reporting and follow-up of pathology results.

22. However, the bringing about of systemic improvements to health services is not confined to the exercise by the HRC of its investigative powers. Whilst historically there was a tendency to place matters into formal investigation to achieve such outcomes, I have encouraged an increased emphasis in the complaint assessment phase to the identification of areas for systemic improvement. Working cooperatively with providers at this initial stage of the complaints process can lead to better outcomes through an early recognition and acceptance of the need for the implementation of more effective systems or procedures. The willing acceptance by a provider during the assessment phase of the need for change will often be more effective than a process which seeks to impose such change.

Prosecution of Registrants

23. In Queensland it is the registration bodies that are responsible for determining standards of competency that practitioners must meet, making the decision as to whether or not to prosecute individual registrants before disciplinary tribunals, and for then prosecuting disciplinary matters. This is in contrast with the NSW Health Care Complaints Commission ("HCCC") which, in addition to its investigative powers, is charged with the prosecution of individual registrants before disciplinary tribunals, although the registration boards determine the standards of competency to be met. No other State or Territory apart from NSW has given the responsibility for prosecuting disciplinary cases to health complaints commissions.

The Forster Review of HRC

24. I have previously referred to the comprehensive review of the HRC in 2001 undertaken by the Consultancy Bureau, headed by Mr Peter Forster. This review, undertaken at the request of the Department of the Premier and Cabinet, reported in February 2002. The review team noted that the HRC had been established in an environment when a number of professional groups were less than enthusiastic about the idea of an independent health watchdog and commented that as a result, the HRC's legislation was overly prescriptive, to some extent limiting its effectiveness and flexibility. The review made a range of recommendations to enhance the HRC's functions.

25. An observation of the review team was that there had been a tendency for the HRC to adopt a conservative, risk averse approach to dealing with complaints rather than managing cases expediently for practical outcomes. The review team recommended an emphasis on enhanced strategies for local resolution (resolution between the complainant and the health care provider) in the first instance, and a shift in the Commission's emphasis from investigation to conciliation. The majority of the review team's recommendations were endorsed by Cabinet

and have been implemented under my direction. As a result of these recommendations, the HRC has taken huge strides over the past three years, greatly enhancing its timeliness and responsiveness as well as its capacity to facilitate improvement in health care practices and procedures, and in the process significantly strengthening relationships with stakeholders.

Recent Performance of the HRC

26. The HRC receives in the order of 4,500 complaints and enquiries each year. As well as dealing with formal complaints about health services, the HRC has historically played an important "gatekeeper" role referring enquiries to other appropriate bodies where necessary. In 2004, the Commission's reception received approximately 11,500 calls which were assessed and where appropriate, direct assistance was provided to the caller by reception or the call was referred to an Intake Officer for further attention. The high volume of enquiries and complaints suggests that the existence of the HRC is well known to many in the community.

27. At the time of my appointment, the HRC was faced with a significant backlog of complaints that had built up over the years. Caseloads for individual complaints staff averaged between 40 and 50. Given the complexity of many cases, this would be considered by most review bodies to be at the high end. In addition, there were approximately 340 cases that were awaiting allocation in different parts of the HRC. My emphasis has been on the introduction of more streamlined, user-friendly and flexible complaints management processes.

28. My 2002-2003 Annual Report sets out the strategies that were adopted to address this backlog and put complaints management back on track. Firstly, I moved more staff to the Intake area, which is the first point of contact for members of the public. Rather than simply recording details of complainants' concerns and passing them on to other staff to deal with, Intake officers were authorised to attempt to resolve complaints at this early stage if feasible by assisting complainants to take the matter up directly with the provider, or by making appropriate enquiries to facilitate resolution. The HRC's processes were also modified to keep to an absolute minimum the number of stages each case goes through before it is finalised. One of the primary reasons for past backlogs was the strict interpretation of section 76 of the HRC Act, which provides that complaints be assessed within a maximum of 90 days. Given that participation in assessment is entirely voluntary for health service providers, staff often found it difficult to obtain necessary information within the time frames specified for assessment. This resulted in cases being referred to conciliation or investigation for no other reason than that the timeframe for assessment had expired. The sheer volume of cases referred for statutory action in this way led to significant double handling of cases and thereby increased the time taken to finalise cases, with a substantial backlog of cases and frustration on the part of some complainants being the inevitable result.

29. The specialised nature of certain positions within the HRC had also become an issue in dealing with cases in a timely and efficient way. Section 83 of the HRC Act provides that a HRC officer who is a conciliator must not be involved at all in the investigation of health service complaints. The Consultancy Bureau commented on this problem in its review, and recommended that the HRC implement a less specialised structure incorporating broader skills for individuals in order to:

- achieve greater flexibility in the allocation of staff resources;
- minimise redundancy in complaint processing functions; and
- ensure that complainants need only provide full details of their complaints to the HRC on one occasion.

30. To address this issue, delegations were provided to assessment officers to conciliate less complex cases, with support and guidance from more senior officers. This enabled more senior conciliators to focus their attention on the more complex or sensitive cases, but to otherwise permit continuity by the assessing officer in the conciliation phase, thereby avoiding delays previously experienced, and the double handling of cases through the automatic reallocation of complaints to another officer.

31. I have reorganised the Intake area, replacing part-time Enquiry Officer positions with more experienced full-time Intake Officers. Acting on legal advice, I also opted to relax the time frames for assessment on the basis that such time frames were never intended to disadvantage consumers or providers in this way. The end result has been that most cases are now able to be resolved through the intake and assessment processes, processes that are more flexible and less time consuming than more formal statutory action. For example, the types of cases that the HRC would now refer from assessment to conciliation are typically those where it is accepted that an adverse outcome has occurred, and consideration needs to be given to the extent to which the health care provider contributed to that outcome. Most other cases are now able to be resolved, in a very timely way, in assessment. This is consistent with section 30 of the HRC Act, which stipulates that the Health Rights Commissioner should proceed with as little formality and technicality, and as much expedition, as possible.

32. In addition, the HRC has, over the period that I have been Commissioner, had a greatly increased emphasis upon direct/local resolution of complaints between the complainant and the service provider. The HRC promotes direct resolution as the primary and preferred complaint resolution strategy and encourages staff to accentuate the need for complainants to attempt direct resolution. Whilst recognising that there will always be cases where it is inappropriate to do so, the HRC has adopted an active strategy of not actioning complaints unless complainants have first demonstrated reasonable attempts to resolve the complaint directly with the health service provider.

33. Another change introduced by me related to the prior practice of triaging complaints. The prioritising of complaints had led to backlogs and the development of a practice whereby, in some cases, complainants were sent a letter acknowledging receipt of their complaint and notifying them that due to work levels, it would be a period of some months before their complaint was attended to. This practice was discontinued after my commencement and I ceased the dispatch of such letters. All complaints are now dealt with as they are received. It does not follow from this that in certain cases the complaints management processes will not be prioritised, for example when the complaint reveals serious systemic or competency issues requiring immediate attention, or where the complainant may be suffering a terminal illness and common courtesy requires that it receive immediate attention and follow up. However, such prioritisation is factored into the Commission's day to day activities and workload, rather than achieved at the expense of those activities.

34. These changes have served to "streamline" the HRC's complaints handling processes and have eliminated the previous backlog of complaints. The HRC still receives a number of highly complex cases that inevitably take longer than others to finalise, but the revised procedures have freed up more senior staff to focus almost exclusively on these cases, with positive spin-offs for timeliness.

35. The following tables illustrate the increase in efficiency in the HRC's complaints handling processes as a consequence of the initiatives and revised procedures implemented since my appointment:

Table 1 - Complaints awaiting allocation as at:

Date	Number
30 June 2001	225
30 June 2002	approximately 340
30 June 2003	approximately 25
30 June 2004	*Nil
30 June 2005	*Nil

*Complaints are allocated on receipt, thereby ensuring no backlog in allocation.

Table 2 - Complaints open as at:

Date	Number
30 June 2001	1236
30 June 2002	783
30 June 2003	440
30 June 2004	278
30 June 2005	*392

*complaints open as at 30 June 2005 reflect an increase due to the recent influx of Bundaberg Hospital complaints. As noted below, additional staff have been appointed to facilitate the timely handling of these complaints.

Table 3 - Formal Investigations:

Year	00/01	01/02	02/03	03/04	04/05
Formal Investigations completed	63	60	53	39	17
Formal Investigations ongoing	96	96	56	17	Nil*

*as at 15 July 2005.

36. In each of the 3 years since my appointment the HRC has resolved more complaints than there were new complaints received.

HRC Structure/Budget

37. The HRC operates to a budget of just under $3 million funded primarily by quarterly endowments received from Queensland Health. It operates with a full time equivalent staff of approximately 26 people with its priority being to maximise the number of officers dedicated to the complaints handling process (intake, assessment, conciliation and investigation) which is the core business of the Commission. Employee expenses comprise approximately 75% of the Commission's total expenditure. During my term as Commissioner I have introduced and encouraged a range of strategies including the multi skilling of HRC officers, increased flexibility in the allocation of staff resources to key complaint management functions, external secondments to like agencies to further develop skills and broaden work experience, and eliminated the high resource redundancy factor associated with an over emphasis on staff

specialisation. These strategies have, I believe, resulted in enhanced job satisfaction and a minimising of staff turnover.

Funding Arrangements/Independence

38. As already emphasised, the HRC operates autonomously and reaches decisions on cases in an entirely independent manner. To guard against any perceptions of bias, registered health practitioners are not qualified to be appointed as Commissioner. Another important aspect of independence, however, is financial independence. There are risks that perceptions of the HRC's independence as an external review body could be damaged if it is seen to be financially reliant on another agency, where that agency is likely to be the subject of complaints to the HRC.

39. In accordance with section 33 of the HRC Act, I am required to prepare and give a draft budget to the Minister for Health for each financial year. The Minister must then decide the HRC's budget. Once the budget is approved, funding is provided to the HRC by way of quarterly grants from Queensland Health. In practice, the HRC's budget allocation comes out of funds that the Treasurer has already allocated to Queensland Health. This places the HRC in the somewhat invidious position that any increased funding it obtains for new initiatives must come out of funds that are already allocated to provide health services to Queenslanders. It is a reality that health budgets are finite and that the priority is to ensure that as much of that budget allocation as possible goes into the actual provision of health care. These "realities" have implications for the resourcing of the HRC under its current arrangements. I note that in its submission dated 3 June 2005 to the previous Inquiry, the Office of the Public Advocate - Queensland expressed concerns as to the impact of these arrangements on the HRC's perceived independence and advocated the Commission's removal from the health portfolio and that its funding be freed from the domain of Queensland Health.

40. I do not have any particular concerns that the HRC's independence will be compromised if its budget appropriation remains within the Ministerial Portfolio Statement ("MPS") of the Minister for Health (although an alternative would be for the HRC to appear along with a range of other independent review agencies, as part of the Premier's MPS). I do believe that as a minimum, the HRC's annual appropriation should be listed as a separate line item within the budget papers and thus be formally approved independently of Queensland Health's budget. I note that when the HRC was reviewed by the Consultancy Bureau in 2002, Mr Peter Forster whilst noting expressions of concern at the perceived impact of the HRC's funding (and reporting) arrangement on its independence, believed that such arrangements were appropriate and whilst not compromising the independence of the HRC in principle, recommended that the Health Rights Commissioner accompany the Minister for Health to meetings of the Cabinet Budget Review Committee to emphasise the independence of the HRC from Queensland Health. This recommendation has been implemented. In my view, it would also seem desirable for the HRC's annual appropriation to be forwarded directly to it by Treasury rather than via Queensland Health or alternatively that a Parliamentary Committee could be vested with responsibility for recommending the annual budget required by the HRC.

Accessing External Review

41. In the course of the previous Inquiry proceedings, reference was made to the importance of maintaining effective access to independent health complaints mechanisms such as the HRC. This applies both to patients and to health service staff who may have concerns about the actions of a colleague. Under its existing legislation, the HRC has the power to deal with both categories of complaints, referring matters for consideration by a registration board where warranted.

42. It is clear that some clinical staff at Bundaberg Base Hospital ("BBH") had become concerned about Dr Patel some time before issues relating to his competence became public. I understand that Inquiry transcripts indicate some were also aware that they could complain directly to the HRC or to the Medical Board of Queensland, although no complaints were received by the HRC directly from clinical staff. I do appreciate that reporting a practitioner to internal management or to an external review body is not an easy decision for another practitioner to take. It would have been open to me to accept such complaints had they been made. Section 59 of the HRC Act provides that a health service complaint may be made to the Commissioner by a person other than the user of the health service or the user's representative, if it is considered in the public interest to do so. The Health Rights Commissioner may also accept an anonymous health service complaint in the public interest or may choose to keep information provided by a complainant confidential if there are special circumstances and if it is considered to be in the complainant's interests to do so.

43. The HRC has received in the vicinity of 40,000 complaints since its establishment, suggesting that the availability of its services are well known to a significant section of the community. Nevertheless, the HRC has looked to innovative ways of increasing community awareness. For example, I initiated a project in conjunction with the Crime and Misconduct Commission, Queensland Ombudsman, Anti-Discrimination Commission and Children's Commission aimed at promoting community access and awareness through joint activities such as advertising on multicultural radio programs. All HRC staff participate in public awareness activities. The HRC has plans in place to appoint an officer to assist with specialist indigenous outreach.

44. An additional effective means of increasing public awareness would be to place an obligation on health service providers, when responding to complaints, to advise complainants of their right to seek further independent review from the HRC. There have been occasions in the past where both public and private providers have referred complainants to the HRC, but this has occurred on an occasional and apparently ad hoc basis. Such referrals could become a legislative requirement (similar to section 34 of the *Freedom of Information Act 1992* or section 48 of the NSW *Administrative Decisions Tribunal Act 1997*), but at the very least should be adopted as a formal policy across the whole of Queensland Health.

Synopsis of Bundaberg Complaints

45. Complaints are received by the HRC through its Intake area conducted under the supervision of the HRC's Complaints Manager. Where the Complaints Manager identifies issues of particular interest, including, for example, a pattern of complaints with respect to a particular service provider (whether hospital or doctor), it is normal practice for him to raise such issues with me. However, as at March 2005 the name of Dr Patel had attracted no significance, nor any level of recognition with me or within HRC. A review of the HRC's complaints and enquiries database indicates that during the two year period from 1 April 2003 to 31 March 2005, the HRC had received six written complaints concerning the provision of health services at BBH. This was not a material level of complaints for that period of time from a provider of the size of BBH. None of these complaints concerned services provided by Dr Patel. There were three telephone enquiries about BBH received over the same period (two in 2004 and one in March 2005) where Dr Patel was named as the treating doctor. In each instance the callers were happy to take their concerns up directly with BBH. The HRC advised them of their right to come back to the HRC if they wished to take the matter further but none did so prior to April 2005.

46. On 4 February 2005 I met with Ms Kym Barry and I believe Ms Judy Simpson representing the Queensland Nurses Union. The purpose of the meeting, which as best I recall lasted 20 minutes or so, was not for Ms Barry and Ms Simpson to lodge a complaint with the HRC, but rather for them to obtain an understanding of the HRC's functions, powers and procedures.

The meeting was fairly high level and I did not make a diary note of the meeting. As far as I can recall, issues were raised concerning a hospital on the Gold Coast and a hospital in the Wide Bay area. I cannot recall whether or not specific reference was made to Bundaberg, or to the individual doctors concerned, but accept that such references may have been made. If the doctors were referred to their names did not, at that time, mean anything to me.

47. I walked Ms Barry and Ms Simpson through an overview of the HRC's powers and its procedures. I also explained that if serious issues of competency on the part of an individual practitioner were involved the HRC would consult with the Medical Board of Queensland, as required under the HRC Act, and depending upon the circumstances, the matter may be referred immediately onto the Board for investigation and possibly disciplinary proceedings. The meeting concluded on the basis that the Union representatives would revert to their members to see what they wanted to do. The meeting involved no articulation of issues or concerns such as to cause me to suspect that there was anything occurring of anything like the nature or extent of issues that have subsequently emerged in connection with BBH.

48. On 23 March 2005 the HRC received a copy of Mr Rob Messenger MP's letter to the Minister for Health dated 22 March 2005 raising concerns about Dr Patel. This letter had also been copied to the Medical Board of Queensland. Following receipt of this letter I spoke with Mr Messenger's office to advise that as the letter primarily raised competency issues concerning a registrant, the Medical Board was the most appropriate body to investigate the concerns, and that if Mr Messenger was agreeable, I would confirm with the Medical Board that it would be addressing the matter. Mr Messenger's office confirmed this approach was in order.

49. The HRC first became aware that there may be broader issues concerning Dr Patel through media reporting in early April this year. On 8 April 2005 the Courier Mail reported that the Chief Health Officer of Queensland Health, Dr Fitzgerald, had carried out an investigation into the competency of a surgeon at BBH who had been linked to the death of at least 14 patients and that the surgeon in question had since "fled the country". As at the time of this media report, I had no knowledge of the investigation which had been undertaken by Dr Fitzgerald.

50. Upon it becoming apparent that there would be a larger number of complaints and a broader range of issues to be addressed in connection with BBH than was previously indicated, I contacted Mr Messenger and advised that the HRC would clearly need to be involved in the assessment and investigation of the complaints, and asked that he refer any additional matters of which he became aware to the HRC. Mr Messenger has continued to do this.

51. To assist those impacted by the incidents which were beginning to emerge, I determined that the HRC should send a senior officer to Bundaberg to liaise with potential complainants and to facilitate the receipt of complaints. My Complaints Manager attended Bundaberg for this purpose for the week of 18 April - 22 April 2005.

52. The HRC's presence in Bundaberg was advertised in local Bundaberg media (print and radio) from 16 April 2005. Over 70 formal complaints or enquiries were received in the course of that week. A priority in this initial period was to ensure that patients in need of medical treatment could receive it. I engaged in liaison with Queensland Health as to its response to this concern, and ascertained that Queensland Health had arranged to send approximately 9 patient liaison officers to Bundaberg (at that time, BBH did not appear to have an on-site patient liaison officer) whose immediate priority was to make arrangements for those patients in need of treatment. I also agreed a protocol with Queensland Health that it would advise patients seen by its liaison officers in Bundaberg of their right to complain to the HRC, and that the HRC would inform complainants who were potentially in need of treatment of the opportunity to make contact with a Queensland Health liaison officer. While in Bundaberg the HRC's Complaints Manager arranged for the urgent review of some complainants' immediate health needs.

53. On Tuesday 26 April 2005 I attended Bundaberg to meet with representatives of the Patient Support Group (Ms Crosby and Mr Fleming), the local State Members (Mr Messenger and Ms Cunningham), and the Acting District Manager of the Bundaberg Health District. The purpose of these meetings was to outline the HRC's processes, to report on the HRC's response to the Bundaberg concerns, to enhance awareness of patient rights and entitlements, and to progress the timely receipt by HRC of copies of patient medical records. I also undertook radio interviews and held a press conference whilst in Bundaberg to further facilitate these purposes.

54. Also on 26 April I established, within the HRC, a special unit specifically to address Bundaberg complaints. This unit is headed by a senior officer and also comprises 3 experienced officers dedicated to the assessment of the complaints, and 2 experienced officers whose focus is on identifying and investigating systemic issues which may exist within BBH, and considering recommendations that should be made to address such issues. I have appointed 3 additional staff from outside of the HRC to provide back-up support to other areas of HRC responsibility whilst this special unit is in place to address the Bundaberg complaints.

55. The Patient Support Group subsequently invited the HRC to attend a public meeting held on 12 May 2005. The HRC's Complaints Manager attended this meeting, which was also attended by Dr Fitzgerald and by officers from the Commission of Inquiry and from the CMC who each explained their respective roles.

56. As at 5 August 2005, the number of formal complaints received by HRC concerning health services provided by BBH has grown to 97, with more complaints still being received. In addition, there have been 40 enquiries received ~~since that date,~~ not yet the subject of formal complaints. Of the complaints received as at 5 August, 69 relate directly to treatment provided by Dr Patel.

57. Annexed hereto are the following Schedules detailing information extracted from the HRC's complaints and enquiries database:

"DK2" Schedule of Complaints received by HRC concerning BBH during the period 1 April 2003 - 5 August 2005. Complaints received prior to 1 April 2005 are highlighted in bold. Where the complainant can be identified by reference to the previous Commission of Inquiry's patient key code, this is noted on the Schedule as are the complaints which involve Dr Patel;

"DK3" Schedule of Enquiries received by HRC concerning BBH during the period 1 April 2003 - 5 August 2005, being matters which have not, at this stage, resulted in formal complaints. Once again, enquiries received prior to 1 April 2005 are highlighted in bold, and where the patient can be identified by the patient key code, this is noted, as are the circumstances where the enquiry involves Dr Patel.

58. The HRC has notified the Medical Board of Queensland of these complaints and will keep the Board informed of developments. The HRC understands that the Board, for its part, is investigating individual matters with a view to making a decision as to the prosecution of Dr Patel, and the HRC will formally consult with the Board at the end of its complaint assessment process in accordance with usual practice.

59. Although no formal findings have yet been reached, assessment of these complaints by HRC is well advanced. I have appointed an independent expert to assist with this process. A recently retired surgeon from interstate with well over 20 years senior consultancy and teaching experience in public health systems has agreed to provide independent advice on the standard of care provided in each case. He is currently working at the HRC's offices to review clinical issues arising from complaints as expeditiously as possible. A considerable number of cases have already been reviewed, which reviews have identified a range of significant inadequacies

in the standard of care provided to patients of Dr Patel. The results of the reviews will also be made available to the Medical Board of Queensland to assist in its deliberations.

60. The HRC has put in place arrangements with Queensland Health to facilitate the prompt assessment, and where appropriate, resolution of these complaints, including the payment of compensation. Queensland Health have appointed Ms Julie Cameron of Messrs Corrs Chambers Westgarth to act as its legal liaison person with HRC, and Queensland Health has fully cooperated with the HRC in providing access to patient records and other relevant information.

61. Procedures that are featured in complaints about Dr Patel include bowel, abdominal, gall bladder, kidney and gynaecological surgeries as well as hernia repairs, endoscopies and oesophagectomies. Some of the procedures were initially commenced via laparoscopy but later progressed to open surgery due to intraoperative complications.

62. As mentioned, the HRC special unit is also reviewing systemic problems with the delivery of health care services at BBH to determine to what extent changes may be necessary to improve the quality and safety of these services. Some of the concerns that have been raised by complainants relate to:

- patients being discharged too early following surgery;
- the scope of surgical practice at the hospital;
- informed consent;
- post-operative infection rates and monitoring of surgical complication rates;
- adequacy of diagnostic investigations and reporting;
- apparent absence of any appropriate mechanism for prioritising referrals requiring urgent specialist consultation;
- complaint handling practices at the hospital;
- communication between hospital staff and management;
- adequacy and validity of documentation; and
- coronial notifications.

Other Matters

63. The Terms of Reference for the Commission of Inquiry include requirements that it enquire into:

- the role and conduct of the Queensland Medical Board in relation to the assessment, registration and monitoring of overseas-trained medical practitioners (Term of Reference 2(a)); and
- any substantive allegations, complaints or concerns relating to the clinical practice and procedures of other medical practitioners at the Bundaberg Base Hospital or other Queensland public hospitals raised at the previous Commission of Inquiry (Term of Reference 2(c)).

Reference is made briefly hereunder to two matters pertaining to those Terms of Reference.

Term of Reference 2(a)

64. The HRC's recent review of a complaint (unrelated to Bundaberg) which has been satisfactorily resolved, caused my attention to focus upon a circumstance pertaining to the registration and supervision arrangements for medical practitioners in "areas of need" which I consider appropriate to identify in this statement. Dr Fitzgerald, in his statement to the previous Inquiry, noted that new registrants who do not hold Australian recognised qualifications should only be permitted to practise under supervision and annexed to his statement the draft Guidelines for Supervision prepared by the Medical Board. I understand that those Guidelines were recently accepted and endorsed by the Board.

65. The relevant situation is where, for whatever reason, the supervisory arrangements or other conditions of practice for "areas of need" registrants are not complied with. My concern is that in the event of a registrant or supervisor failing to notify the Medical Board, there appears to be potential for the unsupervised practice of such a registrant to continue undetected for some months.

66. The Guidelines set out a number of circumstances in which registrants may be required by the Medical Board to practise under supervision. These include overseas trained doctors who have not completed the Australian Medical Council examinations. Prior to accepting a position, such as in an "area of need", a registrant is required to obtain the approval of the Board in regard to the appropriateness of the position. It is my understanding that the Board may choose to approve such a proposal subject to certain conditions. These may include the degree of required supervision and that the relevant professional College undertake an assessment of the registrant within a specific period.

67. The Guidelines require the supervisor to ensure that the registrant practises in accordance with the approved work arrangements and to notify the Board of non-compliance with or any proposed changes to the supervision arrangements. The registrant must ensure compliance with the arrangements and the Board has the right to take action against the registrant for non-compliance.

68. While these Guidelines contain some significant improvements to past practice, I am concerned that they still may not provide a watertight system to protect the public. For example, the HRC's enquiries into the complaint referred to above revealed that a College had not completed its assessment of a registrant within the period specified by the Board. Enquiries made with the Executive Officer of the relevant College revealed that a "paper" assessment had been carried out but that the assessment would not be considered to be complete until an on-site assessment (by a Fellow of the College) of the registrant's clinical abilities had occurred. No date had been set for that assessment even though the registrant had been practising in the area of need for some months, although that assessment was arranged following the intervention of the HRC. The HRC enquired of the Medical Board whether it is advised when an assessment has been completed and was advised that the Board would normally not become aware that the assessment had not been completed until an application for renewal of the registration was made one year after the initial application was approved.

69. I accept that this case may be an exceptional one. I also appreciate the resource implications of making regular follow up checks and the burden of imposing supervisory responsibilities on already very busy practitioners. I would be concerned, however, if the public could be placed at risk by a practitioner practising for any length of time after the deadline for compliance with a condition has passed without having met that condition or while being otherwise in breach of a condition specified by the Medical Board. I support the introduction of tougher penalties for registrants who fail to report such non-compliance, but wonder whether further steps may be

required to ensure a "fail safe" mechanism for registering doctors to practise in areas of need . Such additional steps might include:

- an agreement that Colleges notify the Board immediately any required assessments have been carried out;
- automatic follow up by the Medical Board (with both the College and the registrant) if such notifications are not received by the designated date;
- increased responsibilities for Queensland Health in monitoring compliance with Board registration conditions,
- requirement that some overseas trained doctors first undergo a period of intensive supervision in a major teaching hospital before being allocated to an area of need; and
- a *mandatory* requirement for supervisors to conform with the reporting guidelines with strict penalties for supervisors (not just registrants) who fail to comply.

Term of Reference 2(c)

70. Reference is made in the HRC's annexed Submission to the previous Commission of Inquiry (attachment "DK1") to a series of complaints concerning another senior staff specialist at the BBH, whose name is the subject of a non-publication order by the previous Commission of Inquiry. It is not proposed to set out the details of that matter in this statement, although I can speak to those details in my oral evidence in the event the Commission regards it relevant that I do so.

71. The circumstances of that matter are, however, also relevant in another context, in that they represent a circumstance in which the practitioner concerned was investigated by the Medical Board and the Board forwarded to the HRC a report of its investigation in accordance with s.116 of the *Health Practitioners (Professional Standards) Act*. Upon review of the report, the HRC did not agree with the Medical Board's findings and recommendations, and following further representations, including a meeting by me with the Medical Board, the Board agreed to obtain further expert opinion in relation to the matter. The handling of this complaint is a practical illustration of the HRC's independent oversight role of Medical Board investigations, described by Mr O'Dempsey in his evidence to the previous Commission as an "additional failsafe".

72. The HRC has received a total of 36 complaints concerning the provision of health services at the Hervey Bay and Maryborough Hospitals. These complaints have been, or are currently being assessed. A large majority of these complaints have been received in recent months, subsequent to the public release of the Review by Drs Giblin and North of Orthopaedic Health Care in the Fraser Coast Health Region ("the Review"). Of these 36 complaints, 11 relate specifically to orthopaedic surgery undertaken by doctors referred to in the Review. These comprise:

(a) Dr Naidoo - two complaints, one of which relates also to Drs Khursandi and Krishna;

(b) Dr Padayachey - one complaint;

(c) Dr Khursandi - one complaint which relates also to Drs Naidoo and Krishna. In addition there is an oral complaint currently being followed up by the HRC with the complainant;

(d) Dr Sharma - two complaints, one of which was withdrawn during assessment; and

(e) Dr Krishna - five complaints, one of which has been closed and another of which relates also to Drs Naidoo and Khursandi. In addition, the HRC is following up with the respective complainants two oral complaints made concerning Dr Krishna.

73. The joint complaint was received by the Commission in November 2004. The balance of the complaints have been received since late April 2005. The remainder of the 36 complaints relate to treatment involving a range of other practitioners and procedures across a range of disciplines including surgical, medical (accident & emergency) obstetrician and gynaecology, hygiene, ophthalmology, cardiology and the such like. The HRC is keeping the Medical Board of Queensland informed with respect to complaints in respect of which competency or professional standards issues are identified.

74. I have established within the Commission a special unit to deal with the complaints emanating from the Fraser Coast Health Region. On 15 August I met with the members of the Hervey Bay Support Group to explain the Commission's processes and procedures, and the steps being taken by the Commission through the special unit to deal with their complaints in a timely manner. I also met at that time with the District Manager of the Health Service to facilitate the provision by Queensland Health of prompt responses to requests by the HRC for information relevant to these complaints. I also met on that occasion with a number of the Queensland Health Patient Liaison Officers appointed to assist in addressing the concerns of these complainants.

Complaints Handling in the Queensland Public Health Sector

75. Following are my observations in relation to complaints handling systems and procedures in the Queensland public health sector from the experience and perspective of the HRC as the existing independent external review body with respect to complaints about health services. These observations are made under the following headings:

(a) institutional cultural issues within Queensland Health;

(b) open disclosure;

(c) better practice in complaints management;

(d) incident reporting; and

(e) the effectiveness of independent review.

Institutional cultural issues

76. It appears to me that one of the primary lessons to be learned from the recent events at BBH is the need to develop and nurture an organisational culture across Queensland Health that welcomes and values complaints. Health consumers are entitled to expect that they can have complaints addressed at a local level by people who are committed to understanding their concerns and to resolving them in a fair and effective way. Witnesses at the Inquiry have made reference to a culture at BBH that does not encourage patients or staff to come forward with concerns or, if concerns are raised, does not respond positively to them. It may be inferred that this culture extends more widely than BBH.

77. You cannot have a quality health system in the absence of a culture that welcomes complaints and values feedback. It is a matter of concern, therefore, that at the time when such a large number of complaints began to materialise, there was no patient liaison officer in place at BBH. The unavailability of an officer specifically designated to deal with complaints would

appear to send all the wrong messages. Patients are more likely to complain if they feel that their concerns will be taken seriously and that the effort of making a complaint has some realistic chance of making a difference. Staff members are likewise unlikely to come forward if they feel their concerns will be trivialised or, worse still, fear being victimised in some way.

78. In my experience, health practitioners too often respond negatively or defensively to complaints, sometimes motivated by fear of litigation, perhaps through annoyance that their professional integrity or standing has been challenged, or because they are quite legitimately troubled by a culture of blame that seems to pervade a significant portion of the health system. In my view it is important to recognise that systemic change alone will not satisfactorily resolve this problem. At its heart this is a cultural, not a systems issue, and I agree with the observations made by Mr Forster in his interim report that:

- a learning culture must be embedded where it is understood that mistakes are inevitable and questioning is encouraged in a "no blame" environment; and
- leadership must be provided by clinicians to drive this agenda for change.

79. Senior clinicians and managers need to show strong leadership in espousing a culture that values complaints and responds openly and positively to them. In my experience as Health Rights Commissioner, when people complain about a health service they have certain key expectations: they want their concerns to be acknowledged and understood; they want an explanation of what happened and why; they want an apology; and if their complaint reveals inadequate practices or procedures, they want action taken to avoid the same thing happening to someone else. Health service providers must be prepared to listen to their patients and learn from their complaints.

80. Patient complaints must be seen as an essential component of this change agenda. In conjunction with incident reporting and, where appropriate, clinical audits, complaints provide a rich source of data that can be used to monitor the effectiveness of existing health systems and to identify cases where individual standards need to be improved. Health service providers are offered a valuable lead in this regard from recent national guidelines on open disclosure, complaints handling and incident reporting promulgated by the Australian Council for Safety and Quality in Health (the Safety and Quality Council).

Open disclosure

81. The Safety and Quality Council's recent Open Disclosure Project encourages health providers to openly acknowledge when things go wrong and to provide reassurance to patients and their carers that lessons learned will help prevent their recurrence. The basic principles endorsed by the Council, which I understand have also been endorsed by Queensland Health are:

- *Openness and timeliness of communication* – when things go wrong, the patient and their support person should be provided with information about what happened, in an open and honest manner at all times.
- *Acknowledgment* – all adverse events should be acknowledged to the patient and their support person as soon as practicable. Health care organisations should acknowledge when an adverse event has occurred and initiate the open disclosure process.
- *Expression of regret* – as early as possible, the patient and their support person should receive an expression of regret for any harm that resulted from an adverse event.

- *Recognition of the reasonable expectations of patients* – the patient and their support person may reasonably expect to be fully informed of the facts surrounding an adverse event and its consequence, treated with empathy, respect and consideration and provided with support in a manner appropriate to their needs.

- *Staff support* – health care organisations should create an environment in which all staff are able and encouraged to recognise and report adverse events and are supported through the open disclosure process.

- *Integrated risk management and systems improvement* – investigation of adverse events and outcomes is to be conducted through processes that focus on the management of risk. Outcomes of investigations are to focus on improving systems of care and will be reviewed for their effectiveness.

- *Good governance* – open disclosure requires the creation of clinical risk and quality improvement processes through governance frameworks where adverse events are investigated and analysed to find out what can be done to prevent their recurrence. It involves a system of accountability through the organisation's chief executive officer or governing body to ensure that these changes are implemented and their effectiveness reviewed.

- *Confidentiality* – policies and procedures are to be developed by health care organisations with full consideration of the patient's, carer's and staff's privacy and confidentiality, in compliance with relevant law, including Commonwealth and State/Territory Privacy and health records legislation.

82. A Support Package developed by the Safety and Quality Council has recently been released, providing practical tools for use in implementing the Standard. This package should be widely disseminated throughout all health sector facilities to encourage open communication between health practitioners and patients (or their families) when things go wrong. Queensland Health should seek to identify organisations (both within Queensland Health and elsewhere) who have implemented such practices as role models to demonstrate the benefits of open disclosure. Hospitals that have put this approach into practice respond extremely well to complaints and achieve the best outcomes for all concerned.

Better Practice in Complaints Management

83. The Safety and Quality Council also recently sponsored a project to develop *Guidelines for Better Practice in Complaints Management.* These guidelines were developed in association with the Australasian Council of Health Complaints Commissioners (of which I am a member), the Royal Australasian College of Physicians and the Health Issues Centre. The guidelines recognise that the provision of high quality health care requires productive partnerships between consumers and providers in which consumers are actively encouraged to provide feedback (both positive and negative) to health care providers. Such feedback should be used to inform improvements to the quality of service and to help reduce adverse incidents.

84. Specific guidelines promulgated by the Safety and Quality Council include:

- where serious action is warranted, this needs to be identified promptly and appropriate action taken;

- management should take responsibility for effective complaints management and all staff should be aware of and routinely use complaints mechanisms;

- the manner in which a complaint is assessed or investigated needs to be clear, fair to the parties and provide just outcomes; and

- complaints data should be recorded so that individual cases can be reviewed and trends and issues identified in order to bring about systems improvement.

85. Queensland Health and other health care providers would do well to incorporate these guidelines in their own training courses on complaints handling and should make complaint handling an essential part of induction courses for all health practitioners. Further to this, it is fundamentally important that patients be able to discuss their concerns directly with the clinician who provided the service. Where an adverse outcome results from a procedure, it is, in my view, unacceptable for the practitioner who performed the procedure to delegate responsibility for informing the patient, or the patient's family, to a more junior practitioner. I apprehend that the value and importance of effective and sensitive communication is sometimes underestimated by busy clinicians.

86. I also believe it would be advantageous that a clear pathway be established to enable complaints data to be fed into a central unit within Queensland Health charged with collating, analysing and disseminating that information in order to bring about systems improvement. Such information should be made available to the HRC which should be responsible for monitoring Queensland Health's complaints management system and to cross reference Queensland Health data with complaints made directly to the HRC. It is, in my opinion, important to be able to cross-reference complaints made at the local level with complaints made to the HRC and, indeed to registration bodies, to be able to identify trends. This would assist in ensuring that the successful local resolution of individual complaints does not obscure more disturbing patterns of conduct. For example, a worrying number of similar complaints against a provider within Queensland Health might only become evident through an aggregation of complaints received by the HRC, the Medical Board and the health district in which the practitioner operates.

87. I have earlier adverted to the importance of an experienced patient complaints officer available in each health service to receive complaints and ensure appropriate local resolution action. Such officers need to be adequately empowered to deal with the complaints they receive and require the strong support of management and clinicians. In addition to such support they require appropriate training in complaints management. In accordance with Section 10(f) of the HRC Act, one of the key functions of the HRC is to assist providers to develop procedures to effectively resolve health service complaints. HRC staff already meet on a regular basis with Queensland Health complaints officers based in the Brisbane metropolitan area. Appropriately resourced, the HRC could play an expanded role in the training of Queensland Health staff responsible for complaint handling in hospitals and other public health facilities. The HRC is well equipped to provide such a training function given its experience in dealing with health complaints and the fact that, as the specialist external complaints body, it is experienced in identifying the barriers to successful complaints resolution at the local level.

Incident reporting

88. Incident reporting is another important way to improve health care by drawing lessons from things that go wrong. The Final Report of the Quality in Australian Health Care Taskforce recommended that identification and investigation of adverse events, or incidents that may lead to adverse events, should be routine for hospitals and other organisations where health care is delivered. Major incidents and, in particular, surgical deaths should be monitored not only by individual hospitals but also centrally to identify any potentially worrying trends.

89. The effectiveness of incident reporting relies on a number of factors, such as simple and accessible reporting mechanisms, but above all it relies on staff support. The recent review of clinical services at BBH conducted by Queensland Health referred to a tendency to adopt a

punitive approach to staff who reported incidents, rather than an approach that used incident reporting as an opportunity to learn. For incident reporting to be of any value, clinical staff need to have a clear understanding of the types of incidents they are required to report, and a strong commitment to that process. The level of commitment will in turn depend on management support and encouragement. Staff must feel encouraged and empowered to report adverse events. This is more likely to be the case if they can see that reporting of clinical incidents leads to improvements in the overall standard of care; less likely if they feel that they will be targeted or punished for what they report. There also need to be clear systems in place to facilitate the making of reports (put simply, the forms need to be easy to fill out or the data easy to input) and to analyse data in a meaningful way. Finally, there needs to be the capacity to link data from complaints and clinical incident reports, to provide the fullest possible picture of clinical and quality levels. Analysis of such data needs to be undertaken by appropriately skilled and resourced staff at both local and central levels, to provide maximum capacity to recognise risks and identify trends and thus afford maximum protection to the public.

The Effectiveness of Independent Review

90. By acting as an alternative dispute resolution process, health complaints systems provide a viable and inexpensive means of resolving claims of medical negligence without recourse to legal action. They also provide a user-friendly forum for canvassing a myriad of other issues that may arise between practitioners and their patients where financial compensation is not an issue. At the same time, health complaints can bring an invaluable patient perspective to quality improvement. It is important that information gleaned from complaints is fed back into the system to help improve health practices and procedures. As stated in the HRC's submission to the previous Inquiry, by this means one person's complaint may help in improving the health system for all users.

91. In 1992 the Consumers' Health Forum of Australia set down the following minimum standards that it felt health consumers would expect of independent health complaints bodies:

- recognition of the health rights of consumers, including the right to participate in all possible aspects of complaints procedures;
- universal coverage of all health services. Private and publicly provided services should be covered by health complaints bodies;
- independence based in legislation. The complaints body should be established by legislation as a way of ensuring that it can not be easily disbanded after a change of government or government policy;
- public recognition and accessibility. Obviously, the complaints system must be widely known and hold credibility in the community. It must also be easily accessible;
- consumer advocacy and support through the complaints system. Some consumers will need to have others speaking on their behalf in the process of complaining;
- adequate authority and powers to resolve complaints through conciliation, investigation and appropriate redress;
- role in improving the quality of health services. Wherever improvements are possible, the complaints body should be able to report back to health services on appropriate practices;

- co-ordination of the health complaints system. The complaints system should also be open to review and evaluation;

- accountability and appeals. Complaints bodies should be accountable to those they serve and should include processes to enable consumers to complain about, and appeal decisions made by, the body; and

- adequate resources. Obviously, to be effective a complaints body needs to be adequately resourced.

92. These standards which I strongly endorse, are consistent with those of the Taskforce on Quality in Australian Health Care which recommended that the performance of complaints systems should be measured and compared against criteria such as accessibility, timeliness of response, quality of written response and resulting action and should be a routine part of government monitoring of health care safety and quality.

93. I attach, for completeness, copies of the Annual Reports of the HRC for the periods since my appointment as Commissioner:

"DK4" 2002 - 2003 Annual Report

"DK5" 2003-2004 Annual Report.

Dated 19 September 2005

David Arthur Kerslake

Witness