Report of the
Queensland Ombudsman

QUEENSLAND
ombudsman

The Neville Report

An investigation into the adequacy of the health complaint mechanisms in Queensland, and other systemic issues identified as a result of the death of Elise Neville, aged 10 years.

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Abbreviations and Dictionary

ACCC	Australian Competition and Consumer Commission
ACEM	Australian College for Emergency Medicine
ACSQHC	Australian Council for Safety and Quality in Health Care
ADR	Alternative dispute resolution
AIMS	Australian Incident Monitoring System
AMA	Australian Medical Association
AORU	Audit and Operational Review Unit within QH
ASMOFQ	Australian Salaried Medical Officers Federation Queensland
BHCI	Bundaberg Hospital Commission of Inquiry
CAC	Complaint Advisory Committee of the MBQ
CC	Complaints Coordinator
CCC	Clinical Coordination Centre
CCCP	Clinical Coordination Centre Project
CH	Caloundra Hospital
CH ED	Caloundra Hospital Emergency Department
CMC	Crime and Misconduct Commission
CMP	Complaints Management Project
DES	Department of Emergency Services
DG	Director-General of QH
EARC	Electoral and Administrative Review Commission
ED	Emergency Department
Elise	Elise Susannah Neville
Executive Director	Executive Director of Medical Services, SCHSD
HCCA	Health Care Complaints Act 1993 (NSW)
HCCC	Health Care Complaints Commission (NSW)
HDC	Health and Disability Commissioner
HPPSA	Health Professionals (Professional Standards) Act 1999
HRC	Health Rights Commission
HRCA	Health Rights Commission Act 1991
HSA	Health Services Act 1991
HSP	Health service provider
IHSC	Independent Health Services Commission
MBQ	Medical Board of Queensland
MUARC	Monash University Accident Research Centre (Vic)
NA	Nursing Act 1992
NHS	National Health Service (UK)
NPSA	National Patient Safety Agency (UK)
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
OCHO	Office of the Chief Health Officer
OFT	Office of Fair Trading
OHPRB	Office of the Health Practitioner Registration Boards
Ombudsman Act	Ombudsman Act 2001
PSC	Professional Standards Committee of the QNC
QAS	Queensland Ambulance Service
QCC	QEMS Coordination Centres (Brisbane & Townsville)
QEMS	Queensland Emergency Medical System
QEMSAC	Queensland Emergency Medical System Advisory Committee
QH	Queensland Health
QH PSC	Patient Safety Centre within QH

QHSR	Queensland Health Systems Review
QISU	Queensland Injury Surveillance unit
QNC	Queensland Nursing Council
QPHCI	Queensland Public Hospitals Commission of Inquiry
QPS	Queensland Police Service
RCA	Root Cause Analysis
RCH	Royal Children‟s Hospital, Brisbane, Queensland
RN	Registered Nurse
RN1	the Registered Nurse who triaged Elise upon her initial presentation to the ED at Caloundra Hospital
RN2	the other Registered Nurse who was on duty in the ED at the time of Elise‟s initial presentation to Caloundra Hospital
SAISS	South Australian Injury Surveillance System
SCHSD	Sunshine Coast Health Service District
The Code	Code of Health Rights and Responsibilities
The Commissioner	Commissioner of the Health Rights Commission
The complainants	Dr Gerard Neville and Mrs Lorraine Neville
The Coroner	the State Coroner for Queensland
The External Investigator	an interstate Clinical Professor of Neurosurgery appointed by Dr Buckland in 2004 to conduct an independent investigation into some of the concerns raised by Elise‟s incident
The medical officer	the junior doctor who attended to Elise at both her presentations to the ED at the Caloundra Hospital
The Minister	Minister for Health
The Nevilles	Dr Gerard Neville and Mrs Lorraine Neville
Tribunal	Health Practitioners Tribunal
UK	United Kingdom
VISU	Victorian Injury Surveillance Unit
WA	Western Australia
WPA	Whistleblowers Protection Act 1994

Executive Summary

The incident

In January 2002, Dr Gerard & Mrs Lorraine Neville, and their three children, including Elise, aged 10 years, were holidaying in rental accommodation at Kings Beach, Caloundra.

On Sunday 6 January, Elise Neville retired to bed at approximately 9.30pm. She went to sleep in the top bunk of a bunk bed. The top bunk was not fitted with safety guard rails. The next morning, at approximately 1.50am, Elise fell from the top bunk onto the floor of the bedroom. Dr Neville checked Elise for injuries and noted that there was no blood on Elise"s head or evidence of any obvious breaks or other visual injuries. Elise remained conscious but complained that her head hurt. An ice pack was applied to the left side of her head and Dr Neville attempted to resettle Elise while he kept her under observation. She was monitored by her parents for a short period of time, but she later became very agitated and vomited. Dr Neville and his wife then took Elise to the Caloundra Hospital (CH) where she was examined.

The Nevilles arrived with Elise at the Emergency Department (ED) of the CH at approximately 3.20am. Elise was examined by a medical officer. There were two registered nurses on duty who also interacted with Elise and her parents. The medical officer who examined Elise recorded in his notes that there was "*unlikely significant injury – not required CT*[1] *– would require sedation*." The CH was not equipped with a CT scanner at that time. Dr Neville requested that Elise be admitted for observation, but this request was not agreed to. Elise was discharged and the Nevilles left the hospital at approximately 4.25am.

After returning to their accommodation, Elise"s condition deteriorated. Shortly after 7.00am on Monday 7 January, the Nevilles called an ambulance. Elise was taken to the CH where she was later evacuated by heliambulance to the Royal Children"s Hospital (RCH) in Brisbane for emergency specialist treatment.

Upon arriving in Brisbane, a CT scan was taken which showed that Elise had suffered an extensive left sided extradural haematoma and a skull fracture. She was taken to theatre immediately but her neurological condition remained very poor after surgery. Tests carried out on 9 January 2002 confirmed that brain death had occurred and there was no chance of recovery.

Tragically, Elise passed away later that day without having regained consciousness.

The complaints

Shortly following Elise"s death, the Nevilles lodged formal complaints with Queensland Health (QH), the Health Rights Commission (HRC), the Medical Board of Queensland (MBQ) and the Queensland Nursing Council (QNC) concerning the standard of care provided to Elise by the medical officer and the nursing staff on duty at the time of Elise"s first and second presentations at CH. Their allegations included:

- unprofessional conduct by the medical officer and the two registered nurses whom they dealt with;

[1] Computerised tomography (formerly called a CAT scan).

- delay in providing appropriate treatment;
- delay in transferring Elise to the RCH in Brisbane; and
- concerns about the accuracy of a preliminary investigation report prepared by QH about the incident.

The Nevilles also made a formal complaint to the Office of Fair Trading (OFT) about the adequacy of safety regulations applying to bunk beds in Queensland.

After conducting preliminary inquiries under s.22 of the *Ombudsman Act 2001*, I subsequently advised each of the agencies complained about that I would conduct an investigation under the Act.

The investigation

The focus of my inquiry has been to review the administrative actions taken by each of the agencies in response to the complaints by the Nevilles. As a result of my preliminary inquiries, I resolved to investigate:

- the adequacy of QH‟s response to the Nevilles‟ complaint;
- the adequacy of the health complaint mechanisms in Queensland, and what changes should be made to provide a more efficient health complaints system; and
- health complaint mechanisms in other jurisdictions, to determine if there is a best practice model.

The submission to the Bundaberg Hospital Commission of Inquiry

By letter dated 3 May 2005, Commissioner AJH Morris QC, Chairman of the Bundaberg Hospital Commission of Inquiry (BHCI) invited me to lodge a written submission regarding:

- appropriate systems of accountability to ensure the proper processing, investigation and resolution of complaints about clinical practice and procedures at Queensland Health hospitals;
- the role of the Queensland Ombudsman in respect of such complaints; and
- the desirability or otherwise of establishing a specific „Health Ombudsman‟ for Queensland.

On 23 May 2005, I also received a summons from the BCHI to produce all documents received or created by my Office in investigating the Nevilles‟ complaint. Officers of the BCHI advised my officers that the Inquiry intended to call Dr Neville to give evidence about the matter within about a week. I decided to delay completion of my investigation in case the Inquiry obtained evidence or made recommendations relevant to my investigation.

In response to Commissioner Morris‟ invitation, I provided a detailed submission to the Inquiry in August 2005. The submission contained details of my investigation of the Nevilles‟ complaint as a case study demonstrating the inefficiencies in the health complaints system in Queensland.

The purpose of my submission was to:

- provide an overview of the current health complaints system in Queensland;

- identify deficiencies in the system;
- review health complaints systems in other jurisdictions; and
- make recommendations for an enhanced system in Queensland.

The BCHI was closed down before it could finalise its inquiries into the Nevilles‟ complaint. Dr Neville was not called to give evidence before the BCHI.

My submission was also provided to the Queensland Public Hospitals Commission of Inquiry (QPHCI) conducted by Commissioner Davies and the Queensland Health Systems Review (QHSR), also known as the Forster Review.

The QPHCI did not specifically investigate the Nevilles‟ complaint, but included in its final report a summary of my submission on their complaint and broadly endorsed my proposals for reform of the health complaints system.[2]

The Coroner and publication of my report

On 14 February 2003, the Nevilles wrote to the State Coroner asking that an inquest be held into Elise‟s death[3].

The State Coroner informed the Nevilles that there would be a coronial inquest into Elise‟s death following completion of the independent investigations by the HRC, the MBQ and the QNC.

On 24 March 2004, my officers met with representatives of the State Coroner‟s office to discuss the Coroner‟s position in relation to the holding of an inquest into Elise‟s death and the relevance to that issue of other independent investigations concurrently being undertaken by the HRC, MBQ & QNC. My officers were informed that, while there was no formal policy requiring the Coroner to await the outcome of other associated investigations, it was the Coroner‟s preferred position to await the outcome of all other investigations and disciplinary proceedings before holding an inquest in order that all relevant information could be made available to the inquest.

At the time of compiling this report, the State Coroner had not allocated a date for the inquest.

Section 57A(2) of the Ombudsman Act allows me to provide a copy of this report to the State Coroner to "*help an inquiry*". I intend to take this step.

Additionally, s.52 of the Ombudsman Act also allows me to provide a report to the Speaker of the Queensland Legislative Assembly for tabling in the Assembly. I generally take this step if my investigation identifies significant systemic problems that are a matter of public interest. However, in this case, the State Coroner has indicated the intention to hold an inquest and it would not be appropriate for me to issue a public report that may give the appearance of pre-empting the Coroner‟s findings.

[2] Final Report of the QPHCI dated 30 November 2005 at paragraphs 6.254, 6.257,6.449,6.467-6.468 & 6.477-6.481.
[3] Section 7B(6) of the Coroners Act 1958.

Systemic issues

My investigation identified a number of significant flaws with the health system in Queensland. These include:

- unsafe working hours for junior doctors;
- a junior doctor being left in charge of a hospital emergency department without adequate supervision and without appropriate clinical protocols; and
- QH‟s inadequate response to an adverse event (for example, QH did not conduct an internal investigation or provide "open disclosure" to the Nevilles).

My investigation also considered the adequacy of safety regulations in respect of bunk beds and found them to be inadequate.

The most concerning aspect of the Nevilles‟ complaint however was the inability of the health complaints system to provide for one investigation that could cover all aspects of the complaint. The Nevilles saw their complaint as being essentially about one incident. However, the health complaints scheme dictated that their complaint had to be split, and different aspects of it referred to different agencies for action.

In the last four years, six separate bodies (not including my Office) have been involved in inquiring into aspects of the adverse incident involving Elise (that is, the State Coroner, the HRC, the MBQ, the QNC and QH, and the CMC concerning two allegations of official misconduct in respect of QH officers). Putting aside the involvement of the State Coroner and the CMC, the fact that this complaint necessitated investigations by the HRC, the MBQ and the QNC (as well as the external investigation commissioned by QH as the health service provider), is indicative of an inefficient, dysfunctional and compartmentalised health complaints system.

As a result, there were:

- four separate investigations by four different health related agencies, all acting under different legislation and with different internal policies and procedures;
- four different investigation reports delivered at different times and with different outcomes; and
- considerable delays brought about by the numerous consultation processes during the assessment and investigation processes.

Particulars of maladministration

I consider that various administrative actions of QH, the HRC, the MBQ and the QNC were, at times, unreasonable and/or based wholly or partly on a mistake of fact or law, within the meaning of s.49(2) of the Ombudsman Act.

Specific opinions about decisions and actions that I consider involve maladministration are discussed at the following chapters in the report:

Queensland Health
Chapter 3
- The adequacy of clinical record keeping

- The failure to provide open disclosure following an adverse event
- The application of a policy of non admission of children
- The inadequacies of the administrative systems in place
- The decision not to undertake an investigation
- The standard of care provided
- The adequacy of the Executive Director‟s report

Health Rights Commission
Chapter 5
- The quality of the initial HRC investigation

Medical Board of Queensland
Chapter 6
- The initial failure of the MBQ to take action to impose conditions on the registration of the medical officer

Queensland Nursing Council
Chapter 7
- The adequacy of the initial QNC investigation
- The adequacy of the QNC‟s investigation of RN 2
- Delay in taking disciplinary action by the QNC
- Delay by the QNC out of concern for prejudicing other legal proceedings

Office of Fair Trading
Chapter 9
- The adequacy of mandatory safety standards in relation to bunk beds

Opinions

I formed the following opinions:

Queensland Health

Opinion 1

The clinical documentation relating to both of Elise's presentations at CH ED was inadequate. This amounted to unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 2

QH failed to engage in a process of open disclosure with the Nevilles following Elise's death. The failure to do so was unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 3

The absence of a written policy on the admission of children to CH led to staff believing children were not to be admitted.

Opinions 4 and 5

4. The administrative system in place at the CH ED at the time of Elise's presentations was defective in that it was based on actions and decisions of QH that were unreasonable and wrong (within the meaning of s.49(2)(b) and (g) of the Ombudsman Act). In particular:

(a) At a peak holiday time, the ED was staffed by one second year junior doctor, contrary to the standard recommended (since March 1999) by the ACEM and recommendations included in QH's 2001 report of "The review of Emergency Services, Sunshine Coast Health Service District".

(b) This staffing deficiency was compounded by rostering practices that required excessive hours of work by junior doctors, such that the junior doctor who attended to Elise at her first presentation was in the 20th hour of a continuous shift.

(c) The problems inherent in leaving a junior doctor in charge of an ED were compounded by the lack of ready access to written protocols for the treatment of significant medical conditions commonly presenting at EDs, especially, in this case, the lack of ready access to a written protocol covering the assessment and treatment of paediatric head injuries.

(d) A practice had been allowed to develop among clinical staff at CH ED of refusing admission of children on the basis that Nambour General Hospital was better resourced to deal with those patients. This practice had developed to the point where many clinical staff understood it to be a firm policy. The management of CH had not taken sufficient steps to make clear to clinical staff that there was no such policy and that admission of children could occur where that was necessary in the best interests of the proper treatment of a child patient (even if referral to Nambour General Hospital was preferable in non-urgent cases).

5. This defective system is likely to have contributed to the mistakes made in the assessment of Elise.

Opinion 6

QH's decision not to undertake an investigation (including a Root Cause Analysis) in response to the death of Elise was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act having regard to the gravity of the allegations made by the Nevilles about the standard of care provided to Elise by CH.

Opinion 7

QH failed to provide an appropriate standard of care to Elise at her first presentation to CH ED on 7 January 2002.

Opinion 8

QH should have reviewed the Executive Director's report following the very serious allegations raised by the Nevilles about its accuracy and its failure to do so was unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Health Rights Commission

Opinion 9

(a) The HRC's initial investigation of the Nevilles' complaints was inadequate.
(b) In the circumstances, particularly having regard to the Nevilles' serious concerns about the level of care provided to Elise by CH, the Commissioner should have provided to the Nevilles details of all of the adverse comments he made to QH following his initial investigation.

The HRC's actions amounted to unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Medical Board of Queensland

Opinion 10

The MBQ should have taken action under s.59 of the HPPSA to impose conditions on the registration of the medical officer at its meeting of 11 March 2003, when it reviewed its earlier decision not to take such action. The MBQ's actions amounted to unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Queensland Nursing Council

Opinion 11

I am satisfied that:
(a) the Nevilles, as part of their initial written complaint (a copy of which was sent to the QNC), raised the allegation that RN 1 had deliberately fabricated records of Elise's assessment.
(b) this allegation raised questions about RN 1's honesty and not simply questions about her competence.

Opinion 12

The QNC's investigator should have sought corroboration from QH for RN 2's assertion that, at the time Elise was treated at CH, RN 2 was not the nurse in charge. The failure to do so was unreasonable administrative action, within the meaning of s.49(2)(b) of the Ombudsman Act.

Opinion 13

In the circumstances, there was no justification for the QNC to delay its determination of whether or not disciplinary action should be taken against RN 1 out of concern for prejudicing her in respect of other legal proceedings or possible legal proceedings. Such delay was unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Office of Fair Trading

Opinion 14

The existing mandatory safety standard in relation to bunk beds is ineffective in addressing safety issues associated with bunk beds purchased prior to 1 November 2002.

Queensland Ambulance Service and Queensland Health

Opinion 15

The information available suggests that system changes implemented as a result of the review of Queensland's aeromedical services have provided Queensland with a more efficient and better coordinated clinical and transport service.

Recommendations

I make the following recommendations under s.50(1) of the Ombudsman Act:

Queensland Health

Recommendation 1

1.1 QH expedite the implementation of the national pilot program on open disclosure in Queensland's public hospitals.

1.2 In the meantime, QH develop policy options for redress for persons identified as having suffered a detriment owing to failings in the provision of health care, for example, the making of an apology or an *ex gratia* payment.

Recommendation 2

QH should follow its NSW counterpart and undertake to produce an annual public report on incident management in the Queensland public health system. The report should include an analysis of the causes (clinical and systemic) of health care incidents as revealed by Root Cause Analysis of sentinel and other adverse events.

Recommendation 3

QH ensure that formal admission policies/guidelines exist in all public hospital emergency departments and that all ED staff are adequately trained in the application of these policies/guidelines prior to commencing duties in those departments.

Recommendation 4

QH determine, as quickly as possible, an interim standard on safe working hours for doctors in public hospitals for implementation by QH pending finalisation and implementation of any standard being developed by the MBQ.

Recommendation 5

QH progressively implement as quickly as possible, the management practices aimed at alleviating the ill-effects of excessive working hours, recommended in the AMA Safe Hours Campaign and Risk Management Strategies.

Recommendation 6

QH adopt and implement (at least) the following aspects of the December 2001 policy document published by the ACEM:

- **Written protocols regarding the treatment of the specific conditions listed in the ACEM policy be available in all QH EDs at all times;**
- **The protocols stipulate the kinds of medical condition when consultation must occur with a senior doctor;**
- **An audit be undertaken of the CKN accessibility and ease of use for clinicians in EDs;**
- **All junior medical staff employed in QH EDs be involved in an ongoing learning program in paediatric emergency medicine.**

Recommendation 7

QH expedite implementation of its revised Clinical Incident Management Policy and supporting Implementation Standard and ensure that appropriate training and support are available to all Health Service Districts.

Recommendation 8

QH provide an apology to the Nevilles for its failure to provide an appropriate standard of care to Elise.

Recommendations 9 and 10

9. **A record should be created and attached to all copies of the Executive Director's report held by QH detailing the inaccuracies contained in the report.**
10. **QH should also forward a copy of the attachment to every agency known to have obtained a copy of the Executive Director's report, and request that the attachment be added to the report.**

Recommendation 11

QH immediately undertake an independent review of the paediatric qualifications and training provided to ED nursing staff in CH to ensure that an acceptable standard of paediatric care is available at all times.

Recommendation 12

QH finalise the implementation of its complaints management database as a matter of priority.

Recommendation 13

Steps be taken to improve coordination of data collection practices within QH to minimise duplication of effort.

Recommendation 14

Feedback be given to all health districts at regular intervals (quarterly or six monthly) on the analysis of complaints and other health data for quality improvement purposes.

Recommendation 15

QH, in implementing any changes to its internal complaints management system in response to the recommendations made by the QHSR and the QPHCI, also have regard to:

- **recommendations 12, 13 and 14 of this report; and**
- **my recommendations in Appendix 3 of this report.**

Health Rights Commission and Queensland Health

Recommendation 16

In respect of the complaint about the Executive Director's report, no effective investigation occurred because of the HRC's opinion that it lacked jurisdiction. The proposed Health Quality and Complaints Commission Act should empower the Health Quality and Complaints Commission to investigate administrative actions incidental to a health service. This could be achieved by expanding the meaning of "health service".

Queensland Nursing Council

Recommendation 17

QNC cease its practice of delaying consideration of disciplinary action pending the completion of criminal or other proceedings unless, in the circumstances of a particular case, it has obtained legal advice that there are valid reasons for doing so.

Recommendation 18

QH seek legal advice on the circumstances in which it is appropriate for a health practitioner registration board or the QNC to delay consideration of disciplinary action pending the completion of criminal or other proceedings.

Recommendation 19

QH provide me with a copy of that advice.

Recommendation 20

If the advice supports the position that disciplinary proceedings should be suspended wherever a registrant the subject of a disciplinary investigation has or may be charged with a criminal offence, QH should seek legislative amendments to:

- **abrogate the privilege against self-incrimination in disciplinary proceedings before those bodies and their related tribunals, and**
- **protect admissions made in any such proceedings from being used in other legal proceedings.**

Recommendation 21

The Director-General of Queensland Health cause a review to be undertaken of the disciplinary regime for health practitioners, taking into account the recommendations I made about this issue in my submission to the BHCI and the QPHCI (see Appendix 1).

Office of Fair Trading

Recommendations 22, 23 and 24

22. All Queensland government agencies that own, manage or fund establishments which use bunk beds as sleeping accommodation for children ensure that the bunk beds comply with the current mandatory safety regulations.

23. The OFT seek the Minister's agreement to prepare a regulatory impact statement examining the costs and benefits of a regulation requiring all commercial suppliers of accommodation utilising bunk beds to ensure that the bunk beds comply with the 2003 mandatory safety standard. In the course of preparing the regulatory impact statement, the OFT should consult stakeholders in the relevant industry on the practical difficulties and/or financial burdens of complying with such an obligation, and canvass practical solutions such as implementation within a period of (say) three years.

24. The OFT take steps:

24.1 to develop a joint communication strategy with the Commission for Children and Young People and Child Guardian, the Queensland Injury Surveillance Unit and Queensland Health to raise public awareness of the changes to mandatory safety standards for bunk beds based on Australian Safety Standard 4220:2003, and the hazards of unsafe sleep environments for children generally, including bunk beds.

24.2 to form a joint working party with representatives from the entities referred to in 21.1 with a view to considering the feasibility of establishing and promoting government funded programs focused on removing "unsafe" bunk beds from private residences.

Queensland Health

Recommendation 25

QH conduct periodic systems evaluations of retrieval services as planned.

1 Background

1.1 Introduction

I have completed my statutory investigation of a complaint made to the Queensland Ombudsman on 22 December 2003 by Dr Gerard Neville and Mrs Lorraine Neville (the Nevilles).

Their complaint raised significant concerns alleging maladministration by Queensland Health (QH) that may have contributed to the death of their daughter Elise on 9 January 2002, and about the adequacy of subsequent actions taken by QH, the Health Rights Commission (HRC), the Medical Board of Queensland (MBQ), the Queensland Nursing Council (QNC) and the Office of Fair Trading (OFT) in response to complaints they had made.

1.2 The role of the Queensland Ombudsman

The Ombudsman is an officer of the Parliament[4] empowered to deal with complaints about the administrative actions of Queensland government departments, public authorities and local governments.

Under the *Ombudsman Act 2001*, I have authority to:

- investigate maladministration by public sector agencies, in response to complaints, although I can also investigate on my own initiative;
- make recommendations to an agency being investigated about ways of rectifying the effects of its maladministration and improving its practices and procedures;
- consider the administrative practices of agencies generally and make recommendations, or provide information or other assistance, to improve practices and procedures.

In investigating the administrative actions of officers of public sector agencies, the Ombudsman must consider whether the actions were (among other things[5]):

- unlawful, unreasonable or unjust;
- taken for an improper purpose, on irrelevant grounds, or having regard to irrelevant considerations;
- based wholly or partly on a mistake of law or fact; or
- wrong.

If I consider that an agency‟s actions involve maladministration, I may provide a formal report to the principal officer of the agency. In my report, I may make recommendations to rectify the specific maladministration or to improve the agency‟s policies, practices or procedures with a view to minimising the prospect of problems recurring.

If an agency does not implement my recommendations, I can report the matter to the Premier or prepare a report for Parliament[6].

[4] Section 11(2) of the Ombudsman Act.
[5] Section 49(2) of the Ombudsman Act.
[6] Section 51(3) and (4) of the Ombudsman Act.

The Ombudsman can investigate administrative actions of an agency[7], including Queensland agencies that provide health services, deal with complaints about the provision of health services, and regulate the health service professions.

However, the Ombudsman is expected to liaise with other complaints entities to avoid inappropriate duplication of investigative activity[8] and would not ordinarily accept an initial complaint about the provision of a health service if the complaint more appropriately fell within the jurisdiction of the HRC, the MBQ (or another registration board), or the QNC.

Furthermore, in most cases, my Office will not accept a complaint unless the complainant has tried to resolve it with the agency that is the subject of the complaint.

In the 2004-2005 financial year, my Office received 339 health-related complaints. Of those:

- 256 related to QH;
- 50 related to the HRC;
- 33 related to a various registration boards or the QNC.

In accordance with our normal practice in relation to QH complaints, many of the 256 complaints received (126) were referred to QH for internal review, while an additional 37 complaints were referred to the HRC or to the relevant Health Practitioner Registration Board.

1.3 Procedure for gathering evidence

Section 25 of the Ombudsman Act provides as follows:

> *25 Procedure*
>
> *(1) Unless this Act otherwise provides, the ombudsman may regulate the procedure on an investigation in the way the ombudsman considers appropriate.*
>
> *(2) The ombudsman, when conducting an investigation:*
>
> *(a) must conduct the investigation in a way that maintains confidentiality; and*
>
> *(b) is not bound by the rules of evidence, but must comply with natural justice; and is not required to hold a hearing for the investigation; and*
>
> *(c) may obtain information from the persons, and in the way, the ombudsman considers appropriate; and*
>
> *(d) may make the inquiries the ombudsman considers appropriate.*

Section 49(2) outlines the grounds upon which an Ombudsman may make a recommendation.

[7] Sections 8 and 9 of the Ombudsman Act.
[8] Section 15 of the Ombudsman Act.

The Ombudsman Act is silent as to what standard of proof is required to be met before the Ombudsman can be satisfied that grounds exist for forming an opinion for the purposes of s.49(2). This question is of special importance where an opinion could be considered adverse to an individual.

1.4 Standard of proof and sufficiency of evidence

The question of the sufficiency of evidence requires some assessment of weight and reliability. In making that assessment, the standard of proof, appropriate to the opinions required to be formed, needs to be applied.

Two standards of proof are known to the common law, the criminal standard and the civil standard. The criminal standard requires proof beyond reasonable doubt. The civil standard requires proof on the balance of probabilities. "Balance of probabilities" essentially means that, to prove an allegation, the evidence must establish that it is more probable than not that the allegation is true.

The civil standard of proof applies in investigations conducted by an Ombudsman.

The strength of evidence necessary to establish an allegation on the balance of probabilities may vary according to the seriousness of the issues involved. In the case of *Briginshaw v Briginshaw* (1938) 60 CLR 336, Dixon J remarked that:

> *The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved.*

1.5 Procedural fairness and natural justice

The terms "procedural fairness" and "natural justice" are often used interchangeably within the context of administrative decision-making.

The rules of procedural fairness have developed to ensure that decision-making is both fair and reasonable.

Several sections of the Ombudsman Act either state or reinforce the principle that persons the subject of adverse comment should be provided with an opportunity of being heard in relation to a matter before I form a final opinion.

Section 25(2) of the Ombudsman Act provides that when conducting an investigation, I must comply with the "principles of natural justice".

Section 26(3) of the Ombudsman Act provides that, if at any time during the course of an investigation it appears there may be grounds for making a report that may affect or concern an agency, the principal officer of that agency must be offered an opportunity to comment on the subject matter of the investigation before the report is made.

Section 55 of the Ombudsman Act provides that any report under the Act must not make comment adverse to any person unless that person has been given an opportunity of making submissions about the proposed adverse comment. If, after assessing those

submissions, I still propose to make adverse comment, I am required to ensure that person's defence is "fairly stated" in the final report.

While the courts have emphasised the need for flexibility in the application of the rules of procedural fairness and natural justice depending on the circumstances of each individual case, procedural fairness or natural justice generally requires an investigator conducting an administrative investigation to:

- inform people against whose interests a decision may be made of the substance of any allegations against them or the grounds for adverse comment in respect of them;
- provide people with a reasonable opportunity to put their case, whether in writing, at a hearing or otherwise;
- hear all parties to a matter and consider submissions;
- make reasonable inquiries or investigations before making a decision, forming an opinion or taking any action;
- ensure that no person decides a case in which they have a direct interest; and
- act fairly and without bias and conduct the investigation as expeditiously as possible.

Essentially, the provision of natural justice to an individual helps to ensure that that person‟s legitimate rights and interests are safeguarded.

This report[9] was provided to the Directors-General of QH and OFT, the Health Rights Commissioner and the Executive Officers of the MBQ and QNC in proposed form to allow those persons an opportunity to comment on the subject matter of the investigation before my final report was completed. Relevant parts of the report were also provided to Dr Stable and to Dr Buckland, who were former Directors-General of QH, to allow them to provide comments. Responses were received from each of these agencies and persons. These responses have been incorporated into the report at various points. Other relevant information supplied by QH has been summarised in Appendix 8.

This report contains recommendations made pursuant to s.50 of the Ombudsman Act. Section 51 of the Ombudsman Act states that if an agency is given a report under s.50 that makes recommendations, the Ombudsman may ask the agency‟s principal officer to notify within a stated time of:

- the steps taken or proposed to be taken to give effect to the recommendations; or
- if no steps, or only some steps, have been or are proposed to be taken to give effect to the recommendations, the reasons for not taking all the steps necessary to give effect to the recommendations.

In accordance with this provision, I will be asking the relevant Directors-General and Executive Officers to advise me of the steps taken, or proposed to be taken, to give effect to the recommendations I have made.

1.6 Directors-General of Queensland Health

There were three Directors-General of Queensland Health during the period of my investigation. Dr Stable was Director-General until January 2004, although he was on leave from 31 October 2003. Dr Buckland was Acting Director-General from 31 October 2003 and Director-General from 29 April 2004 to 27 July 2005. Throughout my report I

[9] In some cases, only the relevant parts of the report were provided to the agencies concerned.

have referred to each Director-General as the "then Director-General of QH" and identified the relevant Director-General I am referring to by name in a footnote.

Where I have otherwise referred to "the Director-General of QH", I am referring to the current Director-General, Ms Uschi Schreiber.

1.7 The incident

In January 2002, the Nevilles, with their three children, including Elise aged 10 years, were holidaying in rental accommodation at Kings Beach, Caloundra.

On Sunday 6 January, Elise Neville retired to bed at approximately 9.30pm. She went to sleep in the top bunk of a bunk bed. The top bunk was not fitted with safety guard rails.

At approximately 1.50am on 7 January 2002, the Nevilles were awoken by a loud crashing noise followed by crying. They immediately checked the children‟s bedroom and found Elise lying on the floor beside the bunk bed. She appeared to have fallen approximately 1-1.5 metres from the top bunk. Elise was lying on her right side, conscious and crying. Elise sat up and Dr Neville asked her where she hurt and she responded by saying her head hurt a lot and she touched the left side of her head to show where it hurt. Dr Neville checked Elise for injuries and noted that there was no blood on Elise‟s head or evidence of any obvious breaks or other visual injuries. Elise reaffirmed that it was just her head that hurt. An icepack was applied to the left side of her head. Dr Neville attempted to resettle Elise and observed her closely for a short while.

Elise did not settle well and at about 3.00am became very agitated and vomited about ten minutes later. Dr and Mrs Neville decided to take Elise immediately to the Caloundra Hospital (CH) which was less than 5 minutes away by car.

At approximately 3.20-3.25am, the Nevilles arrived with Elise at the Emergency Department (ED) of the CH. They were met by a registered nurse (RN 1). The Nevilles advised RN 1 that Elise had fallen from the top bunk of a bunk bed earlier in the morning hitting her head, had complained of a bad headache/pain in the head and had vomited a short time ago. RN 1 advised the Nevilles to take Elise into one of the treatment rooms in the ED where she met them a few moments later. RN 1 obtained some details from the Nevilles and then undertook a short assessment of Elise. RN 1‟s clinical notes record that Elise had a fall from a bunk bed, she had a GCS of 15 (Glascow Coma Score[10], worst score 3, normal level of response 15), normal power in her limbs, both eyes were equal to a pupil scale of 4mm and reactive, and a pulse rate of 54.

Upon completion of her assessment, RN 1 reportedly advised the medical officer on duty (the medical officer) that she had completed her triage assessment of a young girl who had presented after falling from the top bunk of a bunk bed. She also advised that there had been no reported loss of consciousness, she was complaining of a headache, generalised aches and pains, had vomited once and had a GCS of 15.

At approximately 3.35 am, the medical officer arrived at the treatment room to undertake an assessment of Elise. After obtaining a brief history from the Nevilles concerning Elise‟s fall and subsequent medical condition, the medical officer conducted an examination of Elise.

[10] Standard test for head trauma patients.

The medical officer"s clinical notes of 7 January 2002 record that upon examination, Elise was:

> "*very poorly compliant, sleepy but easily rouseable. GCS 15, moving all limbs spontaneously and grossly normal tone. Unable to fully assess due to non compliance. Unlikely significant injury. Not required CT- would require sedation."*

During the medical officer"s assessment of Elise, Dr Neville recalls that he raised the possibility of whether a CT scan should be performed to determine if there was an underlying head injury. In response, the medical officer recalls he advised the Nevilles that CT scans were not necessarily performed for every head injury and that if he considered Elise had suffered a significant head injury he would be initially inclined to refer her to Nambour General Hospital which was better able to treat children. CH was not equipped with a CT Scanner[11].

The Nevilles also recall inquiring of the medical officer whether Elise could be admitted to CH for observation. The medical officer advised Dr Neville that it was his understanding that the hospital did not admit children for observation for a number of reasons. Dr Neville queried this advice. The medical officer (who was only new to the ED) sought confirmation from the two nurses on duty, RN 1, and a second registered nurse (RN 2), that children were not admitted to the CH. Dr Neville says he pointed out that he was not asking that Elise be admitted, rather that she be observed for a period of time in the ED, but the medical officer dismissed this as an option and followed through with his decision to discharge Elise home.

The medical officer provided instructions to the Nevilles that they should return if Elise had persistent headache that was not relieved by Panadol, or further vomiting. He recommended that, if these symptoms occurred, they take Elise directly to Nambour General Hospital which was another 30 minutes away (approximately) by road. Contrary to standard hospital procedure, the medical officer failed to provide the Nevilles with a Head Injury Patient advice form upon discharging Elise. The Nevilles recall they left the hospital at approximately 4.25-4.30am.

Upon arriving back at their holiday accommodation, Dr Neville tried to settle Elise on their bed where he could continue to observe her. She was initially restless, but eventually appeared to settle and fall asleep. However upon checking Elise sometime shortly after 7.00am, it was obvious that her condition had deteriorated. An ambulance was called. It arrived at approximately 7.20am. The ambulance intended to take Elise to Nambour General Hospital. However, her condition further deteriorated *en route* and the ambulance diverted to CH. The ambulance report shows that during transport Elise suffered a respiratory arrest and her GCS was recorded as 3. This means there was no eye opening, no response to stimulation and no response to voice.

The ambulance arrived at CH at 7.45am, where Elise was taken into the ED. On re-admission, Elise"s GCS was confirmed at 3.

The attending doctor was the same medical officer who attended Elise at her first presentation. Given Elise"s advanced state of deterioration, the medical officer contacted the emergency medical physician at Nambour General Hospital for instructions. He was provided with treatment instructions and advised that a medical retrieval team would be

[11] Statement of the medical officer dated 27 June 2002 provided to the HRC.

organised and would travel from Nambour to prepare Elise for evacuation by heliambulance to the Royal Children‟s Hospital (RCH) in Brisbane for specialist treatment.

The medical retrieval team arrived at CH at 8.50am. Elise was prepared for evacuation and at approximately 9.40am was airlifted by heliambulance with the medical retrieval team in attendance. Upon arrival at the helipad at the RCH at approximately 10.03am the medical retrieval team accompanied Elise to the receiving unit of the RCH for a CT scan of the head. The CT scan showed an extensive left sided extradural haematoma and a skull fracture. Elise was taken to theatre immediately where the extradural haematoma was drained.

The medical progress notes indicate that Elise‟s neurological condition remained very poor after surgery. Her pupils remained fixed and dilated and there was no improvement in her neurological level. Tests carried out on 9 January 2002 confirmed that brain death had occurred and there was no chance of recovery. At approximately 5.35pm that day, Elise‟s life support was turned off and she passed away without having regained consciousness.

A post-mortem was not performed on Elise at the request of her parents. This request was based on compassionate grounds and was endorsed by Coroner Christine Clements in accordance with s.11 of the *Coroners Act 1958*.

At the request of the RCH, two officers of the Queensland Police Service (QPS) attended the RCH on 9 January 2002 for the purpose of obtaining signed statements from the Nevilles concerning the circumstances surrounding Elise‟s death. At that time, they made allegations of negligence on the part of CH staff in respect of Elise‟s first presentation to CH. The QPS then commenced a coronial investigation into Elise‟s death.

The then Director-General of QH[12] was also immediately informed of the incident and Elise‟s subsequent death. On or about 9 January 2002, Dr Stable contacted the Executive Director of Medical Services (the Executive Director), Sunshine Coast Health Service District (SCHSD) and asked that he find out what had happened in respect of the incident and to send him a brief report as soon as possible.

On 11 January 2002, the Executive Director provided his report to Dr Stable. The report concluded that the early management of Elise had been reasonable.

1.8 Summary of the complaints made to the agencies

Shortly after Elise‟s death, the Nevilles lodged formal complaints with QH, the HRC, the MBQ and the QNC concerning the standard of care provided to Elise by the medical officer and the nursing staff on duty at the time of Elise‟s first and second presentations at CH. Their allegations included:

- an unsatisfactory level of care and service provided by CH;
- unsatisfactory professional conduct[13] by the medical officer and the two registered nurses (RN 1 & RN 2) on duty;
- delay in providing appropriate treatment; and
- delay in transferring Elise to the RCH.

[12] Dr Stable.
[13] As defined in the Health Professionals (Professional Standards) Act and s.31(1)(e) of the Nursing Act.

A further complaint was made about the internal "Preliminary Investigation Report", prepared by the Executive Director and provided to the then Director-General[14] of QH on 11 January 2002.

The Nevilles also lodged a complaint with the OFT about the inadequacy of existing safety regulations applying to bunk beds.

1.9 Particulars of complaint to Ombudsman

An Assistant Ombudsman met with the Nevilles on 22 December 2003 to discuss their complaints. Subsequently, the Nevilles provided my Office with a brief covering letter and four A4 folders of documents relating to their complaints.

A detailed analysis of that material revealed a number of serious concerns about the adequacy of the health complaints system in Queensland, and the actions and decisions of various government agencies responsible for investigating the health services provided to Elise (namely, QH, the HRC, the MBQ and the QNC). It also raised concerns about the adequacy of safety regulations for bunk beds (OFT).

1.9.1 Allegations in relation to QH

The Nevilles' principal allegations about QH were:

- The internal report prepared by the Executive Director for the then Director-General[15] of QH into the incident was false and misleading.
- Failure by QH to take action to suspend the medical officer and RNs 1 & 2 from duty, or limit their duties, pending the outcome of external investigations by their registrant boards.
- Unreasonable refusal by the then Director-General of QH[16] to carry out a full internal investigation into the circumstances surrounding Elise's death.
- QH failed to adequately respond to an adverse/critical incident and to provide „open disclosure[17]".
- An external investigation commissioned by the then Director-General of QH[18] in early 2004 failed to adequately address its limited terms of reference.
- The medical retrieval process is inadequate.

1.9.2 Allegations in relation to the HRC

The Nevilles' principal allegations about the HRC were:

- A 15 month delay in the HRC determining that it did not have jurisdiction to investigate their complaint about the internal report prepared by the Executive Director[19].

[14] Dr Stable.
[15] Dr Stable.
[16] Dr Stable.
[17] Open Disclosure is a process of open communication with patients and their nominated support person following an adverse event. It includes a discussion about what has happened, why it happened and what is being done to prevent it from happening again.
[18] Dr Buckland.
[19] The Executive Director has since retired from QH.

- A lengthy delay in the investigation process of the HRC.
- The HRC‟s initial investigation and report (dated 4 September 2003) into their complaint against QH was grossly inadequate in that:
  - it failed to cover all issues raised in the complaint;
  - many of the investigation findings were not supported by the facts;
  - no recommendations were made in the report for improvement;
  - the HRC provided them with a different version of the investigation‟s findings from the version sent to QH;
  - the HRC failed to allow them an opportunity to comment on the initial report prior to its release.

1.9.3 Allegations in relation to the MBQ

The Nevilles‟ principal allegations about the MBQ were:

- Unreasonable delay in the MBQ conducting and completing its investigation of the conduct of the medical officer.
- MBQ‟s refusal to take any interim action to suspend, or impose interim restrictions on, the medical officer‟s registration pending the outcome of its investigation into his conduct.
- The MBQ‟s unreasonable refusal to investigate their complaint against the Executive Director.

1.9.4 Allegations in relation to the QNC

The Nevilles‟ principal allegations about the QNC were:

- Lengthy delays in the investigation of the complaints against RNs 1 & 2 and in the QNC making a decision as to what, if any, disciplinary action was to be taken against either of them.
- Lengthy delay in finalising a review of its decision as to the disciplinary action to be taken against RN 1.
- Failure by the QNC to take appropriate disciplinary action against either RN.
- Failure to adequately investigate their allegation that RN 1 “fabricated observations and recorded incorrect and misleading information on triage documentation”.

1.9.5 Allegations in relation to the OFT

The Nevilles‟ principal allegations about the OFT were:

- Considerable delay in promoting amendments to existing regulations in relation to bunk beds.
- Failure to introduce safety regulations that applied to all bunk beds (both new and existing, and in the domestic and commercial environments).

1.10 The investigation

The focus of my investigation has been to review the adequacy of the health complaint mechanisms in Queensland and the legislative framework under which they operate. As a result of my preliminary inquiries, I resolved to investigate the following:

- the adequacy of QH‟s response to the complaints;
- the adequacy of the health complaint mechanisms in Queensland, and what changes should be made to provide a more efficient health complaints system;
- the health complaint mechanisms in other jurisdictions, to determine if there is a best practice model.

My investigation identified a number of significant flaws with the current health system in Queensland. These include:

- unsafe working hours for junior doctors;
- a junior doctor being left in charge of a hospital ED without adequate supervision and without appropriate clinical protocols; and
- QH‟s inadequate response to an adverse event[20] (for example, QH did not conduct an internal investigation or provide "open disclosure" to the Nevilles).

My investigation also considered the adequacy of existing safety regulations in respect of bunk beds.

1.11 The Health Practitioners Tribunal

On 20 January 2004, the MBQ found, after investigation, that the medical officer who treated Elise had failed to:

- properly examine Elise;
- suspect that Elise‟s symptoms were a possible sign of a significant head injury; and
- refer Elise for specialist treatment.

Accordingly, the MBQ considered:

> *there is sufficient evidence to conclude that* [the medical officer‟s] *management of Elise Neville at her first presentation to Caloundra Hospital on 7 January 2002, constitutes unsatisfactory professional conduct.*

The MBQ referred the matter to the Health Practitioners Tribunal for hearing. On 8 November 2004, the Tribunal accepted a guilty plea by the medical officer and imposed a number of stringent conditions on his registration.

In handing down its decision, the Tribunal accepted that there were some significant mitigating circumstances which included the medical officer‟s inexperience and fatigue. The District Court Judge hearing the matter was very critical of the lengthy shifts doctors in public hospitals were expected to work.

1.12 Submission to the Bundaberg Hospital Commission of Inquiry

By letter dated 3 May 2005, Commissioner AJH Morris QC of the BHCI invited me to lodge a written submission regarding:

[20] The Australian Council for Safety and Quality in Health Care (ACSQHC) was established in January 2000 by all Australian Health Ministers to lead national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. The ACSQHC defines an adverse event as *an incident where unintended harm resulted to a person receiving health care.*

- appropriate systems of accountability to ensure the proper processing, investigation and resolution of complaints about clinical practice and procedures at Queensland Health hospitals;
- the role of the Queensland Ombudsman in respect of such complaints; and
- the desirability or otherwise of establishing a specific „Health Ombudsman" for Queensland.

Completion of this report was delayed so that I could prepare a detailed submission in response to Commissioner Morris" request. The purpose of my submission was to:

- address issues relevant to the BHCI"s Discussion Paper No. 2, *Whistleblowers in the Queensland Public Health Sector*;
- provide an overview of the current health complaints system in Queensland;
- identify deficiencies in the system;
- review health complaints systems in other jurisdictions; and
- raise proposals for an improved health complaints system in Queensland.

The submission contained details of my investigation of the Nevilles" complaint, as a case study demonstrating flaws and inefficiencies in the current health complaints system in Queensland.

My submission was lodged with the BHCI on 26 August 2005 approximately one week before it ceased operation. A copy of the submission was also provided to the Queensland Health Systems Review (QHSR) and subsequently to the Queensland Public Hospitals Commission of Inquiry (QPHCI), which, in its final report, broadly endorsed my proposals for reform of the current system. Part 2 of my submission dealt with issues relating to health complaints systems. A copy of the relevant part appears at Appendix 1 of this report.[21]

I was recently provided with the exposure draft of the Health Quality and Complaints Commission Bill 2006 which incorporates several of the proposals contained in my submission to the former BHCI.

1.13 Complaints Management Project

Since March 2003, my Office has been helping public sector agencies (including QH) to improve their systems for managing customer complaints through a project named the Complaints Management Project. The aim of the project has been to assist agencies by evaluating the strengths and weaknesses of their existing complaints management arrangements and identifying potential improvements. As part of this project, my Office has also developed and published useful information to help agencies in developing an effective complaints management policy and procedures.[22]

One of the principles underpinning the project is the importance of "frontline complaints handling" – that is, the timely resolution of complaints at the local level. Any good complaints management model should focus on resolving the bulk of complaints at the frontline, while also providing for further internal and external review. This principle has

[21] My submission to the Bundaberg Hospital Commission of Inquiry (BHCI) is available on the Queensland Public Hospitals Commission of Inquiry (QPHCI"s) website at www.qphci.qld.gov.au.

[22] Queensland Ombudsman "Developing Effective Complaints Management Policy and Procedures", March 2004 and supporting Fact Sheets (can be accessed from www.ombudsman.qld.gov.au).

also guided the design of my proposed new health complaints model, endorsed by the QPHCI.

1.14 The Coroner

On 14 February 2003, the Nevilles wrote to the State Coroner asking that an inquest be held into Elise‟s death[23].

The State Coroner informed the Nevilles that there would be a coronial inquest into Elise‟s death following completion of the independent investigations by the HRC, the MBQ and the QNC.

On 24 March 2004, my officers met with representatives of the State Coroner‟s office to discuss the Coroner‟s position in relation to the holding of an inquest into Elise‟s death and the relevance to that issue of other independent investigations concurrently being undertaken by the HRC, MBQ & QNC. My officers were informed that, while there was no formal policy requiring the Coroner to await the outcome of other associated investigations, it was the Coroner‟s preferred position to await the outcome of all other investigations and disciplinary proceedings before holding an inquest in order that all relevant information could be made available to the inquest.

At the time of compiling this report, the State Coroner had not allocated a date for the inquest.

It is my intention to provide a copy of this report to the State Coroner to "help an inquiry" under s.57A(2) of the Ombudsman Act.

1.15 Recent legislative development

The Health Quality and Complaints Commission Bill 2006 was passed by the Legislative Assembly on 25 May 2006.

The Act is expected to commence on 1 July 2006.

[23] Section 7B(6) of the *Coroners Act 1958*.

2 The investigation

2.1 Initiation

On 13 February 2004, QH, the MBQ and the QNC were informed of my intention to commence preliminary inquiries under the Ombudsman Act in respect of the Nevilles‟ complaint. The HRC was similarly informed on 16 February 2004. Particular information was requested from those agencies under s.22 of the Act (which requires that principal officers of agencies give the Ombudsman reasonable help in the conduct of a preliminary inquiry) for the purpose of determining whether the complaint should be investigated.

At that time, most of the agencies were still finalising their own investigations in response to complaints previously made to them by the Nevilles about different aspects of the incident. It was not until late 2004 that most agencies completed their investigations, and provided relevant evidence to my Office. In the meantime, considerable research was undertaken by my staff (for example, concerning the health complaints systems of other jurisdictions, doctors‟ working hours, and safety regulations and injury statistics relating to bunk beds) so as to assist with a proper assessment of the broader issues arising from the Nevilles‟ complaints.

After all relevant material had been assessed, I wrote to each of the agencies[24] informing them of my intention to conduct an investigation of the complaints and seeking their response to specific issues. All agencies willingly provided their responses without any need for formal powers to be exercised under the Ombudsman Act.

The focus of my investigation has been on the adequacy of:

- QH‟s response to the Nevilles‟ complaints; and
- the health complaints system in Queensland (my investigation of this issue has included detailed examination of health complaints systems in other jurisdictions, to assess whether there is a best practice model).

My investigation identified other issues of significant public interest. These include:

- unsafe working hours for junior doctors;
- a junior doctor being left in charge of a hospital ED without adequate supervision and without appropriate clinical protocols;
- QH‟s inadequate response to an adverse event (for example, QH did not conduct an internal investigation or provide “open disclosure” to the Nevilles); and
- inadequate safety regulations in respect of bunk beds.

2.2 Process

2.2.1 Queensland Health

The following actions were taken for the purpose of investigating the complaints about QH:

[24] Including the OFT.

- My officers met with two senior QH officers on 13 February 2004 to inform them of my intention to conduct preliminary inquiries in respect of the Nevilles‟ complaint and to ascertain the current position in relation to QH‟s response to the incident, and to the investigations undertaken by other external health complaint agencies. My officers were informed that the matter was being personally handled by Dr Buckland, the then Acting Director-General of QH.
- On 4 March 2005, I wrote to Dr Buckland, informing him of my intention to investigate the Nevilles‟ complaint and seeking his response to specific issues arising from the complaint.
- My officers met with two representatives from QH‟s Legal and Administrative Law Unit for the purpose of clarifying information and documents that I was seeking from QH (and which QH subsequently provided).
- On 17 June 2005 my officers (together with a CMC officer) met with two senior QH officers for the purpose of discussing the policy reasons for amendments made in the late 1990s to legislation governing Queensland‟s external health complaints system.
- On 12 January 2006, I wrote to Ms Uschi Schreiber, Director-General of QH seeking certain information and documents in response to an article that appeared in the *Sunday Mail* on 18 December 2005.
- On 6 April 2006, I wrote to Ms Ushi Schreiber, Director-General of QH seeking an investigation of certain allegations in relation to the possible alteration of a report provided to the Nevilles.

2.2.2 Health Rights Commission

The following actions were taken for the purpose of investigating the complaints about the HRC:

- Notice of my intention to conduct preliminary inquiries under s.22 of the Ombudsman Act concerning the Nevilles‟ complaint was provided to the Health Rights Commissioner[25] on 16 February 2004. The Commissioner was invited to respond to concerns raised by the complaint and to comment on the status of the HRC‟s review of its earlier investigation of the incident.
- I wrote to the Commissioner on 19 May 2005 to inform him of my intention to investigate the complaint and to seek his response to specific issues.
- On 27 June 2005, my officers met with the Commissioner for the purpose of discussing the complaint and deficiencies in the existing health complaints system in Queensland.
- The Commissioner allowed my staff access to the HRC‟s files relating to its handling of the complaints made to it by the Nevilles.

2.2.3 Medical Board of Queensland

The following actions were taken for the purpose of investigating the complaints about the MBQ:

- The MBQ was informed on 13 February 2004 of my intention to conduct preliminary inquiries, under s.22 of the Ombudsman Act, in respect of the Nevilles‟ complaints. Inquiries were also made concerning proposed disciplinary action to be taken by the MBQ in respect of the medical officer.

[25] David Kerslake.

- Subsequent inquiries were made of the MBQ‟s solicitors on a number of occasions in relation to the disciplinary proceedings pending before the Health Practitioners Tribunal.
- On 24 May 2005, I wrote to the Executive Officer of the MBQ to inform him of my intention to investigate the complaint and sought the MBQ‟s response to specific issues.

2.2.4 Queensland Nursing Council

The following actions were taken for the purpose of investigating the complaints about the QNC:

- On 13 February 2004, the QNC was informed of my intention to commence preliminary inquiries, under s.22 of the Ombudsman Act, in respect of the Nevilles‟ complaints. Informal inquiries were also made to ascertain the current position in relation to the QNC‟s investigation of the complaints made to it by the Nevilles in respect of RNs 1 & 2.
- My officers met with the QNC and its lawyers on 16 April 2004 to discuss proposed actions to be taken by the QNC following completion of its investigations of RNs 1 & 2, in particular its proposal to stay any disciplinary proceedings pending the outcome of a possible coronial inquest into Elise‟s death.
- On 24 May 2005, I wrote to the Executive Officer of the QNC to advise of my intention to investigate the Nevilles‟ complaint, and sought a response to specific issues.

2.2.5 Office of Fair Trading

The following actions were taken for the purpose of investigating the complaints relating to the OFT:

- On 27 July 2004, my officers met with the Manager of the Product Safety Branch of OFT to discuss the current safety regulations in respect of bunk beds, and actions taken by OFT to increase awareness of the risks associated with bunk beds and to enforce compliance with the new safety standard and regulations.
- On 6 October 2004, additional information was sought from OFT.
- On 1 September 2005, I wrote to the Director-General of the Department of Tourism, Fair Trading and Wine Industry Development informing her of my investigation of the complaint and sought responses to specific issues.

2.3 Other independent investigations

2.3.1 Coronial investigation

The Nevilles were interviewed by two QPS officers on 9 January 2002 and asked to provide signed statements concerning the circumstances surrounding Elise‟s death. The QPS then commenced a coronial investigation into Elise‟s death.

During its investigation, the QPS obtained signed statements from a number of the medical, nursing and support staff who attended Elise at either or both of her presentations to the CH ED on 7 January 2002, and also obtained an expert opinion from a prominent

neurosurgeon in Brisbane. In giving this opinion about the treatment provided to Elise by CH, the neurosurgeon commented:

> *It is considered unacceptable for a patient, following head injury to "talk and die". Elise Neville is one who "talked and died".*
>
> *In a sophisticated medical system, such as we enjoy, with ready access to hospitals of ascending levels of sophistication, it is tragic and unacceptable that an event such as this should occur.*

The QPS investigation concluded that:

- Injury was a contributory cause of death: police inquiries show that Elise fell about 1.435 metres from a top bunk bed on 7 January 2002, resulting in a head injury and subsequent severe brain swelling, culminating in brain death.
- There were circumstances surrounding the initial and second presentation of Elise Neville at CH that may have been prejudicial to her condition and warrant further inquiry. The investigation highlighted two areas for consideration:
  - the medical assessment of treating staff (the medical officer who treated Elise at CH and RN 1); and
  - an evaluation of the operating policies and practices of CH.

The QPS officers provided their report to the Coroner on 30 January 2003 with a recommendation that the Coroner should consider holding an inquest.

As I have already mentioned, on 14 February 2003, Dr Neville wrote to the State Coroner asking that an inquest be held into his daughter's death.[26]

The State Coroner informed the Nevilles that there would be a coronial inquest into Elise's death, following completion of the independent investigations by the HRC, the MBQ and the QNC.

On 24 March 2004, my officers met with representatives of the State Coroner's office to discuss the Coroner's position in relation to the holding of an inquest into Elise's death and the relevance to that issue of other independent investigations concurrently being undertaken by the HRC, MBQ & QNC. My officers were informed that, while there was no formal policy requiring the Coroner to await the outcome of other associated investigations, it was the Coroner's preferred position to await the outcome of all other investigations and disciplinary proceedings before holding an inquest in order that all relevant information could be made available to the inquest.

At the time of completing this report, the State Coroner had not allocated a date for the inquest.

It is my intention to provide a copy of this report to the State Coroner to "help an inquiry" under s.57A(2) of the Ombudsman Act.

2.3.2 Investigation by the Crime and Misconduct Commission

On 24 March 2003, the Nevilles lodged a complaint with the CMC about the Executive Director, alleging official misconduct. Their allegation was:

[26] s.7B(6) of the *Coroners Act 1958*.

> *That on 11 January 2002,* [the Executive Director] *provided a deliberately false and misleading report to Dr Stable, Director General of Health, in regard to the health services provided to Elise at Caloundra Hospital on 7 January 2002. Further, that he did this for purposes of covering–up the gross negligence and lack of competency of the relevant medical and nursing staff at Caloundra Hospital, as well as failures in the emergency retrieval system.*

On 8 September 2003, the Nevilles wrote again to the CMC raising further allegations of official misconduct, this time against the District Manager of the SCHSD, and allegations that the then Director-General of QH[27], and the then Honourable Minister for Health, Ms Wendy Edmond, had failed to discharge their statutory duty under the *Crime and Misconduct Act 2001* to report any possible or suspected official misconduct.

In response, the CMC informed the Nevilles that the CMC would await the finalisation of the re-investigation by the HRC, and the findings of the State Coroner, on the basis that any suspected "official misconduct" by a public official would be referred to the CMC by the Health Rights Commissioner, or by the State Coroner.

On 21 September 2004, I wrote to Mr Brendan Butler SC, who was the then Chair of the CMC, outlining my Office‟s review of the Nevilles‟ complaints about the Executive Director, and seeking further assessment by the CMC.

The CMC undertook to investigate the matter and, on 16 August 2005, informed the Nevilles that it did not consider there was any suspicion of official misconduct arising. However, the CMC advised that it would reconsider the matter if any further evidence indicative of official misconduct was revealed by the BHCI or the coronial inquest.

The CMC considered a further complaint by the Nevilles about the District Manager of the SCHSD, alleging that he had provided false information to Dr Stable in a memorandum dated 15 January 2002 about the existence of a policy of non admission of children to CH.

The CMC considered the available evidence and formed the opinion that the advice provided to Dr Stable by the District Manager (namely, that CH had a policy of non admission of children) appeared to be inconsistent with other advice he had provided to the HRC (namely, that CH‟s policy did not prohibit the admission of children) and referred the matter to the Audit and Operational Review Unit of QH for investigation.

The Nevilles wrote to the Acting Director-General[28] of QH on 27 November 2005 seeking advice as to the progress of its investigation of this matter. The Acting Director-General wrote to the Nevilles on 9 January 2006 with the following advice:

- QH conducted an investigation into the matter and provided its determination to the CMC on 27 September 2005.
- QH advised the CMC that it had concluded that the District Manager‟s allegedly inconsistent comments could be attributed to an ambiguous use of the word "policy" and that this issue did not raise a suspicion of official misconduct.
- The CMC subsequently confirmed that it agreed with QH‟s determination and that the Department was not required to take any further action in relation to the matter.

[27] Dr Stable.
[28] Ms Schreiber.

The Nevilles wrote to the CMC on 26 January 2006 raising concerns about the outcome of QH‟s investigation. The CMC reviewed the matter and responded to the Nevilles on 6 March 2006 with the following advice:

> [The District Manager had] *briefed the Director-General after consulting with senior medical officers of the Caloundra Hospital who advised him of the existence of the policy. The CMC takes the view that further investigations are unlikely to establish, to the standard of proof required for disciplinary proceedings, that the unwritten policy or practice as described by* [the District Manager] *was invented after Elise's death. Even if the individual hospital staff members advised investigators that they were unaware of the existence of the policy, the CMC would be unable to exclude the possibility that this was the result of poor communication, a lack of training or both.*
>
> *....The CMC has determined that there is insufficient evidence of official misconduct by* [the District Manager] *which would warrant disciplinary action against him. The issues relating to the competency and effectiveness of management of the Sunshine Coast Health Service District are matters for Queensland Health.*[29]

2.3.3 Liaison with Crime and Misconduct Commission

Section 15 of the Ombudsman Act provides that I can liaise with another complaints entity like the CMC in order to avoid the "inappropriate duplication of investigative activity."

It is my intention to provide a copy of this report to the CMC for that purpose.

[29] I discuss this issue at section 3.4.2 of this report.

3 Queensland Health

3.1 Actions taken by QH in response to issues relating to the death of Elise Neville

3.1.1 Preliminary investigation report by QH

On or about 9 January 2002, the then Director-General of QH[30] contacted the Executive Director of the SCHSD and asked that he find out what happened in the Neville matter and send a brief preliminary report to him as soon as possible. Dr Stable has advised that he did not ask the Executive Director to perform a full investigation into the incident and that the Executive Director's report was not meant to be anything other than a brief report to him.

Dr Stable states that "*he asked for a report as to what had occurred, to provide some information about the circumstances of* [Elise's] *death, and specifically the competence of the staff concerned."*

In response to the request, the Executive Director undertook the following course of action:

- on 10 January 2002, interviewed in person:
  - the medical officer who attended Elise at CH ED;
  - the acting Director of Nursing (DON) at CH;
  - the retrieving doctor (an Emergency Medicine physician from Nambour General Hospital) on two occasions;

- on the same day, interviewed by phone:
  - the registered nurse (RN 1) who triaged Elise upon presentation to CH ED; and
  - a Queensland Ambulance Service Operations officer; and

- examined case notes from CH and from the Nambour General Hospital retrieval team.

The Executive Director did not speak to the Nevilles. It is not clear from QH's records whether Dr Stable asked the Executive Director to form an opinion about the standard of care that had been provided to Elise.

On 11 January 2002, the Executive Director completed his "preliminary investigation report into circumstances surrounding the death of Elise Neville" for presentation to Dr Stable.

The report concluded:

> *In summary, it is my belief that this patient's early management was reasonable. The medical officer had no indication to do other than what he did and only with the wisdom of hindsight could the early management have been different.*

[30] Dr Stable.

3.1.2 QH's decision to await the outcome of other independent external investigations

On 7 February 2002, the Nevilles wrote a detailed letter of complaint to the then Director-General[31]. The letter outlined the events surrounding Elise's two presentations to CH on 7 January 2002, the alleged conduct of the medical officer and of RN 1 and RN 2, and the treatment received by Elise. Their complaint raised a number of allegations, including:

- the competency of the medical officer, in particular the adequacy of his examination of Elise;
- the medical officer's inadequate response to the concerns they raised regarding Elise;
- the lack of empathy displayed by RN 1 and RN 2;
- the policy of CH not to admit children;
- the policy being accorded precedence over appropriate clinical care in the circumstances of Elise's condition;
- the retrieval process, in particular the length of time it took to transfer Elise from CH to the RCH in Brisbane.

Dr Stable responded to their complaint on 1 March 2002 by providing them with a copy of the Executive Director's report, together with copies of medical and departmental documents relating to Elise's presentations to CH.

The Nevilles considered that these documents did not address their concerns but reinforced the legitimacy of their concerns. In addition, they believed the Executive Director's report was "inept" and contained "deliberately false and misleading information" (the latter allegation, if true, could amount to official misconduct).

The Nevilles subsequently forwarded a 21 page letter to Dr Stable outlining all of their concerns and seeking a full investigation by QH. Dr Stable's response was to advise the Nevilles that, because the HRC, the relevant professional registration bodies (MBQ and QNC) and the Coroner were likely to conduct their own investigations into the complaints, he did not propose to undertake any further investigations until the outcomes of those independent inquiries were known.

At the request of the Nevilles, Dr Stable met with them on 16 July 2002 to discuss a number of issues, specifically:

- his decision not to take any action in response to their concerns pending the outcome of investigations by the HRC, MBQ, QNC and the Coroner; and
- the Executive Director's report.

The meeting did not bring about any change to QH's position of awaiting the outcome of the independent investigations and Dr Stable sent a follow-up letter dated 11 September 2002 which stated:

> *My commitment to the process in train is absolute... .*

Dr Stable was Director-General of QH until January 2004, but was on leave from 31 October 2003.

[31] Dr Stable.

3.1.3 Decision to appoint an External Investigator

In December 2003, the Nevilles brought their still unresolved concerns to the attention of the then Acting Director-General of QH[32] who agreed to commission an interstate Clinical Professor of Neurosurgery (the "External Investigator") to conduct an independent review of some of the complaint issues raised by the Nevilles. The terms of reference provided to the External Investigator were as follows:

1. To review the management of children who present with head injuries at CH, including the adequacy of the systems and processes used by the hospital upon such presentation.
2. To examine the appropriateness of the Executive Director"s report (including clinical and non-clinical components) and concerns raised by Dr Gerard and Mrs Lorraine Neville.
3. To examine the appropriateness of QH"s response to concerns raised by Dr Gerard and Mrs Lorraine Neville in respect of the management of their daughter Elise at CH when presenting with head injuries on 7 January 2002.
4. To make recommendations in relation to the above, including, if appropriate, improvements to the systems and processes at CH.
5. Final report to be completed by 19 May 2004.

The External Investigator presented his report to the then Director-General of QH[33] in early June 2004. His findings and recommendations are contained in Appendix 2. The Nevilles were provided with a copy of the report[34].

While the Nevilles noted that the External Investigator had made a number of significant adverse findings and recommendations, they did not consider that he had adequately addressed terms of reference 2 and 3; in particular, that he failed to consider the accuracy of the Executive Director"s report and the appropriateness of Dr Stable"s decision not to conduct an internal investigation into what was a "sentinel" adverse event.

The Nevilles raised these concerns at a meeting with the then Director-General of QH[35] on 22 June 2004. The Nevilles have stated that, although Dr Buckland had shared some of their concerns, he indicated there was little further he could do, other than to forward to the External Investigator a copy of the Nevilles" letter outlining their concerns with his report.

3.1.4 Recent apology to the Nevilles

On 13 February 2006, the Nevilles met with the Director-General of QH[36] to discuss with her their continuing concerns about how QH responded to their complaint about the care provided to Elise. The Director-General agreed to formally respond to them within a week of their meeting.

The Nevilles have provided me with a copy of the Director-General"s response to them dated 17 February 2006 which contains the following advice:

[32] Dr Buckland.
[33] Dr Buckland.
[34] I discuss the report prepared by the External Investigator at section 3.5 of this report.
[35] Dr Buckland.
[36] Ms Schreiber.

Before proceeding I wish to apologise on behalf of Queensland Health for how we have dealt with your complaint since you first raised your concerns in 2002, and for the distress and pain this has caused you and your family.

At the heart of my apology is the recognition that it would have been of great benefit to yourselves and to this organisation had a full and independent investigation of the treatment of Elise by Caloundra Hospital been conducted in 2002 as requested by you.

The Director-General advised the Nevilles she would greatly appreciate the opportunity to meet with them again following release of my final report to discuss my opinions and recommendations.

The Nevilles have welcomed the Director-General"s apology and indicated their willingness to meet further with the Director-General following completion of my report.

3.2 QH's response to the complainants' allegations

I have set out below QH"s response to each of the complainants" allegations, as contained in Dr Buckland"s letter to me dated 20 June 2005.

3.2.1 QH failed to conduct an adequate investigation into the circumstances surrounding the death of Elise Susannah Neville, following emergency treatment provided at the Caloundra Hospital on 7 January 2002. QH adopted as its administrative response, the legal position of the Sunshine Coast Health Service District (SCHSD) which was to deny liability for the incident.

Dr Buckland responded to the first issue[37] as follows:

Queensland Health"s consistently stated response to the incident has been to participate and assist to the fullest extent reasonable the various independent inquiries. The outcome of those independent inquiries was, from an early time, always intended to guide where necessary an appropriate departmental response. That indication was provided to Dr and Mrs Neville by the former Director-General, Dr Stable, as early as in his letter dated 11 April 2002, and was restated in a number of subsequent letters.

However, while the above stated position more accurately reflects what has been the response of Queensland Health to the incident, I hasten to add that the above should not be taken as indicating that I consider that the Department"s response to the incident was optimal.

On the contrary, I must for reasons that I will explain below, regrettably, agree that better investigative processes would now, and even at that time, be considered desirable, even though the reasons for the approach taken are I believe readily understandable.

By way of explanation, quite simply, I would expect that if a similar incident occurred today in a Queensland Health hospital, there would be a better investigation undertaken by the Department. ... Specific details were provided in my interim response dated 24 May 2005 regarding the steps which the Department has taken, and indeed was taking at the time of Elise"s death, to implement the Incident Management Policy and the approach to Root Cause Analysis. Those initiatives implement an acceptable policy and procedure for responding to critical incident/adverse events.

[37] Alleged failure to conduct an adequate investigation.

> *Unfortunately, as explained in the interim response, at the time of Elise's death no endorsed statewide approach was in place. The more apparent formal options then available with respect to investigating the matter were to either appoint an independent investigator (as was done much later with the appointment of the External Investigator) and/or to participate in and allow independent inquiries to run their course as was preferred. The adoption of this latter option would not have been considered usual practice at the time.*

As to the second issue[38], Dr Buckland said that it was incorrect to state that the response by QH to the incident was the adoption of the legal position of denying liability. He based his statement on the fact that a formal response had never been provided to the Nevilles from the district or any other departmental representative in which there had been a statement made or indication provided that would amount to a denial of liability. He also said that to allege a denial of liability from a legal perspective, suggests that there has been a claim made, such as a civil claim that would warrant QH adopting a definitive position with respect to "liability". That had not been the case.

3.2.2 The level of care provided to Elise at Caloundra Hospital was adversely affected by:

- **a policy of "non-admission of children" which extended to not allowing observation of children in the emergency department, and a culture of non-care in relation to children;**
- **inadequate emergency procedures and protocols;**
- **poor record keeping.**

Dr Buckland commented that no QH officer, including himself, could be reasonably expected to comment definitively on whether these or any other factors adversely affected the level of care provided to Elise, as neither he nor any other QH officer had conducted a comprehensive investigation. He said that the determination as to the appropriateness of the level of care provided to Elise at CH was a matter for the various independent agencies which have conducted investigations into the incident.

He noted, however, that where some of these factors had already been the subject of investigation and recommendations by the HRC, those recommendations had been acted upon.

Dr Buckland concluded that, ultimately, the level of care provided to Elise was determined by the clinical judgment exercised by the attending medical officer.

3.2.3 QH failed to conduct an adequate investigation into [the Nevilles'] allegation that the Executive Director's report (dated 11 January 2002) into the incident was "inept and contained deliberately false and misleading information."

Dr Buckland explained that, while the Nevilles initially raised their concerns regarding the Executive Director‟s report in a meeting with Dr Stable on 16 July 2002, no request was made by the Nevilles at that time for an investigation into their allegations regarding the report. He believed that they had preferred to pursue their complaint through the HRC and the MBQ.

[38] Alleged adoption of legal position.

It was not until 16 December 2003 that the Nevilles wrote to Dr Buckland informing him of their dissatisfaction with the outcome of their complaints to the HRC and the MBQ. Dr Buckland then met with the Nevilles on 19 January 2004 to discuss their concerns, and agreed to conduct a review.

In February and March 2004, the necessary administrative steps were taken to finalise the appointment of the External Investigator as an investigator under the *Health Services Act 1991*. This process included direct consultation with the Nevilles as to the terms of reference, including scope to broadly investigate the appropriateness of the Executive Director‟s report.

After being informed (by letter dated 28 June 2004), of the Nevilles‟ rejection of the External Investigator‟s findings concerning the report, Dr Buckland wrote to the MBQ on 23 August 2004 seeking reasons for its earlier decision to elect not to take any action on the Nevilles‟ complaint against the Executive Director. The MBQ declined to provide any information in response to that letter, based upon legislative confidentiality grounds.

As the Executive Director had by that time resigned from QH, Dr Buckland decided there was no value in attempting to pursue the matter further. Dr Buckland considered there was no realistic likelihood that the Executive Director would assist any further investigations into his actions that might lead to an allegation of unsatisfactory professional conduct, nor was there any substantive action that QH could now take against him in any event.

Dr Buckland also stated that as the nature of the complaint about the Executive Director raised allegations of unsatisfactory professional conduct, it was quite appropriate for QH to proceed on the basis that the matter was one for the MBQ. However, it was not appropriate for him to speculate or comment upon the merits of the MBQ‟s decision on that matter.

Dr Buckland said he could understand why the Nevilles were dissatisfied with the report, but there was no suggestion that the report was ever something that would be relied upon in determining a departmental response to the incident, nor was it comprehensive. He said this was clear from Dr Stable‟s advice to the Nevilles in his letter dated 11 April 2002, wherein he indicated that QH would not consider accepting the report, but would await the outcomes of the independent inquiries.

Dr Buckland also pointed out that if a similar incident were to occur today, he would expect that the QH response would be to follow the QH *Incident Management Policy*, rather than seek an informal report in the nature of that compiled by the Executive Director.

3.2.4 The report prepared by the External Investigator, which was commissioned by QH, failed to address the nominated Terms of Reference and was therefore inadequate and should not have been accepted in the form submitted.

Dr Buckland responded as follows:

> *The nature of this complaint presupposes that the Department has accepted* [the External Investigator‟s] *report as being comprehensive.*
>
> *As I discussed with Dr and Mrs Neville in our meeting on 22 June 2004, I also hold reservations regarding the adequacy of* [the External Investigator‟s] *report.*

Faced with a report which was considered to be inadequate, the remaining investigative option available to the Department in this case seems limited to appointing a new investigator to undergo the process again. There seemed to be little value, from a pragmatic perspective, in requiring [the External Investigator] *to re-write or revisit his report in detail such that it resulted in an outcome with which Dr and Mrs Neville would be satisfied. Taking such an approach would be contrary, I would suggest, to the whole notion and ethos of the appointment of an independent investigator.*

There is, of course, an inherent risk in taking the step of appointing an independent investigator that there will be dissatisfaction with the report ultimately compiled.

In any event, there remains the further, independent investigation including a Coronial Inquest in which the various issues of concern will I expect continue to be raised.

3.2.5 The "retrieval" process was inadequate, in particular, the length of time it took for Elise to be transported to Brisbane.

QH's response to this issue relied on the findings of the HRC and an independent opinion obtained by the HRC from Dr R Manning[39], and referred to in the HRC's final report. Dr Manning's report was "*neither critical of the decision to choose to use air transport over road transport, nor the time taken to transport Elise to Brisbane*". Other endemic system issues in retrieval and emergency services raised by Dr Manning had previously been acknowledged by the SCHSD.

3.3 Clinical and systems problems raised by the Nevilles' complaint

The investigations conducted by the HRC, MBQ, QNC and the External Investigator, all found that a number of clinical and systems problems contributed to Elise's death. In this respect I make reference to the following statement[40] by a member of the MBQ's Complaints Advisory Committee (CAC):

If fault in the management of this child led to this tragic outcome, we should be looking to a system problem .... Even if failure of the staff on duty at Caloundra to recognise the seriousness of the child's condition is attributed to their inexperience or to incompetence or negligence, the "system" should provide protection for patients ....

The following is a summary of the clinical and systems problems identified by those investigations:

- the inappropriateness of long hours of work for a doctor in the ED;
- the inappropriateness of a junior doctor (having regard to his lack of experience as Junior House Doctor) working unsupervised and without proper treatment protocols in the ED;
- in January 2002 there were no protocols in place at the CH giving guidelines on the management of paediatric head injury (nor were there in April 2004); nor was there any formal mechanism for medical officers to consult with specialists in head injury when in doubt;
- confusion by ED staff over whether or not there was a policy at CH against admitting children for observation.

[39] Dr Manning is the Director of the Medical Retrieval Unit of the NSW Ambulance Service.
[40] Statement of "Further Comments on the Complaint by Dr Neville" dated 14 February 2003 by Dr IS Wilkey of the Complaints Advisory Committee of the Medical Board of Queensland.

The investigations also identified the following problems:

- poor/incomplete clinical documentation by the medical officer and RN 1 in respect of Elise"s first presentation and generally in respect of Elise"s second presentation;
- a culture of non-disclosure following an adverse event, in part due to the legal framework set up to protect QH from liability;
- inadequate incident management by QH including a failure to conduct a Root Cause Analysis (RCA).

Given the significance of these issues with respect to public safety and improving the provision of health services in Queensland, I have addressed a number of them in more detail, namely:

- Safe working hours for doctors;
- Appropriate staffing, supervision and protocols in EDs;
- Adequate clinical record keeping;
- Open disclosure following an adverse event; and
- Clinical incident management.

3.3.1 Safe working hours for doctors

The effects on the medical officer of the length of the shift he had worked at the time he first examined Elise Neville (that is, 20 hours into a 24 hour shift) were considered by the MBQ in its investigation of the medical officer for "unsatisfactory professional conduct". The MBQ"s investigation report quoted[41] one of the medical experts who provided an opinion for the purposes of the investigation, as follows:

> *...But considering the length of* [the medical officer"s] *shift and probably the lack of concentration and his tiredness I can see how it happened that* [the medical officer] *was satisfied with his assessment and that he did not think he had to do anything else even in view of her "poor compliance*" (p36 of the investigation report);
>
> *I am convinced that the tiredness and probably lack of concentration contributed to* [the medical officer"s] *poor judgement* (p38 of the report);
>
> *I see it as a system problem that our public hospitals put junior doctors into positions where they have to deal with presentations beyond their expertise. Combined with the fact that working long shifts reduces the decision making ability to a similar level as a person with 0.05 blood alcohol content.* (p39 of the report).

Furthermore, in proceedings against the medical officer for unsatisfactory professional conduct, the Chair of the Health Practitioners Tribunal, Her Honour Judge Richards, in giving the Tribunal"s decision, expressed particular concern about the length of hours worked by the medical officer:

> *It seems extraordinary in this day and age that anyone, let alone someone in a position of such responsibility, should be asked to work such long hours.*
>
> *One does not need medical evidence to know that anyone who is in the 20th hour of a continuous shift must have reduced capacity to assess the situation when it presents itself.*

[41] Report dated 14 September 2003 by Dr Johannes Wenzel, Director of Emergency Medicine, Dandenong Hospital, Victoria.

If this tragedy leads to nothing else, it should lead to the abolition of such brutally long shift hours, which must in itself reduce the standard of care available to patients.

Long shift hours worked by doctors, particularly junior doctors in public hospitals, has been a contentious issue for many years.

In late 1997, the Australian Medical Association (AMA) engaged consultants to conduct studies in a number of public hospitals to identify the underlying cultural and organisational systems that contribute to junior doctors‟ work practices, current rostering practices and hours of work. The case studies were conducted in seven public hospitals in four States, namely Queensland, New South Wales, Victoria and South Australia.

For the purposes of the case studies, the consultants relied on the following considerations in determining a benchmark of 50 hours per week as constituting "long" hours:

- the European Union defines 48 hours as the upper limit of an acceptable standard working week;
- the medical profession in the UK has established an average of 56 hours as the upper limit for a working week for hospital employed junior doctors[42]; and
- community standards, expressed through Federal and State industrial awards, have consistently adopted a standard working week considerably less than 50 hours.

In summary, the case studies revealed that, on average, less than 20 per cent of the general workforce, but approximately 70% of junior doctors, had work hours in excess of 50 hours per week. Moreover, approximately 40% of junior doctors worked in excess of 60 hours; just over 15% worked more than 70 hours; and approximately 5% worked more than 80 hours.

Adequate work breaks are important for a safe system of work. The study also revealed that, on average, junior doctors worked 8.5 hours before they had a break. Continuous work periods in excess of 16 hours without a work break were reported by some doctors.

The doctors were asked to comment on factors that cause long hours. Their responses included:

- inadequate numbers of medical staff;
- rosters schedule long hours;
- inadequate coverage for known times of increased workload, for example, winter, holiday periods;
- difficulties in co-ordinating workflow, for example, ward rounds rostered late; problems in organising ancillary staff.

The changes that hospital management could introduce in the future to manage junior doctors‟ hours were also addressed:

- increase staffing;
- improve rostering practices, for example, make more "doctor friendly"; quarantined breaks;

[42] In 1990, the United Kingdom adopted an agreement, the "New Deal", to phase in reduced hours for junior doctors.

- improved use of technology to increase efficiency of communication, for example, email, voicemail;
- restructure management of workload, for example, increased use of ward clerks;
- develop a team approach to patient management;
- reduce the maximum number of allowable hours;
- redefine roles and responsibilities between nursing staff and junior doctors.

Following on from this study, in March 1999, the Federal Council of the AMA adopted the *National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors* which had been developed by the AMA in response to long standing concerns about the impact of shiftwork and extended hours on hospital doctors, particularly junior doctors. The risks that fatigue and sleep deprivation create for both the health and safety of the individual doctor and for the quality of care afforded to patients, were addressed in the code.

The purpose of the code was to provide guidance on how to eliminate or minimise risks arising from the hazards associated with shiftwork and extended working hours. The code was a voluntary code developed to be compatible and consistent with Workplace Health and Safety (WH&S) legislation in each State and Territory. The code contributes to awareness about a particular hazard or risk to workplace health and safety, and the ways of mitigating that hazard or risk.

The code operates in the context of WH&S legislation that enshrines a general duty of care for employers to provide and maintain a safe and healthy workplace. That general duty includes:

- providing and maintaining a safe system of work (for example, work scheduling);
- providing adequate information, training, instruction and supervision to employees;
- consulting with employees and elected representatives on health and safety at work; and
- monitoring conditions at work to ensure exposure thresholds are not breached.

With shiftwork and extended hours, it is well-recognised that lack of sleep/fatigue can adversely affect task performance levels, individual health and safety and the safety of others. Workplace health and safety legislation requires risks associated with shiftwork and extended hours to be controlled[43]. In Queensland, the *Workplace Health and Safety Act 1995* provides that employers who conduct a business or undertaking are obliged to protect workers, and persons who perform a work activity for the purposes of the business or undertaking, and this includes protection from the adverse effects of fatigue[44].

Specific regulations require employers to identify hazards, assess any risks associated with hazards, and implement controls for risk so far as is practicable. A hospital administration which fails to identify hazards and assess risks arising from excessive working hours for doctors could be in breach of a duty of care owed to doctors as employees as well as being in breach of the WH&S Act. Further, permitting a doctor to carry out duties while so fatigued that a patient‟s safety is endangered would be a breach of duty owed to the patient.

[43] Sections 28 and 29 of the Workplace Health and Safety Act place obligations on an employer to ensure the safety of members of the public and the workplace health of each employee. Section 29A also provides that persons who conduct a business have a responsibility to ensure the workplace health and safety of each person who performs a work activity for the purposes of the business.

[44] Risk Management Advisory Standard 2000.

Importantly, the AMA code includes a "Risk Assessment" checklist and guide and information on risk control. It recommends a series of risk control strategies including:

- Design principles for scheduling to minimise risks to doctors" health.
- Provision of information to doctors on hazards associated with shiftwork and extended hours; adequate supervision by supervisors aware of hazards related to shiftwork and extended hours; consultation with employees through WH&S committees; appropriate training of doctors to minimise the risks associated with extended hours and shiftwork.
- Facilities and services to minimise risks, for example, rest areas to facilitate short breaks from duty, and 8 hours undisturbed sleep between shifts; easy access to nutritional food and beverages.
- Monitoring and review of incidents and risks.

The AMA code also identifies that a required element of a safe system of work is the reporting of incidents that either caused injury, or had the potential to do so. Comprehensive and thorough reporting enables remedial/preventative action. The code further provides that hospitals should establish policies and procedures that:

- define the kinds of incidents that should be reported;
- encourage staff to report incidents;
- enable incidents to be recorded and analysed for underlying causes;
- ensure incidents are investigated and any required corrective action is taken;
- make information available for the monitoring and review process.

The code was one part of a broader education and awareness program (AMA"s Safe Hours Campaign) to change the existing individual and organisational beliefs and culture that support working hours and patterns that would be considered unacceptable in most other industry sectors.

I am advised that the AMA code was never endorsed or applied by QH.

During 2000-2001, the AMA conducted detailed risk assessment audits of 417 junior doctors" work schedules and classified each doctor"s work schedule into one of three risk categories in the code, that is, lower (average 45 hours), significant (average 60 hours) or higher (average 80 hours). The data indicated that, during the audit period, 24% of doctors fell into the higher risk category during the audit period. Total hours for some higher risk doctors exceeded 100 per week, with one doctor reporting a period of 63 hours of continuous hospital duty. 54% fell within the significant category, and 22% in the lower category.

The data also indicated that, while the total weekly work hours were important, a number of other variables contributed to the level of risk associated with a roster. These included whether the work was undertaken at night, whether shifts exceeded 14 hours, the extent of on-call commitments, access to work breaks, and the long term work pattern.

The characteristics of the risk assessment audit data collected by the AMA were broadly consistent with the trends identified in other much larger data collections covering the medical workforce and highlighted the systemic nature of unsafe work and rostering practices for junior doctors across the hospital system.

Clinical studies have demonstrated that the performance impairment of an individual after 17-18 hours of sustained wakefulness is equivalent to that of a blood alcohol concentration greater than 0.05%, rising to 0.10% after further wakefulness (Dawson and Reid 1997: Williamson and Feyer 2000). The risk assessment data collected by the AMA indicated that the performance of doctors in the higher risk category, and many in the significant risk category, would, at times, be impaired to the extent of impacting on the health of the doctor and the safety of medical care provided to patients. The AMA study observed that if performance impairment were the result of alcohol intoxication, prevailing hospital policies would prevent these doctors from working.

While the AMA acknowledged that many hospitals had taken measures to review their medical rostering and work practices in the light of the AMA‟s Safe Hours campaign, nevertheless, the data indicated that significantly more needed to be done to address the issue of unsafe rostering practices for junior doctors if the identified risks were to be minimised.

The Australian Council for Safety and Quality in Health Care (ACSQHC) was established in January 2000 by all Australian Health Ministers to lead national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. An important focus of the Council‟s work is to ensure that health care professionals operate in environments appropriately supported to deliver the safest possible care. In this context, the Council set up the Safe Staffing Taskforce to lead its work on safe staffing. The taskforce‟s work embraces the relationship between human resource issues and (in this case) clinical outcomes, and takes into account performance issues such as fatigue, workload and staffing practices including rostering, the determination of the appropriate staff skill and role mix for any function, staff numbers, staff supervision and team functioning.

While most health professional awards cover hours of work in a way that would facilitate good rostering, the ACSQHC see supply and demand issues as being responsible for many staff working extended hours, or junior staff working with minimum supervision, in most health disciplines.

The taskforce has considered the effects of fatigue and noted that its greatest threat to performance is that individuals are often unaware they are fatigued or, if they are aware, they are unaware of the consequences it may have. Research has shown that fatigue can diminish a range of functions including[45]:

- vision and perception;
- memory;
- performance monitoring;
- error management;
- decision making;
- motivation and attitudes;
- communication; and
- ability to cooperate.

Other factors which add to fatigue include:

[45] Australian Council for Safety and Quality in Health Care (ACSQHC) Safe Staffing: Discussion Paper July 2003.

- the hours worked and the pattern and type of workload;
- breaks within and preceding the work period;
- inadequate sleep, from both quality and duration viewpoints; and
- sleep debt, the cumulative effect of inadequate sleep.

Fatigue is one of the potential causative factors printed on the incident monitoring form for the Australian Incident Monitoring System (AIMS)[46]. Knowledge of the factors that cause fatigue, and an awareness of the critical functions which may be impaired, lay the foundation for good fatigue management strategies, rostering principles and guidelines, and their application.

Suggestions made for better management of this problem include:

- better regulation;
- fatigue management;
- training and education;
- risk management and mitigation;
- improved data collection on issues of safe staffing and analysis;
- improving the contribution of effective teamwork to safe staffing; and
- emerging technologies (for example, automated rostering systems that are established according to fatigue management guidelines).

Workplace Health and Safety Queensland has developed a *Fatigue Management Guide*[47] which addresses the effects of fatigue, shiftwork and extended working hours. The guide also details how fatigue should be managed as part of risk management. Section 22(2) of the Workplace Health and Safety Act provides for five basic steps in the risk management process:

- identifying hazards
- assessing risks that may result because of these hazards
- deciding on control measures to prevent or minimise the level of risks
- implementing control measures
- monitoring and reviewing the effectiveness of control measures.

These steps form the basis of the *Risk Management Advisory Standard 2000* that came into effect on 1 February 2000.

While the ACSQHC states there is no direct evidence that fatigue is resulting in a cost to the health system, it does point out that the available evidence suggests that a proportion of adverse events could be related to fatigue, and that the financial and human burden of error is high.

In addressing the problem, the biggest issue for the health system will be the available supply of health professionals to fill additional shifts, given the chronic under-supply of doctors. In Holland, which moved to a maximum 48 hour working week for junior medical staff, it was reported that 1000 additional positions were required to fill rosters.

[46] Australian Incident Monitoring System (AIMS) is a software tool that captures information from a wide variety of sources to enable "deconstruction" and "classification" of incidents from "near misses" to "sentinel events" in a consistent way, so that subsequent detailed analysis is possible.

[47] Guide can be found on the Department of Industrial Relations website www.dir.qld.gov.au/workplace/subjects/fatigue/index.htm.

Addressing a similar problem, the European Commission decided to phase in the maximum working hour week over a period of 13 years so as to not put too much strain on the industry.

In 1993, the Council of the European Union introduced the *Working Time Directive* (WTD) which aimed at protecting the health and safety of workers in the European Union. It laid down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The Directive was enacted in UK law as the *Working Time Regulations* (WTR) and took effect from 1 October 1998.

The main features of the WTR include:

- no more than 48 hours per week (averaged over a reference period);
- 11 hours continuous rest in 24 hours;
- 24 hours continuous rest in seven days (or 48 hours in 14 days);
- 20 minute break in work periods of over 6 hours; and
- for night workers an average of no more than eight hours work in 24 over the reference period.

The 1998 WTR was enacted as part of UK Health and Safety legislation and applied to all National Health Service (NHS) staff with the exception of doctors in training[48]. However, an amendment was introduced to provide that, from 1 August 2004, doctors in training would be subject to weekly working time limits, to be phased in as follows:

- 58 hours from 1 August 2004 to 31 July 2007;
- 56 hours from 1 August 2007 to 31 July 2009;
- 48 hours from 1 August 2009.

It is possible for doctors in training to sign a waiver and "opt out" of the 58 hour WTD ceiling after 1 August 2004, but contracts requiring them to work outside the regulations are illegal. In assessing what is actual work time, "on call" time is included as actual work time, if the doctor in training is required to be at their place of work, even if they are resting (or even sleeping) for the whole of the "on call" period.

This has involved the NHS looking at alternatives to see whether the service for patients can be delivered completely differently, for example:

- using new non-medical roles supporting and substituting for doctors in training to provide first "on call" out-of-hours cover;
- collapsing tiers of cover and/or cross-covering between specialties;
- new service models and team working patterns;
- development of emergency medical/multi-disciplinary teams providing cover across a hospital at night; and
- redesigning services across several sites in some cases.

Changes to service delivery to bring the working hours of doctors in training into compliance with the WTD have provided an opportunity for all members of the health care team (not just nurses), to review their contribution to patient care, and to develop their roles. Many nurses, for example, have extended their roles to run clinics, perform minor

[48] General practitioners do not fall within the ambit of the Working Time Directive as they are self-employed.

surgery, admit and discharge patients, and request tests and investigations. A national programme of "pilot projects" has commenced to test many of the solutions proposed to assist the implementation of WTD for doctors in training. One such project, the "Hospital at Night" project, was aimed at redefining how medical cover is provided by hospitals during "out of hours" period[49].

The European and UK approach to addressing the problems associated with reducing the working hours of doctors (particularly junior doctors) should provide some valuable guidance and assistance in addressing the same problems in Australia.

QH's response to safe working hours issue

QH also responded to my concern about the numbers of hours the medical officer who treated Elise Neville had been working (approximately 20 hours) when Elise first presented for emergency care.

The then Director-General of QH[50] advised that he considered the issue of safe working hours for doctors to be a professional standards issue as opposed to an industrial relations issue. Therefore, he had approached the MBQ to accept the role of developing, implementing and monitoring standards that relate to safe hours of work for doctors. The MBQ agreed that the issue was consistent with both its legislative functions and strategic direction and that it was appropriate for it, as an independent statutory authority, to establish a standard, rather than a standard being developed by any one employer, professional association or college.

I am advised that the MBQ has sought additional funding from QH to cover this project. However, concerns have already been raised about the anticipated two year project timeframe.

The Executive Director of the MBQ has informed my officers that work is underway on a draft Discussion Paper that would invite submissions from interested persons and organisations. It appears that it may be 12 months before a draft standard on safe working hours is ready for publication and a further round of consultation.

Other recent developments

Following the criticisms of QH"s rostering practices made by Her Honour Judge Richards in the recent Health Practitioners Tribunal decision[51], the AMA in conjunction with the Australian Salaried Medical Officers Federation of Queensland (ASMOFQ), reinvigorated and relaunched the AMA"s Safe Working Hours Campaign and produced a Safe Hours Report 2005.

This report provides a useful summary of the significant problems with extended hours of work and fatigue (a common situation in the public health system), and what is being done internationally and in other high risk industries (for example, road and air transportation) to address the problems. In order to ensure doctors are working safe hours throughout the Queensland public health system, the report makes a number of recommendations including that QH:

[49] www.dh.gov.uk "European Working Time Directive FAQ".
[50] Dr Buckland.
[51] Section 3.3.1.

- adopt the Risk Management process detailed in the *Workplace Health and Safety Risk Management Standard 2000* and assess the workplace hazards of lengthy working hours and/or rosters.
- develop and implement, in conjunction with key medical and industrial bodies, a safe work hours policy.
- investigate and implement the Centre for Sleep Research‟s rostering model by the end of 2005.

The report‟s recommendations also outline what the authors considered to be an acceptable standard for hours of work including a 48 hour week and the maximum length of any shift to be 12 hours (except in cases of genuine medical emergency) and guidelines for fatigue breaks and on call rostering practices[52].

Commissioner Davies, in his final report of the QPHCI, noted that a consistent theme throughout the evidence before the Commission was the impact of unsafe working hours on clinical standards and patient safety[53]. However, the Commissioner did not make any specific recommendation in relation to this issue.

I consider that the issue of unsafe working hours endangering public health and safety is too significant for QH to delay taking appropriate action. The dangers are illustrated by Elise Neville‟s case.

The issue of fixing a maximum number of hours for clinicians is fraught with difficulty at a time when a shortage of qualified practitioners is forcing temporary closures of hospital EDs. A ceiling on hours may exacerbate those difficulties. Nevertheless, I consider the risk to public health and safety of taking no action to mitigate the dangers of unsafe working hours to be unacceptable.

3.3.2 Appropriate staffing, supervision and protocols in EDs

The External Investigator reported that the CH is a 70 bed regional hospital. CH is located 40 kms from Nambour General Hospital which is a 350 bed major, secondary referral and teaching hospital. At the time of the incident, the CH ED was staffed by two registered nurses and a junior doctor on call in the hospital.

The External Investigator considered the population demographics and the number of annual presentations to the ED at the time of the incident. He reported that, in January 2002, the population in the SCHSD was approximately 280,000 persons, with an additional one million visitors per year (peaking in school holiday times). The CH ED had some 8,000 to 10,000 presentations per year. The medical staff of the hospital consisted of a Medical Superintendent, a Senior Medical Officer and 4-5 junior doctors staffing the ED. The External Investigator did not specifically address the adequacy of the staffing of CH to meet population demands (especially during holiday periods) or the level of resources required to meet the growth of ED activity/demand for services at the time of the incident (demand was reportedly expanding at a rate of approximately 30% per year[54]).

[52] Australian Salaried Medical Officers Federation Queensland (ASMOFQ)/Australian Medical Association (AMA) Safe Hours Report 2005- Recommendations and Future Directions at pages 28-30.
[53] Queensland Public Hospitals Commission of Inquiry (QPHCI) Final Report dated 30 November 2005 at paragraphs 6.233-6.236 at page 403.
[54] Undated and unsigned report into the death of Elise Neville prepared by the External Investigator at page 2.

However, he commented that, as population grows, so does the clinical risk of an adverse event unless the facility is equipped and staffed appropriately.

The External Investigator reported that in January 2002 (time of the incident), there were no protocols or guidelines in the CH ED about the management of head injuries in children, nor were there instructions on how expert consultation for various acute clinical conditions could be sought[55]. This situation had not changed by April 2004 when the External Investigator visited the CH ED in the course of his investigation. Apparently, junior doctors in the ED at the time of the incident were given verbal instructions concerning the management of such cases, provided advice was sought[56]. No guidelines or protocols were in place to alert junior doctors to the possible types of acute medical conditions that may require further consultation with a more senior/experienced doctor.

In December 2001, the Australian College for Emergency Medicine (ACEM) issued a policy document which aimed to establish standards for the provision of services to children and adolescents who attend EDs in Australia. While the policy was mainly directed at services provided by EDs with a dedicated paediatric resident and consultant staff, the policy recommended that all hospitals should seek, within their practical limits, to attain the same standards.

The ACEM policy recommended that information (preferably in the form of written protocols) regarding the treatment of specific conditions be made available in the ED at all times. Head injury was one of a large number of conditions listed as requiring protocols. The policy also recommended that junior medical staff be involved in an ongoing learning program in paediatric emergency medicine.

In the opinion of the External Investigator, it was not appropriate for the CH ED to be staffed in January 2002 (a peak holiday period) by one junior doctor working unsupervised, and without proper protocols to which to refer. The External Investigator also considered that the hours of work required of the junior doctor were inappropriate for an ED doctor.

At the time of writing his report (April 2004), the External Investigator noted that there had been some improvements to the CH ED, by way of improved access to clinical information, staff increases in the ED, and the appointment of an experienced senior medical officer who was developing protocols for the management of clinical states and the training of junior staff. He also noted that the Director of Nursing was developing training programmes for nurses in triage, and had increased nursing numbers.

The External Investigator recommended that:

- The ED should be staffed by relatively experienced third and fourth year doctors, who had received training in emergency medicine before appointment to the CH ED.
- QH should urgently develop and promulgate guidelines on the assessment and treatment of head injury (with special emphasis on paediatric head injury) and ensure that education programs on the guidelines were implemented across the health system.
- When staff shortages become critical, it may be wise to close the CH ED and refer patients to Nambour General Hospital.

[55] The External Investigator also noted at page 6 of his report that Queensland Health guidelines for clinical emergencies produced in 1998 and again in 2001 made no specific mention of head injury management, particularly concerning paediatric head injury care.

[56] External Investigator"s report at page 3.

- A firm and stable consultative link be established between CH and Nambour General Hospital on a 24 hour basis seven days a week, so that junior doctors at CH could seek assistance when necessary from senior medical officers at Nambour General Hospital. A telemedicine network would assist with this.

In its guidelines on *Responsibility for care in emergency departments* (March 1999), the ACEM noted that in smaller EDs, there may be times when there are no specialists, senior medical officers or advanced trainees in emergency medicine on duty. In these instances, the ACEM does not believe that primary responsibility for the care of emergency patients in designated EDs can be vested in junior medical staff. Therefore, in these circumstances, while there must always be a medical officer in charge of the ED, the primary responsibility for care must be determined by the hospital (which has legal responsibility for a system deficiency) and the arrangements must be published to all staff of the ED.

QH's response

In his response to me dated 20 June 2005, the then Director-General[57] made these points:

- It should be recognised that shortages in the number of medical practitioners is a problem throughout Australia and is not limited to emergency medicine. The problem is particularly pronounced, as it is for many professional services, in regional or remote areas of the State.

- While there may not be ideal staffing levels in all QH EDs, there is support available through initiatives including the following:

    1. The recent creation of Clinical Co-ordination Centres (CCC) in Brisbane (operational from July 2004) and Townsville (operational from October 2005), which any doctor in QH can contact for advice. These CCCs are manned 24 hours a day, seven days a week by a specialist in emergency medicine. These specialists are able to give telephone advice regarding patient management as well as co-ordinate patient movement if required.

    2. The Clinicians Knowledge Network (CKN) provides on-line access to the full Micromedex database series, including Emergindex. Micromedex is a system of databases pertaining to drugs, acute/emergency care, toxicology, alternative medicine and reproductive risk. It contains clinical protocols for hundreds of acute/emergency conditions, as well as dozens of emergency texts and journals. This is accessible from every personal computer in every ED and acute service in QH, 24 hours a day, seven days a week. This was introduced in 2001.

    3. There have been improvements in the orientation of medical staff, and there are improved standards of supervision and monitoring of junior medical staff through the accreditation processes of the MBQ and the Colleges.

- Apart from these initiatives, regular (6 to 12 monthly) strategic meetings are held and attended by representatives from the QH hospitals where the top EDs are located. At these meetings problems can be aired and possible strategies discussed.

[57] Dr Buckland.

QH's 2001 report of "The Review of Emergency Services, Sunshine Coast Health Service District"

On 18 December 2005, the *Sunday Mail* published an article disclosing the existence of a report written by the former medical superintendent at Nambour General Hospital in 2001[58], entitled *Review of the Emergency Services* (DEM[59]), *Sunshine Coast Health Service District* (the DEM Report). The *Sunday Mail* article suggested that QH had ignored recommendations made in the DEM Report that might have helped save Elise Neville's life. As the DEM Report had not been previously provided to me by QH during the course of my investigation, I sought a copy.

The DEM Report revealed that a review of the emergency services provided by the SCHSD was undertaken in 2001 as a result of concerns raised by "Corporate Office" that it was not meeting reasonable and accepted performance standards. A working party was convened to investigate the concerns and recommend remedial action. The final DEM Report was based on at least two other reports provided during the review period by two external experts (one by a consultant in emergency medicine from Victoria, and one by a senior ED nurse from the Princess Alexandra Hospital in Brisbane).

The DEM Report focussed on the ED at Nambour General Hospital, but also addressed issues relating to the other EDs in the SCHSD, that is, those at Caloundra, Noosa and Gympie hospitals.

The DEM Report was completed in September 2001 and included a total of 22 recommendations, mostly relating to a need for increased staffing levels and arrangements for increased training of clinical staff.

Under the heading "Emergency Arrangements at Caloundra", the following recommendations were made:

Recommendation 9

- *Until such time as PHOs[60] are able to be recruited, the incumbent SMOs[61] should be encouraged to maintain 24 hour on duty cover for the ED.*

Recommendation 10

- *Caloundra Hospital appoint 5 PHOs to staff the ED at* ***all*** *times [my emphasis].*

Recommendation 11

- *The ED PHOs are not to have responsibility for inpatients at Caloundra during normal working hours (although they could cover night call for inpatients)."*

I sought QH's formal response as to what action, if any, was taken in respect of the DEM Report and its recommendations.

QH's response

[58] This officer later became the Executive Director referred to in this report who prepared the report for Dr Stable discussed in section 3.1.1.
[59] Department of Emergency Medicine.
[60] Principal House Officer (PHO) has at least 2 years post registration medical experience.
[61] "Senior Medical Officer" (SMO) includes a Medical Superintendent, Deputy Medical Superintendent, Assistant Medical Superintendent, Senior Staff Specialist, Staff Specialist, General Practitioner and Medical Officer as defined by the District Health Services- Senior Medical Officers and Resident Medical Officers Award- State 2003.

By correspondence dated 6 February 2006 & 21 February 2006, I received the following advice from the Director-General[62]:

- The DEM report was prepared at the request of the then District Manager (SCHSD).
- The report was tabled at the District Executive Committee (DEC) meeting on 25 September 2001 for Executive Members to consider the recommendations. The DEC endorsed the recommendations contained in the report at its next meeting on 9 October 2001.
- Recommendation 9 of the report states that "SMOs should be encouraged to maintain 24 hour on duty cover for the Caloundra DEM until the PHOs are able to be recruited". It would be incorrect to conclude that the absence of 24 hour coverage at the time Elise presented meant that such encouragement had not occurred.
- Recommendation 10 of the report relates to the recruitment of additional medical staff for the CH ED. Recruitment processes commenced in October 2001 and the medical officers had all commenced duty by 11 March 2002. This was considered to represent a reasonable period in which to have completed the required process of advertising, recruitment, and selection of suitably experienced medical officers.
- All 5 appointments were made at the level of Principal House Officer (PHO) level which accords with recommendation 10.
- From the District"s perspective, appointment at PHO level is not considered to be one that is "junior". The position of PHO sits above that of an intern or "junior house officer"[63], those being levels that more certainly could be described as junior appointments[64].
- the current medical coverage for the CH ED is provided by two specialists, two SMOs and five PHOs.

3.3.3 Adequate clinical record keeping

In Queensland, there is a statutory obligation for all public authorities to make and keep full and accurate records of their activities, an obligation which includes public hospitals and medical records[65]. This obligation is supported by Queensland Government Information Standards 40 & 41.

The AMA Code of Ethics provides that every patient has a right to expect that accurate records will be maintained. Medical records are a crucial historical record of the care provided to a patient, and are essential for medico-legal purposes. An information booklet produced by QH on clinical documentation provides a useful summary of the importance of maintaining complete and accurate documentation in the medico-legal context:

- good notes, good defence;
- bad notes, bad defence; and
- no notes, no defence.[66]

[62] Ms Schreiber.
[63] „Junior House Officer" (JHO) is defined as a medical practitioner in the first year of service after eligibility for full registration as a medical practitioner.
[64] Source document is the District Health Services- Senior Medical Officers and Resident Medical Officers Award- State 2003.
[65] Section 7 of the Public Records Act.
[66] Clinical Documentation Information Booklet produced by Queensland Health as part of its Quality Improvement and Enhancement Program 1999-2004.

The QH information booklet highlights several key issues with respect to standards of documentation:

- **Accuracy**:- To be an accurate record of the patient‟s care, one must document all significant events, including history, diagnosis, treatment, changes in behaviour or status, adverse events, the patient‟s questions, statements and information provided, as they happened and in sufficient detail.
- **Written in a timely manner**:- To ensure accuracy, notes in the medical record should be made at the time of examination or as soon as possible thereafter. Notes written hours later or the next morning are likely to have their accuracy questioned.
- **Objectivity**:- It is better to document observations, rather than subjective assessments. If an opinion is recorded, it should be a clinical opinion supported by the recording of objective data that gave rise to that opinion.
- **Legibility**:- Documentation is of little value if handwriting cannot be understood by other clinicians and may lead to misinterpretation that may be responsible for significant error in patient care. Printing an entry and the author‟s name under their signature can assist identifying the author if this needs to be ascertained at a later date. Avoid shortened entries and abbreviations.
- **Formatting details**:- Entries to be written in black ball point pen, include date and time of the entry, be signed, name and designation clearly printed below the signature.
- **Amendments**:- Do not retrospectively amend a record by attempting to delete or obscure notes. If an amendment is to be made, it is preferable to:
  - simply put a neat line through the mistake (original entry must remain legible);
  - add the new material;
  - add a note in the margin stating why the amendment has been made; and
  - initial the change (in some instances it may be wise to have the correction witnessed by a colleague).

The availability of accurate and sufficiently detailed clinical records is essential for the provision of effective ongoing care for patients.

Clinical documentation completed by the medical and nursing staff in respect of both of Elise‟s presentations to the CH ED came under scrutiny during the various investigative processes.

In his statement to the MBQ, the medical officer deposed to writing up his clinical notes in respect of Elise‟s first presentation some time after the Nevilles had left with Elise. He said that, as he was quite tired at that stage, he left the notes with the intention of reviewing them and completing them after he had rested. It was not until two days later (that is, 9 January 2002, the day Elise passed away) that the medical officer made a further entry in Elise‟s chart further documenting his recollection of events on the morning of her presentation (7 January 2002). The Nevilles allege that the further notes made by the medical officer on 9 January 2002 were not an accurate record of his actual assessment.

In his statement to the MBQ, the medical officer accepted that in several respects his clinical notes did not accurately reflect his assessment. For example, he stated that he physically examined Elise‟s head to determine whether there was a fracture, but accepted that his clinical notes do not record that he did so.

The Nevilles also raised concerns about the quality of RN 1‟s notes of her triage assessment of Elise, for example, her failure to adequately record the fact that Elise had been suffering a headache since her fall. The Nevilles also queried the two different ink

types and handwriting evident on the face of Elise‟s clinical chart. This anomaly was not canvassed until recently when the QNC sought a statement from RN 1 (approximately 34 months after the incident) as to the possible reason for the different ink types. Her explanation for the different ink types was that some of the triage notes had actually been made by the medical officer and not by her. Her explanation, if correct, means that she made no record in respect of the following key clinical facts:

- one episode of vomiting;
- that Elise had had a headache since the fall; and
- she had hit her head as a result of the fall.

RN 1 provided an earlier statement to the police (dated 3 October 2002) and gave a copy to the QNC. In it, she states that she continued to monitor Elise‟s pulse rate from the central area of the ED and noted it had increased from her first recorded pulse rate of 54. She does not state what it increased to (other than to state Elise‟s observations were stable and within normal range), nor is there any record of it on Elise‟s clinical chart.

The Commissioner[67] in his report (dated 28 June 2004) also commented that the HRC‟s investigation had been hampered by the fact that limited medical notes were made of Elise‟s second presentation to the CH ED. The Clinical-Coordinator – Retrieval Request and Patient Advice form for Elise‟s retrieval was also not available to the HRC because it had been lost.

The Commissioner commented:

> *I accept … that in the heat of an emergency medical notes take a "back seat" to the immediate needs of the patient… This and the stress of the situation may understandably have some impact on the adequacy or accuracy of notes made at a later date. Staff may later only be able to estimate the times that certain actions were undertaken rather than record them precisely.*

The Nevilles say that the lack of detailed, complete and timely clinical records added to their concern about the adequacy of the emergency treatment provided to Elise.

I have formed the following opinion:

Opinion 1

The clinical documentation relating to both of Elise's presentations at CH ED was inadequate. This amounted to unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

The Commissioner also reported that the SCHSD had since advised that regular documentation audits are carried out on a six-monthly basis and documentation for clinical staff is now covered in continuing medical education sessions. In addition, the SCHSD‟s *Handbook for Medical Officers* was revised in December 2003, to include a section on documentation and was provided to all commencing medical staff as part of their orientation.

[67] Health Rights Commission.

He also reported that the SCHSD was raising awareness of documentation standards for nursing staff by education sessions undertaken twice per year.

On this basis, the Commissioner was satisfied that the SCHSD had responded appropriately to his findings on documentation issues.

I do not propose to make any additional recommendations about this issue.

3.3.4 Open disclosure following an adverse event

A large part of the Nevilles‟ motivation in pursuing their complaint (as it is with many people who lodge formal complaints after a critical incident) was to ensure any possible system issues that may have contributed to Elise‟s incident were identified and rectified as quickly as possible, so that others do not have to suffer from similar preventable errors in the future.

It is understandable that patients and their carers/families want to understand what happened, to feel that there is genuine regret for what happened, and that steps are being taken to minimise the risk of similar tragedies or events occurring.

In addition to the recent inquiry into events at Bundaberg Hospital, other high profile inquiries into major shortcomings in the provision of health care, including the King Edward Hospital (WA) and the Campbelltown and Camden Hospitals (NSW) investigations, revealed environments unsupportive of openly disclosing adverse events, failure by management to respond to those events, and poor communication with patients and their families.

In July 2003, the ACSQHC introduced a national *Open Disclosure Standard*, which was endorsed by all Australian Health Ministers at the time. The standard was developed with considerable input from a range of health care professionals, consumers, and health and community organisations across the country. The standard promotes a clear and consistent approach by Australian hospitals to open communication with patients and their nominated support person following an adverse event.

The standard defines open disclosure as the open discussion of incidents that result in harm to a patient while receiving health care.[68] The core elements include:

- an acknowledgement that the event has occurred;
- an expression of empathy or regret for the harm the patient has suffered;
- a factual explanation of what occurred, the clinical implications of the event and the treatment;
- an analysis of the causes;
- correction of the preventable causes and explanation of the steps being taken to manage the event and prevent a recurrence: and
- feedback to the affected patient and/or his/her carers.

There appears to be a considerable amount of uncertainty and confusion on the part of health care professionals and health care providers about disclosing information following an adverse event. There is concern that open disclosure will amount to an admission of

[68] Open Disclosure Standard by the Australian Council for Safety and Quality in Health Care (ACSQHC) dated July 2003 at page 1.

liability[69]. The ACSQHC believes that active management of adverse events through the exchange of timely and appropriate information is vital to drive and support improvements in the safety and quality of our health care system. A key step in this process is encouraging greater openness in response to adverse events.

The ACSQHC *Open Disclosure Standard* states that for health care professionals, there is an ethical responsibility to maintain honest communication with patients and any support person, even when things go wrong. By ensuring that there is good communication when an adverse event occurs, the HSP can begin to look at ways to prevent them from recurring[70].

The *Open Disclosure Standard* aims to foster commitment from health care organisations to:

- providing an environment where patients and their support person receive the information they need to understand what happened;
- creating an environment where patients, their support person, health care professionals and managers all feel supported when things go wrong; build investigative processes to identify why adverse events occur; and
- bringing about any necessary changes in systems of clinical care, based on the lessons learned.

While the *Open Disclosure Standard* was endorsed by all Australian Health Ministers in July 2003, it has no legal standing and exists purely as a resource for organisations seeking to implement open disclosure. The ACSQHC has developed an education and support package to assist with the implementation of this standard. With support from the ACSQHC, it is the responsibility of individual health care organisations to implement the standard.

The acceptance of open disclosure by health service providers should lead to increased trust, reduced anger, better and quicker investigative procedures, improved safety systems, increased satisfaction by patients and/or their carers involved in adverse events, and perhaps reduced litigation.

Both the External Investigator‟s report and the HRC report identified system deficiencies as having contributed to the death of Elise Neville. In trying to account for QH‟s failure to communicate appropriately with the Nevilles about the incident, the External Investigator offered his opinion that the legal framework set up to protect QH from admitting any sort of liability may have hindered the process of open disclosure. However, he also observed that open disclosure would of course have been difficult without a formal investigation into the incident. In other words, the Nevilles had been poorly served in two important respects.

Open disclosure is a key part of incident management. QH‟s *Incident Management Policy* (introduced in June 2004) states that the ACSQHC *Open Disclosure Standard* is to be followed as part of the management of adverse events. However, lingering concerns about "open disclosure" amounting to an admission of liability, and about the potential for documents containing candid (or sometimes tentative) analysis of system failings and human error to be obtained for litigation purposes, have delayed its acceptance in practice.

[69] I discuss this issue at section 3.4.3 of this report.
[70] Page 1.

At the time of Elise‟s incident, the ACSQHC *Open Disclosure Standard* had not been released. QH has also advised that at the time of the incident, QH did not have any policies, practice or procedure describing how to progress open disclosure of adverse clinical events. Whether open disclosure occurred and, if so, the procedure followed, was decided on a case by case basis.

In January 2005, the Australian Health Ministers reaffirmed their commitment to piloting the standard with pilot reviews to be assessed at the Australian Health Ministers Conference in December 2006 prior to full implementation. Accordingly, by the time the standard is fully introduced by QH into all of its health districts, it will be in excess of three years since the ACSQHC released the standard.

QH has advised that a structured piloting plan of the *Open Disclosure Standard* within QH is currently under development by the Safety Improvement Unit, Patient Safety Centre. Seven of QH‟s health service districts are pilot sites participating in the national pilot (Townsville, Rockhampton, Princess Alexandra, QEII, Cairns, Bundaberg and the Royal Brisbane and Women‟s Hospital), together with one private health service provider (Uniting Health Care, once funding arrangements have been approved). The Patient Safety Centre recently commenced its open disclosure training program in March 2006, with training offered to a number of clinicians (medical, nursing and allied health) in the pilot sites for open disclosure.

It is understood that the Mater Hospital, although not part of the national pilot, has implemented an *Open Disclosure Standard* which has been operational for in excess of 18 months.

I have formed the following opinion:

Opinion 2

QH failed to engage in a process of open disclosure with the Nevilles following Elise's death. The failure to do so was unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Dr Stable's response to opinion 2

(Response supplied by solicitors acting for Dr Stable in a letter dated 11 May 2006.)

Dr Stable notes the External Investigator on page 8 of his report commented that:

"It would seem that the legal framework set up to protect Queensland Health from admitting any sort of liability may have hindered the process of open disclosure".

My client does not know what "legal framework" the External Investigator is referring to. As Director General, Dr Stable says he encouraged open disclosure; in particular encouraging administrative access so that patients could easily access their medical files. This was well documented in the relevant Queensland Health policies of the time.

In my client"s opinion, it is incorrect of the External Investigator to say that the legal framework set up was to protect Queensland Health from admitting any sort of liability, and may have hindered the process of open disclosure. Queensland Health had no influence over the Police, the Coroner, the Health Registration Boards or Health Rights Commission, all of which were investigating and involved in the matter.

Dr Stable accepts that Queensland Health had no formal open disclosure policy, as now held, at the time of Elise Neville"s death. As indicated in section 3.3.4 of the Ombudsman"s report, open disclosure was an evolving process adopted by Queensland Health in June 2004.

On a personal level Dr Stable did discuss Elise"s case with Dr and Mrs Neville. My client cannot remember on how many occasions this occurred, but it was on more than one occasion. This would have been in the early stages of the matter. Dr Stable says that Dr Neville was, understandably, extremely angry about the circumstances surrounding the death of his daughter.

Unfortunately, at this point in time, my client does not have clear recollections about what discussions were had between Dr and Mrs Neville, Queensland Health or the District regarding this incident. If there was a lack of disclosure, there was certainly no intention on my client"s part to prevent full and open discussion with Dr and Mrs Neville regarding their daughter"s death.

I make the following recommendation:

Recommendation 1

1.1 QH expedite the implementation of the national pilot program on open disclosure in Queensland's public hospitals.

1.2 In the meantime, QH develop policy options for redress for persons identified as having suffered a detriment owing to failings in the provision of health care, for example, the making of an apology or an *ex gratia* payment.

QH response to recommendation 1 (Letter dated 16 May 2006)

Recommendation 1 is being implemented.

To provide you with up-to-date information about the implementation of the Open Disclosure pilot, I refer you to the March 2006 edition of Patient Safety Matters, the newsletter of Queensland Health‟s Patient Safety Centre. In addition to the information contained in the newsletter, I also note that the clinician Open Disclosure Peer Support Group workshops are currently underway in Brisbane with 95 clinicians participating in the training up to April 2006.

The options for redress incorporated in the open disclosure training program include an expression of regret including saying sorry, an explanation to the patient and their family or support person of what happened, taking appropriate remedial action and an explanation of what will be done to reduce the likelihood of it happening again in the future.

3.3.5 Clinical incident management

Background

Health care is one of the most complex activities that humans engage in, and there are inherent risks of harm associated with being a patient. The *Quality in Australian Health Care Study* (QAHC study) published in 1995 found that 16.6% of admissions were associated with an adverse event. Approximately half (51.2%) of the adverse events were assessed as having a high preventability. 13.7 % of the adverse events reported resulted in permanent disability, and 4.9% resulted in death. Subsequent re-analysis of this data to allow for international benchmarking indicated that the Australian adverse event rate may be closer to 10% making it comparable to findings in the UK, NZ and Denmark.

This study was the impetus for the development of patient safety management systems to help prevent the incidence of adverse events. These systems have evolved primarily from lessons learned from other high risk industries such as the commercial aviation and the oil and gas industries. These industries have achieved exemplary safety records through positive attitudes to safety and the operation of effective safety management systems.

A safety management system is a series of cross-organisational processes designed to protect against risks. The processes are used to identify, classify and manage risks to the safety of an organisation‟s operation. They are an integral part of an organisation‟s risk management framework.

The goal of a patient safety management system is to actively seek to minimise harm to patients as they journey through the health care system. It is an integrated set of policies, procedures and work practices that are used to monitor and improve patient safety. It recognises the potential for errors to occur and the need to establish robust defences to ensure that these errors do not result in adverse events.

Adopting a systems approach to safety improvement in the health care sector requires a fundamental shift in the way that adverse events and near misses are dealt with. Adverse events should be viewed as opportunities for learning, investigation and improvement.

Clinical incident management is a key aspect of a patient safety management system. Incident management includes a system-wide and honest examination of errors to generate the improvements necessary to stop adverse events from being repeated. Preventing errors depends on identifying deficiencies in the sequence of events leading to an incident/adverse event and addressing those deficiencies. It is crucial to capture all the relevant information about an incident, investigate all of its causes and to take decisive action to protect patients from a recurrence of that kind of incident. The success of incident management largely depends on a culture of openness in which errors are acknowledged and reported so as to reduce the chance that others will make the same mistakes.

QH has an *Incident Management Policy* that was introduced in June 2004 (this is currently under review). The policy defines incidents[71] and outlines the processes and management of incidents and identifies ten sentinel event types as requiring investigation by QH. The policy provides that adverse events of a high and extreme level must undergo a Root Cause Analysis and requires formal disclosure of the event and the central reporting of sentinel events.

The final report of the QHSR noted that the effectiveness of QH's *Incident Management Policy* had been hindered by the lack of a comprehensive information system for incident reporting, the lack of tools for incident analysis, limited training for staff in analysis techniques and limited resources in the districts to set up training and maintain systems. QH's Patient Safety Centre (QH PSC) is addressing these issues[72].

The QH PSC was established in early 2005, with the role to prevent patient harm resulting from healthcare. The QH PSC focuses on providing support and resources to enable clinicians and managers to effectively identify and address key safety problems. It also focuses on the management and prevention of adverse events through a number of initiatives such as the Safety Improvement Unit, the Clinical Practice Improvement Unit and Open Disclosure[73].

Incident monitoring and reporting

Incident management involves the monitoring and reporting of adverse events in health care.

Incident monitoring is defined as:

> *A method of collecting detailed qualitative data about any unintended incident, no matter how seemingly trivial or commonplace, which could have or did harm anyone, patient, staff or visitor. The incident may or may not have been preventable, and may or may not have involved an error on the part of the health care team*[74].

Since the national release of the results from the QAHC study, a number of patient incident reporting and monitoring systems have evolved. One of these is the Australian

[71] An "incident" is defined in the policy as any event including an adverse incident or circumstance which could have, or did lead to unintended and/or unnecessary harm to a person or the organisation, and/or a complaint, loss or damage.

[72] Final Report of the Queensland Health Systems Review dated 30 September 2005 at page 183.

[73] Information derived from Queensland Health's July 2005 Issue paper prepared for the Bundaberg Hospitals Commission of Inquiry (BHCI) titled "Safety and Quality".

[74] Australian Council for Safety and Quality in Health Care (ACSQHC) "Functional Specifications for Incident Reporting and Management Systems" October 2002.

Incident Monitoring System (AIMS). AIMS is a software tool that captures information from a wide variety of sources to enable "deconstruction" and "classification" of incidents from "near misses" to "sentinel events" in a consistent way, so that subsequent, detailed analysis is possible.

AIMS is currently being used in a number of health systems in other States. Incident reporting occurs at the health unit sites in paper form and is then entered and coded using specific software. This data contains confidential information on those involved in the incident and is protected from legal discovery under Australian Commonwealth Quality Assurance legislation.

The coding of the information provides the means for understanding the underlying causes of the incident and for analysing the contributing factors. This analysis supports the preparation of a range of comprehensive reports to assist management in identifying problems and remedial action.

The organisation provides the software that collects the data from the health units with all identifying information removed. This anonymous data is then keyed into an aggregated database that allows all health units to receive comparative information linking their performance with other "like" organisations. The de-identified data supports the aggregation of low frequency events at international level and is therefore effective for identifying and coordinating system-based strategies to better detect, manage and prevent problems[75].

In addition to incident monitoring systems, incident reporting is also an integral component of the safety improvement process. It is acknowledged as playing a vital role in a national approach to collecting, analysing and learning from information about things that go wrong in the health care system.

The ACSQHC has developed a national specification for incident reporting and management systems. This national specification aims to support the reporting and management of incidents at the local level and to identify better ways to manage hazards and risks to improve systems of care.

The systematic anonymous reporting of incidents can be used as a warning device, flagging problem areas that impact on quality and safety of care. The development and implementation of interventions based on the information derived from the process can link incident reporting and management to broader quality of care improvement.

The value of incident reporting lies in its capacity to gather information about "near misses". Near misses are the "free lessons" that allow the system to mobilise against a more serious occurrence in the future. Analysis of many incidents can reveal recurrent patterns of cause and effect and since "near misses" occur more frequently than bad outcomes, they yield the number required for more penetrating qualitative analyses.

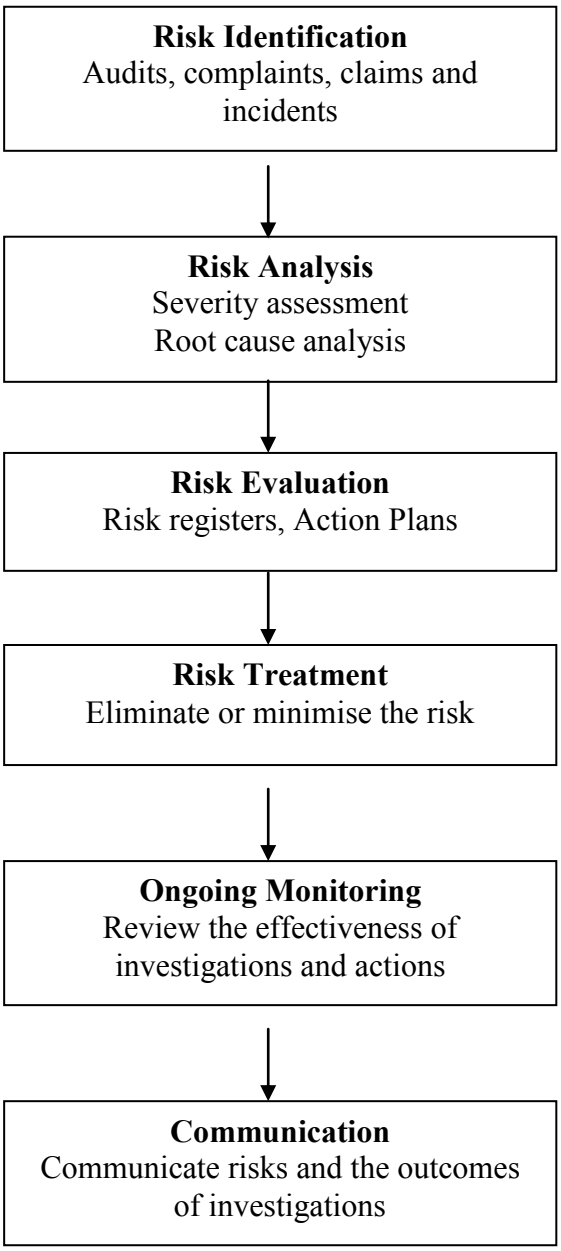
QH has developed a web-based electronic incident reporting system (PRIME) which aims to facilitate the reporting and management of clinical incidents including sentinel events and near misses and enables the analysis of incident trends. Implementation and use of PRIME by the QH Districts is not mandatory at this stage. Accordingly, I am advised that only 64% of the State has fully completed implementation of the system.

[75] Information obtained from the Australian Patient Safety Foundation Inc. website www.apsf.net.au.

While human error can never be entirely eliminated, errors can also be seen as being shaped and provoked by "upstream" systemic factors, which include the organisation"s strategy, its culture and the approach of management towards risk and uncertainty. The associated counter measures are based on the assumption that, while we cannot change the human condition, we can change the conditions under which people work so as to make them less prone to error. When an adverse event occurs, the important issue is not who made the error but how and why did the defences fail and what factors helped to create the conditions in which the errors occurred. The systems approach recognises the importance of resilience within organisations and also recognises the process of learning as enhancing resilience.

Since sentinel/adverse events rarely have a single, isolated cause, attempts to prevent or mitigate adverse events need to address not just single event chains, but systems as a whole. Well designed systems can minimise the harmful effects of errors by anticipating their occurrence and detecting them at an early stage.

The following is an example of an "adverse event management process"[76]:



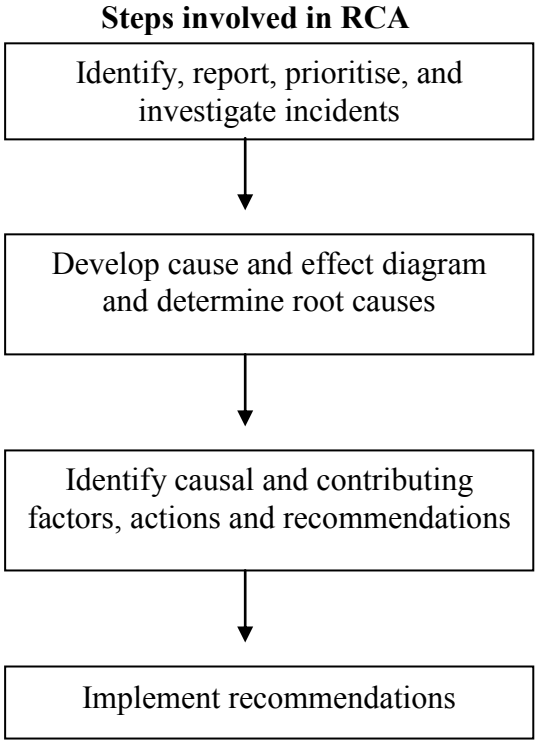
Root cause analysis

Root cause analysis (RCA) is widely used in respect of major industrial accidents and is increasingly being used in health care. RCA is a tool used in systems-based learning for identifying what happened, why it happened, and what can be done to prevent it from happening again. It focuses on how to improve systems in order to prevent major incidents. It is particularly valuable for investigating sentinel events.

Investigations are undertaken using a standardised methodology, to identify vulnerabilities in management systems and clinical practices. RCA identifies the organisational conditions (for example, policies and resources) and human factors (for example, communication and fatigue) that enable adverse events to occur.

[76] NSW Health Clinical Governance Unit – Adverse Event Management Program Overview (August 2003).

Through RCA, teams can discover the errors that contribute to system failures underlying adverse events or near misses. Systematically applying RCA may uncover common "root causes" that link a group of problems that might not appear to be related [77].



The External Investigator noted in his report that QH had never conducted a formal investigation into the events leading to Elise Neville‟s death, nor did it conduct an RCA study. In this aspect alone, he felt the Nevilles had been "badly served" by QH.

In its first report (2003-2004) on incident management in the NSW public health system, NSW Health reported that analysis of RCA data disclosed a number of common causes of serious accidents including:

- unavailability of policies, procedures and guidelines;
- the work environment (including scheduling and staffing issues); and
- inadequate supervision of junior staff.

Significantly, these were three of the factors the External Investigator identified as having adversely affected the standard of care provided to Elise by CH. The sharing of information derived from the RCA process is vitally important to reducing the recurrence of similar incidents. The findings and lessons learnt during the year, if shared with all health services, can be used by them to assist in reviewing their own processes and in developing preventative strategies to improve patient safety and enhance consumer confidence.

Dr Buckland, in his letter to me dated 24 May 2005, advised that in January 2002, there was no endorsed State-wide approach to incident management or to RCA in QH. In November 2002, both Princess Alexandra Hospital and Townsville Hospital launched Patient Safety Programs based on the USA‟s Veterans Health Administration (VHA) Root Cause Analysis. In April 2003, the VHA Root Cause Analysis process was endorsed by

[77] Spring 2003 Newsletter of the Australian Council for Safety and Quality in Health Care (ACSQHC).

the ACQSHC for national use. Training was provided in Adelaide and Melbourne and eight staff attended as participants and four staff as trainers from QH. After these courses, QH‟s Integrated Risk Management Program commenced work on contextualising the VHA Root Cause Analysis package for use in QH.

The QH PSC has developed a two day RCA training program that was rolled out across Health Service Districts in mid 2005. 37 Patient Safety Officers have been trained and deployed to ensure the technical rigour of the RCA process. The QH PSC expects that all 37 Health Districts will have a broad base of staff trained in RCA by August 2006 (currently approximately 500 staff have been trained in 16 Health Districts). A formal training package and resource material have been developed.

Public reporting on incident management within the public health system

The ACSQHC has gained agreement from all States and Territories to a common set of "core sentinel events". These eight event categories are agreed indicators of system problems that will be reported nationally from 2005 and analysed in future. However there are many more types of incidents in healthcare not included in the "sentinel events" list.

Victoria was the first State to publish an annual public report on sentinel events that occurred in Victorian public hospitals. In the 2002-2003 report, a total of 79 sentinel events[78] was recorded, with root cause analyses revealing 210 system issues. The corresponding figures for 2003-2004 were 85 sentinel events and 283 system issues[79]. These figures indicate that in most sentinel events, more than one systems issue contributed to the incident.

NSW has followed Victoria‟s example and published its first public annual report on incident management in the NSW public health system for 2003-2004. Unlike Victoria however, the NSW report covered all adverse events (not just sentinel events) within its facilities. I understand this was the first time a State or Territory had taken this step.

The final report of the QHSR recommended that QH produce a public report on sentinel events as per NSW and Victoria.[80] I believe QH needs to report publicly on more than just sentinel events and follow NSW‟s example of publicly reporting on incident management within its health facilities. I see this as a positive way for QH as a State health body to demonstrate commitment to transparent and accountable incident management systems.

I make the following recommendation:

Recommendation 2

QH should follow its NSW counterpart and undertake to produce an annual public report on incident management in the Queensland public health system. The report should include an analysis of the causes (clinical and systemic) of health care incidents as revealed by Root Cause Analysis of sentinel and other adverse events.

[78] State Government of Victoria sentinel event list has 9 categories of events (rather than the 8 categories defined by the Australian Council for Safety and Quality in Health Care (ACQSHC), the additional category being "Other catastrophic event").
[79] State Government of Victoria Sentinel Event Program Annual Reports for 2002-03 & 2003-04.
[80] Final Report of the Queensland Health Systems Review dated 30 September 2005 at page 185.

QH response to recommendation 2 (Letter dated 16 May 2006)

Improved reporting on clinical performance and clinical incidents is being implemented.

The *Health Services Amendment Act 2005*, assented to 28 November 2005, amended the *Health Services Act 1991* to require the chief executive to give the Minister an annual report about the performance of public hospitals including a number of key indicators. The key indicators include clinical performance, including the quality of care and clinical practice. The first report is required in 2006.

In March 2006, Queensland Health issued a Discussion Paper "*A New Framework for Clinical Governance in Queensland Health*" with an invitation for comments by 19 May 2006. The paper sets out proposed approaches to improving patient safety, quality and effectiveness of health care in Queensland Health facilities. Once the consultation period has been completed, the approaches contained in the paper will be assessed and definitive policies developed. The Discussion Paper includes a proposal at p.13 that the Patient Safety and Quality Board will provide an annual report on quality of care in Queensland Hospitals.

Queensland Health will publish regular patient safety reports using data from PRIME. These reports will be made available to the public through the Queensland Health website and will focus on sharing lessons learnt from a state-wide analysis of de-identified clinical incident and adverse event data. The reports will also outline vulnerable safety improvement initiatives being implemented to address any systems vulnerabilities identified. The first report is expected to be released in 2006.

3.4 Observations on issues relating to the Nevilles' specific complaints

3.4.1 Allegation that there existed a policy of non admission of children at CH

In the Nevilles" letter to Dr Stable dated 7 February 2002, they alleged they were told by the medical officer who treated Elise that it was not the policy of CH to admit children. This was also confirmed by RNs 1 & 2 who were on duty at the time.

SCHSD response to this allegation

Dr Stable sought advice from the District Manager of the SCHSD in respect of this allegation. The District Manager responded to Dr Stable on 15 January 2002 with the following advice:

> *I have confirmed that it is currently not the District's policy to admit children at Caloundra for observation. Children in the lower triage categories (i.e. 4 & 5) may be held in the Department of Emergency Medicine for observation for a period of time but are not admitted.*
>
> *..I have spoken with the Executive Director of Medical Services concerning the non-admission policy. He in turn has discussed it with the Directors of Emergency Medicine and Paediatrics. All maintain that there are no trained paediatric staff at Caloundra (i.e. nurses and medical officers) and as there is no facility (equipment other than emergency equipment) for investigation and treatment of children, any child requiring prolonged observation or admission should be transferred to Nambour.*

As this position does not meet your expectations as expressed to me this morning, I would appreciate your confirmation that you still require the removal of the non-admission policy or some modification to it.

In a briefing note to Dr Stable in April 2002, endorsed by the District Manager of the SCHSD, the following further advice was provided:

Children were routinely admitted to Caloundra Hospital prior to obstetric services being discontinued in 1990. Admissions became infrequent once Nambour General Hospital, appointed a full-time paediatrician in 1996. Children requiring observation and or/minimal treatment and who are aged approximately five years or above may be kept and observed for a short period at the discretion of the medical officer on duty/call. Any children requiring extended observation, ongoing treatment, or children under five years of age are transferred to Nambour General Hospital.

At the time in question (January 2002) it would appear that there is only one medical officer who routinely admits older children for treatment (eg those with gastroenteritis).

Further advice was provided by the District Manager of the SCHSD to the HRC in response to its investigation of this aspect of the Nevilles' complaint:

Caloundra Hospital has never had an official policy regarding the non-admission of children, as this was always considered a matter for clinical judgement having regard to the available staff and equipment resources.

The practice at Caloundra Hospital as at January 2002, was that children in the lower triage categories could be held for observation for limited periods of time, but that if the admission of a young child was required for regular observations, then the preferred practice was to transfer the patient to Nambour General Hospital where paediatric facilities and specialist care is available.

On the basis of this and other information provided by the SCHSD, the HRC concluded that there was not a formal "non-admission of children" policy in place at CH at the time of Elise's presentation[81].

Irrespective of the Commissioner's conclusion that the hospital's policies did not preclude the admission of children, the evidence clearly suggests that a number of key executive, medical and nursing staff associated with CH at the relevant time were of the opinion children were not to be admitted to CH.

In a letter to the Commissioner dated 26 March 2004, the medical officer explains the source of his understanding of the policy:

During my first year as intern at Nambour Hospital, we (all interns that were present at the Intern Education meeting) were told, very clearly: if you need to admit a child send them to Nambour. Do not keep them at Caloundra and Maleny Hospital.

In line with instruction received I have never admitted children to either Maleny or Caloundra Hospital.

RNs 1 and 2 in their statements to the QNC dated 3 October 2002 and 27 June 2002 respectively, confirm it was also their understanding that children were not to be admitted

[81] Health Rights Commission (HRC's) report dated 4 September 2003.

to CH, with RN 1 (who had been working at CH since May 2001) also stating she had never seen young children on the ward.

In the absence of any clearly documented policy, it is not surprising that a certain amount of confusion or misunderstanding developed over the admission or otherwise of children to CH. The External Investigator in his report concluded that staff‟s confusion on this issue was a major contributing factor in the outcome of the case and recommended that the issue be fully investigated by QH. It would appear QH did not take any action in response to this recommendation. However, the HRC investigated the issue and reported on its findings in its June 2004 report.

QH have an obligation to ensure its staff are properly informed on all relevant policies, practices and procedures, especially those that have a potential bearing on the standard/level of care to be provided to the public. The medical officer who treated Elise was clearly of the same opinion:

> *Whether or not admission of children to Caloundra or Maleny is a formal policy or a „culture" of behaviour, I expect Queensland Health, as my employer, to convey to me any important information I need to function efficiently as an employee.*[82]

I have formed the following opinion:

Opinion 3

The absence of a written policy on the admission of children to CH led to staff believing children were not to be admitted.

I make the following recommendation:

Recommendation 3

QH ensure that formal admission policies/guidelines exist in all public hospital emergency departments and that all ED staff are adequately trained in the application of these policies/guidelines prior to commencing duties in those departments.

QH response to recommendation 3 (Letter dated 16 May 2006)

Queensland Health supports recommendation 3 and is considering options for implementation.

It is also noted that the Caloundra Health Service has developed a paediatric admission policy.

[82] The medical officer‟s letter dated 26 March 2004 to the Commissioner in response to his final report dated 28 June 2004.

3.4.2 Adequacy of response by QH, as the health service provider, to a complaint about an adverse event

In their letter to the then Director-General of QH[83] on 7 February 2002 (approximately one month after Elise‟s incident), the Nevilles requested that the Director-General *“carefully investigate the culture of that* [Caloundra] *hospital..”* and *“investigate the events fully and independently of Caloundra Hospital and the Health Service District, and…take appropriate action”*.

In reviewing the appropriateness of Dr Stable‟s decision not to investigate the Nevilles‟ complaints, I have considered the following factors:

- the complaints related to an adverse event and raised a number of concerns about the adequacy of the provision of health services by CH;
- the complaints also raised a number of systemic issues, including an alleged practice that children were not to be admitted to CH; and
- the likely timeframes associated with the finalisation of inquiries undertaken by other external complaint agencies and the Coroner.

At the time of this incident[84], QH did not have an endorsed State-wide approach to adverse events or incident management. It was not until June 2004 that QH introduced an *Incident Management Policy*. Even so, having regard to the gravity of the concerns raised by the Nevilles, QH‟s decision not to conduct its own investigation is open to question.

The External Investigator made the following adverse findings in respect of QH‟s lack of response to the incident:

- *Sadly QH has never conducted a formal investigation into events leading to the death of Elise, nor has it conducted a “root cause” analysis. In this manner Dr and Mrs Neville have been badly served.*
- *QH has not responded in an appropriate manner to Elise‟s parents in so much that no attempt would appear to have been made to discuss with the parents issues of systems which may have failed or been inadequate;*
- *„Open Disclosure‟ was difficult because of the legal framework set up to protect QH from liability and because no formal investigation was ever conducted.*

I have made inquiries of QH to ascertain the complaint management policy and procedure in place at the time of Elise‟s death. QH advised[85] that, at the time:

- there was no written procedure for complaints management within the district;
- although not clearly documented, there was a mechanism for managing complaints received via the HRC, and complaints directed to the District Manager;
- QH was establishing a policy and procedure on how to respond to a critical incident/adverse event; however, no policy or procedure had been introduced into all healthcare facilities;
- QH‟s current *Health Complaints Management Policy* was not introduced until after Elise‟s incident (effective date 31 August 2002);

[83] Dr Stable.
[84] January 2002.
[85] Dr Buckland‟s letter to me dated 24 May 2005.

- a formalised complaints management procedure was being developed at the time of the response, by the recently formed Clinical Governance Unit.

It appears that QH's acknowledged lack of response to the Nevilles' complaint stemmed from an *ad hoc* approach to dealing with patient complaints.

As previously indicated, QH's initial response was to await the outcome of the various other independent inquiries likely to take place as a result of the incident and be guided by their outcomes. One difficulty with this decision is that it ought to have been appreciated that there would be a significant delay (given the number of agencies and the varying processes involved) before the outcome of the external investigations was known. I also note that QH was under no statutory obligation to implement or act upon recommendations made by the HRC or riders made by the Coroner.

I have reviewed the actions taken by QH following the incident and make the following observations:

- While a "preliminary investigation report" was furnished by the Executive Director several days after the incident, the focus of the report was limited to whether or not Elise's management by the medical officer was reasonable.
- The district did not undertake a risk assessment as an immediate response to the incident.
- Although QH did not have an *Incident Management Policy* at the time, it could have relied on its "Code of Conduct 2000" to investigate some of the Nevilles' concerns about the conduct of the medical officer and the nurse who treated Elise. For example, failure to provide a head injury advice form to the Nevilles at Elise's first presentation or record key clinical background information, may amount to breaches of an employee's obligation under the Code to exercise proper skill, diligence, care and attention.

  This is an important issue, because many complaints made to a registration board about the conduct or competence of a registrant, even if proven, will not amount to "unsatisfactory professional conduct" (the threshold for a registration board to take action), but may amount to "unsatisfactory service". Although some conduct may not be within the jurisdiction of a registration board, it should be of concern to an employer.

  It is relevant that, in this case, the Health Practitioners Tribunal, in imposing a disciplinary sanction on the medical officer who treated Elise on 7 January 2002, made it clear that a competent experienced doctor should have assessed Elise's clinical presentation as requiring admission for observation for at least four hours, or immediate referral to the ED at Nambour General Hospital.

- QH's decision to roster medical staff on a 24 hour basis, rather than an "on call" basis, did not address the substantive issue of "unsafe working" hours for junior doctors.

Independent investigations by the HRC and the External Investigator appointed by QH have disclosed that not only human error, but also systemic issues, contributed to Elise's death. While the possibility of "human error" can never be totally removed, specific actions can be taken to reduce the likelihood of human error occurring, for example, an effective risk management program that, in this instance, should have identified the need for better rostering practices (allowing for quarantined breaks) and better training on

identifying fatigue and its effects, to reduce some of the risks associated with long/shift hours.

I have formed the following opinions:

Opinions 4 and 5

4. The administrative system in place at the CH ED at the time of Elise's presentations was defective in that it was based on actions and decisions of QH that were unreasonable and wrong (within the meaning of s.49(2)(b) and (g) of the Ombudsman Act). In particular:

(a) At a peak holiday time, the ED was staffed by one second year junior doctor, contrary to the standard recommended (since March 1999) by the ACEM and recommendations included in QH's 2001 report of "The review of Emergency Services, Sunshine Coast Health Service District".

(b) This staffing deficiency was compounded by rostering practices that required excessive hours of work by junior doctors, such that the junior doctor who attended to Elise at her first presentation was in the 20th hour of a continuous shift.

(c) The problems inherent in leaving a junior doctor in charge of an ED were compounded by the lack of ready access to written protocols for the treatment of significant medical conditions commonly presenting at EDs, especially, in this case, the lack of ready access to a written protocol covering the assessment and treatment of paediatric head injuries.

(d) A practice had been allowed to develop among clinical staff at CH ED of refusing admission of children on the basis that Nambour General Hospital was better resourced to deal with those patients. This practice had developed to the point where many clinical staff understood it to be a firm policy. The management of CH had not taken sufficient steps to make clear to clinical staff that there was no such policy and that admission of children could occur where that was necessary in the best interests of the proper treatment of a child patient (even if referral to Nambour General Hospital was preferable in non-urgent cases).

5. This defective system is likely to have contributed to the mistakes made in the assessment of Elise.

I make the following recommendations:

Recommendation 4

QH determine, as quickly as possible, an interim standard on safe working hours for doctors in public hospitals for implementation by QH pending finalisation and implementation of any standard being developed by the MBQ.

QH response to recommendation 4 (Letter dated 16 May 2006)

Recommendation 4 is being implemented.

The recent Medical Officers (Queensland Public Health Sector) Certified Agreement (No.6) 2005 includes specific provisions about a range of interim fatigue reporting and management arrangements including the implementation of a $3.6M Alert Doctors Strategy over a period of eighteen-months to commence from 1 January 2006. The Agreement requires a comprehensive policy on fatigue management to be developed by 31 December 2006.

Clause 7.1 of the Certified Agreement sets out a range of interim fatigue reporting and management arrangements that effectively constitute an interim standard on safe working hours.

The Medical Board of Queensland is also preparing a discussion paper in relation to doctors‟ hours of work and managing fatigue risks. This will be released for public comment.

Recommendation 5

QH progressively implement as quickly as possible, the management practices aimed at alleviating the ill-effects of excessive working hours, recommended in the AMA Safe Hours Campaign and Risk Management Strategies.

QH response to recommendation 5 (Letter dated 16 May 2006)

Recommendation 5 is being implemented.

As noted in the comments on recommendation 4, Queensland Health is developing an Alert Doctors Strategy.

The Alert Doctors Strategy is a multi-project work program that aims to address the risks associated with medical officer fatigue in Queensland Health. This includes risk management, work and role redesign, work pattern changes, and fatigue management policies and education. The deliverables for this strategy will be:

- Education programs for doctors and managers on fatigue management and prevention.
- Risk assessments and risk management plans for all districts, services, and streams of care, at appropriate micro and macro levels.
- Policies and guidelines for risk control.
- Workforce design solutions to address fatigue risk areas. This project will examine changes to work design and workflow; the use of expanded, advanced practice, or new roles; and working pattern changes.
- A communication strategy to inform staff of the progress of the strategy.
- Mechanisms to implement the solutions identified.

The DG has approved that the University of South Australia‟s Centre For Sleep Research be given sole provider status to tender to partner with Queensland Health in the implementation of the Strategy. The Centre has previously undertaken a National Health and Safety Quality Council project to develop practical fatigue management principles for health care professionals. The work of the head of the Centre … was also relied upon by the AMA in the development of their Safe Hours Standard. The implementation of the Queensland Health strategy will be guided by the Centre‟s latest research in relation to managing fatigue risks in a health care environment.

Recommendation 6

QH adopt and implement (at least) the following aspects of the December 2001 policy document published by the ACEM:

- **Written protocols regarding the treatment of the specific conditions listed in the ACEM policy be available in all QH EDs at all times;**
- **The protocols stipulate the kinds of medical condition when consultation must occur with a senior doctor;**
- **An audit be undertaken of the CKN accessibility and ease of use for clinicians in EDs;**
- **All junior medical staff employed in QH EDs be involved in an ongoing learning program in paediatric emergency medicine.**

QH response to recommendation 6 (Letter dated 16 May 2006)

Queensland Health supports the implementation of treatment protocols and recognises the need to make advice and support available to rural and regional emergency departments.

There have been a large number of recent initiatives focussed upon the performance of Emergency Departments and the support of doctors who work in departments with minimal or no senior medical staff.

Election commitment funding has enabled Emergency Departments to employ more doctors and nurses across the State. The mini budget has provided additional funding in 2005 for new services and maintenance of existing services with $280.3m over five years, allocated for emergency departments. This includes $2.2 million funding for the development of emergency telehealth to provide advice and support to rural and regional emergency departments supported by Royal Brisbane and Women‟s Hospital, Princess Alexandra Hospital and The Townsville Hospital emergency department staff specialists. Currently, Fraser Coast Health Service District has a telehealth link between Maryborough and Hervey Bay Emergency Departments to allow junior medical officers access to emergency advice from the senior medical staff at Hervey Bay.

The recent establishment of Clinician led Emergency Department Networks in each Area Health Service ensures that clinicans will be actively involved in identifying priority action areas. For example, the Central Area Health Service ED network has identified lack of standardised protocols as one of the main priority action areas. The group is working with the Clinical Practice Improvement Centre to ensure that clinicans needs are met through the standarised protocols.

Many of the issues identified by external investigations long after Elise‟s death would have been apparent to QH had it investigated the cause of the incident as soon as it occurred. A competent investigation would have revealed:

- poor documentation in clinical records;
- lack of adequate clinical protocols in the ED;
- a junior doctor being left unsupervised and in charge of an ED;
- lengthy shifts/hours for doctors; and
- inadequate paediatric qualifications for ED nurses.

QH‟s lack of response resulted in frustration and disappointment for the Nevilles that may have been avoided by providing them with timely advice about what actions were being taken by the SCHSD to improve the level of health services provided by CH.

Although external complaint agencies were investigating different aspects of the matter, there was no impediment to QH working collaboratively with those agencies in undertaking its own investigation including, for example, a detailed risk assessment and incident/root cause analysis. QH should also have engaged in open communication with the Nevilles about all aspects of the incident. These steps would not have involved duplication of investigative actions of the other agencies.

I have formed the following opinion:

Opinion 6

QH's decision not to undertake an investigation (including a Root Cause Analysis) in response to the death of Elise was unreasonable within the meaning of s.49(2)(b) of the Ombudsman Act having regard to the gravity of the allegations made by the Nevilles about the standard of care provided to Elise by CH.

Dr Stable's response to opinion 6

(Response supplied by solicitors acting for Dr Stable in a letter dated 11 May 2006.)

On the day Elise Neville died, Dr Stable says he made enquiries about the incident with the Executive Director. Having been advised of Elise Neville"s death, Dr Stable says he wanted reassurance that the necessary steps were being undertaken to avoid, if at all possible, any further such tragedies if obvious steps could be immediately taken. Dr Stable specifically recalls in the conversation, asking about the competence of the medical officer involved.

Dr Stable instructs me that he also asked Dr Youngman to correct any misapprehension at the District or hospital level about the treatment of children at Caloundra Hospital, hence Dr Youngman"s email.

Since Dr Stable knew Dr and Mrs Neville well, he attended Elise Neville"s funeral.

Due to Dr Stable"s involvement in this case at an early stage, and his attendance at Elise"s funeral, it was strongly suggested to my client that he was biased against the Health District staff.

Dr Stable instructs that he formed the view in the circumstances that it was best to have external agencies conduct enquiries, as would happen with most deaths in the health system. This view was based on many factors. Dr Neville worked for Queensland Health, and had been a colleague of Dr Stable"s at Medical School, and there were strong suggestions about perceived bias. Dr Stable says he recalls raising this at the time with Senior Queensland Health Staff and perhaps the Minister but also Dr and Mrs Neville during one of their meetings with him. The case was an extremely emotional one for all involved. Dr Stable says he wished to ensure the process was transparent and felt the best way to do this was to leave the matter in the hands of the Police, Coroner, Health Practitioner"s Boards and Health Rights Commission, all of whom were conducting extensive enquiries.

In addition, Queensland Health had a Paediatric Mortality Committee which would have reviewed Elise"s case as well in due course, and which reported directly to the Minister.

The External Investigator"s report appears to have been commissioned by the Director-General at the time – Dr Steve Buckland. On page 1 of the report, paragraph 7 it states:

„The persons directly involved in the care of Elise Neville ... were not interviewed as some are subject of enquiries by the respective Registration Boards and the Coroner. In view of these facts, it was deemed not appropriate to discuss issues with them".

That situation applied when Dr Stable was Director-General. Initially, the Police, and then the Coroner and the various Registration Boards and others were investigating the matter. Dr Stable says he is concerned therefore that the External Investigator is critical on page 7 of his report when he states that:

„Sadly Queensland Health has never conducted a formal investigation to the events leading to the death of this child".

Following the receipt of Dr Stable"s advice, my officers made further inquiries with QH about any reports that may have been created in respect of this case by the Paediatric Mortality Committee referred to in Dr Stable"s letter. The Chair of the Committee provided the following information to QH which was then provided to me:

> *"... the Mortality Committee's activity in each case is simply to review the paperwork to ensure the coding of the cause of death is correct and in this case, the coding would be ‚head trauma due to fall". That is what the code refers to in the excel spreadsheet.*
>
> *There is no paperwork at all apart from the chapter in the annual report which you will have a copy of. We do not make reports to the Minister about any cases. The annual report is submitted to the Minister. ...*
>
> *We do not make deliberations about the circumstances of individual cases other than that (categorise the death) and our overall recommendations about preventability are based on the grouped categories and are generic recommendations. ..."*

Dr Buckland in his letter to me dated 24 May 2005 stated that a similar incident occurring today would be dealt with according to QH"s *Incident Management Policy*. I have been advised that, following structural changes within QH and the recent QPHCI and the QHSR, a comprehensive revision of this policy has been completed by the QH PSC. It is expected that the revised *Clinical Incident Management Policy* and supporting *Implementation Standard* will be endorsed by the Director-General in the near future and that there will be a staged implementation period.

I make the following recommendation:

Recommendation 7

QH expedite implementation of its revised Clinical Incident Management Policy and supporting Implementation Standard and ensure that appropriate training and support are available to all Health Service Districts.

QH response to recommendation 7 (Letter dated 16 May 2006)

Recommendation 7 is being implemented.

The revised Clinical Incident Management Policy has been distributed for feedback and is expected to be finalised for implementation within 3 months. Training and support to health service districts will be led by the Patient Safety Centre including through its District Support Team and network of Patient Safety Officers.

3.4.3 "Denial of liability" by QH

The Nevilles alleged that rather than conduct a proper investigation, QH adopted as its administrative response the legal position of the SCHSD which was to deny liability for the incident. The then Director-General of QH[86] has submitted that this allegation is incorrect (see section 3.2.1 above).

QH is correct in saying that the Nevilles have never made a claim, such as a civil claim, that would require QH to formulate and state a definite position with respect to "liability", and that it has never issued a statement or indication that would amount to a denial of liability as its legal response.

The Nevilles" fundamental concern is QH"s lack of an appropriate response to a critical incident. The Nevilles wanted open disclosure principles to be applied by QH in responding to Elise"s incident and have interpreted QH"s response as a denial of liability. The External Investigator formed the opinion that open disclosure was difficult because of the legal framework set up to protect QH from liability, and because no proper investigation was ever conducted by QH.

As noted above, the open disclosure process includes the making of an "apology" or "expression of regret" by the health service provider (as soon as possible following an adverse event) to the patient or their family, in addition to the disclosure of known facts surrounding the incident.

Health care professionals hold understandable concerns that an "apology" may not serve their best interests (or those of the hospital employing them), because:

- it could be used against them by the patient as an "admission" against the interests of the health care professional, either as an admission of liability or admission of some other factual matter; and
- it may imperil or compromise their entitlement to coverage from their insurers by constituting the kind of "admission" that is forbidden by the terms of their insurance cover.

Some medical insurers/Medical Defence Organisations (MDO) are supportive of open communication and apology in an appropriate case[87]. It seems that the real challenge lies in "finding the right words" which won"t be legally construed as amounting to an "admission of liability". The proponents of open disclosure contend that, properly

[86] Dr Buckland.

[87] The December 2005 Newsletter published by the Medical Defence Organisation of South Australia Ltd openly encourages its insured members to provide an apology following an adverse incident.

employed, it can often be instrumental in a decision by the aggrieved patient/carer not to pursue a civil action against the health service provider.

In Queensland, there is currently some legislative protection from civil liability for an "expression of regret". Section 71 of the *Civil Liability Act 2003* provides:

> *An "expression of regret" made by an individual in relation to an incident alleged to give rise to an action for damages is any oral or written statement expressing regret for the incident to the extent that it does not contain an admission on the part of the individual or someone else*. (my underlining)

Section 72 goes on to provide:

> *An "expression of regret" made by an individual in relation to an incident alleged to give rise to an action for damages at any time before a civil proceeding is started in a court in relation to the incident is not admissible in the proceeding.*

In NSW, the *Civil Liability Act 2002* provides that an apology made by, or on behalf of, a person in connection with any matter alleged to have been caused by the person does not constitute an express or implied admission of liability and is not admissible in any civil proceedings.

In my submission to the BHCI, I commented that the existing provisions of Queensland's Civil Liability Act were too limited in their application in that, unlike the NSW provisions, the Queensland provisions protect from admissibility in a civil proceeding an expression of regret only "to the extent that it does not contain an admission of liability on the part of the individual or someone else."

Having regard to the findings of the External Investigator and the Health Practitioners Tribunal in disciplinary proceedings against the medical officer, I am of the opinion that ss.71 and 72 of the Civil Liability Act should be amended to correspond with the aforementioned NSW provisions. Such an amendment would, in the case of HSPs, encourage open disclosure in circumstances where a person has been affected by an adverse event.

I intend to raise this issue with the Director-General of the Department of Justice and Attorney-General.

I have formed the following opinion:

Opinion 7

QH failed to provide an appropriate standard of care to Elise at her first presentation to CH ED on 7 January 2002.

I make the following recommendation:

Recommendation 8

QH provide an apology to the Nevilles for its failure to provide an appropriate standard of care to Elise.

QH response to recommendation 8 (Letter dated 16 May 2006)

Queensland Health supports recommendation 8.

3.4.4 Inaction by QH in respect of the Executive Director's report

In responding to the Nevilles' concerns about the Executive Director's report, QH advised that the report was never intended to be relied upon in determining a departmental response to the incident. However, it is difficult to accept that it played no part in QH's decision not to conduct an investigation.

Irrespective of whether the report was intended to be relied upon by QH or not, or whether it was simply a "preliminary incident report" rather than an "investigation report", it was an official departmental document and appropriate care was required in its preparation.

One potential consequence of preparing a report into a fatal incident is that the report may be requested by external investigative/regulatory agencies, and be accepted as accurate/soundly based. I note that QH released the report (as evidence relating to the incident) to other external agencies investigating the incident.

A review by QH of the Executive Director's notes of his interview with the medical officer would have revealed two significant inaccuracies in the report itself. The first is that the Executive Director states in his report that the medical officer could not find the Head Injury Advice form to give to the Nevilles. In fact, the interview notes indicate that the medical officer informed the Executive Director that he did not know where the form was kept, which is materially different. In circumstances where the Nevilles had requested that Elise be admitted for observation, but the medical officer had decided she should be sent home, the report implies that the medical officer tried to locate the relevant forms but they were not where they ought to have been. The account the medical officer gave to the Executive Director was that he did not know where the forms were kept, and apparently no searches or inquiries were made to find them.

The MBQ received a copy of the Executive Director's report, which was in turn provided to one of the medical experts who submitted an opinion to the MBQ as part of its investigation of the medical officer. It is evident from the expert's opinion that he relied on the information conveyed in the Executive Director's report that the medical officer could not find the form. Thus, while the report may not have been relied upon by QH in a material way, it was relied upon by others.

The second glaring inaccuracy in the report is the Executive Director's assertion that the nurse stated that the "child was normal but sleepy and grumpy". In fact, the Executive Director's record of his telephone interview with RN 1 shows that she stated the "child was irritable and hard to settle down for examination". Had QH reviewed the report and identified this inaccuracy, it would have had reason to question the validity of the report's conclusions.

The Nevilles' allegations about other deficiencies in the report were later substantiated by the MBQ.

As the report had been provided to other external agencies and the Nevilles had challenged its accuracy, I consider that QH should have undertaken further investigations with a view to verifying its accuracy or notifying the Nevilles and the other relevant external agencies of any inaccuracies.

I have formed the following opinion:

Opinion 8

QH should have reviewed the Executive Director's report following the very serious allegations raised by the Nevilles about its accuracy and its failure to do so was unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Dr Stable's response to opinion 8

(Response supplied by solicitors acting for Dr Stable in a letter dated 11 May 2006.)

As Dr Stable has instructed us to indicate in his response to opinion 6, on the day Elise died he made enquiries regarding this incident of the Executive Director. Dr Stable did not ask him to perform a full investigation into the incident. He asked for a report as to what had occurred, to provide some information about the circumstances of Elise Neville"s death, and specifically the competence of the staff concerned.

Dr Stable has asked me to refer to page 7 of the report of the External Investigator. He states that:

„Unfortunately it would seem that [the Executive Director"s] *report has been taken as an investigative report and criticised as such, indeed the report as an investigative report was inadequate as it was never intended to do more than report an incident".*

Dr Stable says the Executive Director"s report was not meant to be anything other than a brief report to him. The contents of the report were not the cause of my client"s decision to leave the investigation in the hands of the Police, Coroner, Health Practitioner"s Boards and Health Rights Commission. Dr Stable says his reasons for this are outlined in his response to opinion 6.

I make the following recommendations:

Recommendations 9 and 10

9. **A record should be created and attached to all copies of the Executive Director's report held by QH detailing the inaccuracies contained in the report.**
10. **QH should also forward a copy of the attachment to every agency known to have obtained a copy of the Executive Director's report, and request that the attachment be added to the report.**

QH response to recommendations 9 and 10 (Letter dated 16 May 2006)

Queensland Health does not object to implementing recommendations 9 and 10, but notes that the intended public release of your report will place on the public record your opinion about the inaccuracies contained in the report, and so also achieve the outcome of disclosure of the inaccuracies to relevant agencies.

3.4.5 QH's response to the findings and recommendations contained in the reports by the HRC and the External Investigator

It has already been noted that QH declined to conduct an investigation of the Nevilles‟ complaint (until the appointment of the External Investigator more than two years after the incident), or a root cause analysis, on the basis that investigations were being undertaken by the independent health complaint agencies.

As a consequence of inquiries the HRC made of the SCHSD in its initial investigation, the Health Rights Commissioner noted that the SCHSD had implemented some changes that related to a number of the systemic issues raised by the Nevilles‟ complaint. These included:

- From 14 January 2002 (that is, one week after Elise‟s presentation), the rostering system was changed so that medical staff were rostered on a 24 hour basis (rather than "on call" between the hours of 10.00pm and 8.00am). It was claimed that this ensured that medical staff who had been working continuously long hours would not be called during the night.

- On 15 January 2002, a direction was issued by the (former) General Manager (Health Services) QH to the District Manager confirming that he could not accept the continuation of the existing practice at CH regarding the admission of children. In other words, it was made clear to the SCHSD that children were to be admitted to CH, and that only clinical considerations should determine the treatment to be provided.

- Certain actions were taken by the SCHSD to increase staff awareness of documentation standards (for example, inclusion of documentation standards as part of continuing medical education sessions).

By letter dated 4 March 2005, I asked QH to report on what steps, if any, it had taken in response to the recommendations included in the investigation reports prepared by the

HRC and by the External Investigator. In a letter dated 24 May 2005, the then Director-General of QH[88] responded as follows:

The External Investigator"s report

In relation to the External Investigator"s report[89], Dr Buckland stated that:

- there were two recommendations included in the body of the report, and a further 12 recommendations listed in its conclusion;
- the two recommendations included in the body of the report were actioned by the Director-General during his meeting with the Nevilles on 22 June 2004[90] (the first recommendation was that the Director-General clarify with the Nevilles the nature of the Executive Director"s report; the second recommendation was that the Director-General discuss with the Nevilles relevant systemic issues and any actions by QH to address those issues);
- while not strictly in response to the other 12 recommendations, a number of initiatives had been implemented at district level which satisfied the substantive recommendations.

Although the listed initiatives go some way towards addressing a number of the issues covered in the 12 recommendations, it is not clear whether all issues covered by the recommendations have been appropriately addressed as of the date of QH"s response to me.

QH"s response to my query about actions it has taken to implement the recommendations by the External Investigator and by the Health Rights Commissioner indicates that no formal "response plan" was implemented by QH following receipt of those reports.

HRC"s report of June 2004

The Health Rights Commissioner made four substantive recommendations for further action by QH in his June 2004 report. He noted that the SCHSD had undertaken to review his report with a view to implementing those recommendations within its capacity. The Commissioner considered there should be no question about its ability to implement all recommendations, with the support of QH where appropriate. The Director-General was requested to monitor the changes and report back to the Commissioner within 12 months on the implementation of the recommendations, with an initial progress report after six months. I am advised that QH failed to provide the Commissioner with the six-monthly interim progress report as requested.

In response to a facsimile from the Commissioner on 29 April 2005, QH wrote to the HRC on 24 May 2005 outlining the actions taken by QH up to that date to implement the recommendations contained in the Commissioner"s report of June 2004. Once again its response referred to actions it had taken which were not as a direct response to his recommendations. Accordingly, on 26 September 2005, the Commissioner wrote to the

[88] Dr Buckland.
[89] Appendix 2.
[90] The Nevilles have advised that Dr Buckland did not clarify with them the type of report submitted by the Executive Director, but said that he was of the opinion that, irrespective of the type of report, the Executive Director had been asked to complete, the report should have been factually accurate. The Nevilles also say that Dr Buckland did not discuss any systemic issues with them. Dr Neville"s diary notes of their meeting with Dr Buckland support their account.

Director-General[91] of QH seeking more detailed information concerning QH‟s specific responses to the first three of his substantive recommendations. (The fourth recommendation concerned the aeromedical retrieval system which is separately addressed in Chapter 10 of my report.) The Director-General of QH replied on 29 October 2005. The specific questions, and QH‟s responses, were as follows.

Recommendation 1 – Developing a positive culture for caring for children at Caloundra Hospital

Q.1 Is the appointment of a Director of Caloundra Emergency Department full-time or shared with Nambour?
Q. 2 What changes have been made to ensure 24 hour experienced medical coverage?

A.1 A FACEM (Fellow of the Australian College of Emergency Medicine) commenced full time at the Caloundra Health Service in June 2005.
A.2 Principal house officers are now rostered for a series of overlapping shifts to provide continuous coverage. This includes a rostered 12 hour night shift between 8.00pm and 8.00am. Senior Medical Officer coverage is provided by a rostered and rostered on–call combination.

I am informed that principal house officers are medical practitioners who are at least in their second year of service after eligibility for full registration as a medical practitioner. Accordingly, while the ED now appears to be staffed by more experienced medical officers, the new rostering regime does not address the inherent dangers associated with extended working hours.

Recommendation 2 – QH provide accredited courses – emergency nursing for children (Caloundra ED Nursing staff not skilled in caring for children)

Q. Could you please clarify whether [QH] has provided [CH] nurses with an accredited course dealing with emergency care for children?

A. Of the 16.8 nursing FTE currently employed in the Caloundra ED, 13 have completed a recognised Paediatric/Paediatric Life Support program within the last twelve months. A number of the staff have also received other qualifications that contain a paediatric component.

Advice sought from two independent hospitals as part of the HRC‟s investigation indicated that the nurses assigned to those hospitals‟ EDs had training in advanced paediatric nursing (or higher level training), because of the complexities associated with the observation and care of children. I understand that the level of paediatric expertise available in a hospital‟s ED is determined by a range of factors including the number of children likely to present to the ED including during times (such as school holidays) when the population swells. Therefore, I am uncertain whether the training provided to the CH ED nursing staff is commensurate with the standard of training provided to ED nursing staff in comparable hospitals.

[91] Ms Schreiber.

I make the following recommendation:

Recommendation 11

QH immediately undertake an independent review of the paediatric qualifications and training provided to ED nursing staff in CH to ensure that an acceptable standard of paediatric care is available at all times.

QH response to recommendation 11 (Letter dated 16 May 2006)

Recommendation 11 is being implemented.

The Director of Nursing, Sunshine Coast District is currently conducting a review of education and staff development services being provided for nurses in the district. The review will include an assessment of the paediatric qualifications and training provided to nursing staff in the Caloundra Hospital emergency department. Queensland Health will provide a copy of the review upon completion for your consideration if required.

A position of Director Education, Staff Development and Research has recently been created in the district. The new position will promote and maintain education and staff development standards for nursing services within the district.

Recruitment is currently underway for a District Director of Emergency Medicine to coordinate the provision of emergency services across the District.

Recommendation 3 – QH periodically audits the care of children in Caloundra Hospital

Q. Other than auditing documentation, have any particular reviews been undertaken regarding the admission and/or transfer of children? If so, could you please provide details.

A.1 Ongoing monitoring occurs as part of the district‟s approach to this issue rather than there having been any specific review(s) undertaken regarding the care of children.

A.2 The SCHSD Clinical Governance Unit (CGU) was established in April 2005 and its responsibilities include clinical incident management, root cause analysis coordination, clinical risk register coordination, complaints management, medico-legal coordination and credentialing and clinical privileging.

A.3 The district implemented its Clinical Incidents Policy in May 2005.

A.4 A Caloundra Health Service Mortality and Review Committee has been established in line with the CGU. The functions of that group include mortality and morbidity case reviews and investigation and follow-up of serious adverse events for adults and children.

I have been advised that the Commissioner is satisfied with QH"s response. I have no further recommendation to make.

3.5 Recent allegation about copy of External Investigator's report provided to Dr Neville

On 21 June 2004, QH provided Dr Neville with an unsigned and undated copy of the External Investigator"s report[92].

Dr Neville recently advised my Office that he was concerned that this copy of the report had been altered to delete a statement critical of QH.

Dr Neville based this allegation on the following:

- For the purpose of consulting with Dr Neville on an application under the Freedom of Information Act, QH recently provided him with a signed and dated copy of the External Investigator"s report;
- Page 8 of the signed and dated report contains the following paragraph (which does not appear in the unsigned and undated copy he was given on 21 June 2004):
  The District, like many similar health districts throughout Australia, has not had adequate funding to keep pace with rapidly growing populations and community expectations.
- There is a typed heading "REPORT INTO THE DEATH OF ELISE NEVILLE" at the top of each page of the signed and dated report.
- The copy of the unsigned and undated report provided earlier to Dr Neville contains the same typed heading at the top of each page except page 9.
- However, page 8 of the unsigned and undated report contains both the typed heading at the top of the page and an identically worded and formatted heading at the bottom of the page.
- The paragraph missing from the unsigned and undated report appears at page 8 of the signed and dated report.
- This suggests that the paragraph was deleted from Dr Neville"s copy of the unsigned and undated report, as a result of which the typed heading on page 9 moved to the bottom of page 8.

Dr Neville had previously advised my Office that Dr Buckland verbally advised him that he would be provided with a copy of the External Investigator"s report and that no confidentiality constraints would apply. He subsequently received the unsigned and undated copy which he accepted as the External Investigator"s report.

As a result of these allegations, I requested QH to:

- inquire into the possible deletion of the paragraph from the copy of the unsigned and undated report provided to Dr Neville on 21 June 2004; and
- provide me with a report on its inquiry and findings.

[92] The findings and recommendations of the External Investigator are contained in Appendix 2.

3.6 Response by Queensland Health

The Ethical Standards Unit of QH conducted the investigation I had requested and provided me with a copy of its report[93]. The report concluded:

> *"The Investigating Officer found that the allegation that officers from the Department deleted the relevant paragraph prior to providing the report to Dr Neville on 21 June 2004 was not substantiated."*

The report stated:

> "*...the available evidence clearly indicates that* [the External Investigator] *sent* [the Executive Manager[94]] *a copy of his report by email on 2 June 2004. This copy of the report had the paragraph on page eight included. The Director-General subsequently reviewed this report and on 4 June 2004* [the Executive Manager] *sent* [the External Investigator] *a version of the report which included adjustments made by the Director-General (highlighted in red). The paragraph on page eight was highlighted in red.*
>
> *On 4 June 2004* [the External Investigator] *sent another version of the report back with his comments regarding the adjustments highlighted in blue. Under the relevant paragraph on page eight he had included the words "this is a significant problem throughout Australia as populations expand and staff at most levels expressed this view over the District finances."*
>
> *At some time between 4 June 2004 and 7 June 2004 the Director-General and* [the External Investigator] *subsequently had a telephone discussion in relation to various areas of the report, including the validity of the relevant paragraph on page eight.*
>
> *On 7 June 2004* [the External Investigator] *forwarded* [the Executive Manager] *the "final report after (his) discussion with Steve[95]". Within this version of the report* [the External Investigator] *had deleted the paragraph on page eight.*
>
> *Accordingly, there is clear evidence that* [the External Investigator] *deleted this paragraph from the report after discussions with the Director-General.* ***Therefore the allegation that officers of the Department deleted the paragraph prior to providing it to Dr Neville is not substantiated.*** (my emphasis)

3.6.1 Inquiries undertaken

The Ethical Standards Unit undertook a number of inquiries in an attempt to establish the facts surrounding the creation, receipt and release of the various versions of the External Investigator's report. The unit:

- Undertook a retrieval of copies of the two versions of the report that Dr Neville presented to my Office.
- Convened a meeting with relevant officers from the Legal and Administrative Law Unit within QH (LALU) to discuss the files held by that unit.
- Conducted a telephone interview with the Executive Manager.
- Conducted a review of all documentation contained within the relevant files held by the LALU.

[93] References to the Director-General throughout the Queensland Health report are references to the then Director-General, Dr Buckland.
[94] The Executive Manager employed within the Director-General's office.
[95] Dr Buckland.

- Conducted a telephone interview with the External Investigator.
- Examined the email account of the Executive Manager.

The Executive Manager, when interviewed by the Ethical Standards Unit, was unable to recall the exact circumstances surrounding the eventual receipt of the External Investigator"s report, but believed the report was received by email and later by hard copy. She stated:

- The External Investigator "*asked the department to look at the (draft) report and provide feedback*";
- Dr Buckland read the report and had a subsequent discussion with the External Investigator about the report;
- She was present during their conversation and recalls it was "*quite heated*" and that they specifically discussed the paragraph in question. Dr Buckland wanted to know "*what basis he* [the External Investigator] *had for making the statement that the District was underfunded"*. The External Investigator advised *"it was an assumption that he made after discussions with people (during his investigation) who had mentioned the issue"*. Dr Buckland responded, "*he did not have an objection to the statement appearing in the report and did not disagree with his view, but believed that he needed to reference the statement to something*".
- She was unable to recall how or if the statement was removed from the report, or whether the External Investigator provided another version of the report after removing the statement. She had *"no recollection of deleting any paragraph*" from the report prior to releasing it to Dr Neville.

The Ethical Standards Unit made telephone contact with the External Investigator who immediately remembered the paragraph in question. The External Investigator provided the following advice:

- He had forwarded his first report, a draft version, to the Director-General and within this report had indicated the view that the District was underfunded. He had formed this view from conversations with people in the District and his own knowledge.
- He spoke with the Director-General about the contents of his report and the Director General had "*refused to accept that the District was not adequately funded."*
- After this discussion "*he then submitted a second version of the report with this paragraph removed.*" However when asked by the interviewing officer if he could specifically recall removing the paragraph from the report himself he stated that "*he could not remember if he left it in the report and said that"sthe report*" or if he "*later removed it.*" He could not recall whether he had sent a second version of the report with the paragraph removed.

The interviewing officer from the Ethical Standards Unit subsequently emailed the External Investigator both versions of the report. Version 1 is the unsigned and undated copy of the report provided to Dr Neville by QH on 21 June 2004 with the relevant paragraph removed. Version 2 is the signed version of the report dated 3 June 2004 with the paragraph included. On 27 April 2006, the External Investigator advised via email:

> *"I have reviewed my files and the 2 copies of the report both the draft and final report contain reference to inadequate funding in the Sunshine Coast Health Service and the draft makes comment that this information was supplied to me by Health Department Officers. In the final report the comment of from where the information was obtained was*

omitted. I have no idea why my unsigned report was forwarded (to Dr Neville) as my final report and why the comment of inadequate funding was removed."

The QH (FOI officer) who recently provided Dr Neville with the signed version of the External Investigator‟s report dated 3 June 2004 (version 2) was also interviewed by the Ethical Standards Unit.

The FOI officer advised that after reviewing files held by the LALU as part of an FOI process, she located what she believed to be the "final" version of the report and processed this report as part of the application. This was version 2 of the report recently provided to Dr Neville. The LALU hard copy files were subsequently reviewed by the Ethical Standards Unit, but the files did not contain any documentation in relation to discussions surrounding the relevant paragraph of the report.

The Ethical Standards Unit also reviewed the email records of the Executive Manager. This review showed the following:

- **2 June 2004**- email from the External Investigator to the Executive Manager with his report attached. The email includes advice that "*the final edition with an accompanying letter is going off tomorrow*" (this is version 2 of the report recently received by Dr Neville which includes the relevant paragraph on page 8)
- **4 June 2004**- email from the Executive Manager to the External Investigator emailing back a copy of his report with some adjustments (highlighted in red) made by the Director-General on the basis "*he is not aware of any evidence that supports the statements..*" (relevant paragraph on page 8 is highlighted in red)
- **4 June 2004**- email from the External Investigator to the Executive Manager attaching another version of the report. He responds in the email "*…I have highlighted in blue my comments concerning the comments of the DG…"* (This is actually version 3 of the report and contains an additional comment added by the External Investigator to the relevant paragraph on page 8)
- **7 June 2004**- email from the External Investigator to the Executive Manager with the subject line „*The Final Report!!!!!".* Within this email the External Investigator states: *"please find attached the FINAL REPORT after my discussions with Steve… please destroy the other copies …"* (relevant paragraph on page 8 is removed)

Because the advice provided by the External Investigator in his email of 27 April 2006 to the Ethical Standards Unit was inconsistent with the evidence gathered by QH (that is, the External Investigator had *"... no idea ... why the comment of inadequate funding was removed*"), my officers sought his further clarification about what had occurred.

The External Investigator has since advised my officers, after considering the results of the investigation, that he, as author of the report, had made the alterations.

3.7 Observations

I make the following observations about the External Investigator‟s report:

- The External Investigator‟s report dated 3 June 2004, gives the appearance that it was originally provided to QH as the final report. On 2 June 2004, the External Investigator had sent an email to the Executive Manager titled "Report re the death of Elise Neville" stating that: "*The **final edition** with an accompanying letter is going off tomorrow..."* The External Investigator also advised Dr Buckland in his letter of 3 June

2004, which enclosed the signed and dated hard copy of the report, that he *"... would be happy to answer any queries concerning it and I would be grateful if you would let me know your views when you have read the report*". This letter also enclosed a memorandum of fees and costs for the investigation. This report is the only "hard copy" signed and dated version of the External Investigator's report ever provided to QH. This explains why it was the report identified by the QH FOI decision-maker.

- The version of the report attached to the External Investigator's email of 7 June 2004 was submitted by the External Investigator following a telephone discussion he had with Dr Buckland after Dr Buckland's refusal, according to the External Investigator, "*to accept that the District was not adequately funded*". However, according to the Executive Manager, Dr Buckland had told the External Investigator that Dr Buckland *"... did not have any objection to the statement appearing in the report and did not disagree with* [the External Investigator's] *view, but believed that he needed to reference the statement to something."*

- A comparison of the two versions of the External Investigator's report provided to Dr Neville reveals that the paragraph on page 8 was not the only statement subsequently deleted from the External Investigator's report of 3 June 2004. A statement on page 2 of that report was also altered to omit the bolded words:

  > *"..However this hospital does suffer from access and exit block as ED attendances are increasing* ***and the inpatient bed stock is not large enough to deal with the demand****...."*

- The External Investigator's email on 4 June 2004 to the Executive Manager attached a third version of the report. In this version, the External Investigator includes a reference to the source of his statements on pages 2 and 8 about the District being under funded. This was in response to Dr Buckland's earlier request that the statements be referenced. The additional wording appears in two places:

  > *"This information supplied by the ED staff at Nambour Hospital."* (appears after the paragraph on page 2 that mentions inadequate bed stock) and
  >
  > *"This is a significant problem throughout Australia as populations expand and staff at most levels expressed this view over the District finances."* (appears after the relevant paragraph on page 8)

  Both of these statements are missing from the unsigned and undated report created on 7 June 2004, a copy of which was provided to the Nevilles on 21 June 2004.

- The deletion of these two statements is the only difference between the 7 June 2004 version and the 3 June 2004 version. The deleted statements, in suggesting that the District (in particular Caloundra Hospital) was under funded and under resourced to cope with current public demand, were possibly relevant to the Nevilles' allegation that Caloundra Hospital was adversely affected by a policy of non-admission of children[96].

- The Ethical Standards Unit had to resort to "backup" files of the Executive Manager's email records in order to piece together an explanation of the circumstances surrounding the different versions of the External Investigator's report. QH should

[96] Section 3.2.2.

have requested the External Investigator to provide a signed and dated copy of the final report created on 7 June 2004.

3.8 Independence of External Investigator

The outcome of the Ethical Standards Unit investigation (namely, that the report of the External Investigator was amended following a telephone discussion with the then Director-General, Dr Buckland), raises a number of issues. The email records that were located during the investigation suggest that the only amendments sought and made to the report related to the two comments concerning inadequate funding of certain QH services. However, Dr Buckland has since advised that he also raised with the External Investigator the issue of the Executive Director‟s report in the telephone discussion referred to. The Ethical Standards Unit investigation did not locate any file note or other record of the telephone conversation between Dr Buckland and the External Investigator.

As I have already stated[97], the Nevilles were not satisfied with the External Investigator‟s report. While they noted that the External Investigator had made a number of significant adverse findings and recommendations, they did not consider that he had adequately addressed terms of reference 2 and 3. In particular, the Nevilles felt that the External Investigator had failed to consider their allegations about the Executive Director‟s report and the appropriateness of Dr Stable‟s decision not to conduct an internal investigation into what was a "sentinel" adverse event.

The Nevilles advised me that they raised these concerns at a meeting with Dr Buckland on 22 June 2004. They claim that although Dr Buckland said he shared some of their concerns, he indicated that there was little further that he could do other than to forward the External Investigator a copy of the Nevilles‟ letter outlining their concerns with his report. Dr Buckland subsequently provided the External Investigator with a copy of the Nevilles‟ letter.

However, in a letter to me dated 20 June 2005, Dr Buckland, in responding to an allegation by the Nevilles that the report prepared by the External Investigator failed to address the nominated terms of reference and was therefore inadequate and should not have been accepted in the form submitted, stated:

> *The nature of this complaint presupposes that the Department has accepted* [the External Investigator‟s] *report as being comprehensive.*
>
> *As I discussed with Dr and Mrs Neville in our meeting on 22 June 2004, I also hold reservations regarding the adequacy of* [the External Investigator‟s] *report.*
>
> *Faced with a report which was considered to be inadequate, the remaining investigative option available to the Department in this case seems limited to appointing a new investigator to undergo the process again. There seemed to be little value, from a pragmatic perspective, in requiring* [the External Investigator] *to re-write or revisit his report in detail such that it resulted in an outcome with which Dr and Mrs Neville would be satisfied. Taking such an approach would be contrary, I would suggest, to the whole notion and ethos of the appointment of an independent investigator.*
>
> *There is, of course, an inherent risk in taking the step of appointing an independent investigator that there will be dissatisfaction with the report ultimately compiled.*

[97] Section 3.1.3.

> *In any event, there remains the further, independent investigation including a Coronial Inquest in which the various issues of concern will I expect continue to be raised.*

Although Dr Buckland may have advised the Nevilles that he shared some of their concerns about the report provided by the External Investigator, the email records identified by the Ethical Standards Unit investigation indicate that Dr Buckland did not raise, in writing, any concerns he had about the adequacy of the report with the External Investigator.

After the External Investigator became aware that Dr Buckland had advised the Nevilles that he had concerns about the report, the External Investigator sent an email to the Executive Manager stating:

> *I am also surprised that the Director-General has chosen to express concern over my report to Dr & Mrs Neville when as you are aware I have made three attempts to speak to him concerning the report and when I finally did* ***the only concern he expressed was my comments in the draft report where I had expressed concern over adequate funding of the Sunshine Coast Health Service.*** (my emphasis)

I accept the conclusion of the Ethical Standards Unit investigation that the External Investigator amended the report, after a telephone discussion with Dr Buckland, and provided QH with a document by email that he intended to be the final report. Significantly, the External Investigator asked for earlier copies of the report to be destroyed[98].

I also accept that there is an argument that Dr Buckland, as Director-General, was entitled to discuss with the External Investigator any comments, opinions and recommendations contained within the report. As mentioned, the External Investigator's letter of 3 June 2004 had advised Dr Buckland that he (the External Investigator) *"... would be happy to answer any queries concerning it and would be grateful if you would let me know your view when you have read the report*."

On the other hand, it may be argued that Dr Buckland's interaction with the External Investigator was inconsistent with the subsequent statement made in his letter of 20 June 2005 to my Office, in which he said that requiring the External Investigator to rewrite or revisit his report so as to achieve an outcome with which the Nevilles would be satisfied would be contrary "*to the whole notion and ethos of the appointment of an independent investigator*."

The Nevilles were never made aware that Dr Buckland had asked the External Investigator to justify some comments in his report. The Nevilles claim that Dr Buckland gave them the impression that it would be inappropriate in the circumstances for him to challenge the contents of the report and that nothing further could be done to have the External Investigator revisit the report.

I provided a copy of this part of my report to Dr Buckland for his comment. His solicitors provided the following response by letter dated 13 June 2006:

> 1. *This is the first opportunity that Dr Buckland has been given to respond to the allegation about deletion of paragraphs in the report of the External Investigator. In*

[98] The earlier copies were not destroyed. Any destruction would have been contrary to the provisions of the Public Records Act.

particular, he was not contacted for his response by the Ethical Standards Unit of Queensland Health during its investigation, which would have been an expected outcome in terms of procedural fairness and natural justice for this investigation. The following comments give not only the response of Dr Buckland to the allegation of Dr and Mrs Neville, but also Dr Buckland's response to the substantive factual issues.

2. *The complaint to the Ombudsman had been made prior to the engagement of the External Investigator. Therefore all those involved in responding to the concerns raised by Dr and Mrs Neville were more acutely aware than usual of the need for an open and transparent process, which would inevitably be the subject of external scrutiny.*

3. *At no time was there any attempt to subvert the course of the investigation or conceal anything from Dr and Mrs Neville. Dr Buckland emphatically denies any suggestion to the contrary.*

4. *Dr Buckland arranged for some brief written comments to be emailed to the External Investigator referring to highlighted paragraphs in the investigation report, which was attached to the email, and then followed this up with a telephone conversation with the External Investigator.*

5. *The email was directed to what Dr Buckland perceived to be the main statements in the investigation report which were made without any factual support. This was not intended to cover all issues in relation to the investigation report.*

6. *Dr Buckland considered that one of the primary issues for the External Investigator to deal with in his report was the issue of the Executive Director's report. Therefore, in their telephone conversation Dr Buckland raised with the External Investigator that the investigation report did not adequately address the matter of the Executive Director's report.*

7. *The External Investigator was emphatic that he was not going to pursue the issue of the Executive Director any further in his report.*

8. *Given the response to this matter when raised, and the view held by the External Investigator, Dr Buckland formed the opinion that there was not much point in pursuing the issue of the terms of reference any further with the External Investigator.*

9. *Dr Buckland therefore rejects as incorrect any finding that he did not raise any concerns about the adequacy of the report with the External Investigator.*

10. *Dr Buckland limited the remaining discussion to what he perceived to be the unsubstantiated comments made with no evidence to support them.*

11. *During the discussion about this issue, Dr Buckland indicated to the External Investigator that this was an investigation into the facts, and on the issue of funding he was not concerned if comments about this remained in the report, but if they did remain in the report there needed to be facts to support the comments made.*

12. *Dr Buckland did not request changes to the report, what was requested was substantiation.*

13. *Dr Buckland did not request that the External Investigator remove any paragraphs in the investigation report, did not make any changes to the investigation report himself nor did he give any direction to staff about this (other than the highlighting referred*

to above in the email correspondence), and he gave no direction in relation to destruction of copies of the report.

14. *Dr Buckland would not, and did not, take action to compromise the independence of the External Investigator.*

15. *In his subsequent meeting with Dr and Mrs Neville where they raised concerns about the investigation report, the reason that Dr Buckland conveyed to them his view that there was little he could do was based upon Dr Buckland's experience when speaking with the External Investigator about the terms of reference and also his strong view that there were limitations about what could be done in relation to an independent investigation.*

16. *Dr Buckland did give the External Investigator the response of Dr and Mrs Neville, but no further response was received from the External Investigator to the matters raised by them. Dr Buckland also wrote to the Medical Board of Queensland seeking reasons for its earlier decision to not take any action against the Executive Director, but the Board declined to respond citing confidentiality grounds.*

17. *There is no inconsistency between the actions of Dr Buckland detailed above and the response given to the Ombudsman in the letter of 20 June 2005. Dr Buckland's response in the letter of 20 June was directed to the issue asked, namely whether the report ought not to have been accepted. The reasons for this are set out in the letter of 20 June.*

Comment

I am not satisfied that the evidence shows that Dr Buckland acted inappropriately or inconsistently in relation to the External Investigator's report.

In the final analysis, investigations have established that it was the External Investigator himself who deleted the relevant passages from the report. He was not Dr Buckland's subordinate but an experienced, independent specialist. Whether the External Investigator deleted the passages with some reluctance or not is of little account, as ultimately, he was prepared to do so.

4 Queensland Health's complaints management framework

4.1 Complaints management

QH currently has a complaints management process based on the QH *Complaints Management Policy* (No. 15184 approved on 23 July 2002) which outlines how complaints are to be received and then handled. In developing the complaints management process, regard was had to *AS 4269-1995: Complaints Handling*[99].

The policy covers complaints received by any QH staff member about any aspect of a health service before, during or after the provision of a service. Complaints can be made verbally or in writing to QH by a user, their advocate, carer or family member, groups of consumers or consumer organisations, or general members of the public.

QH‟s *Complaints Management Policy* (the policy) is supported by a comprehensive *Complaints Management Handbook* (the handbook) as well as a *Guidance Document to the Queensland Health Complaints Management Policy*. The handbook states that the complaints process is an organised way of responding to, recording, reporting and using complaints to improve the service. It acknowledges that consumers want:

- it to be easy to make a complaint;
- to be listened to, understood and taken seriously;
- to be treated politely and with respect;
- staff to focus on solving the problem and not be defensive or give consumers the "run around";
- a timely response;
- the complaint to be investigated fairly with no cover-ups;
- to be told what is happening and what has happened and not be "left in the dark."

Once received, complaints are required to be assessed immediately and categorised as negligible, minor, moderate, major or extreme. Delegated staff at the point of service are required to attempt to resolve all "negligible and minor complaints". Complaints classified as moderate, major or extreme, plus any unresolved minor complaints, are to be referred to the complaints coordinator within each Health Service District. Where possible, such complaints are to be investigated and assessed and, where appropriate, referred to the District Executive.

Under the policy, the complaints coordinator for each Health Service District has several important duties including:

- coordinating the complaints management process;
- ensuring that complaint information is considered as part of district quality improvement and risk management processes;
- managing and reviewing outcomes and investigations;
- coordinating staff training on complaint management.

The handbook contains some common examples of the types of complaints relating to health service delivery such as:

[99] Australian and International Standard (ASISO) 1002-2006 "Customer Satisfaction – Guidelines for Complaints Handling in Organisations" has replaced AS4269-1995.

- dissatisfaction with the type or level of treatment provided to a user (for example, at a public hospital) such as unsuitable care, misdiagnosis, communication issues, non-consent to procedures;
- general dissatisfaction with the health care or services received such as waiting lists or inappropriate diet;
- concerns that relate to unsatisfactory conduct of HSPs[100];
- limited or no access to personal records, disrespectful behaviour, lack of privacy, and/or confidentiality breaches.

The handbook also links risk management with complaints management. In other words, complaints are also to be assessed to determine whether the level of risk for a specific complaint is acceptable or not. It provides a matrix for use in trying to determine the level of risk. QH‟s *Integrated Risk Management Policy* provides that each district, branch or other accountable area is required to maintain a register of all risks to the organisation.

In June 2004, QH also introduced an *Incident Management Policy* (23360) which directs that Managers are required to report and manage sentinel events[101] and events with very high and extreme risk ratings. The policy was introduced to enable QH to learn from the underlying causes of incidents, and near misses, and to improve systems in order to reduce the likelihood of recurrence. (As noted above, this policy has recently been reviewed and is awaiting endorsement by Executive Management before its staged implementation).

The handbook outlines the timeframes for handling complaints. Basically, complaints should be acknowledged, or referred to external agencies for handling, within three working days of being received, or the need for referral being identified. Relevant staff should endeavour to resolve complaints within a 28 day timeframe, otherwise complainants are to be advised of progress of the complaint every 28 days until the complaint is resolved.

A health service may decide to undertake an investigation of any matter. Those complaints that cannot be resolved at the point of service, or those that are of a more serious nature (namely, those categorised as moderate, major or extreme), will usually be investigated.

Depending on the degree of seriousness of the matter being investigated, investigations may be conducted internally by a number of nominated QH employees including the line manager, the complaints coordinator, a senior member of the health care team or an investigator appointed by the Audit and Operational Review Branch. Complaints may also be referred to and investigated by an external agency like the HRC, MBQ or QNC.

The Director-General of QH may appoint a person as an auditor or investigator under s.52 of the *Health Services Act 1991* (HSA). The functions of an investigator are to investigate and report to the Director-General on any matters relating to the management, administration or delivery of "public sector health services" (that is, a health service provided by the State), for example, matters relating to clinical practices and standards of health care in the delivery of public sector health services[102].

[100] Health service providers.
[101] Sentinel events are rare events that lead to catastrophic patient outcomes. The Australian Council for Safety and Quality in Health Care (ACSQHC) has endorsed a national list of sentinel events that includes, for example, retained instruments or other material after surgery requiring re-operation or further surgical procedure.
[102] Section 55 Health Services Act.

There is no requirement for QH to consult with the HRC or any of the registration boards at any time during the complaints process. However, QH may refer a complainant to an external entity at the end of the internal complaint process. For example, a complaint about a registered health practitioner may be referred to the relevant health professional registration board if it raises issues relating to professional competence, such as a series of errors, or a pattern of behaviour demonstrating a lack of knowledge, skill or ability, and/or poor judgment based on problems with assessment, analysis or decision-making. The District Manager (or delegate) is responsible for such a referral.

The handbook states that QH recognises that many "minor" complaints can be resolved through the provision of information, or an explanation of why things happened the way they did, together with an apology and recognition of the effect the situation had on the complainant.

With more complex complaints, resolution may be achieved with the assistance of a trained mediator or conciliator, or by a process of facilitation. (A facilitator assists in defining issues, and in assisting and taking steps to encourage disputing parties to reach a mutually acceptable resolution of their differences.)

4.1.1 Assessment of QH's Complaints Management Policy and Procedures

In March 2003, my Office initiated the Complaints Management Project (CMP), which involved my staff assistaing 11 State and local government agencies to implement complaint handling systems that meet recognised national and international standards. For the purposes of the project, my Office produced several publications, including fact sheets explaining the essential components of a best practice complaints management system, and a template to follow when drafting complaints management policies and procedures. These documents are available on our website[103].

At the time the project commenced, QH, which was one of the agencies participating in the project, had recently finalised its new policy and procedures for managing complaints received from members of the public.

Each of the agencies involved in the project, including QH, carried out a self-assessment of their current complaints management systems using an audit and assessment checklist which my Office designed for that purpose.

As I have mentioned, QH‟s complaints management system is based on its *Complaints Management Policy* (No 15184 approved on 23 July 2002). The policy relates to complaints made "by or on behalf of a consumer or a group of consumers regarding the provision of a health service". A complaint can be made orally or in writing.

The policy does not apply to complaints made by QH employees that involve Public Interest Disclosures (PIDs) or that relate to staff grievances or other staff concerns. Nor does it apply to complaints made to QH about public health issues (for example, complaints about food outlets).

QH‟s policy on Whistleblowers is IRM 3.1-4, *Policy and Procedures for the Management of Public Interest Disclosures – In Accordance with the Whistleblowers Protection Act*

[103] **www.ombudsman.qld.gov.au.**

1994. Its policy for handling staff complaints is Policy IRM3.5, *Grievance Resolution and EB5 Grievance Settling; and Industrial Disputes*. My Office did not review those documents as part of the project because its focus is on complaints from members of the public.

My officers reviewed a copy of the completed audit and assessment checklist provided by QH. Based on their review of the checklist and other information relating to QH‟s complaint management process, my officers prepared a report of their assessment, which I provided to the then Director-General of QH[104] on 8 March 2004.

My report concluded that the QH system (assuming QH complied with its complaint policies and procedures) "compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management."

However, I considered that the system could be improved. In particular, I recommended that QH:

- develop and establish a central complaints database to enable complaints data across all districts to be collated and analysed; and
- improve awareness of the QH complaints management system on the part of QH staff across all districts.

My first recommendation was based on my view that a centralised database for recording complaints data across all Health Service Districts is an essential component of an effective complaints system. The existing systems within the districts had limited compatibility which meant there was little capacity to:

- identify significant complaint issues, or complaint trends in order to devise and implement co-ordinated remedial strategies, or
- ensure an appropriate level of consistency in the management of complaints across all districts.

The second recommendation resulted from my assessment that there was no program in place to ensure consistent staff awareness across Health Service Districts concerning the complaints management system. For the system to operate effectively, I considered it essential that QH staff, especially those who deal directly with the public, be aware of the system.

Although the policy specified that "all staff receive training on complaints handling within six months of commencement and at least every 3 years thereafter", information that my Office received indicated that training was conducted on an *ad hoc* basis within and across districts and hence there was no guarantee that consumer complaints were being dealt with in accordance with the process. I suggested that QH should conduct surveys of staff awareness of the system.

In relation to training for QH officers who deal with complaints, I made no recommendation because of advice from QH that it had a comprehensive training regime for complaints staff, as outlined in its complaints management handbook. QH also advised that complaints coordinators are selected and trained in accordance with the principles outlined in QH‟s policy and handbook and all undergo a two day training session.

[104] Dr Buckland.

My Office has not conducted any audit to determine whether QH is providing such training as this is not part of the current phase of the CMP.

In the course of the project, I made several other suggestions to improve QH‟s complaints management system, one of which resulted in the QH website being amended to include a dedicated section on consumer complaints.

Following receipt of my report, QH commenced work to develop a State-wide consumer feedback information system/database for the management and tracking of consumer complaints, as well as for receiving information concerning critical incidents and for risk management purposes (PRIME).

QH also advised that, in accordance with my recommendation, it planned to provide further training to staff to raise awareness of its complaints management process and that this training would be provided in conjunction with training associated with the implementation of the new database.

I am informed that the complaints management function of PRIME was trialed by two health districts and a number of problems with the system were identified. Work has commenced to address these problems but it is likely that implementation may be further delayed to enable completion and implementation of QH‟s new complaints management system. This development is in response to recommendations made in the final report of the QHSR.

I am also informed that the database is not intended to capture information concerning PIDs under the Whistleblowers Protection Act (WPA). Under current QH procedures, details of PIDs are provided to the Audit and Operational Review Branch of QH which is responsible for:

- ensuring that proper recording processes are in place for filing and receiving PIDs; and
- maintaining confidential files on disclosures.

As mentioned above, the purpose of the CMP is to assist agencies, including QH, to implement complaints management procedures and systems that meet recognised standards. The project does not involve auditing whether agencies are complying with those procedures. For example, QH‟s complaints system imposes various responsibilities on the complaints coordinator in each district.

The evidence presented to the BHCI and the QPHCI indicated that QH‟s complaint system was not operating in accordance with its procedures. For example, in some districts, complaints coordinators had not been appointed or the role had been given to junior officers. Therefore, further action needs to be taken by QH to improve its current complaints management. In formulating these proposals, I have also had regard to QH‟s publication *Issues Paper for Bundaberg Hospital Commission of Inquiry – Complaints Management, July 2005*.

4.1.2 Proposals for further improving QH's complaints management system

In my submission to the BHCI dated August 2005, I outlined a number of proposals for improvements to QH‟s intemal complaints management. These were:

- QH develop a central Complaints Management Unit that would be responsible for:
    - overall internal complaints management including devising, implementing, reviewing and improving complaints systems;
    - providing advice and training to all complaints staff about both patient and staff complaints;
    - monitoring and reviewing local complaints handling to ensure that all complaints are actioned in a timely and appropriate manner;
    - investigating, or monitoring the investigation (at the local level) of, all complaints categorised as moderate, major or extreme;
    - liaising with the external complaint agency, where an unresolved complaint is escalated by the complainant to external review;
    - the collection and analysis of consumer feedback on QH health services;
    - benchmarking, conduct of complaint trend analysis, and auditing of complaints processes in the districts;
    - providing regular analysis reports about internal complaints management back to health districts and to senior management; and
    - liaison with the Patient Safety Centre to provide inputs from analysis of patient complaints data, into strategies for quality improvement initiatives/activities.
- All Health Service Districts should have a dedicated complaints coordinator (CC) appointed at the level of A05 – A07 (depending on the size of the relevant district/branch), to ensure that CCs have an appropriate skill level, and sufficient seniority in the organisation, to credibly manage complex patient complaints. CCs should be accredited in complaints handling. There should be one State-wide position description (PD) as opposed to each district having its own PD for the role. It is acknowledged that some of the smaller health districts that do not receive many complaints may only require a part-time CC. The CC should report directly to the district/branch manager (or in large districts, to an appropriate manager at senior executive level). The CC needs to have the standing and influence to ensure that serious attempts are made to resolve complaints at the local level wherever possible, and that issues warranting closer examination by management are escalated appropriately.
- All staff responsible for the receipt, referral and actioning of complaints should be adequately trained in respect of QH‟s Complaints Management Policy and Handbook.

<u>Coordination of health data management systems</u>

One of the important issues exposed during the hearings of the BHCI was the need for health services to maintain well integrated data management systems. In the case of Bundaberg (and potentially elsewhere), the local patient complaints register and the adverse events and sentinel events records were not reconciled or integrated in any way, which impeded capacity to identify systemic issues relevant to patient safety and delayed effective intervention.

Furthermore, a scan of the QH data management practices revealed a number of instances where data relevant to patient safety and quality improvement activities was collected via more than one source, for example, as part of preparations for accreditation surveys and for measured quality improvement activities. This duplication of effort in data collection and reporting requirements wastes resources and is understandably a source of frustration for staff.

It is also significant to note that several witnesses at hearings of the BHCI gave evidence that they seldom, if ever, received any feedback on the outcome of data collection and reporting activity.

Enhancing research on patient complaints and patient safety matters

At present, there is considerable scope for QH to enhance the scope and transparency of its patient complaints and patient safety data management practices. Without reliable quantitative data, performance management and quality improvement activity are hampered.

In view of the recent events at QH, the public will soon be seeking reassurance that the circumstances leading to these events have been addressed and that the situation has significantly improved. Developing the capacity to undertake research of reliable data will assist QH to demonstrate that the problems in the existing system are being addressed.

If, as proposed, QH implements improved data management practices as a priority then it would be possible to commence a range of research activity aimed at identifying the factors that could lead to improvements in patient safety and reduce the incidence of complaints. Good data would enable health care facilities to identify the most significant factors influencing public confidence in the health care system.

In my report to QH on its complaints management system[105], I recommended that QH establish a central complaints database so that State-wide data could be analysed and the results fed back to the districts for business improvement purposes. Therefore, I make the following recommendations:

Recommendation 12

QH finalise the implementation of its complaints management database as a matter of priority.

QH response to recommendation 12 (Letter dated 16 May 2006)

Recommendation 12 is being implemented.

PRIME consumer feedback component has been developed and trialled in one district health service. Revisions to the system are currently being assessed as a consequence of the outcomes of the trial.

[105] Queensland Ombudsman"s Complaints Management Queensland Health Feedback Report of 8 March 2004.

Recommendation 13

Steps be taken to improve coordination of data collection practices within QH to minimise duplication of effort.

QH response to recommendation 13 (Letter dated 16 May 2006)

Recommendation 13 is being implemented.

The continued implementation of PRIME will improve coordination of data collection relating to consumer feedback and clinical incident reporting.

Recommendation 14

Feedback be given to all health districts at regular intervals (quarterly or six monthly) on the analysis of complaints and other health data for quality improvement purposes.

QH response to recommendation 14 (Letter dated 16 May 2006)

Recommendation 14 is being implemented.

The Queensland Health Discussion Paper "*A New Framework for Clinical Governance in Queensland Health*" proposes that the Quality Measurement and Strategy Unit in the Reform and Development Division will provide clinical indicator data to District Health Services on a monthly basis (lagged by eight weeks from the end of the month) together with quarterly and annual aggregations, as well as a quarterly Area Action Report highlighting clinical indicators where District Health Service performance is aberrant (para. 86).

Queensland Health will publish regular patient safety reports using data from PRIME. These reports will be made available to the public through the Queensland Health website and will focus on sharing lessons learnt from a state-wide analysis of de-identified clinical incident and adverse event data. The reports will also outline safety improvement initiatives being implemented to address any systems vulnerabilities identified. The first report is expected to be released in 2006.

4.1.3 Response by the Queensland Health Systems Review to my recommendations in respect of QH's internal complaints management system

On 7 September 2005, a representative of the QHSR met with one of my investigating officers to discuss proposed reforms to QH‟s internal complaints management, which the

QHSR intended to recommend. By letter dated 20 September 2005, I provided comments on those proposals. Those comments are set out in Appendix 3 to this report.

The proposals contained in the final report of the QHSR varied in some respects from the proposals outlined to my Office. It is not known at the time of finalising this report whether QH intends to implement the recommendations made by QHSR, or modify them in light of recommendations made by the QPHCI. I am advised that QH is undertaking a review of its *Complaints Management Policy* in light of recommendations made by both inquiries.

I consider that the comments set out in Appendix 3 remain relevant and valid and can be adapted to accommodate whatever structural arrangements QH chooses to implement for its internal complaints management system.

I make the following recommendation:

Recommendation 15

QH, in implementing any changes to its internal complaints management system in response to the recommendations made by the QHSR and the QPHCI, also have regard to:

- **recommendations 12, 13 and 14 of this report; and**
- **my recommendations in Appendix 3 of this report.**

QH response to recommendation 15 (Letter dated 16 May 2006)

Recommendation 15 is supported and is being implemented. QH officers with responsibility for implementing changes to the internal complaints management system have given close consideration to the QHSR and QPHCI, and have met with the Office of the Queensland Ombudsman to discuss reforms.

5 Health Rights Commission

5.1 Actions taken by the HRC

On 28 March 2002, the Nevilles lodged a formal complaint with the HRC seeking an investigation into the following allegations:

- The medical officer who treated Elise was incompetent and dangerous and should not be allowed to continue to practise medicine.
- The medical officer fabricated many of the clinical details recorded in Elise‟s medical file and misrepresented others, in particular, the additional notes he wrote in Elise‟s medical file on 9 January 2002.
- The Executive Director failed blatantly in his duty to investigate the circumstances surrounding Elise‟s presentation to the CH ED. Instead, he knowingly and deliberately produced a report that was false and misleading in at least two highly material particulars. His report is a blatant cover-up of the true events.
- RN 1 and RN 2 displayed a lack of empathy and an uncaring attitude.
- RN 1 fabricated some aspects recorded in Elise‟s medical file regarding her clinical assessment of Elise.
- Both RNs relied upon a non-existent "policy" in relation to the non-admission/observation of children at CH to override clinical care.
- There existed a "culture of non care" at CH, at least in respect of children.
- There are major failings in the public health system, including the medical retrieval system. In particular, the helicopter retrieval from Caloundra to Brisbane took over 2½ hours, where a fast land ambulance could have done the trip in about 45 minutes.

5.1.1 HRC's assessment

On 10 May 2002, the HRC informed the Nevilles that their complaints had been accepted for assessment and summarised the key issues as follows:

- care provided to Elise by CH;
- care provided by the medical officer;
- care provided by RN 1;
- care provided by RN 2; and
- the investigation report by the Executive Director.

On 10 May 2002, the HRC wrote to the District Manager of the CH with particulars of the issues raised by the Nevilles‟ complaint. The District Manager responded by seeking an opportunity to respond to each of the concerns raised by the Nevilles in the environment of an HRC conciliation. The HRC declined the District Manager‟s suggestion on the basis that, in accordance with s.74(5) of the *Health Rights Commission Act 1991* (HRCA), the complaint was not suitable for conciliation because of the serious public interest issues raised by the complaint.

5.1.2 HRC's investigation

The HRC completed its assessment of these issues on 8 August 2002 and retained for investigation issues 1 and 5 on the basis that they were "health service complaints" within the scope of s.57 of the HRCA. Because issues 2, 3 and 4 were about a registered medical officer and two registered nurses, the HRC had a statutory obligation to consult with the

Medical Board of Queensland (MBQ) and the Queensland Nursing Council (QNC) respectively, to determine whether each body would accept for further action the complaints about its registrants.

The MBQ agreed to accept for investigation the complaint about the medical officer. The QNC agreed to accept for investigation the complaint about one of the registered nurses but not the other.

The HRC directed its inquiries in relation to issues 1 and 5 to the District Manager of the SCHSD. The SCHSD initially responded to the HRC in respect of both issues. However, on 13 January 2003 (some 9 months after the complaint issues were first raised with the SCHSD), lawyers for the SCHSD challenged the HRC's jurisdiction to investigate issue 5[106]. Dr Neville was notified of this on 7 February 2003 and advised that the HRC had sought Crown Law advice on the matter. Upon considering Crown Law's written advice, Dr Neville was contacted by telephone on 19 March 2003 and advised that the HRC did not have jurisdiction to continue investigating issue 5. The Nevilles were advised that the Commissioner would refer the complaint about the Executive Director to the MBQ[107] and ask that it consider taking further action on the complaint. The MBQ subsequently declined to investigate the complaint[108]. I have made a recommendation[109] in this report to expand the meaning of "health services". That recommendation has been implemented.

The Nevilles have queried the actions of QH in challenging the HRC's jurisdiction to investigate the Executive Director's report, on the basis that such a challenge was contrary to Dr Stable's assurances that his "*commitment to the process in train* [was] *absolute*". While this appears anomalous, it is a fundamental principle of the rule of law that government agencies should not exceed the boundaries of their statutory jurisdiction, and I cannot criticise an agency for drawing attention to a jurisdictional issue of this kind.

After being informed that the MBQ had also refused to investigate the Nevilles' complaint against the Executive Director, the Commissioner wrote to the Minister for Health (the Minister) on 5 January 2004 seeking a written direction from her under s.31(1)(d) of the HRCA authorising him to investigate that complaint[110]. The HRC was informed that Dr Neville had recently met with the then Director-General of QH[111] and QH had undertaken to commission an independent review (by the External Investigator) of its overall response to the Nevilles' complaints, including in respect of the Executive Director's report. In these circumstances, the Minister did not give approval for the HRC to investigate the Nevilles' complaint about the Executive Director's report[112].

As it transpired, the Nevilles were critical of the External Investigator's failure to adequately address their concerns about the Executive Director's report, and Dr Buckland appeared to accept that the External Investigator's report was deficient in this regard. Dr

[106] To enliven the jurisdiction of the HRC, complaints must be "health service complaints" within the scope of s.57 of the Health Rights Commission Act and satisfy the definition of a "health service" as set out in s.3 of the Act. The definition of a "health service" includes "a service provided to an individual for, or purportedly for the benefit of human health" including services provided by a hospital and registered providers and "an administrative service directly related to a health service".
[107] Section 57(1)(f) of the Health Rights Commission Act.
[108] Section 6.2.6.
[109] Recommendation 16.
[110] Section 31(1)(d) of the Health Rights Commission Act provides that the Minister may give a written direction to the Commissioner to investigate a health service complaint under part 7.
[111] Dr Buckland.
[112] See Appendix 1 for a further discussion of this issue.

Buckland‟s reasoning for not pursuing the matter further is outlined at sections 3.2.3 & 3.2.4 of this report.

5.1.3 HRC investigation report

The HRC provided its investigation report (a three page letter) to the Nevilles on 4 September 2003 (that is, approximately 18 months after having first received their complaint). Its findings can be summarised as follows:

Non-admission/observation of children

There was no "non-admission of children" policy in existence at the time of Elise‟s presentation to CH. On the contrary there were policies in place to support the practice of admission of children. However, those policies also gave clear guidelines as to the various patient conditions that warrant transfer to another facility better equipped to treat that condition. Generally, medical staff are encouraged to transfer a child where they were not 100% sure of the diagnosis and/or the child did not have a stable condition. The HRC considered this to be a reasonable practice.

The HRC found the two nurses whom the medical officer consulted were cognisant of the policy. However, in their statements to the QPS, the nurses claimed that, in their experience, children were not admitted to CH. As for the medical officer, the HRC was unable to make a definitive finding.

Retrieval issue

The HRC discussed this issue having regard to the following questions:

- Whether air transport is the preferred choice for retrievals; and
- Whether this choice was appropriate for Elise Neville.

As a result of its inquiries into this issue, the HRC confirmed that decisions about the mode of retrieval transport are made on a "case by case" basis having regard to a number of factors. In Elise‟s case, the retrieving doctor advised that those factors included:

- land ambulance speed would have been that of a "code 2", that is, within speed limits with flashing lights and the use of the siren only when necessary;
- experience of the time it takes to prepare a patient for each mode of transport;
- the pilot‟s estimated time of arrival at the retrieval site; and
- possibilities of being detained by road works, density of traffic at time of retrieval, or traffic accidents.

As to whether the retrieval doctor‟s decision in Elise‟s case was appropriate, the HRC also considered advice received from the retrieval pilot. The pilot explained that, at 8.15am when he was contacted by the Queensland Ambulance Service (QAS), there was no "on duty" pilot, rather he was the pilot "on call". He immediately contacted Nambour General Hospital and advised them of an estimated arrival time of 45–55 minutes. In estimating this time, the pilot took into account the weather conditions, the time for the heliambulance to "wind up" and the flying time. It was then up to the retrieval doctor to decide whether to proceed or not.

On the information supplied, the HRC considered that, at the relevant time on a Monday morning, it was highly likely that a road ambulance would have encountered peak hour traffic. In summary, its calculations were that there would have been only a difference of a few minutes if road transport had been the choice of transport. The HRC concluded that it could not make a finding that the choice of air transport was unreasonable.

The HRC"s report did not include any adverse findings or recommendations.

The HRC did note, however, that some changes had been made by the SCHSD following the incident which impacted upon the CH. These included:

- rostering medical staff on a 24 hour basis, rather than an "on call" schedule. It was claimed this would ensure that a medical officer had not been working continuous long hours should the officer be called during the night;
- upgrading CH"s services to the community as a result of some additional funding being made available to the District.

The HRC provided a copy of its investigation report to the District Manager of CH under a separate letter, which also included some additional comments that were not provided to the Nevilles. These comments included:

- Documentation (Elise"s clinical chart at CH):
    - The medical officer made retrospective notes of Elise"s first attendance in her clinical chart two days later that were in greater detail than those notes written at the time of the actual assessment.
    - There were no observations recorded by the nursing staff, despite the relevant nurses advising the HRC during its investigation that they had been monitoring Elise"s vital signs.
    - Also, there were no medical notes made of Elise"s second presentation at 7.45am on 7 January 2002.

- The "Clinical Coordinator - Retrieval Request" form for Elise"s retrieval was not available to the HRC as the retrieval doctor advised it had been lost.

- The HRC compared CH"s "Head Injury - patient advice" form (which the medical officer failed to provide to the Nevilles upon discharging Elise after her first presentation to CH ED) with a number of similar forms from other EDs that see children and/or adults. It was noted that in each of the other forms there was an instruction for parents to check the child periodically either hourly or 2 hourly to determine whether the child was able to be aroused. It was therefore suggested that the CH review the information on its current form.

The Nevilles met with the Health Rights Commissioner (the Commissioner) on 12 September 2003 to inform him of their dissatisfaction with the outcome of the HRC"s investigation. In particular, they queried the absence of any adverse findings or recommendations. The Commissioner provided the Nevilles with a copy of the HRC"s letter to the District Manager which contained the additional comments. The Nevilles could not understand why these additional comments had not been included in the HRC"s report given to them. The Nevilles were not satisfied with the Commissioner"s explanation that the comments dealt with minor issues and wrote to him in these terms:

Your letter to [the District Manager of CH] *is hardly a "covering letter". It is actually further findings of your investigation and it contains details that are highly critical of Caloundra Hospital. It should have been given to us as a matter of course as we are the complainants in this matter. We are appalled by this double standard…*

We are totally dismayed by what you have done. In fact we are no longer confident that the HRC is an unbiased and independent health complaints agency.

5.1.4 HRC review

The Nevilles raised numerous concerns about the adequacy of the HRC"s investigation and report. Accordingly, the Commissioner agreed to conduct a review. On 28 June 2004, some nine months later, the Commissioner completed his review and issued a subsequent report. This 20 page report bore little resemblance to the HRC"s earlier report. The Commissioner emphasised in his revised report that some of the issues raised by the Nevilles were intrinsically very difficult, and the HRC"s re-examination of those issues had led to different conclusions. The Commissioner concluded that:

Elise"s tragic death has highlighted significant systemic issues at Caloundra Hospital.

Care of children

Perhaps the most significant findings in this report centred around the issues dealt with under the topic of "Care of children." While the Commissioner re-affirmed the HRC"s earlier finding that there was no "non admission of children" policy in existence at the time of Elise"s presentation at the CH, the Commissioner went on to say that, on review, he held serious concern that there appeared to have been an informal understanding among at least some staff at CH, reinforced by common practice, that children were not to be admitted.

The Commissioner further considered the allegation made by the Nevilles that a culture of "non-care of children" existed at CH. He found that the Nevilles " *had raised a legitimate concern"* and that *"there was a lack of awareness among at least some staff of the hospital"s capacity and obligation to provide an appropriate level of care for children who presented.*"

Head injury forms and documentation standards

In relation to the topics of head injury forms and documentation, the Commissioner noted that QH had satisfactorily improved the information contained on its Head Injury - Patient Advice form. He was also satisfied that QH had taken adequate steps to increase the awareness amongst medical and nursing staff of documentation standards and procedures, supported by monitoring and evaluation processes.

Retrieval

The Commissioner, in reconsidering the retrieval issue, sought an independent expert opinion from Dr Ron Manning, Director of the Medical Retrieval Unit of the Ambulance Service of NSW. On the basis of his opinion, the Commissioner made three recommendations which he considered should be taken into account in a then review being undertaken of the Queensland retrieval/transfer system by the Queensland Emergency

Medical Scheme[113]. Of particular importance was his recommendation that a State or Regionalised Retrieval Co-ordinations System be instituted to ensure that coordination and mission clinical governance occur independently of, and in parallel with, vehicle and retrieval team response.

The Commissioner's recommendations

While the Commissioner noted that extra funding had been provided to CH since Elise‟s death, and other changes had been instigated that would go towards improving the systemic issues, the Commissioner still made a number of recommendations including:

- QH investigate the introduction of an accredited course that would assist staff in smaller hospitals to be proficient in the current practices of emergency care of children as well as a process of specialist clinical oversight and review.
- QH undertake periodic auditing to monitor the effectiveness of the changes already introduced at CH to ensure the changes are both effective and sustainable.
- As a matter of urgency, the District Manager review the comments made by the Commissioner about the culture of staff at CH and initiate appropriate action to bring about sustainable changes, so that there is no doubt in anyone‟s mind as to the level of care that can and should be afforded to children at CH. Senior management of QH should monitor the review.

In summarising his recommendations, the Commissioner requested that the Director-General of QH report back to him within twelve months on the implementation of the recommendations included in his report, with an initial progress report after six months.

As I have mentioned[114], on 29 April 2005, the Commissioner contacted the Director-General‟s office seeking QH‟s progress report. QH provided a detailed response, but the Commissioner was not satisfied that the actions taken by QH had adequately addressed, or were specifically in response to, the recommendations contained in his report. The Commissioner therefore sought a follow up report from QH seeking further clarification of some matters. QH‟s response is set out at section 3.4.5 above.

5.2 HRC's response to complainants' allegations

I have set out below the HRC‟s response to each of the complainants‟ allegations, as provided to my Office during a meeting with the Commissioner on 27 June 2005.

5.2.1 That there was a 15 month delay in the HRC determining that it did not have jurisdiction to investigate the Nevilles' complaint about the Executive Director

The HRC has advised that it accepted the Nevilles‟ complaint about the Executive Director on the basis it was a "health service complaint" because it fell within the terms of the definition of "health service" in s.3(1) of the HRCA as "an administrative service directly related to a health service". The investigation had made substantial progress, with the full co-operation from the SCHSD, before the jurisdiction issue was first raised by lawyers for the SCHSD on 13 January 2003 (that is, 10 months after the Nevilles‟ complaint was first received by the HRC). Dr Neville was advised on 7 February 2003 that this issue had been raised.

[113] Section 10.4.
[114] Section 3.4.5.

The Commissioner sought Crown Law advice on the matter, which was provided on 10 February 2003 (that is, within 4 weeks of the jurisdiction issue first having been raised). Relying on Crown Law‟s advice, the Nevilles were informed on 19 March 2003 that the HRC did not have jurisdiction to continue investigating their complaint about the Executive Director. Accordingly, a period of 11 months (rather than 15 months) elapsed before the Nevilles were informed that the HRC now accepted that it lacked jurisdiction to investigate this issue. I am satisfied that the basis of objection to the HRC‟s jurisdiction was a technical legal point that would not necessarily have been apparent from the outset when the HRC accepted the complaint.

5.2.2 There was a lengthy delay in the investigation process

The Commissioner responded to this allegation as follows:

- A timeframe of 11 months to complete its investigation was not inordinate given the complexity of the investigation.
- The original complaint comprised a copy of a letter from the complainants to the Director-General of QH that was 19 typewritten pages, a 6 page letter to the HRC, and copies of numerous other documents. The complainants in a meeting with the HRC also raised various other issues.
- A lot of information was gathered from a wide variety of sources.

5.2.3 That HRC's initial investigation and report were grossly inadequate

The Commissioner responded to this allegation as follows:

- The HRC did not fail to investigate all issues, rather the complaint about the Executive Director‟s report was "out of jurisdiction".
- The Commissioner met personally with the Executive Director of the Office of the Health Practitioner Registration Boards (OHPRB) to urge it to accept the complaint about the Executive Director of the SCHSD. When that was refused, the Commissioner reaffirmed his offer to the Nevilles to seek the Minister‟s approval to investigate the complaint about the Executive Director‟s report.
- The facts in this case were difficult to establish, given there were different versions provided by the medical officer and nurses who attended to Elise; for example, the complainants alleged the medical officer who treated Elise agreed to keep Elise for observation and then changed his mind after seeking advice from the two nurses. However, the medical officer was equally adamant that he never intended to keep Elise for observation. There was no independent evidence that would enable the HRC to reconcile these different views.
- The HRC endeavoured to work closely with all the parties. In terms of natural justice, the Commissioner was not required to provide the complainants with a right to respond prior to releasing his initial report.
- There were findings in the initial investigation report that remained unchanged in the subsequent report. These relate to the Nevilles‟ assertions that a burr holes procedure should have been performed and to the chosen method of retrieval. In both cases the subsequent report confirmed findings made in the initial report.
- The only information not included in the HRC‟s initial report to the Nevilles related to documentation standards. At the time it was not considered to be of particular significance having regard to changes that QH had already implemented and the punitive measures sought by the complainants.

The Commissioner denied that there was anything furtive in his actions.

In a letter dated 16 July 2004 to the former Minister for Health, Mr Gordon Nuttall, the Commissioner acknowledged that perhaps one criticism was justified in respect of the HRC‟s initial investigation of the complaint. This concerned its original investigation of CH‟s approach to the admission of children and the HRC‟s inability to sufficiently explore the distinction between “policy” and “culture”. With the benefit of hindsight, the Commissioner agreed that the HRC should have placed greater focus on the practices and understandings of staff regarding the admission of children, as opposed to whatever formal policies may have been in existence.

5.3 Observations

One of the principal objectives of the HRC is to provide for the oversight, review and improvement of health services. Elise‟s incident was clearly an “adverse event” and such events are rarely the result of a single act or omission. More often than not, an adverse event will occur as a result of a number of “root causes”. Accordingly, it is important that there is a comprehensive investigation into such incidents, so that these “root causes” are identified and steps can then be taken to reduce the likelihood of such an incident occurring again.

The brevity of the HRC‟s initial investigation report, in comparison with its second investigation report (which was undertaken only as a result of the Nevilles‟ persistence in pressing their concerns), is of some concern. The second report reflects a more detailed analysis and investigation of the complaint issues, with an independent expert opinion having been sought on at least one of the issues (the retrieval issue). The HRC‟s explanation for the inadequacy of the first report is that the complexity of the issues raised, and the bulk of the documentation provided by the Nevilles, made it difficult to identify issues of substance until detailed discussions were held with the Nevilles during which they expressed their dissatisfaction with the initial investigation report. The serious nature of the allegations made and the potential systemic issues raised by the complaint, certainly warranted a comprehensive investigation and detailed report.

The HRC‟s investigation could have been greatly assisted by QH, as the health service provider, taking an active role in properly investigating the incident. An RCA[115] could have been undertaken by QH and the results provided to the HRC for independent analysis and assessment of the steps required to address the “root causes” that contributed to Elise‟s fatal incident.

As explained in the submission reproduced in Appendix 1 to this report, I also believe the investigation of the Nevilles‟ complaint was severely hampered by the fact that the fragmented health complaints system in Queensland required that their complaint be split and different aspects of it investigated by a number of complaint agencies. This was inimical to an effective and coordinated investigation of the incident.

[115] Root cause analysis.

I have formed the following opinion:

Opinion 9

(a) The HRC's initial investigation of the Nevilles' complaints was inadequate.
(b) In the circumstances, particularly having regard to the Nevilles' serious concerns about the level of care provided to Elise by CH, the Commissioner should have provided to the Nevilles details of all of the adverse comments he made to QH following his initial investigation.

The HRC's actions amounted to unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

I make the following recommendation:

Recommendation 16

In respect of the complaint about the Executive Director's report, no effective investigation occurred because of the HRC's opinion that it lacked jurisdiction. The proposed Health Quality and Complaints Commission Act should empower the Health Quality and Complaints Commission to investigate administrative actions incidental to a health service. This could be achieved by expanding the meaning of "health service".

HRC response to recommendation 16 (Letter dated 4 May 2006)

Thank you for the opportunity to comment on your report.

I have noted and accept the opinions set down in the report. I also note your support for improvements to Queensland"s health complaints system which were identified in my previous Annual Report. A number of these recommendations have been included for consideration in the proposed legislation to establish a new Health Quality and Complaints Commission.

I sincerely hope that finalisation of your report will assist Dr and Mrs Neville and their family to move forward after this most tragic incident.

QH response to recommendation 16 (Letter dated 16 May 2006)

Recommendation 16 has been implemented.

The Health Quality and Complaints Commission Bill 2006, tabled in Parliament on 9 May 2006, implements recommendation 16 by expanding the meaning of "health services" about which complaints may be made, and in regard to which the Health Quality and Complaints Commission may use its investigative powers.

6 Medical Board of Queensland

6.1 Actions taken by the MBQ

On 10 April 2002, the MBQ received a written complaint from the Nevilles about the actions of:

- the medical officer; and
- the Executive Director.

The MBQ considered the complaint at its consultation meeting with the HRC on 17 April 2002 and it was agreed that the complaint would be retained by the HRC for assessment. Upon finalisation of the assessment by the HRC, the MBQ met again with the HRC on 7 August 2002, and agreed to accept for investigation the complaint about the medical officer. At that stage, the HRC had retained for investigation the complaint about the Executive Director.

6.1.1 Decision not to take action under s.59 HPPSA

In the Nevilles‟ original letter of complaint to the MBQ, they sought that the medical officer be immediately suspended and that the MBQ seek the deregistration of both the medical officer and the Executive Director.

If the MBQ reasonably believes at any time, whether on the basis of a complaint or otherwise, that a registrant poses an imminent threat to the wellbeing of vulnerable persons, then s.59 of the HPPSA empowers it to take immediate action to suspend, or impose conditions on the registrant‟s registration, if necessary, to protect the vulnerable persons. This power is subject to an express qualification that *"the board must take the action the board considers is the least onerous necessary to protect the vulnerable persons."*[116]

The Nevilles‟ request was considered by a member of the Complaints Advisory Committee[117] (CAC) of the MBQ on 12 April 2002. The CAC member considered that on the available information, there was insufficient grounds to suspend the medical officer‟s registration or to seek the deregistration of either the medical officer or the Executive Director.

The Nevilles wrote to the MBQ again on 4 November 2002 asking that it reconsider its decision not to take any interim action in regard to the medical officer‟s registration. In support of their request, they provided a copy of an expert medical opinion by a prominent Brisbane neurosurgeon obtained by the QPS[118] as part of its coronial investigation.

In his report, the neurosurgeon said:

[116] s.59 (3) HPPSA

[117] Complaints Advisory Committee of the MBQ oversees the conduct of investigations and assists the Board‟s decision making in relation to complaints. It comprises four members, three of whom are medical practitioners, and the other is a "public member of the Board". Of the three medical practitioners, two are members of the Board, and one is a medical practitioner independent of the Board.

[118] Queensland Police Service.

> "[Elise's] *'poor compliance and sleepiness' were an early manifestation of the effects of an extradural haematoma. It is considered unacceptable for a patient, following a head injury to 'talk and die'. Elise Neville is one who talked and died.*
>
> *In a sophisticated medical system, such as we enjoy, with ready access to hospitals of ascending levels of sophistication, it is tragic and unacceptable that an event such as this should occur."*

The MBQ sought the advice of the CAC. The CAC member who provided the earlier advice, reviewed the Nevilles' submission and the neurosurgeon's report. In his written advice dated 14 February 2003 he concluded *"suspension or imposition of conditions under section 59 is not the least onerous action necessary in the circumstances"*. The advice also recommended that the MBQ's investigation be stayed until the outcome of the coronial inquiry was known.

The MBQ considered the Nevilles' submissions, the neurosurgeon's report and the advice of the CAC at its meeting of 11 March 2003. In deciding it was not necessary to take action under s.59 HPPSA in respect of the medical officer, the MBQ gave the following reasons for its decision[119]:

- [the neurosurgeon's] report does not reflect that [the medical officer's] practice is an imminent threat to vulnerable persons;
- [the medical officer] does not have a pattern of poor practice;
- [the medical officer] currently works in a supervised environment and is currently in the GP training program; and
- advice from Nambour General Hospital indicates that [the medical officer] is practising at a competent level for a junior doctor.

The MBQ communicated this decision to the Nevilles. The Nevilles subsequently wrote to the MBQ on 14 May 2003 expressing their dissatisfaction with this decision.

6.1.2 Investigation by MBQ

On 27 August 2002, the MBQ appointed an investigator from the OHPRB[120] to carry out the investigation. The OHPRB is responsible for carrying out investigations on behalf of the individual health practitioner registration boards. The Nevilles have advised that the investigator verbally informed them that the investigation would take approximately six months.

Subsequently, the Nevilles made repeated complaints about the delay in the OHPRB completing its investigation and on 24 June 2003 the OHPRB appointed an External Investigator to conduct the investigation. The Nevilles state that, at this point, it became evident to them that very little active investigation had taken place up to that time. The External Investigator completed the investigation within six months and provided a draft investigation report to the MBQ for its consideration.

On 20 January 2004, approximately 17 months after receiving the complaint for investigation, the MBQ provided the Nevilles with a copy of the final investigation report. The MBQ found that the medical officer had failed to:

[119] MBQ's letter to the Nevilles dated 16 May 2003 providing statement of reasons for decision not to take action under s.59 of the HPPSA.
[120] Office of Health Practitioner Registration Boards.

- properly examine Elise;
- suspect that Elise‟s symptoms were a possible sign of a significant head injury; and
- refer Elise for specialist treatment.

Accordingly, the MBQ concluded:

> *there is sufficient evidence to conclude that* [the medical officer‟s] *management of Elise Neville at her first presentation to Caloundra Hospital on 7 January 2002, constitutes unsatisfactory professional conduct.*

6.1.3 Decision of the Health Practitioners Tribunal

The MBQ referred the matter to the Health Practitioners Tribunal for hearing. On 8 November 2004, the Tribunal accepted a guilty plea by the medical officer and imposed a number of conditions/sanctions on his registration.

In handing down its decision, the Tribunal accepted that there were some significant mitigating circumstances which included the medical officer‟s inexperience and fatigue. The District Court Judge hearing the matter was very critical of the lengthy shifts doctors are expected to work[121].

6.1.4 Complaint about the Executive Director

After the HRC discontinued its investigation of the Nevilles‟ complaint about the Executive Director, the MBQ was requested by both the Health Rights Commissioner and the Nevilles to accept that complaint for investigation.

On 10 September 2003, the MBQ wrote to the Nevilles and advised them that, upon advice from its CAC, it had resolved to reject their complaint for investigation. Its reasons for rejecting the complaint were as follows:

- The complaint did not fall within s.48 of the Health Practitioners Act (Grounds for complaint) in that the conduct complained of did not appear to provide a ground for disciplinary action.
- The CAC concluded that it was reasonable to assume that the Executive Director, as Medical Superintendent, had conducted an immediate assessment of risk factors at the hospital rather than a substantial and detailed examination/investigation.
- The fact that the content of the report or conclusions drawn may be subject to some criticism or, at the end of the investigation the report can be demonstrated to be flawed, does not make it unsatisfactory professional conduct to which the *Health Practitioners (Professional Standards) Act 1999* should apply.

The Nevilles sought a review of this decision but it was upheld upon review.

6.2 MBQ’s response to the Nevilles’ allegations

On 24 May 2005, I wrote to the Executive Officer of the MBQ seeking a response to the allegations raised by the Nevilles. On 1 June and 14 June 2005 I received correspondence from the MBQ‟s lawyers providing its response. The response is summarised as follows:

[121] Section 3.3.1.

6.2.1 There was an unreasonable delay by the MBQ in commencing and completing the investigation of the medical officer

- The MBQ did not have any record of telephone conversations with the Nevilles on 25 October 2002 and 18 December 2002 in which they were allegedly told the investigation into their complaint about the medical officer would take approximately six months. Accordingly, it was unable to confirm or deny their assertions.

- The factors which resulted in a delay in commencing and finalising the investigation of the medical officer included the referral of the complaint to the HRC, untimely resignation of the investigator appointed on 27 August 2002, and the backlog of complaints faced by the Complaints Unit at that time.

- The delay in commencing an investigation into the Nevilles‟ complaint against the medical officer is explained by the fact that, under s.51 of the HPPSA, the MBQ is required to refer such a complaint to the HRC. Once referred, consultation takes place between the MBQ and the HRC to determine whether or not the MBQ will investigate the matter. At a meeting between the MBQ and the HRC on 17 April 2002, a decision was made to refer the Nevilles‟ complaint to the HRC for assessment. Once a complaint is referred to the HRC for assessment, the MBQ does not take any further action unless and until the complaint is referred back to it for further action. Under s.74 of the HRCA, the complaint was referred back to the MBQ for action on 8 August 2002. The MBQ then noted at its meeting on 27 August 2002 that an investigator was to be appointed.

- The appointed investigator resigned from his position on or about 6 June 2003, following unexpected leave in the three weeks prior to his resignation. This prompted the appointment of an External Investigator on 24 June 2003.

- In August 2002, the MBQ had 295 investigations, with each investigator responsible for approximately 50 investigations. The Nevilles were advised by letter of 6 May 2003 that there was a backlog of complaints. Additional resources were allocated to the Complaints Unit from April 2003 to clear the backlog. This facilitated their complaint being referred to an External Investigator on 24 June 2003.

The Executive Officer of the MBQ in a letter to the Minister for Health dated 22 June 2004, advised that the Board had focused significant resources through the OHPRB to ensure that complaints against registrants were handled in an efficient and effective way. While the investigation of the Nevilles‟ complaint had taken an excessive time, the Board was concurrently improving the quality of its systems and processes through many (previously outlined) initiatives. Ultimately, the Board and the OHPRB aimed to achieve a benchmark of six months for completing the majority of investigations. Given the backlog of complaints currently being addressed and the data available at that time, it was expected that the benchmark would be achieved within the next financial year.

6.2.2 The MBQ failed to keep the complainants adequately informed of the progress of its investigations

The Board remained in contact with the complainants over the course of the investigation into their complaint. The Board supplied a schedule that outlined correspondence from the MBQ to the Nevilles.

I note that the schedule discloses that there was no correspondence to the Nevilles from 7 August 2002 (the date the HRC referred the complaint back to the MBQ for investigation) until 6 May 2003.

6.2.3 The MBQ failed to take interim action against the medical officer pending the outcome of its investigation

Under s.59 of the HPPSA the MBQ may suspend or impose conditions on a practitioner‟s registration where the MBQ reasonably believes that the practitioner "poses an imminent threat to the well-being of vulnerable persons and immediate action…is necessary to protect the wellbeing of the vulnerable persons".[122]

After having considered the recommendation of the CAC, the complainants‟ correspondence and the independent expert‟s opinion, the Board did not consider that the medical officer‟s practice posed an imminent threat to vulnerable individuals.[123] The reasons for this decision are outlined at section 6.1.1.

6.2.4 There was undue delay in responding to the request for a review of the decision not to take interim action against the medical officer

In a letter to the Nevilles from the Executive Officer dated 6 May 2003, he acknowledged and apologised for the delay in responding to their request for a review of the decision and advised of the Board‟s decision on review. He explained that the delay was due in part to a backlog of complaints at that time; however this was being addressed by the provision of additional resources.

6.2.5 Undue delay in the process of referring the investigation report to the Complaints Advisory Committee (CAC)

The role of the CAC is to oversee investigation reports and provide the Board with assistance in assessing the merit of complaints. Preliminary investigation reports are considered by the CAC, which may make further recommendations prior to the report being referred to the Board. The process is designed not to cause undue delay in the finalisation of investigations. Rather the CAC is in a position to provide valuable recommendations and assist the Board in its decisions with respect to complaints.

6.2.6 The MBQ's refusal to accept the complaint against the Executive Director

The complaint was considered having regard to ss.48 and 124 of the HPPSA. The Board agreed with the CAC‟s view that the Executive Director‟s report was not the result of a substantial investigation, and that any demonstrated flaws would not amount to unsatisfactory professional conduct. The Board therefore denied the allegation that its decision was unsound.

[122] The expression "wellbeing of vulnerable persons" is defined in the schedule to the HPPSA to include the safety and welfare of users of the registrant‟s services.

[123] MBQ‟s letter of 6 May 2003 to the Nevilles providing a statement of reasons for its decision of 11 March 2003 to take no action under s.59 of the HPPSA.

6.3 Observations

6.3.1 Delay in progressing the investigation

The Nevilles have indicated that one of the frustrating aspects of the MBQ‟s investigation of the medical officer, was the lengthy delay by the initial investigating officer in advancing the investigation.

The evidence indicates that, in the 10 months between the initial investigator being appointed (27 August 2002) and the date of appointment of the second investigator (24 June 2003), the following steps were undertaken to advance the investigation:

- the Nevilles were interviewed in respect of their complaint;
- medical records from the relevant health authorities were sought and received by the MBQ on 13 February 2003;
- advice was sought and received from a member of the CAC on 15 March 2003 concerning the report of the independent expert that was forwarded by the Nevilles in support of their complaint;
- draft particulars of the complaint were sought and received from MBQ‟s solicitors on 28 February 2003.

It is clear that very few active steps were taken by the initial investigator towards advancing the investigation. The Nevilles‟ allegation is therefore well founded.

The MBQ has advised that at the time the Nevilles‟ complaint was first allocated to the initial investigator, a review of its operations had revealed that there were some 295 investigations on hand, with each investigator being responsible for approximately 50 investigations. This backlog of complaints was the primary reason provided by the MBQ for the delay in completing its investigation of the medical officer and responding to the Nevilles‟ request for a review of its decision not to take any interim action against the medical officer.

Fifty investigation files appears to be an excessive caseload for one investigator to handle within a reasonable timeframe, depending on their complexity.

If the MBQ was aware of this situation when it received the Nevilles‟ complaint, it should have informed them of the potential for delay.

The Nevilles‟ frustration with the delay would have been exacerbated if, as they state, they were informed on a number of occasions that the investigation would take approximately six months to complete.

6.3.2 Decisions made by the MBQ

The Nevilles also raised concerns about the adequacy of several decisions made by the MBQ, specifically:

- its decision not to take any interim action against the medical officer pending the outcome of its investigation and the hearing of the matter by the Health Practitioners Tribunal; and
- its decision not to accept their complaint against the Executive Director.

As mentioned at section 6.1.1, under s.59 of the HPPSA, the MBQ may suspend, or impose conditions on, the registration of a registrant if the MBQ reasonably believes that the registrant poses an imminent threat to the wellbeing of vulnerable persons. As noted above, the MBQ did not consider that the available evidence indicated that the medical officer posed an imminent threat to the wellbeing of vulnerable persons and therefore it did not suspend the medical officer"s registration or impose any conditions.

However, nearly three years after the incident, the Health Practitioners Tribunal, even after taking into account a number of mitigating factors (in particular, the medical officer"s inexperience, the lack of adequate supervision and fatigue), considered it necessary to impose "stringent conditions" on the medical officer"s registration. These conditions required that he practise under close supervision for a period of 12 months with reporting obligations.

In making its order, the Tribunal said:

> *"... a mistake with consequences of the magnitude experienced in this case call for caution to ensure that the public is protected from a repeat of any further behaviour by the registrant, which may fall below the necessary standard for a competent practitioner".*[124]

The lengthy delay in bringing the case before the Tribunal meant there were no restrictions on the medical officer"s right to practice for a considerable time. Having regard to his inexperience, the need for protection of the public from further errors of professional judgment was at its highest immediately after the incident rather than some three years later when, with greater experience, he should have required less supervision.

Solicitors for the MBQ provided the following response to these observations by letter dated 4 May 2006:

> *The Board"s suspension power is found in s.59 of the HPPA. That power is subject to the express qualification that "the board must take the action the board considers is the least onerous necessary to protect the vulnerable persons". It may be noted that a similar qualification attends the power of the Health Practitioners Tribunal (the Tribunal) to make interim orders pending the hearing and determination of a disciplinary matter: see s.231(3), HPPA. In contrast, the Tribunal"s powers of suspension and imposition of*

124 Health Practitioners Tribunal decision at p7.

conditions after finding disciplinary charges proved is not qualified in this way: see s.241(b) and (g) of the HPPA.

The reasoning in the report on the subject of suspension following the initial complaint, based upon the actions that the Tribunal took at the conclusion of the disciplinary hearing therefore proceeds upon the false premise that outcome of the exercise of the powers that the Tribunal was then able to exercise provides some indication into the adequacy or otherwise of the actions taken by the Board in the immediate aftermath of the complaint and in relation to the quite different statutory power then available to the Board.

The Board has already made submissions to you in relation to the considered value judgement it made on the subject of suspension or the imposition of conditions in the immediate aftermath of the complaint. These are not repeated. The Board has, over the years, gained considerable institutional experience of the operation of the suspension powers conferred on it by s.59 and upon the Tribunal by s.231 of the HPPA. Further, it has like institutional experience of the attitude of the Court of Appeal in relation to the granting of stay orders in respect of appeals from the Tribunal where the decision under appeal is one of suspension or cancellation of registration.

As to the latter, even in a case where a practitioner had been found guilty by the Tribunal of unsatisfactory professional conduct constituted by the serial exploitation of a vulnerable female patient and suspended from practice for 12 months by the Tribunal, and remained in practice in the small town concerned, and in respect of a power (see s.351, HPPA) not qualified in the way ss.59 and 231 are, the Court of Appeal stayed the operation of that suspension order pending the hearing and determination of the appeal.[125]

While, of course, such cases all turn on their peculiar facts, and the Court of Appeal case mentioned is no different in this regard, there is a qualitative difference, recognised by the HPPA, between the circumstances warranting interim suspension or the imposition of conditions and what might be the ultimate sequel to a disciplinary process. Further, there is a qualitative difference between behaviour indicative of a systemic weakness or want of competency in a practitioner and a single incident that may or may not provide such an indication. The Board accepts unreservedly (and routinely considers in relation to complaints arising from isolated incidents whether) isolated incidents may provide insight into a more systemic problem with a particular registrant. In this particular case, for reasons you have been given, the Board made a considered value judgement that the case was not one in which the power conferred upon by s.59 could reasonably be exercised to suspend or impose conditions.

The institutional experience of the Board in relation to the Tribunal's exercise of the interim order power by the Tribunal is that, in many a case where the ultimate finding proves to be suspension or cancellation, no interim suspension order has preceded that outcome.

On the reasoning exposed [in your] *report, every professional disciplinary case, medical or otherwise, where interim suspension has not occurred but which, after a hearing in which charges are found proven, results in suspension or cancellation of registration, is indicative of a failure on the part of the disciplinary body in not suspending or a failure on the part of a review body in overturning that interim suspension. Further, on that same reasoning, every such case presents an example, as you evidently presently consider to be the case, of a failure to serve the objects of the relevant governing statute.*

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125 Medical Board of Qld v Thurling [2003] QCA 346 (McMurdo P), 8 August 2003; the registrant's appeal as to severity of disciplinary outcome was subsequently dismissed, q.v. [2003] QCA 518, 21 November 2003.

Such reasoning is, with respect, fallacious. The Board respectfully contends that the reasoning that you have adopted ... is flawed and invites you to reconsider the matter.

Comment re lack of immediate action

I am well aware that the MBQ's power to take action under s.59 of the HPPSA is qualified by the words "the Board must take the action the board considers is the least onerous necessary to protect the vulnerable persons" and that no such qualification applies to the Health Practitioners Tribunal. Nor do I suggest (as the MBQ's response claims) that the fact that a tribunal makes an order impacting on a registrant's registration indicates that the MBQ should necessarily have taken earlier action against the registrant under s.59.

Whether the MBQ should take such action will always depend on the circumstances of the case. Much of the MBQ's response focuses on its decision **not to suspend** the medical officer and the likely availability of relief from a court had the MBQ taken action to do so.

However, I do not believe the response satisfactorily addresses why the MBQ did not take interim action **by imposing conditions** on the officer's registration, having regard to the information it had in its possession, at least on 11 March 2003, when it reviewed its decision in 2002 not to take action under s.59.

In forming this opinion, I have taken into account the following:

- The medical officer's error of judgment had fatal consequences.

- In reviewing its decision not to take action under s.59 of the HPPSA, the MBQ considered the report of the neurosurgeon consulted by the QPS. In his report, the neurosurgeon stated that it was "*unacceptable for a patient, following a head injury to „talkand die*"" as Elise had done. The neurosurgeon went on to state that the incident was "*tragic*" and that it was "*unacceptable that an event such as this should occur*" in a "*sophisticated medical system*".

  One of the MBQ's reasons for not taking action under s.59 of the HPPSA on the basis of the neurosurgeon's report was its assessment that the report did not reflect that the medical officer's "practice [*was*] an imminent threat to vulnerable persons".[126] The neurosurgeon had presumably not been asked by the police to give an opinion on this specific issue. Nonetheless, in my view, the comments of the neurosurgeon and the conclusion of the MBQ are not easily reconcilable.

- The other factors taken into account by the MBQ in deciding not to take action under s.59 of the HPPSA are summarised at section 6.1.1. These included that the medical officer was, at the time the MBQ considered the matter, involved in the GP training program and working in a supervised environment. However, the officer was working in a similar environment at the time of the incident.

- The lengthy delay in bringing the case before the Health Practitioners Tribunal meant that there were no restrictions on the medical officer's right to practice until the Tribunal's decision on 8 November 2004.

[126] MBQ's letter to the Nevilles dated 16 May 2003 providing statement of reasons for decision not to take action under s.59 of the HPPSA.

Taking into account the above issues, I have formed the following opinion:

Opinion 10

The MBQ should have taken action under s.59 of the HPPSA to impose conditions on the registration of the medical officer at its meeting of 11 March 2003, when it reviewed its earlier decision not to take such action. The MBQ's actions amounted to unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

Comment re decision not to investigate Executive Director

I note the reasons given by the MBQ for not accepting for investigation the Nevilles" complaint about the report prepared by the Executive Director. That decision involved the MBQ taking a fairly narrow interpretation of its investigative jurisdiction.

The MBQ took the view that the preparation of the report was essentially an action involving public administration rather than professional competence. On the other hand, the Executor Director expressed opinions in his report about clinical issues no doubt relying on his medical knowledge.

These are matters of statutory interpretation on which minds can reasonably differ. My principal concern is that no agency or person investigated the erroneous statements and opinions in the report.

The HRC commenced to investigate the matter before concluding that it was outside its jurisdiction. The Commissioner"s attempt to obtain a reference from the Minister was unsuccessful because at that time the External Investigator had been appointed to inquire into several issues including the adequacy of the Executive Director"s report. However, ultimately, the External Investigator did not investigate the issue either.

However, I note that in this instance, the complaint could have been dealt with by QH on the basis that it may involve unsatisfactory service, though not "unsatisfactory professional conduct".

Solicitors for the MBQ provided the following response in relation to my comments in my proposed report about the MBQ"s decision not to investigate this issue[127]:

> *Whether or not there is a need to amend these provisions is a matter for political value judgement by the Parliament. The Board accepts that your statutory functions include the ability to voice the concern that you have about these provisions, and that remains so even though other interested stakeholders might perceive that not every public service managerial issue gives rise to unprofessional conduct.*

As I have stated at section 3.4.4, QH should have reviewed the Executive Director"s report when the Nevilles made serious allegations about its accuracy.

As a result of submissions I made to the implementation committee for the Health Quality and Complaints Commission, the meaning of the expression "health service" in the new Act includes "an administrative process or service related to a health service". This means

[127] In its letter dated 4 May 2006.

that the new Commission will have the power to investigate a complaint about a report of the kind prepared by the Executive Director.

7 Queensland Nursing Council

7.1 Actions taken by the QNC

The QNC received a copy of the Nevilles‟ complaint against RN 1 and RN 2 on 11 April 2002.

On 1 May 2002, the QNC consulted with the HRC in relation to the complaint. It was agreed that the complaint would be retained by the HRC for assessment. In August 2002, the HRC referred the complaint back to the QNC for action. The QNC accepted for investigation the complaint about RN 1 but declined the complaint about RN 2. The complaint about RN 1 raised allegations concerning her competence and conduct, namely, that she:

- displayed an uncaring attitude and unprofessional manner;
- failed to complete an appropriate triage assessment; and
- fabricated observations and recorded incorrect and misleading information on triage documentation.

An investigator[128] was appointed by the QNC on 6 September 2002. On 27 November 2003, the investigator completed her investigation and submitted her report. In summary, the investigator found sufficient evidence to warrant a finding that there were concerns regarding RN 1‟s competence. The report also raised concerns about the conduct of RN 2.

The QNC sought legal advice, and the advice of a specialist in emergency medicine, in relation to the investigator‟s findings. After considering this further advice, the QNC resolved on 5 March 2004 to:

- await any inquiry/inquest by the Coroner before making a determination as to what action, if any, should be taken against RN 1; and
- initiate an investigation in relation to RN 2.

In a statement dated 21 June 2005 provided to my Office, the Executive Officer of the QNC explained that the first recommendation was consistent with its previous practice in order to ensure that procedural fairness is accorded to nurses facing disciplinary action.

The QNC asserted that:

- if disciplinary action were to be instigated by the QNC prior to a coronial inquiry, a nurse‟s right to refuse to answer questions at a coronial inquest on the grounds of self-incrimination could be prejudiced; and
- if the QNC were to prefer a charge prior to a coronial inquest, a nurse would be at liberty to seek a stay of those proceedings from the Nursing Tribunal pending the outcome of that inquest.

On 19 March 2004, the QNC initiated an investigation into the conduct of RN 2. The investigator completed her report in July 2004. The investigator expressed the view that:

> *The nurse, with her level of experience and knowledge, should have enquired further regarding the doctor's question and provided the doctor with additional options.*

[128] Referred to as an “inspector” in the Nursing Act.

While the investigator found the allegation against RN 2 was substantiated, she did not consider that RN 2‟s conduct amounted to discreditable conduct.

7.1.1 Action following investigation

On 22 July 2004, following finalisation of the investigation of the conduct of RN 2, the QNC sought the advice of senior counsel as to whether there was sufficient evidence to prefer a charge of gross negligence, malpractice or conduct discreditable to a registered nurse against RN 1 or RN 2. The advice is dated 17 August 2004.

After considering senior counsel‟s advice, and subsequent recommendations by the Professional Standards Committee[129] (PSC), the QNC, at its monthly meeting on 3 September 2004, decided that it held concerns regarding RN 1‟s knowledge of triage assessment and functioning as a member of a multidisciplinary team. The QNC decided[130] that, before preferring a charge against RN 1, it would convene a pre-charge "without prejudice" meeting to attempt to resolve the concerns raised by the Nevilles. This course of action was in accordance with QNC policy. As no formal disciplinary action was to be taken, the QNC believed it could proceed prior to the coronial inquest without potentially prejudicing the nurse‟s rights.

Also at the meeting on 3 September 2004, the QNC decided there was insufficient evidence to warrant taking any disciplinary action against RN 2. However, in a letter informing her of its decision, the QNC took the opportunity to remind RN 2 of her obligations as a nurse operating in a multidisciplinary team, as well as the importance of practising as a nurse in a manner that could not lead a reasonable person to form the view that she lacked empathy or was uninterested.

By letters dated 10 September 2004, the Nevilles sought reviews of the decisions not to take any formal disciplinary action against either RN 1 or RN 2. The Nevilles reminded the QNC that the investigation reports supported their belief that the actions of both nurses had contributed to Elise‟s death. As a result of the Nevilles‟ submissions, the QNC decided to defer the pre-charge "without prejudice" meeting with RN 1.

At the QNC‟s monthly meeting on 1 October 2004, the QNC reaffirmed its decision not to take any disciplinary action against RN 2. It refrained from making any decision about RN 1 until it had sought further legal advice concerning some of the issues raised by the Nevilles‟ submission of 23 September 2004.

In upholding its earlier decision in respect of RN 2, the QNC pointed out that the decision to investigate RN 2 was based on the understanding that she was the nurse in charge of the shift. The investigation revealed, however, that the CH had a policy which did not designate which nurse was in charge of a shift. In light of that and the fact that RN 2 did not assess Elise, the QNC considered that there was no basis upon which to question the competency of RN 2.

In considering the Nevilles‟ allegation that RN 2 was totally lacking in empathy, it was the opinion of the QNC that even if proven, this was not conduct that could give rise to any disciplinary action.

[129] An advisory committee of the QNC which considers reports relevant to the conduct, health and competence of nurses, oversees the effective management of the professional standards function of the QNC and, as necessary, submits recommendations to Council.

[130] At its monthly meeting on 3 September 2004.

After a meeting with the Nevilles on 5 October 2004 to further discuss their concerns, the QNC wrote to RN 1 seeking a statutory declaration from her (by 17 November 2004) addressing a number of issues, in particular her triage assessment of Elise and a description of the steps she undertook to make the various assessments which she relied on in determining the GCS[131]. The Nevilles believed this information should have been obtained during the investigation, as it was relevant to determining what disciplinary action was justified.

RN 1's statutory declaration was not received by the QNC until May 2005 (some seven months after being requested). On 25 August 2005, the QNC reaffirmed its decision of 3 September 2004, that is, that RN 1 undertake re-education in triage assessment and functioning as a member of a multidisciplinary team. The re-education was to include a formative assessment component and the nurse would then be required to sit an oral examination at the offices of the QNC before an expert panel. If a satisfactory outcome was not reached, a charge would be preferred against RN 1, and referred to the Nursing Tribunal[132] for hearing and determination.

On 18 November 2005, RN 1 took part in a pre-charge "without prejudice" meeting as a result of which she agreed to an undertaking. The QNC endorsed the undertaking at its meeting on 2 December 2005 and determined not to refer the matter to the Nursing Tribunal for disciplinary action.

7.2 QNC's response to the Nevilles' allegations

In reply to my letter dated 24 May 2005, the QNC responded as follows to the allegations raised by the Nevilles' complaint against the QNC.

7.2.1 There was a lengthy delay in the QNC finalising its investigation into the alleged conduct of RNs 1 & 2

The QNC provided detailed statements by its Executive Officer, and by the investigator who conducted the investigations of both nurses, setting out the actions taken in response to the Nevilles' complaints against RN 1 and RN 2. In summary, they advised:

- In accordance with its statutory duty, upon receipt of the Nevilles' complaint about the two nurses, the QNC consulted with the HRC as to what action should be taken. The HRC retained the complaint for assessment and then, on 7 August 2002, referred the complaint back to the QNC for action. The QNC was precluded by the provisions of the *Nursing Act 1992* from taking any action on the complaint until the HRC had referred the complaint back to it for action.

- After seeking legal advice, the QNC agreed to investigate the complaint against RN 1 but not RN 2. An investigator was appointed by the QNC on 6 September 2002.

[131] Glascow Coma Score.

[132] Under s.87 of the Nursing Act, the Tribunal consists of the following members: (a) 1 lawyer; (b) 12 registered nurses nominated by Council, of whom 6 are to be chosen by Council from a panel of names submitted by associations accepted by Council as representatives of nurses; and (c) 3 persons, representing those who use services provided by the nursing profession. However, the Tribunal, when it sits, consists of only five members comprising the lawyer, three registered nurses and one consumer representative.

- In preparing the particulars of the complaint, the QNC sought advice from the HRC and its legal advisers, and consulted extensively with the Nevilles and a paediatric nursing expert and other experts.

- Particulars of the complaint were provided to RN 1 and she was given the opportunity to provide a submission in response.

- Upon receipt of her response, the investigator sought expert opinions from a paediatric nurse and a medical practitioner.

- The QNC sought other relevant expert medical opinion and access to evidence which the State Coroner had obtained relating to Elise"s death.

- The investigation report was referred to the QNC"s solicitors for advice.

- Following receipt of this legal advice, further discussions were undertaken with one of the medical experts who provided expert advice to clarify the standard of nursing care he expected of an ED[133] nurse in this matter. This further advice was referred back to the QNC"s solicitors.

- Subsequent legal advice and the investigation report were referred to the PSC[134] for recommendations as to what action, if any, should be taken following the outcome of the investigation.

- A copy of the investigation report was then sent to RN 1, care of her lawyers, inviting her to make a further submission. This was done to satisfy the obligation imposed on the investigator by s.103(5)(b) of the Nursing Act[135].

- In accordance with a further statutory duty, the QNC also forwarded a copy of the investigation report to the Health Rights Commissioner for his comments. The Commissioner concurred with the conclusions reached in the investigation report, but expressed concern over the QNC"s decision to await the outcome of the coronial inquest before making a determination in relation to the findings of the investigation report.

- The investigator completed her report about RN 1 on 27 November 2003, just short of 15 months after her appointment. This is longer than the average time taken for QNC investigators to complete investigations (being 6 months) but compares favourably with similar investigations undertaken by other nurse regulatory authorities in Australia and overseas.

- It was accepted that there had been a delay in commencing the investigation of RN 2. However, it was only after considering the investigation report about RN 1 and legal advice concerning the opinions of one of the experts that it became evident there was a prospect of disciplinary action against RN 2. That prospect was based on the premise

[133] Emergency Department.
[134] Professional Standards Committee of the QNC.
[135] Section 103(5) (b) of the Nursing Act provides that on conclusion of the investigation, the inspector must provide to the person a written outline of the report and general particulars of findings adverse to the person.

that RN 2 had responsibility for RN 1 on the shift, a premise later found to be mistaken[136].

- QNC investigations took place against the possibility of a coronial inquiry. The QNC had initially deferred a decision on RN 1‟s investigation pending the outcome of any action arising from a coronial inquiry. The QNC subsequently determined to make a decision on the complaint against RN 1 notwithstanding that a coronial inquiry may be held. The earliest the QNC could have made a decision on RN 1 was 2 April 2004 (although it would not have had the advantage of senior counsel‟s advice at that time). The QNC‟s decision was made on 3 September 2004.

The QNC informed the Minister for Health (in a letter dated 19 July 2004) that the average timeframe from the initiation of an investigation to the presentation of an investigation report was approximately 6 months. The investigation of RN 1 took longer than this average given the complexity of the issues involved, which required legal advice to be obtained on more than one occasion throughout the course of the investigation, as well as the commissioning of expert reports. The investigation of RN 2, however, took much less than the average time.

7.2.2 The QNC failed to properly consider all relevant considerations when determining whether disciplinary action should be taken against RN 1 or RN 2

When making its decision of 3 September 2004, the QNC had the benefit of:

- advice from its solicitors, and senior counsel‟s opinion, about the prospects of successful disciplinary action against RN 1 and/or RN 2;
- investigation reports of the investigator;
- recommendations of the PSC (which the QNC adopted) from the PSC‟s 1 September 2004 meeting; and
- the written concurrence of the Health Rights Commissioner with the recommendation of the PSC.

7.2.3 There was a lengthy delay in the QNC conducting a review of its decision about disciplinary action against the two nurses

On the QNC‟s instructions, its solicitors wrote to the Queensland Nurses Union (which was then acting for RN 1) on 3 November 2004 seeking the provision of a statutory declaration to address a number of questions about RN 1‟s completion of the triage assessment form. The solicitors received the statutory declaration on 17 May 2005. The QNC was informed that, during this period, RN 1 sought different legal representation. RN 1 also made an FOI application to the QNC.

The statutory declaration was sent to the Nevilles for comment on 26 May 2005 and their response was received by letter dated 10 June 2005. The QNC‟s solicitors were instructed to brief senior counsel to reconsider the complaint against RN 1 in light of, amongst other things, the Nevilles‟ letter of 23 September 2004, the statutory declaration of RN 1, and the Nevilles‟ letter of 10 June 2005.

[136] Discussed at section 7.3.2.

The QNC reconsidered the matter at its meeting of 26 August 2005 and decided to reaffirm its decision of 3 September 2004.

7.3 Observations

7.3.1 QNC's investigation of RN 1

Conduct

In a letter addressed to me dated 21 June 2005, the QNC said:

> *... by letter dated 23 September 2004 the Nevilles raised the issue that* [RN 1] *had made entries in the triage assessment form that were ‚deliberately false". Council had previously treated the complaint as one relating to competence. Whilst the Nevilles had always maintained that* [RN 1] *had not properly assessed some of the components for a Glascow Coma Score, it had not been previously articulated by the Nevilles that they were alleging a deliberate falsehood, as opposed to ‚mere" incompetence. This allegation put a different complexion on the complaint as* [RN 1"s] *conduct became the focus rather than only her competence. Such an allegation is very serious and, if proved, would very likely result in the suspension or cancellation of the nurse's registration thereby justifying a referral to the Nursing Tribunal as sought by the Nevilles.*

I have considered the evidence gathered in this matter and find some inconsistencies with this statement. The evidence includes:

- In the Nevilles" original letter of complaint dated 28 March 2002 to the HRC, a copy of which they sent to the QNC, they said:

  > ***..we are adamant that she*** [RN 1] ***has fabricated some aspects of her clinical assessment of Elise*** *as outlined in the attached information.* (my emphasis)

- A file note made by the QNC"s investigator during an interview with the Nevilles on 13 September 2002 states:

  > *They* [the Nevilles] *do allege that her* [RN 1"s] *triage assessment was inadequate* ***and take issue with a number of allegations made by the nurse in that regard***. (my emphasis)

  The investigation report states that, by letter dated 3 April 2003, the nurse was notified of the particulars of the complaint and invited to provide a submission addressing the particulars. Particulars of the complaint included:

  > *3. documentation information in the Hospital's Emergency Department Flow sheet which the* ***nurse knew, or ought to have known, was false****, namely .... :* (my emphasis)

- The QNC received RN 1"s submission dated 3 October 2002 in May 2003. It was noted that the nurse"s submission was the same statement provided by her to QPS investigators. As such, it did not provide a specific response to the particulars of the complaint. No other submission was sought by the QNC or provided by the nurse during the investigation.

- In her letter to me dated 21 June 2005, the QNC"s Executive Officer advised (in response to the Nevilles" submission of 23 September 2004 seeking a review of the QNC"s decision about disciplinary action proposed to be taken against RN 1) that:

> *I decided that further information was required to determine if there was any substance to this allegation* [that RN 1 made entries in her triage assessment notes that were deliberately false] *as* [RN 1"s] *submission to the inspector had not fully canvassed all actions taken by her during the triage assessment.*

On 20 July 2005, the Nevilles wrote to the QNC in the following terms:

> *Any suggestion that the first time we raised this matter of false/fabricated clinical entries by* [RN 1] *was our letter of 23 September 2004 is demonstrably wrong and frankly, offensive.*
>
> *The QNC"s problem is that the Investigation Report failed to deal with this issue of false/fabricated documentation.*

The Nevilles raised this issue with my Office for assessment.

I have formed the following opinion:

Opinion 11

I am satisfied that:

(a) the Nevilles, as part of their initial written complaint (a copy of which was sent to the QNC), raised the allegation that RN 1 had deliberately fabricated records of Elise's assessment;

(b) this allegation raised questions about RN 1's honesty and not simply questions about her competence.

This opinion was included in my proposed report, a copy of which was provided to the QNC for comment. The QNC provided its response by letter of 10 May 2006 as follows:

QNC response to opinion 11

The QNC accepts the Neville complaint raised issues of both honesty and competence about RN 1.

However, the QNC also made the following comment in relation to this opinion:

> *Council would ask for recognition that its investigation dealt with both aspects of this complaint, notwithstanding that the initial investigation report focused on competence issues. In that regard Council seeks an acknowledgment that it has complied with its duty to conduct an adequate and fair investigation of the complaint, and that the decisions that it reached at the conclusion of the investigations were fair and reasonable in all the circumstances. The fact that the complainants do not agree with the decisions made by Council does not, by itself, mean that Council has not fulfilled its duties.*

Comment

I acknowledge that the QNC investigation eventually dealt with both aspects of the Nevilles' complaint.

I am unable to provide the other acknowledgements sought by the QNC because:

- The initial investigation failed to consider the Nevilles' allegation that RN 1 had made entries in the triage assessment form that were "deliberately false". This failure resulted in a lengthy delay in finalising the complaint.
- RN 1's statutory declaration was provided to the QNC in May 2005, more than three years after the incident. Accordingly, there was a real risk that RN 1's recollection of the events could have been impaired by such a lengthy delay.
- The QNC did not refer the matter to the Nursing Tribunal for determination and, therefore, the Tribunal did not make any findings of fact in relation to the different versions of RN 1 and the Nevilles.

Having regard to the above, I am unable to express any opinion about the appropriateness of the QNC's decisions.

Decision to convene a pre-charge "without prejudice" meeting

A pre-charge "without prejudice" meeting may be held after an investigation, if the QNC considers that the seriousness of the findings (I assume this includes, in some cases, potential findings) does not warrant referral to the Tribunal, or where the matter, if proven, would not result in cancellation or immediate suspension of registration. The purpose of the "without prejudice" meeting is to determine whether the nurse is prepared to provide an undertaking to the QNC with a view to preventing a recurrence of such conduct, or improving the nurse's practice standards instead of a charge being referred for hearing by the Tribunal[137].

As reported in section 7.1.1, rather than commence formal disciplinary proceedings against RN 1, the QNC decided it would convene a pre-charge "without prejudice" meeting to attempt to resolve the concerns raised by the Nevilles. The Nursing Tribunal has indicated its support for the pre-charge without prejudice meeting process. The Chairperson of the Tribunal said in the QNC's 2005 Annual Report[138] that this process is appropriate ***where there is agreement by the complainant, the Nursing Council and the respondent nurse*** *that the complaint can be appropriately dealt with at an early juncture, as this process avoids the expense, time and emotional distress which may accompany a full hearing and determination before the Tribunal.* [my emphasis]

The Nevilles wrote to the QNC on 10 and 23 September 2004 raising a number of concerns about the QNC's decision not to refer the charge to the Nursing Tribunal for hearing and determination. While the QNC met with the Nevilles on several occasions, it is clear from the evidence that the Nevilles' approval to convene a pre-charge without prejudice meeting between the QNC and RN 1 was not sought prior to the QNC reaching that decision[139]. The Nevilles were strongly opposed to the decision for a number of reasons, including:

[137] QNC's Information Sheet No. 6 "Without Prejudice" Meetings.
[138] At page 32.
[139] The QNC's position is that there was and is no legal requirement to obtain such consent.

- There had been no findings made by Council on material questions of fact in regard to RN 1's involvement in the matter. The Nevilles considered this to be "totally out of line with community expectations", particularly when the matter involved the death of a 10 year old child from what was typically a fully treatable injury.

- The Nevilles were the key witnesses to the matter, and yet they had been afforded no opportunity to challenge the evidence provided by RN 1. The Tribunal would have provided the best forum for all the evidence to be considered and findings made based on an assessment of credibility of the accounts of RN 1 and the Nevilles.

- The HRC's findings that a practice had developed at CH of not admitting children and that CH had failed to discharge an "obligation to provide an appropriate level of care" apparently included RN 1. This coupled with the findings of the QNC's investigation was sufficient, in the Nevilles' opinion, to warrant the possibility of suspension or cancellation of RN 1's registration, penalties which could only be considered by the Tribunal.[140]

Given that the complaint was received by the QNC in August 2002, it took the QNC over three years to finalise the matter. The QNC has submitted that a portion of this timeframe should be attributed to the fact that it took RN 1 some seven months to provide it with a statutory declaration addressing allegations including the deliberate falsification of the triage assessment form.

In my proposed report, I stated the following proposed opinion:

Proposed opinion A

Having regard to the statement of the Chairperson of the Tribunal about the circumstances in which the pre-charge without prejudice meeting process is used, the QNC should not have used the process without the Nevilles' approval. The QNC's decision to use the process was unjust administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

A copy of my proposed report was provided to the QNC for comment. The QNC provided its response by letter of 10 May 2006 as follows:

QNC response to proposed opinion A

The proposed opinion fundamentally misconceives the QNC's role as a regulatory authority.

The QNC provided the following comment in support of its response:

> *This opinion relies on the statement made by the Chairperson of the Nursing Tribunal in Council's 2005 Annual Report. The Chairperson and the Nursing Tribunal are separate from Council and act independently. This statement was made by the Chairperson and is not endorsed by Council. Council's policies do not envisage a complainant approving*

[140] The Nevilles' letter to the QNC dated 23 September 2004.

any outcome from a complaint, or indeed even to attend a without prejudice meeting. Council is not the agent of a complainant.

Council's duties are to conduct an adequate and fair investigation of the complaint made to it and to justify the decision which it reaches at the end of an investigation. These duties are central to regulatory bodies with a statutory obligation to protect the interests of the public. These duties do **not** *require that Council seek the approval of a complainant to any action it may take. It has never been the case that an authority such as Council must seek the approval or consent of a complainant to any decision Council makes regarding disciplinary action.*

Accordingly it is Council's view that the statement of the Chairperson you have extracted from the 2005 Annual Report cannot be seen as authority for the proposition that Council could only seek to resolve the complaint against RN 1 by means of a pre-charge without prejudice meeting process with the approval of the complainants. The Chairperson's statement is clearly incorrect.

To require the complainants" approval would not only misconceive Council's function but also make its function unworkable. Council's function as the regulator of professional standards is to protect the public. This function must be contrasted with conciliation of complaints between complainants and health service providers, one of the functions of the Health Rights Commission. That function is not fulfilled by Council. Indeed, Council's public protection role may in some circumstances be in conflict with the objective or motivation of a complainant. If, for example, a complainant sought to withdraw a complaint, Council may nevertheless have a statutory obligation to act on the complaint if the complaint revealed issues concerning public health and safety. Conversely, Council is not obliged to prefer a charge against the nurse merely on the basis that a complainant says it should do so. In each case Council must exercise its own discretion having regard to the seriousness of the complaint and whether an appropriate outcome can be achieved to protect the interests of the public without resorting to an adversarial complaints resolution process.

Any system of regulation of professions that requires the regulatory authority to seek the approval of a complainant to any aspect of its disciplinary function would greatly erode its efficacy and effectiveness.

[Your proposed report sets] *out some of the reasons why the Nevilles were strongly opposed to Council's decision not to charge the nurses. The report does not seek to record Council's response to these criticisms as set out in a letter from Council to your office dated 21 June 2005. In particular, it is relevant to note:*

- *Council does not make findings on material questions of fact as suggested by the Nevilles. This is a complete misconception on Council's role. Findings on questions of fact are made by the Nursing Tribunal. In this case Council looked at the worst likely outcome for RN 1 and considered that the Tribunal would not order anything more onerous than the outcome that was reached with RN 1 at the pre-charge without prejudice meeting. Council reached these views after having the advantage of advice from its solicitors and senior counsel. In addition, there was a risk that even if parts of the complaint were proved, that the conduct of RN 1 would not satisfy the more onerous test of discreditable conduct with the ultimate result that the charge would be dismissed. In all the circumstances Council's resolution of the complaint against RN 1 was seen as best fulfilling its legislative objective of ensuring the safety and health of the public.*
- *Council's function is not to provide complainants with an opportunity to* challenge *the evidence of a registrant. The evidence of all relevant witnesses is gathered during the course of the investigation so Council can decide whether any disciplinary action should be taken.*

- *In relation to* [the Nevilles‟ claim that despite the fact they were key witnesses, they were not afforded an opportunity to challenge the evidence of RN 1] *the Nevilles were provided with the opportunity of responding to the evidence of RN 1. They took that opportunity and also discussed their views of RN 1‟s evidence at the 2 meetings with Council‟s solicitor. Accordingly the Nevilles‟ views about the evidence of RN 1 were well known to Council.*

Comment

As a result of the QNC‟s submission, I have withdrawn proposed opinion A about the pre-charge without prejudice process. However, it is unfortunate that the QNC did not note and correct the Chairperson‟s misapprehension during the preparation of the annual report. For obvious reasons, it is important that the public is not misled by statements made in an agency‟s annual report.

7.3.2 Investigation of RN 2

The QNC has advised that its decision to investigate RN 2 was based on the understanding that RN 2 was the nurse in charge of the shift. The investigation however, concluded that the CH had a policy that did not designate which nurse was in charge of the shift. In those circumstances, and given that RN 2 did not assess Elise, the QNC determined there was no basis to question her competency[141]. The Nevilles have questioned this decision.

I have considered the investigation report and find that the only evidence to support QNC‟s conclusion that the CH had a policy that did not designate which nurse was in charge of a shift, is a letter from QH‟s lawyers dated 21 May 2004 stating that RN 2 had informed them that that was the case. The letter reads:

> *On 7 January 2002, [RN2] was not formally designated as the nurse in charge of the shift. As at that date, Caloundra Hospital had no written position description for the role of „charge nurse" and [RN2] had not received any specific training or instruction as to any requirements and expectations of that position.*

A copy of the alleged “policy” was not included in the investigation report. Other evidence (not included in the report) in the form of a memorandum dated 15 January 2002, to the then Director-General of QH[142] from the then District Manager responsible for CH appears to suggest there was no such policy. The memorandum reads:

> *The doctor treating the child in question sought confirmation from the* ***DEM nurse in charge*** (my emphasis) *that children are not admitted at Caloundra for observation.*

The Nevilles sought to reconcile this inconsistency by seeking a copy of the alleged policy pursuant to an application made under the *Freedom of Information Act 1992*. The Freedom of Information officer for the QNC responded (by letter dated 4 November 2004):

> *I could not locate such a document in the files. I therefore spoke with the investigator…who informed me that there was not such a document. The statement was meant to indicate that, at Caloundra Hospital, it was not the practice for one nurse designated as in charge of the shift. The term “policy” appears to have been used in error in this context.*

[141] Letter from the QNC to the Health Rights Commissioner dated 7 September 2004.
[142] Dr Stable.

The investigation report does not include any other evidence to support RN 2's statement. Therefore, the statement amounts to uncorroborated and self-serving evidence, and so the QNC should have exercised caution in relying on it as a basis for determining that no action could be taken against RN 2. Independent confirmation should have been sought from QH and CH as to whether or not RN 2 had managerial/leadership responsibilities as the most experienced nurse on the shift.

The Nevilles also alleged that the QNC failed to give proper weight to other relevant considerations, including some of the key findings of its own investigator. They included:

- The investigator's finding (based on independent expert medical opinion obtained during the investigation) that:

  > *The nurse, with her level of experience and knowledge, should have enquired further regarding the doctor's question and provided the doctor with additional options.*[143]

- The investigator's finding that:

  > *Aspects of the nurse's conduct are of concern and appear to have altered the course of action taken by the doctor. This is a factor that contributed to the negative outcome for Elise. However the nurse's conduct does not amount to discreditable conduct.*

It is not apparent from the reasons given by the QNC for its decision whether or not these issues were taken into account.

It appears that the QNC, in reaching its decision, accepted senior counsel's advice that there were no grounds for disciplinary action against RN 2. I do not know whether senior counsel, in formulating the advice, had regard to the investigator's findings noted above. However, it is clear that the advice relied on RN 2's uncorroborated assertion that she had not been formally designated as the nurse in charge of the shift.

In my proposed report, I said that, in the circumstances, I was unable to say whether the QNC's decision was unreasonable or not.

In its response, the QNC said:

> *... there appears to be a criticism of Council for accepting senior counsel's advice when that advice did not refer to the investigator's findings .... Senior counsel was fully briefed with all material arising from the complaint including the investigation reports concerning both nurses. The absence of a reference to the investigator's findings in the advice of senior counsel does not lead to a conclusion, as the report seems to suggest, that such material was not fully considered.*
>
> *You reach the conclusion in respect of RN 2 that you are unable to say that Council's decision was unreasonable. Council is disappointed that you have not reached the affirmative conclusion that Council's decision was reasonable. Council's actions were strongly influenced by legal advice, including the advice of senior counsel who is very experienced in this area of law. Senior counsel was, as noted earlier, fully briefed with all relevant documents. Based on that advice Council determined not to take action*

[143] Page 35 of QNC's investigation report into a complaint about the conduct of [RN 2] dated July 2004.

against RN 2. Council wonders what more it can do when it acts in good faith and in reliance on the advice of highly experienced senior counsel.

Comment

Notwithstanding the QNC‟s response, the fact remains that its decision not to take disciplinary action against RN 2 was based upon RN 2‟s uncorroborated assertion that the CH had a policy that did not designate which nurse was in charge of a shift. The QNC‟s investigator later confirmed that there was no such written policy.

The legal advice QNC obtained also relied on RN 2‟s assertion. For that reason, I am unable to reach "an affirmative conclusion that the Council‟s decision was reasonable", as the QNC suggests I should. I have formed the following opinion:

Opinion 12

The QNC's investigator should have sought corroboration from QH for RN 2's assertion that, at the time Elise was treated at CH, RN 2 was not the nurse in charge. The failure to do so was unreasonable administrative action, within the meaning of s.49(2)(b) of the Ombudsman Act.

7.3.3 Deferring disciplinary action

I have a further concern about the practices that have apparently developed at the QNC when dealing with complaints about registered nurses where there is also a prospect of a coronial inquiry or criminal charges.

Firstly, I can see no justification for the QNC to delay investigation of a complaint on the basis that the Coroner‟s Office or the QPS are also investigating the matter, unless some agreement has been reached with the Coroner or the QPS to that effect, or some other valid reason exists in a particular case (for example, the disciplinary investigation and/or proceedings would affect the well-being of a key witness in potential criminal proceedings).

One of the primary responsibilities of the QNC (and indeed the MBQ and other registration boards) is to protect the public from incompetent, careless or otherwise unsatisfactory performance of professional services by registrants. This will normally require the QNC to investigate and take appropriate action as quickly as possible when a complaint of substance is received.

In my view, it is inconsistent with that primary responsibility of protecting the public, and inappropriate for a body like the QNC to give undue weight to concerns about prejudicing the legal entitlement of a registrant to invoke the privilege against self-incrimination in coronial or criminal proceedings.

There is no „double jeopardy‟ principle in Australian law that prevents disciplinary action against a professional person or employee arising out of conduct that has resulted, or could also result, in criminal charges (and vice versa).

In my proposed report, I said:

If, the QNC remains concerned about taking action in such circumstances, it should seek legal advice. If that advice supports the QNC's concerns, it should seek an appropriate legislative amendment to abrogate the privilege against self-incrimination in disciplinary proceedings involving the QNC and the Nursing Tribunal (and indeed for disciplinary action involving the MBQ and other professional registration boards). The amendment should also provide that admissions made in those proceedings are protected from being used in other legal proceedings. There are existing legislative precedents to that effect.

On that basis, I included in my proposed report the following opinion:

Proposed opinion B

There is no justification for the QNC to delay taking appropriate action in respect of a registrant out of concern for prejudicing the registrant in respect of other legal proceedings.

The QNC provided the following response to proposed opinion B in its letter of 10 May 2006:

QNC response to proposed opinion B

The proposed opinion is not justified or supportable.

My proposed report also included the following recommendations:

Proposed recommendations C

C.1 QNC cease its practice of delaying consideration of disciplinary action pending the completion of criminal or other proceedings, unless there were valid reasons for doing so in the circumstances of a particular case.

C.2 Legislative amendments be sought to abrogate the privilege against self-incrimination in disciplinary proceedings before those bodies and their related tribunals and to protect admissions made in any such proceedings from being used in other legal proceedings.

The QNC provided the following response to proposed recommendations C.1 and C.2 in its letter of 10 May 2006:

QNC response to proposed recommendations C.1 and C.2

Proposed recommendation C.1 is not justified or supportable.

Proposed recommendation C.2 requires wider consultation given the potentially significant ramifications it may have to the administration of justice.

The QNC provided the following additional comments on the proposed opinion B and on proposed recommendations C.1 and C.2:

It was generally the case that Council would defer disciplinary action when a nurse was either charged with a serious criminal offence or could be the result of an adverse finding of a coroner. The basis for this practice was that:

- *The nurse had a right to claim privilege from self-incrimination at a coronial inquiry and could not be compelled to give evidence at a criminal trial. In these circumstances the nurse's right to make a submission to Council's investigator could be prejudiced.*
- *It was helpful to Council to await the outcome of any criminal action (whether or not arising out of a coronial inquiry) as a conviction would readily facilitate proof of the relevant conduct before the Nursing Tribunal.*
- *It is Council's experience that the Nursing Tribunal would not hesitate to adjourn disciplinary action if criminal proceedings arising from the same conduct were not finalised.*

Notwithstanding this general practice of deferring disciplinary action, it is often the case that Council took action in relation to nurses" licences pending the outcome of disciplinary action. That action could take the form of a suspension under section 67 of the Nursing Act 1992, the imposition of limitations and conditions under section 65, or referral for a health assessment under section 66 to inform Council of any further interim action it should take to protect the public. In some instances nurses have undertaken not to practice pending the outcome of criminal trials. In these ways Council has been able to protect the public pending finalisation of its investigation and any consequent disciplinary action.

The position changed somewhat in relation to coronial inquiries as a result of enactment of the Coroners Act 2003 which removed the privilege against self-incrimination. Council understands that privilege would still apply to any coronial inquiry that may be instigated arising from the Neville complaint.

It is common for Council not to investigate or make a final determination on any disciplinary action pending the outcome of criminal charges. In these circumstances it is also common that the nurse's licence will be suspended pending the outcome of that criminal action. There are a number of reasons for allowing criminal charges to run their course, including:

- *Council is not granted access to the Police file (and its investigations) until after criminal action is finalised.*
- *An investigation by Council may prejudice an investigation by Police or criminal action.*
- *The Nursing Tribunal will in all likelihood adjourn any disciplinary action until criminal charges are finalised.*
- *A criminal conviction would secure proof of the relevant conduct for Council's purposes under the Evidence Act 1979 thereby obviating the necessity for Council to investigate.*

Each case is judged on its own particular circumstances. Council has only held investigations in abeyance or deferred consideration of disciplinary action when there are valid reasons for doing so in the circumstances of each particular case, and particularly only where interim action in the most serious cases is able to be taken by Council on the facts available to it in order to protect the public, such as imposing a suspension or limited registration.

As regards your [proposed opinion]*, it is not just the issue of ensuring fairness to a registrant that Council has determined to hold investigations in abeyance or deferred*

taking disciplinary action. There are other issues which also must be taken into account. These, as noted above, include the advantage of a criminal conviction in securing proof of the conduct in the disciplinary proceedings, as well as the likelihood the Nursing Tribunal would grant an adjournment to a respondent pending finalisation of any criminal action.

There will be cases where it would be entirely inappropriate for Council to investigate a complaint or prefer a charge when criminal charges are still pending. For example in Hewitt v Medical Board of Western Australia [2004] WASCA 170, the Western Australian Supreme Court had to determine whether the Medical Board had delayed in taking disciplinary action against a doctor alleging sexual intercourse and other exploitive behaviour when criminal charges were pending. Miller J., in dismissing any suggestion of unwarranted delay by the Board, said:

> *"Clearly, resolution of all criminal proceedings was required before any disciplinary proceedings could be contemplated."*

There are, therefore, a number of factors that are relevant for Council in determining whether to defer an investigation or disciplinary charge pending other legal proceedings. Only one of those factors is potential prejudice to a registrant. The [proposed opinion] *is too simplistic and does not reflect the myriad of competing rights, obligations and duties that Council must consider where parallel legal proceedings are on foot.*

[Proposed recommendation C.1] *is unnecessary as Council has always treated each case on its own circumstances.*

The legislative amendments you propose in [proposed recommendation C.2] *to prevent the use of admissions made in disciplinary proceedings from use in other legal proceedings is superficially attractive. However, this change would not overcome a number of other factors requiring resolution of criminal charges as a priority, such as the potential prejudice to police investigations. This issue requires more detailed analysis, such as whether the amendment proposed may affect later perjury charges arising from a disciplinary hearing.*

In summary, there is no justification for [proposed opinion B or proposed recommendation C.1]. *The legislative amendment proposed in* [proposed recommendation C.2] *does not address all relevant factors Council must consider in determining whether to defer disciplinary action. Such an amendment has potentially significant implications in the administration of justice and requires wider consultation.*

Comment

Elise Neville passed away in January 2002. Therefore, the provisions of the *Coroners Act 2003* would not apply to any inquest that might now be convened and the applicable legislation is the *Coroners Act 1958*. I therefore agree that the entitlement to claim privilege contained in the 1958 Act would be available to any person who might give evidence before an inquest.

I agree with much of the QNC"s response insofar as it sets out the principles governing the conduct of disciplinary proceedings in circumstances where other legal proceedings have been or may be instituted. However, I disagree with the QNC"s application of those principles to the circumstances of the complaint against RN 1. That is, I disagree with the QNC on what constitute "valid reasons" for deferring action.

The objective[144] of the Nursing Act is "to make provision for ensuring safe and competent nursing practice". That objective was not met in the circumstances of RN 1's case because approximately three and half years passed before the QNC obtained an appropriate undertaking from RN 1. Some of the delay was caused by the QNC's decision that it should not commence disciplinary proceedings until the coronial inquiry had been completed. However, as mentioned at section 1.14 of my report, the QNC's approach resulted in the unsatisfactory situation where both the QNC and the Coroner were awaiting the outcome of the other body's inquiry before finalising their own inquiry.

After considering the QNC's response, I have formed the following opinion:

Opinion 13

In the circumstances, there was no justification for the QNC to delay its determination of whether or not disciplinary action should be taken against RN 1 out of concern for prejudicing her in respect of other legal proceedings or possible legal proceedings. Such delay was unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.

After considering the QNC's submissions on my proposed recommendation C.1, I remain concerned about the QNC's approach to this issue and make the following recommendation:

Recommendation 17

QNC cease its practice of delaying consideration of disciplinary action pending the completion of criminal or other proceedings unless, in the circumstances of a particular case, it has obtained legal advice that there are valid reasons for doing so.

I accept that a relevant consideration in making such a decision would be that, in a particular case, the QNC is able to take interim action in order to protect the public, for example, by imposing a suspension or limited registration.

In respect of my proposed recommendation C.2, after considering the QNC's submission, I have decided to direct this recommendation to QH because of its relevance to other health practitioner registration boards. I therefore make the following recommendations.

[144] Section 3 of the Nursing Act.

Recommendation 18

QH seek legal advice on the circumstances in which it is appropriate for a health practitioner registration board or the QNC to delay consideration of disciplinary action pending the completion of criminal or other proceedings.

Recommendation 19

QH provide me with a copy of that advice.

Recommendation 20

If the advice supports the position that disciplinary proceedings should be suspended wherever a registrant the subject of a disciplinary investigation has or may be charged with a criminal offence, QH should seek legislative amendments to:

- **abrogate the privilege against self-incrimination in disciplinary proceedings before those bodies and their related tribunals, and**
- **protect admissions made in any such proceedings from being used in other legal proceedings.**

8 The health complaints system in Queensland

One of the most significant issues raised by the Nevilles‟ complaint to my Office was their allegation that:

> *The current health complaints system in Queensland is inadequate and inaccessible to the majority of complainants.*

On the basis of the information obtained during my preliminary inquiry, this aspect of the complaint became the primary focus of my investigation.

8.1 Issues raised by the Nevilles' complaint concerning the adequacy of the current health complaints system

8.1.1 Fragmented health complaints system

The most concerning aspect of the Nevilles‟ complaint was the inability of the current health complaints system to provide for one investigation that could cover all aspects of the complaint. The Nevilles saw their complaint as being essentially about one incident. I agree. However, the current health complaints system dictated that their complaint had to be split, and different aspects of it referred to different agencies for action.

In the last three years, there have been six separate inquiries (not including my inquiry) into aspects of the adverse incident involving Elise Neville (that is, by the State Coroner, the HRC, the MBQ, the QNC and QH, and by the CMC concerning the allegations of official misconduct against two QH officers. Putting aside the involvement of the State Coroner and the CMC, the fact that this complaint necessitated investigations by the HRC, the MBQ and the QNC (as well as the external investigation commissioned by QH as the health service provider), is indicative of an inefficient, dysfunctional and compartmentalised health complaints system.

As a result, there were:

- four separate investigations by four different health related agencies, all acting under different legislation and with different internal policies and procedures;
- four different investigation reports delivered at different times and with different outcomes;
- considerable delays brought about by the numerous consultation processes during the assessment and investigation processes.

From the complainants‟ perspective, this is far from an optimal complaint process.

In the HRC‟s Annual Report for 2003-2004, the Health Rights Commissioner commented on the obvious frustration for all parties involved with the Nevilles‟ complaint in having to deal with a number of inquiries into the one incident with separate findings delivered at different stages. In his opinion, an optimal complaint handling process would involve:

- a single report covering all of the issues which in turn would have provided a more complete picture of events; and
- centralised complaint handling and information gathering processes, at least in the initial stages of dealing with a complaint.

A complaint handling process based on these principles will not only provide for a more timely and cost effective process, but also reduce the possibility of duplication of investigations, and uncertainty about who has jurisdiction to investigate what.

8.1.2 Lengthy process

Given the serious nature of the allegations raised by the Nevilles‟ complaint and the possibility of an ongoing risk to public safety, they expected, not unreasonably, that their complaints would be dealt with in a timely manner.

The following table summarises the health complaints process applicable to the Nevilles‟ complaint:

Process	Legislative basis	HRC	MBQ	QNC
Receipt of complaint by agencies	s.67 HRCA	28/3/02	10/4/02	11/4/02
1st consultation with HRC			17/04/02	1/5/02
HRC receives more specific complaints about the two nurses and Caloundra Hospital		2/5/02		
HRC accepts for assessment all complaints & seeks submissions from providers	s.69 HRCA	10/05/02		
HRC forwards copy of complaints about registrants	s.69 HRCA		10/5/02	10/0502
HRC consults with MBQ & QNC before making decision about what further action is to be taken	s.71 HRCA		7/8/02	7/8/02
Assessment by HRC completed and complaints referred to MBQ & QNC for further action	s.71 HRCA	7/8/02	7/8/02	7/8/02
Assessment period by HRC	s.76 HRCA	10/05/02 to 7/08/02 (89 days)		
QNC accepts for investigation complaint against RN 1				21/8/02
QNC appoints an investigator to commence investigation of RN 1				6/9/02
HRC commences its investigation in relation to CH, SCHSD, the Executive Director and other systemic issues	s.95 HRCA	24/9/02		
MBQ appoints an officer of the OHPRB as investigator to investigate complaint about the medical officer	s.73 HPPSA		27/8/02	
MBQ appoints an external consultant to take over investigation of the medical officer	S.73 HPPSA		24/6/03	
HRC completes its investigation of CH & SCHSD and issues first report (complaint about the Executive Director dropped due to lack of jurisdiction)	s.125 HRCA	4/9/03 (investigation takes approx 11 months)		
QNC completes investigation of RN 1 and produces its report				27/11/03 (investigation takes 14 months)
External consultant completes investigation on behalf of MBQ and report issued			2/1/04 (investigation takes approx 17 months)	
QNC appoints an investigator to commence investigation of the Nevilles‟ complaint against RN 2				19/3/04
HRC conducts a review of its investigation and issues a 2nd report		28/6/2004 (review takes 9 months)		
QNC completes its investigation of RN 2 and issues a report				16/7/2004 (4 months to complete investigation)

The explanations offered by each health complaint agency for the lengthy delays have been canvassed in earlier chapters of this report.

8.1.3 Delays in the MBQ and QNC finalising disciplinary processes

It must be remembered that the Nevilles‟ complaint raised serious allegations concerning the conduct and competence of medical and nursing staff employed in an ED of a regional public hospital, and systemic issues impacting on the quality of service provided by the hospital. Accordingly, it is necessary to consider whether the interests of the public were adequately protected during the time that investigations by the MBQ and the QNC were continuing.

As mentioned earlier, it took in excess of two and a half years before any disciplinary action was taken against the doctor who treated Elise. This is of particular concern given that the Health Practitioners Tribunal ultimately decided that specific conditions should be imposed on the doctor‟s registration.

The QNC took the same amount of time to reach a determination that some form of disciplinary action was warranted against one of the nurses investigated (RN 1). Furthermore, although a limitation was subsequently placed on the nurse‟s licence to practise as a registered nurse in December 2005, it may be some time before the undertaking provided by the nurse to complete relevant courses is actually satisfied.

While I acknowledge that some disciplinary investigations and disciplinary processes can be complex, and legal requirements to accord procedural fairness can add to delays, the primary object of protecting the public from incompetent, careless or otherwise unsatisfactory conduct by registered health practitioners is frustrated by any undue delays in investigating such conduct and taking appropriate protective action. The interests of the health practitioners/registrants complained about were also adversely affected by the extensive delays in dealing with the Nevilles‟ complaints.

8.2 Submission to the Bundaberg Hospital Commission of Inquiry

With all the media attention that has surrounded the two Commissions of Inquiry into the Bundaberg Hospital and other Queensland public hospitals (BHCI and QPHCI) and the Queensland Health Systems Review (QHSR), it is now common knowledge that implementation of QH‟s internal complaints management was haphazard and the system as a whole provided inadequate protection for complainants.

Based on my review of QH‟s internal complaints management process in response to the Nevilles‟ complaint and my Office‟s research of complaints management by other jurisdictions both nationally and internationally, I provided a detailed submission to the former BHCI in August 2005[145], the primary purpose of which was to:

- provide an overview of the current health complaints system in Queensland;
- identify deficiencies in the system;
- review health complaints systems in other jurisdictions; and
- make proposals for an enhanced system in Queensland.

[145] A copy of the relevant part of my submission (Part 2: Issues relating to health complaints systems) appears at Appendix 1.

The submission contained details of my investigation of the Nevilles‟ complaint to help highlight the deficiencies of the current external health complaints system in Queensland. The submission also included proposals for a reformed health complaints system.

My submission was received by the BHCI one week before it ceased operations. I also forwarded a copy to the QHSR headed by Mr Peter Forster, and to the BHCI‟s successor, the QPHCI.

My staff had discussions with Mr Forster‟s staff about the framework for an appropriate health complaints system for QH. This was followed up by a letter to Mr Forster highlighting some concerns I had about his intended proposals for QH‟s internal complaints management. A copy of that letter can be found at Appendix 3 to this report.

As I mentioned in my last annual report, I do not believe that Mr Forster‟s review gave my proposal for an external health complaints system appropriate consideration. His report merely contained the recommendation that a "separate and short review be conducted of the legislation and working arrangements existing between external complaints bodies", including my Office.

Mr Forster recommended the establishment of a new Independent Health Commission that would absorb the existing functions of the HRC, and have numerous additional functions. In accordance with that recommendation, the government has announced that the Health Quality and Complaints Commission will commence on 1 July 2006.

The proposals in my submission to the former BHCI[146] are readily adaptable to the relevant unit or division of the new Commission that takes over the functions currently performed by the HRC.

Some of the key proposals in my submission for a new external health complaints system were:

- That the new Commission should provide complainants with a "one stop shop". It would have jurisdiction to deal with all aspects of complaints in relation to both registered and non-registered providers of health services in both public and private sectors, with powers to assess complaints, attempt informal resolution or formal conciliation, investigate more serious complaints (using coercive powers if necessary), and recommend disciplinary action. The MBQ, QNC and other registration boards would no longer conduct investigations of complaints about their own registrants, except by arrangement with the Commission[147].

- Generally, before the Commission would accept a complaint, the complainant would be required to demonstrate that there had been attempts to resolve the matter with the relevant health service provider. However, there should be exceptions to this, for example where there was an immediate risk to the health and safety of any person, or where a complaint was made by a staff member of the relevant health service provider who was fearful of reprisal[148].

[146] Appendix 1.
[147] Page 74 of the Ombudsman‟s submission to the Bundaberg Hospital Commission of Inquiry (BHCI) dated August 2005.
[148] Page 77 of the Ombudsman‟s submission to the Bundaberg Hospital Commission of Inquiry (BHCI) dated August 2005.

- The Commission should be able to initiate disciplinary proceedings and order simple remedies[149].

In his report on the QPHCI, Commissioner Davies QC broadly endorsed my proposals for a reformed external health complaints system. In particular, he observed that there were obvious advantages in having one independent body which could act upon complaints from patients and health practitioners or on its own initiative, with powers to assess and to investigate doctors, nurses, allied health professionals, public and private hospitals, and which had the power to conciliate but also to adjudicate, discipline and suspend in cases where there existed a real risk to patients[150].

In my submission to the former BHCI, I identified a number of weaknesses in the current jurisdiction and powers of the HRC[151]. The Health Rights Commissioner also identified a number of these weaknesses as key legislative and policy issues. In his 2004-2005 Annual Report[152], he sought the following jurisdictional reforms:

- Apart from reinstating the HRC‟s powers to investigate individual registrants, consideration should be given to empowering the HRC to compel providers to respond to complaints and supply relevant information at the initial assessment stage.

- The HRC be empowered (like its counterparts in all other States and Territories) to conduct an investigation of all the issues raised in a complaint, consulting with other bodies where appropriate.

- The HRC be vested with the power to investigate issues (that warrant investigation in the public interest but where an actual complaint is not received) of its own motion or initiative, as is the case with NZ‟s Health and Disability Commissioner.

I support the Commissioner‟s suggestions.

I note that the Health Quality and Complaints Commission Bill 2006 incorporates several of the proposals contained in my submission to the BCHI and endorsed by Commissioner Davies in his report; for example, the “one stop shop” for health service complaints, own motion investigations and the power to obtain information from providers.

However, the Bill does not incorporate the following proposals:

- Following the initial intake of a complaint, the new Health Quality and Complaints Commission should, in all appropriate cases, attempt early informal resolution of the complaint (that is, without detailed assessment or investigation), before a matter is assessed as to whether it is suitable for conciliation or should be referred for investigation.
- My proposals in relation to a new disciplinary regime for registrants[153].

In my proposed report, I made the following recommendation:

[149] Page 75 of the Ombudsman‟s submission to the Bundaberg Hospital Commission of Inquiry (BHCI) dated August 2005.
[150] Paragraph 6.480 at page 465 of the Queensland Public Hospitals Commission of Inquiry (QPHCI) report.
[151] Section 3.4.3 of the Ombudsman‟s submission to the Bundaberg Hospital Commission of Inquiry (BHCI).
[152] Pages 5 and 6 of the Health Rights Commission‟s 2004-2005 Annual Report.
[153] Proposals 5.4.14-5.4.18 contained in Appendix 1.

Proposed recommendation D

The Director-General of Queensland Health take steps to ensure that my recommendations contained in Appendix 1 (and specified above) are given proper consideration by any person or body responsible for developing the proposals for the new Health Quality and Complaints Commission.

QH, QNC and MBQ all responded to that proposed recommendation as follows:

QH response to proposed recommendation D (Letter dated 16 May 2006)

Recommendation D has been implemented.

The development of proposals for the new Health Quality and Complaints Commission has been led by Dr John Youngman, the Independent Advisor to the Minister for Health on the implementation of the commission. Dr John Youngman has met with you to discuss your recommendations for the new Health Quality and Complaints Commission and reported the outcomes of his discussions with you to the Inter Departmental Committee established to coordinate the establishment of the commission.

QNC response to proposed recommendation D (Letter dated 10 May 2006)

Recommendation D is opposed by the QNC as the report is based on a number of misconceptions. Parliament should debate the Health Quality and Complaints Commission Bill 2006 without any further consideration at committee level.

The QNC provided the following comments in support of its response to recommendation D:

> *Council considers that many of your proposed recommendations have the potential to seriously detract from the current level of public health and safety afforded by Council and the other health practitioner boards. In particular:*
>
> - *The health complaints scheme proposed does not focus sufficiently on wider public health and safety issues. These wider issues are currently mandated to Council and the other boards. By reducing the role of Council and the Boards in the regulation of the professions will weaken the structure currently in place.*
> - *It is a retrograde step to appoint a single inspector to deal with a complaint against a number of different registrants where different professional standards will apply. A strength of the investigation processes of Council is that nurses, who have intimate knowledge of clinical practice and professional standards, conduct the investigations. Council does accept that an overarching body should be empowered to coordinate and oversee investigations but there should be a consultative process so that complaints can be „split" for investigation as was the previous system. There is minimal duplication in splitting complaints given that the focus of each investigation will be entirely different. This enables Council's specialist investigators to inquire into the conduct of nurses.*
> - *Council's processes are continually being improved. In 2005 calendar year Council issued 17 notices of charge. The average time lapse for these matters between*

Council"s receipt of the complaint or knowledge enabling Council to inform itself of the relevant professional standards issue (such as a breach of an undertaking) and the issuing of the notice of charge was less than 14 months. Of those 17 matters, 11 are finalised (that is the Nursing Tribunal has heard the charge and made orders), 2 matters have been heard and are awaiting the Tribunal"s decision and the remaining 4 matters are set down for hearing in the week commencing 29 May 2006.

- *It is dangerous for a single body to be empowered to prosecute health practitioners and also to conciliate complaints against them. This dual role has significant potential to concentrate on the resolution of complaints to the satisfaction of the individual complainant at the expense of the broader, and often more important, public health and safety issues. Paragraphs 5.4.12 and 5.4.14 of the report seem to go so far as to suggest that a complaint, even if serious, will be resolved upon successful conciliation with apparent disregard of the public interest. Council contends that a system of professional regulation and complaints resolution where an independent commission (such as the presently constituted Health Rights Commission) conciliates complaints in the interest of the individual complainant and Council and the other boards act as the regulators of professional standards in the wider public interest, is the clearly desirable model.*
- *The reduced role of Council and the other boards suggested in paragraph 5.6.6 is unworkable in practice. The residual roles proposed for Council cannot, in practice, be neatly and conveniently separated from its disciplinary functions which deal with complaints about nurses" conduct, health and competence. Council is in a far better position to determine how to handle these complaints given its roles in determining the scope of nursing practice in Queensland, accreditation of nursing courses in Queensland and recognition of overseas nursing qualifications. Further the report does not address how Council"s current role in exercising the powers under section 65 to 68 is to be addressed. These powers are often exercised at short notice in conjunction with complaints and require a specialist authority like Council to be the caretaker of those powers. The report also fails to recognise that the management of impaired practitioners not infrequently requires disciplinary action.*
- *Further to the preceding paragraph, it follows that Council remains in the best position to determine what matters should be prosecuted and to act as the prosecuting authority. As a specialist authority with intimate knowledge of the nursing profession, Council should continue in its role as prosecutor.*
- *The proposed abolition of the Nursing Tribunal is ill advised as the Tribunal is a highly specialised body which is able to deal with charges expeditiously as the statistics for charges issued in 2005 demonstrate.*
- *The referral of disciplinary charges against nurses to the Health Practitioner Tribunal is undesirable as that tribunal is not able to handle charges as expeditiously as the Nursing Tribunal. This is not a criticism of the HPT but recognition of the effectiveness of the Nursing Tribunal which only deals with nurses and is entirely funded by Council.*

It must be recognised that the Neville complaint is not representative of many complaints Council regularly deals with. In particular:

- *The investigation of RN 1 was one of the longest in Council"s 13 year history;*
- *It is rare in Council"s experience for a complaint to be made against a nurse and another health practitioner registered under another Act;*
- *A very significant number of complaints are not made by health service users.*

MBQ response to chapter 8

(Response supplied by solicitors acting for the MBQ in a letter dated 4 May 2006.)

Systemic Issues

The Board accepts that your governing statute confers upon you a function of reporting upon systemic issues that an individual complaint made to your office may disclose.

In a sense, in this case, events have overtaken matters since the lodgement of the Neville complaint in relation to systemic issues concerning the handling of health complaints. The resources available to the Board, backlogs, turnaround times and complainant liaison procedures are now quite different to when the Neville complaint was lodged both with the Board and with your office. More particularly and importantly, two recent and comprehensive commission of inquiry reports have recently been delivered to the State Government which touch upon the health complaints system in our State[3]. The Board made comprehensive submissions to these public inquiries. These are incorporated by reference and not further repeated here. The State Government has signified a disposition to act upon recommendations made by these inquiries. The Board supports the State Government in that endeavour. It seems, with respect, that you remain unrepentant about submissions that you made to one such inquiry that the inquiry chose not to act upon, as it was entitled to do.

The Board accepts, of course, that a virtue of the ombudsman system is to draw attention to ways of improving the quality of public administration in our State both in individual cases and systemically. However, given that the reports of the commissions of inquiry are so recent, the Board respectfully suggests that there is now greater utility in your deferring reporting upon systemic issues until such time as experience has been gained in the operation of the measures recommended by these commissions of inquiry. You have the Board‟s assurance that it will co-operate in any future such inquiry by your office.

3. Queensland Public Hospitals Commission of Inquiry (Davies Report), November 2005, esp. at p.462, paragraph 6.474 et seq; and Queensland Health Systems Review Final Report, September 2005 (Forster Report), pp.190 et seq.

Comment

QH has advised that proposed recommendation D has been implemented. This was on the basis that I had met with Dr John Youngman, the independent advisor to the Minister for Health on the implementation of the new Health Quality and Complaints Commission for the purpose of providing him with a copy of my proposed report and to discuss the draft legislation for the proposed commission. Accordingly, I have chosen not to respond in any great detail to the concerns raised by the MBQ and QNC on the basis that they were also consulted during the process of the establishment of the Health Quality and Complaints Commission and the new legislation. However, some of the concerns raised do warrant some additional comment.

In relation to my proposal for a reformed external health complaints system, the MBQ has suggested that I should defer reporting upon systemic issues concerning the handling of complaints in light of the two recent reports of the QHSR and the QPHCI (Davies report).

I am unable to agree with this suggestion. The QHSR report focused on internal complaints management by QH, as opposed to the broader external health complaints system. The broader health complaints system was considered to a limited extent by the QPHCI. Commissioner Davies stated in his report that he did not consider that the evidence and submissions he received during the limited time accorded to his inquiry, enabled him to be in a position to recommend in any detailed way the indicia of a better system. However he broadly endorsed my proposals for a reformed external health complaints system [154]. In particular, Commissioner Davies stated:

> "*There were obvious advantages in having one independent body which could act upon complaints from patients and health practitioners or on its own initiative with the power to assess and to investigate doctors, nurses, allied health professionals, private hospitals and public hospitals and which had the power to conciliate but also adjudicate, discipline and suspend in cases where there exists a real risk to patients."*

I am pleased to note that a number of my recommendations contained in my submission to the two commissions of inquiry have already been incorporated into the Health Quality and Complaints Commission Bill 2006. I have been advised that the limited timeframe provided to draft this legislation did not provide adequate opportunity to consider broader aspects of the external health complaints system, in particular the current disciplinary processes. However, it is understood that further consideration will be given to these aspects in the future. In the meantime, having regard to the deficiencies in the current system as exposed by my investigation into the Neville complaint, it is my responsibility to report on these systemic issues without further delay.

The QNC considered that an external health complaints system, that involved the appointment of a single investigator to deal with a complaint against a number of different registrants to whom different professional standards apply, would be a retrograde step. With respect, this is a misconception of my proposal.

As outlined in Appendix 1, my proposal is that the Commissioner have a broad discretion in determining the best investigative approach. For example, where the Commissioner receives a complaint about a number of different registrants, the Commissioner may:

- split the complaint and refer an aspect of a complaint about a registrant to the relevant registration body (for example, MBQ/QNC) for investigation or other action, while maintaining the authority to coordinate and oversee the investigation/action; and or
- retain the complaint for investigation with the option of appointing a number of investigators (team approach) drawing on a suggested mix of skills and qualifications, as opposed to one investigator having carriage of the whole complaint.

In response to my proposal to refer the disciplinary process for health practitioners, the QNC considered that, in respect of nurses, it remains in the best position to determine what matters should be prosecuted and to act as the prosecuting authority. As outlined in Appendix 1, my proposal involves the registration bodies retaining a role in the disciplinary process, although to a lesser extent. In particular, under the scheme I proposed:

- before making a decision to refer a matter for disciplinary action, the Commissioner would have access to advice from a panel of experts (including clinical advice) and to a review of the evidence undertaken by an independent lawyer.

[154] QPHCI (Davies report), November 2005, esp. at p.464 & 465, paragraphs 6.479-6.480.

- the Health Practitioners Tribunal and the new Disciplinary Committee I recommended would each include a representative of the relevant registration body.

Accordingly, I consider that the disciplinary regime I propose appropriately recognises and incorporates the expertise that can be added to the disciplinary process by involving the Boards/QNC.

Having considered the submissions of QH, QNC and MBQ and taking into account the imminent commencement of the Health Quality and Complaints Commission, I acknowledge that a review of the broader health complaints system is not practicable before the Commission commences.

However, I maintain my view that the disciplinary system for health practitioners should be reviewed in accordance with my recommendations in Appendix 1, which were broadly endorsed by Commissioner Davies.

Therefore, I make the following recommendation:

Recommendation 21

The Director-General of Queensland Health cause a review to be undertaken of the disciplinary regime for health practitioners, taking into account the recommendations I made about this issue in my submission to the BHCI and the QPHCI (see Appendix 1).

9 Bunk beds

Bunk beds have become a very common piece of children‟s furniture, not only in the home environment but also in the likes of holiday rental accommodation and school camps. However, bunk beds have been identified as a significant cause of serious injury in the home, especially to young children. Whether complying with safety requirements or not, bunk beds are inherently dangerous (and more so for children) because of their height.

Elise Neville‟s death from injuries sustained in a fall from a top bunk (while sleeping) is, to my knowledge, the only reported death of this kind in Australia. There have been two other reported deaths from injuries other than from falling, one a three-year-old girl in 1989, and another three-year-old child in 1998[155].

Nevertheless, the actual number of injuries occurring to children from the use of bunk beds is alarming. In February 2004, Choice magazine reported that each year about 4,000 Australian children need medical care because of bunk bed related injuries. About 400 of them require hospital treatment, mostly for broken bones and concussion.

The causes of major injury associated with bunk beds is falling from the top bunk, head and limb entrapment, and hanging by protrusions in the vicinity of the top bunk. The reported bunk bed falls and entrapments are related to the height of the upper bunk from the floor, the lack of guard rails or the design of the guard rails. Children aged less than four years (who are not the intended occupants of a top bunk) are most at risk of head entrapment resulting from asphyxiation by hanging[156]. These factors are not a serious risk for older children (15 years plus) and adults using the product. Accordingly, a bunk bed is not necessarily unsafe if used appropriately by older children or adults, and for this reason, it is considered that the product would not meet the criteria for a product ban or recall under the provisions of the Trade Practices Act[157].

The precise number of bunk beds supplied in the Australian market is not known. However, one industry estimate put the annual supply total in 2001 at 60,000 for domestic use and 10,000 for commercial use.

9.1 OFT's response to the Nevilles' complaint

The Nevilles wrote to the then Minister for Fair Trading, the Honourable Merri Rose (the Minister) on 11 April 2002, informing her of Elise‟s death following a fall from a bunk bed, and seeking advice as to any current Queensland legislation dealing with guard rails for bunk beds, or any other aspects relating to the safety of bunk beds generally.

On 9 May 2002, the Minister responded to the Nevilles‟ letter, informing them of the following:

- According to data from the Queensland Injury Surveillance Unit (QISU), bunk beds were associated with at least 450 injuries and accounted for 6% of furniture related injuries in Queensland in the period 1998-2001;

[155] Both these children died as a result of being trapped by the head.

[156] Bunk Bed Injuries in Australia - the case for a mandatory safety standard" (1998) by Wendy Watson, Joan Ozanne-Smith, Stephen Begg and Voula Stathakis, Monash University Accident Research Centre, Melbourne, Victoria.

[157] Regulatory Impact Statement on Bunk Bed Safety Requirements prepared by the Consumer Affairs Division, Department of the Treasury (Cwth) July 2001.

- Australian Standard AS/NZS 4220 covering bunk beds was introduced in August 1994; however, the standard was not mandatory;
- The lack of compliance with this standard by industry had been a growing concern and had been on the agenda of the Ministerial Council for Consumer Affairs (MCCA) for some time;
- The MCCA had agreed to introduce mandatory national safety requirements for bunk beds on 1 May 2002; however, due to a number of procedural difficulties, the date had been extended to 1 November 2002. This national safety regulation would be administered by the Commonwealth Government and enforced by the Australian Competition and Consumer Commission (ACCC);
- The Minister intended introducing corresponding mandatory safety requirements for bunk beds by way of an amendment to the Queensland *Fair Trading Regulations 2001* on 1 November 2002. Several other States also intended to introduce complementary legislation in order to harmonise mandatory safety standards across the country.
- One of the key features of the proposed mandatory safety requirements would be a requirement that guard rails be affixed on all four sides of the upper bunk bed so that the risk of falling from the upper bunk would be minimised.

Following receipt of the Minister‟s letter, the Nevilles made further inquiries with the Product Safety Branch of OFT to determine the likely extent of application of the new mandatory standard. They were advised that the proposed standard would have limited application, in that it was expected to apply only to bunk beds **sold on or after 1 November 2002**. In other words, the new standard would not cover bunk beds installed in domestic and commercial premises prior to 1 November 2002. Thus, for example, the owner of holiday rental accommodation would not be legally obliged to take any steps to ensure that existing bunk beds complied with the new standard. The same situation would apply for school camp and backpacker accommodation, hostels, correctional facilities, and the like.

The Nevilles wrote to the Minister again on 26 September 2002 outlining their concerns in relation to deficiencies they perceived with the proposed standard. The Minister responded by advising that the OFT was exploring the possibility of introducing further legislation to require all bunk beds in commercial use to comply with the new standard. The Minister also advised that she had requested a review of the OFT‟s policy position on bunk beds to enable her to reassess its appropriateness. She did observe, however, that it was simply not feasible to legislate against all hazards and that, inevitably, decisions in relation to product safety must be determined on the basis of risk versus cost and practicability. Having said that, the Minister indicated that she would also continue to alert consumers and the industry to the dangers of bunk beds in an attempt to ensure they are aware of the risks and how to prevent injuries to children.

Some 12 months later, the Nevilles wrote to the Minister seeking advice as to the outcome of her review of OFT‟s policy position on bunk beds.

The Minister‟s response dated 7 November 2003 can be summarised as follows:

- In order to provide the Nevilles with the most informative response, the Minister had awaited the outcome of the review of the bunk bed standard (which was completed in September 2003) before providing them with an update. The updated standard now provided for a warning that children under the age of nine should not use an upper bunk, and that this warning should be visible on all bunk beds. The amendment to the age from six years to nine years had been made based on injury data which showed

that injuries associated with bunk beds substantially reduced after a child reached the age of nine years.

- The Minister agreed that bunk beds, without appropriate safety features, are an unsafe option, hence the reasoning behind the introduction of the mandatory standard and the information provided in OFT‟s publications.
- As to how best to minimise the risks associated with bunk beds in commercial premises, that issue was still being examined by the OFT, with discussions taking place with the Department of Industrial Relations in regard to the possible application of Workplace Health and Safety legislation to the issue.
- Similarly, industry and consumer education would continue to be pursued. Anecdotal evidence suggested this approach was having a positive effect in the marketplace.
- In addition to those measures, contact had been made in October 2002 with the Unit Owners‟ Association of Queensland and the Queensland Resident Accommodation Managers‟ Association, informing them of the new standard and recommending that information be conveyed to their members. Correspondence was also forwarded to the Real Estate Institute of Queensland (REIQ) in an effort to circulate the information to its industry members.

The Nevilles also wrote to Standards Australia[158] about their concern in relation to the newly revised standard requiring labelling on bunk beds stating that top bunks are very dangerous for children under the age of nine years. Given Elise was aged ten years and three months when she fell from the top bunk suffering fatal injuries, the Nevilles felt that this message wrongly reassured parents that it was safe for children over nine years of age to use a top bunk.

Standards Australia informed the Nevilles that their comments would be considered when the standard was next revised[159].

9.2 Introduction of Australian Safety Standard 4220:1994

The death of a three year old girl in 1989 by entrapment/asphyxiation resulting from the use of a bunk bed prompted the South Australian Health Commission to conduct research into the dangers of bunk beds. That work, together with increased concern among health professionals over the number and severity of bunk bed related injuries, led to the introduction of Australian Safety Standard 4220:1994.

The standard (which was non-binding) specified safety requirements for bunk beds in terms of material, construction, design and performance specifications.

The general response by commercial manufacturers to the introduction of a voluntary standard was that, while a number of manufacturers made a safer bunk bed, most continued to produce an unsafe product.

In 1998, the Monash University Accident Research Centre (MUARC) in Melbourne undertook a study to establish an evidence base for a proposed injury reduction program, and to determine whether or not there was a case for a mandatory safety standard. It was clear from its study that bunk beds present a potentially life-threatening hazard to children. It was also clear that, in Australia, the voluntary standard and the market place had been

[158] Standards Australia is recognised through a Memorandum of Understanding with the Commonwealth Government as the peak non-government standards development body in Australia.

[159] Due 2007.

ineffective in achieving compliance since publication of the Standard in 1994. The following recommendations were made to increase the safety of bunk beds:

- the current revision of the Australian Standard AS/NZS 4220:1994 Bunk Beds should be made mandatory;
- non-compliant bunk beds should be recalled to reduce the number of hazardous bunks in the community;
- there should be monitoring of injury rates in the 5-9 year age-group caused by falls while sleeping in the upper bunk particularly in relation to the presence or absence of Standard-compliant guard rails;
- there should be an extensive and ongoing education program to warn parents and care-givers of the inherent dangers of bunk beds and to encourage appropriate use.

9.3 Injury statistics : case for reform

In 1998 it was estimated that, in Australia, in the under 15 age-group, there were at least 2,100 bunk bed related injuries treated annually by hospital EDs. Of these, 390 cases resulted in hospital admission, mostly for fractures and concussion. The majority of those injuries (86%) occurred in children under the age of 10 years with injuries peaking in the 5-9 age-group. The main cause of non-fatal injury was falls from the top bunk resulting in a fracture (33%), mainly to the upper extremity (75%)[160].

The study undertaken by MUARC considered Victorian injury data[161] to determine the most common causes of falls from bunk beds. The most common activity associated with a fall was playing (32% of falls). Over half of those falls occurred in the under five age-group (55%), with about 40% in the 5-9 age-group and only 4% in the 10-14 age group. After playing, sleeping was the next most common activity associated with falls. The majority of injuries (64%) occurred in the 5-9 age-group, 19% in the 10-14 age-group and the remainder (17%) in the under fives. The study concluded that a high proportion of 5-9 year olds falling from bunk beds while sleeping suggested that children of this age may not be developmentally ready to sleep in a top bunk[162].

Injury statistics gathered by the Queensland Injury Surveillance Unit (QISU) were consistent with findings of the Victorian study. For the period 1998 to 2002, there were 652 presentations of children under the age of 15 for bunk bed related injuries, as recorded by participating EDs in Queensland[163].

QISU advised that, amongst the bunk bed injuries:

- 90% involved falls;
- 51% involved children aged 5-9 years, 39% were under 5 years of age;
- the most frequent injury was a fracture (33%) followed by intracranial injury (20%), open wound (18%), superficial injury (11%) and sprain or strain (10%);
- the head or face was the most frequently injured body part (45%) followed by lower arm (30%);

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160 Bunk Bed Injuries in Australia - the case for a mandatory safety standard by Wendy Watson et al (1998), at page 1.

161 Data was collected by the Victorian Injury Surveillance System.

162 Watson op. cit. at pp.91-92.

163 This data was based on ED presentations to the following hospitals: Mater Children‟s Hospital, Mater Adult Hospital, Mater Private Emergency Care Centre, Queen Elizabeth II Jubilee Hospital, Redland Hospital, Logan Hospital, Royal Children‟s Hospital, Mt Isa Hospital and Mackay and District Hospital.

- 32% were described as "playing" when the injury occurred and 43% resting or sleeping;
- 58% occurred between 7.00pm and 7.00am;
- bunk beds in private homes accounted for 96% of injuries and only 8 cases (1%) occurred at holiday accommodation;
- 22% resulted in admission to hospital and 38% had a triage category of urgent or greater.

The Victorian Injury Surveillance Unit (VISU) also provided statistics on bunk bed related injuries. Their data was based on injury presentations to 28 Victorian EDs (representing approximately 80% of Victorian EDs) for the period 1996-2003. The statistics can be summarised as follows:

Age group	Number of presentations	Percentage
0-4	595	35.8%
5-9	710	42.8%
10-14	231	13.9%

Yearly injury statistics broken down:

Year	Injuries
1999	196
2000	191
2001	188
2002	211
2003	238

The South Australian Injury Surveillance System (SAISS) is a large database of injury surveillance records that are collected from the EDs of just two public hospitals within the Adelaide metropolitan area. It produced a report in 2003 describing bunk bed injuries between January 1986 and July 2003. The report recorded that:

- there had been 759 injuries in the reporting period;
- although there had been a slight drop in bunk bed injuries since 2001, generally the number of bunk bed injuries had been steadily increasing since 1990;
- injuries from bunk beds occurred predominantly to children, with 97.5% of all injuries occurring to children aged 16 years and under;
- 75% of all bunk bed injuries occurred to children under 9 years of age, with 25.3% of all bunk bed injuries occurring to children aged under four years;
- most bunk bed injuries occurred domestically in the injured person"s home (82.2%);
- another location for bunk bed injuries was holiday accommodation (7.3%);
- 49.7% of bunk bed injuries occurred when the injured person was playing or undertaking a recreational activity;
- 39.1% of injuries occurred when the injured person was sleeping in the bunk bed;
- 22.5% of bunk bed injuries presenting to the hospitals for treatment were admitted.

9.4 Introduction of a mandatory standard for bunk beds

A standard can be made mandatory by either a consumer protection notice published in the Commonwealth Gazette or by a Trade Practices regulation. In declaring mandatory standards, the government specifies minimum requirements that must be met before products are sold. Mandatory standards are usually introduced after concerns about a particular product have been raised, either because accidents have occurred in Australia or overseas, or because a standard has been introduced that is relevant to the Australian situation.

As a result of continuing injuries associated with the use of bunk beds and the relatively low level of compliance with the voluntary standard, the MCCA agreed in 2001 to support the introduction of a mandatory safety standard for bunk beds based on AS/NZS 4220:1994[164]. As mentioned earlier, the standard was to be introduced on 1 May 2002; however, because of a number of procedural difficulties, the date was extended to 1 November 2002. The national safety regulation is administered by the Commonwealth Government and enforced by the ACCC.

In order to harmonise mandatory safety standards across the country, a number of State and Territory governments also simultaneously introduced complementary legislation on 1 November 2002. In Queensland, mandatory safety requirements for bunk beds were introduced by way of an amendment to the *Fair Trading Regulation 2001*. Section 83(1) of the *Fair Trading Act 1989* allows for regulations to be made to prescribe safety standards for specified goods or services. Product regulations generally expire after five years, with a review generally being conducted about 12 months before the expiry date to determine whether the standard should continue in its current, or in a revised form.

The UK and USA also have mandatory safety standards, which cover much the same hazards as the Australian standard, for example, safety gaps, minimal protrusion hazards and guard rails. Under the Australian mandatory safety standard AS/NZS 4220:2003, bunk beds must have:

- no gaps that produce a head entrapment hazard (that is, those that are between 95-230mm) in any part of the bed structure, including the guard rails;
- a guardrail fitted to all four sides of the upper bunk bed; the top of the guardrail must be at least 160mm above the top of the mattress so that the risk of falling from the upper bunk is minimised;
- no hanging hazards caused by protrusions in the upper bed area;
- no protrusions within a bunk bed or elevated bed, except for dome nuts less than 5mm in height; and
- no protrusions that could snag clothing more than 600mm from the ground.

The mandatory standard also provides for information labelling (for example, a leaflet to be supplied with the bed stating that the "upper bunk must be more than 2 metres from any ceiling fan", "children under the age of 9 should not use the upper bunk due to the statistical chance of significant injury"), markings and warning notices to be visibly marked on all bunk beds, the most noteworthy being:

[164] Introduced by Consumer Protection Notice No. 2 of 2002 and later amended by Consumer Protection Notice No.1 of 2003.

Warning: Top Bunks are very dangerous for children under 9.

These mandatory requirements only apply to the supply/sale of new bunk beds, and the sale of second hand/used bunk beds by a commercial trader such as a second hand dealer (meaning private sales are not covered), to the domestic consumer market in Queensland from 1 November 2002. The mandatory standard does not cover bunk beds supplied to the non-domestic market such as holiday units, resorts, and other situations where the service is predominantly accommodation (for example, school/sports/recreational camps).

The OFT considers it likely that many thousands of holiday units in Queensland contain bunk beds that do not meet the safety requirements in the standard.

It is accepted that bunk beds which conform to the new standard will still pose a significant risk to children, given that approximately half of bunk bed related injuries occur as a result of children playing on the top bunk. However, it is expected that the standard will have its most beneficial effect in reducing risks associated with children falling while sleeping/resting.

The new mandatory standard does nothing to address the safety issues associated with bunk beds supplied to the domestic consumer market prior to 1 November 2002, and which did not comply with the earlier voluntary standard. Since bunk beds have considerable longevity for serviceable use, it may be many years before the majority of bunk beds in the market place are "compliant". Thus, ongoing action is required to help raise awareness of the potential dangers associated with "non compliant" bunk beds.

9.5 OFT's actions following the introduction of mandatory safety requirements

The OFT has informed my Office that, following the introduction of the mandatory bunk bed standard, it undertook the following steps to address the risks still associated with bunk beds:

- wrote to key stakeholders in the commercial property industry, that is, Unit Owners Association of Queensland and the Queensland Resident Accommodation Managers" Association informing them of the new mandatory safety requirements and suggesting that, while its members are not covered by the standard, they still be informed of the new requirements;
- made recommendations to a number of other organisations with a view to improving the safety of bunk beds used in the commercial environment, including the Insurance Council of Australia and the Division of Workplace Health and Safety in the Department of Industrial Relations.
- wrote to second hand dealers and pawnbrokers to inform them of their responsibilities under the new mandatory standard;
- conducted a mail out to 60 manufacturers and retailers of bunk beds, providing them with a comprehensive compliance guide;
- contacted the REIQ with a recommendation that it publish an article in its industry journal on the issue of bunk bed safety in residential units;
- pursued industry and consumer education on bunk bed safety, for example, occasional segments on consumer affairs television programs about bunk bed safety;

- published a consumer guide to bunk bed safety; and industry compliance guide about bunk beds; and the *About Babies and Children's Safety* booklet which contains a section on bunk beds;
- provided a range of information on the OFT website on bunk bed safety for both consumers and business;
- co-ordinated a media campaign to inform owners of existing bunk beds on how to make them safer in both a commercial and domestic environment;
- conducts compliance checks in the retail sector at least once every 12 months to ensure suppliers remain aware of their obligations. These checks focus on those traders most at risk of breaching the mandatory safety standard, such as second hand dealers.

OFT also advised that its product safety division had implemented a *Bunk Bed Safety Awareness raising activity plan for 2004-2005* aimed at reducing injuries associated with bunk beds. The main features of the plan are shown in the following table:

Activity	When
Email and direct mail out to residential unit managers (who are licensed with OFT) regarding their obligations to provide a safe sleeping environment for visitors and guidance on bunk bed safety	By end of November 2004
Media campaign to inform consumers about bunk bed safety and advise them to check with their holiday accommodation provider to ensure the bunk beds are safe. This was State-wide.	By December 2004
Compliance spot checks to ensure the standards are being complied with, with an emphasis on second hand dealers.	By April 2004
Follow up contact with previously consulted organisations to reinforce the key safety issues associated with bunk beds. These include: Insurance Council of Australia, the Division of Workplace Health and Safety, the Queensland Resident Accommodation Managers‟ Association, the REIQ, Tourism Queensland and the Unit Owners Association of Queensland, furniture suppliers and second hand dealers.	By June 2005
Liaise with Brisbane Extra to reinforce the message of bunk bed safety through the electronic media.	By end of December 2004

OFT advised my Office that the issue of regulating bunk bed safety on a wider scale than just the domestic consumer market has been on the OFT‟s product safety agenda since the introduction of the mandatory standard. In particular, OFT has been considering the possibility of introducing new regulatory requirements for all bunk beds in holiday units, resorts, school camp facilities and hostels to comply with the safety standards. Discussions have also taken place with the Department of Industrial Relations in regard to the possible application of Workplace Health and Safety legislation to this issue.

In a letter dated 26 October 2005, the Director-General of the Department of Tourism, Fair Trading and Wine Industry Development advised me that the department was in the process of developing a proposal for preparation of a Regulatory Impact Statement on the issue of regulating bunk beds in commercial settings, for the purpose of seeking information and views from all stakeholders.

9.6 Bunk beds in government-owned establishments

In March 2004, I wrote to a number of State government agencies seeking advice as to whether the agency owned, operated or funded any facilities that provided children with accommodation using bunk beds and, if so, whether those bunk beds were fitted with guard rails to prevent occupants from accidentally falling.

The Department of Local Government, Planning, Sport and Recreation (DLGPSR) advised that it owns 12 sport and outdoor recreation centres in Queensland which provide group accommodation. All centres have bunk beds and all such beds are fitted with guard rails. When bunk beds are installed or existing beds are upgraded, DLGPSR abides by Standards Australia AS/NZS 4220:2003 Safety Standard for bunk beds.

The Department of Aboriginal and Torres Strait Islander Policy also responded by advising that it provides funds to a number of diversionary centres and hostels across the State. Two centres provide bunk beds for individuals who either require emergency accommodation, or require diversion from custody due to alcohol or substance abuse. A hostel in Brisbane and another in Mt Isa have bunk beds, not all of which have safety guard rails on the upper bunk. No information was provided as to whether or not those bunk beds are used to accommodate children on occasions.

9.7 OFT's response to the complainants' allegations

In a letter to me dated 26 October 2005, the Director-General of the Department of Tourism, Fair Trading and Wine Industry Development provided the following responses to allegations raised by the Nevilles' complaint:

9.7.1 There was an unreasonable delay by the OFT in taking steps to cause amendments to be made to regulations in relation to safety requirements for bunk beds. The amendments were not passed until November 2002

The Commonwealth mandatory standard was introduced in November 2002. By introducing mandatory safety standards that accorded with the Commonwealth safety standards, Queensland was able to capitalise on the development and progression of the national initiative and substantially shorten the timeframe normally required for the introduction of any legislative amendment.

It should be noted that Queensland promoted the introduction of a mandatory safety standard for bunk beds and in 1999 produced a draft discussion paper which was circulated to other regulators for comment. A large amount of this information was used to prepare the Commonwealth's Regulatory Impact Statement in 2001.

9.7.2 Amendments proposed by the OFT were too narrow because they did not apply to all bunk beds, including those supplied in the commercial environment and those sold prior to the introduction of the mandatory safety standard in 2002

The intention of the mandatory safety standard was to reduce the risk of injury associated with bunk beds in the domestic environment, as injury data indicated that the domestic environment was by far the most likely location for bunk bed injuries. This is supported by injury statistics supplied by the QISU (noted above) which disclose that from 1998 to 2002, 96% of bunk bed injuries occurred in the home.

Bunk beds supplied as part of a service could possibly be regulated under s.83 of the *Fair Trading Act 1989* by introducing a mandatory safety standard for the service of supplying a bunk bed as part of an accommodation package in a commercial setting. This issue is currently being considered by OFT; however, OFT says there are a number of difficulties with this idea, particularly:

- defining what is a commercial setting;
- whether existing bunk beds would actually be caught by such a mandatory safety standard for accommodation services;
- challenges of enforcing this type of standard; and
- consideration of the costs associated with introducing such a standard when, since the introduction of the Commonwealth standard, all bunk beds sold must be compliant.

The mandatory safety standard introduced in November 2002 did not apply to bunk beds supplied before that date. To introduce such a requirement would not have been a practicable option given that bunk beds were already supplied and being used by householders. Had the requirement been retrospective, the situation may have occurred where suppliers of bunk beds would have been compelled to recall, or retrofit with safety features, bunk beds that were supplied many years before. This would have been extremely difficult to regulate.

9.7.3 The existing safety regulations in relation to bunk beds are inadequate; in particular, the information labelling to be affixed to all new bunk beds to be sold after 1 November 2002

The mandatory safety standard covers the main hazards of falling, entrapment and hanging and is considered to be one of the most stringent mandatory safety standards for bunk beds in the world.

There is no requirement under the standard for warnings to be placed on bunk beds, as safety and warning labels are viewed as the least effective injury prevention tool. It has been argued that these types of labels are completely ineffective and merely provide a mechanism for industry to mitigate liability. Labels also provide parents and caregivers with a false sense of security in relation to the product being „safe“ for any child within the age range depicted in the warning statement.

The most effective methods for injury prevention are product design and the setting of performance requirements to address hazards associated with a product. Provisions of the mandatory safety standard utilise these methods by gap and guardrail requirements and protrusion requirements based on size and strength data of children from three years of age and upwards.

I have formed the following opinion:

Opinion 14

The existing mandatory safety standard in relation to bunk beds is ineffective in addressing safety issues associated with bunk beds purchased prior to 1 November 2002.

I make the following recommendations:

Recommendations 22, 23 and 24

22. All Queensland government agencies that own, manage or fund establishments which use bunk beds as sleeping accommodation for children ensure that the bunk beds comply with the current mandatory safety regulations.

23. The OFT seek the Minister's agreement to prepare a regulatory impact statement examining the costs and benefits of a regulation requiring all commercial suppliers of accommodation utilising bunk beds to ensure that the bunk beds comply with the 2003 mandatory safety standard. In the course of preparing the regulatory impact statement, the OFT should consult stakeholders in the relevant industry on the practical difficulties and/or financial burdens of complying with such an obligation, and canvass practical solutions such as implementation within a period of (say) three years.

24. The OFT take steps:

24.1 to develop a joint communication strategy with the Commission for Children and Young People and Child Guardian, the Queensland Injury Surveillance Unit and Queensland Health to raise public awareness of the changes to mandatory safety standards for bunk beds based on Australian Safety Standard 4220:2003, and the hazards of unsafe sleep environments for children generally, including bunk beds.

24.2 to form a joint working party with representatives from the entities referred to in 24.1 with a view to considering the feasibility of establishing and promoting government funded programs focused on removing "unsafe" bunk beds from private residences.

OFT response to recommendations 22, 23 and 24 (Letter dated 15 May 2006)

Recommendation 22

OFT is willing to assist the relevant government agencies in implementing this recommendation through the provision of expert advice on bunk bed safety.

Recommendation 23

Agreed.

Recommendation 24

Agreed.

10 Medical Retrieval System in Queensland

10.1 Background

The 1990 Queensland Joint Parliamentary Select Committee of Enquiry into Ambulance Services recommended the formation of an interdepartmental committee between the Queensland Ambulance Service (QAS) and QH. The resultant Emergency Health Services Coordination Advisory Committee began to address a range of policy initiatives and procedures of common interest aimed at standardising arrangements in Queensland for the development of an emergency medical system. The principal result of that analysis was a policy framework known as the Queensland Emergency Medical System (QEMS).

QEMS was established in 1997 as an interdepartmental framework to facilitate quality improvements to emergency medical services in Queensland, focussing on an integrated and coordinated system of care for the acutely ill and injured.

10.2 Elise Neville's retrieval

The retrieval of Elise from CH and transportation to RCH in Brisbane involved a number of different agencies or teams. The retrieval process was first activated by the emergency call for an ambulance to transport Elise to CH. After Elise received treatment in CH ED by a resuscitation team, the medical officer then contacted Nambour General Hospital (NGH) requesting assistance with the management of treatment for Elise. A retrieval team from NGH was organised to attend upon CH. NGH then contacted the QAS seeking transport of the retrieval team to CH, and contacted the Sunshine Coast Helicopter Rescue Service to provide emergency transport for Elise and the retrieval team from CH to RHC. Upon arrival at CH, the retrieval team from NGH had to take over the primary medical care of Elise and coordinate the transfer of Elise by heliambulance to RCH. This process took approximately 2½ hours before Elise was able to receive treatment at RCH for an injury for which medical intervention was time critical.

As part of its investigation for the Coroner"s Office, the QPS obtained a medical opinion from a neurosurgeon, who provided the following comments about the time taken to retrieve and transport Elise to the RCH:

> *It took approximately two and a half hours after the re-attendance at the Caloundra General Hospital for the child to arrive at the Royal Children"s Hospital for definitive treatment. This delay is unacceptable as such a journey from Caloundra General Hospital to the Royal Children"s Hospital would have taken one hour by fast road transport. The use of helicopter transport in these circumstances warrants inquiry.*

The Nevilles also felt that road transport would have been the fastest option for transfer of Elise to the RCH. They said that after Elise had received emergency treatment at CH, staff stood around waiting for the heliambulance to arrive, when that time could have been better spent transporting Elise by emergency road transport.

10.3 HRC investigation

The HRC investigated the Nevilles‟ complaint about Elise‟s retrieval. The following information is taken from the Commissioner‟s report of 28 June 2004:

- The medical consultant from NGH who retrieved Elise to the RCH advised that decisions on the preferred mode of transport were made on a "case by case" basis taking into account road and weather conditions, and most importantly, the condition of the patient;
- The medical consultant responsible for making the decision to air vac Elise to RCH was well experienced in retrievals and based the decision on individual experience and local knowledge rather than objectively based criteria;
- Information provided by a QH emergency medicine consultant with extensive retrieval experience about the procedures relating to retrievals revealed:
  - there were no standard operating procedures for retrievals that were routinely accepted by all participants as policy. Rather the primary principle guiding the decision was to determine the clinical and transport process that would best meet the needs of the patient, while at the same time ensuring the safety of all those involved in the transport process, namely the patient, health service personnel and the general public; and
  - for those patient transports that are greater than two hours or 200kms by road, consideration should be given to the use of aerial transport. This conforms to QH Policy noted in *Policy Statement 1993, Interhospital Ambulance Road Transfers and Interhospital Aeromedical Transfers*. However, this was not a hard and fast rule.
- While the helicopter rescue service was available on a 24 hour basis, the pilot was scheduled on duty between the hours of 9.00am and 5.00pm and another pilot was available on an "on call" basis from 5.00pm until 9.00am. This meant that at the time the helicopter rescue service was contacted at 8.10am there was no pilot on duty;
- An independent opinion regarding Elise‟s retrieval was obtained from Dr R Manning, Director, Medical Retrieval Unit, NSW Ambulance Service. In summary, he was neither critical of the decision to choose air transport over road transport nor the time taken to transport Elise to the RCH. However, he did believe there was potential to save time with a different "parallel" system of coordination and clinical care in place to coordinate the retrieval process:

> *The retrieval and vehicle activation system described in this case is a sequential one whereby the recognised critically ill patient is transported by the ambulance service to the nearest hospital, followed by management and resuscitation by hospital staff, followed by the same hospital staff once concluding immediate resuscitation efforts making contact with the retrieval clinician, who in turn is required to make contact with the transport service as well as being required to perform coordination, clinical advice and retrieval roles. Such a sequential process is inherently rate limiting.*

What the HRC report failed to include was Dr Manning‟s comment that "given the prevailing retrieval and vehicle activation system as described above, the time taken to transport the patient from CH to RCH was probably the fastest achievable by the staff involved. However, a different system could afford **significant time savings** (my emphasis)"[165].

[165] Expert opinion by Dr Manning - letter to the Health Rights Commission dated 19 December 2003.

By way of further explanation, Dr Manning noted that a number of the preparatory and coordination functions could have been performed by structures and staff independent of those required to provide immediate patient care and retrieval. He explained how the *NSW Retrieval System Early Notification of Trauma Protocol* would have managed Elise‟s incident as parallel processes. For example, at the time the ambulance officers notified that they were transporting a critically injured patient to a non-referral hospital, the retrieval system could have been notified prior to the arrival of the patient at the first hospital. Simultaneously, following predetermined vehicle selection guidelines, the appropriate transport mode and retrieval team would have been activated. A clinical coordinator who was not responsible for undertaking the retrieval would have taken responsibility for making contact with the treating hospital providing clinical advice and ensuring that the retrieval was progressing well. The clinical coordinator would also have made contact with the appropriate receiving hospital and maintained an overall clinical governance watch over the progress of the incident.

The Health Rights Commissioner formed the view that the system of retrieval afforded to Elise was not optimal and that, had there been a better retrieval system, there may have been a better response. The helicopter service needed to be online earlier (pilot now commences his shift at 8.00am instead of 9.00am) and there should have been more formal processes for decision-making and co-ordination of the retrieval. He made a number of recommendations for improving the retrieval process. One of them was that a State or Regionalised Retrieval Co-ordination System be instituted to ensure that coordination and mission clinical governance occur independent of, and in parallel with, vehicle and retrieval team response. QH‟s response to that recommendation and the Commissioner‟s other recommendations are set out at 10.5 below.

10.4 Recent reviews of the aeromedical retrieval system in Queensland

The Queensland Emergency Medical System Advisory Committee (QEMSAC) is an interdepartmental committee involving QH and the Department of Emergency Services (DES) established to advise the relevant Ministers, through the relevant Directors-General, on emergency medical services in Queensland. In July 2003, QH and DES through QEMSAC commenced a review of the system of clinical coordination and operational aspects of aeromedical services in Queensland. The aim of the review (referred to as the “Clinical Coordination Centre Project” (CCCP)) was to provide a more coordinated and consistent approach to clinical coordination for aeromedical services in Queensland.

As part of that review, on 18 November 2003, QEMSAC endorsed the establishment of an independent review of the aeromedical retrieval system in Queensland. The Directors-General of QH and DES ratified this on 2 December 2003. This review (called the Wilson Review) resulted from a coronial rider made by Coroner Hennessey on 20 August 2003:

> *That there be an immediate independent review of the aeromedical retrieval system on both an operational and clinical basis and a commitment made by the organisations and departments responsible for the system to implement any changes recommended by the review.*

In total there have been three independent reviews which impact on the aeromedical retrieval system in Queensland:

- an aeromedical services review of the Torres Strait and Northern Peninsula area (report dated 4 November 2003), known as the Elcock Review; and

- an independent review of Queensland‟s aeromedical and air rescue network, commissioned by DES, and undertaken by private consultants (report dated 30 April 2004), known as the Cornish Review; and
- an independent review of Queensland‟s aeromedical retrieval system (report dated 24 August 2004), known as the Wilson Review.

I have been advised that reports from these reviews were attached to Cabinet submissions dated 24 April 2004 and 13 May 2004. I have been permitted to read the reports but, given their confidential status, it is not appropriate to discuss their contents.

However, all three reports have made wide-ranging recommendations aimed at improving the standard of service provided by the aeromedical retrieval system including by the more effective integration and clinical coordination of services.

In late 2004, a sub-committee called the QEMS Aeromedical Sub-Committee (the sub-committee) was established to manage the implementation of recommendations arising out of these three reviews. I am advised that the agreed recommendations have now been implemented and will be subject to review in the near future.

Queensland now has a joint-agency (QH & QAS) single point clinical coordination centre in Brisbane (known as the QCC: QEMS Coordination Centre) which is co-located with the QAS at the Ambulance and Fire Communications Centre, with the responsibility of providing coordination of patient transport needs across central and southern health zones of Queensland. A similar QCC has been established in Townsville and provides for similar arrangements for northern Queensland from Mackay to the Torres Strait.

The functions of the QCCs are to improve advice on clinical care, coordinate the transfer of patients between facilities and to determine the transport needs on clinical grounds. Both QCCs are staffed by senior medical officers and nurses from QH and QAS communications staff and involve collaboration between QH, QAS and the Royal Flying Doctor Service.[166]

10.5 QH's response to HRC's recommendations

In QH‟s letter to the Health Rights Commissioner dated 24 May 2005, it provided the following responses to the recommendations (in bold type below) in the Commissioner‟s report of June 2004, concerning Queensland‟s aeromedical retrieval system.

> ***An evidence based process be undertaken to objectively determine the most appropriate transport vehicle and retrieval team to undertake missions between various hospitals matched against clinical urgency and time of day.***

On 15 June 2004, *Inter Facility Transport Operational Guidelines* (IFT Operational Guidelines) were approved by QH and DES. These guidelines came into effect on 1 July 2004, and incorporate the QAS.

These guidelines, which were developed collaboratively by clinical, operational and strategic staff in QH and QAS, provide clear guidance for QH staff when ordering patient transport. Clinical co-ordination is now provided by two QH centralised clinical co-ordination centres, named QEMS Co-ordination Centres (QCC), one in Brisbane which

[166] Queensland Emergency Medical System (QEMS) Advisory Committee Outputs Report 2004.

commenced operations on 2 August 2004 and one in Townsville which commenced in October 2005. These centres are supported by QAS communication staff with central aircraft tasking and coordination capability, and by senior medical consultants with the role of:

- providing specialist medical advice and facilitating communication between referring health facilities, retrieval teams, and receiving health facilities;
- providing clinical supervision of the tasking of aircraft resources, flight and aeromedical road leg bookings, and communication with QAS regional communication centres;
- clinical data collection, analysis and reporting to a clinical oversight committee.

> ***Consideration be given to the applicability and suitability of the NSW Early Notification of Trauma Protocol to the Queensland environment.***

The principles and elements of the NSW protocol were reviewed during the development of the QCCs and are being further evaluated in the current Queensland Trauma Plan Project.

> ***That a State or Regionalised Retrieval Coordination System be instituted to ensure that coordination and mission clinical governance occur independent of and in parallel with vehicle and retrieval team response.***

The QEMS coordination policy, in accordance with international and national standards[167], specifies that in all circumstances, every reasonable action is to be taken in a timely manner to provide patients at risk with a clinically appropriate, coordinated and supervised patient retrieval and/or ambulance service.

All employees and all contractors of both QH and DES, when deployed in clinical coordination and patient retrieval and transport services, are required to be fully conversant with and exercise their patient care practice and operational decision-making, consistent with those standards.

Following QH‟s response, the HRC sought an updated opinion from Dr Manning in response to the outcome of the review of Queensland‟s retrieval processes. Dr Manning (who contributed to the review process) was able to verify that the review process was very thorough and that QH appeared to be very committed to addressing the issues. He considered the recommendations made by the review were appropriate and that the new centralised process provided by the QCCs was along the lines recommended by him in his earlier opinion. He did suggest however, that the new process should be subject to ongoing review. Consequently, the Commissioner wrote to QH on 15 June 2005 seeking a response to the following:

> *I noted that Queensland Health has undertaken a review of its retrieval processes. It would seem appropriate, where major system changes are implemented such as in this case, that their effectiveness be appraised at a later stage. I would be grateful therefore, if you could advise whether a schedule has been developed for ongoing review of the revised processes.*

[167] Minimum Standards for the Transport of the Critically Ill - Australian and New Zealand College of Anaesthetists and Australian College of Emergency Medicine; and the Civil Aviation Act, Regulations and Civil Aviation Orders - Australian Civil Aviation Safety Authority.

QH responded by advising that an ongoing quality system review process is provided through a Clinical Coordination & Patient Retrieval Service Oversight Committee which meets quarterly under the Chairmanship of the Chief Health Officer.

In addition, there is a QEMS Quality Council being established whose function will be to provide advice and make recommendations to the Directors-General and Ministers for QH and DES concerning emergency health service delivery. It is planned to conduct ongoing and periodic system evaluations and the first of these will be conducted in November-December 2006, 12 months after the full implementation of the new patient retrieval arrangements.

Comment

It is evident from the IFT Operational Guidelines that the QCCs have the potential to provide a better-informed and coordinated medical transport service to Queensland. On a practical level, I have considered whether the newly developed processes can provide a better retrieval service than the one that was provided to Elise (keeping in mind that it took approximately 2½ hours to transfer her from CH to RCH for medical treatment that was time critical). In Elise‟s case, the decision to transport her by air to the RCH was made by the retrieval doctor from Nambour General Hospital. The IFT Operational Guidelines provide that the medical officer responsible for the care of the patient at the referring facility (the responsible medical officer) is responsible for making the initial assessment of the mode of transport required by the patient. The patient‟s clinical condition is the major determinant used when choosing mode of transport. The following is a guide for that medical officer:

Initial clinical assessment of transport mode	Estimated road transport time (one way) between referring and receiving facility	Activate
Air		Clinical Coordination network. Use Medical Transport System Activation diagram.
Road	> 3.5 hours	Clinical Coordination network. Use Medical Transport System Activation diagram.
Road	< 2.25 hours	QAS. Use Road Ambulance Ordering Guide.
Road	Between 2.25 and 3.5 hours	Either Clinical Coordination network or QAS, where agreed local protocols exist. Use Medical Transport System Activation diagram. (Clinical Coordination network and QAS to collaborate on resource allocation on an individual basis.)

The above table provides that if an initial assessment is made to transport the critically ill patient by air (as was done in Elise‟s case), then the responsible medical officer activates the Clinical Coordination network. The Queensland Medical Transport (QMTS) System Activation flow chart in the IFT Operational Guidelines then provides that contact is made with the clinical coordinator at the QCC for clinical coordination. The clinical coordinators at the QCC in Brisbane (which services the SCHSD) are senior QH medical consultants also well experienced in retrievals. The role of the clinical coordinator is to

provide clinical advice and to assess individual clinical needs against total resource availability and demand in collaboration with the responsible medical officer, the QAS desk and Aeromedical desk both co-located with the clinical coordinator at the QCC. The clinical coordinator collaborates with QAS to determine transport mode and priority. In other words, the QH clinical coordination and QAS desk functions work in combination to achieve a joint assessment of the most appropriate medical transport service.

I am advised that the QAS desk has the capacity to know where all transport (road and aeromedical aircraft) are at any one time and its availability and capability. This information can be crucial in determining the best mode of transport in any given situation, particularly one that is time critical.

Accordingly, it is apparent that this process will now enable decisions about the most appropriate mode of transport to be more objective and evidence-based rather than based on local knowledge alone.

QH should be allowed an opportunity to conduct periodic evaluations of the services and report those findings.

I have formed the following opinion:

Opinion 15

The information available suggests that system changes implemented as a result of the review of Queensland's aeromedical services have provided Queensland with a more efficient and better coordinated clinical and transport service.

I make the following recommendation:

Recommendation 25

QH conduct periodic systems evaluations of retrieval services as planned.

QH response to recommendation 25 (Letter dated 16 May 2006)

Recommendation 25 has been implemented.

Queensland Health has stipulated a formal review of retrieval services at 6 monthly periods in the CMS contract. A Clinical Coordination and Retrieval Services Oversight Committee has also been established.

Appendices

(Footnote references in this part of the report are references to text in the appendices and are not references to text in my report.)

Appendix 1: Ombudsman's submission to the BHCI

PART 2: Issues relating to health complaints systems Chapters 3-5

Chapter 3. The current health complaints system in Queensland

It should be noted that, while the HRC is considered to be the primary agency for dealing with health related complaints, it is only one element in a broad complaints system which includes formal complaint mechanisms in private and public hospitals (and other elements of the public health system), and the professional registration boards. Under the current health complaints system in Queensland, complaints can be directed to:

1. the relevant HSP;
2. the HRC and/or the relevant health practitioner registration board/QNC; or
3. the Ombudsman (if the complaint relates to a government agency within the Ombudsman"s jurisdiction).

3.1. The relevant health service provider

The current system requires complainants to attempt to resolve their health service complaint at the initial point of service. This is reflected in the HRCA which provides[168]:

> *"Before deciding to accept a health service complaint for action, the commissioner is to be satisfied-*
>
> *(a) that all reasonable steps have been taken by the complainant to resolve the complaint with the provider:.."*

While there is currently no reciprocal legislative duty on an HSP to resolve a complaint with a complainant, it logically follows that for the system to work effectively, HSPs need to have adequate systems in place in order to receive complaints and respond to them in a timely manner. One of the statutory functions of the HRC is to assist providers to develop their own effective complaints handling procedures[169].

A useful guide to complaint handling is Australian Standard *AS4269-1995: Complaints Handling*, which sets out the essential elements for the management of complaints from inception to resolution or final determination (as the case may be), irrespective of the nature of the complaint or the size of the organisation receiving the complaint. The Standard, which is currently advisory only, provides information that can be used to design a process for handling complaints in both the public and private health sectors. The Standard specifies several essential elements for effective complaint handling, including:

- appropriate systems for recording complaints and their outcomes;
- appropriate reporting on the operation of the complaint-handling process against documented performance standards;
- regular reviews of the process to ensure that it is efficiently delivering effective outcomes.

[168] Section 71(2) HRCA.
[169] Section 10 HRCA.

Australian Standard *AS4269* is currently being reviewed and it is expected that it will be amended to substantially reflect the current international standard *ISO 10002- Quality Management - Customer Satisfaction - Guidelines for complaints handling in organisations* which was introduced in July 2004. The ISO covers elements such as:

- visibility
- accessibility
- objectivity and impartiality
- confidentiality
- separating complaints-handling procedures from disciplinary procedures
- monitoring
- continual improvement.

My Office has also produced a number of publications designed to help public sector agencies make good decisions and manage complaints effectively. These publications are available on our website www.ombudsman.qld.gov.au and include:

- Developing Effective Complaints Management Policy and Procedures;
- Effective Complaints Management fact sheets; and
- Complaints Management Audit and Assessment checklist.

While these publications have been designed specifically for public sector agencies, any HSP could easily adapt them.

It is also important for an HSP to develop strategies for internal and external communication of its complaints management policy and procedures to ensure customers and staff know how complaints are handled by that organisation.

3.1.1 QH's complaints management framework

QH currently has a complaints management process based on the QH Complaints Management Policy (No. 15184 approved on 23 July 2002) which outlines how complaints are to be received and then handled. In developing the complaints management process, regard was had to *AS 4269-1995: Complaints Handling*.

The policy covers complaints received by any QH staff member about any aspect of a health service before, during or after the provision of a service. Complaints can be made verbally or in writing to QH by a user, their advocate, carer or family member, groups of consumers or consumer organisations, or general members of the public.

QH"s Complaints Management Policy (the policy) is supported by a comprehensive "Complaints Management Handbook" (the handbook) as well as a "Guidance Document to the Queensland Health Complaints Management Policy". The handbook provides that the complaints process is an organised way of responding to, recording, reporting and using complaints to improve the service. It acknowledges that consumers want:

- it to be easy to make a complaint;
- to be listened to, understood and taken seriously;
- to be treated politely and with respect;
- staff to focus on solving the problem and not be defensive or give consumers the "run around";

- a timely response;
- the complaint to be investigated fairly with no cover-ups;
- to be told what is happening and what has happened and not be "left in the dark."

Once received, complaints are required to be assessed immediately and categorised as negligible, minor, moderate, major or extreme. Delegated staff at the point of service are required to attempt to resolve all "negligible and minor complaints". Complaints classified as moderate, major or extreme, plus any unresolved minor complaints, are to be referred to the complaints coordinator within each Health Service District. Where possible, such complaints are to be investigated and assessed and, where appropriate, referred to the District Executive.

Under the policy, the complaints coordinator for each Health Service District has several important duties including:

- Coordinating the complaints management process;
- Ensuring that complaint information is considered as part of District quality improvement and risk management processes;
- Managing and reviewing outcomes and investigations;
- Coordinating staff training on complaint management.

The handbook contains some common examples of the types of complaints relating to health service delivery such as:

- dissatisfaction with the type or level of treatment provided to a user (for example, at a public hospital) such as unsuitable care, misdiagnosis, communication issues, non-consent to procedures;
- general dissatisfaction with the health care or services received such as waiting lists or inappropriate diet;
- concerns that relate to unsatisfactory conduct of HSPs;
- limited or no access to personal records, disrespectful behaviour, lack of privacy, and/or confidentiality breaches.

The handbook also links risk management with complaints management. In other words, all complaints are also to be assessed to determine whether the level of risk for a specific complaint is acceptable or not. It provides a matrix for use in trying to determine the level of risk. QH‟s Integrated Risk Management Policy provides that each District, Branch or other accountable area is required to maintain a register of all risks to the organisation.

In June 2004, QH also introduced an *Incident Management Policy* (23360) which directs that Managers are required to report and manage sentinel events[170] and events with very high and extreme risk ratings. The policy was introduced to enable QH to learn from underlying causes of incidents and near misses and to improve systems to reduce the likelihood of recurrence.
The handbook outlines the timeframes for handling complaints. Basically, complaints should be acknowledged, or referred to external agencies for handling, within 3 working days of being received, or the need being identified. Relevant staff should endeavour to

[170] Sentinel events are rare events that lead to catastrophic patient outcomes. The ACSQHC has endorsed a national list of sentinel events that includes, for example, retained instruments or other material after surgery requiring re-operation or further surgical procedure.

resolve complaints within a 28 day timeframe, otherwise complainants are to be advised of progress of the complaint every 28 days until the complaint is resolved.

A health service may decide to undertake an investigation of any matter. Those complaints that cannot be resolved at the point of service, or those that are of a more serious nature (namely, those categorised as moderate, major or extreme), will usually be investigated.

Depending on the degree of seriousness of the matter being investigated, investigations may be conducted internally by a number of nominated QH employees including the line manager, the complaints coordinator, a senior member of the health care team or an investigator appointed by the Queensland Audit and Operational Review Branch. Complaints may also be referred to and investigated by an external agency like the HRC, MBQ or QNC.

The Director-General of QH may appoint a person as an auditor or investigator pursuant to s.52 of the *Health Services Act* (HSA). The functions of an investigator are to investigate and report to the Director-General on any matters relating to the management, administration or delivery of "public sector health services" (that is, a health service provided by the State), for example, matters relating to clinical practices and standards of health care in the delivery of public sector health services[171].

There is no requirement for QH to consult with the HRC or any of the registration boards at any time during the complaints process. However, QH may refer a complainant to an external entity at the end of the internal complaint process. For example, a complaint about a registered health practitioner may be referred to the relevant health professional registration body if it raises competence concerns because of a series of errors, or a pattern of behaviour demonstrating a lack of knowledge, skill or ability, and/or poor judgment based on problems with assessment, analysis or decision-making. The District Manager (or delegate) is responsible for such a referral.

QH recognises that many “minor” complaints can be resolved through the provision of information, or an explanation of why things happened the way they did, together with an apology and recognition of the effect the situation had on the complainant.

With more complex complaints, resolution may be achieved with the assistance of a trained mediator or conciliator, or by a process of facilitation. Facilitation is utilised when a group or parties with divergent views want to reach a goal or complete a task to their mutual satisfaction. A facilitator assists in defining issues, and in assisting and taking steps to encourage the parties to reach consensus.

3.1.2 Assessment of QH’s Complaints Management Policy and Procedures

In March 2003, my Office initiated a project called the Complaints Management Project (CMP), which involved my staff giving assistance to 11 State and local government agencies to implement complaint handling systems that meet recognised national and international standards. For the purposes of the project, my Office produced several publications, including fact sheets explaining the essential components of a best practice complaints management system, and a template to follow when drafting complaints management policies and procedures. These documents are available on our website[172].

[171] Section 55 HSA.
[172] **www.ombudsman.qld.gov.au.**

At the time our project commenced, QH, which was one of the agencies participating in the project, had recently finalised a new policy and procedures for managing complaints received from members of the public.

Each of the agencies involved in the project, including QH, carried out a self-assessment of their current complaints management systems using an audit and assessment checklist which my Office designed for that purpose.

The QH complaints management system is based on QH"s Complaints Management Policy (No 15184 approved on 23 July 2002). The Policy relates to complaints made "by or on behalf of a consumer or a group of consumers regarding the provision of a health service". A complaint can be made orally or in writing.

The Policy does not apply to complaints made by QH employees that involve PIDs or that relate to staff grievances or other staff concerns. Nor does it apply to complaints made to QH about public health issues (for example, complaints about food outlets).

QH"s policy on Whistleblowers is IRM 3.1-4, *Policy and Procedures for the Management of Public Interest Disclosures – In Accordance with the Whistleblowers Protection Act 1994.* Its policy for handling staff complaints is Policy IRM3.5, *Grievance Resolution* and EB5 *Grievance Settling; and Industrial Disputes.* We did not review those documents as part of our CMP because the focus of the CMP is on complaints from members of the public.

My officers reviewed a copy of the completed audit and assessment checklist provided by QH. Based on their review of the checklist and other information relating to QH"s complaint management process, my officers prepared a report of their assessment, which I provided to the then Director-General of QH[173] on 8 March 2004.

Particulars of the QH complaints management process have been explained earlier[174]:

Our report concluded that the QH system (assuming QH complied with its complaint policies and procedures) "compares very favourably to those in most other departments and meets nearly all the criteria for good complaints management."

However, we considered that the system could be improved. In particular, we recommended that QH:

- Develop and establish a central or common complaint database to enable complaints data across all Districts to be collated and analysed.

- Improve awareness of the QH complaints management system on the part of QH staff across all Districts.

Our first recommendation was based on the fact that QH did not have a centralised database for recording complaints data across all Health Service Districts. In our view, this is an essential component of an effective complaint system. The existing systems within the Districts had limited compatibility which meant there was little capacity to:

[173] Dr Buckland.
[174] 3.1.1.

- identify significant complaint issues, complaint trends or improvement strategies, or
- ensure an appropriate level of consistency in the management of complaints across all districts.

The second recommendation resulted from our assessment that there was no program in place to ensure consistent staff awareness across Health Service Districts concerning the complaints management system. For the system to operate effectively, we considered it essential that QH staff, especially those who deal directly with the public, be aware of the system.

Although the Policy specified that "all staff receive training on complaints handling within six months of commencement and at least every 3 years thereafter", information that we received indicated that training was conducted on an *ad hoc* basis within and across Districts and hence there was no guarantee that consumer complaints were being dealt with in accordance with the process. We suggested that QH should conduct surveys of staff awareness of the system.

In relation to training for QH officers who deal with complaints, we made no recommendation because of advice from QH that it had a comprehensive training regime for complaints staff, as outlined in its complaints management handbook. QH also advised that complaints coordinators are selected and trained in accordance with the principles outlined in QH‟s policy and handbook and all undergo a two day training session.

We have not conducted any audit to determine whether QH is providing such training as this is not part of the current phase of our CMP.

In the course of the project, we made several other suggestions to improve QH‟s complaints management system one of which resulted in the QH website being amended to include a dedicated section on consumer complaints.

Following receipt of our report, QH commenced work to develop a State-wide consumer feedback information system/database for the management and tracking of consumer complaints as well as for receiving information concerning critical incidents and for risk management purposes.

QH also advised that, in accordance with our recommendation, it planned to provide further training to staff to raise awareness of its complaints management process and that this training would be provided in conjunction with training associated with the implementation of the new database.

I am informed that the database has been developed and is currently undergoing testing in a Health Service District.

I am also informed that the database is not intended to capture information concerning PIDs under the WPA. Under current QH procedures, details of PIDs are provided to the Audit and Operational Review Branch of QH which is responsible for:

- ensuring that proper recording processes are in place for filing and receiving PIDs, and
- maintaining confidential files on disclosures.

It needs to be understood that the purpose of the CMP is to assist agencies, including QH, to implement complaints management procedures and systems that meet recognised

standards. The project does not involve auditing whether agencies are complying with those procedures. For example, QH‟s complaints system imposes various responsibilities on the complaints coordinator in each District. However, it is noted that QH‟s Initial Submission to the Inquiry dated 16 May 2005 (p.38) stated that the Bundaberg Health Service District "has had no dedicated Complaint Coordinator".

Based on the evidence presented to the BHCI, I believe further action needs to be taken by QH to improve its current complaints management. In formulating these proposals, we have also had regard to QH‟s publication "Issues Paper for Bundaberg Hospital Commission of Inquiry – Complaints Management, July 2005".

3.1.3 Proposals for further improving QH's complaints management system

I propose that:

- QH develop a central Complaints Management Unit that will be responsible for:
    - overall internal complaints management including devising, implementing, reviewing and improving complaints systems;
    - providing advice and training to all complaints staff about both patient and staff complaints;
    - monitoring and reviewing local complaints handling to ensure that all complaints are actioned in a timely and appropriate manner;
    - investigating, or monitoring the investigation (at the local level) of, all complaints categorised as moderate, major or extreme;
    - liaising with the external complaint agency, where an unresolved complaint is escalated by the complainant to external review;
    - the collection and analysis of consumer feedback on QH health services;
    - benchmarking, conduct of complaint trend analysis, and auditing of complaints processes in the districts;
    - providing regular analysis reports about internal complaints management back to health districts and to senior management; and
    - liaison with the Patient Safety Centre to provide inputs, from analysis of patient complaints data, into strategies for quality improvement initiatives/activities.
- All Health Service Districts should have a dedicated complaints coordinator (CC) appointed at the level of A05 – A07 (depending on the size of the relevant District/Branch), to ensure that CCs have an appropriate skill level, and sufficient seniority in the organisation, to credibly manage complex patient complaints. CCs should be accredited in complaints handling. There should be one State-wide position description (PD) as opposed to each District having its own PD for the role. It is acknowledged that some of the smaller health districts that do not receive many complaints may only require a part-time CC. The CC should report directly to the District/Branch Manager (or in large Districts, to an appropriate manager at senior

executive level). The CC needs to have the standing and influence to ensure that serious attempts are made to resolve complaints at the local level wherever possible, and that issues warranting closer examination by management are escalated appropriately.

- All staff responsible for the receipt, referral and actioning of complaints should be adequately trained in respect of QH"s Complaints Management Policy and Handbook.

Coordination of health data management systems

One of the important issues exposed during the hearings of the BHCI was the need for health services to maintain well integrated data management systems. In the case of Bundaberg (and potentially elsewhere), it is understood that the local patient complaints register and the adverse events and sentinel events records were not reconciled or integrated in any way, which significantly impeded capacity to identify systemic issues relevant to patient safety and delayed effective intervention.

Furthermore, a scan of the QH data management practices revealed a number of instances where data relevant to patient safety and quality improvement activities is collected via more than one source, eg. as part of preparations for accreditation surveys and for measured quality improvement activities. This duplication of effort in data collection and reporting requirements wastes resources and is understandably a source of frustration for staff.

It is also significant to note that several witnesses at hearings of the BHCI gave evidence that they seldom, if ever, received any feedback on the outcome of data collection and reporting activity.

The following proposals are made to address these deficiencies:

(i) QH should finalise the implementation of its web-based complaints database as a matter of priority.
(ii) Consideration should be given to amending the Health Act to establish a new statutory data collection of adverse events and complaints relevant to patient safety for public and private health care facilities. This database would be maintained by the QH Information Centre.
(iii) Steps should be taken to improve and streamline coordination of data collection practices within QH to minimise duplication of effort.
(iv) Feedback should be given at appropriate intervals (quarterly or biannually) to all services providing data for quality improvement or accreditation purposes.

Enhancing research on patient complaints and patient safety matters

At present, there is considerable scope for QH to enhance the scope and transparency of its patient complaints and patient safety data management practices. Without reliable quantitative data, performance management and quality improvement activity are hampered.

In view of the recent events at QH, the public will soon be seeking reassurance that the circumstances leading to these events have been addressed and that the situation has significantly improved. Developing the capacity to undertake research of reliable data will assist QH to demonstrate that the problems in the existing system are being addressed.

If, as proposed, QH implements improved data management practices as a priority then it would be possible to commence a range of research activity aimed at identifying the factors that could lead to improvements in patient safety and reduce the incidence of complaints. Good data would enable health care facilities to identify the most significant factors influencing public confidence in the health care system. Funding for such research could be provided to monitor the public health care system only (for example, through enhanced funding to the Patient Safety Centre in QH) or alternatively to capture data on the entire health sector in Queensland (through enhanced funding to a remodelled HRC to undertake research specifically on consumer complaints and patient safety issues within both the public and private sectors).

3.2 Complaints management by the HRC

If a complainant is unable to resolve a complaint with the service provider or is dissatisfied with the outcome or response provided, the complainant can seek the assistance of the HRC in resolving the complaint. If a complaint or serious allegation is about a registered health practitioner or registered nurse/midwife, the complainant may also take the complaint direct to the relevant health practitioner registration board or the QNC.

Part 5 of the HRCA outlines the types of complaints which can be made to the HRC, the assessment process, and what action can be taken if the HRC accepts a complaint.

Complaints may be made about any aspect of care or treatment provided anywhere in Queensland by any health service or health care practitioner, whether operating in the public or private sector. However, complaints must be raised with the HRC within 12 months of knowledge of the cause for complaint.

Only a person prescribed by s.59 of the HRCA may make a complaint to the HRC, that is:

- the user of the health service or his/her representative;
- someone with sufficient interest to act on behalf of the user if the user cannot choose a representative;
- if the user has impaired capacity, an appropriate attorney or the Adult Guardian or other guardian;
- the Minister for Health;
- anyone else the Commissioner considers should be permitted to make the complaint in the public interest.

If a complainant is not a prescribed person under s.59, the HRC does not have jurisdiction to assess or investigate the complaint. In these cases, the HRC may refer the complainant to the relevant registrant‟s board or other body.

3.2.1. Assessment process

Upon receipt of a complaint, the HRC undertakes a formal assessment and acts as an impartial link between the complainant and the HSP to resolve the complaint. The HRC may elect to facilitate resolution of a complaint even before formal assessment of the complaint has been undertaken.

Where the complaint is retained by the HRC for assessment, the Commissioner may invite submissions from the complainant and/or the provider and must invite a submission from the registration board.

Before deciding to accept a complaint for action, the HRC must be satisfied that, if at all practicable, the complainant has taken all reasonable steps to resolve the complaint with the provider[175].

The HRC endeavours wherever possible to take an informal and conciliatory approach to resolution of health complaints as the HRCA specifically refers to proceedings being conducted with "*as little formality and technicality, and with as much expedition, as practicable*[176]."

From commencement of an assessment, the Commissioner has a statutory time limit of sixty (60) days in which to assess the complaint. This period, however, may be extended by a further thirty (30) days in certain circumstances, for instance, if the complaint is too complex to assess in 60 days or the Commissioner considers the complaint can be satisfactorily resolved[177].

Upon assessing a complaint, the Commissioner must decide whether to take any action[178]. If the complaint is about a registered provider, the Commissioner must consult with the Board prior to taking action[179].

If the HRC decides to accept for action a complaint about a provider (other than a registered provider), the HRC may[180]:

- conciliate the complaint (under Part 6 HRCA);
- investigate the complaint (under Part 7 HRCA); or
- refer the complaint to another entity (s.73 HRCA).

3.2.2 Complaint about registered provider

Generally, the Commissioner must immediately assess a health service complaint[181]. However, where the complaint is about a registered provider, the Commissioner must refer it to the registered provider's registration board without assessment and not take any further action in relation to the complaint if:

- the Commissioner considers it is in the public interest for the complaint to be immediately referred to the registered provider's registration board; and
- after consulting with the registration board about the complaint, the board agrees it is in the public interest for the board to immediately deal with the complaint[182].

In addition, if the Commissioner believes:

[175] Section 71 HRCA.
[176] Section 30(1)(a) HRCA.
[177] Section 76 HRCA.
[178] Section 71(1) HRCA.
[179] Section 71(3) HRCA.
[180] Section 73(2) HRCA.
[181] Section 67 HRCA.
[182] Section 68 HRCA.

- the registered provider poses an imminent threat to the life, physical or psychological health, safety or welfare of users of the provider's services, or another person or class of person, or the registered provider; and
- immediate action to suspend, or impose conditions on, the registered provider's registration appears necessary to protect the person or persons,

the Commissioner must immediately refer the complaint to the registration board[183].

The HRC meets regularly with representatives from the health registration boards for the purpose of discussing complaints received and determining how best those complaints should be handled.

The Commissioner must not take any action about the complaint until the first of the following happens:

- the Commissioner receives the registration board's comments (usually to be provided within 14 days of the Commissioner consulting with the board)[184]; or
- the registration board advises the Commissioner that the board does not intend to give any comments; or
- the time for providing comments ends[185].

The Commissioner must have regard to any comments made by the registration board in making the decision[186]. If the registration board has advised the Commissioner it considers the complaint warrants investigation or other action by the board, the Commissioner must not decline to take action on the complaint, but must refer the complaint to the board[187].

3.2.3 Conciliation

Conciliation under the HRCA is a relatively formal process, that is accorded a number of statutory protections, in contrast to informal methods of dispute resolution that may be undertaken at the Intake or Assessment stage.

On accepting a complaint about an HSP, the Commissioner has a primary obligation to try to resolve the complaint by conciliation if the Commissioner considers it can be resolved in that way[188]. A decision to conciliate a complaint must take into account the public interest[189].
Conciliation is a flexible process which focuses on helping people to resolve their complaint about an HSP, through discussion and negotiation. Both the complainant and the HSP must agree to a matter proceeding to conciliation. The Conciliator acts impartially in the process and tries to encourage settlement of the complaint in a way that is acceptable to both parties. Some examples of the possible outcomes of conciliation include:

- an explanation of what happened;
- an apology;

[183] Section 77 HRCA.
[184] Section 71(5)(a) HRCA.
[185] Section 71(6)(a) HRCA.
[186] Section 71(6)(b) HRCA.
[187] Section 71(7) HRCA.
[188] Section 73 (3) & s. 74 (4) HRCA.
[189] Section 73(4) & s. 74(5) HRCA.

- financial settlement;
- quality assurance changes;
- change in health care provision.

If no satisfactory outcome has been reached, the complainant still retains the right to commence civil action[190]. The Commissioner may also decide to commence an investigation into the complaint. However, any information gathered for the purposes of conciliation or anything said or admitted during conciliation cannot be used by the Commissioner as a ground for investigation or inquiry[191] and is not admissible as evidence in a proceeding before a court, tribunal or disciplinary body.

3.2.4 Investigation process

Investigation is a formal process whereby the Commissioner gathers and analyses information concerning a complaint, and then forms a view as to the reasonableness or otherwise of the action being investigated. The Commissioner has substantial powers to obtain information and records, and to interview relevant parties. A report may be issued at the end of an investigation with recommendations to appropriate persons/organisations.

However, the Commissioner has no power to investigate a registered provider.

Where the complaint is about a registered provider and the Commissioner and the registration board have agreed that the complaint requires investigation or other action by the board, the Commissioner must immediately refer the complaint to the board[192]. If the Commissioner and the board cannot agree, the Minister will decide[193].

3.3 Complaints management by the registration boards

The Health Practitioner Registration Boards (the boards) have a legislative duty to protect the public by ensuring health care is delivered by registrants in a professional, safe and competent way. The boards must also aim to uphold the standards of practice within the health care professions and to maintain public confidence in their profession.

Each board is responsible for the determination of professional standards, assessment of applications for registration and investigation of complaints. If a board reasonably believes at any time, whether on the basis of a complaint or otherwise, that a registrant poses an imminent risk to the health or safety of others, the board has authority to suspend, or impose conditions on, the registrant"s registration[194].

The boards may institute disciplinary action against their registrants for "unsatisfactory professional conduct", a term defined in the Schedule Dictionary to the HPPSA.

3.3.1 Complaint handling by the boards

If users of health services are unable to resolve their complaint directly with the registered provider, they may lodge a complaint with the HRC or the appropriate registration board. As mentioned earlier, the HRC and the boards consult regularly about complaints.

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190 Any civil action must be commenced within a period of three years from the incident that led to the complaint.
191 Section 91 HRCA.
192 Section 74 HRCA.
193 Section 74(7) HRCA.
194 Section 59 HPPSA.

A complaint about a registrant may be made to the registrant's board about any aspect of the registrant's conduct or practice, or another matter relating to the registrant, that appears to provide a ground for disciplinary action against the registrant[195]. Also, a complaint may be made to a board about a matter for which a complaint may be made under the HRCA[196].

While most complaints are dealt with by the HRC in the first instance, the boards will deal with certain types of complaint, for example:

- complaints about compromised standards of practice;
- sexual misconduct;
- complaints made by one practitioner about another practitioner; and
- complaints about medico-legal reports.

A registration board must investigate the registrant:

(a) if directed by the Minister ;
(b) where the registration board and the Commissioner have agreed the board is to investigate the complaint; or
(c) where the board has suspended or imposed conditions on the registrant"s registration.

In addition, a board may investigate a registrant of its own motion (that is, without a complaint being received) if it reasonably believes that an aspect of the registrant's conduct or practice, or another matter relating to the registrant, may provide a ground for disciplinary action against the registrant[197].

An investigation is commenced by the appointment of an investigator or investigative committee. The HPPSA provides for who may be appointed as an investigator, including a member of a board, the Executive Officer of a board, a member of the board"s staff (with the consent of the Executive Officer) or other person considered by the board to have the necessary expertise or experience to be an investigator[198].

The registration boards have similar investigative powers to the HRC (Part 5 Division 5 of the HPPSA). However, unlike the HRC, the boards have power to compel a registrant to respond to a complaint and provide stated information within a reasonable time. A penalty can be imposed for failure to provide the requested information[199].

Upon finalisation of an investigation, a preliminary report and/or a final report is prepared by the board, including the findings and proposed action to be taken by the board[200]. A copy of the report is provided to the Commissioner who may provide comments about the report within 14 days after receiving the report or such longer period as agreed to by the board[201].

[195] Section 48(1) HPPSA.
[196] Section 48 HPPSA.
[197] Section 63 HPPSA.
[198] Section 73 HPPSA.
[199] Sections 78 & 79 HPPSA.
[200] Sections 114 & 115 HPPSA.
[201] Section 116 HPPSA.

After providing the Commissioner with a copy of the report, the board must not take any action on the complaint until one of the following happens:

a) the board receives the Commissioner's comments about the report and considers the comments;
b) the board receives advice that the Commissioner does not intend to give any comments;
c) the period for the Commissioner to give comments about the report ends. [202]

Section 118 of the HPPSA outlines the types of action the board may take upon finalisation of the investigation. For example, the board may decide to refer a disciplinary matter for hearing by a panel or by the Health Practitioners Tribunal (the Tribunal) or start proceedings to prosecute the registrant for an offence. Where appropriate, the board may also decide to enter into an undertaking with the registrant, with the registrant‟s agreement, about the registrant‟s professional conduct or practice. This will be recorded in the board‟s register for the term of the undertaking.

As soon as practicable after deciding what action to take under s.118, the board must give written notice about its decision to the registrant, the complainant, and the Commissioner[203] and then proceed with the relevant action.

The HPPSA provides that the purposes of disciplinary proceedings and disciplinary action against registrants are:

(a) to protect the public;
(b) to uphold standards of practice within the health professions; and
(c) to maintain public confidence in the health profession[204].

There are a number of grounds outlined in the HPPSA[205] that the registration boards can rely on when commencing disciplinary action against a registrant, including:

- the registrant has behaved in a way that constitutes unsatisfactory professional conduct;
- the registrant has failed to comply with a condition on practice imposed under that Act or the Health Practitioner Registration Act under which the registrant is registered, or an undertaking entered into under the HPPSA.

The term “unsatisfactory professional conduct” is defined in the Schedule to the HPPSA. It includes professional conduct that is of a lesser standard than that which might reasonably be expected of the registrant by the public or the registrant‟s professional peers. It also includes professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgment or care, in the practice of the registrant‟s profession. This definition gives a wider scope to “unsatisfactory professional conduct” than “conduct discreditable to the profession” or “professional misconduct” as previously understood and applied, because the concept embraces public and peer group perceptions of what is acceptable conduct.

A registrant‟s board may start disciplinary proceedings against a registrant if it reasonably believes a disciplinary matter exists in relation to the registrant. This may be in response to

[202] Section 116 HPPSA.
[203] Section 120(1) HPPSA.
[204] Section 123 HPPSA.
[205] Section 124 HPPSA.

a single complaint received about the registrant or a number of complaints which may suggest a pattern of conduct or practice.

Part 6 of the HPPSA provides a three level disciplinary framework to which the MBQ may refer disciplinary matters. The three levels are:

- Disciplinary proceedings conducted by the MBQ (in the form of a hearing or by correspondence);
- Professional Conduct Review Panel;
- Health Practitioners Tribunal (the Tribunal).

The three levels differ in the constitution of the disciplinary body, and in the severity of the sanction which may be imposed if allegations against the registrant are proven.

The QNC is governed by the provisions of the Nursing Act, and has similar functions and disciplinary powers and procedures as the boards, but in respect of registered nurses and midwifes. It also meets regularly with the HRC for the purpose of discussing the management of complaints about registered nurses/midwives received by either itself or the HRC.

3.4 Development of Queensland's current health complaint mechanisms

Queensland experienced a significant health reform process in the 1990s. The establishment of the HRC in 1992 followed the inquiry into Ward 10B of the Townsville General Hospital during the 1980s.

3.4.1 The previous scheme

When it was established in 1992, the HRC had jurisdiction to investigate complaints against registered health providers. If it was decided that a complaint warranted action, the HRC had the power to retain the complaint for conciliation or investigation, or it could refer the complaint to whichever of the registration boards it determined had the most appropriate functions and powers to deal with the case[206].

The ability of a board to investigate complaints about its own registrants was somewhat hampered, for a number of reasons:

- a board was required to refer any complaint it received to the HRC (even though there was no reciprocal requirement for the HRC to refer a complaint to the board);
- there was no legislative provision to enable boards to require the HRC to refer to a board complaints on which the board wished to take action;
- except for the MBQ, the boards lacked investigative powers.

Under this scheme, the HRC was the primary agency for investigating and resolving health service complaints, with the boards mostly responsible for addressing disciplinary issues arising from health care complaints. However, under this scheme, the HRC did experience some operational problems. The disciplinary provisions of the health practitioner registration Acts did not dovetail with the HRCA, and this created the potential for delay and an increased risk that professional standards issues could be overlooked.

[206] Section 121 of the *Health Rights Commission Act,* as then in force.

During the consultation stage of the reform process, a number of concerns about the old scheme were raised, including:

- the absence of parallel jurisdiction to the HRC to accept and investigate complaints;
- doubts about the admissibility of the HRC‟s investigation reports in disciplinary proceedings before the boards;
- inadequate powers of the boards to investigate disciplinary matters;
- deficiencies in the statutory consultation requirements (for example, the Commissioner was not required to consult a board before making an assessment decision and a board was not required to advise the Commissioner when disciplinary proceedings were being commenced);
- inability of the Commissioner to refer complaints to a board without going through the assessment process, which was causing delays in disciplinary matters being addressed.

3.4.2 The current scheme

In the late 1990s, 13 Acts relating to health care were passed which substantially addressed these concerns and reformed the existing health complaints system. The most notable of these was the HPPSA which had been under discussion and consultation for six years before it became law in 1999.

The operations of the HRC were affected by the passing of the HPPSA, because it removed the HRC‟s powers to investigate complaints against registered providers and placed them instead in the hands of Queensland‟s health practitioner registration boards. This shift in power to the boards represented a judgment that complaints against individual registered practitioners should be primarily assessed and actioned on the basis of peer review.

The then Commissioner expressed strong concerns about this change during the proposal stage of the Act. In the HRC‟s Annual Report 1999-2000 at p.4, he said: "*If the investigation of complaints is to be seen to be undertaken in an open and accountable manner this can best be achieved by an independent and impartial agency."* Many did not see the registration boards as meeting these criteria. As a consequence of their protests, the proposed legislation was amended to give the HRC a role in monitoring complaints referred to a board for investigation, with the board being required to provide its investigation reports to the HRC for comment.

Under the new legislative scheme, the HRC was left with its existing jurisdiction to investigate complaints against:

- non-registered practitioners; and
- institutions/organisations providing a health service, including both public and private hospitals.

The intention of the reforms was to better protect the public by:

- enabling the boards to investigate complaints about their own registrants and initiate disciplinary proceedings for unsatisfactory professional conduct; and
- freeing up the HRC to more readily carry out its statutory function of overseeing, reviewing and improving the health system.

It was anticipated that this model would allow the HRC to continue to oversee the handling of complaints about health services, through monitoring complaint handling by the boards thereby promoting consistent approaches by the different boards.

Provisions were introduced into the respective Acts to require the boards and the QNC to keep the HRC informed of all matters relating to an investigation, and to forward to the Commissioner a copy of the reports on an investigation prior to taking action on the matter.

In considering the reports, the boards and the QNC are required to have regard to the comments of the Commissioner. There is no statutory requirement for boards and the QNC to comply with comments made by the Commissioner. However, the Commissioner in his 2003-2004 Annual Report, stated that, where he had commented on or raised issues requiring further attention by a board, the board had taken those comments into account before making a final decision.

If the Commissioner considers a board has not taken appropriate action in response to his comments, he may give a report to the Minister.[207]

3.4.3 Weaknesses in the current jurisdiction and powers of the HRC

A comparative study of the HRCA and corresponding legislation in other states and territories in Australia and New Zealand indicates that the HRC"s jurisdiction and powers in respect of health service complaints are limited in comparison to its counterparts, in particular, with respect to:

(i) the limited category of persons who may complain to the HRC;
(ii) the HRC"s lack of power to compel a registered provider to respond to a complaint;
(iii) the HRC"s lack of jurisdiction to formally investigate complaints about registered providers, or to initiate "own motion" investigations on matters that may be in the public interest;
(iv) the HRC"s lack of power to impose any formal sanction on HSPs (particularly unregistered providers who are not subject to any prosecutorial or disciplinary action by another body), and limited involvement (that is, commenting on action proposed by a registration board) in decisions about disciplinary action against registered HSPs.

Who may complain to the HRC

Section 59 of the HRCA provides that a complaint may be made to the HRC by:

- the user of the health service or his/her representative;
- someone with sufficient interest to act on behalf of the user if the user cannot choose a representative;
- the Legal Friend or Adult Guardian;
- the Minister for Health; and
- anyone else the Commissioner may accept a complaint from in the public interest.

Section 59 effectively excludes complaints from non-users of a health service (for example, another HSP, clinical or administrative staff of an organisation providing health

[207] Section 126 HCRA.

services, or whistleblowers) unless accepted by the Commissioner as a complaint concerning a health service which should be accepted in the public interest.

The New South Wales Health Care Complaints Act (HCCA) provides that "any person" may make a complaint[208]. This is considered preferable in that it enables independent external review of complaints from both users of a health service, and other potential complainants of the kinds indicated above.

The HRC"s lack of power to compel a registered provider to respond to a complaint

When the HRC receives a complaint about a registered provider, the Commissioner is to assess the complaint to determine whether or not to accept it for action. However, while the HRC has power to require a non-registered provider, or an organisation, to respond to a complaint and to provide information, it has no power to make the same requirement of a registered provider. Rather, the HRC can only invite a response from a registered provider[209]. A refusal by a registered provider to co-operate with the HRC"s enquiries can lead to unnecessary delay in the complaint being progressed.

This often leads to the HRC having no other option but to refer the matter to the relevant board, which does have the power to compel a registered provider"s co-operation with a board"s investigation of a complaint (although the board will only investigate complaints that raise issues sufficiently serious as to potentially involve "unsatisfactory professional conduct" as defined in the Schedule to the HPPSA).

The Commissioner in his 2003-2004 annual report (p.9) noted that one way around the above problem would be for the HRC to be given the power to obtain relevant information and to require providers to respond to a complaint. This would bring the HRC into line with interstate Commissions that currently have this power.[210]

The HRC"s lack of jurisdiction to formally investigate complaints about registered providers or to initiate "own motion" investigations

The HRC is the only Commission in Australia that does not have jurisdiction to investigate a complaint about a registered provider. All other interstate Commissions have a discretionary power to investigate such complaints.

In Victoria, if a complaint relating to a registered provider is received by the Commission, it must refer the complaint to the appropriate registration board if, after consultation with the provider"s registration board, the Commissioner considers that the board has the power to resolve or deal with the matter and the matter is not suitable for conciliation[211].

In other jurisdictions, the Commissioner"s view prevails in respect of more serious complaints, for example, complaints involving issues of a systemic nature or complaints relating to professional conduct, or complaints raising concerns about public health or safety or the public interest[212]. In other words, in these jurisdictions the Commission may

208 Section 8 of the *Health Care Complaints Act 1993* (NSW).

209 Section 70 HRCA. The only obligation on a registered provider is to advise the HRC whether or not he/she intends to make a submission.

210 Section 28 of the *Health and Community Services Complaints Act 2003* (NT); s.30 of the *Health and Community Services Complaints Act 2004* (SA).

211 Section 19(6) *Health Services (Conciliation and Review) Act 1987* Vic.

212 Section 48 *Health and Community Services Complaints Act 1998* (NT)*; s.40 Community and Health Services Complaints Act 1993* (ACT); *s.26 Health Care Complaints Act 1993* (NSW)*; s.43 Health and*

exercise a discretion to investigate in the interests of public health or safety, or if the complaint raises significant issues as to the provider's practice.

One of the flaws in the HCRA is that, although the HRC must refer all complaints about registered providers to the relevant registration board, the boards are not compelled to accept a complaint for action, and will only do so if they consider the complaint is sufficiently serious to warrant their intervention because it may involve unsatisfactory professional conduct (as defined in the Schedule to the HPPSA) by a registered provider.

This creates a hiatus for complaints against a registered provider which have substance, but which the board considers are not sufficiently serious for it to take action (because they would not reach the standard for disciplinary action, that is, "unsatisfactory professional conduct", as defined). The HRC has no power to investigate such complaints against a registered provider (unless specific permission is obtained from the Minister on a "case by case basis"). In these circumstances, the complainant may well have no avenue for independent review.

The Neville complaint provides an example of the difficulties that can arise when a board declines to accept a complaint for further action (on the basis that the conduct complained of does not appear to provide a ground for disciplinary action). After the MBQ declined to accept the Nevilles' complaint about the Executive Director, the Commissioner sought the Minister's approval for the HRC to investigate the matter. The Minister refused on the basis that QH had appointed an External Investigator to investigate this aspect of the Nevilles' complaint. In my view, the External Investigator did not adequately address this issue, with the result that this aspect of the Nevilles' complaint has never been adequately investigated. This situation could have been avoided if the HRC had the power to investigate aspects of a complaint that relate to the conduct of a registered HSP.

The HRCA does not empower the HRC to conduct "own motion" investigations. The Health and Disability Commission in New Zealand and a number of interstate Commissions have the power to initiate investigations[213] on their own motion, as does the newly formed Legal Services Commission in regulating the legal profession in Queensland, and my Office.

<u>The HRC's lack of power to impose any formal sanction on HSPs (particularly unregistered providers who are not subject to any prosecutorial or disciplinary action by another body), and limited involvement in decisions about disciplinary action against registered HSPs</u>

The HRC is able to accept for investigation complaints about non-registered providers (primarily, organisations such as hospitals, hostels or nursing homes and a number of alternative therapists not subject to professional registration requirements). However, in instances of unsatisfactory service (no matter how egregious) it is unable to impose any formal sanction or initiate any disciplinary action against that provider, and there is no other disciplinary body able to take on this role.

Community Services Complaints Act 2004 (SA)*; s.46 Health Services (Conciliation and Review) Act 1995)* WA.

213 For example, s.59 HCCA; s. 40 *Community and Health Services Complaints Act 1993*(ACT); s. 43 *Health and Community Services Complaints Act 2004* (SA); s.48 *Health and Community Services Complaints Act 2003*(NT).

The boards and the QNC are empowered to take disciplinary action against registered providers before established disciplinary bodies. While the Commissioner is unable to initiate, or direct a board or the QNC to initiate, disciplinary action, the Commissioner does have some limited input into the process. Where the Commissioner has requested a board or the QNC to provide him with reasonable reports during an investigation, the board /QNC must give the Commissioner a report about the findings of the investigation and the action taken or proposed to be taken (including any proposed disciplinary action to be taken against the registrant the subject of the investigation). The Commissioner may then make comment or recommendations to the board/QNC about any proposed disciplinary action to be taken. The HRCA also makes provision for the Commissioner to intervene in a proceeding against a registered provider before a disciplinary body at any time during the proceedings[214].

The only jurisdictions in which the Commissions are empowered to prosecute cases against individual registrants before disciplinary bodies are New South Wales and New Zealand. In both jurisdictions, the decision whether to take any disciplinary action is made by a Director of Proceedings, who is a senior lawyer employed by the Commission (see Appendix 4 for more detail).

Some commentators believe that a Commission having a prosecutorial role is inimical to obtaining co-operation by registered HSPs for the resolution of complaints through negotiation and formal conciliation, which should be the primary emphasis of a health complaints body[215]. The contrary view is that decisions on possible disciplinary action should not be left in the hands of registration boards comprised mostly of members of the relevant health care profession.

In Queensland, we have a precedent for the prosecutorial model in the recently established Legal Services Commission, which may indicate a legislative preference for removing control of professional regulation and discipline from bodies comprising members of the relevant profession.

The Legal Services Commission currently initiates disciplinary proceedings against legal practitioners if, after investigation, there is a "reasonable likelihood of a finding by a disciplinary body of unsatisfactory professional conduct or professional misconduct" and "it is in the public interest to do so". When the evidence warrants it, the Legal Services Commissioner prosecutes legal practitioners before the Legal Practice Committee or, for more serious matters, the Legal Practice Tribunal. Accordingly, there is an established precedent in Queensland for an independent complaints agency that investigates, or monitors the investigation of, complaints about the provision of professional services, and makes decisions about whether or not to initiate disciplinary proceedings.

214 Section 130 HRCA.

215 D.Thomas (ed.). *Medicine called to Account: Health Complaints Mechanisms in Australia, UNSW Press, 2002 p.8.*

Chapter 4. Health complaints models interstate and overseas

4.1 Australia and New Zealand

The various bodies established in Australian States and Territories and in New Zealand for receiving and investigating health care complaints (called "Commissions" here for the sake of brevity) differ in their jurisdiction and powers. In general though, they all have jurisdiction to:

- receive health care complaints;
- attempt to resolve complaints, primarily through a process of mediation or conciliation between the service provider and the complainant; and
- oversee, review and improve the overall health system.

The Commissions are also, to varying degrees, empowered to investigate "systemic" issues. The New Zealand Health and Disability Commissioner is among those offices which have a wider brief, with the ability to investigate and prosecute private and public providers, orthodox and alternative therapists and, importantly, to initiate "own motion" investigations.

The complaints mechanisms set up in all Australian States and Territories, other than in New South Wales, are based on a conciliation approach. The New South Wales Health Care Complaints Commission is the only Australian Commission that, like the New Zealand Health and Disability Commissioner, is empowered to prosecute health practitioners before registration boards, tribunals and professional standards committees. However, conciliation has been introduced in New South Wales as an alternative to the Commission"s prædominantly prosecutorial approach.

The proponents of the conciliation approach argue that, when medical errors or misadventures occur, the best way to deal with them is through non-legal conflict resolution measures. Furthermore, the conciliation approach enables those who have suffered medical misadventure to obtain financial compensation. They also argue that an adversarial, legalistic approach is not the best way to promote efficiency and effectiveness in the health care area, or to deal with situations in which human error rather than intentional misconduct has resulted in adverse events.

Until March 2005, the New South Wales Health Care Complaints Commission provided an advocacy role for complainants. On that date, it lost that role and took on a role as an impartial body for alternative complaints resolution. This provides a less formal option to the conciliation approach and is completely independent of the investigative processes of the Commission. The New Zealand Commission is now the only jurisdiction that has an advocacy role for complainants.

While there are some subtle differences, the individual processes of the Commissions are very similar.

The following table summarises the key processes of the Commissions in each State/Territory and New Zealand.

	QLD	NSW	VIC	NT	WA	ACT	TAS	SA	NZ
Health Commission	x	x	x	x	x	x	x	#	x
Formal Investigative role	x	x	x	x	x	x	x		x
Formal Conciliation role	x	*	x	x	x	x	x		x
Advocacy role									x
Legislation includes services for aged				x		x			
Legislation includes services for disabled				x		x			x
Consult with Boards	x	x	x	x	x	x	x		x
Prosecutorial function		x							x
Assessment timeframe	x	x	x	x	x		x		
Extension of Assessment option	x	x	x						
Code of Health Rights & Responsibilities				x			x		x
Act recently reviewed/under review		x		x	x	x	x	x	

*In New South Wales the conciliation function is carried out by the Health Conciliation Registry. This was previously a separate body within the New South Wales Department of Health. However, on 1 March 2005, the Registry was integrated with the New South Wales Health Care Complaints Commission (HCCC) so that the existing conciliation service could be better utilised and all alternative dispute resolution functions could be performed efficiently under the auspices of the HCCC. It has retained its independence, in that it is not subject to the direction or control of the Commissioner when carrying out its conciliation function.
Since 1 March, the HCCC also has a complaints resolution role (refer to Division 9 of the *Health Care Complaints Act 1993* as amended).
#Currently, the SA Ombudsman considers health complaints but only those relating to public providers. The SA Parliament has passed legislation to establish a Health and Community Services Complaints Commissioner. The Act is expected to operate from mid to late 2005.

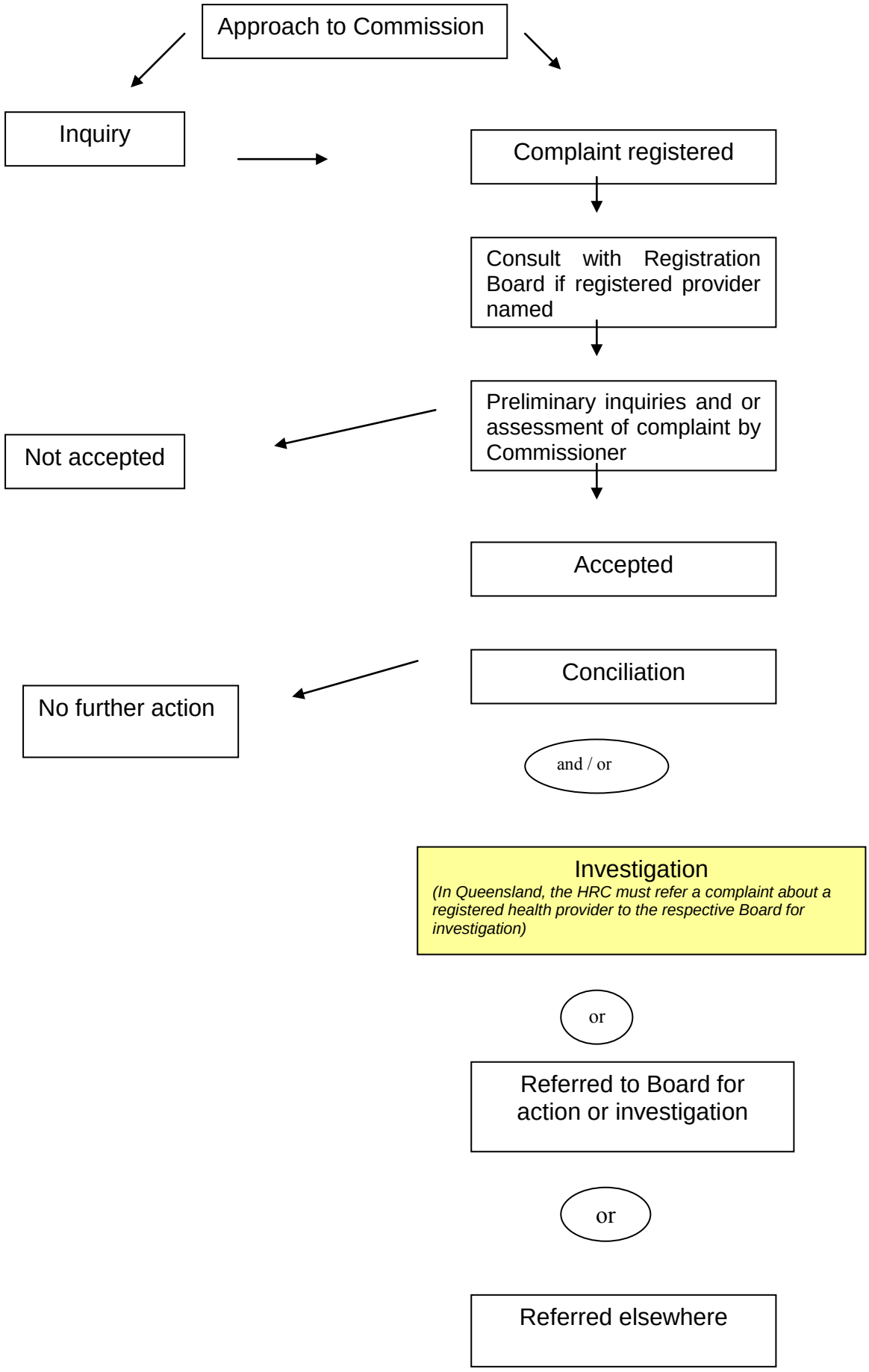
4.1.1 Relationships between the Commissions and the registration authorities

In Australia, the respective Commissions and registration boards generally have a statutory obligation to report complaints about registered providers to each other, and consult on the best way to manage the complaint. A complaint may be referred to the board if the Commission considers the board has power to deal with it, or if the complaint is not suitable for conciliation. There is a requirement for written protocols to ensure consultation occurs and, where the legislation is silent, on how disagreements regarding management of a complaint are to be resolved.

Except in Western Australia, there is no requirement for a Commission to obtain the complainant"s consent before referring a complaint received about a registered provider to a registration board for action. In Western Australia, the Office of Health Review has a statutory obligation to obtain the written consent of the complainant before referring the complaint to the registration board for action[216].

The following flowchart represents the standard processing of complaints by the Commissions (with the exception of New South Wales):

[216] Section 31 *Health Services (Conciliation and Review) Act 1995* WA.


Approach to Commission
Inquiry
Complaint registered
Consult with Registration Board if registered provider named
Preliminary inquiries and or assessment of complaint by Commissioner
Not accepted
Accepted
Conciliation
No further action
and / or
Investigation
(In Queensland, the HRC must refer a complaint about a registered health provider to the respective Board for investigation)
or
Referred to Board for action or investigation
or
Referred elsewhere

4.2 New Zealand

In New Zealand, the complaint mechanism established by the *Health and Disability Commissioner Act 1994* NZ is the primary method for dealing with complaints about the quality of health care and disability services.

The New Zealand model employs a code, entitled the *Code of Health and Disability Services Consumer"sRights* (the Code), that has a binding effect on all providers of health and disability services. The Code sets out ten rights, including the right to be treated with respect, to be free from discrimination or exploitation, to dignity and independence, to services of an appropriate standard, to give informed consent, and to complain.

The role of the Commissioner is to protect the rights of consumers of health and disability services, and facilitate the fair, simple, speedy and efficient resolution of complaints. There is a national network of independent advocates (free service) under the Director of Advocacy. There is also an officer called the Director of Proceedings who is an employee of the Commissioner"s office but who acts independently of the Commission in exercising the powers and performing the duties and functions of the position[217]. The objectives of the Act are achieved through the Code, the establishment of a complaints process to ensure enforcement of the rights in the Code, and the ongoing education of providers and consumers.

The Commissioner is also able to undertake investigations on his/her own initiative. This enables the Commissioner to fulfil the role of "consumer watchdog" and to ensure public safety.

All complaints made to the registration boards must be referred to the Commissioner. Once this occurs, no disciplinary action can be taken by the registration board until the Commissioner, or the Director of Proceedings, has dealt with the matter and decided to take no further action. Only at that point can the registration board take up the matter.

However, referral of a complaint to the Commissioner does not preclude a registration board from considering a member"s fitness to practice for reasons other than discipline, namely health or disability or competence to practice.

The Commissioner"s options in respect of complaints are to take no further action, to investigate, or to refer the complaint to formal mediation or to advocacy. Advocates can assist a consumer in resolving a complaint with a provider. The advocate, after hearing the complaint, can provide free advice about the rights of the complainant and provide support in deciding what course of action to take.

If the Commissioner decides to investigate a complaint, an investigator is appointed. Once all relevant information has been gathered, the Commissioner may ask an expert in the area to review the information and advise whether the services provided met the appropriate professional standards. Taking into account the expert advice and other relevant evidence, the Commissioner determines whether the rights in the Code have been breached.

If the Commissioner forms an opinion that a provider has breached the Code, the respective parties are notified and the provider will be given an opportunity to make a

[217] Section 15 *Health and Disability Commissioner Act 1994* (NZ).

written submission. In reporting the final decision, the Commissioner may refer the matter to the Director of Proceedings, who may bring disciplinary and/or other proceedings. On referral to the Director of Proceedings, the principal avenues of redress are a claim before the Human Rights Review Tribunal, or disciplinary proceedings before a health professional disciplinary body. The Director may decide to take action in both forums. If the Director of Proceedings decides to take no action, an individual is able to take his or her own case to the Human Rights Review Tribunal.

The Commissioner does not have any power to award compensation. Examples of recommendations that may be made where a provider has not met the obligations under the Code include:

- an apology;
- a refund of some or all of the money a consumer has paid for services that are found to be below expected standards;
- a change in the way the provider does things, or changes to organisational policies.

The Commissioner can also ask the Minister for Health to take steps to improve a service if an investigation reveals a problem, or if new rules are needed to protect consumers.

4.3. United Kingdom (UK)- National Health Service

In 1999, a national evaluation of the National Health System (NHS) complaints procedure revealed that the public considered the procedure was not sufficiently independent. A further report released in 2003 found the complaints system was perceived as inconsistent, and that complaints took too long to be processed.

As a result, the UK Department of Health decided that a new complaints system should be set up, incorporating a second level of review by an independent organisation, the Healthcare Commission (HCC). The HCC is an independent inspection body for both the NHS and private and voluntary healthcare. The aim of the HCC is to increase patient confidence in the NHS complaints procedure, and to improve services in the NHS by pinpointing where things are going wrong in an independent, fair, consistent and timely manner. The HCC has the power to charge the NHS Trusts[218] for reviewing complaints made against them.

[218] Trusts are public bodies that provide health services.

An outline of the changes to the complaints process is summarised below:

	Old Process (est. 1996)	New Process (July 2004)
Stage 1 - Local Resolution	Patient, or someone acting on their behalf, complains to the organisation or practitioner concerned.	(Unchanged)
Stage 2 - Independent review	If the patient was unhappy with the response obtained at stage 1, they could apply for an independent review overseen by an NHS convener - usually a non-executive Director of the Trust to which the complaint was made. If the individual was unhappy with the convener"s initial response, a panel consisting of the convener, a chair nominated by the strategic health authority, and one other, would be established to hear the complaint.	If the patient is unhappy with the response obtained at stage 1, they can apply to the HCC for an independent review. Trusts can also refer complaints to the HCC with the patient"s consent. If the individual is still unhappy after the initial review and investigation by the case manager, they have the option of having their case heard by an independent panel. There are set timescales and phases the HCC works to in handling these requests.
Stage 3 - Health Service Ombudsman	If a patient was unhappy, the complaint could be referred to the Health Service Ombudsman.	If a patient is still unhappy, complaint can still be referred to the Health Service Ombudsman and, in some circumstances, the HCC will refer complainants directly to the Ombudsman.

The success of the new NHS complaints procedure depends on good complaints handling locally, by the service provider. The HCC works with the Department of Health to identify best practice complaints handling and to promote good clinical practice.

Under the new system, an individual needs to bring a complaint to the HCC within two months (60 days) of receiving a formal written response from the trust or health practice concerned. The only exception to this is if the complaint has been with the trust or practitioner for more than six months without a formal response, in which case the HCC can be asked to investigate.

All requests for an independent review by the HCC are acknowledged within two days. A member of the complaints team then conducts an initial review of the case, with the help of expert advice if necessary, to determine whether further investigation is needed. To ensure consistency, a team leader reviews any recommended course of action by the case manager. Both the complainant and organisation/practitioner complained about are advised of the decision and any recommendations within 20 days. The following table summarises the complaints process and the timeframes involved.

ACTION	TIME
Acknowledge complaint	Within two days of receipt
Obtain consent forms (obtain medical records)	Up to 5 days
Call for papers, including views of organisation complained against on the complaint	Up to 20 days
Expert advice identified and received	Up to 30 days
Decision on what will happen to the case	Up to 10 days
Communication to all parties	Immediately following decision on what is to happen to the case
If investigation agreed, terms of reference drafted	Two days
Comments from parties	Up to 10 days
Identify and secure experts	Up to 20 days
Arrange interviews, call for further papers, write report, quality assurance	Must be completed within 90 days of decision to investigate unless there is good reason
Request from complainant or organisation complained against for hearing by a panel	Within 40 days of report
Panel established	Within 48 days of the receipt of the request
Draft report for checking by parties for factual accuracy	Within 10 days of panel hearing
Receipt of comments and checks for quality	Within 10 days of deadline for comments
Issue report	

N.B. Some of the timeframes may be concurrent.

The HCC investigates allegations of, or information suggesting, serious failings that have a negative impact on the safety of patients, clinical effectiveness or responsiveness to patients such as:

- a higher than anticipated number of unexplained deaths;
- serious injury or permanent harm, whether physical, psychological or emotional;
- events that put at risk public confidence in the healthcare provided, or public confidence in the NHS generally;
- a pattern of adverse events or other evidence of high risk activity;
- a pattern of failures in services or teams, or concerns about these;
- allegations of abuse, neglect or discrimination against patients.

Other failings with less serious effects on patient safety may be subject to review by the HCC.

If the decision is made to carry out further investigation, the investigation‟s terms of reference are agreed upon with both the complainant and the organisation/practitioner. Even if a complaint has been made to a statutory professional regulatory body, an investigation by the HCC and full report of the investigation findings are provided to both parties at the end of the investigation.

If individuals are unhappy with the outcome of the investigation, they have a right to request an independent panel be established to hear their concerns. The panel consists of three members of the public, who are not connected to the NHS but who have been specially trained to deal with NHS complaints. The panel will hear both sides of the

complaint. They will also make recommendations for resolution and/or for improving services where appropriate. In the majority of cases, the whole process should take no longer than six months.

The panel is not adversarial, but must uphold the principles of fairness and consistency. The standard of proof is the civil standard of "balance of probabilities". The majority view prevails.

Accurate records approved by the panel members are kept of conclusions and recommendations, and the reasons for reaching the conclusions. The panel makes two sets of recommendations: one concerned with redress for the individual and the other regarding improvement of the services (where appropriate). A full report is available to the parties and an anonymised report is published and available on the HCC website. At every stage of the procedure, anonymised information is fed into the HCC"s baseline information systems on the organisations complained against, to facilitate analysis of patterns or trends.

The boards of the relevant NHS trusts are responsible for putting into operation the recommendations (if any) in the investigation and panel reports. The HCC expects NHS bodies to be able to demonstrate how they have improved systems as a result of information from complaints. This involves the NHS service providers producing action plans based on recommendations from the HCC investigations, panel hearings and reports.

One of the problems faced by review panels under the old system was that they often had incomplete information on which to make a judgment. Under the new system the panel will have a full investigation report and so will not need to reinvestigate issues that have been established.

An individual can expect that the HCC will pursue an explanation and acknowledgement of what went wrong, and action to put the matter right. Where warranted, the HCC seeks an apology for the patient and can also recommend the healthcare provider change the way it works so that similar things don"t happen again and that lessons are learnt from what went wrong. The HCC is unable to seek compensation for the complainant/patient.

Where complaints involve different aspects of care, such as a GP service and a hospital for acute care, the HCC can look at the whole of the patient"s experience. The HCC works with other agencies to ensure that the complaint investigation covers the whole of the patient"s experience, rather than separate investigations for different elements of a complaint. In this way it helps to avoid duplication of investigation for healthcare organisations and makes it easier for the relevant bodies to learn from complaints.

By carrying out its responsibilities for inspection and audit of healthcare, the HCC is in a position to ensure that information from complaints is used by local organisations to improve services.

Clear cases of negligence are referred to the General Medical Council.

The HCC also shares information obtained from complaints with the National Patient Safety Agency (NPSA). The NPSA is a special health authority created in July 2001 to establish a national system for identifying adverse events and near misses in healthcare by:

- gathering information on causes; and

- acting to reduce risk and prevent similar events occurring in the future.

The NPSA was established to help address the estimated 900,000 incidents (at that time) either harming or nearly harming NHS hospital inpatients in the UK each year.

As well as making sure errors are reported in the first place, the NPSA promotes an open and fair culture in the NHS and encourages the reporting of incidents and "near misses" without undue fear of personal reprimand in the knowledge that, by sharing their mistakes, others will be able to learn lessons and improve patient safety. It proactively works to develop national solutions to prevent incidents that affect patient safety and aims to discover why things go wrong, rectify incorrect actions and make it harder to do the wrong thing.

The NPSA‟s areas of work originate from a number of sources including individual patients, patient groups, clinical experts, healthcare professionals and coroners. Issues are also identified by a national reporting and learning system and data from other organisations in the UK and abroad.

When the NPSA identifies an issue, it builds up a complete picture using information from a number of sources. Solutions are designed in partnership with clinical experts and patients, and then piloted in NHS organisations to assess their impact. The NPSA undertakes risk assessments at every stage, evaluates the effectiveness of solutions and learns from the results. The following summarises the different stages of the NPSA process:

- understand the patient safety issue
- identify areas for solution development
- explore possible solutions
- test and refine solutions and
- monitor solutions and track progress.

Chapter 5. Proposals for a new health complaints system

5.1 Shortcomings of the existing health complaints system in Queensland

The Neville investigation demonstrates a number of significant shortcomings and problems with the current health complaints system in Queensland. The system is difficult for many complainants to access and navigate. This is illustrated by the difficulties Dr Neville experienced in trying to obtain timely and appropriate outcomes from the system. Dr Neville is a medical practitioner (although his field is medical research), with highly developed research skills, and as a senior QH official, had a good understanding of the relevant systems. His travails highlight the difficulties liable to be experienced by others who attempt to use the current system without the advantages Dr Neville possessed.

The shortcomings of the current system can be summarised as follows:

- A fragmented health complaints system, involving several health complaint agencies, each with limited jurisdiction, but whose jurisdictions can overlap to varying degrees and are not well integrated. This results in:
    - inability of one agency to investigate all aspects of a complaint (for example, if the HRC investigates a complaint against a hospital it has to stop at the point where clinical competence of a registered provider becomes an issue);
    - complainants having to decide on the most appropriate agency to which to direct their complaint, or whether separate aspects of the one complaint may need to be referred to another agency or agencies for assessment, investigation and/or other action;
    - potential for duplication where a complaint has been split and a number of agencies are investigating different issues arising from the same incident;
    - annoyance for the complainant and witnesses when different agencies seek different kinds of information (relevant to the issues they have jurisdiction to investigate) at different times;
    - inability to produce one coordinated response following investigation of a complaint which has been split because different agencies have sole jurisdiction to deal with particular issues.
- A system that is not consumer-focused or user-friendly, principally because of the fragmentation referred to above, but also through:
    - lack of information by HSPs about their complaint processes;
    - a "culture" that does not welcome complaints thereby discouraging complainants for fear of reprisal;
    - "open disclosure" principles[219] not being broadly implemented;
    - lack of readily available support and advice for complainants who may require assistance in presenting and resolving their complaints with HSPs (for example, complaints coordinators in each QH Health Service District or an independent patient advocacy service).
- The system itself tends to foster delay through requirements for cross-referral and consultation between agencies with overlapping jurisdiction (or gaps in their jurisdiction), and because of the HRC"s inability to compel a registered provider to

[219] Part 5.9.2 below.

respond to a complaint during the assessment phase. With regard to the latter, the HRC may frequently have no option but to refer a complaint to the relevant registration board (which does have coercive powers), but the registration board will only take action if it believes the matter may involve unsatisfactory professional conduct. This has a relatively high threshold test which would not be met in many instances of unsatisfactory service by HSPs.

- There is a perceived or potential lack of impartiality in registration boards, comprised of members of the relevant profession, conducting an investigation, and undertaking disciplinary action, against „one of their own" (*cf*. recent moves to have an independent Legal Services Commissioner, rather than the Queensland Law Society Inc, take responsibility for supervision of complaints and disciplinary matters involving the legal profession).

- There is currently no provision for the centralised collection of complaints data, that could be analysed to reveal recurring problems and trends, as a basis for quality improvement measures.

5.2 Key features of a better health complaints system

A quality complaints system should be:

- accessible and user friendly to everyone, including those with special needs;
- fair and impartial in its processes;
- timely and efficient in dealing with complaints;
- committed to achieving fair remedies and promoting systemic improvements;
- accountable and transparent in its operations;
- committed to best practice and continuous improvement;
- cost effective;
- subject to periodic review.

A comprehensive coordinated system is needed for handling health complaints in Queensland. The primary means of dealing with such complaints should be the internal complaint management processes of the HSPs themselves. Each HSP should be required to implement a complaint handling procedure that complies with the Australian Standard.

In the case of QH, its internal complaint process should be enhanced as proposed at part 3.1.3 in Part 2 of this submission. That process also needs to be supplemented by appropriate procedures for encouraging and acting on PIDs and providing safeguards for those who make them, as recommended in Part 1 of this submission.

An independent body is also needed with overriding responsibility for all complaints (referred to here as "external complaints") that cannot be resolved by the relevant HSP or that are not appropriate to be resolved by the HSP. That body would deal with external complaints itself or ensure they are appropriately dealt with by another body.

In summary, this body should:

- receive and assess all external complaints about health service provision in both the public and private sectors, including complaints about registered providers, as well as non-registered providers;

- wherever possible, attempt early informal resolution of complaints, and where that is not successful, provide access to mediation and conciliation;
- investigate all aspects of the more serious complaints, including complaints about registered providers;
- refer cases warranting disciplinary action to a new disciplinary body (that would deal with disciplinary issues currently dealt with by the boards/QNC) or, in more serious cases of unsatisfactory professional conduct, to the Health Practitioners Tribunal (as is currently the position);
- be empowered to order minor remedial action for breaches by HSPs of a Code of Health Rights and Responsibilities;
- centralise the recording, collation and analysis of complaint data, so that complaint trends can be identified enabling complaint reduction measures and service delivery improvements; and
- be funded independently of QH, and report to Parliament and not to a Minister.

The focus of both internal and external complaint management should, wherever practicable, be more consumer focussed by providing complainants with ready access to informal complaint resolution processes and explanations for the causes of complaints. Furthermore, the system should focus not only on redressing the effect of poor decisions and service, but also on identifying and addressing the cause of recurring complaints and systemic failure.

Specific details of the recommended new health complaints system are set out in part 5.4, followed by reference to some other issues which should be considered in order to improve current arrangements.

5.3 Response to the BHCI proposals for a "One Stop Shop"

The BHCI has suggested that the best approach to dealing with the deficiencies in the existing public sector health complaints environment is to establish a "one stop shop" such as a Health Sector Ombudsman.

It is considered that a "one stop shop" is an appropriate model for external complaints resolution. However, the primary emphasis should be on local complaints resolution, with independent investigation, oversight and review where the matter cannot be satisfactorily resolved directly with the relevant HSP.

There should also be strong emphasis on non-adversarial complaints resolution processes, and on learning from patient complaints information to improve patient safety outcomes.

Within QH, a State-wide network of adequately resourced complaints coordinators would assist other measures referred to above for improving systems for, and outcomes from, local complaint resolution.

Local complaint resolution should be complemented by a remodelled HRC to provide a comprehensive health complaints system. Legislative amendment will be required to empower the HRC to take a more effective and central role in resolution of complaints that cannot be resolved locally with the HSP, in improving standards of health service provision, and in professional disciplinary matters. The HRC will need additional funding if it is to perform these responsibilities effectively.

The BHCI Discussion Paper made the recommendations numbered 1-5 below in relation to the role of the Health Sector Ombudsman, and I have made comments below about those proposed functions.

1. Receive complaints from any interested party, including patients, clinical staff, administrative staff, and the general public

Adopting the approach proposed in the BHCI Discussion Paper potentially adds a further layer or step in the complaints resolution process by requiring all complaints to go first through a central bureaucracy (which would have to be substantial given the number of complaints that are currently made each year) rather than encouraging direct local resolution wherever possible in the first instance.

It is considered preferable that, as the initial response, the local complaints coordinator work with the complainant to resolve the complaint with the HSP at the local level. Part of the receipt and referral function would involve facilitating access to alternative dispute resolution mechanisms where appropriate. The matter would be escalated to the appropriate entity where necessary.

Broadening the scope of persons eligible to complain would be better dealt with by an administrative policy within public sector health services and an amendment to the HRCA that entitles health practitioners to complain.

2. Refer complaints to the appropriate authority, whether it be the hospital administration, QH, the HRC, or the MBQ

Having a Health Sector Ombudsman screen and refer complaints would require substantial resources that could be better directed to enhancing the capacity of service providers to deal effectively with complaints at the local service delivery level and for better resourcing a remodelled HRC to undertake expanded functions and to achieve better performance in terms of timeliness.

3. Monitor the investigation and handling of complaints, to ensure that they are addressed and dealt with, both fully and expeditiously

The vast majority of complaints do not require monitoring because they should be resolved quickly and easily at the local level. For those matters which cannot be resolved, a remodelled HRC should take responsibility for timely complaint resolution, and providing more resources to that body would be more a effective allocation of resources.

Public sector health complaints could be centrally monitored directly via the web based complaints management system that is currently being trialled by QH. A similar and linked system could be established by the HRC to capture complaints from the public and private health sectors that are escalated for independent investigation.

To ensure that complaints related to patient safety are appropriately monitored and investigated, another option would be to establish a statutory data collection integrating all complaints related to patient safety, as well as serious adverse and sentinel events reports. *The Health Act 1937* could be amended to create a duty for such matters to be reported by public and private health care providers and complaints management entities to the QH

Information Centre. This data would then be available for research and intervention focussed on quality improvement and patient safety.

4. Where necessary, ensure the investigation of the complaint is escalated to the appropriate level if it cannot be resolved at a lower level; and

5. Ensure that the complainant receives feedback regarding the outcome of the complaint

The model proposed in this submission should satisfy recommendations 4 and 5 through reform or enhancement of existing entities, without establishing a further agency or duplicating existing systems.

These requirements could become part of an operational protocol or administrative instruction to staff employed in complaints management at the local level. In the case of both public and private sector health service organisations, the escalation of unresolved complaints could be facilitated by ensuring that complaints coordinators report directly to the Senior Manager at the health facility. In the public sector this could be monitored by the complaints management unit in QH via the web-based complaints system.

It is reasonable to expect a complainant, who is dissatisfied with the relevant HSP‟s attempts at local resolution, to directly refer the complaint to a remodelled HRC for independent external review. The referral process should be straightforward because the HRC would be, in effect, a „one stop shop‟ at the external review stage.

In keeping with adopting a non-adversarial approach to complaints management, it is proposed that following the HRC‟s assessment of a matter, an attempt should be made to conciliate the complaint provided it is considered suitable for conciliation. The most recent HRC Annual Report suggests that there is already a heavy demand on these services and an associated backlog of cases, so it may not be possible to extend the availability of formal conciliation without additional resources.

Furthermore, the HRC‟s current practice of trying to informally resolve complaints prior to finalising its formal assessment should be continued as it is less resource intensive than conciliation under the HRCA.

5.4 Outline of the proposed health complaints system

The following outline is provided of the key features of the proposed new health complaints system.

5.4.1 In relation to QH and public sector HSPs, the system will involve a three stage complaints process, as is presently the case:

- Stage 1 - Delegated staff will resolve minor complaints at the point of service wherever possible.
- Stage 2 - More serious complaints and any unresolved minor complaints will be referred to the complaints coordinator within each Health Service District for resolution, but with monitoring and review by a central Complaints Management Unit[220].

[220] Section 3.1.3 of Part 2.

- Stage 3 – Independent external review by a remodelled HRC, which for the purposes of this submission, is referred to as the Independent Health Services Commission (IHSC).

In addition, the Queensland Ombudsman will retain jurisdiction to review administrative action of public sector health agencies, including the IHSC, and investigate systemic issues.

5.4.2 Private sector HSPs should adopt a similar complaint management system with any necessary modifications and be subject to review by the IHSC.

5.4.3 The complaint resolution process of each HSP should be based on the current Australian Standard for Complaints Handling 4269:1995 (or as revised). This could be made a condition of their registration/licensing.

5.4.4 A "Code of Health Rights and Responsibilities" (the Code) should be developed similar to codes presently in existence in the Northern Territory, Tasmania, and New Zealand [*copies of these Codes are reproduced as Appendix 5 of this report*]. The main function of the Code is to establish standards to assess the conduct of HSPs. The Code will provide for the consumer"s right to complain about breaches of the Code.

5.4.5 To emphasis its independence, the IHSC should be accountable directly to Parliament rather than to the Health Minister and should be independent of QH in its operations and funding.

5.4.6 The jurisdiction of the IHSC should be broader than that of the HRC, particularly in the areas of assessment and investigation. The IHSC should have coercive powers to compel registered and non-registered providers to provide information and documents, at the assessment and investigation stages.

5.4.7 The IHSC should provide complainants with a "one stop shop" in that it should have jurisdiction to deal with all aspects of complaints in relation to both registered and non-registered providers, and in both the public and private sectors.

5.4.8 The IHSC should be able to accept complaints from any person, that is, not only recipients or users of health services (or their representatives), but other registered providers, including employee health practitioners complaining about health service provision by an organisation that employs them. The current measures in the HRCA[221] aimed at protecting complainants from reprisals, should be retained for the expanded class of prospective complainants.

5.4.9 Following the initial intake of a complaint, the IHSC should, in all appropriate cases, attempt early informal resolution of the complaint (that is, without detailed assessment or investigation), before a matter is assessed as to whether it is suitable for conciliation or should be referred for investigation.

5.4.10 The IHSC should have a discretion to decline to accept a complaint, or decline to take further action on a complaint, if legal proceedings have been commenced. However, the IHSC may retain the complaint if it is in the public interest to do so,

[221] For example, s.64, s.142.

for example, if the complaint raises systemic issues or the possibility of unsatisfactory professional conduct by the HSP.

5.4.11 The initial objective of the IHSC in most cases will be to attempt to resolve complaints primarily through a process of informal resolution or conciliation.

5.4.12 Where informal resolution or conciliation is not successful, the IHSC will be empowered to investigate the complaint, or to refer the investigation of less serious matters to the relevant HSP (such as a hospital with a substantial investigative capacity) or to the relevant registration board/QNC. The HSP or the board would be obliged to investigate the referral, and report to the IHSC on the investigation.

5.4.13 The IHSC should be able to undertake investigations on its own initiative.

5.4.14 Where the Commissioner, after investigation, is satisfied that a breach of the Code has occurred, the Commissioner should be able to order that simple remedies be provided, for example:

- that an explanation or apology be given;
- that the HSP take remedial action to improve systems or procedures;
- that the consumer be provided with a refund for an unsatisfactory service;
- that restitution be made for additional expenses.

5.4.15 When assessing or investigating a complaint, the IHSC should have access to relevant professional advice from a panel of clinical experts, or to legal advice.

5.4.16 The grounds for taking disciplinary action should be the same as at present, namely, conduct by a registered HSP that is "unsatisfactory professional conduct", according to the current definition in the HPPSA.

5.4.17 The Commissioner should be able to initiate disciplinary proceedings for less serious instances of unsatisfactory professional conduct before a Health Practitioners Disciplinary Committee which would be able to impose a range of sanctions on registered HSPs, including conditions or undertakings, reprimands and fines.

5.4.18 For more serious instances of unsatisfactory professional conduct, the Commissioner should be able to initiate proceedings before the Health Practitioners Tribunal which would be able to impose the same range of sanctions as the proposed Health Practitioners Disciplinary Committee with the additional power to suspend or cancel an HSP"s registration, and make orders as to costs of the proceedings.

Code

The proposed model calls for a Code of Health Rights and Responsibilities to be developed, published, and given practical effect and enforceability through empowering the IHSC to investigate breaches of the Code, and, in appropriate cases, award minor remedies where a breach of the Code is established. The provisions of the Code should also provide a reference point for complaint resolution at the local level.

It is notable that ss.37-39 of the HRCA already provide for the Health Rights Commissioner to develop a Code for consideration by the Minister, although the Act is silent on what the Minister is to do after considering the proposed Code.

My inquiries have disclosed that a draft Code was developed and submitted to the then Minister for Health in 1994, but I am not aware of any further action being taken in respect of it (although I note that QH currently has a Public Patient Charter which sets out a number of specific rights and responsibilities for the benefit of public patients).

5.5 Complaint resolution by HSPs (local complaints resolution process)

It has already been noted that, under the existing scheme, a complainant must have taken all reasonable steps to resolve a complaint with the relevant HSP before the HRC will decide to take any further action. This should also be a feature of the proposed model.

Experience indicates that it is generally good practice to resolve complaints locally at the "point of service" [222]. This approach helps HSPs to maintain good relationships with their customers and encourages HSPs to take responsibility for dealing with sub-optimal service and to take an open and improvement-focused approach to customer feedback. It also recognises that many people do not want to formally complain to an external body but simply want some action taken so that "the same thing does not happen to someone else".

Local resolution involves the service provider attempting to resolve a complaint as directly and as quickly as possible, with the primary aim of addressing the complainant's concerns. Data from the UK reveals that the local resolution stage in the NHS complaints process is effective in dealing with the vast majority of health related complaints. In fact, between 96 and 98% of written complaints do not proceed beyond the local stage.[223]

Current information from QH indicates that a lesser rate of approximately 85% of complaints are resolved by frontline complaint handling. Implementation of the proposals in this submission is likely to substantially increase the incidence of local resolution of complaints.

Management and resolution of complaints at the point of service delivery are important elements of quality management and require an HSP to have an effective complaint handling system in place. A benefit of such a system is the identification of areas for improvement to raise the quality of service provided to the community.

An effective complaint handling system should also provide for the receipt of complaints from staff. Staff are in the best position to identify potential risks or existing problems

[222] Ombudsmen commonly define complaints as "any expression of dissatisfaction". Others draw a distinction between complaints and concerns or complaints and service delivery issues.

[223] "Achieving local resolution" ICAS Resources for the Complaints Journey www.icasresources.com.

with the quality of health services being provided. Therefore they should be able to raise these with their employer in the knowledge that they will be appropriately acted upon. This is a key aspect of quality management (see section 5 of Part 1 of this submission for proposals on enhancing protections for whistleblowers).

If a complainant is dissatisfied with the outcome provided at the local level or "point of service", then the HSP"s complaints system should provide for internal review (this may not be practicable with small health practices). If an HSP does not have the capacity, or any process, for internal review, the complainant should have the right to take the complaint to the IHSC. Furthermore, an HSP should have an obligation to advise the complainant of their right to seek external review, and how to do so, where the complainant expresses dissatisfaction with:

- the outcome of local resolution and the HSP has no internal review process; or
- the outcome of internal review.

5.6 Details of proposed IHSC's process

5.6.1 Intake/Early Resolution

Where a complaint is received by the IHSC, as part of the intake process, the complainant should generally be required to demonstrate that they have attempted to resolve the matter with the HSP. There should be exceptions to this, for example, where there is an immediate risk to the health or safety of a user or consumers, or where a complaint is made by a staff member of the relevant HSP who is fearful of reprisal.

Wherever appropriate, staff of the IHSC should encourage complainants to employ alternative dispute resolution mechanisms, or directly facilitate resolution of the complaint at the local level to promote early resolution of the complaint.

The IHSC should be able to receive complaints from any person, including employees of QH or a HSP.

This jurisdiction is significantly wider than that of the HRC. It is submitted that creating an independent body capable of considering health service complaints from both consumers and persons "in the system" will enhance public confidence in the health system.

5.6.2 Assessment

The IHSC should undertake an assessment of all external complaints. This is a departure from the current process which also enables the boards to assess complaints received about their registrants.

The IHSC should give written notice of the making of a complaint, the nature of the complaint and the identity of the complainant, to the person against whom the complaint is made. However, the IHSC should have a discretion to withhold provision of the notice, or some details that would normally go in a notice, if disclosure would be likely to:

- prejudice the investigation of the complaint; or
- place the health or safety of a person at risk; or
- place the complainant or another person at risk of reprisal.

The IHSC may also seek a response/submission from the person complained about.

In certain circumstances it will also be appropriate for the IHSC to provide details of the complaint to the relevant board/QNC and invite a submission.

If, at any time, the Commissioner suspects that a complaint involves or may involve official misconduct, the Commissioner will be obliged to refer the matter to the CMC.

The Commissioner should also refer to the Ombudsman matters involving maladministration of a kind more appropriate for the Ombudsman to deal with, in accordance with protocols to be developed with the Ombudsman.

The Commissioner should have power to recommend interim action against an HSP during or immediately following assessment. For example, if the IHSC has concerns that a registrant poses a risk to patients or the public, it may recommend that the relevant registration board consider suspending, or imposing conditions on, the registrant‟s registration. If the board refuses to impose the recommended restrictions, the Commissioner should be empowered to apply to the Health Practitioners Disciplinary Committee for an order imposing interim conditions or suspension.

Under the existing system, the HRC has no power to recommend to a board that it take interim action against a registrant.

5.6.3 Conciliation

With the consent of both parties, matters may be referred for conciliation if considered appropriate after initial assessment by the IHSC. The HRC currently has the same power.

However, in a recent meeting with my officers, the current Commissioner adverted to a flaw in the current conciliation process in that he has no power to take action against an HSP if, during the conciliation process, it becomes evident that the HSP has been guilty of conduct that would normally attract some form of disciplinary action. This problem may be difficult to address in that, while there is a public interest in disciplinary action being taken in appropriate cases, there is also a public interest in having a conciliation process that encourages open disclosure in a confidential setting with a view to reaching a mutually acceptable outcome.

5.6.4 Investigation

The IHSC should undertake, monitor or review, the investigation of all external complaints whether the complaint relates to a registered or non-registered provider, in a public or private health service. This will provide complainants with one centralised independent complaints body.

The registration boards would no longer conduct investigations of complaints about their own registrants, except by arrangement with the Commissioner, and subject to monitoring and review by the Commissioner. This should remove any potential or perceived “conflict of interest”. This is a significant change from the existing system.

Examples of matters that would be investigated by the IHSC include:

- complaints where conciliation is not agreed to by both parties or has been unsuccessful;
- complaints raising matters of public interest or concerns about policies/practices that have broader implications for public health care;
- complaints that are not of an isolated nature but may reflect systemic problems;
- complaints that may involve cause for taking disciplinary action.

The IHSC should be able to conduct investigations informally or by exercising coercive investigative powers.

Investigators should have a mix of skills. Some should have a clinical background. Furthermore, the IHSC should engage (on sessional rates of pay) a variety of clinicians to form a panel of experts from which the IHSC may seek advice on clinical or technical issues during the assessment or investigation process.

If a report of the IHSC includes any recommendations for specific action by the HSP, the HSP should be obliged to submit advice to the IHSC outlining a plan for the implementation of the recommendations and an associated timeframe.

The IHSC should be given power to make recommendations about, or to impose some minor remedies for, breaches of the Code, for example, an apology; order to improve systems or procedures, order for restitution or a refund; an explanation to the complainant as to what went wrong and what has been done by the HSP to ensure it doesn‟t happen again. It may be appropriate to also provide that:

- where an investigation has resulted in disciplinary action against an HSP, the IHSC‟s proposed jurisdiction to award a compensatory remedy should not be exercised until after disciplinary proceedings have been finalised; and
- where a complainant commences a civil action for damages against an HSP, there should be, in any award of damages made by a court, a set-off for any compensatory award made by the IHSC.

The IHSC should be able to provide a report to a registrant‟s board if the Commissioner has concerns about an aspect of a registrant‟s conduct, although that conduct may not amount to “unsatisfactory professional conduct” (for example, unsatisfactory service attributable to impairment).

If, as a result of an investigation, the IHSC considers that disciplinary action should be taken for unsatisfactory professional conduct, such action would be taken in accordance with the disciplinary process discussed below.

The Commissioner may also wish to consult with a member of the panel of experts (or obtain other specialist advice) or seek legal advice, before making a final decision as to whether a matter should be referred for disciplinary action.

As an alternative to initiating disciplinary action before the Health Practitioners Disciplinary Committee in less serious instances of unsatisfactory professional conduct, the Commissioner should have a discretion, in appropriate cases, to accept an undertaking from an HSP (for example, to undertake additional skills training, or to perform certain health services only under qualified supervision) if the Commissioner considers that that course of action will afford satisfactory protection to consumers of health services. The Commissioner would make arrangements with the relevant registration board to supervise

compliance with the undertaking(s). Breach of an undertaking should itself be a sufficient ground for disciplinary action.

5.6.5 Disciplinary action

Under the proposed scheme, the Commissioner would take over the existing role of the boards/QNC of determining whether disciplinary action should be initiated against a registered HSP.

Another model operates in New South Wales and New Zealand where the decision about whether disciplinary action should be instituted is made by a senior lawyer called the Director of Proceedings, employed by the relevant complaints commission. A summary of the role of that officer in New South Wales and New Zealand is provided in Appendix 4 [*reproduced as Appendix 4 of this report]* . It is an option that could be considered for Queensland, if it is considered that there are advantages in having the Commissioner recommend disciplinary action to a semi-independent legal expert, who would assess the available evidence, decide whether it warranted the laying of disciplinary charges, and prosecute the proceedings.

It is proposed that disciplinary proceedings be heard by:

(1) the Health Practitioners Disciplinary Committee, chaired by a legal practitioner of 10 years standing, assisted by a member of the relevant registration board, and a community representative appointed from a panel; or
(2) the Health Practitioners Tribunal chaired (as now) by a District Court judge, assisted by the Chair of the relevant registration board, and a community representative appointed from a panel.

The Health Practitioners Disciplinary Committee would hear less serious cases of unsatisfactory professional conduct. It would have power to:

- order the imposition of conditions (including limited registration or enrolment);
- obtain an undertaking from the registrant;
- impose fines (to a monetary limit or penalty units); or
- reprimand.

This Committee would also be able to impose interim suspension, or interim conditions, on a registrant pending the outcome of an investigation.

The Health Practitioners Tribunal would hear more serious matters of unsatisfactory professional conduct and have power to impose all of the above sanctions, as well as the power to:

- suspend or cancel a registrant‟s registration;
- make orders as to costs.

The proposed scheme does not contemplate a continued role for the Nursing Tribunal, which in 2003-2004 dealt with only eight cases (according to the QNC‟s Annual Report for that financial year). Its functions can be performed by the Health Practitioners Tribunal.

5.6.6 Role of the registration boards

Unless the Commissioner considers a matter is more appropriately investigated by a board, the board would not investigate a complaint against one of its registrants.

Furthermore, the board would no longer have the responsibility for making decisions about disciplinary action to be taken against their registrants. However, it is proposed that the boards would continue to undertake the balance of their existing functions, for example:

- registration and maintaining a roll of registrants;
- promoting continuing education;
- competitive regulation;
- managing impaired and self reported practitioners with health concerns;
- supervising/overseeing compliance with conditions/undertakings or other disciplinary sanctions ordered by the Health Practitioners Disciplinary Committee and Health Practitioners Tribunal, or undertakings by an HSP that are accepted by the IHSC as a suitable alternative to initiating disciplinary action before the Health Practitioners Disciplinary Committee.

5.7 Independent Patient Advocacy Services

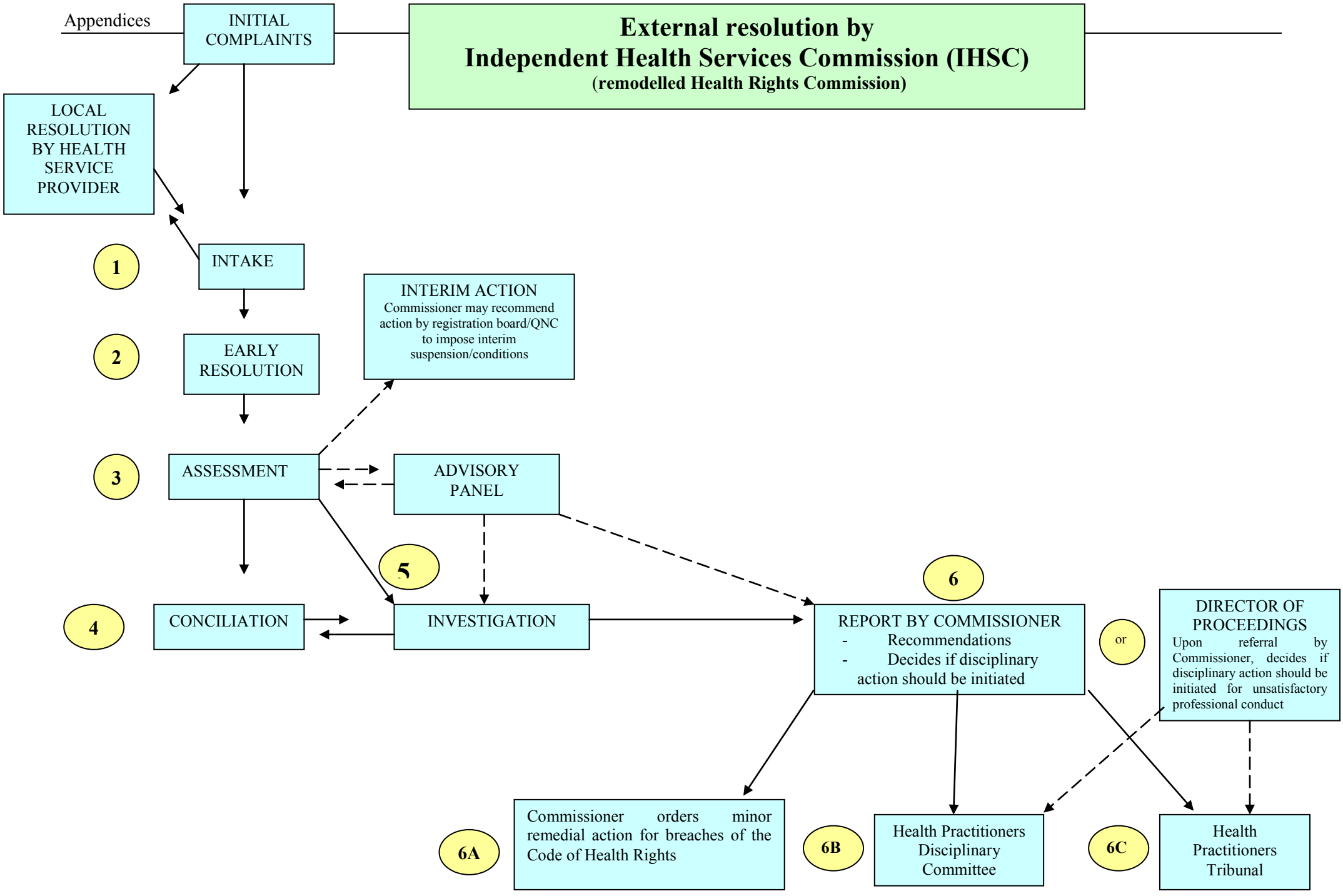
Appendix 5 [*reproduced as Appendix 6 of this report]* contains information about the independent patient advocacy services that operate in the UK and New Zealand. Those services assists complainants through all stages of the complaints process, and provide information about consumer rights to consumers and HSPs. It is recommended that consideration be given to whether the likely benefits of establishing an independent patient advocacy service (including whether it will facilitate high levels of complaint resolution at the local level) will outweigh the costs of establishing and maintaining such a service. In the context of the recommendations made in this submission for an improved health complaints system, a patient advocacy service should be viewed as an optional extra rather than as an essential component of the system.

5.8 Flow chart

The steps of the complaint process under the proposed new system are shown in the flow chart on the following page.

External resolution by Independent Health Services Commission (IHSC)

(remodelled Health Rights Commission)



5.9 Other issues

5.9.1 Lack of a uniform health complaints system

There is presently no uniform system of patient complaints management across the private and public health sectors within Queensland. The *Private Health Facilities Act 1999* enables the Chief Health Officer to make standards on a wide range of matters for the protection of the health and wellbeing of patients receiving health services at private health facilities. However, the Chief Health Officer does not have authority to require private health facilities to establish patient complaints processes.

If all health consumers in Queensland are to be guaranteed access to patient complaints systems which focus on processes for local resolution, this issue will need to be addressed by legislative amendments.

Consideration should be given to amending s.12(2) of the *Private Health Facilities Act 1999* to empower the Chief Health Officer to make standards with respect to patient complaints management systems within the private health sector in order to guarantee all patients access to complaints processes that meet recognised standards.

5.9.2 Open disclosure and protection from civil liability

In July 2003, the Australian Council for Safety and Quality in Health Care (ACSQHC) introduced a National "Open Disclosure" Standard, which was endorsed by all Australian Health Ministers at the time. The Standard promotes a clear and consistent approach by Australian hospitals to open communication with patients and their nominated support person following an adverse event. "Open Disclosure" refers to open communication when things go wrong in health care. The elements include:

- an expression of regret;
- a factual explanation of what happened;
- consequences of the event; and
- steps being taken to manage the event and prevent a recurrence.

QH"s *Incident Management Policy* (introduced in June 2004) states that the ACSQHC Standard on Open Disclosure is to be followed as part of the incident management of adverse events.

QH has advised that a structured piloting plan of the Open Disclosure Standard within QH is currently under development by the Safety Improvement Unit, Patient Safety Centre. In January 2005, the Australian Health Ministers reaffirmed their commitment to piloting this Standard with pilot reviews to be assessed at the Australian Health Ministers Conference in December 2006 prior to full implementation.

Queensland Health currently has five Health Service Districts that are pilot sites participating in the national pilot (Townsville, Rockhampton, Princess Alexandra, QE11, and The Royal Brisbane and Women"s Hospital), with two more under negotiation.

One of the impediments to open disclosure by HSPs and individual registrants is concern about civil liability. However, in many cases, people who raise concerns about provision of health services simply want an explanation and an apology.

To encourage HSPs to provide explanations and apologies in the interests of resolving health service complaints, it is proposed that the legislation for an IHSC should include provisions making it clear that an apology provided by an HSP to a person who has (including through an agent) made a complaint directly to the HSP, or to the IHSC, does not constitute an express or implied admission of fault or liability by the HSP, and is not relevant to the determination of fault or liability in any civil proceeding brought against the HSP. Evidence of an apology should not be admissible in any civil proceedings as evidence of fault or liability of the HSP who provided the apology. The *Civil Liability Act 2002* NSW affords an appropriate model in that regard: see s.67(1), s.68(definition of apology), s.69.

It is considered that ss.69-72 of the *Civil Liability Act 2003* Qld are too restricted, compared to the New South Wales provisions. The Queensland provisions protect from admissibility in a civil proceeding only an expression of regret "to the extent that it does not contain an admission of liability on the part of the individual or someone else".

It may be preferable to amend the general provisions in ss.69-72 of the *Civil Liability Act 2003* Qld, to correspond with the aforementioned New South Wales provisions. There is no reason for limiting these recommended changes to health service complaints, as the desirability of encouraging apologies in appropriate cases is just as relevant in many other areas. However, if that does not occur, specific provisions relating to HSPs are considered necessary for the proposed new health complaints system to work efficiently and effectively.

Appendix 2: Findings and recommendations by the External Investigator

Findings

- In January 2002 there were no protocols in place at the hospital giving guidelines on the management of paediatric head injury and neither was there in April 2004 when the Investigator visited the ED.

- It was inappropriate for a junior doctor to be working unsupervised and without proper protocols in the ED.

- The hours of work were also inappropriate for the doctor in the ED.

- The confusion by the staff over the admission or otherwise of children for observation was a major factor in the outcome of this case and the issue needs a very complete investigation by QH.

- The [Executive Director‟s] report was not an investigative report as no investigation was carried out nor was he asked to. Rather it was simply an "incident report".

- Sadly QH have never conducted a formal investigation into the events leading to the death of Elise nor has it conducted a "root cause" analysis. In this manner Dr and Mrs Neville have been badly served.

- QH have not responded in an appropriate manner to Elise‟s parents in so much that no attempt would appear to have been made to discuss with the parents issues of systems which may have failed or been inadequate.

- "Open disclosure" was difficult because of the legal framework set up to protect QH from liability and because no formal investigation was ever conducted.

- Some system improvements have been made including:

    - the appointment of a senior medical officer to the ED at Caloundra who is working on developing protocols for the management of clinical states and the training of junior staff;
    - Director of Nursing is developing training programmes for nurses in triage and has increased nursing numbers.

Recommendations

- Attempts be made to clarify with Dr and Mrs Neville the type of report the [Executive Director] wrote.

- Dr and Mrs Neville be interviewed again by the Director-General of QH for the purpose of discussing the process issues that would appear to have contributed to Elise‟s death and to outline the steps taken to rectify these issues in the hope of minimising risk of such a future event.

- There be an urgent review of the district ED arrangements including management and supervision of clinical care.

- QH should urgently develop and promulgate guidelines on the assessment and treatment of head injury (specifically paediatric) and ensure that education programmes are put in place for these across the health districts.

- Clinical staffing in the ED at Caloundra Hospital to be consistent, drawing resources from Nambour General Hospital on a rotational basis.

- The ED should be staffed by experienced 3rd or 4th year post graduate doctors who have received training in the ED before going to Caloundra.

- The district should develop clinical policies for Caloundra Hospital and medical education activities, especially for the ED staff.

- ED staff should be competent in intubation and resuscitation, especially when left without senior supervision after hours.

- A firm and stable communicative link for doctors be established between Caloundra and Nambour hospitals on a 24hr basis seven days a week. A telemedicine network would also assist with this.

- Nursing training and competency programmes should continue.

- When staffing issues become critical it may be wise to close down the ED and refer patients to Nambour General Hospital.

- Consideration be given to the possibility of one of the two privately owned CT scanners in the Caloundra area to be relocated to the Caloundra Hospital.

- Current work being done to define the emergency medical systems should be expedited.

- The current retrieval systems should be enhanced by overall regional coordination.

Appendix 3: Extract from my response to Peter Forster of the Queensland Health Systems Review

Central Complaints Management Unit

One of the key improvements to QH‟s internal complaints management system I proposed in my submission to the BHCI (at part 3.1.3) was the establishment of a central complaints management unit. I listed nine functions for such a unit, falling into three broad categories:

(a) designing, reviewing and improving QH complaint handling systems, and providing advice and training for complaints staff;
(b) oversighting complaints handling in the districts to ensure timely and appropriate outcomes; taking charge of investigations, or else monitoring local investigations, of the more serious complaints;
(c) analysing of complaint data to provide appropriate feedback to districts, and inputs for quality improvement initiatives.

Having a central supervising unit would promote a consistent and comprehensive approach to complaints management and complaints analysis and this remains my preferred model. However, I note that your proposed model also addresses the functions in paragraphs (b) and (c) above, albeit in a different way. In particular, your model provides for:

- an Area Complaints Manager (ACM) to perform the role of oversight/internal review of complaints in the districts,
- the HRC to provide external review and to monitor and/or take over at any stage complaints being investigated by QH, and
- the Clinical Performance and Safety Improvement Services unit to undertake data analysis for quality improvement.

Your proposed model does not address the functions in paragraph (a). Furthermore, I believe there are some weaknesses in the model you are proposing and I have set out below my recommendations for addressing those weaknesses to ensure that a health complaints system is created that is both user-friendly and cost-effective.

Frontline Complaint Handling

The system you are proposing indicates that you consider that frontline complaints handling is a key component of effective complaints resolution. This is also our view, based on our lengthy experience in complaint resolution and the research we undertook nationally and internationally for our Complaints Management Project (see part 3.1.2 of our submission).

However, the resourcing of that function is a critical determinant of its success. This means that for frontline complaints handling to operate effectively in QH, those who carry out that responsibility must be given sufficient time to devote to it. This has been one of the problems with QH‟s current system – the responsibilities of the Complaints Coordinator role have simply been added to an officer‟s other responsibilities.

Therefore, I believe that, at least in the larger districts, a dedicated Complaints Coordinator will be needed whose sole responsibility will be to resolve complaints in a timely manner.

In smaller districts, the officer who has this responsibility may also be able to perform other duties but still needs to be readily available to attempt resolution of complaints, from staff and patients alike, and not be placed in a situation where the complaint management role is constantly competing with other work commitments.

Having one person dedicated solely to complaints resolution also removes the possibility of a conflict of interest (perceived or actual) arising in respect of other duties performed by your proposed DCCs.

Further, without a dedicated Complaints Coordinator in the districts, the timeframe for local resolution (15 days) appears to be unrealistic.

Finally, whatever model is established, the role of the Complaints Coordinator needs to be clearly visible and promoted both internally and externally.

HRC's role

I consider it important that there be external oversight of serious complaints received by the districts. If the HRC is to perform that oversight role (rather than a central complaints management unit within QH) by monitoring the QH Complaints Database, then it is essential that serious complaints be flagged on the database to facilitate that external monitoring. The volume of complaints received by QH each year is so high, that a body like the HRC, with limited resources, would only be able to focus on the most significant cases and issues.

Therefore, I think it would be a mistake to abandon the system of categorising complaints according to their seriousness, even if the system were simplified to just two categories - minor (encompassing the current categories of negligible and minor) and serious (encompassing the current categories of moderate, major and extreme).

Next, I think it will be impracticable and a waste of the HRC‟s resources to automatically escalate to the HRC all complaints (including minor ones) that can‟t be resolved by QH within 30 days. It is preferable that minor complaints be resolved at the local level, or referred to the HRC by the complainant taking that step when dissatisfied with attempts at local resolution.

The HRC‟s brief would be to monitor complaints about patient care, rather than staff complaints about human resource or industrial matters that did not impact on patients. To facilitate external monitoring by the HRC of complaints on the QH Complaints Database, the database would need to be capable of:

- differentiating patient complaints from staff complaints;
- differentiating staff complaints about patient care, or matters which impact on patient care, from other staff complaints;
- flagging complaints that qualify as public interest disclosures under the Whistleblowers Protection Act, so that the special requirements of that Act are observed.

As noted, I do not consider it necessary (and indeed it would be liable to clog the external complaints system) for all complaints to be escalated to the HRC for external review if not resolved by QH within 30 days.

In respect of minor unresolved complaints, the District Complaints Coordinator (DCC) should be required to provide the complainant with details of the avenues of external review available to them. The onus would then be on the complainant to seek external review if so desired.

Also, in relation to complaints in the serious category, the HRC should have the option of taking over the investigation of an unresolved complaint, or continuing to monitor an investigation being undertaken by QH at the local level.

Three stage internal review process

The Australian Standard for Complaints Handling in Organisations (AS4269-1995) recommends only two stages for internal complaint handling – that is, frontline/local complaints resolution and internal review. Accordingly, the proposed three-stage internal complaint process for staff complaints appears unnecessarily cumbersome and will lead to "complainant burn-out". In my view, staff complaints relating to patient care that are categorised as serious, should be referred to the HRC after the second stage (internal review).

I note that if the HRC is to receive complaints about patient care from employees of a Health Service Provider, an amendment will be required to the Health Rights Commission Act.

Appendix 4: Director of Proceedings

New South Wales Model

The function of determining whether a complaint should be prosecuted before a disciplinary body and by whom (that is, by the Commission or some other person or body for prosecution) is undertaken by the **Director of Proceedings** (s.90B HCCA). If the Director determines that a complaint should be prosecuted before a disciplinary body by the Commission, the Director will prosecute the complaint. The Director does not exercise any other function of the Commission other than this function and is not subject to the direction and control of the Commissioner in dealing with any particular complaint that has been referred by the Commissioner to the Director for consideration. Criteria for determinations of the Director include:

- the protection of the health and safety of the public;
- seriousness of the alleged conduct the subject of the complaint;
- the likelihood of proving the alleged conduct;
- any submissions by the HSP.

New Zealand Model

Director of Proceedings is an independent statutory officer appointed under the *Health and Disability Commissioner Act 1994* and is a lawyer. Although the Director may provide representation or assistance to complainants in any forum (for example, a court, tribunal, inquiry), the primary focus is on disciplinary proceedings or proceedings before the Human Rights Review Tribunal.

In certain circumstances where the Commissioner forms the opinion that a breach of a consumer‟s rights has occurred, the Commissioner may refer the case to the Director of Proceedings. The Director reviews the Commission‟s file and makes an independent decision whether or not to take any further action. The Director can lay a disciplinary charge before the Health Practitioners Disciplinary Tribunal, issue proceedings before the Human Rights Review Tribunal or both. A team of lawyers and assistants work with the Director in reviewing files and prosecuting cases.

Appendix 5: Northern Territory, New Zealand and Tasmanian Code of Health Rights

1. Northern Territory

CODE OF HEALTH RIGHTS AND RESPONSIBILITIES
INTRODUCTION TO THE CODE

The Code confers a number of rights and responsibilities on all users and providers of health and community services in the Northern Territory.

The rights and responsibilities set out in the Code are not absolute. The obligation imposed on users and providers is to take reasonable action in all circumstances to give effect to the Code.

When a complaint is made, the Commission will consider the reasonableness of the action taken by the provider, in light of the circumstances. The circumstances in a particular case may include the user's state of health or well-being and any resource constraints operating at the time.

The Code does not override duties which are set out in Territory or Commonwealth legislation.

Principle 1: Standards of Service

1. Users have a right to:
    a. timely access to care and treatment which is provided with reasonable skill and care ;
    b. care and treatment which maintains their personal privacy and dignity;
    c. care and treatment free from intimidation, coercion, harassment, exploitation, abuse or assault;
    d. care and treatment that takes into account their cultural or ethnic background;
    e. providers who seek assistance and information on matters outside their area of expertise or qualification;
    f. services provided in accordance with ethical and professional standards, and relevant legislation;
    g. services which are physically accessible and appropriate to the needs arising from an impairment or disability; and
    h. services provided without discrimination, as set out in relevant Territory and Commonwealth legislation.

Principle 2: Communication and the Provision of Information

1. Providers have a responsibility to:
    a. provide accurate and up to date information responsive to the user's needs and concerns, which promotes health and well-being;
    b. explain the user's care, treatment and condition in a culturally sensitive manner, and in a language and format they can understand. This includes the responsibility to make all reasonable efforts to access a trained interpreter;
    c. answer questions honestly and accurately;
    d. provide information about other services, and as appropriate, how to access

these services;
e. provide prompt and appropriate referrals to other services, including referral for the purpose of seeking a second opinion; and
f. provide the user with a written version or summary of information, if requested.

2. Users have a responsibility, to the best of their ability, to:

a. provide accurate and timely information, about their past care and treatment and issues affecting their condition; and
b. inform the provider of issues that might interfere with participation in care or treatment recommended by the provider.

Principle 3: Decision Making

1. Subject to any legal duties imposed on providers, users have a right to:
   a. make informed choices and give informed consent to care and treatment;
   b. seek a second opinion;
   c. refuse care and treatment, against the advice of the provider;
   d. withdraw their consent to care and treatment, which includes the right to discontinue treatment at any time, against the advice of a provider;
   e. make an informed decision about body parts or substances removed or obtained during a health procedure. This includes the right to consent or refuse consent to the storage, preservation or use of these body parts or substances; and
2. In non-emergency situations, providers have a responsibility to seek informed consent from users before providing care and treatment by:
   a. seeking consent specific to the care and treatment proposed, rather than a generalised consent;
   b. discussing the material risks, complications or outcomes associated with each care or treatment option;
   c. ensuring the user understands the material risks, complications or outcomes of choosing or refusing a care or treatment option;
   d. where relevant, explaining the legal duties imposed on providers which prevent users from refusing a type of care or treatment, such as those imposed by the Mental Health and Related Services Act and the Notifiable Diseases Act;
   e. providing users with appropriate opportunities to consider their options before making a decision;
   f. informing users they can change their decision if they wish;
   g. accepting the user's decision; and
   h. documenting the user's consent, including the issues discussed and the information provided to the user in reaching this decision.
3. Providers have a right to treat without the user's consent where:
   a. treatment is provided in a life threatening emergency or to remove the threat of permanent disability and it is impossible to obtain the consent of the user or the user's personal representative; or
   b. treatment is authorised or required under Territory or Commonwealth legislation.
4. Where a provider reasonably considers that a user has diminished capacity to consent, the user still has a right to give informed consent to a level appropriate to their capacity.

5. Where a provider considers a user lacks the capacity to give informed consent, a provider must, except under specific legal circumstances, seek consent from a person who has obtained that legal capacity under the Adult Guardianship Act or other relevant legislation.

Principle 4: Personal Information

1. Users have a right to information about their health, care and treatment. However, they do not have an automatic right of access to their care or treatment records.
2. Providers may prevent users from accessing their records where:
    a. legislative provisions restrict the right to access information; or
    b. the provider has reasonable grounds to consider access to the information would be prejudicial to the user's physical or mental health.
3. Providers have a responsibility to protect the confidentiality and privacy of users by:
    a. ensuring that the user's information held by them is not made available to a third party unless:
        - the user gives written authorisation for the release;
        - subject to subpoena or pursuant to legislation; or
        - it is essential to the provision of good care and treatment and the provider obtains the user's consent. This may take the form of consent to share information between a treating team.
    b. providing appropriate surroundings to enable confidential consultations and discussions to take place;
    c. having policies and procedures in place, including policies relating to the storage of information, and ensuring all staff are aware of these;
    d. communicating with the user and other providers involved in their care and treatment in an appropriate manner and environment.

Principle 5: The Relationship between User and Provider

1. Both users and providers have a responsibility to treat each other with respect and consideration.
2. Providers have a responsibility to:
    a. make clear the standards of behaviour and language acceptable in the relationship between user and provider;
    b. make clear the circumstances under which they will restrict or withdraw the services they provide;
    c. advise users if and why they are unable to provide a service the user has requested; and
    d. subject to those responsibilities regarding emergency treatment, remove, or seek the removal of any person whose behaviour is considered dangerous to the provider or service users.
3. Users have a responsibility to ensure they do not endanger or deliberately put the safety of the provider or other service users at risk. This responsibility is extended to the user's family members, friends, carers and advocates in their interactions with the provider.
4. Providers have a right to be able to provide care and treatment free from intimidation, coercion, harassment, exploitation, abuse and assault.

Principle 6: Involvement of Family, Friends, Carers and Advocates

1. Users have a right to:

   a. involve their family, friends, carer or advocate in their care and treatment;
   b. withhold information from family members, friends and carers on their care and treatment, or request the provider do so;
   c. seek help from an advocate if required.
2. Providers have a responsibility to:
   a. respect the role family members, friends, carers and advocates may have in the user's care and treatment, and the user's right to withhold information from them; and
   b. recognise the carer's knowledge of the user and of the impact care and treatment options may have on the user's health and well-being.

Principle 7: Research, Experiments and Teaching Exercises

1. Providers have a responsibility to:
   a. inform users if the care or treatment offered to them is experimental or part of a teaching or research exercise, of its functions and aims, and of their avenues for complaint;
   b. inform users they can withdraw from the research, experiment or teaching exercise at any stage; and
   c. accept the user's refusal to take part in research, experiments and teaching exercises.

Principle 8: Complaints and Feedback

1. Providers have a responsibility to:
   a. provide a mechanism for users to give feedback or make complaints about their care and treatment;
   b. inform users of the complaint process and of how to make a complaint;
   c. ensure that complaints are dealt with in an open, fair, effective and prompt manner, and without reprisal or penalty; and
   d. provide users with information about external complaint resolution mechanisms and advocates.
2. Users and providers have a responsibility to be fair, truthful and accurate when making or responding to a complaint.

2. New Zealand

The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996

1. Consumers have rights and providers have duties

1) Every consumer has the rights in this Code.
2) Every provider is subject to the duties in this Code.
3) Every provider must take action to -
   a) Inform consumers of their rights; and
   b) Enable consumers to exercise their rights.

2. Rights of consumers and duties of providers

The rights of consumers and the duties of providers under this Code are as follows:

RIGHT 1
Right to be Treated with Respect

1) Every consumer has the right to be treated with respect.
2) Every consumer has the right to have his or her privacy respected.
3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Maori.

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

RIGHT 3
Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.
2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.
3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.
5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including -
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
   c) Advice of the estimated time within which the services will be provided; and
   d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
   e) Any other information required by legal, professional, ethical, and other relevant standards; and
   f) The results of tests; and
   g) The results of procedures.
2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.
3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about -
   a) The identity and qualifications of the provider; and
   b) The recommendation of the provider; and
   c) How to obtain an opinion from another provider; and
   d) The results of research.
4) Every consumer has the right to receive, on request, a written summary of information provided.

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.
2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.
3) Where a consumer has diminished competence, that consumer retains the right to make informed choices and give informed consent, to the extent appropriate to his or her level of competence.
4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where -

a) It is in the best interests of the consumer; and
b) Reasonable steps have been taken to ascertain the views of the consumer; and
c) Either, -
   i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
   ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

5) Every consumer may use an advance directive in accordance with the common law.
6) Where informed consent to a health care procedure is required, it must be in writing if -
   a) The consumer is to participate in any research; or
   b) The procedure is experimental; or
   c) The consumer will be under general anaesthetic; or
   d) There is a significant risk of adverse effects on the consumer.
7) Every consumer has the right to refuse services and to withdraw consent to services.
8) Every consumer has the right to express a preference as to who will provide services and have that preference met where practicable.
9) Every consumer has the right to make a decision about the return or disposal of any body parts or bodily substances removed or obtained in the course of a health care procedure.
10) No body part or bodily substance removed or obtained in the course of a health care procedure may be stored, preserved, or used otherwise than
   (a) with the informed consent of the consumer; or
   (b) for the purposes of research that has received the approval of an ethics committee; or
   (c) for the purposes of 1 or more of the following activities, being activities that are each undertaken to assure or improve the quality of services:
      (i) a professionally recognised quality assurance programme:
      (ii) an external audit of services:
      (iii) an external evaluation of services.

RIGHT 8
Right to Support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.

RIGHT 9
Rights in Respect of Teaching or Research

The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

RIGHT 10
Right to Complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

2) Every consumer may make a complaint to -
   a) The individual or individuals who provided the services complained of; and
   b) Any person authorised to receive complaints about that provider; and
   c) Any other appropriate person, including -
      i. An independent advocate provided under the Health and Disability Commissioner Act 1994; and
      ii. The Health and Disability Commissioner.
3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.
4) Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.
5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.
6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -
   a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and
   b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of -
      i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and
      ii. The Health and Disability Commissioner; and
   c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and
   d) The consumer receives all information held by the provider that is or may be relevant to the complaint.
7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, -
   a) Decide whether the provider -
      i. Accepts that the complaint is justified; or
      ii. Does not accept that the complaint is justified; or
   b) If it decides that more time is needed to investigate the complaint, -
      i. Determine how much additional time is needed; and
      ii. If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.
8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of -
   a) The reasons for the decision; and
   b) Any actions the provider proposes to take; and
   c) Any appeal procedure the provider has in place.

3. Provider Compliance

A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

The onus is on the provider to prove it took reasonable actions.

For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

4. Definitions

In this Code, "**Advance directive**" means a written or oral directive:

(a) By which a consumer makes a choice about a possible future health care procedure; and
(b) That is intended to be effective only when he or she is not competent.

"**Choice**" means a decision:

(a) To receive services.
(b) To refuse services.
(c) To withdraw consent to services.

"**Consumer**" means a health consumer or a disability services consumer; and, for the purposes of rights 5, 6, 7(1), 7(7) to 7(10), and 10, includes a person entitled to give consent on behalf of that consumer.

"**Discrimination**" means discrimination that is unlawful by virtue of Part II of the *Human Rights Act 1993*.

"**Duties**" includes duties and obligations corresponding to the rights in this Code.

"**Ethics committee**" means an ethics committee :

(a) established by, or appointed under, an enactment; or
(b) approved by the Director-General of Health.

"**Exploitation**" includes any abuse of a position of trust, breach of a fiduciary duty, or exercise of undue influence.

"**Optimise the quality of life**" means to take a holistic view of the needs of the consumer in order to achieve the best possible outcome in the circumstances.

"**Privacy**" means all matters of privacy in respect of the consumer, other than matters of privacy that may be the subject of a complaint under Part VII or Part VIII of the Privacy Act 1993 or matters to which Part X of that Act relates.

"**Provider**" means a health care provider or disability services provider.

"**Research**" means health research or disability research.

"**Rights**" includes rights corresponding to the duties in this Code.

"**Services**" means health services, or disability services, or both; and includes health care procedures.

"**Teaching**" includes training of providers.

5. Other Enactments

Nothing in this Code shall require a provider to act in breach of any duty or obligation imposed by any enactment or prevents a provider doing an act authorised by any enactment.

6. Other Rights

An existing right is not overridden or restricted simply because the right is not included in this Code or is included only in part.

3. The Tasmanian Charter of the Rights & Responsibilities of Health Service Users and Providers (currently under review)

Charter of the Rights and Responsibilities of Health Service Users and Providers

The Charter of Health Rights and Responsibilities has been developed following consultation with health service users, referred to as consumers in this Charter, and health service providers.

When viewed as a partnership, the relationship between the health service consumer and the health service provider is more likely to benefit the health outcomes of the service consumer. While the health service provider has a responsibility to meet certain rights of the health service consumer, the consumer in turn, should also assume some responsibility for their own health care.

This Charter is intended to be used as a guideline to maintain the balance of rights and responsibilities, and strengthen the relationship between, health service users and health service providers.

Who is covered by the Charter?

The Charter is in place for any person who gives or receives a health service including those who are under age or whose capacity to be self determining is limited. Under the Health Complaints Act 1995, someone who is not yet 14 years of age is considered to be under age.

The parent or guardian of a child who has not attained the age of 14 years, claims the rights and responsibilities listed in this Charter on behalf of that child. Similarly, if the carer of a person with limited capacity has guardianship in the area of health care, they too can claim the rights and responsibilities listed in this Charter on behalf of that person.

Do the rights described in the Charter always apply?

Sometimes health service providers may not be able to meet all of the rights of the health service consumer. Similarly, consumers may not always be in a position to meet all of the rights of the provider. However, both providers and consumers should always do what they reasonably can under the circumstances.

What services are covered by the Charter?

The *Health Complaints Act 1995* sets out the requirement for a Charter of Health Rights. Under Schedule 1, Part 1 the Act also describes services that are recognised as health services for the purpose of the Act. These services are covered by the Charter.

1. A service provided at a hospital, health institution or nursing home.

2. A medical, dental, pharmaceutical, mental health, community health, environmental health or specialised health service or a service related to such a service.

3. A service provided in association with the use of premises for the care, treatment or accommodation of persons who are aged or have a physical disability or mental dysfunction.

4. A laboratory service provided in support of a health service.

5. A laundry, dry cleaning, catering or other support service provided to a hospital, health institution, nursing home or premises referred to in item 3, if the service affects the care or treatment of a patient or resident.

6. A social work, welfare, recreational or leisure service, if provided as part of a health service.

7. An ambulance service.

8. Any other service provided by a provider, for or purportedly for, the care or treatment of another person.

9. A service provided by any of the following:

- audiologist;
- audiometrist;
- optical dispenser;
- dietitian;
- prosthetist;
- physiotherapist;
- dental prosthetist;
- psychotherapist;
- radiographer;
- podiatrist;
- therapeutic counsellor; or

any other service of a professional or technical nature provided for, or purportedly for, the care or treatment of another person or in support of a health service.

10. A service provided by a practitioner of massage, naturopathy or acupuncture or in another natural or alternative health care or diagnostic field.

11. The provision of information relating to the promotion or provision of health care or to health education.

12. Any other service provided by a person registered by a registration board.

RIGHT 1: ACTIVE PARTICIPATION IN HEALTH CARE

The Rights of the Health Service Consumer

The health service consumer has the right to take an active role in his/her own health care. This role includes making decisions about his/her own health care and being responsible for those decisions.

- The health service consumer has the right to choose a health service provider subject to several conditions including the treatment required and whether the consumer is a public or private patient.

- The right to be provided with information enables the consumer to make informed decisions about his/her own health care. This information might include:

  - diagnosis, the possible nature of the illness or disease;
  - test results and their implications;
  - the approach to proposed treatment or further investigation as well as,
    a) what that entails;
    b) the expected benefits;
    c) any likely side effects that may occur;
    d) any recognised risks associated with that investigation and/or treatment;
  - other options for investigation and/or treatment;
  - the likely consequences of any treatment option available;
  - the likely consequences of not having any particular treatment or procedure;
  - an estimate of the costs of any particular treatment or procedure or other health service fees; and
  - advice regarding additional services, facilities and support groups.

  This information should be presented in a way to best ensure the consumer"s understanding. The information should be simple and straightforward. If necessary diagrams, models or other visual aids should be used.

  Those with physical or intellectual limitations such as visual, auditory or verbal difficulties and those who have other difficulties with language or communication have the right to be offered alternative means of information dissemination. These alternatives may include, among others, interpreters and/or translation services, large print or audio tapes. In theses cases and where a health service consumer has limited capacity, information can be provided to a guardian or person authorised by the consumer.

- The right to feel comfortable and at ease and be encouraged to take an active role in his/her own health care in being consulted about options and by participating in decisions.

- The right to take notes, ask questions and expect honest, comprehensive and direct answers in order to clarify information provided by health service providers.

- The right to take sufficient time to absorb and consider information, seek advice and additional information from other sources, and discuss issues with family, friends and supporters.

It may not always be possible to fully exercise this right particularly in emergency situations where there is often little time to consult and consider.

- The right to not only be informed by the provider about his/her condition and options, but to offer suggestions and feedback and discuss these with the provider.

- The right to choose any treatment option available and have the provider respect that decision, even if they prefer a different option.

  It is important to note that the provider is not required to provide any treatment with which he/she does not agree and has the right to withdraw from the provision of treatment.

- The right to grant, withhold or withdraw consent for treatment or performance of a procedure at any time.

The Rights of the Health Service Provider

- The provider has the right to inquire about all aspects of the health of the consumer so that he/she is able to provide the highest level of quality health care possible. The information about which the provider might inquire includes:

  ◊ condition, symptoms and health history;
  ◊ outside factors that may impact on health care provision such as work, sport, family, home life and life style choices;
  ◊ changes to circumstances;
  ◊ expectations of the provider;
  ◊ outcomes for health and well-being; and
  ◊ the level of involvement the consumer wants in making decisions about his/her own health care.

  The provider has the right to have this information presented openly, with honesty and in a straightforward manner.

- The right to be told if the consumer does not understand the information provided or if he/she would like more information.

- The right to be informed if the consumer is consulting, or receiving treatment from, another health care provider.

- The right to be informed if the consumer is unable or unwilling to proceed with any care or treatment.

- The right to express any concerns if he/she does not agree with a decision made by the consumer about his/her health care, and have those concerns acknowledged.

- The right to withdraw from the provision of care if the consumer elects to proceed with an option for health care about which the provider expresses concerns.

- The right to be given notice if the consumer is unable to attend an appointment.

RIGHT 2: INDIVIDUALISED SERVICE THAT IS FREE FROM DISCRIMINATION

Discrimination generally refers to unfair or less favourable treatment of a person based on a range of personal attributes or criteria that might include gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation, political belief or activity, cultural belief or activity, situation, circumstance, economic or social status.

The Rights of the Health Service Consumer

- The health service consumer has the right to receive health services regardless of gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation, political belief or activity, cultural belief or activity, situation, circumstance, economic or social status.

- The right to receive health services where the values and beliefs and associated judgments, attitudes, opinions and behaviours of the provider in relation to the areas listed above, do not impact on the provision of care.

- The right to receive health services free from any harassment, exploitation, abuse, deception, assault or fraud.

- The right to receive health services free from physical intimacy unrelated to the health service or medical treatment and free from unwarranted attention of a sexual nature.

- The right to be treated with dignity, courtesy and respect.

- The right to receive health services where the needs, wishes and background of the consumer are known, and considered in the provision of his/her health care.

- The right to withdraw from service provision if the provider behaves in an unacceptable way or places the consumer under duress.

The Rights of the Health Service Provider

- The provider has the right to request information about the consumer‟s background, needs and wishes so that he/she can consider the impact of these on the provision of health care, for example:

  - if the consumer feels that his/her gender, age, race, ethnicity, physical or intellectual disability, religion, sexual orientation, political belief or activity, cultural belief or activity, situation, circumstance, economic or social status will have an impact on his/her health or provision of care, the consumer should inform the provider.

- The right to be informed if the needs or wishes of the consumer are not being met or if the provider has been intrusive, insensitive or inconsiderate of the background of the consumer.

- The right to be informed if the consumer wishes to seek a second opinion.

- The right to expect reasonable courtesy and respect from the consumer.

- The right to provide health services free from any harassment, exploitation, abuse, deception, assault or fraud.

- The right to refuse to provide a health service if he/she has a conscientious or other objection.

  In these circumstances the provider should refer the consumer to another provider who may be able to provide the service or to a support group or organisation who can assist the consumer in seeking appropriate service provision.

- The right to refuse service if the consumer behaves in a threatening or unacceptable way or places the provider or those working with the provider under duress.

RIGHT 3: CONFIDENTIALITY, PRIVACY AND SECURITY

The Rights of the Health Service Consumer

- The health service consumer has the right to have his/her personal health information and any matters of a sensitive nature kept confidential.

  No identifying information about the consumer, his/her condition or treatment may be disclosed without his/her consent unless the disclosure is required or authorised by law.

  In some cases, the provider is legally required to disclose health issues under mandatory reporting requirements or in the public interest.

- The right to be informed if the provider is required to disclose information about his/her health due to mandatory reporting requirements or in the public interest.

- The right to know who may have access to his/her personal health record, within the bounds of confidentiality.

- The right to know what sort of information is kept on his/her health record.

- The right to nominate another person who may receive information about the consumer‟s health status and care. This person does not necessarily have to be a next of kin.

- The right to have information about his/her health status and care passed on to another provider, at his/her request.

- The right to expect that staff of health service facilities are bound by confidentiality agreements, and will be disciplined if these agreements are breached.

- The right to health service facilities which ensure his/her privacy when receiving health care.

- The right to be treated with sensitivity as regards his/her confidentiality and privacy.

- The right to expect that information about his/her health is kept securely and cannot be easily accessed by unauthorised persons.

  Any record that contains personal information about the consumer‟s health should not be left in reception areas or treatment rooms. When the provider or another authorised person does not have a file, it should be stored securely. The same applies to computer or electronic records.

  Similarly, health service providers should not talk about consumer‟s health or care where other unauthorised persons can overhear them.

The Rights of the Health Service Provider

- The provider has the right to discuss the health care and treatment of a consumer with other providers for advice and support, in the best interest of the consumer‟s health and well-being.

RIGHT 4: ACCESS TO COMPLAINTS MECHANISMS

The Rights of the Health Service Consumer

- The health service consumer has the right to complain about health services and health service providers if he/she has reason to be dissatisfied with the service that he/she has received.
- The right to be informed about complaints procedures.

  Complaints procedures might be internal to the health service that the consumer has been using or external like the Registration Boards or The Health Complaints Commissioner.

- The right to access complaints procedures that are easy to use.

- The right to have his/her complaint dealt with promptly, fairly and without any adverse effect or discrimination arising as a consequence of having made a complaint.

The Rights of the Health Service Provider

- The provider has the right to be made aware of complaints about him/her or the service provided.

- The right to have a complaint against him/her, lodged with the appropriate authority in accordance with established complaints procedures with supporting documentation as required.

  An appropriate complaints procedure might be internal to the health service or a Registration Board, or the Office of the Health Complaints Commissioner.

- The right to be made aware of the outcomes the consumer would like to achieve in making his/her complaint.

RIGHT 5: CARERS

The Rights of Carers

The relationship between the health service consumer and the provider is the primary relationship. While those who provide care for health service consumers have rights and responsibilities as part of their role as carer, their rights are secondary to the rights of the health service user in the consumer/provider relationship. However, carers have the right to be treated with respect.

The parent/s of a child under 14 years of age is not considered to be a carer. However, the carer of a person with limited capacity for self determination does possess the rights listed in this section.

- Carers have the right to have their particular knowledge about the person in care considered and included in the health service provision for the person in care.

- Carers have the right to be involved in care planning and delivery, especially where it impacts on their role as carer.

- Carers have the right to information about the care of the health service user, support services and equipment, including support services and training for themselves as carers.

The Rights of the Health Service Provider

- The provider has the right to be informed when changes in the health status, circumstances, needs or treatment outcomes of the consumer impact on his/her health or treatment.

RIGHT 6: THE CONTRIBUTION OF THE HEALTH SERVICE PROVIDER

The Rights of the Health Service Provider

- The provider has the right to be acknowledged for their contribution to health care and their commitment to providing quality care.

- The right to recognition and respect for the level of training undertaken by providers and for the knowledge, skills and experience providers bring to the provision of consumer‟s health care.

- The right to expect that the advice provided and the treatment he/she dispenses will be considered and followed, and if this is not possible or does not occur, he/she will be informed.

- The right to feedback on the health services provided including positive and negative comment where appropriate or necessary.

  This might include participating in evaluation exercises or questionnaires about services.

- The right to reasonable expectations from consumers about the level of care and treatment that can be provided.

  Consumers should realise and acknowledge the limitations of health services and health service providers. For example, consumers may have to wait to receive service, attend a different provider or be referred.

- The right to expect consumers to pay accounts promptly or if there is any difficulty in doing so, to discuss the matter with the provider.

Appendix 6: The Independent Patient Advocacy System in the UK and New Zealand

The Patient Advocacy System as it operates in other jurisdictions such as the UK and New Zealand, functions as an independent service funded via grants from the National Health Service (NHS) to existing community based organisations or, as in the case of New Zealand, via staff contracted by the Health and Disability Commissioner (HDC). In New Zealand, there is a total of 26 equivalent full-time staff working throughout the country, and in the UK, there is a total of 180 full time equivalent staff. In both instances, independent Patient Advocates operate in *tandem* with the network of Complaints Coordinators employed by health service providers.

The rationale for establishing these services was to intervene to resolve complaints as early as possible, address the perceived power imbalance which exists between health service providers and complainants and to ensure that the public have access to an independent support service to assist them through all stages of the complaints process.

Both the UK and the New Zealand systems are premised upon the assumption that local complaint resolution is always the preferred approach and should be achieved wherever possible. In the UK, data indicates that approximately 97% of health complaints do not proceed beyond the stage of local resolution.[224] In New Zealand, the HDC reported that in 2004 approximately 85% of complaints were resolved locally with advocacy assistance, or as a result of the consumer"s own action after advocacy, and on average only 4% were escalated to formal complaints with the HDC.[225]

In both countries presently using this model, the Patient Advocate requires that in the first instance, complainants who are able to, must take up their complaint directly with the service provider in order to attempt to sort out their concern. Only if complaints are unable to be resolved locally with the HSP, do complaints proceed to external review. Patient Advocates help clients identify the options for taking forward their complaints. This may include coaching consumers to handle the issue themselves (where appropriate), an option that a number of consumers appreciate. Many say that once they have the options explained to them, they are able to "get on with it". Patient Advocates also make sure lessons from users' experiences arising from the complaint are fed back into the service and to those responsible for scrutinising the delivery of health care services.

UK Patient Advocates do not assist clients who want to commence, or who are already involved in, litigation against a HSP, nor do they directly investigate complaints.

Patient Advocates in the UK encourage local complaint resolution in order to provide prompt investigation and resolution of the complaint at local level, aiming to satisfy the complainant and be fair to staff. A verbal response or explanation from the HSP is often the best way of resolving concerns quickly. An advocate may assist a complainant by meeting with or writing to HSPs, accessing medical records or other information related to the health service, or formulating a formal complaint.

In the UK, the NHS complaints reforms aim to change attitudes to complaints so they are integral to clinical governance and service improvement. There, Patient Advocates attempt

[224] ICAS Resources for the Complaints Journey http://www.icasresources.com/reviewoptions2.html.
[225] NZ HDC 2004 Annual Report p.13. http://www.hdc.org.nz/files/pagepublications/report2004.pdf.

to differentiate at the outset between complaints which are relatively minor in nature and relate to purely "personal grievance" matters and those which have a relevance to "clinical governance", that is, those that might indicate that a health professional has placed a patient at risk or has delivered a poor standard of care.

Patient Advocates generally attempt to ensure "personal grievance" complaints are addressed by way of conciliation and mediation to restore, if possible, the relationship of trust between the health professional and the complainant. However Patient Advocates are likely to encourage more formal consideration of "clinical governance" complaints, so that the health service concerned can address the issues raised as part of its clinical governance responsibilities.

In the UK, when Patient Advocates consider that there is a serious risk to patient safety or there is clear evidence of malpractice, the advocate, with the advice of their line manager, will work with the complainant to identify how the complaint can be dealt with as promptly and thoroughly as possible, preferably via more formal processes.

Those who support the Patient Advocate concept argue that the Patient Advocate plays an important role in making the system more accessible, enhancing public confidence in the fairness of the process and improving trust in the complaints resolution system. Citing the results of its 2004 survey of complainants who used its investigation services, the New Zealand HDC observed that only 46% of complainants were satisfied overall with the fairness of the process (in contrast to 80% of providers), although interestingly in the HDC"s 2003 evaluation of customer satisfaction the parties surveyed who had experienced advocacy, reported much higher levels of satisfaction (over 86% of complainants *and* providers).[226]

In its 2004 Annual Report, the New Zealand HDC observed that the number of new complaints remained fairly static (1,142 compared to 1,159 in the previous year), but the Office made considerable progress in clearing the backlog of open files. The HDC considered this progress could be attributed to the "greater use of advocacy and intervention by HDC"s complaints assessors, improving the speedy low-level resolution of complaints." Therefore, despite concerns that patient advocacy systems entrench adversarial processes, are unpopular with HSPs and unnecessarily complicate health complaints resolution systems, the New Zealand experience suggests that this may not be correct.

Should a similar independent patient advocacy model to the New Zealand or UK systems be adopted in Queensland with a comparable level of service provision, it is estimated that 28 EFT (A06) Patient Advocates would be required State-wide plus a State-wide coordinator (A08) and administrative support officer (A03).

As mentioned earlier, until March 2005, the New South Wales Health Care Complaints Commission provided an advocacy role for complainants but lost that role when it took on its alternative complaints resolution role.

[226] NZ HDC 2004 Annual Report p.1 http://www.hdc.org.nz/files/pagepublications/report2004.pdf.

Appendix 7: Documents obtained during the course of the investigation

Documents supplied by the Nevilles

- 4 x A4 Folders of documents pertaining to their complaints including internal agency documents obtained via Freedom of Information processes with QH, MBQ and the QNC
- additional FOI documents obtained by the Nevilles as a result of applications made with the MBQ and QNC
- QPS Coronial Investigation report dated January 2003
- copies of all correspondence provided by the Nevilles to the Minister for Health, QH, HRC, MBQ, QNC, CMC and the State Coroner and those agencies" responses
- a number of newspaper, medical journal and other articles and information on issues raised by the Nevilles" complaint

Queensland Health

General correspondence and internal documents

- copy of the Nevilles" letter of complaint to QH dated 7 February 2002
- copy of letter from QH to the Nevilles dated 1 March 2002
- copy of the *Preliminary Investigation Report* by the Executive Director, SCHSD dated 11 January 2002 and associated documents
- copy of the Nevilles" further letter of complaint to QH dated 10 March 2002
- copy of QH"s letter to the Nevilles dated 11 April 2002
- copy of letter from the Minister for Health, Ms Wendy Edmond to the Nevilles dated 29 August 2002
- copy of letter from Minter Ellison Lawyers to the District Manager, SCHSD dated 22 November 2002
- copy of the Nevilles" letter to QH dated 28 June 2004
- copy of letter from QH to the Health Rights Commissioner dated 24 May 2005 and attachments *QEMS Coordination and Patient Retrieval Service Policy* dated 1 July 2004 and *Inter Facility Transports Operational Guidelines*
- copy of Summons issued by the Coroner to the Director of Medical Services, Caloundra Hospital and the Director of Medical Services, Nambour General Hospital to produce relevant documents
- copy of an internal QH email dated 21/2/03
- copy of internal memorandum concerning the "Management of Coronial Data Processes" dated 6 October 2003
- copy of the Investigation Report by the External Investigator
- copy of QH"s letter to the MBQ dated 9 March 2005
- copy of letter to QH from the Chairperson of the MBQ dated 29 March 2005
- additional correspondence obtained from QH via a Freedom of Information application by the Nevilles
- internal memorandum concerning the "Admission of Children to Caloundra Hospital"
- copy of the 2001 Report by QH *The Review of Emergency Services, SCHSD* and other supporting and associated documents

Policy and other internal documents

- QH Information Sheet #2 *Integrated Risk Management for Clinical and Corporate Services* dated February 2002
- QH Policy statement *Incident Management Policy* dated 10 June 2004
- QH *Integrated Risk Management Policy* dated 10 June 2004
- guidance document *QH Integrated Risk Management for Clinical and Corporate Services Program* dated March 2002
- QH‟s *Complaints Management Policy* dated 30 July 2002 and *Complaints Coordinators Handbook* dated September 2002
- Industrial Relations Policy IRM 3.1-5 *Official Misconduct- Requirements and Process for Reporting* dated April 2002
- copy of the final draft- QH *Incident Management Policy & Clinical Incident Management Implementation Standard*
- copy of the QH *Open Disclosure Project Plan*

Health Rights Commission

- all files held by the HRC pertaining to the Nevilles‟ complaint
- HRC‟s initial investigation report dated 3 September 2003
- HRC‟s investigation report dated 28 June 2004
- legal advice from the Crown Solicitor to the Health Rights Commissioner dated 10 February 2003

Medical Board of Queensland

- Nevilles‟ letter of complaint dated 22 March 2002
- MBQ‟s Annual Report 2002/2003
- letter from the MBQ to the Health Rights Commissioner dated 13 November 2003, enclosing a copy of the Investigation Report into the conduct of the medical officer
- numerous other correspondence between the MBQ and the HRC concerning the MBQ‟s investigation of the medical officer and subsequent disciplinary action

Queensland Nursing Council

- Investigation Report into the conduct of RN 1
- Investigation Report into the conduct of RN 2
- Memorandum of Advice from Senior Counsel to the QNC‟s Lawyer dated 17 August 2004

Appendix 8: Additional information supplied by QH in response to the recommendations

Information on actions implemented previously provided to the Health Rights Commission and Queensland Ombudsman

- Appointment of additional medical staff to provide a 24-hour roster service rather than on-call basis (commenced 14 January 2002).
- Additional funding of $525,000 for the Caloundra Emergency Department in the 2003/04 financial year (including medical and nursing staff increases).
- Conversion of a section of the ED into a dedicated two-bay observation area was completed in 2005.
- Additional paediatric equipment has been purchased including a new paediatric resuscitation trolley, a new neonatal resuscitation trolley, and a new wall mounted paediatric monitor. Other resources include a computer-based paediatric fluid resuscitation program. There is also a mechanism to access paediatric equipment annually through the District‟s Give Me 5 for Kids campaign.
- The District‟s Handbook for medical officer‟s was revised in December 2003 to include a section on documentation and is provided to all commencing medical staff as part of their orientation.
- Twice yearly documentation audits are completed and documentation is one of the key staff development focus areas.
- A number of medical and nursing staff have been credentialed in through the paediatric course of the Pre Hospital Life Support Training (PHTLS) or the paediatric component of the Trauma Nursing Course.
- A Fellow of the Australian College of Emergency Medicine (FACEM) commenced full time at Caloundra in June 2005.
- Since that time the FACEM has undertaken the rostering for the department to ensure appropriate skill mix. Principal House Officers (PHOs) are rostered for a series of overlapping shifts to provide continuous coverage. This includes a 12-hour night shift between 8pm and 8am. Senior coverage is provided by a rostered and rostered on-call combination.
- A Queensland Health *Incident Management Policy* was implemented in June 2004 and is supported locally by the implementation of a District Clinical Incidents Policy in May 2005. The Sunshine Coast Health Service District Clinical Governance Unit (CGU) was established in April 2005 and its responsibilities include clinical incident management, root cause analysis coordination, clinical risk register coordination, complaints management, medico-legal coordination and credentialing and clinical privileges coordination. The District Policy provides standards for the documentation and management of all actual and potential incidents involving patients including sentinel events and serious adverse events.
- A Caloundra Health Service Mortality and Review Committee has been established in line with the CGU. The functions of that group include mortality and morbidity case reviews and investigation and follow-up of serious adverse events for adults and children.

Additional actions implemented that have not previously been reported to the Health Rights Commission or the Queensland Ombudsman.

- Allocation of $900,000 additional funding in 2005/06 for Emergency Department enhancements at Caloundra including increased medical, nursing, medical imaging and administrative staff.
- An ultrasound service was commenced at Caloundra in July 2005.
- Announcement of a $50 million redevelopment of the Caloundra Health Service in 2005. The redevelopment is one of the components currently being considered by the health planners in draft a health services plan for the District (which also incorporates the Health Hub, the new tertiary facility to be located on the central coastal areas, and the future of the Nambour campus).
- Recruitment is currently underway for a District Director of Emergency Medicine to coordinate the provision of emergency services across the District.
- The District is currently negotiating an outsourcing arrangement for CT scanning services in Caloundra.
- The Director of Nursing, Sunshine Coast District is currently conducting a review of education and staff development services being provided for nurses in the district. The review will include an assessment of the paediatric qualifications and training provided to nursing staff in the Caloundra Hospital emergency department.
- A position of Director Education, Staff Development and Research has also recently been created in the district. The position will promote and maintain education and staff development standards for nursing services within the district.

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