

Contents

Commissioner's Summary	2
Health Services Review Council: President's Report	3
The Council	4
Membership	4
Statutory Functions	6
The Role of the Commissioner	6
Guiding Principles	6
Expectations and Standards	6
<i>Health Records Act 2001</i>	6
Other Statutory Roles	6
Liaison, Training and Promotion	6
Public Interest Issues	7
Health Records Found by Members of the Public	7
Analysis of Complaint Trends	8
2005/2006 Summary	8
Enquiries	9
Seriousness	9
Seriousness Rating	9
Who Complained?	9
How Complaints Are Managed	10
How Were the Complaints Resolved?	10
Assessment Report	11
Conciliation Report	12
Aboriginal Liaison Officer's Report	14
Registrar's Report	16
Prisoner Complaints	17
Primary Issues in HSC&R Complaints	18
Primary Issues in HRA Complaints	21
Complaints Against Health Services Providers	22
Medical Practitioners	22
General Practitioners	23
Dentists	24
Dental Prosthetists	24
Hospitals	24
Psychiatric Services	25
Hospital Complaints Data	26
Executive Services	28
Appendices	37

Glossary of Abbreviations

ATSI	Aboriginal & Torres Strait Island
CALD	Culturally and Linguistically Diverse
CLO	Complaints Liaison Officer (Hospitals)
FOI	<i>Freedom of Information Act 1982</i>
HCIP	Health Complaints Information Program
HRA	<i>Health Records Act 2001</i>
HSC	Health Services Commissioner
HSC&R	<i>Health Services (Conciliation & Review) Act 1987</i>
HSRC	Health Services Review Council
OHSC	Office of the Health Services Commissioner

Commissioner's Summary



The 2005 to 2006 period has been a very busy one for the Office of the Health Services Commissioner (OHSC). The primary role of the Office is to receive and resolve complaints from users about health services with a view to improving the overall quality of health services. The legislation, which established the Office, also makes it clear that as well as being an independent complaints resolution body, which deals with users complaints, the Health Services

Commissioner (HSC) also has a duty to suggest ways in which the guiding principals of health care may be carried out and to help service providers to improve the quality of health care.

Accordingly, there are many activities and processes in which I and my Officers are involved. Promotion of the Office is a time consuming task but one which is enjoyable and important. The Act says the HSC must be accessible and to be accessible people need to know about us. Poster and brochure campaigns have continued throughout the year and I gave many presentations and participated in media activities as well as conferences, seminars and workshops.

I was kept extremely busy in the October-December quarter with speaking engagements. This occurs every year because many health services hold their Annual General Meetings during October and November. Services visited this year included Horsham, Coleraine, Ballarat, Sale, Beaufort and Skipton, Dousta-Galla, Western District, North Western Mental Health and Mt. Eliza.

In health, despite strenuous efforts to promote the OHSC, many people with genuine complaints do not lodge them. This may be because they don't believe they will achieve anything, fear of reprisal or they are unaware of HSC services. Promotion of the OHSC must continue to be done in ways that do not jeopardise the excellent relationship the OHSC enjoys with provider and consumer organisations that provide much needed and valued expertise.

The HSC continues to have a constructive and helpful relationship with the Health Services Review Council, (HSRC) which includes the provision of advice, assistance with projects and attendance at some public gatherings. I congratulate the HSRC on finalising the *Guide to Complaint Handling in Health Services*. This was a time consuming project, which encountered a few difficulties along the way, but the final product has been extremely well received in the community and it has been worth the effort.

Interestingly, and in common with a number of other agencies of accountability, the actual number of complaints received has declined in the year under review. We have assumed this is because there was a surge in complaints because of tort law changes and business has now returned to normal. The OHSC continues to be

involved in providing advice on a wide range of policy issues, discussion papers and community based consultation processes. These can be complex and it is important that the OHSC is consulted because of our independent status and because we are not representing any particular stakeholder group.

Health Records Act complaints continue to focus on failure by health service providers to provide access to health records and privacy issues, especially disclosures of confidential information without consent. Staff have been kept busy trying to sort out the complexities arising from doctors retiring or leaving the country without making adequate arrangements for transfer or storage of patient records.

Despite adverse media coverage of mental health services complaint numbers are not high with 24 being recorded this year. This included complaints, made by patients experiencing mental illness, about hospitals and doctors as well as other mental health services. The three major issues complained about at hospitals continue to be communication, access and treatment.

The six monthly meetings of the Australian and New Zealand Health Complaint Commissioners, provide a useful forum for open discussion with the Chatham House Rules applying. This year the Commissioners met in Perth and Alice Springs. The additional pressure placed on the Queensland Commission because of the inquiries and investigations into Dr Patel meant Queensland was unable to continue to organise and host the National Complaints Conference. Victoria volunteered to take this on and the Conference will be held in Melbourne on 16 and 17 November 2006 with an assessment workshop on the afternoon of 15 November 2006. In previous years there were alternating conferences with one being organised by the Commissioners and the other by the Complaints Officers. This year the two will be held together in Melbourne.

I also take this opportunity to thank the hard working staff of the OHSC. This year has been quite stressful and the support given to staff by each other and to me is very much appreciated.

A handwritten signature in black ink that reads "Beth Wilson". The signature is written in a cursive style.

Beth Wilson
Health Services Commissioner

Health Services Review Council: President's Report

The HSRC provides advice to the Minister of Health and the Health Services Commissioner on Victoria's health complaints system. The HSRC also promotes the operations of the Office of the Health Services Commissioner, particularly focussing on the guiding principles that underpin the *Health Services (Conciliation and Review) Act 1987*.

To this end the HSRC undertook a best practice in complaint handling project as outlined in last year's Annual Report to assist health care services to better deal with complaints and adverse events.

Guidelines were developed for use in health services and the HSRC was delighted that Minister Pike formally launched the *Guide to Complaint Handling in Health Services* at Royal Melbourne Hospital in December 2005. Minister Pike stressed how important it was that complaints were taken seriously and people listened to. She highlighted how much could be learned from good complaint handling and congratulated the HSRC on a timely, accessible, attractive and useful document.



The Hon. Bronwyn Pike MP, Minister for Health launching the HSRC's "Guide to Complaint Handling in Health Services"

Complaint Liaison Officers (patient representatives) and other stakeholders were consulted to ensure the Guide was helpful and representative and it has now been distributed to all hospitals and community health centres in Victoria. The Guide targets Complaints Liaison Officers (patient representatives), Quality Managers and Chief Executive Officers. Copies can be downloaded from the OHSC's website.

The HSRC believes that good complaint handling is a window of opportunity for improvement in our health services and is delighted at the positive feedback it has received on the usefulness of the Guide. It is also pleasing that the Victorian Ombudsman has drawn on the guidelines when developing a good practice guide to complaint handling for his office.

I would like to particularly thank fellow HSRC members Marcia Coleman and Susan Bunting and Michael McDonald and Lyn Buchanan from the OHSC for their efforts in ensuring the successful

completion of this project. I would also like to thank the Commissioner for her support for the project and of course the Department of Human Services (DHS) and Victorian Managed Insurance Association for funding it.

The HSRC is currently in the process of completing a training package to accompany the Guide which will also be widely distributed.

There have been three major issues that the HSRC has focused on during the year. The first relates to the Dr Patel scenario in Queensland and Council questioning the systems we have in place to minimise the risk of the same thing happening in Victoria. The scope of our discussion has included medical credentialing, medical workforce issues particularly in rural areas, reporting of deaths in hospital to the coroner, OHSC processes for picking up multiple unrelated complaints about a health practitioner and possible screening methodologies as an alert to unexpected deaths in hospital.

The HSRC invited Dr David Ranson from the Victorian Institute of Forensic Medicine to discuss the possible underreporting of deaths in hospital and the proposed changes to the Coroner's Act.

Dr John Humphreys, Professor of Rural Health Research at Monash University presented his findings of a joint project between Monash University of Rural Health and the HSC which highlighted that there a fewer complaints against health practitioners in rural areas.

Invitations have also been extended to DHS and the Medical Registration Board to discuss some of these issues further.

The second issue the HSRC agreed to focus on is the storage of medical records after it was identified by the HSC as a concern for practitioners. Discussions have been held with the College of General Practitioners, medical insurers and the AMA. The HSRC's aim is to facilitate an outcome that assists health practitioners by providing an effective, accessible and affordable solution to the storage of their records.

The third area of focus for the HSRC continues to be around issues associated with newborn screening for genetic disorders, particularly the use of Guthrie Cards. The HSRC initiated a forum for key stakeholders sometime ago which resulted in a Review Committee set up to make recommendations to the Minister for Health.

The HSRC awaits the outcome of this process and is keen to ensure the unresolved issues around obtaining fully informed consent for all future uses including research, privacy, ownership and appropriate storage of the cards will be successfully addressed.

I would like to thank my HSRC colleagues for their support and wise counsel through out the year. Also for their unwavering commitment to ensuring Victoria has an effective and accessible health complaints system that not only satisfactorily addresses individual complaints, but facilitates improvements in broader health systems so the benefit flows to all users.

The HSRC is appreciative of the administrative support provided to it by the OHSC, particularly the efforts of Michael McDonald, Manager, Executive Services.

Finally, the HSRC looks forward to continuing the constructive and mutually respectful relationship it enjoys with the Commissioner Beth Wilson over the next 12 months and thanks her for her ongoing support of the work of the HSRC .

Health Services Review Council: President's Report

The Council

Under the *Health Services (Conciliation and Review) Act 1987* (HSC&R), the Council has the following functions:

1. To advise the Minister on the health complaints system and the operation of the Commissioner;
2. To provide expertise, guidance and advice to the Commissioner;
3. To promote the Commissioner, the operations of the Commissioner and the guiding principles in the Act;
4. To advise the Minister and Commissioner on issues referred to the Council by the Commissioner;
5. With the Minister's approval, to refer matters relating to health service complaints to the Commissioner for inquiry.

Membership

Council members are representatives of providers, users and independent people in relation to the health system. The Council includes a representative with experience in matters affecting the privacy of individuals in relation to health information, representing both interests of organisations that handle information as well as consumers.

The current membership is listed below.



Robyne Schwarz (*President*)

Robyne joined the Council in 2003 as an independent representative. She has both Physiotherapy and Social Work qualifications and was a senior practitioner at the Royal Children's Hospital (RCH) for 15 years. Robyne has been a National Director and State President of the Australian Association of Social Workers and has lectured in Social Work at the University of Melbourne. She is currently President of Jewish Care and a member of the Osteopath's Registration Board. Robyne brings to the Council experience as a health services practitioner, along with expertise in quality improvement and community participation in healthcare and clinical governance system development.



Pam Barrand

Pam is a lawyer with the Youth Legal Service of Victoria Legal Aid. She is a Board Member of the Eastern Health Network, a member of the Mental Health Review Board and participates in a number of community working groups including City of Whitehorse Youth Issues Working Group, Refugee Youth and Justice Working Group and the Court Network Consultative Group of the Children's Court. Pam is also a sessional member of the Victorian Civil and Administrative Tribunal.



Susan Bunting

Susan is currently an independent consultant for the Australian Council on Healthcare Standards, a member of the Data Review Committee of the Australian Childrens' Cancer Study Group Research Protocol 8 and a consumer advocate in healthcare.

She is also a lawyer, policy analyst and applied bio-ethicist with over 20 years experience.



Marcia Coleman

Marcia has had extensive high-level experience in the health sector spanning the last 27 years. Her experience has been heavily oriented to the identification and management of risk and key issues, change management, corporate governance, communication and consultation. She is presently Chairman of Australians Donate, the peak body for organ and tissue donation for transplantation in Australia.



Judith Congalton

Judith is Chief Executive Officer at MECWA, a not for profit company providing residential aged care, in home services and community services across metropolitan Melbourne and in Shire of Cardinia. Judith has held a number of leadership positions across both public and private acute hospital sector over the past 25 years. She is committed to continuous improvement and has been instrumental in creating and progressing the development of quality programs throughout her career.

Judith's professional activities include being a Surveyor with Australian Council on Healthcare Standards for 19 years. She is a Fellow, Royal College of Nursing Australia, Associate Fellow College of Health Service Executives and Member Australian Institute of Company Directors.

Health Services Review Council: President's Report



Associate Professor Albert Frauman

Albert is the Acting Head of Clinical Pharmacology and Therapeutics at Austin Health/University of Melbourne, Co-Director of the Victorian Toxicology Service and Head of the Drug Evaluation Unit of the University of Melbourne. Albert has longstanding activities in clinical medicine, teaching and research as a hospital and academic physician. He has expertise in pharmaceutical evaluation for the Therapeutic Goods Administration and strong interests in quality use of medicines and pharmacoconomics. He chairs the Drug Utilisation Sub-Committee and sits on the Drug Trials Subcommittee and Drug and Therapeutics Committee of Austin Health. He sits on a number of key State and Commonwealth therapeutics committees as a clinical pharmacologist, including the Poisons Advisory Committee of DHS and the National Drugs and Poisons Schedule Committee (Department of Health and Ageing). He is also actively involved in professional advisory roles, sitting on the Royal Australasian College of Physicians' Victorian State Committee and the College's Federal Therapeutics Committee.



Jamie Gardiner

Jamie is a human rights advocate. He has long been on the executive of Liberty Victoria, of which he is now a Vice-President. Since 2000 he has been a part-time Equal Opportunity Commissioner, and a Member of the Mental Health Review Board. As a gay activist Jamie has been campaigning for an end to discrimination, both in the law and under the law, for over 30 years. He was a founding member of the Victorian AIDS Council, and took part in the mostly successful campaign in the 1980s to have a health policy for HIV/AIDS that respected human rights, in a public health model.



Dr Geoff Markov

Geoff is a Consultant Physician and Rheumatologist working in both private practice and public hospital settings in suburban Melbourne. Having trained in Australia and the United States, he has considerable experience in issues concerning patient care, medico-legal affairs and clinical governance. He is a member of the Medicare Participation Review Committees of the Health Insurance Commission, has provided expert opinion on cases brought before courts in Federal and State jurisdictions, and is a lecturer and examiner for the Medical School at the University of Melbourne.



Dr Paul Nisselle AM

Paul has been a provider representative on the Health Services Review Council since 1994. He was in general practice in Elwood for 18 years before entering the medical indemnity industry in 1989. He is now Senior Advisor, Risk Management for the Medical Defence Association of Victoria. He is a Past-President, Past Chairman and Past Federal Councillor of AMA Victoria and has served on the Medical Practitioners Board of Victoria.



Dr Andrew Rothfield

Andrew joined the Council in 2005 as an individual with experience in health information privacy. He currently works part-time as a medical officer in obstetrics and gynaecology at Northern Hospital, and his most recent full-time role was as Chief Information Officer for Southern Health.

Andrew has significant skills in the analysis of health information, and is interested in issues relating to informed consent and the confidentiality of health information.



Dr Penny Weller

Penny is Lecturer in Law at Victoria University. She has a background in primary health care nursing and public health practice. As an academic she has continued research and teaching in health law, public health law and human rights. She has contributed a socio-legal perspective to projects in public health law and policy including research ethics for young people, young people in the criminal justice system, national prevention policy for drug related harm, and public health emergency powers.

One member left the Council this year. Catherine Dean has made significant contributions. I would like to thank her for her efforts and wish her well in the future.

I would like to welcome the two new members, Penny Weller, and Albert Frauman who have been recently appointed to Council.

Robyne Schwarz
President

Statutory Functions

The Role of the Commissioner

The OHSC was established in Victoria in 1988 by the *Health Services Conciliation and Review Act (HSC&R) 1987*. The Commissioner's role is to receive, investigate and resolve complaints from users of health services, to support health care services in providing quality health care and to assist them in resolving complaints. The legislation also requires that information gained from complaints should be used to improve the standards of health care and prevent breaches of these standards.

The HSC&R states that the Commissioner is to:

- a) Deal with users' complaints; and
- b) Suggest ways in which the guiding principles may be carried out and help service providers to improve the quality of health care.

The purposes of the Act include:

- a) To provide an independent and accessible complaint mechanism for users of health services; and
- b) To provide a means for reviewing and improving the quality of health service provision.

Guiding Principles

The guiding principles of the HSC&R promote:

- a) Quality health care given as promptly as circumstances permit; and
- b) Considerate health care; and
- c) Respect for privacy and dignity of persons being given health care; and
- d) The provision of adequate information on services provided or treatment available in terms which are understandable; and
- e) Participation in decision making affecting individual health care; and
- f) An environment of informed choice in accepting or refusing treatment or participation in education or research programs.

Expectations and Standards

The guiding principles establish the range of responsibilities for health services and the basis upon which a person might complain if a breach of these responsibilities has occurred. They establish a framework for the HSC to become involved in improving health services and report on problems identified and improvements made. The Commissioner also has the overall function of suggesting ways of improving the quality of health services.

HRA

The HSC is also responsible for the administration of the legislation dealing with the privacy of health information and an individual's right to have access to their own information. The HRA commenced on 1 July 2002. The purpose of the HRA is to promote fair and responsible handling of health information by:

- a) Protecting the privacy of an individual's health information that is held in the public and private sectors; and
- b) Providing individuals with a right of access to their health information; and
- c) Providing an accessible framework for the resolution of complaints regarding the handling of health information.

Organisations holding health information must manage the health information, which relates to individuals, in accordance with the Health Privacy Principles (HPP's) in the HRA, subject to any specific provisions about the management of health information in any other Act.

Individuals are now able to seek access to health information about them held by any person or organisation in the private sector. The *Freedom of Information Act 1982* (Fol) continues to provide a mechanism for individuals to seek access to their health information held by public sector organisations. However, in the event of a refusal of access to health information under the Fol Act, the HRA also provides an avenue for these refusals to be conciliated.

Individuals can now complain to the HSC when their health information has not been managed in accordance with the HRA, or where they have experienced difficulties accessing their health information. The HSC assesses complaints and, if a complaint is accepted, it may be conciliated, investigated or dismissed. Where a complaint is dismissed, the individual has the right to take their complaint to the Victorian Civil and Administrative Appeals Tribunal (VCAT).

Other Statutory Roles

The OHSC provides training to a wide range of health service users, providers and organisations that hold health information. This is in accordance with our functions as outlined in section 9 of the Act. A cooperative working relationship exists between the OHSC and the complaints liaison officers at public hospitals and with many other health services in Victoria. Consultation with consumer organisations can be direct or through "umbrella" organisations like the Health Issues Centre.

Liaison, Training and Promotion

The OHSC consults regularly with the 12 professional Registration Boards about complaint handling in accordance with section 19(6) of the Act. Regular meetings between the OHSC and the Boards are held to determine the most effective and efficient ways of handling complaints about registered practitioners. This process avoids double handling and ensures the legislative requirements are met. The HSC also discusses relevant issues with the Ombudsman, the Mental Health Review Board, the Intellectual Disability Review Panel, the Office of the Public Advocate, the Coroner, the Privacy Commissioner, the Commissioner for Equal Opportunity, the Infertility Treatment Authority and other relevant authorities. These links assist our work, especially where the management of complaints involves more than one Office.

The Commissioner places strong emphasis on promotion and training to improve accessibility of the OHSC to the public and health service providers. During the year under review the HSC has been represented at many conferences and venues to promote the work of the Office. The Commissioner conducted 51 presentations, 3 lectures, 6 launches and participated in 17 conferences and 5 hypotheticals/forums, 3 Seminars and many media interviews in the 2005/06 financial year.

Public Interest Issues

Some concerns have been raised over the years by families of women who have made allegations of sexual assault by family members. These concerns focus on the techniques thought to be used to recover traumatic memories in people receiving counselling. Following a number of submissions to the DHS in the Review of the Regulation of Health Professions, the Minister for Health requested this Office to inquire into the practice of recovered memory therapy. In the Inquiry the Office reviewed scientific literature, and consulted with experts and other interested people. The matter proved to be highly controversial with very different views expressed at all levels. The Inquiry found little evidence of recovered memory therapy being actively used in Victoria, however some recommendations were made concerning the need to review the education of service providers and to increase the awareness of the community about options in therapeutic counselling. Memory plays an important role in all psychological therapies but the focus of this inquiry was on the deliberate practice of suggesting trauma has occurred. The inquiry report can be found on the website at www.health.vic.gov.au/hsc.

The Office has a commitment to involvement in organisations and projects to improve health care for Victorians. This year we contributed to the Respecting Patient Choices Project at the Austin Hospital, an end of life health care project and to the Open Disclosure pilot run through the Department. We also enjoy an ongoing co-operative relationship with the Health Services Liaison Association (HSLA) the professional association of complaints officers and continue to provide them with support wherever possible.

Our role in research continued through the ARC Linkages grant with Monash University in Bendigo to study the reasons why there are proportionally fewer complaints received from rural areas. This led to the acceptance for publication of "There's No Point Complaining" in the Australian Health Review.

Health Records Found by Members of the Public

The OHSC is occasionally contacted by members of the public who have found health records in public places. The HSC has a responsibility under the HRA to determine how the records were lost or mislaid and ensure that the problem is rectified. In one case, a member of the public found a list of in-patients of a ward of a public hospital. The list contained the patients' medical conditions and treatment plans. HSC staff met with the manager of the relevant unit in the hospital. The hospital was able to determine which staff member had mislaid the patient list. The staff member was a trainee on placement and had left the hospital. Measures were put in place in an attempt to ensure that such a breach of confidentiality not happen again. The Commissioner was pleased with the steps taken by the hospital.

On another occasion, the HSC was contacted about a doctor who had closed his practice and thrown out medical records in a rubbish bin that was accessible to the public. The doctor had not left any details of a forwarding address or telephone number. OHSC staff went to the former practice and found original medical records in a bin and retrieved them. Once contacted the doctor claimed the records were old and could be disposed of. The Doctor's obligations under the legislation were explained, including the need to dispose of medical records only after 7 years since the last service was provided to the patient and it must be done securely. Once aware of his obligations the doctor took the records back and implemented a system for patients to obtain their original records, or have them sent to their new doctor.

The OHSC has a commitment to involvement in organisations and projects to improve health care for Victorians

Analysis of Complaint Trends

Throughout this Report anecdotal information has been used to illustrate the type of complaints received. Details have been altered to protect confidentiality and, wherever possible, actions taken or resolutions achieved have been indicated.

2005/2006 Summary

There has been a slight decrease in the number of new complaints received in the past year. At the moment it is not clear why this is so, but it is a trend also noticed by other complaint agencies. From analysis of data over the past four years it seems possible that there was a surge in complaints because of the changes to tort legislation affecting compensation claims and numbers may now have returned to the levels prior to these events. The trend will be monitored to see if it continues into the next year. Summary complaint data from the past year is shown in Table 1.

Table 1: New Complaints and Enquiries

Complaints: 2005-2006				
	Enquiries by Telephone	Single Contact	Accepted Cases	Total
HSC&R	6402	931	1013	8346
HRA	2265	113	118	2496
Total	8667	1044	1131	10842

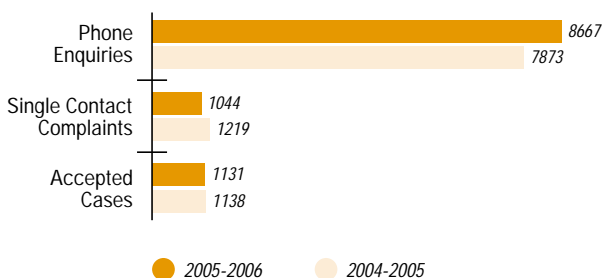
Complaints: 2004-2005				
	Enquiries by Telephone	Single Contact	Accepted Cases	Total
HSC&R	6081	1072	1025	8178
HRA	1792	147	113	2052
Total	7873	1219	1138	10230

The total number of complaints recorded is made up of single contact complaints and accepted cases. Single contacts are registered complaints that were not subsequently confirmed in writing at the time of this Report. Some complaints are confirmed several months after the initial contact. Typically every year around one half of registered complaints will not be confirmed and will be closed as single contact cases. These complaints have decreased by 15% from the previous year.

Accepted cases are the complaints that were confirmed in writing during the year. There does not appear to be much variation in these from the previous year.

When single contact and accepted cases are added together there was a 7% decrease in the total number of complaints for the year.

Figure 1: Complaints and Enquiries; July 2005 - June 2006



Enquiries

It can be seen in Tables 1 and 2 that the number of general enquiries has increased over the past year. These are calls for advice and information which do not lead to the registration of new complaints. There are regular requests for advice and information about access to health records and health privacy and these account for about one quarter of all enquiry calls. The other enquiries are many and varied and hence 48% are recorded as "other" or "referred elsewhere". Officers taking these calls often have to do some research before calling back to ensure callers are given appropriate advice and referrals.

Table 2: Enquiry Types

HRA Issues (2265)		HSC&R Issues (6402)	
Access to Records	12%	Brochure	3%
Brochure	1%	Fees	8%
Fees	2%	Food & Environmental Health Issues	10%
Privacy Information	10%	Health Insurance	3%
Referred to FOI Act	1%	Hospital Waiting Lists	2%
		Other	23%
		Referred Elsewhere	25%
	26%		74%

Seriousness

Complaints are rated for seriousness when they are first received based on the information provided. The ratings are reviewed on closure when the additional information available has been assessed.

Seriousness Rating

1. Low:

A phone call, letter or an explanation should easily resolve the problem. Included in this rating are complaints that are frivolous, vexatious, obviously misconceived or where an investigation is unwarranted.

2. Medium:

Frequently there has been a misunderstanding; issues involving access to records, disputes about costs, discourtesy, diagnostic or treatment errors or differences of opinion without serious sequelae.

3. High:

There may be significant quality assurance implications, where changes in practice are needed to avoid a recurrence or there is a need for policy development. These also include complaints associated with possible negligence leading to personal injury, professional misconduct, unlawful or unethical acts, lack of informed consent with serious adverse outcomes.

The seriousness rating of complaints closed in the past year can be seen in Table 3 (next page).

Analysis of Complaint Trends

Table 3: Seriousness by Issue at Closure

HRA	2005 - 2006					2004 - 2005				
	Low	Medium	High	Total	%	Low	Medium	High	Total	%
Access & Correction	51	36	0	87	4%	68	52	1	121	5%
Anonymity	2	0	0	2	0%	6	1	0	7	0%
Collection	6	7	1	14	1%	7	4	2	13	0%
Data Quality	10	10	0	20	1%	6	7	1	14	1%
Identifiers	0	1	0	1	0%	1	1	0	2	0%
Info Available to another HSP	10	5	0	15	1%	4	1	0	5	0%
Openness	0	0	0	0	0%	2	1	0	3	0%
Transborder Data Flows	0	0	0	0	0%	0	0	0	0	0%
Transfer/Closure of HSP	3	1	0	4	0%	2	2	0	4	0%
Use & Disclosure	54	52	4	110	5%	38	54	7	99	4%
None	0	0	0	0	0%	0	1	0	1	0%
Total	136	112	5	253	12%	134	124	11	269	11%

HSC&R	2005 - 2006					2004 - 2005				
	Low	Medium	High	Total	%	Low	Medium	High	Total	%
Access	142	57	7	206	9%	126	62	6	194	8%
Administration	64	18	0	82	4%	64	20	1	85	4%
Communication	193	48	3	244	10%	185	81	7	273	12%
Cost	111	16	1	128	6%	114	27	0	141	6%
Not Specified	1	1	1	3	0%	26	37	3	66	3%
Rights	72	30	12	114	5%	105	42	6	153	6%
Treatment	676	505	86	1267	54%	562	513	113	1188	50%
Total	1259	675	110	2044	88%	1182	782	136	2100	89%

Grand Total	2005 - 2006	2004 - 2005	Total	%
	1395	787	2297	100%
	61%	34%	5%	100%

The majority of complaints received are rated as “low” seriousness and this is consistent from year to year. The majority of these complaints can be resolved by further explanation for the complainant.

Who Complained?

A complainant is defined as the person who makes the complaint. This is most often the patient or consumer of the health service but can be the next of kin or legal representative or a person appointed by the service user to complain on their behalf. Complaints can be accepted from third parties at the discretion of the Commissioner where a user is unable to complain on their own behalf.

The consumer profile shown in Figure 2 (below) and Table 4 (right) indicates that 60% of consumers in the complaints recorded were women. This is similar to data from previous years.

Figure 2: Consumer Gender

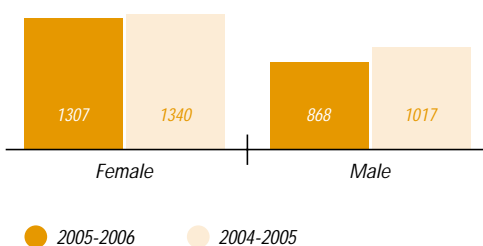


Table 4: Consumer Profile

Age Range	Female	Male	Total
0 to 01	4	5	9
01 to 04	8	14	22
05 to 14	10	26	36
15 to 24	25	23	48
25 to 34	79	41	120
35 to 44	95	69	164
45 to 54	123	47	170
55 to 64	48	39	87
65 to 74	36	38	74
75 +	68	37	105
Unknown	811	529	1340
Total	1307	868	2175

How Complaints are Managed

The OHSC is structured into three teams (*see Organisation Chart on page 36*) with the Assessment and Conciliation teams responsible for managing the complaints received in the Office.

The enquiry telephone line operates from 9am to 5pm, four days a week and from 9am to 1pm on Fridays. At other times messages may be left on the answering machine. Assessment Officers are usually the first point of contact for members of the public and have a broad knowledge of health issues and, where appropriate, can provide referrals to other agencies if the enquiry does not come within the jurisdiction of the HSC.

When enquiries are received by telephone, an Assessment Officer listens and assesses the issues the caller is presenting. As required by the Act the Officer advises and encourages callers, where appropriate, to make direct contact with the service provider as the first step in resolving the complaint. It is hoped many of the unconfirmed complaints are resolved in this way. The OHSC accepts that not everyone is able to do this for him or herself and can and does assist whenever necessary.

If the complaint is about a health service provider, and the complainant is unable to resolve the matter directly, a complaint form is sent out. The service user is asked to complete the form, sign an authorisation and give details of the complaint. The Act requires that complaints made on the telephone or in person must be confirmed in writing. Staff can assist in this process.

Assessment Officers record all potential complaints on the database as cases. If a complaint is not confirmed in writing, the matter is closed although complaints identified as serious may be followed up. If a complaint is from a person from a culturally or linguistically diverse background the officer may use interpreter services and assist the person to make the complaint. Assessment Officers are also available to talk with prospective complainants if they attend the office and appointments can be made by telephoning the Helpline on 86015200.

Confirmed complaints are entered on the database in detail, including a summary of the complaint. A file is made up and an acknowledgment letter sent to the complainant.

The complaint is then sent to the health service provider who is asked to respond within 14 days. A written response will be sent to the OHSC and this is usually sent to the complainant for comment. This process resolves the majority of complaints. A clear explanation from the health service and, where appropriate, an apology continues to be the most effective means of resolving complaints.

The maximum time a complaint may remain in the assessment stage is 84 days. If a case is not resolved within this time the Commissioner can decide to refer the case to conciliation. The referral can occur earlier if the circumstances of the case warrant this.

The conciliation process is quarantined from all other processes within the OHSC and its aim is to encourage settlement of the complaint by arranging informal, confidential discussions between the parties.

Within two weeks of receiving the referral the conciliator writes to the parties giving details of the arrangements for the discussions. These proceedings are privileged and nothing said or disclosed during the conciliation may be admitted in any court action. The process is entirely voluntary; at any stage in the negotiations either party can decide not to proceed any further and this ends the matter in conciliation.

Generally complaints in conciliation fall into two categories. One group requires further explanation as to what happened and expert advice or opinion may be used for this purpose. The other is a claim for damages, compensation or remedial treatment where there have been allegations or sometimes evidence of negligence. Often they involve elements of both. A claim for compensation is usually negotiated between the parties and their advisors, with the conciliator as the link, with or without a meeting.

When there is a dispute about a health service provider's liability for a claim then, with the agreement of the parties, an independent expert opinion can be sought. The conciliator organises this from an expert in the relevant field. Copies of this opinion go to the parties who use it as a basis for further negotiations.

If conciliation results in the payment of damages or compensation then release documents are prepared.

How Were the Complaints Resolved?

The complaints closed in enquiry are those that were not confirmed in writing. The resolution of these may be that the caller felt it was sufficient to tell someone why they were unhappy and to be listened to, however they may also remain unresolved and the person may decide to proceed with the complaint at some time in the future. There is a one year time limitation on complaints but the Commissioner has the discretionary power to extend this.

The confirmed cases are resolved either in the initial assessment process or they are referred to conciliation. A very small number are referred for investigation but this only happens when mediation and conciliation or referrals to registration boards are not feasible options. This year approximately 75% of confirmed cases were resolved in assessment.

The stages at which complaints were resolved can be seen in Table 5 below.

Table 5: Resolution Stages

Stage of Complaint Process	HRA	HSC&R	Total	%
Closed in Enquiry (Single Contact Complaints)	113	931	1044	45%
Closed in Assessment	100	867	967	43%
Closed in Conciliation	40	243	283	12%
Closed in Investigation	0	3	3	0%
Total Cases Closed	253	2044	2297	100%

How Complaints are Managed

Assessment Report

The Assessment Team is the intake area for all complaints to the OHSC under the HSC&R and the HRA. In addition to the management of these complaints, the team also provides the helpline telephone service to the community. The helpline receives enquiries and potential complaints and also refers callers to other services such as the Environment Protection Authority and the health inspectors employed by local government.

Each Assessment Officer manages a caseload of complaints, which they assess to see how the issues may be resolved.

A woman complained about her treatment at a beauty therapy clinic. She had been embarrassed about her skin and wanted to know whether the laser treatment offered might assist her. She was assured that it could help and was advised there might be some risks involved but these were uncommon and minor in nature. She proceeded to have the treatments and was alarmed that her skin blistered and bled and took considerable time to recover. She now has some residual pigmentation and scarring that a dermatologist has warned may be permanent. The clinic refunded her fees and provided some topical skin care creams to aid healing.



(L-R): Assessment Officers Kate Kennedy, Piotr Nyczek and Jill Aitken

The number of HRA enquiry phone calls has continued to increase but complaint numbers have stabilised, as most health service providers are now aware of the Act and its implications.

A rural doctor called to ask what his obligations were when he received a request for access to health records from a solicitor on behalf of a patient. He had understood the Health Records Act 2001 was to assist individuals to gain access to their health information and was not intended to give cheap access to solicitors seeking information for a litigation case. The doctor was advised that an individual could nominate anyone to act for him or her in requesting access to requests and the doctor was obliged to comply with the request as if it came from the individual.

Where there is an inconsistency between the HRA and another Act the other Act overrides the HRA. So while a complainant may believe they have a right of access to their health records under the HRA, it may be that their access is prohibited or constrained by the terms of another Act. The HSC has been generally pleased at the open approach to access demonstrated by the vast majority of providers.

In Table 6 the reader can see the broad resolution categories for complaints resolved in the assessment stage. There is scope on the database to record more than one outcome to a complaint, however only the first outcome is reported in the table at right.

Table 6: Resolution in Assessment

Assessment	2005/06	2004/05
Apology	2%	5%
Concern Registered	0%	0%
Costs Refunded	5%	6%
Declined	16%	18%
Explanation Offered	34%	49%
Objective Not Obtained	7%	6%
Procedural Change	0%	0%
Referred Elsewhere	21%	12%
Service Obtained	8%	3%
Withdrawn by User	7%	1%
	100%	100%

As in previous years the most frequent outcome in assessment is the provision of further explanations for the complainant. Sometimes advice is obtained from various independent practitioners who assist the OHSC in resolving complaints but frequently the service provider is able to give a more detailed explanation in response to the complaint.

Some complaints may be referred to the appropriate Registration Board after discussions with the Board in the initial stages and others, under the HRA, may be referred to VCAT at the request of the complainant.

A woman complained she had been refused obstetric services in her community hospital because of her age. She wanted to give birth in a hospital where it was easy for her family and friends to visit her after the birth and she was also concerned about travelling to the city when in labour. The Hospital explained that while they understood the disappointment the woman felt, they were not insured for the provision of services to anyone categorised as a "high risk" patient as this woman had been. They would not be able to provide the level of care needed if complications arose. The explanation was accepted.

How Complaints are Managed

Conciliation Report



Keith Jackson,
Chief Conciliator

This year has been one of consolidation, including the refining of many of our procedures. There have also been some new developments in the staffing of the conciliation team.

The team meets weekly to discuss all matters that affect the conciliators, including the handling of the interesting and unusual complaints, our processes for dealing with the issues that arise from the conciliation of complaints, the events of the preceding week, any legal developments and any developments in our dealings with our stakeholders. The individual conciliators also meet monthly with the Chief Conciliator to review all their files and to discuss any difficult issues that arise from the complaints.

All the conciliation standard letters and correspondence such as outlines of procedures have been reviewed and re-written to ensure consistency and simplicity of language.

The team has consisted of 12 staff, including four part-time staff and one staff member who is working as a conciliator part-time while she is on sabbatical leave from her Hospital. We have had two medically trained conciliators working part-time during the year. We have not employed medically trained conciliators before and to our knowledge neither have any of our counterparts throughout Australia. Accordingly, we were interested to see how the parties to the complaints against medical practitioners would respond to a medically trained conciliator. No problems have been encountered as the parties have been consulted carefully and any potential conflicts of interest have been dealt with immediately. The conciliators have found that the immediate access to medical advice on the issues they are dealing with has been most useful and has facilitated the quick settlement of many complaints.

Table 7: Resolution in Conciliation

Type of Resolution	2005/06	2004/05	2003/04	2002/03
Apology Given	4%	7%	6%	7%
Change in Procedure/Policy	0%	0%	1%	1%
Compensation	10%	9%	17%	17%
Explanation/Information Provided	64%	67%	66%	65%
Total Resolved	78%	83%	90%	90%
Referred to Board	5%	1%	0%	1%
Non-conciliable	17%	16%	10%	9%
Total	100%	100%	100%	100%

Example 1

The *Wrongs and Limitation of Actions Act (Insurance Reform) Act 2003* continues to have an impact upon our work. When there is a dispute between the parties to a complaint as to whether the complainant meets the thresholds for impairment (over 5% permanent physical and over 10% permanent psychological) in order to be able to claim general damages, increasingly the conciliators are asked by the parties to arrange for impairment assessments. As with opinions on liability that are obtained for the purposes of conciliation, the impairment assessments are obtained on a neutral basis for the use of both parties in conciliation and are paid for by the OHSC. These assessments have added another step to the process of conciliation when there is a claim for general damages.

An example of the resultant complicated negotiations in conciliation follows:

After an accident, Mr M, the user, was taken to Public Hospital A by ambulance. He requested an x-ray of his arm as he informed the doctor and staff he was able to feel the grating of bones in the arm as he moved. He repeated this request two or three times and received the same reply that it was unnecessary, as he did not have a break; the swelling would go down in approximately three weeks and he would be alright.

After a period of three weeks with increasing pain he returned to Public Hospital A and was told to go to his own doctor where an x-ray was done that showed a fracture of his arm. A repair procedure was performed at Public Hospital B.

Mr M was left with a number of problems, including pain, and weakness in his dominant arm.

*An opinion was sought from an independent orthopaedic surgeon who concluded that Mr M did meet the greater than 5% permanent impairment threshold as prescribed under the *Wrongs and Limitations of Actions Act 2003* and that the care provided did not meet that of a reasonable standard.*

There was a dispute between the parties regarding various aspects of the consultant's opinion and assessment, so a supplementary opinion was obtained.

*The dispute over the impairment assessment continued so the impairment assessment was referred to a Medical Panel under the *Wrongs Act 1958* for a determination. The Panel found the degree of whole person impairment resulting from the physical injury to the claimant in the claim did satisfy the threshold level.*

In conciliation, Mr M then put forward a proposal for settlement for a significant figure of compensation. In addition to requesting financial information, the solicitor acting for Public Hospital A then required Mr M to be examined by an orthopaedic surgeon for an assessment of the extent of the impairment that would have arisen from the accident, even with immediate surgery. The consultant found the majority (80%) of Mr M's impairment was due to the delay in diagnosis and treatment.

The complaint was settled in conciliation for a substantial amount.

How Complaints are Managed

Example 2

Every year a number of claims for compensation that could also have been dealt with by the Courts are settled in conciliation.

A man in his mid-20s complained that he had consulted his GP on five occasions over a 12-month period. On each occasion his symptoms were similar, loss of appetite, fatigue and a persistent cough. The GP prescribed antibiotics and suggested the underlying cause might be a generalised anxiety disorder. The complainant was eventually diagnosed with an in-operable non-Hodgkins lymphoma.

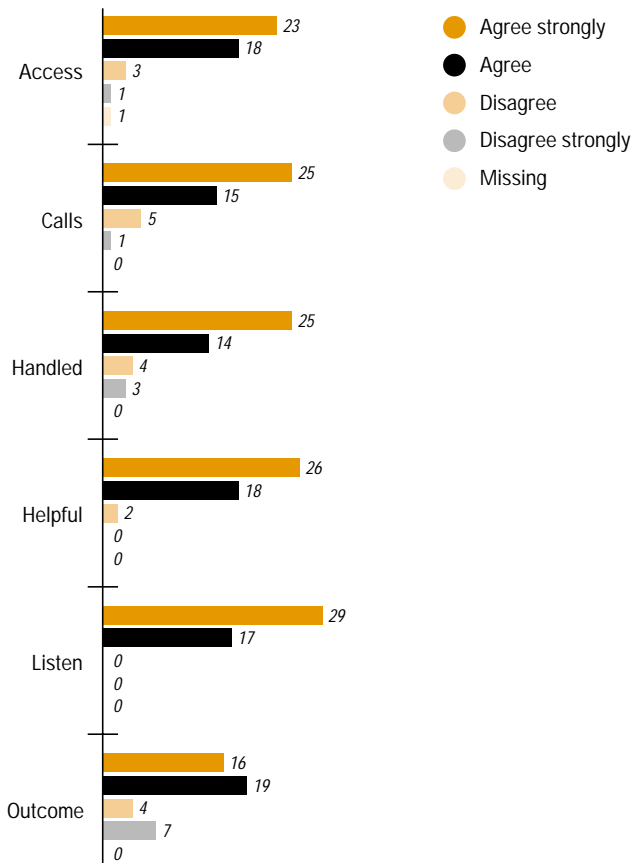
All the negotiations in conciliation were via telephone and correspondence. An independent consultant provided an opinion. An offer of settlement was made, based on the complainant's inability to pursue the career he had trained for, together with out-of-pocket expenses. The offer was accepted and the complaint was therefore resolved.

Conciliation Evaluations

Of complainants who returned evaluation forms, 76% were satisfied with the outcome of the conciliation. Over 96% said the staff were helpful, all said they were able to access staff who listened to them and returned calls promptly and 85% indicated they were satisfied with the way their complaint was handled. Obviously not all complainants receive the outcome they want with 24% not satisfied in the outcome.

Figure 3: Complainant's Evaluations

Response Total = 46 from 283 (16% return)

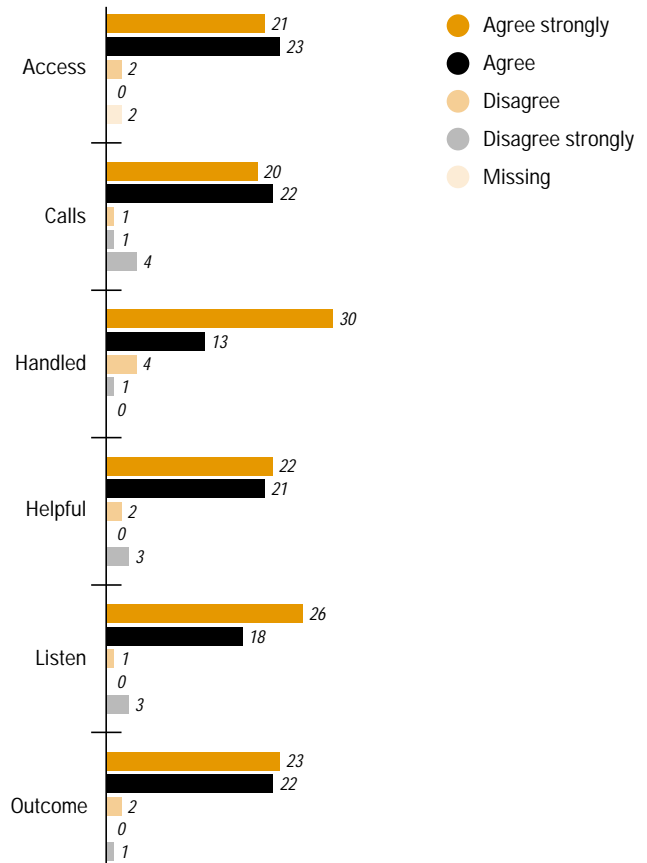


Providers

Ninety four per cent of providers who responded indicated they were satisfied with the outcome. Ninety percent were satisfied with how the complaint was handled. Ninety percent of providers agreed the staff were helpful, they were able to access staff who listened to them and 92% agreed their calls were returned within 24 hours.

Figure 4: Provider's Evaluations

Response Total = 48 from 283 (17% return)



How Complaints are Managed

The following graphs show a weighted average for each question using a 1-4 scale.

Figure 5: Complainant's Evaluations (2005-2006)

Rating: 1 = Disagree Strongly 3 = Agree
2 = Disagree 4 = Agree Strongly

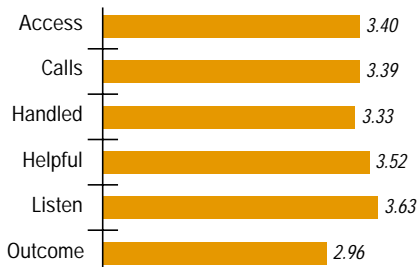
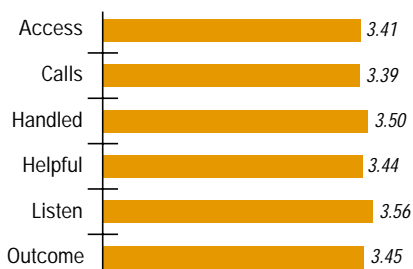


Figure 6: Provider's Evaluations (2005-2006)

Rating 1 = Disagree Strongly 3 = Agree
2 = Disagree 4 = Agree Strongly



Conciliation HRA cases

Example 3

The number of complaints under the HRA that have been referred to conciliation has remained consistent and the range of issues raised by the complaints remains varied and often most unexpected. Complaints remain largely to do with failure to gain access to records, along with the use and disclosure of information.

A woman complained on behalf of her young son that his name had been published on an internet site announcing the prizewinners of an essay competition that was aimed at children with learning difficulties. There was no consent for publication of the name of the child obtained from the parents and the family was not informed that the prizewinners' names might be published. The mother was concerned that her son was identified as having learning difficulties. The organisation withdrew the prize after the mother complained.

The complaint was settled after the organisation agreed to review its privacy policy. The prize was reinstated and an apology given.

Aboriginal Liaison Officer's Report



Sonja Martens,
Aboriginal Liaison Officer

The Aboriginal Liaison Officer (ALO) has a diverse role that involves:

- Liaising and creating networks with Aboriginal and Torres Strait Islander communities;
- Increasing the awareness of the Office within those communities;
- Providing policy advice to the Commissioner on matters pertaining to Indigenous Australians;
- and
- Attending to and conciliating complaints and enquiries involving Aboriginal and Torres Strait Islander parties.

Complaints

The ALO is able to deal with issues in a manner appropriate to Indigenous communities, which enables a number of them to be resolved informally. Not having the ALO position was previously a barrier to many Indigenous people pursuing complaints through the Office. The resolution of Indigenous complaints involve active participation on behalf of the ALO who:

- Assists complainants to formulate their complaints;
- Seeks responses from health providers to those complaints;
- Facilitates conciliation meetings between consumers and health providers;
- Seeks medical records, reports and opinions where appropriate; and
- Negotiates agreements between parties.

An elderly Aboriginal person from rural Victoria was admitted to a large hospital in the metropolitan region for the first time in his life. The hospital Koori worker was away on leave during this time.

At the time of discharge the hospital understood the man was going to be picked up by family members. The family members were of the belief that their local Aboriginal Cooperative was going to provide transport from the hospital to the man's home. The local Aboriginal Cooperative was of the understanding that the hospital would organise and provide transport for the man. When taken to the main exit in a wheelchair, the hospital orderly soon realised that transport wasn't forthcoming. Upon bringing the man back into the hospital, the breakdown in communication regarding the discharge plan was identified.

The ALO facilitated a meeting between the hospital discharge coordinator, the senior social worker, the Koori worker and the Aboriginal Cooperative manager. It resulted in various successful outcomes. More stringent mechanisms were put in place regarding the discharge plan; the social work department developed a contingency plan to accommodate for absences of the Koori worker; and protocols were implemented between the hospital and the Aboriginal Cooperative. It became apparent to the ALO that incidents such as these were not an isolated event, and issues around developing/strengthening interagency protocols were addressed during outreach programs.

How Complaints are Managed

Table 8: ATSI Enquiries and Complaints

Nature of Enquiry/Referral	
Request for Brochures & Reports	559
Speaking Engagements	53
Referral to State Privacy Commissioner	2
Referral to Aboriginal Legal Service	3
Referral to Other Dispute Settlement Service	7
Referred Elsewhere	23
Other Enquiries	53
	736

Nature of Complaint	
HRA Issue	
Access & Correction	2
Data Quality	2
Use & Disclosure	1
	6

HSC&R Issue	
Access	14
Communication	8
Cost	1
Rights	4
Treatment	11
Not specified	0
	38
	44

Outreach - Privacy and Service Delivery Issues

The ALO continued to visit communities across the State and liaised with key stakeholders, responding to requests for information about HRA.

Privacy

Outreach highlighted the following health privacy issues for Aboriginal and Torres Strait Islander people in Victoria:

- The right to access records under the HRA;
- Identifying the appropriate person when wanting to access records;
- Who can access records of a deceased person when several members are seeking access;
- Who can access records of a deceased person when several family members are seeking access;
- The cost of accessing records;
- Privacy implications for health workers in Aboriginal organisations who are in the situation of providing health services to close relatives and/or friends.

Services

There was a significant amount of enquiries regarding difficulties in accessing health services. In addition, consumers and providers identified problems in determining roles and responsibilities of individual agencies when a multi-agency approach was warranted for the health needs of a consumer.

In facilitating workshops and information sessions, the ALO contributed to the implementation and development of intra and inter-agency protocols and procedures. There is a significant improvement in inter-agency collaboration.

The Aboriginal Liaison Officer deals with issues in a manner which is appropriate to indigenous communities

How Complaints are Managed

Registrar's Report



*Shiranee Sinnathamby,
Registrar*

The exchange of consumer complaints/ notifications and the giving and receiving of advice between the Boards and the OHSC continues to assist all parties. These consultations result in the effective management of complaints. In addition to regular weekly meetings between Registrars around individual complaints, networking meetings between complaints handling staff of the OHSC and those of the Boards at which ideas are exchanged and common issues of interest are discussed result in policy development, education and training. These assist to improve the quality of services provided to consumers and providers of health services as well as others involved with our processes.

During the year under review a total of 950 complaints were discussed with the Registration Boards, which was a drop in numbers from the preceding year. The medical practitioner

complaints again topped the list with 536 complaints. As outlined in the graph below, of the remaining 414, 156 complaints were about dentists, 78 about pharmacists, 62 were about psychologists and 54 complaints discussed were about nurses. The remaining 64 complaints were shared between seven Boards. The total number of OHSC complaints formally referred to the registration boards was 45 whilst 20 complaints were received by the HSC from the boards. Of these 65 complaints 43 related to medical practitioners.

The number of referrals received by the HSC from other agencies were: 11 from the Victorian WorkCover Authority, 10 from the State Ombudsman and two from Consumer Affairs whilst four complaints were referred by the HSC to the Aged Care Complaints Resolution Scheme. A total of 12 FoI requests were processed during this period.

The co-operation of the registrars and staff of the registration boards and other agencies the HSC liaises with on a regular basis is greatly appreciated.

Table 9: Dealings with Registration Boards

Organisation	HSC Complaints discussed with Boards	Board Complaints discussed with HSC	HSC Complaints formally referred to Boards	Board Complaints formally referred to HSC
Chinese Medicine Registration Board	1	17	0	0
Chiropractors Registration Board of Victoria	1	9	0	0
Dental Practice Board of Victoria	68	88	2	0
Medical Practitioners Board of Victoria	242	294	33	10
Medical Radiation Technologists Board of Victoria	1	0	0	0
Nurses Board of Victoria	18	36	6	4
Optometrists Registration Board of Victoria	12	3	2	0
Osteopaths Registration Board of Victoria	1	3	0	1
Pharmacy Board of Victoria	10	68	1	4
Physiotherapists Registration Board of Victoria	2	5	0	0
Podiatrists Registration Board of Victoria	7	2	0	0
Psychologists Registration Board of Victoria	2	60	1	1
	365	585	45	20

How Complaints are Managed

Prisoner Complaints

The Office receives complaints from prisoners by letter and through visits to prisons by OHSC staff. The Ombudsman's Office also refers complaints relating to health treatment to the OHSC. The OHSC refers complaints that are either directly related to correctional issues, or cross with correctional issues, to the Ombudsman for their attention. Meetings have then occurred between these two Offices to discuss matters of mutual interest. We continue to liaise with, and refer complaints to, the DHS for their information. A poster campaign continues at all prisons including the two newly opened prisons, Marngoneet and the Metropolitan Remand Centre.

The issues of complaint generally remain the same at each reporting period. Access to services, dissatisfaction with treatment and the provision of medication continue to dominate complaints. The co-operative approach by the health service providers helps bring most complaints to satisfactory resolution. Whilst some prisoners may not be satisfied with the outcome, the responses to their complaints would indicate they are mostly receiving satisfactory services.

New Primary Health Care Standards, which will eventually come into place across the system, will provide clarification of the entitlements to dental treatment for prisoners. Prisoners will no longer have to be sentenced to receive certain treatments. The determination is now based on the length of their incarceration, rather than the length of the sentence. The previous policy caused hardship to some prisoners, especially those on remand for long periods.

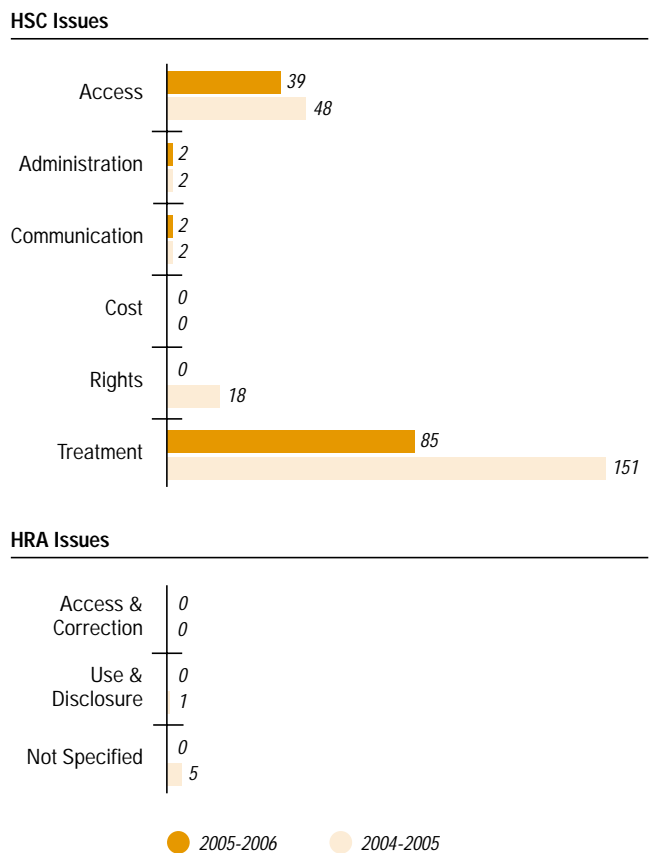
Staff of the OHSC joined a Communications Protocol Working Group initiated by Corrections Victoria to establish a communications protocol between prison health providers and corrections allied health services. A Discussion Paper has now been finalised.

A prisoner complains his doctor has halved his morphine medication, which he requires for his back condition.

Following tests it was determined he was suffering from a long standing degenerative condition, which did not require morphine. It was decided to wean him off the morphine so his condition could be more thoroughly assessed, not masked by morphine. It was also arranged for him to receive physiotherapy.

The prisoner remained dissatisfied with the response. We advised him the OHSC could not intervene further in issues relating to medication and that those decisions were the clinical judgement of the doctor.

Figure 7: Prisoner Complaints



Complaint numbers from prisoners fell when compared with the previous year. This was largely because of a reduced number of HSC visits to prisoners following an evaluation of prisoner complaints against the resource commitment required.

Reasons for Complaints

Complaints received by the HSC are classified according to their underlying issues. The broad categories are as follows:

HSC&R Issue Categories

Issue	Definition
Access	Availability of services in terms of location, waiting times and other constraints that limit use of the service;
Treatment	Diagnosis, testing, medication and other therapies provided;
Communication	Manner of communication such as rudeness, disinterest, quality and quantity of information provided about treatment, risks, outcomes and prognosis;
Cost	Information about costs and fees, discrepancies between advertised and actual costs, charges and rebates;
Rights	Dignity, consent to treatment;
Administration	Support services for providers such as reception, waiting lists, cleaning services, etc.

HRA Issue Categories

Issue	Definition
Access and Correction	Right of individuals to access and correct health information held about them, subject to certain criteria;
Anonymity	Right of an individual not to identify him or herself when it is lawful and practicable;
Collection	How and when health information is collected;
Data Quality	How accurate, complete, up to date and relevant the health information is, having regard to the purpose for which it is held;
Identifiers	The unnecessary use of identifiers, for example the use of a public sector identifier by a private sector organisation can only occur with the individual's consent or if it is required by law;
Information Available to Another Health Service	One health service making information available to another;
Openness	Organisation's policies on the management of health information and steps an individual must take to access their health information;
Transborder	Data flows the transfer of an individual's health information outside Victoria;
Transfer / Closure of a Practice	The process to be followed when a practice or business of a health service provider is sold or closed;
Use and Disclosure	How an organisation has used or disclosed an individual's health information.

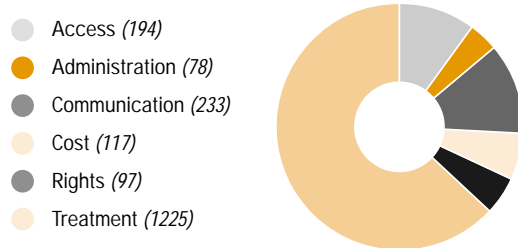
Most complaints identify only one of these as an issue but approximately one in three raises concerns about more than one issue.

Primary Issues in HSC&R Complaints

During the year 1944 complaints were received under the HSC&R Act. These comprised 931 single contacts complaints and 1013 accepted cases. The primary issues in these complaints are shown below.

As in previous years, the main issue for complainants is treatment. This accounted for two thirds of complaints.

Figure 8: Issues Raised



Access

People complain when they are refused access to treatment or circumstances mean that treatment is not available for them.

Access issues raised in complaints are shown in Table 10 below.

Table 10: Access

Access	10%
Communication Breakdown	12
Delay in Admission	17
Delay in Treatment	33
Discharge Arrangements	7
Discharge / Transfer	2
No / Inadequate Service	85
Non Attendance	2
Other	12
Waiting List	9
Refusal to Refer	1
Transport	3
Refused Admission	9
Transfer Unsuitable	2
Total Access	194

A man, requiring surgery at a metropolitan hospital, complains that his surgery has been cancelled on several occasions with little or no prior notice. After contacting the Hospital the HSC was informed that the man has since had his operation.

Reasons for Complaints

Administration

Occasionally people complain about the administrative staff and policies of a health service. They might say they found the receptionist rude and uncaring, or that their messages are not passed to the health professionals in a timely manner. This year the main concern was about various policies and procedures that may have lead to disadvantage for some people. The administration issues in complaints are listed In Table 11.

Table 11: Administrative Issues

Administration	4%
Administration	32
Failure to Provide Certificate	5
Hygiene	9
No / Inadequate Response	22
Other	8
Policy	4
Quackery / Legality	2
Total Administration	82

A family complained they were refused an appointment with their doctor because an adult family member had not paid an earlier account. They explained that the family member had left home some years ago but had not changed his mailing address and the rest of the family had been unaware of the outstanding account. The receptionist had insisted they could not be seen until the account was settled. The HSC contacted the doctor who agreed this was an inappropriate use of the practice policy; it would not happen again and decided to waive the debt.

Communication

The sub-issues where communication was named as the primary concern of a complaint can be seen in Table 12, however experience shows communication is a feature of all complaints. Poor attitude/discourtesy is the most frequent at 30%.

Table 12: Communication

Communication	12%
Absence of Caring	28
Failure to Consult	20
Inconsiderate / Undignified Service	54
Other	9
Poor Attitude / Discourtesy	74
Wrong / Misleading Information	50
Total Communication	235

A man complained that a practice manager at a clinic spoke to him rudely in front of a crowded waiting room to tell him he was no longer welcome in the Clinic because he had made an earlier complaint. The manager agreed he had done this and said it was in line with Clinic policy. The HSC advised the practice manager it was an offence to disadvantage a person who had made a complaint to this Office and if it was necessary to terminate treatment because of a patient's behaviour it was more appropriate for the doctor to advise the patient in a way that would protect their privacy.

Cost

People continue to complain to the HSC that they were not advised about the potential out of pocket costs for health care. It is a reasonable expectation that patients are assisted to give informed financial consent for treatment so they are aware of the commitments they are making. This is particularly the case for anaesthetics where the patient and doctor usually meet only a short time before a procedure. Wherever possible it would be helpful if the treating surgeon had access to likely costs for anaesthetics so patients are aware in advance of out of pocket costs. A small number of people have received accounts for treatments given several years ago. They comment that it is difficult to prove an account has been paid three or four years after the event and they wonder why the service has taken so long to send the account. It is also difficult, if not impossible, to claim rebates from Medicare or private health funds more than two years after the service.

The cost issues raised in complaints can be seen in Table 13.

Table 13: Cost

Cost	6%
Amount Charged	38
Billing Practices	41
Fraud	1
Information on Costs	25
Other	6
Overservicing / Unnecessary Treatment	8
Unnecessary Treatment	1
Public / Private Election	1
Total Cost	121

A woman who needed emergency dental care on a public holiday found a dentist in the telephone book and went to see her that afternoon. She was happy with the care provided but very surprised at the account for the extraction of the tooth, as she had not been advised of this before the procedure. When the woman complained the dentist acknowledged she had not warned the woman of the fees before the extraction and reduced the account to compensate for this oversight.

Reasons for Complaints

Rights

The types of complaints made in relation to rights are shown in Table 14.

Table 14: Rights

Rights	5%
Access to Records	2
Accuracy of Records	5
Assault	7
Discrimination	16
No / Insufficient Consent	8
Other	13
Privacy / Confidentiality	5
Unprofessional Conduct	36
Discrimination Public / Private	1
Refusal to Treat	8
Total Rights	101

A man who attended marriage guidance counselling with his wife was unhappy that the counsellor appeared to take sides with his wife and criticised him in the counselling sessions. His wife informed him the counsellor had advised her to end the marriage and give up on him. The counsellor was a registered psychologist so, after discussions with the Psychologists Registration Board, the complaint was referred to the Board.

As always, an acknowledgment of a problem and an apology is still the most effective way to resolve a complaint

Treatment

Table 15: Treatment

Treatment	63%
Inadequate Diagnosis	164
Inadequate Treatment	511
Medication	77
Negligent Treatment	239
Other	32
Rough Treatment	47
Unskilful / Incompetent Treatment	96
Wrong Diagnosis	28
Wrong Treatment	17
Total Treatment	1211

The mother of a young child complained that the treatment of her son's fractured arm was inadequate as it had not healed correctly and the child had needed surgery. The doctor explained that conservative treatment had been used at first, as surgery should be avoided if it was not necessary. The surgeon who had conducted the surgical repair was consulted and agreed the doctor's care of the child had been reasonable and appropriate and the complication had not been predictable at the time of the injury. The family accepted this advice.

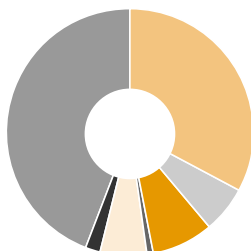
The family of an elderly man had taken him to many doctors and hospitals however no underlying cause for his pain could be found. He was not able to have scans because of claustrophobia and low level dementia, however he had x-rays and ultrasounds and blood tests which revealed nothing which would explain the pain he was experiencing. Eventually it was found he had widespread cancer but this was just a few weeks before he died. The HSC asked an independent expert to review the records and give advice on the care of the patient. The expert advised there had been many health problems that had obscured the eventual diagnosis and the multiple services involved in his care had acted appropriately and reasonably in trying to assist him. The matter was referred to conciliation where a meeting was held and the complaint resolved.

Reasons for Complaints

Primary Issues in HRA Complaints

Figure 8b: Breakdown of Issues - HRA

- Access & Correction (76)
- Collection (15)
- Data Quality (18)
- Identifiers (2)
- Info Available to Another HSP (14)
- Transfer / Closure of HSP (4)
- Use & Disclosure (102)



Complaints under the HRA have stabilised at around 200 a year, or 11% of all complaints to the HSC. HRA inquiries totalled 1792, which was almost a quarter of all enquiries to the HSC. This may be due to an ongoing education campaign conducted by the HSC and individuals becoming aware of their rights.

These complaints are most frequently about the refusal of access to private health records about the complainant and breaches of privacy.

A woman complained she had been refused access to her health records because they had been created prior to the commencement of the HRA in 2002. The Office told the doctor of the complaint and advised her she was obliged to provide at least a full summary of her care. The doctor provided a copy of the records and a summary for no charge.



(L-R): Jesinder Bhullar and Sue Joseph, two members of the HRA team

The major issues in HRA complaints can be seen in Table 16 below.

Table 16: HRA Issues

Access & Correction	
Access refused	59
No written reason for refusal	6
Correction refused	5
Inaccurate information not concealed	6
	76

Anonymity	
Refusal of anonymity	0

Collection	
Breach of in-confidence details	1
Unnecessary collection	7
Unlawful / intrusive collection	6
Third party collection	1
	15

Data Quality	
Data inaccurate, incomplete or out of date	8
Unsatisfactory protection	6
Unlawful deletion	2
Deleted without notation	1
Transferred without notation	1
	18

Identifiers	
Misuse	2
	2

Info Available to Another HSP	
Information refused	8
Unreasonable time in delivery	4
Excessive fee	2
	14

Openness	
Insufficient details given	0

Use & Disclosure	
Disclosure - Inadequate consent	72
Disclosure - Inadequate disclosure	21
Use - Insufficient information	9
	102

Transborder Data Flows	
Unauthorised transborder transfer	0

Transfer/Closure of HSP	
Inadequate notification	1
Unsafe storage of records	3
	4

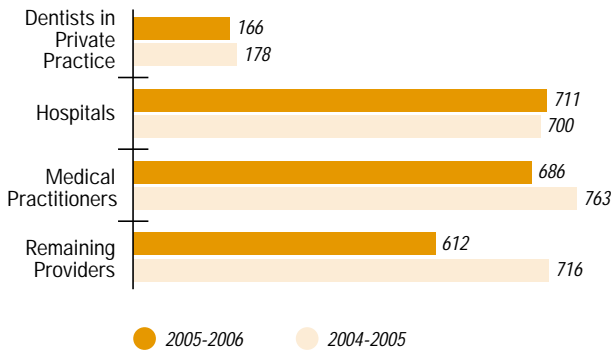
Total	231
--------------	------------

Complaints Against Health Service Providers

Doctors and hospitals were the largest group of respondents to complaints about health services. This is consistent with previous years and expected given the large number of health services they provide.

Please refer to Appendix 1 for a list of providers by type.

Figure 9: Categories of Complaints Against Health Service Providers

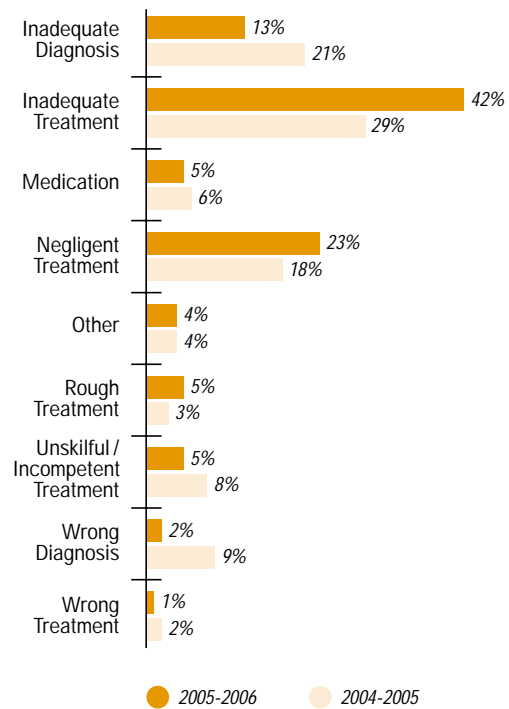


Medical Practitioners

The category of medical practitioners includes specialist service provision but not doctors who are employees of public hospitals. Appendix 2 lists the number of complaints about individual medical specialties.

The most frequently named issues in relation to treatment are inadequate treatment and diagnosis and negligent treatment. In most of these cases there will not be any evidence of negligence, however the patient often will believe this is the case if communication about risks has not been communicated sufficiently or understood.

Figure 10: Treatment Issues - Medical Practitioners



Complaints Against Health Service Providers

General Practitioners

When the number of consultations provided by GP's every year in Victoria is taken into account, the number of complaints could be seen as quite low in that context. General Practitioners are often sole practitioners and a complaint received from HSC can come as a shock if there have never been any previous complaints. Relationships between doctors and their patients are very important and mediation can serve to mend this relationship in some cases. Other patients may move frequently from one doctor to another and it can be more difficult to develop the rapport necessary for good communication and to foster trust.

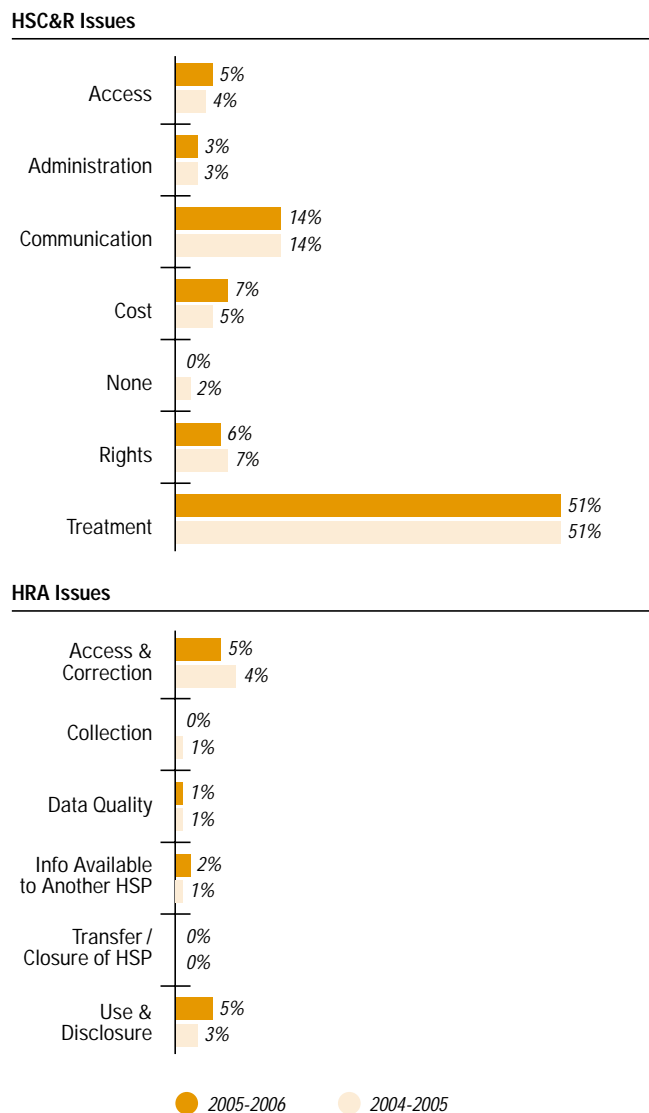
A man complained that his general practitioner had ignored his complaints of back pain for several months telling him he needed to lose weight and exercise more frequently. An x-ray had not shown anything definitive but the GP had not considered further tests were necessary and had not referred him for a specialist opinion. Eventually the man went to see a different GP who referred him to an orthopaedic surgeon who has arranged to conduct spinal surgery.

The doctor said he believes conservative treatment is best for this man however he apologised for not referring him to a specialist for an opinion. Because of the long term relationship the man decided to accept the apology and close his complaint.

Issues in complaints about general practitioners can be seen in Figure 11 (right).

Considering the number of consultations provided by GP's each year, the number of complaints against them is quite low

Figure 11: Issues in GP Complaints



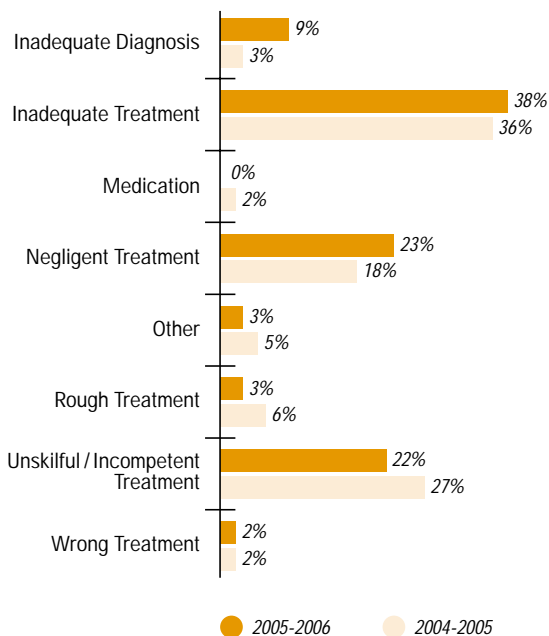
Complaints Against Health Service Providers

Dentists

There was a reduction in the numbers of complaints about dentists this year, even in the context of an overall reduction in complaints. As with doctors, the most frequent issues were about perceived negligence or inadequate diagnosis and treatment.

A young man complained he had seen a dentist because of dental pain and the dentist had x-rayed the tooth and filled it with a warning it may not last. The pain continued and the man returned to the dentist who told him he needed root canal therapy or extraction. Because he could not afford the expensive therapy he had the tooth extracted and asked the dentist to refund the money for the filling. The complaint was discussed with the Dental Practice Board who advised that conservative treatment as a first option was generally considered good practice as long as the tooth was treatable at the first visit. When the dentist became aware of the complaint and the financial circumstances of the man he agreed to refund the cost of the extraction.

Figure 12: Treatment Issues Dentists



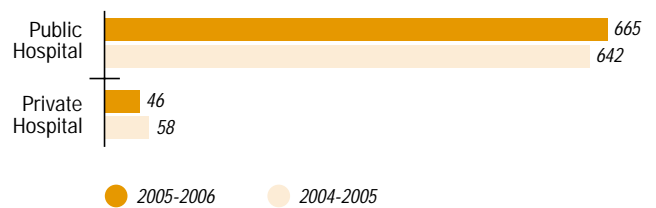
Dental Prosthetists

This year there were eight complaints against dental prosthetists, less than the 14 received in the previous year. These complaints are almost always about dissatisfaction with dentures. It seems a common problem that there may be a need for several adjustments to a denture before a satisfactory fit is achieved.

Hospitals

The majority of complaints about hospitals are in relation to public hospitals. This is in part because public hospitals treat more patients each year and also because complaints about treatment in a private hospital will frequently need to be made against the admitting doctor rather than the Hospital. There is a general lack of understanding in the community about the relationships that exist between private specialists and private hospitals and the fact that many smaller private hospitals do not employ their own doctors as staff.

Figure 13: Public /Private Hospital Comparisons

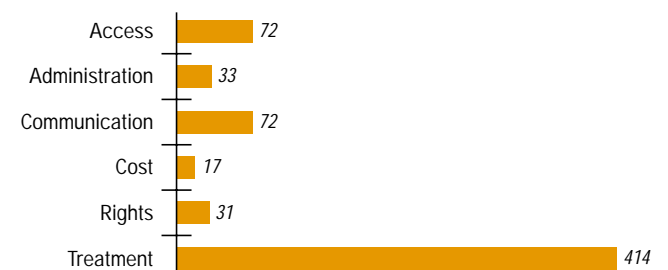


Public Hospital Issues

The majority of complaints about public hospitals are in relation to treatment issues. Complaints about emergency departments are frequently about lack of treatment or inadequate diagnosis and care while inpatients complain about less than optimal outcomes of treatments or unexpected outcomes. Issues in relation to public hospitals are set out in Figure 10 below.

Figure 14: Public Hospital Complaints

HSC&R Issues



HRA Issues



Complaints Against Health Service Providers

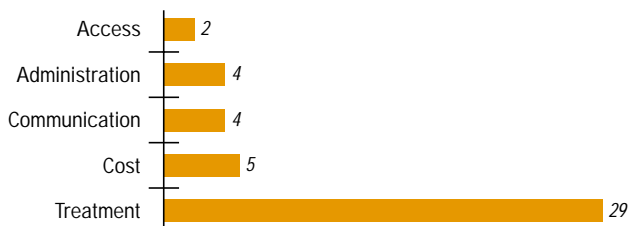
A mother took her daughter to the emergency department of a public hospital as she was vomiting and in pain. A doctor saw her fairly promptly, and gave her analgesia and conducted blood tests. She was then observed for a few hours before being sent home. She became very unwell during the night and was taken to a different hospital where she had surgery for an abdominal condition. The Hospital reviewed the records and said there had been no indications at the time of presentation that there was anything that might require surgery and they felt she would be more comfortable at home. They also expressed regret that the young girl had suffered before her final diagnosis and treatment. The family accepted this explanation and apology.

Private Hospital Issues

The numbers of complaints against private hospitals are comparatively few as any complaints about treatment decisions and outcomes would usually be made against the admitting doctor rather than the Hospital. The exception might be where a nurse has failed to carry out the doctor's instructions.

Figure 15: Private Hospital Issues

HSC&R Issues



HRA Issues



Although some larger private hospitals have emergency departments and doctors on staff, many smaller private hospitals do not employ their own doctors. This is frequently a cause of misunderstandings and it needs to be made clear to prospective patients if this is the case.

A man complained that staff at a private hospital emergency department had been rude and dismissive when he attended with a deep laceration to his leg after an accident at home. After some time without attention he attended a nearby public hospital emergency department where he was seen and sutured promptly. The Hospital apologised and explained it had happened on a very busy night when they were seriously understaffed, and steps had been taken to provide better back up procedures for such events in the future. The Hospital also agreed to refund the fee for attendance in the emergency department and the man was satisfied with this outcome.

Psychiatric Services

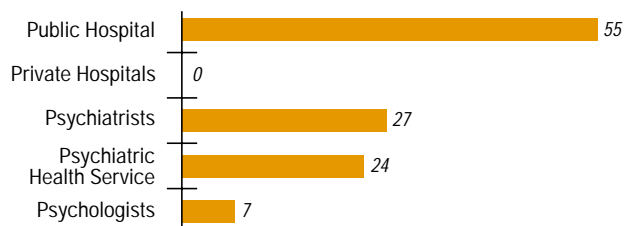
There was a small (9%) increase in complaints about psychiatric services this year.

Figure 16: Psychiatric Services Complaints



The numbers of complaints made against each type of service is shown in Figure 17.

Figure 17: Types of Service



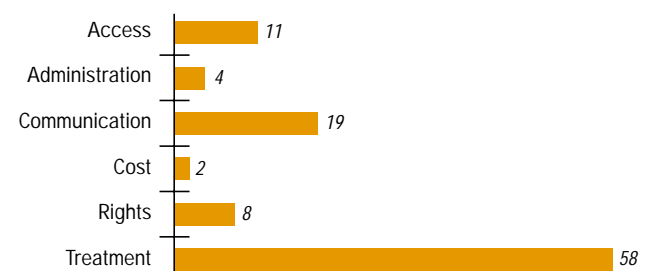
Issues in Psychiatric Service Complaints

The most frequent complaint is that the patient's involuntary status is unwarranted however there are also complaints about treatment and communication issues as well as access to services

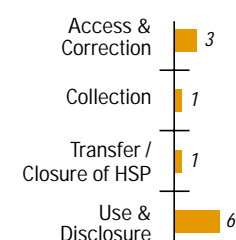
A woman complained that she was unreasonably restrained when she refused to take medication in a hospital providing psychiatric care. She provided photographs that showed bruising to her upper arms. In response to the complaint the Hospital stated the patient had been extremely angry and had threatened violence to staff and so they had called the security team to assist in her management when she was admitted for care. The Hospital explained this was rarely necessary and arranged some additional training for staff in managing aggressive patients in order to minimise the escalation of the aggression.

Figure 18: Issues in Psychiatric Complaints

HSC&R Issues



HRA Issues



Hospital Complaints Data

Complaints Made at Public Hospitals

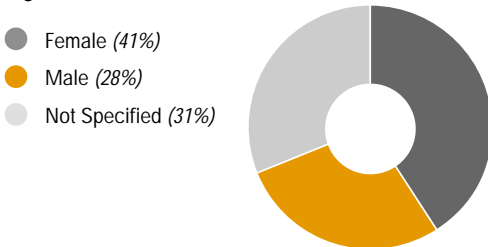
Information contained in this section has been compiled from complaints lodged directly with the Complaint Liaison Officers (CLOs) (or patient representatives) of public hospitals and provided by them to the HSC. Some hospitals utilise the Health Complaints Information Program (HCIP) to record and monitor complaints handled locally within the Hospital. These complaints are separate to those lodged directly with the HSC.

The following trends comprise data provided by 53 public hospitals over the reporting period.

Who Complained and How?

Forty One percent of complainants were female and 28% male and in 31% the gender was not stated. As expected, public patients comprised the largest group (88%).

Figure 19: HCIP - Gender



The majority of complaints were made via telephone call (48%) or letter (30%), 12% by personal visit and 10% by other means.

The age and gender profile of consumers is shown in Table 17 and Figure 15.

Consumer Profile

Table 17: HCIP – Age Analysis

Age	Total
Under 1	112
1 – 4	44
5 – 14	149
15 – 24	350
25 – 34	347
35 – 44	361
45 – 54	83
55 – 64	358
65 – 74	297
75+	484
Not Specified	2089
Total	4674

Table 18: HCIP - Patient Type

Public Patient	4099
Private Patient	17
Dept of Vet Affairs	6
Not Specified	541
TAC	1
Ineligible Patient	2
WorkCover	8
Total	4674

What Was the Complaint About?

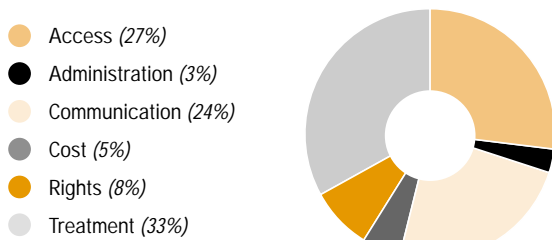
During the period under review the reporting Hospitals received, and dealt with, 4674 complaints. A complaint may be multi-faceted, for example it may be concerned not only with poor communication but may also be about inadequate treatment, however the analysis in this report is based on the primary issue. The diagram below shows the primary issues in complaints. CLOs are not constrained by legislation and may deal with any issues brought to their attention. This gives them flexibility and every year they resolve many complaints promptly and effectively. The HSC supports them through their organisation the Health Services Liaison Association and by providing orientation training and support.

Twenty Four percent of complaints concerned communication issues. Treatment issues increased from 28% last year to 33% this year. Access issues (27%) and cost issues (3%) remained the same. Both rights issues (8%) and administration (3%) decreased in line with 2003 levels.

A major problem with hospitals is their complexity and the fact that sometimes, clinical sections do not communicate well with, for example, administration. This can result in problems and distress for patients and their families.

A more specific analysis of issues forms appendix 3.

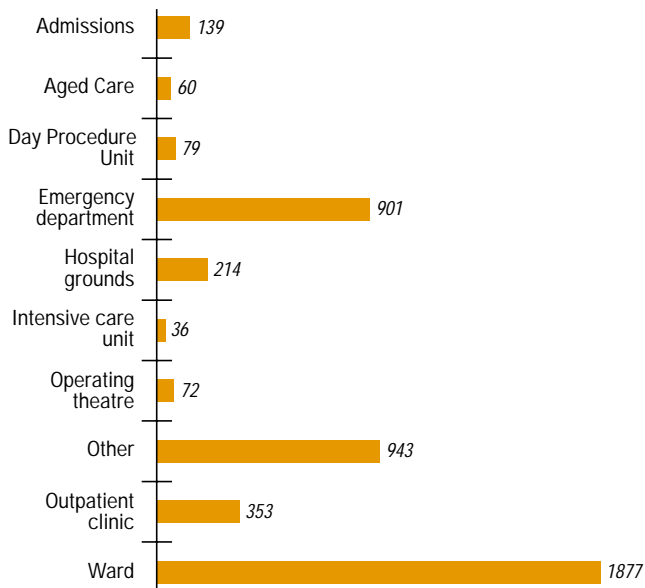
Figure 20: HCIP – Issues



Hospital Complaints Data

Site and Service at Time of Complaint

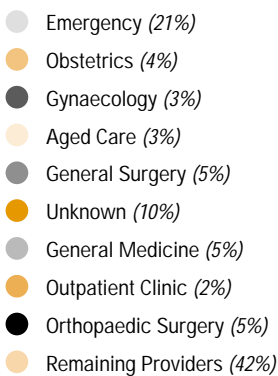
Figure 21: HCIP - Site



Services

Figure 18 shows 21% of complaints were made about services provided in the emergency department, orthopaedic surgery 5%, gynaecology 3%, age care 3%, general medicine 5%, general surgery 5% and outpatient clinic 2%. A more specific list of services forms Appendix 4.

Figure 22: HCIP - Services



How Serious Were the Complaints?

Seventeen percent of complaints were categorised as serious or substantial and 34% as routine. The remaining 49% were listed as either minor or trivial. These complaints will not seem minor or trivial to the complainant and are treated seriously by the CLOs.

Table 19: Seriousness of Complaints

	Trivial	Minor	Routine	Substantial	Serious	Total	
Access	0	898	279	35	68	1280	27%
Administration	0	79	48	5	12	144	3%
Communication	0	473	407	94	137	1111	24%
Cost	0	135	65	9	12	221	5%
Rights	0	184	153	31	15	383	8%
Treatment	0	527	618	180	210	1535	33%
Total	0	2296	1570	354	454	4674	100%
	0%	49%	34%	8%	9%	100%	

Table 20: Outcomes of Complaints

Stage of Complaint Process	Number of Complaints
Resolved	4390
Lapsed	880
Not Upheld	145
Remedial	235
Referred	172
Change in Policy	98
Total Number of Complaints	5920

If complaints are not resolved internally the complainant may be advised of the right to take the complaint to the HSC or the appropriate registration board.

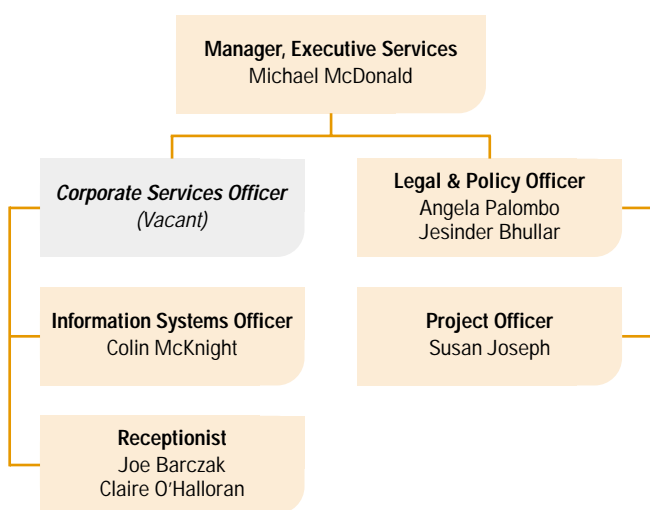
Please refer to Appendix 5 for a full categorisation of complaint outcomes.

Executive Services



Michael McDonald,
Manager, Executive
Services

The Executive Services Unit comprises two staffing streams and provides corporate support services for the Office including Finance, Human Resources, Information Technology, Purchasing, Vehicle Management, Building Services and Reception Services. It is also responsible for the administration of the HRA and the provision of legal advice to the Commissioner and staff.



Department of Human Services - Statement of Understanding

The Office has a Statement of Understanding (SOU) with the DHS.

The purpose of the SOU is to specify the services delivered, including key performance indicators (kpi), by the OHSC as required by the HSC&R and the HRA and it also sets out the funding requirements to deliver the services.

In developing funding requirements and kpi for the delivery of services, the parties agreed to the following general principles:

- The Department recognises and respects the independent status of the OHSC;
- All dealings between the parties are based upon a cooperative partnership;
- All services will be provided in a timely fashion, with skill, care and diligence, according to statutory requirements and to service delivery targets; and
- Communication between the parties will be transparent, direct and timely.

The Commissioner and Manager, Executive Services develop the SOU annually and meet with DHS to review the operations of the OHSC and negotiate priorities and budget requirements for the office.

HRA

The HRA has been operational since 1 July 2002 and the majority of health service providers and holders of health information accept it as part of the environment in which they work.

Nevertheless this Office, specifically the HRA section of the Executive Services team, continues to provide education and training for holders of health information and consumers on their respective responsibilities and rights under the legislation. These organisations include health service providers, government departments and agencies, local government and a number of other holders of health information ranging from employers to child care centres. This year this has been achieved by presenting to approximately 59 groups attended by over 1300 individuals, distributing more than 20,000 brochures, answering over 460 telephone enquiries and providing 86 written responses to issues raised.

Culturally and Linguistically Diverse Communities (CALD)

The OHSC continues its campaign to increase awareness of the office and ensure Victoria's diverse community is fully informed about their rights under the HRA. The Commissioner has had concerns raised with her about the provision of language services, particularly in hospitals.

Interpreter Services, 2006

On Thursday 30 March Daniel Andrews MP, Parliamentary Secretary for Health launched the "Problem with a Health Service or Concerns About Translating and Interpreting Services?" brochure at Footscray's Western Hospital. The brochure a joint initiative between the OHSC and the Victorian Multicultural Commission outlines the rights of patients and the responsibilities of the Department of Human Services (DHS) funded health care providers in their delivery of services to people from a CALD background.

DHS funded agencies are required to provide information in a person's preferred language when they need to be informed of their rights, give informed consent and be advised of critical information relating to one's health and well-being. Individuals also have a right to participate in decision making related to medical and other human service matters that affect them.

The Commissioner thanks the Victorian Multicultural Commissioner, George Lekakis, and his staff, in particular Andrew Waugh-Young for the collaboration and goodwill between the two organisations which ensured the development of a brochure to inform the CALD community of their rights.



(L-R): Daniel Andrews MP, Parliamentary Secretary for Health, Beth Wilson, Health Services Commissioner, George Lekakis, Chairperson Victorian Multicultural Commission and Jon Evans, Chief Executive Officer Western Health.

Human Research Ethics Committees (HREC)

Throughout the year a number of discussions have occurred with various ethics committees and researchers on the impact of the HRA on research activities. In particular the issue of screening for research participants was raised. The Research Guidelines issued by the HSC apply where it is impracticable to obtain consent or when the information is used to obtain consent.

The Guidelines require approval for the research project by a HREC, which should have regard to the matters listed within the Guidelines. The task for the HREC is to decide whether the public interest in the research substantially outweighs the public interest in the protection of privacy, in relation to the use of information or recruitment to a research project. If the HREC, having considered all the matters as required by the guidelines considers that such a test has been met, then the researchers have complied with the legal requirements of the Act.

The Guidelines require HREC to report on the use of the HSC Guidelines for the purposes of Health Privacy Principle 1.1(e)(iii) and 2.2(g)(iii) of the HRA. For the 2005/06 financial year 50 HREC reported they utilised the Guidelines in respect of 85 research applications. Thank you to those committees who reported to us, however as can be seen from the table below not all HREC committees responded and these will be contacted to establish why.

Figure 23: Return of HREC Reports to HSC



Office of the Privacy Commissioner - Privacy Victoria

During 2005-06 the OHSC continued its close working relationship with the Privacy Commissioner, Paul Chadwick and his staff. Staff of both Offices participated in a range of events and training activities, and regularly liaised and consulted on privacy issues. Consultation and collaboration between the offices ensures consistent, clear information and advice is provided to stakeholders on the issues of privacy and health privacy. The two Commissioners have jurisdiction over privacy matters with the Privacy Commissioner responsible for the public sector under the *Information Privacy Act 2001*. Special thanks go to David Taylor, Director, Privacy Awareness and his team for encouraging and developing the mutually beneficial relationship in delivering the joint message on privacy.

Guide to Help Health Services Handle Complaints

The Hon Bronwyn Pike MP Minister for Health launched the *Guide to Complaint Handling in Health Care Services* on 15 December 2005 at the Royal Melbourne Hospital. The Guide targets hospitals' Complaints Liaison Officers (patient representatives), Quality Managers and Chief Executive Officers.

The Guide is designed to help health services providers develop and implement effective complaint-handling practices. It was funded by the DHS and the VMIA and produced by the HSRC. It has been distributed to all hospitals in Victoria and a number of other organisations who have requested it.



Mr Michael Gorton, Former President HSRC, The Hon. Bronwyn Pike MP, Minister for Health, Ms Beth Wilson, Health Services Commissioner and Ms Robyne Schwarz, President HSRC at the launch of the "Guide to Complaint Handling in Health Services"

Train the Trainer

The HRA team continued to offer 'train the trainer' training so privacy and training officers could attend and develop their knowledge of the legislation and train staff in their own organisations. Twenty-two individuals, from various organisations, attended two sessions during the year with the most recent session being on 30 June 2005. The package is available on our website and the offer for training is open to any organisation covered by the HRA.

Infomed

The OHSC again utilised the services of Infomed, which displays patient information in over 400 medical centres throughout Victoria. We rotated our generic brochure, advising patients of our role, with a brochure on the HRA explaining patient's rights and the obligations of health services providers in handling health information. On average over 400 brochures were distributed per month for an annual total of 5000.

2006 Midsumma Festival

The Midsumma Festival, Melbourne's annual gay and lesbian festival, is a federation of arts and cultural events spread over six municipalities and located in over 60 different venues across Melbourne. The Carnival day is the centrepiece of the festival, with approximately 100 stallholders including public, private and community sector organisations.

This year it was held in Melbourne's Treasury Gardens. Sharing a stand with Privacy Victoria, we were able to directly communicate to the many carnival goers from Victoria's Gay, Lesbian, Bisexual, Transgender and Intersex communities.

For members of these communities, privacy of their health information can matter greatly as it may be followed by discrimination or other harm.

Royal Melbourne Show

The OHSC once again collaborated with Privacy Victoria in exhibiting in the Government Expo Centre at the 2005 Royal Melbourne Show (15-25 September). Over 500,000 people attended the Show and approximately 65% of them visited the Government Expo Centre.

It was a great opportunity to alert the public to their privacy rights and also to the fact an organisation exists where they can complain about health services. Together we provided information to the public on information privacy in the public sector and privacy of health information in the public and private sectors. Brochures, information sheets and 10000 wristbands advertising the OHSC were distributed over the duration of the show.

Special thanks go to Darryl Rogan from Information Victoria and his staff for their continuing support and assistance for our attendance at the Royal Melbourne Show.



The OHSC and Privacy Victoria stand at the 2005 Royal Melbourne Show.

Human Resources

Staffing Overview

During the 2005/06 financial year the OHSC had a large percentage of staff absent for various reasons including maternity leave. To cover these absences the office welcomed Sonja Martens as Aboriginal Liaison Officer, Jesinder Bhullar as Legal Officer, Dr Vinay Rane as a part time conciliator and was also grateful to have the part time services of Dr Jacqueline Smith while she was on a sabbatical from Western Hospital. It also gave development opportunities to a number of staff to act in higher positions during the year.

Staff of the OHSC as at 30 June, 2006

Position	Staff Member(s)	Responsibilities
Manager, Executive Services	Michael McDonald	Manages the operations of the Health Records Act 2001 (HRA) and corporate support services.
Manager, Assessment & Investigation	Lynn Griffin	Manages the assessment, acceptance, resolution and referral of all new complaints.
Chief Conciliator	Keith Jackson	Manages the conciliation unit.
Senior Conciliators	Orysia Ckuj Kath Kelsey	Supervise conciliators in their casework and conciliate the more complex cases.
Conciliators	Anna Boulton Lynn Buchanan Christine Lalor Koula Louras Mark McPherson Vinay Rane Jacqueline Smith	Assist parties with a complaint to reach a resolution in a confidential and privileged setting.
Aboriginal Liaison Officer	Sonja Martens	Liaises and conducts outreach work with Aboriginal and Torres Strait Islander communities in Victoria. Performs conciliation functions and responds to inquiries on matters involving these communities.
Conciliation Administration Officer	Julie-Anne Balash	Maintains the conciliation waiting list and provides administrative support to the conciliation team.
Registrar	Shiranee Sinnathamby	Liaises with the professional Registration Boards and assists the Manager, Assessment & Investigations.
Assessment Officers	Jill Aitken Heather Andrew-Rieper Kate Kennedy Piotr Nyczek	Receive inquiry calls, case manage and assist resolution of complaints and provide advice to health service users and providers.
Legal & Policy Officer	Angela Palombo Jesinder Bhullar	Provides legal advice to the Commissioner and oversees Freedom of Information requests and takes a key role in the educating and training health service providers and holders of health information about the HRA.
Project Officer	Susan Joseph	Educates and trains health service providers and holders of health information about the HRA.
Information Services Officer	Colin McKnight	Provides IT support and assistance to staff and hospitals.
Executive Assistant	Gerda Olivier	Provides executive, administrative and keyboard support to the Commissioner.
Receptionist	Joe Barczak Claire O'Halloran	<i>Sandra Popovski (Mental Health Review Board) provided support receptionist duties for the office in the 2005/2006 financial year.</i>

Table 21: Staffing profile at 30 June 2006

Classification	Male	Female	Full Time	Part Time	Ongoing	Fixed Term	EFT*
Executive Officer		1	1			1	1
VPS 6	2	1	2	1	3		2.8
VPS 5	2	11	7	6	10	3	10
VPS 4	2	5	7		7		7
VPS 3	1	1	2			2	2
VPS 2	1	1		2		2	2
Total	8	20	19	9	20	8	24.8

* Effective Full Time The above figures include 2 staff currently working offsite.

Merit and Equity Employment

The OHSC supports specific initiatives of the Office of Public Employment Managing Diversity and Employment Equity goals. The Office follows equal employment opportunity policies when recruiting.

Staff by gender at 30 June 2006 was 20 women and 8 men.

Performance Management

The Office utilises the DHS Progression, Performance and Development performance management system, which provides a framework to manage and develop staff to achieve corporate objectives. The scheme provides for regular and formal assessment of an employee's work performance and allows for access to training and skill development with a greater emphasis on career progression.

Training

The ongoing training and development of staff is a priority of the Commissioner and staff are encouraged to expand their knowledge and skill base wherever possible. During the year 10 staff attended the Administrative Law & Human Rights-Delegations & Appointments Under Legislation Seminar run by the Law Institute of Victoria. Various staff attended a number of other training opportunities including a seminar on Ethics and Equal opportunity, a seminar on respecting patient choices, an FOI conference, a management-training course, Islamic communities in Victoria workshop and a Mood Disorders Support Group seminar.

The office also conducts in house training sessions which are usually held during lunch with invited speakers. We were fortunate enough to have the following present to us:

- Associate Professor Larry McNicol - Chairman of the Victorian Consultative Council on Anaesthetic Mortality & Morbidity
- Education Session by Dr Grant Lester, Consultant Forensic Psychiatrist re vexatious & querulous complainants
- Rodney Syme Voluntary Euthanasia Society & Phil Grano, Office of the Public Advocate
- David Ranson Victorian Institute of Forensic Medicine about reportable deaths
- Maureen Willson - Manager of the Clinical Governance Unit. Department of Human Services
- Mr Jonathan Rush - Chair of the Victorian Surgical Consultative Council.

Occupational Health and Safety

The OHSC is co-located on the same floor as the Mental Health Review Board, Intellectual Disability Review Panel and the Infertility Treatment Authority. Given the similar work environments and relatively small number of staff, the agencies have one Occupational Health and Safety Officer for the floor.

A commitment exists to preventing occupational injuries and incidents are monitored and recorded. Initiatives taken this year include the offer of flu vaccinations to all staff, a review of security procedures and group counselling sessions in addition to one on one sessions for those staff who wished to avail themselves of the offer.

Website

The website (www.health.vic.gov.au/hsc) is featured prominently in all of the Office promotional material. It is a source of information for the community on the role of the OHSC and includes publications produced by the office, appropriate links and information. It again proved popular in 2005/06 with an average of over 3595 unique visitors averaging over 30,000 hits per month. The average number of hits is an increase of over 2000 on last year.

Table 22

The following table is for the period 1 July 2005 to 30 June 2006.

Month	Hits	Sessions	Visitors
July	26,195	2,625	2,231
August	31,329	3,343	2,861
September	31,481	3,329	2,797
October	25,338	2,539	2,157
November	23,437	2,504	2,142
December	16,405	1,734	1,452
January	28,277	4,005	3,380
February	34,649	4,843	4,089
March	42,702	5,963	5,963
April	26,781	5,042	4,263
May	42,679	8,132	6,417
June	35,040	6,860	5,387
Average	30,359	4,243	3,595
Totals	364,313	50,919	43,139

Customer Feedback

Evaluation Survey

At the conclusion of a complaint the OHSC sends with the closure letter an evaluation survey form to complainants and providers. The information returned provides the OHSC with indicators on how we are performing and often contains useful suggestions for further improvement, and where follow up action may be required. The form lists six questions:

1. OHSC staff was helpful in explaining the complaints process
2. I was able to speak to HSC staff when I needed to
3. OHSC Staff returned my calls within 24 hours
4. I felt OHSC staff listened to what I had to say
5. I was satisfied with the way the complaint was handled
6. I was satisfied with the outcome of the complaint

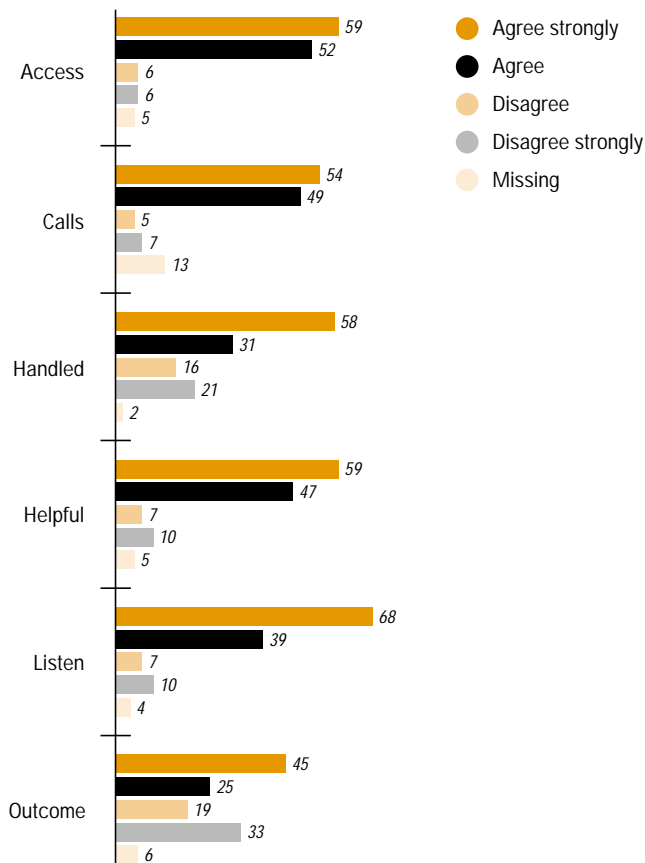
Respondents are asked whether they strongly agreed, agreed, disagreed or strongly disagreed with the question.

Complainants

Fifty seven per cent of complainants were satisfied with the outcome of the complaint compared to 68% last year. Over 86% said the staff were helpful, they were able to access staff who listened to them and returned calls promptly and 70% indicated they were satisfied with the way their complaint was handled. Obviously not all complainants receive the outcome they want with 43% not satisfied in the outcome.

Figure 24: Complainant's Evaluations

Response Total = 128 from 492 (26% return)

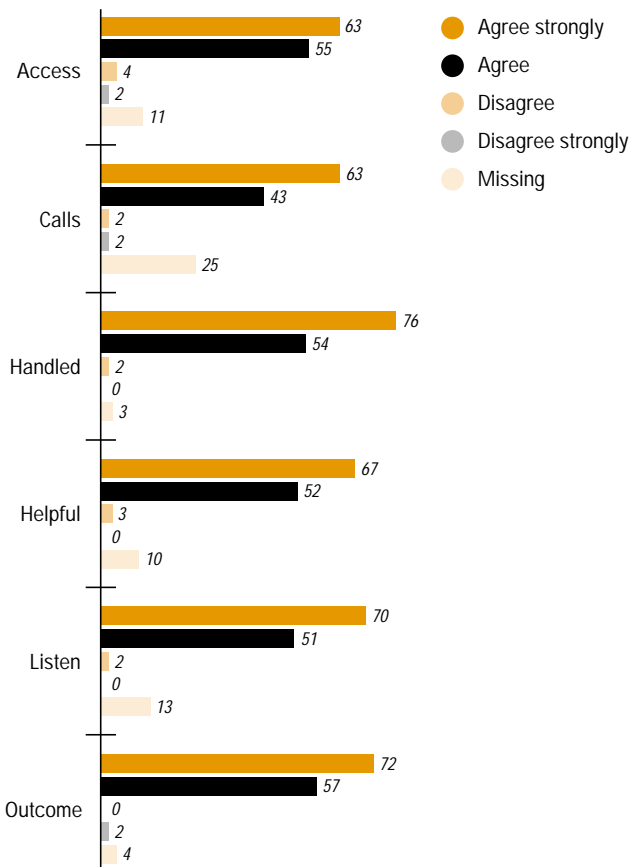


Providers

Ninety five per cent of providers who responded indicated they were satisfied with the outcome; a 4% increase on last year. Ninety eight per cent were satisfied with how the complaint was handled compared to 96% last year. Ninety five per cent of providers agreed the staff were helpful, they were able to access staff who listened to them and 96% agreed their calls were returned within 24 hours which is a significant improvement on the 86% figure from last year which is pleasing as it was an area that was targeted for improvement.

Figure 25: Provider's Evaluations

Response Total = 135 from 492 (27%return)



The following graphs show a weighted average for each question over the last 3 financial years using a 1-4 scale.

Figure 26: Complainant's evaluations

Rating: 1 = Disagree Strongly, 2 = Disagree, 3 = Agree, 4 = Agree Strongly

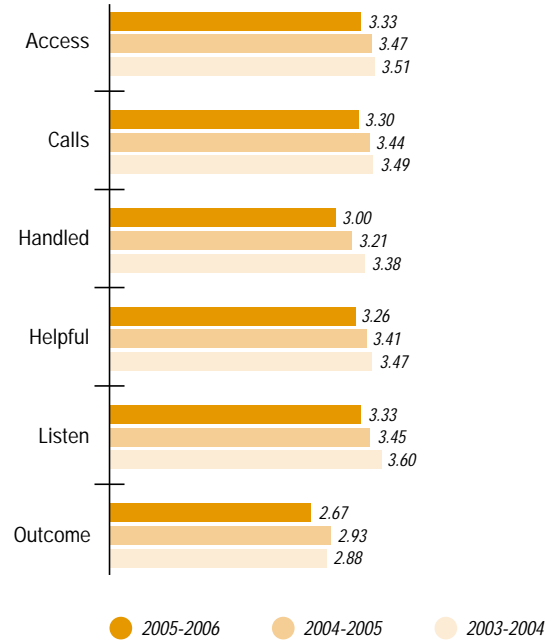
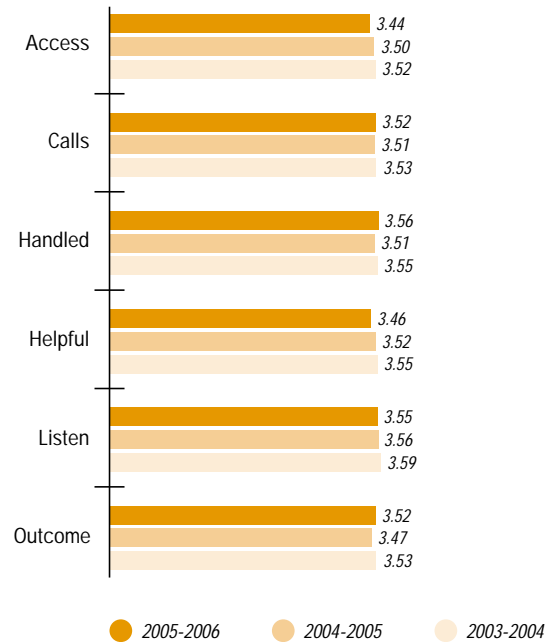


Figure 27: Provider's Evaluations

Rating: 1 = Disagree Strongly, 2 = Disagree, 3 = Agree, 4 = Agree Strongly



Finance

For the 2005/06 financial year the OHSC was allocated \$1,901,321 (excluding indirect expenses) and expended \$1,891,532, being 99.5% of its total allocation resulting in a surplus of just under \$10,000. This was only possible due to the appropriate management of the office' operating expenses to compensate for the under allocation to Salaries which was overspent by \$122,000.

Financial Statements

	Allocated	Actual
Operating Expenses	\$379,084	\$247,324
Salaries	\$1,522,237	\$1,644,208
Total	\$1,901,321	\$1,891,532

Expenditure

Salaries		\$1,644,208
Administrative stationery & operating supplies	\$14,672	
Advertising, publicity & information	\$2,035	
Books / publications / subscriptions / memberships	\$9,670	
Catering	\$5,231	
Graphic design & editing	\$20,025	
Furniture, fittings & equipment	\$4,244	
Interpreter Services	\$4,749	
Investigation Panel	\$36,469	
Maintenance	\$1,836	
Medical reports	\$36,655	
Miscellaneous	\$12,095	
Postal /courier	\$3,360	
Printing	\$37,353	
Staff development, seminars & training	\$14,295	
Telephones \$30,823		
Travel-Airfares, Taxis, Personal Expenses	\$13,582	
Vehicle	\$230	
		\$247,324
Total		\$1,891,532

Compliance and Accountability

Whistleblowers Protection Act 2001

Section 104 of the above legislation requires public bodies to prepare an annual report of operations including a copy of current procedures for dealing with disclosures under the Act. (see Appendix 6)

For the year under review the OHSC reports:

a. Number of Disclosures

No disclosures of any type were made to the Office.

b. Public Interest Disclosures Referred to the Ombudsman

No disclosures of any type were referred by the Office to the Ombudsman for determination as to whether they were public interest disclosures.

c. Disclosures Referred to the Office

No disclosures of any type were referred to the Office by the Ombudsman.

d. Disclosures of Any Nature Referred to the Ombudsman

No disclosures of any type were referred by the Office to the Ombudsman to investigate.

e. Investigations Taken Over by Ombudsman

No investigations of disclosed matters of any type were taken over from the Office by the Ombudsman.

f. Requests Under Section 74

No requests were made under section 74 to the Ombudsman to investigate disclosed matters.

g. Disclosed Matters declined to be investigated

There were no disclosed matters of any type that the Office declined to investigate.

h. Disclosed Matters Substantiated on Investigation

No disclosed matters of any type were investigated, or substantiated on investigation.

i. Recommendations by Ombudsman

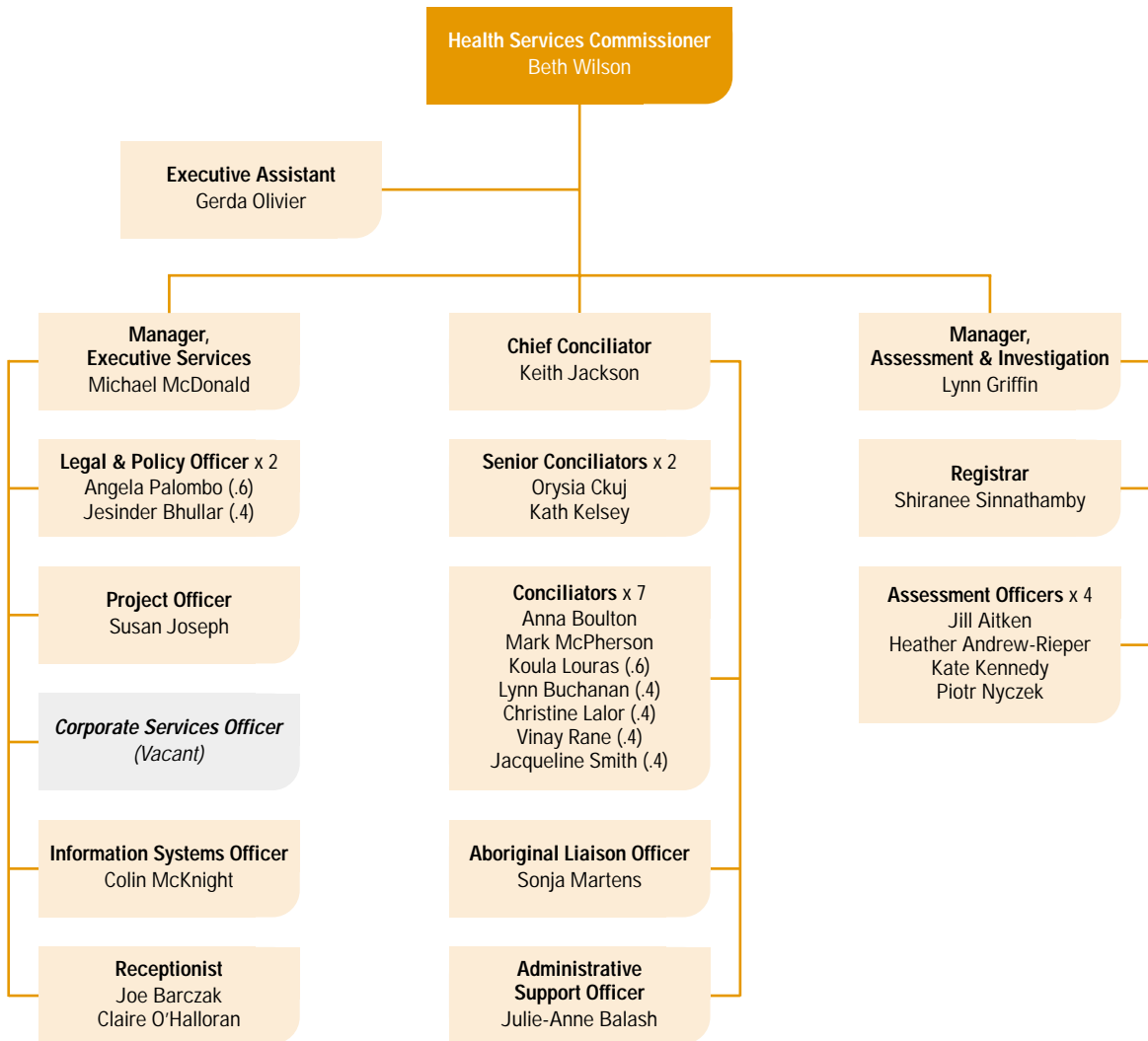
No recommendations were made by the Ombudsman under the *Whistleblowers Protection Act* relating to the Office.

Information Privacy Act 2000

The OHSC is an organisation covered under section 9 of the above legislation. We comply with the Information Privacy Act in its collection and handling of personal information.

Executive Services

Organisational Structure as at 30 June, 2006



Appendices

Appendix 1: Providers by Type

Dentists in Private Practice	166
Hospitals	711
Medical Practitioners	686
Remaining Providers	
Age Care	1
Alcohol & Drug Service	3
Allied Health	5
Alternative Therapist	14
Alternative Therapist Clinic	10
Ambulance Service	19
Audiologist	2
Beauticians / Laser Therapists	6
Business	1
Chiropractor	4
Community Health Centre	30
Commonwealth Dept H&CS	1
Complementary Health	1
Corrections Health	128
Counsellor	4
Department of Human Services	5
Dental Prosthetist	8
Diagnostic Service	36
Education	1
Government	1
Health Insurance	2
Hostel	3
Infant Welfare Centre	6
Insurance Company	4
Law Firms	1
Local Government	1
Locum Service	4
Medical Technician	1
Mental Health	2
Not a health service provider (organisation)	6
Not a health service provider (individual)	10
Nurse	5
Nursing Home	6
Nursing Service	7
Occupational Therapist	4
Optical Dispenser	28
Optometrist	7
Pharmacists	6
Pharmaceutical Supplier	10
Pharmacist	6
Physiotherapist	4
Podiatrist	10
Police	2
Psychiatric Health Service	24
Psychologist	7
Radiographer	1
Rehabilitation Service	5
Statutory Authority	1
Supported Residential Service	2
Not specified	157
	612
Total	2175

Appendix 2: Medical Practitioner Specialities

Allergist	4
Anaesthetist	18
Cardiologist	8
Dermatologist	17
Ear, Nose and Throat	6
Gastroenterologists	5
General Practitioner	240
General Surgeon	7
Group Practice	17
Laser Eye Clinic	1
Locum	2
Mens Health	24
Neurologist	7
Neurological Surgeon	5
Obstetrician / Gynaecologist	26
Oncologist	6
Ophthalmologist	10
Orthopaedic Surgeon	16
Paediatrician	4
Plastic Surgeon	12
Psychiatrist	27
Radiologist	3
Rehabilitation Medicine	3
Respiratory Medicine	1
Rheumatologist	2
Surgeon	25
Urologist	3
Vascular Surgeon	4
Not specified	183
Total	686

Appendix 3: HCIP Issues

Access		Rights	
Absence of Caring (Access)	59	Access to Records	10
Access - Other	777	Accuracy of Records	12
Delay in Admission	42	Assault	13
Discharge Arrangements	130	Discrimination Public / Private	5
Discharge / Transfer	44	Discrimination	17
No / Inadequate Service	95	Failure to Provide Interpreter	2
Non Attendance	5	No / Insufficient Consent	15
Privacy	12	Other - Rights	128
Refused Admission	14	Privacy / Confidentiality	55
Service Busy	38	Property	104
Transfer Unsuitable	2	Refusal to Treat	3
Transport	3	Unprofessional Conduct	19
Waiting List	59		383
	1280		
Treatment		Cost	
Absence of Caring	160	Amount Charged	100
Delay in Treatment	270	Billing Practice	18
Inadequate Diagnosis	89	Information on Ccost	12
Inadequate Nursing Care	184	Other - Cost	83
Inadequate Treatment	361	Public / Private Election	7
Medication Omission / Error	67	Unnecessary Treatment	1
Negligent Treatment	38		221
Other - Treatment	173	Administration	
Rough Treatment	41	Administration - Other	55
Unexpected Outcome	81	Advertising	1
Unskilful / Incompetent	33	Fail. Provide Certificate	3
Wrong Diagnosis	21	Incorrect Documentation	28
Wrong Treatment	17	No / Inadequate Response	22
	1535	Policy	7
		Public Health Standards	8
		Treatment Cancelled	20
			144
Communication		TOTAL	
Absence of Caring	81		4674
Communication Breakdown	189		
Conflicting Information	63		
Failure to Consult	59		
Inadequate Information	220		
Other - Communication	102		
Poor Attitude/Discourteous/Rude	321		
Undignified Service	43		
Wrong / Misleading Information	33		
	1111		

Appendix 4: HCIP Service Provided at Time of Complaint

Accommodation Services	40	Neurology	67
Administrative Services	34	Neurosurgery	81
Admissions	27	Nursing Home	11
Aged Care	124	Nutrition	3
Alcohol & Drug Services	5	Obstetrics	141
Anaesthetics	12	Obstetrics / Gynaecology	68
Audiology	2	Occupational Therapy	9
Awaiting Admission	6	Oncology	41
Car Parking	138	Operating Theatre	14
Cardiac Surgery	40	Ophthalmology	19
Cardiology	63	Orthopaedic Surgery	233
Chaplaincy	2	Outpatients Clinic	86
Chiropody / Podiatry	1	Paediatrics	18
Colorectal	31	Pain Services	11
Day Procedure	103	Palliative Care	12
Dentistry	32	Pathology	18
Dermatology	13	Patient Services	46
Dietician	3	Pharmacy	27
Ear, Nose & Throat	27	Physical Medicine	1
Emergency	960	Physiotherapy	22
Emergency Triage	41	Plastic Surgery	61
Endocrinology	20	Podiatry	8
Environmental Services	5	Prosthetics / Orthotics	4
Finance & Administration	22	Psychiatry	175
Food Services	8	Radiology	70
Gastroenterology	61	Reception / Administration	9
General Medicine	244	Rehabilitation Medicine	37
General Practice	2	Renal / Nephrology	37
General Surgery	248	Respiratory Medicine	37
Gerontology	18	Rheumatology	11
GP Support Res. Services	1	Social Work	27
Gynaecology	126	Specialist Medical	40
Haematology	14	Specialist Surgical	35
Home Care	20	Speech Therapy	1
Infectious Diseases	23	Spinal Injuries Unit	20
Intensive Care Unit	24	Telecommunications	12
Interpreter Services	4	Unknown	483
Liver Transplant	6	Urology	74
Medical Administration	10	Vascular Surgery	45
		TOTAL	4674

Appendix 5: HCIP Outcomes

Resolved	
Agreement Reached	103
Apology	1397
Compensation Paid	47
Explanation Offered	1443
Fee waived or Reduced	18
Fee Refunded	13
Frivolous / Vexatious	32
Information Provided	568
Misunderstanding	94
No Further Action	78
Service / Facility Provided	284
Users View Acknowledged	280
Waiting Time Reduced	33
	4390
Change of Policy	
Censure or Reprimand	15
Policy Change	21
Procedural Change	62
	98
Remedial	
Caution or Warning	13
Censure or Reprimand	17
Remedial Action	205
	235
Referred	
Outcome in Referral	172
	172
Not Upheld	
Complaint Not Upheld	72
No Action Possible	73
	145
Lapsed	
Allowed to Lapse by	109
Insufficient Detail	620
Not Confirmed	16
Unsubstantiated	106
Withdrawn by User	29
	880
Total	5920

Appendix 6: Reporting procedure guidelines under the *Whistleblowers Protection Act 2001*

September 2003	
Contact:	Michael McDonald Manager, Executive Services Phone: 8601 5222
Executive Approval:	9 September 2003
Ombudsman Approval:	14 October 2003
Guideline No. 0302	
Prepared by:	Michael McDonald

These guidelines are for all employees of the OHSC and are available to all members of the public free of charge. They can also be viewed at the OHSC website www.health.vic.gov.au/hsc

Whistleblowers Protection Act 2001

These guidelines are made in accordance with the *Whistleblowers Protection Act 2001* (the Act), which came into effect on 1 January 2002. Consistent with the Act, the policy of the Health Services Commissioner is to encourage and facilitate the making of disclosures, where these are supported by reasonable grounds, related to alleged improper or corrupt conduct.

A staff person or member of the public, who has reasonable grounds to believe improper or corrupt conduct has occurred, is occurring or is about to occur is encouraged to disclose this in accordance with these procedures.

Introduction

- The aim of these procedures is to establish an objective system to encourage and provide support to persons making disclosures ("whistleblowers"), to investigate disclosed allegations of improper conduct, or detrimental action against the person making the disclosure and to enable appropriate action to be taken.
- A disclosure may be made about improper conduct by a public body or public official.

Improper conduct means conduct that is corrupt, a substantial mismanagement of agency resources or conduct involving substantial risk to public health, or to safety or to the environment. The improper conduct must be sufficiently serious to establish (if proved) a criminal offence or reasonable grounds for dismissal from employment.

Corrupt conduct includes conduct by any person (not necessarily an employee) that adversely affects the honest performance of the functions of a public body or a public officer; an employee performing their functions dishonestly or with inappropriate partiality; conduct by an employee or a former employee that amounts to a breach of public trust, or a misuse of information or material acquired in the course of performing their official functions; a conspiracy or attempted conspiracy to engage in corrupt conduct.

- Detrimental action is action taken or threatened against a person disclosing alleged improper conduct and includes action causing injury, loss or damage, intimidation or harassment, discrimination, disadvantage, or adverse treatment to a person's employment, career, profession, trade or business and includes the taking of disciplinary action because of the fact of a disclosure of alleged improper conduct.

Procedures for Handling Disclosures

The OHSC has established the following procedures to facilitate the making of disclosures, investigation of disclosures, and for the protection of persons making disclosures from reprisals by the Health Services Commissioner, or any other employee of the OHSC. A disclosure may be made to the Manager, Executive Services of the OHSC or to the Victorian Ombudsman.

The following procedures apply where a disclosure is made to the OHSC:

1. A disclosure of alleged improper conduct shall be made direct to the Manager, Executive Services (or specifically nominated delegate). Alternatively, the disclosure may be made to the Ombudsman.
2. On receipt of a disclosure, the Manager, Executive Services (or specifically nominated delegate) shall assume the role of the Protected Disclosure Coordinator (PDC) and shall promptly:
 - (a) Meet with the person making the disclosure (unless it is provided anonymously) to ascertain the details of the disclosed matter and invite the complainant to provide a detailed written statement on an "in confidence" basis.
 - (b) Impartially assess the disclosure to determine whether it amounts to a protected disclosure:
 - i. If not, the PDC will explain to the complainant what other remedial action can be taken in the circumstances;
 - ii. If so, the PDC will explain to the whistleblower the protections that s/he receives under Part 3 of the Act and will offer the whistleblower welfare management. Thereafter, the PDC will move to step (c).
 - (c) Determine whether the protected disclosure amounts to a Public Interest Disclosure (PID) within Part 4 of the Act:
 - i. If not, the PDC will explain what remedial action can be taken in the circumstances and that the whistleblower has the right to request that the protected disclosure be referred to the Ombudsman for a review of the PDC's determination. Where the whistleblower is satisfied with the proposed remedial action the PDC will give effect to such action subject to the protection, that the whistleblower enjoys under the Act;
 - ii. If so, the PDC will refer the PID to the Ombudsman for a formal determination as to whether the protected disclosure amounts to a PID.
 - (d) If the Ombudsman determines that the disclosure is a protected disclosure, the Ombudsman may refer it back to the Manager, Executive Services to be investigated.
 - (e) If it is referred back to the Manager, Executive Services, the PDC shall promptly assign an investigator (who may be a senior employee or external solicitor/consultant) to investigate the disclosure and report direct to the PDC who will refer the report to the Ombudsman.
3. If the disclosure relates to the Manager, Executive Services, the disclosure should be made directly to the Ombudsman.
4. Disclosure and investigation material will be treated with the utmost confidentiality and security. Such material is only to be accessed by the Manager, Executive Services as the PDC or by the investigator. Disclosures made under this policy will be investigated swiftly, professionally and discretely.
5. The OHSC is required to include in its annual reports material including the number (if any) and types of disclosures made to it.
6. Where an investigation of a PID reveals that the improper conduct occurred, the PDC will:
 - i. Report the findings of the investigation to the Minister;
 - ii. Take all reasonable steps to prevent the conduct occurring in the future;
 - iii. Bring disciplinary proceedings against the person responsible for the conduct;
 - iv. Refer the matter to the appropriate regulatory body for further consideration.
7. It is a criminal offence:
 - (a) For a person to take detrimental action against a person in reprisal for a protected disclosure (\$6,000 fine or two years imprisonment or both)
 - (b) For a person to reveal confidential information received in the course of or as a result of a protected disclosure except as provided for under the Act (\$6,000 fine or 6 months imprisonment or both)
 - (c) For a person to wilfully obstruct hinder or fail to comply with a lawful requirement of the Ombudsman (\$24,000 fine or two years imprisonment or both)
 - (d) For a person to knowingly mislead or attempt to mislead the Ombudsman (\$24,000 fine or two years imprisonment or both)
 - (e) For a person to knowingly provide false information to the OHSC's Manager, Executive Services intending it to be acted on as a disclosed matter (\$24,000 fine or two years imprisonment or both).

The OHSC is committed to the highest standards of ethics and probity in the performance of its duties and the delivery of its services to the community.

The Ombudsman has published a set of detailed guidelines and the agency will follow these in dealing with a disclosure. A copy of these guidelines is available from the OHSC or can be downloaded from the Ombudsman's website www.ombudsman.vic.gov.au