Annual Report 2008-09

Health and Community Services

Complaints Commissioner

HCSCC Identification

2008-09

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Dear Minister

Health and Community Services Complaints Commissioner
Fourth Annual Report 2008-09

In accordance with the requirements of section 16 (1) of the *Health and Community Services Complaints Act* 2004 I am pleased to provide you with my 2008 - 2009 Annual Report.

Yours sincerely

Leena Sudano

Leena Sudano
Health and Community Services Complaints Commissioner

CONTENTS AT A GLANCE

CONTENTS

1 ABOUT HCSCC

The office of the Health and Community Services Complaints Commissioner, HCSCC, is an independent statutory office established by the *Health and Community Services Complaints Act 2004* (the Act). HCSCC opened on 4 October 2005.

HCSCC provides free information and assistance to resolve complaints about public, private and health and community services, including child protection services.

HCSCC encourages direct resolution with the service provider first. HCSCC may assist when direct resolution with the service provider is either unreasonable or has not succeeded. HCSCC also investigates serious complaints about issues of public interest or safety.

Section 3 of the Act requires HCSCC:

(a) to improve the quality and safety of health and community services in South Australia through the provision of a fair and independent means for the assessment, conciliation, investigation and resolution of complaints
(b) to provide effective alternative dispute resolution mechanisms for users and providers of health, or community services to resolve complaints
(c) to promote the development and application of principles and practices of the highest standard in the handling of complaints concerning health, or community services
(d) to provide a scheme which can be used to monitor trends in complaints concerning health, or community services
(e) to identify, investigate and report on systemic issues concerning the delivery of health, or community services.

HCSCC has a statutory relationship with 10 health professional Registration Boards and also maintains links with:

- regional health and community services providers
- organisations which represent the interests of services users and carers, including people with special needs.

HCSCC VISION

A complaint is an opportunity to:

- get information about what happened
- redress individual grievance and harm
- act to minimise serious harm happening again to others.

HCSCC VALUES

HCSCC upholds the following values:

- independence
- impartiality
- integrity
- accessibility
- providing a voice for people with concerns about services
- excellence in customer service
- team work
- professionalism
- responsiveness to criticism about our performance.

2 COMMISSIONER'S FOREWORD

In our fourth year HCSCC focussed on reaching seldom heard groups and to investigating complaints that raised significant issues about the safety or quality of services. While HCSCC made some progress towards these priorities, increasing demand for HCSCC assistance with complaints - complaints that should have been raised and resolved at the point of service - impaired our ability to reach many people with special needs and to undertake more investigations.

In a parting editorial, Stephen Duckett, a leading contributor to improvements in the Australian health system during the past 35 years, challenged us to recognise and respond better to increased public expectations about care.[1]

Duckett singled out 'meekly waiting for care' and 'patronising care and acceptance of whatever is on offer' as features of the past. He highlighted raised public expectations for up-to-date information, including about alternatives, risks and outcomes and openness when things go wrong. These remarks are arguably applicable to community services, including disability and child protection services.

To these challenges we must add attention to those who can't speak up and who find it difficult to obtain services to which they are entitled.

Raised public expectations are one of the reasons for increasing complaints to services and to HCSCC.

Under the *Health and Community Services Complaints Act 2004,* service providers are responsible for ensuring that:

- they have a local process for managing complaints about their services that meets generally accepted standards
- people who use their services know how a complaint can be made
- they take proper action in response to complaints
- people who use their services are not adversely affected by making a complaint
- people who are unable to resolve a complaint locally are given information about HCSCC.

The majority of contacts to the HCSCC Enquiry Service and complaints accepted by HCSCC, demonstrate that some service providers are not fulfilling these responsibilities.

Among service providers who substantially meet these responsibilities on paper, there is often a large gap between the organisational policy and the awareness and skills among staff to follow the policy. When this happens, the heightened distress and the complaint, are left to an overloaded designated internal complaints handler or HCSCC to remedy.

[1] Health care reform Are we ready for the next big thing? Stephen J. Duckett MJA v 190 n 12 15 June 2009 at 687. In 2008-09 Stephen Duckett was a member of the National Health and Hospitals Reform Commission and Chief Executive Officer, Centre for Healthcare Improvement, Queensland Health, in the wake of Bundaberg and other inquiries into systems failures in Queensland health services.

HCSCC encourages all service providers to audit the experience of people who complain about their services and the experience of their front line staff who respond to complaints, to identify ways they can build the capacity of staff to close the gap between their complaints policy and staff skills to comply with the policy.

Many service providers are paying increased attention to identifying, reporting and acting on incidents, particularly incidents where there is a high risk of serious harm unless action is taken to minimise the same thing happening again. However, the contribution of complaints - client reported incidents - remains undervalued. Many high profile independent investigations after serious failings, both overseas and in Australia, have shown that a pattern of early warning signs, including low level, repeated complaints about a similar issue, or the same practitioner, went unheeded, a missed opportunity to prevent serious harm.

Effective complaints handling at the local level minimises distress and can help to nip preventable harm in the bud. Handling complaints well at the local level is also one way services can show that they value the experience of service users.

In 2009-10 HCSCC will focus on:

- improving reports about the outcomes of HCSCC work beyond individual complaints (section 3 (e))
- systematic outreach to those with special needs, their carers and advocates building on outreach projects to people with disabilities and people from Aboriginal and Torres Strait Islander backgrounds (section 9 (2)-(3))
- establishing the Charter of Health and Community Services Rights (Part 3)
- establishing the Health and Community Services Council (Part 8) and
- progressing other recommendations endorsed by the SA government following the 2008 review of the Act (section 88).

3 FOURTH YEAR HIGHLIGHTS

3.1 Special Needs Outreach Project

Between June and October 2008, HCSCC initiated presentations to groups of community services users with special needs. The aim was to increase their awareness about complaint processes and HCSCC. This work was undertaken as part of HCSCC obligations under section 9(2) of the Act to take into account people with special needs.

Peak community groups and key service providers were contacted resulting in nine sessions. The sessions were conducted in various metropolitan locations, Port Adelaide, Felixstow, Noarlunga, Keswick and Salisbury and two regional centres, Port Augusta and Mt Gambier. A total of 140 people attended the sessions. Only a small number of participants had heard of HCSCC before attending.

The outreach project provided information to many people with reduced capacity who may be isolated from their community, due to disability or old age. Most participants were vulnerable service users with special needs. They said they would not make a complaint because they feared retribution. The outreach sessions engaged with people in their own settings, built rapport and reduced the fear of the complaints process and HCSCC. Feedback from the sessions also confirmed that real stories about complaint experiences engage people and help them to understand their own role in a complaints process.

There was a very positive response to HCSCC getting out to service users and service providers in their own communities. HCSCC has noted an increase in inquiries and complaints from groups and locations where the outreach sessions were conducted.

3.2 *Ever felt like complaining?* Aboriginal and Torres Strait Islander Outreach Project

Between March and June 2009, HCSCC conducted an outreach project consulting Aboriginal and Torres Strait Islander people and workers in Aboriginal and Torres Strait Islander and mainstream health and community services. SA Health and the Department of Families and Communities each contributed $25 000 to the project.

The main aim of the project was to hear directly from Aboriginal and Torres Strait Islander people about their experiences with health and community services. In particular HCSCC wanted to hear from Aboriginal and Torres Strait Islander people about their experiences if they had wanted to complain, or did complain, about a health and community service in the past five years.

Key project questions included:

- What made it hard to speak up?
- What helped to make it possible to speak up?
- Did anything get better after speaking up?
- What would make it easier and safer for Aboriginal and Torres Strait Islander people to speak up when they are not happy about a health, or community service?

The project consultants, Sandy Miller (Wirangu) and Sally Gibson, met many groups and individuals. The project report, information sheets and the HCSCC action plan in response to the report recommendations will be released in spring 2009 and will be available at www.hcscc.sa.gov.au

3.3 SA Parliament - Economic and Finance Committee

HCSCC provided further information about the funding shortfall to meet current statutory obligations in a third annual submission to the Committee in November 2008. HCSCC highlighted a lack of funding to enable the development of the Charter of Health and Community Services Rights, systematic outreach to people with special needs and formal investigations about systemic issues. HCSCC requested the Committee's assistance to secure additional recurrent funding of at least $328 000 a year.

HCSCC also foreshadowed new budget pressures due to additional statutory obligations likely to be proposed after the section 88 Review of the Act and the SA Parliament Social Development Committee Inquiry into bogus, unregistered and deregistered health practitioners. An indirect outcome of the HCSCC submission was a $100 000 once-off funding increase from SA Health in 2009-10.

3.4 SA Parliament Social Development Committee Inquiry 30th Report Bogus, Unregistered and Deregistered Health Practitioners

The Social Development Committee Inquiry into bogus, unregistered and deregistered health practitioners (the SDC Inquiry) started in February 2008. HCSCC provided a preliminary submission to the SDC Inquiry in March 2008.

In October 2008, HCSCC published an information sheet 'Unregistered service providers - what to expect and what to do if you have concerns about an unregistered practitioner' available at: http://www.hcscc.sa.gov.au/cgi-bin/wf.pl?pid=yf1gN&mode=cd&file=../html/documents//02_what's%20new

HCSCC also distributed the information sheet widely to individuals and organisations, including the AMA SA, 10 SA health professional registration boards, Health Consumers Alliance SA, Carers SA and peak bodies representing diverse unregistered health practitioners.

In November 2008, HCSCC made a second submission to the SDC Inquiry. This submission highlighted the shortcomings of the Act in dealing with complaints about four unregistered service providers. HCSCC advocated the adoption of the NSW model of a statutory Code of Conduct for unregistered service providers and associated HCSCC enforcement powers.

The adoption of this model would enable HCSCC to direct an unregistered practitioner to stop practices which do not meet Code of Conduct requirements and to warn the public. The NSW changes came into force in August 2008. Information about the NSW Code is available at: http://www.hccc.nsw.gov.au/html/Code_Contuct_Unregistered_page.htm

On 16 June 2009, the SDC inquiry report was tabled in the SA Parliament. The report is available at: http://www.parliament.sa.gov.au/Committees/Standing/LC/SocialDevelopmentCommittee/CompletedInquiries/30thReportBogusUnregisteredDeregisteredHealthPractitioners.htm

The Committee has requested that HCSCC provides quarterly reports about progress in dealing with complaints about unregistered health practitioners. The Committee has also requested that HCSCC appears before it by June 2010 to report progress towards implementing the SDC Inquiry report recommendations linked to HCSCC.

The Government's response to the SDC Inquiry report is due by October 2009.

3.5 *Health & Community Services Complaints Act 2004* Review

In May 2008, the Minister for Health commissioned a review of the Act as required by section 88. On 3 March 2009 the Minister tabled the review report and the government's response in the SA Parliament. The public submissions to the review, including the HCSCC submission, the review report and the government's response are available at: www.health.sa.gov.au/Default.aspx?tabid=617

HCSCC welcomes the government's endorsement of the majority of the review recommendations. HCSCC particularly welcomes the government's endorsement of almost all the HCSCC recommendations to the review.

SA Health has advised that the government's review recommendation implementation priorities in 2009-10 include:

- developing the Charter of Health and Community Services Rights
- establishing the Health and Community Services Advisory Council
- drafting amendments to the Act
- developing a communication strategy for SA Health complaints resolution services
- scoping a consumer advocacy scheme
- completing an operational review to determine adequate HCSCC recurrent funding.

3.6 *Health Care Act 2008* - Protected Investigations of Serious Incidents and Reporting Investigation Findings.

This Act commenced on 1 July 2008. HCSCC requested that the Minister for Health authorise HCSCC to receive adverse incident analysis reports (root cause analysis) under s72(1)(b) of this Act, like HCSCC's Queensland counterpart.

The Minister has indicated that this may be considered when this part of the Act is reviewed after two years of operation and after the effects of the comparable Queensland provision on open disclosure can also be evaluated.

3.7 *Mental Health Act 2008*

The *Mental Health Bill 2008* was passed by the SA Parliament on 3 June 2009 and will come into effect 1 July 2010. The Bill includes a Community Visitors Scheme (CVS). HCSCC will be consulted about the CVS in 2009-10.

3.8 National Health Professional Regulation and Accreditation

During 2007-08, extensive proposals to establish new national health professional registration and accreditation arrangements, including complaints handling about registered and formerly registered health practitioners, were subject to public consultation. HCSCC was concerned about proposals which cut across the legal obligations and arrangements established between HCSCC and SA health professional registration authorities under Part 7 of the Act. HCSCC concerns were shared, to varying degrees, by interstate statutory health complaints agencies (AHCCs).

Key issues for AHCCs are:

- lack of clarity about the relationships between national and state health professional registration authorities and AHCCs
- ensuring responsiveness, timeliness, transparency and accountability for complaint management about individual registered, or formerly registered, health professionals by health professional registration authorities
- a national complaints register accessible to AHCCs and health professional registration authorities to improve public protection
- ensuring the new arrangements eliminate other barriers which have prevented different complaints agencies, in different states/territories, from sharing information about complaints pending against a registered, or formerly registered, health professional, or adverse findings, or restrictions to practice placed on a registered, or formerly registered, health professional
- a diminished role for AHCCs in resolving complaints collaboratively with health professional registration authorities.

In mid-June 2009, major draft legislation, the *Health Practitioner Regulation National Law 2009*, was released for public consultation. This law creates a single national registration and accreditation system effective from 1 July 2010 for the following health professionals: doctors, chiropractors, dentists, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. From 1 July 2012, the scheme will also include practitioners in Aboriginal and Torres Strait Islander health, Chinese medicine and medical radiation.

The outcome of the consultation process for the final version of the legislation is expected in late 2009. Any consequential changes to statutory arrangements between HCSCC and health professional registration authorities will occur in 2010.

3.9 Serious Complaints and Vulnerable Clients

During 2007-08 several serious complaints involving vulnerable adults, that were poorly handled, prompted HCSCC inquiries about complaints management and reporting in services funded by government departments.

A wide variety of non-government health and community organisations (NGOs) are governed by a common contract. HCSCC advocated improvements in the common contract to ensure that serious complaints are managed swiftly and effectively. The Department of Families and Communities (DFC) and SA Health agreed in principle to this improvement. However NGO concerns resulted in the negotiated feedback and complaints clause falling short of the protections HCSCC sought.

In April 2009, the Commonwealth Ombudsman published Fact Sheet 6 'Complaint handling: Outsourcing', available at http://ombudsman.gov.au/ commonwealth/publish.nsf/ Content/publications_better_practice, which clearly explains the obligations of government agencies contracting with NGOs.

During 2009-10, HCSCC will continue to negotiate with DFC, SA Health and the NGOs to strengthen complaint handling for vulnerable clients.

3.10 Advance Directives Review

Since 2001, a review of Advance Directives has been advocated. Advanced Directives include several ways in which people can document their wishes about how they want aspects of their life managed and decisions made on their behalf, if they become unable to speak for themselves. This can include health care and treatment decisions.

Advanced Directives fall into a number of categories:

- they can be legal documents, or policy documents eg Organ Donor Register; Do Not Resuscitate Orders, or a good palliative care plan made with the agreement of a person, or their family; a Statement of Choices under the Respecting Patient Choices Program; a Ulysses Agreement made by a person with a mental illness
- they can set out personal instructions, or appoint a proxy decision maker eg a medical agent
- they can allow for financial, lifestyle, or health care arrangements.

There are three SA laws which have different advanced directives. Research has found that this is too complex for consumers, carers, health service providers and lawyers to understand. As a result, Advance Directives are not used effectively, leaving families and clinicians without clarity for end of life decision making. This can result in distressing, unwanted and expensive medical interventions.

In 2006-07 the SA Advanced Directives Review started. It included an issues paper and extensive public consultation. In 2007-08 the Review Committee developed recommendations in two stages to provide to the Attorney-General:

1. the law and policy changes needed to support effective Advanced Directives
2. the implementation of Advanced Directives, including a public and health service provider education campaign.

HCSCC receives anecdotal reports and has dealt with several complaints about advance directives. These have involved non-compliance with advance directives, or lack of clarity about them causing distress and difficulty for families and clinicians during end of life decision making, or when a person with a serious mental illness is not well enough to make treatment decisions for themselves.

In May 2009, HCSCC issued a media release 'End of life decision making', available at http://www.hcscc.sa.gov.au/cgi-bin/wf.pl?pid=QxMBr&mode=cd&file=../ html/documents//02_what's%20new

Despite requests from HCSCC through the Minister for Health and others keen to promote greater clarity about Advanced Directives, the Attorney-General has yet to release the SA Advanced Directives Review Committee's recommendations.

3.11 Commission of Inquiry into the Abuse of Children in State Care Mullighan Inquiry recommendations - Act amendments

On 16 June 2009 the *Children's Protection (Implementation of Report Recommendations) Amendment Bill 2009* was introduced to the SA Parliament. HCSCC supports provisions to enable HCSCC to accept a complaint directly from a child about services and about circumstances arising since May 2004 (the date of release of the Layton report) while they were in the care of the state.

4 COMPLAINT RESOLUTION SERVICE

4.1 Complaint Resolution Service Highlights

In 2008-09 HCSCC:

- handled 832 new complaints
- responded to increased demand by successfully trialling an expansion of the Enquiry Service
- recruited three Complaint Resolution Officers with experience in Aboriginal and Torres Strait Islander communities, disability services, equal opportunity conciliation, law and mediation in April 2009
- conducted outreach in country centres and outer metropolitan Adelaide to community services users with special needs
- provided *Safer Conversations* training to 30 senior Country Health SA nursing staff
- provided training for 26 ministerial staff in the health and community services portfolios about managing unusually persistent behaviours by complainants.

4.2 Enquiry Service

The Enquiry Service offers information and advice about complaints, including guidance about how HCSCC can assist people within the scope of the Act. If HCSCC cannot deal with a matter within the scope of the Act, every effort is made to refer the person to another appropriate service.

When a complaint is within the scope of the Act, the Enquiry Service will assist the person:
- to make their complaint directly to the service provider - see Direct Resolution below
- to provide enough information to HCSCC for the Commissioner to decide what action to take on their complaint.

The Enquiry Service is staffed Monday to Thursday, from 10 am to 4 pm and is accessible by:
- telephone 8226 8666, toll free for SA country callers using a landline 1800 232 007
- email from www.hcscc.sa.gov.au
- facsimile 8226 8620
- letter to PO Box 199 Rundle Mall SA 5000.

Expansion of the Enquiry Service

By October 2008, demand for the Enquiry Service consistently exceeded the staffing of one full-time position. In response to demand, HCSCC provided training to an administrative assistant to increase staffing to two full-time Information and Assessment Officers. An experienced Complaint Resolution Officer took on the additional role of Enquiry Service Coordinator to provide day-to-day support and backup.

In April 2009, an Administrative Assistant was added to the Enquiry Service to ensure administrative tasks, such as acknowledgement letters, are completed within service standards.

The trial of these new positions will continue in 2009-10. With the increasing volume of new written complaints, telephone contacts and consultations with registration boards, it is expected that these positions will be required on an ongoing basis. The aim of increasing resources to the HCSCC Enquiry Service is to ensure a high level of service in response to

new matters or enquiries and to improve accessibility and guidance to service providers seeking assistance to resolve complaints. While these aims have been achieved, HCSCC regularly reviews the Enquiry Service to identify areas for improvement within available resources.

4.3 A day in the life of an Information and Assessment Officer

The role of an Information and Assessment Officer is intriguing, interesting and rewarding. We are often the first contact when a person phones HCSCC with a complaint.

Today I was to meet a complainant who has special needs. Boris has limited ability to speak English, his main language is Russian. We use an interpreting service to arrange for an interpreter to attend our office to assist people like Boris to make a complaint. An interpreter, Nataliya, arrived at our office to translate for Boris. It was clear from the beginning that Boris's complaint involved poor treatment he had received during a visit to the dentist. Through the interpreter I was able to tell Boris more about HCSCC's role. I was able to tell him that when a complaint involved a registered service provider, HCSCC could consult with the relevant registration board. I explained to Boris that HCSCC could consult with the Dental Board of South Australia (DBSA) to see if they should investigate his complaint further. Boris looked relieved. He was able to ask me questions about his complaint. I could tell that he was grateful that the interpreter was there to help him. I also let Boris know that if DBSA looked into his complaint further that we would let DBSA know that he required the assistance of an interpreter. With Boris's questions answered, I explained to him that a letter, translated into Russian, would be sent to him explaining what HCSCC would do next. By now the morning had disappeared. Translating takes time but it is very rewarding knowing you are able to assist someone for whom English is a second language. It feels like some barriers have been broken down.

The staff phone roster ensures that the Enquiry Service is always staffed by at least two people. It's now my shift to phone some people who have left a message on the Enquiry Service voicemail. The first caller is anxious because she has just found a cockroach in her meat pie. After calming her down I explained to her that HCSCC does not deal with complaints about food. I advised her that she could contact the Environmental Health Officer at the local council in the area she bought the pie. She was relieved to know that she was being referred to someone who could assist her. I was tempted to ask where she bought the pie!

My next call was with a woman who had undergone eye surgery. The surgery hadn't gone as she had expected and she was now facing blindness in one eye. She had spoken to the specialist about her concerns but she felt the specialist had 'fobbed her off' and that he hadn't taken her complaint seriously. I took down the history of her complaint and sent her our complaint form to complete. I explained HCSCC's next steps and asked her to complete the complaint form with as much detail as she could so that we could assess her complaint in detail.

My Enquiry Service shift continued until 4 pm. During this time, I made many calls, all of which were very different. While some are within HCSCC jurisdiction, many need to be referred to the correct agency.

Once my Enquiry Service shift is finished, I phone a service provider to follow up about issues concerning a complaint made by a prisoner. I am then able to contact the prisoner to provide information about what is happening with their complaint. The rest of the day is spent recording information in the complaints database. It's been a busy but rewarding day.

4.4 Direct Resolution

HCSCC encourages people to resolve their complaint directly with the service provider as required under section 29(5) of the Act. Callers to the HCSCC Enquiry Service receive information and advice about how they may be able to resolve their complaint. The HCSCC brochure '*A guide for consumers'* and information on the HCSCC website, also provide step by step guidance about how to make a complaint directly to the service provider. Further assistance is provided to people who need help to resolve their complaint. For example, if it would be unreasonable to expect the person to approach the service provider, when a person has tried to resolve a complaint directly but this has not worked, or if a complaint is serious enough to warrant HCSCC attention in the public interest.

Special Needs

If a person has special needs, HCSCC provides individually tailored assistance to ensure that their complaint is lodged directly with the service provider, or with HCSCC.

A common example is that HCSCC does not require a complaint to be provided in writing if a person has impaired literacy. HCSCC would obtain details of the complaint verbally and with the person's permission, lodge the complaint on their behalf.

How people respond to HCSCC encouragement to try direct resolution

"I didn't have much time when I spoke to them (the provider) to tell them I was unhappy and I don't think they realised how serious this is for me. I will book a longer appointment next time so I will be able to talk about the problem."

"I thought I would need to ring HCSCC first but it makes sense to see if the provider can sort this out."

"I think I would find it stressful to deal with this face-to-face but I am happy to put it in writing."

What people say after their attempt to raise their complaint directly has failed

"I wanted to meet the people directly involved in my father's care but I was only offered a meeting with a senior person."

"I wrote to them (the provider) three months ago and I haven't heard anything at all."

"I know I got a lengthy written response from the agency but I still disagree with the outcome."

Facilitated Direct Resolution

Most large government services, including public hospitals, the SA Dental Service and Families SA, have a dedicated complaints handler. HCSCC regularly refers people directly to these complaints handlers to facilitate a complaint being lodged and followed up by the service directly. HCSCC has generally found these complaints handlers to be committed and skilled in dealing with complaints.

Facilitated Direct Resolution - Helena and Dave

Helena rang HCSCC to complain about a non-government community service provider. Helena's partner, Dave, an aboriginal man, is a member of the stolen generations. Their only income is Centrelink benefits. The community service provider had been providing home help to support Dave due to his numerous physical and mental health problems. Dave had been receiving gardening and cleaning help and taxi vouchers to get him to appointments.

Helena complained that the case manager had been patronising towards them, offering unwanted advice about budgeting and not listening to what they said. There had also been a misunderstanding with the cleaner and the cleaner had left. The service had not arranged another cleaner.

Helena herself has health difficulties. The loss of the cleaner meant this work fell to Helena, who was already struggling to cope looking after Dave and their two children. Helena had written a letter to the service on Dave's behalf but was unhappy with the answer. She felt that their complaint had been dismissed in favour of the case manager's version of events and that no-one had listened to them. Helena said that she would be willing to attend a meeting with the service to talk about the issues.

HCSCC contacted the service and explained HCSCC's role. The manager was new to the job and was not aware of Helena's complaint. He said that the case manager was a valued and trusted employee but he would sit down with Helena and Dave, listen to what they had to say and try to work towards a solution. Helena and Dave were advised they could return to HCSCC if this didn't fix the problem.

Facilitated Direct Resolution - Shirley and Gerald

Shirley and Gerald are elderly pensioners. Gerald is deaf in one ear and has trouble hearing with the other. Shirley called on Gerald's behalf because he can't hear to use the telephone. He had his hearing tested by the hearing service and the service said they would send his new hearing aids to him as soon as they were ready. Shirley said Gerald had been waiting for weeks for his hearing aids to arrive. Shirley had called the service to find out where Gerald's aids were. The person who answered the telephone told her the service had moved and changed their name. Shirley called HCSCC because she and Gerald didn't know what to do and Gerald really needed his new hearing aids.

HCSCC told Shirley that they would contact the hearing service and get them to call her about Gerald's hearing aids. HCSCC found the new number and called the hearing service. They said they were having problems contacting everyone about their new number and that Gerald's hearing aids were ready. They agreed to call Shirley and let her know.

HCSCC contacted Shirley the next day to find out if the hearing service had been in touch and explained about the delay in contacting her. Shirley said they had and that they had apologised to her. They had given her the new number for the service and said the hearing aids would be posted to Gerald straight away. Shirley said that Gerald was very pleased to find out that he would soon be able to hear.

Shirley then said that Gerald had another complaint that he wanted to talk to HCSCC about. It was a complaint about his doctor. Shirley said Gerald had asked her to mention it as he thought HCSCC might be able to help because they had helped him sort out the other complaint so quickly.

4.5 Complaints Accepted by HCSCC

If an attempt at direct resolution with a service provider has been unsuccessful, or it is not reasonable to expect a person to try direct resolution with a service provider, for example, where the person has special needs, HCSCC will accept a complaint. To assess what action should be taken, HCSCC gathers information about a complaint by making preliminary inquiries under section 30 of the Act. Where possible, HCSCC attempts to resolve a complaint by informal mediation under section 30 (7)-(13) of the Act.

Informal Mediation - Helen and Mia

Helen called HCSCC to make a complaint for her daughter, Mia, who was 19. Helen said that Mia was unhappy with the way the hospital emergency department (ED) nurses had treated her. Helen said Mia had been taken to ED late on a Saturday night after she had a seizure while out with friends. Mia suffers from non-epileptic seizures. Her seizures are unusual, last for an average of 12 minutes and have a long recovery. While recovering, Mia is like a rag doll and unable to speak clearly. Mia wears a medic alert bracelet so people can find out how to help her when she has a seizure. Her medic alert was ignored and the listed procedure was not followed by the hospital.

HCSCC contacted Mia and asked her if she agreed with Helen about her complaint. Mia said she wanted to complain that the ED nurses had cut her clothes away and didn't believe her when she told them that she couldn't do the simple tasks they asked her to do. Mia said they scolded her and treated her like she was not a real emergency. When Mia was ready to go home, no-one helped her to find clothes, or transport. Security services would not return her belongings to her because she could not sign for them.

Helen and Mia had told the hospital complaints service about their concerns but the hospital had said they had done nothing wrong. HCSCC asked Mia and the hospital if they wanted to try informal mediation to work out a way to fix Mia's complaint. An informal mediation meeting gives people a chance to sit down together and explain to each other what happened and why. Mia and the ED Director agreed to try informal mediation. Mia asked Helen to come along for support.

During informal mediation, Mia got a chance to tell the director how she had felt when she was in ED. She explained that the nurses made her feel like she had been naughty and not sick enough to be an emergency. Mia explained that she had left ED feeling so humiliated that she never wanted to go back there, even if she had an emergency.

The director explained to Mia why they needed to cut her clothes away and the reasons that in an emergency, nurses can seem busy and uncaring. The director apologised to Mia and told her they wanted her to feel like she could use their services in the future. Mia asked if she could have the apology in writing and the director agreed to send her a letter of apology.

Together they identified things which could be improved, such as the security policy for returning a person's belongings and customer service skills for busy nurses working in ED. Everyone agreed that although Mia's clothes were cut for a good reason, she should make a claim to the hospital for her ruined clothes.

HCSCC agreed to monitor the changes that the hospital had agreed to make. HCSCC wrote to the hospital and requested that they report to HCSCC on the changes made in ED and to the security services as a result of Mia's complaint. Mia, Helen and the director agreed that informal mediation had been easier then they thought it would be. They thanked HCSCC for giving them the opportunity to use informal mediation to successfully resolve Mia's complaint. They were also pleased that they had helped improve ED services.

Child Protection Complaints

Complaints about child protection remain a low proportion of the complaints received by HCSCC. Many people contact HCSCC to discuss issues that HCSCC cannot deal with, such as personal family matters, or decisions by the Youth, or Family Courts. HCSCC encourages people to discuss such issues with a lawyer and/or a support service.

The majority of complaints received by HCSCC about child protection services are about children who are in the care of the Minister. Wherever possible, HCSCC refers these complaints to the senior supervisor responsible for the child's care, or to the Families SA customer service officer.

If a complaint cannot be resolved this way, HCSCC accepts the complaint. A major part of HCSCC work on these complaints is to ensure:

- that there is accurate information available to the complainant to understand their rights and responsibilities
- that there is a clear communication plan between the complainant and the agency responsible for the children.

Child Protection Services - Carole and Bob

Carole and Bob have cared for Thomas, their 11 year old intellectually disabled grandson since he was 12 months old. Thomas's two younger sisters were cared for by a foster family. Carole contacted HCSCC complaining that her visits with her grand-daughters had been stopped and their visits with Thomas had been reduced to an hour every three weeks.

Carole felt that this decision was a result of her complaint about the foster family's religious indoctrination of her grand-daughters. Carole and Bob felt that the foster family's religious beliefs were making their grand-daughters fearful of them. Carole said this had impacted on her family's relationship with the foster family. Carole asked for her grand-daughters to be placed in her care permanently.

Carole told HCSCC that the attempts to resolve her concerns directly with the case worker had not worked. Carole claimed that the case worker was openly hostile towards her and appeared to be biased towards the foster family. She complained to the Supervisor and requested a different case worker. This request was ignored.

HCSCC wrote to the agency about Carole and Bob's allegations. The agency explained that the decision to stop visits was due to extremely negative behaviours by the girls before their visits to their grandparents. It was decided to work out the reasons behind the girls' distress before starting visits again. The agency stated that they were aware of the foster family's religious convictions but did not see this as harmful to the girls' emotional well being. The agency also considered that it was not in the best interest of the girls to be placed in their grandparents care as they had been with the foster family since they were both toddlers.

Soon after the agency's response, Carole contacted HCSCC to explain that the agency had undertaken further investigations into her complaint. Carole told HCSCC that her grand-daughters had now been placed in her care following their removal from the foster family. Carole was satisfied with HCSCC action in assisting her to communicate her concerns to the agency and to have the girls returned to her care.

Child Protection Services - Penny

Penny has five children aged between two and 10 years old. Unfortunately, due to a number of serious issues, Penny is unable to care safely for her children. The oldest child, Emma, was removed from Penny's care after very serious injuries as a baby. The risk was so high that Penny's other children were all removed from her care at birth. The five children are under a Youth Court Guardianship order until they are 18 years old and Families SA is their legal guardian. The children all live with the same foster family.

Over the years Penny has had regular supervised contact with her children. While the children were very young, they had generally accepted these visits. However, as the children have grown, they have become reluctant to see their mother. Some of the reasons include Penny's very poor personal hygiene and comments she makes which upset them. Emma, who had serious injuries as a baby, was angry with her mother and was very clear that she did not want the visits.

After significant efforts by the agency to help Penny to address her issues and improve the quality of her contact with her children, it was clear that the visits were harmful to the children and could not continue. The agency obtained psychological assessments of the children which confirmed this. The agency told Penny that visits would be stopped but could recur if the children requested it. Penny complained to HCSCC that visits with her children had been stopped.

HCSCC started a preliminary inquiry into Penny's complaint. HCSCC examined the children's court orders and case plans. The four younger children had court orders that allowed the agency, with good reason, to stop visits. In HCSCC's assessment it was reasonable that the agency had stopped the visits based on the children's wishes and the psychological reports. Emma had a different court order which stated visits should continue, with no mention of her wishes. This court order was made when she was very young and the agency had already applied to change the order, as she had clearly expressed her wish not to see her mother.

Although Emma's current court order said that the agency should continue visits, HCSCC did not recommend this as the psychological reports confirmed that the visits were damaging for Emma. HCSCC explained to Penny that the agency were meeting the generally expected standard by acting in Emma's best interests.

This is a very sad situation for everyone. HCSCC acknowledged to Penny that it is very distressing for her not to be able to see her children. HCSCC encouraged Penny to send her children cards and letters as they may wish to see her in future.

A Day in the Life of a Complaint Resolution Officer

The thing I enjoy most about my job is talking to people and helping to find a resolution to their complaints. Although some things can't be put right, other things can sometimes help, such as compassionately providing accurate information about what happened. Most people are comforted to find out what will be done to prevent the same thing happening to someone else.

My first meeting was with Peter and a doctor and senior nurse from a public hospital. Peter had gone into hospital for a routine test. It was expected that he would have the test and leave hospital the same day. While Peter was lying down to have the test, his lower leg got caught underneath the table. Unfortunately, Peter's leg muscle was torn and he needed to remain in hospital for surgery. Although Peter recovered, he was concerned about how this could have happened and felt that medical staff were reluctant to talk to him about the accident while he was at the hospital.

I explained to everyone at the meeting about HCSCC and let them know that the meeting was to help Peter to have his complaint heard and addressed. Peter started the meeting by saying that he was a keen amateur sportsman and this unexpected injury meant he was unable to participate in his favourite sport, golf, for quite some time.

The doctor and the nurse did a good job of explaining to Peter what went wrong and were very sincere and kind when speaking to him. They agreed to look further at the complaint and we will all meet again in a few weeks. Peter told me afterwards that he was happy that the staff took his complaint seriously.

After the meeting, I went to an SA Health training session. The session by Dr John Wakefield, Senior Director Patient Safety Centre, Queensland Health, was about open disclosure. This is a really important topic because open disclosure is about health staff explaining to patients when things go wrong and putting them right.

I spent the afternoon writing letters and telephoning people I needed to catch up with about their complaints. One of the calls I made was to Janine. Janine lives with multiple sclerosis (MS) and has a hearing impairment. She lives in a small unit in an outer metropolitan area. Unfortunately all of Janine's family are interstate. Janine finds it difficult to do many of the daily tasks most people take for granted. She relies on support workers coming to her home to help out. Janine's complaint is that although her MS has got worse in the last few years, she has not received any additional support. I needed to tell Janine the progress I had made on her complaint and I organised a TTY phone call to do so. TTY is a telephone with a keyboard that has a small display screen for text and Janine has one in her home. HCSCC doesn't have a TTY machine, so we use the National Relay Service. This great service is easy to use, as a person at the National Relay Service listens to what I say and types it up so that Janine can read it on her TTY machine. HCSCC will always organise things like TTY, or interpreters, if people need them. Janine seemed a little down when I rang but said a friend was coming to visit her later. I reassured Janine that her complaint was being taken very seriously and that I would call her again in a few weeks.

Every day at HCSCC is different. What doesn't change is our priority, which is to improve the quality and safety of health and community services.

HCSCC - Registration Authorities

Constructive HCSCC relationships with the 10 SA health professional registration authorities (the boards) under Part 7 of the Act are maintained through regular telephone consultation and meetings.

In late 2008, HCSCC adopted the practice of automatic consultation with the boards. On receiving a complaint about a registered service provider, HCSCC consults the relevant board to determine the most appropriate body to manage the complaint. Combined with regular reports from the boards, this ensures appropriate information sharing between HCSCC and the boards.

Section 77 of the Act requires the boards to report to HCSCC about their complaints and action taken in response to them. The Nursing and Medical Boards of South Australia provide monthly reports to HCSCC about the complaints they receive, the status of their investigations and the investigation outcomes. All other boards provide quarterly reports. In 2009-10 the *Health Practitioner Regulation National Law 2009* is likely to impact the Part 7 statutory relationship with the boards and the section 77 reports.

HCSCC Registration Boards - Diane

The complainant, Diane, was a cosmetic physician. She was the Executive Officer of a representative body in the field of cosmetic procedures. She complained that a cosmetic clinic was using untrained and unqualified staff to carry out cosmetic procedures. She stated that industry standards require a clinic to employ doctors as consultants and alleged that this clinic did not meet this requirement. She claimed that instead, a clinic nurse consulted a cosmetic physician who was based interstate.

HCSCC consulted the Medical and Nurses Boards about the complaint. The Nurses Board (NBSA) advised that Diane had already made the same complaint to them. They had begun investigating it. The Medical Board (MBSA) accepted the complaint from HCSCC for investigation.

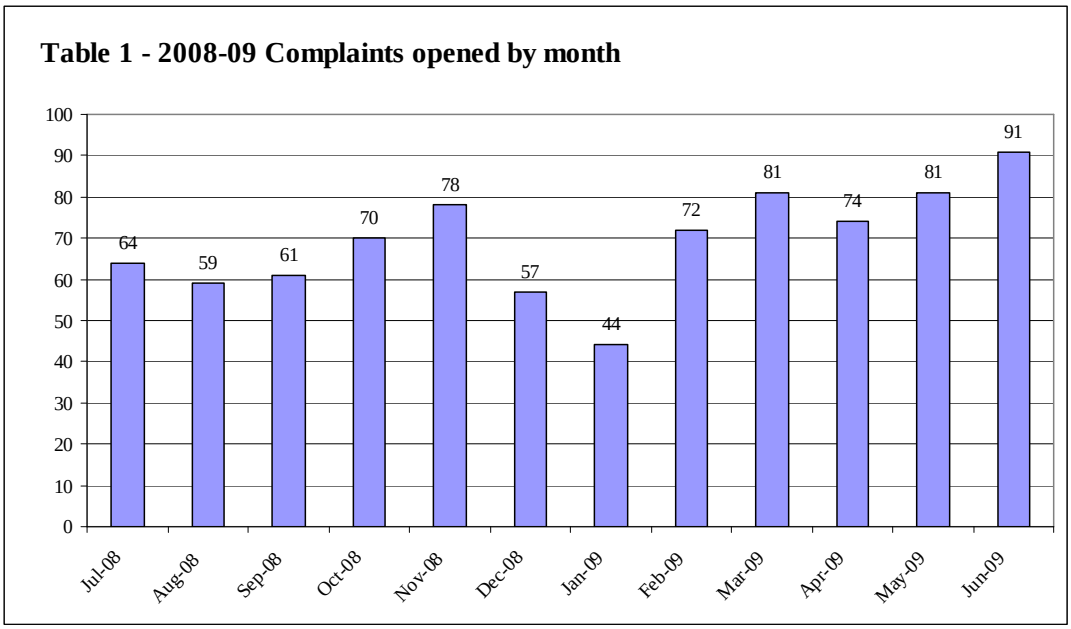
The NBSA investigation found no unprofessional conduct on the part of the nurse employed by the clinic. The MBSA advised HCSCC that while they did not find any evidence of unprofessional conduct by the doctor, they had counselled the doctor about compliance with industry regulations. The MBSA and HCSCC also made recommendations to the government about national regulation of cosmetic procedures.

Information and Reporting Project

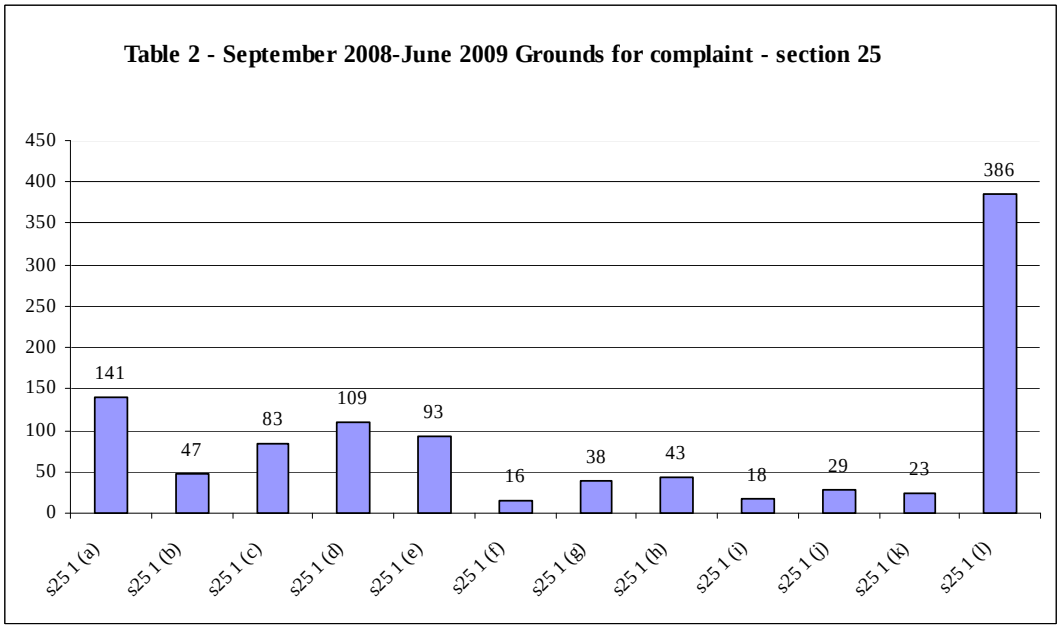
Since 2007 HCSCC has progressively upgraded the complaints management IT system, ProActive, to improve complaints management and reporting. The tables set out below are the outcome of this work. Despite extensive HCSCC financial and staff investment to upgrade ProActive, the data generated is neither reliable, nor adequate for internal complaints management and external reporting. The majority of statutory complaints agencies in Australia, including most health complaints agencies, use a complaints management IT system called Resolve. HCSCC will consider the feasibility of replacing ProActive with Resolve in 2009-10.

New Complaints

Of 832 new complaints received, 214 were referred to the service provider to attempt direct resolution with the complainant.



Average new complaints a month: 70



Note: a single complaint may raise more than one ground:

s25 1 (a)	service not provided
s25 1 (b)	service not necessary or inappropriate
s25 1 (c)	unreasonable manner in providing service
s25 1 (d)	lacked due skill
s25 1 (e)	unprofessional manner
s25 1 (f)	failure to respect privacy or dignity of service user

s25 1 (g)	quality of information
s25 1 (h)	access to records denied or information from records not provided
s25 1 (i)	unreasonable disclosure of information
s25 1 (j)	action on complaint not taken by provider
s25 1 (k)	acted in a manner inconsistent with the Charter
s25 1 (l)	didn't meet expected standard of service delivery.

Due to HCSCC database reporting deficiencies the breakdown of issues raised in new complaints by type of service is only available for January to June 2009. A single complaint may raise more than one issue.

Table 3 - January-June 2009
Issues complained about - Health

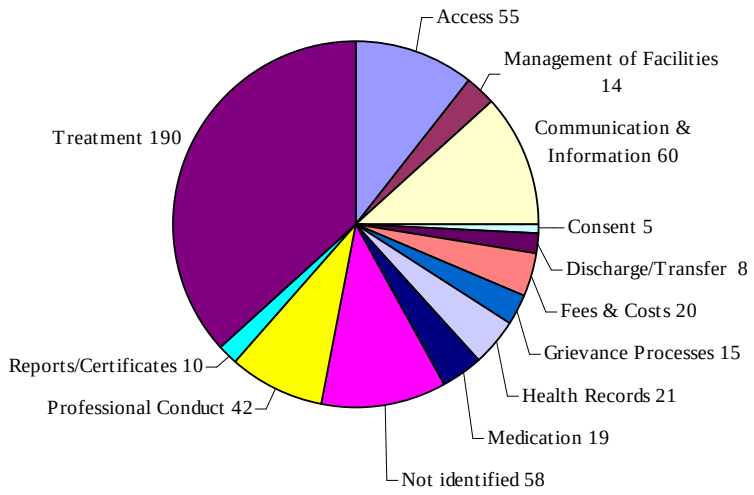


Table 4 - January-June 2009
Issues complained about - Community Services

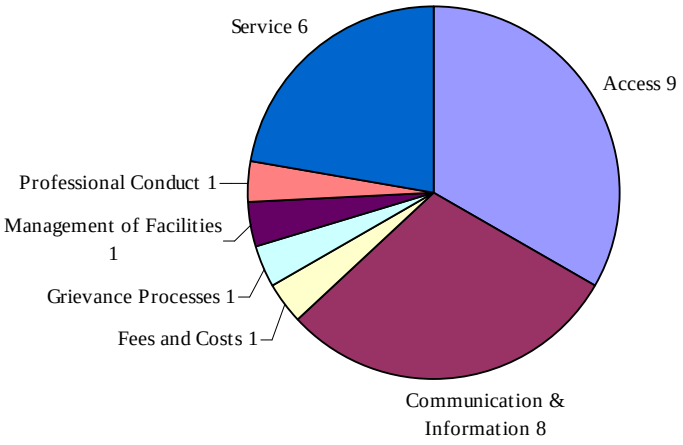


Table 5 - January-June 2009
Issues complained about - Child Protection

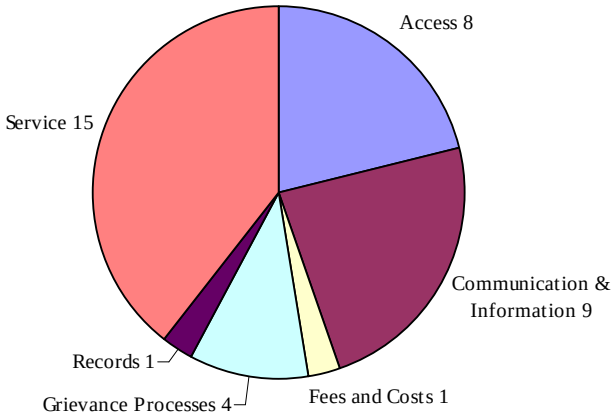


Table 6 - September 2008-June 2009
Mode of contact with HCSCC

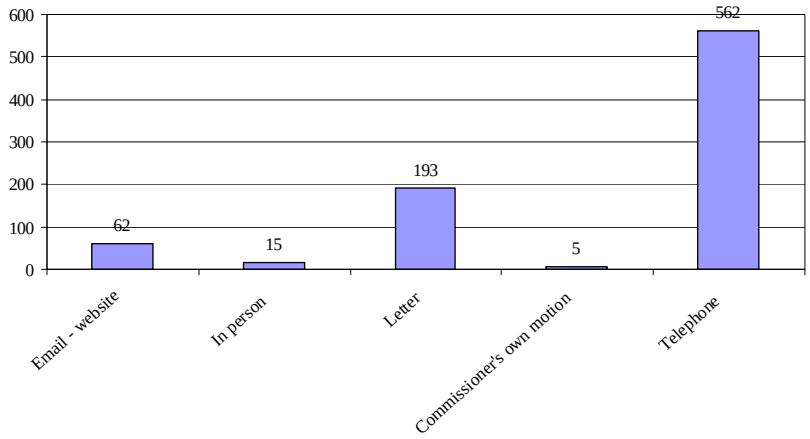


Table 7 - September 2008-June 2009
Location of service provider

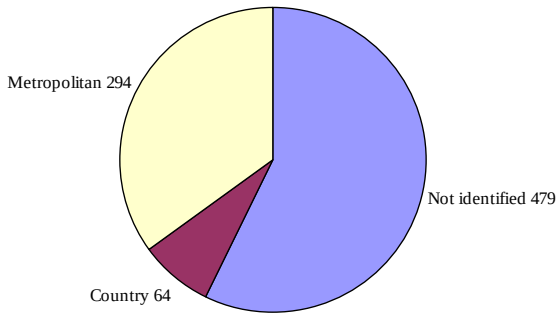


Table 8 - September 2008-June 2009
Residential location of person contacting HCSCC

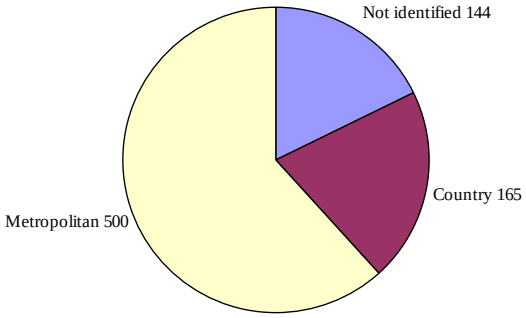


Table 9 - September 2008-June 2009
Role of contact person

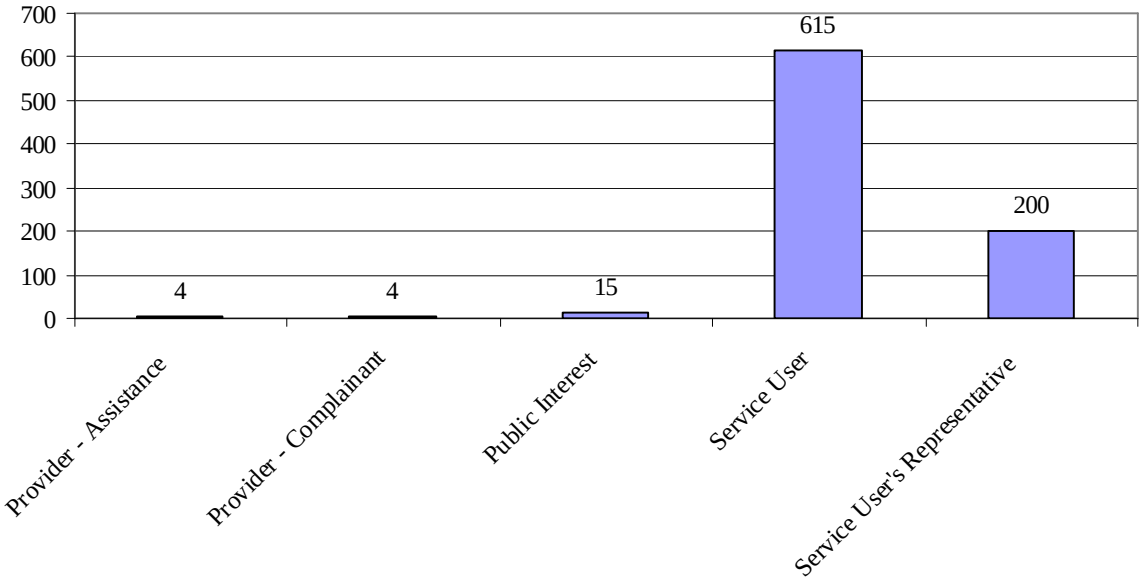


Table 10 - September 2008-June 2009
Gender of contact person

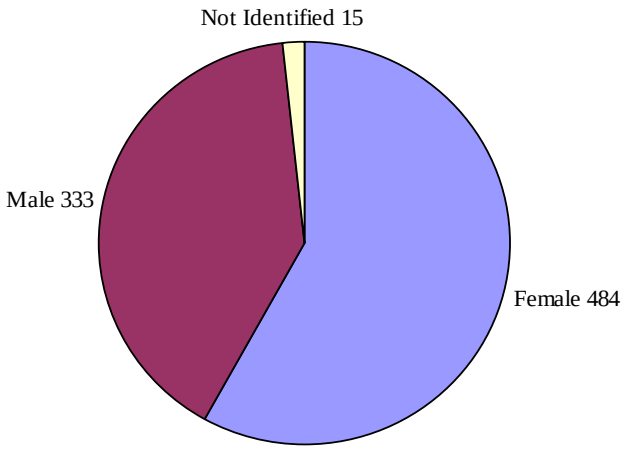


Table 11 - September 2008-June 2009
Contact from people with special needs

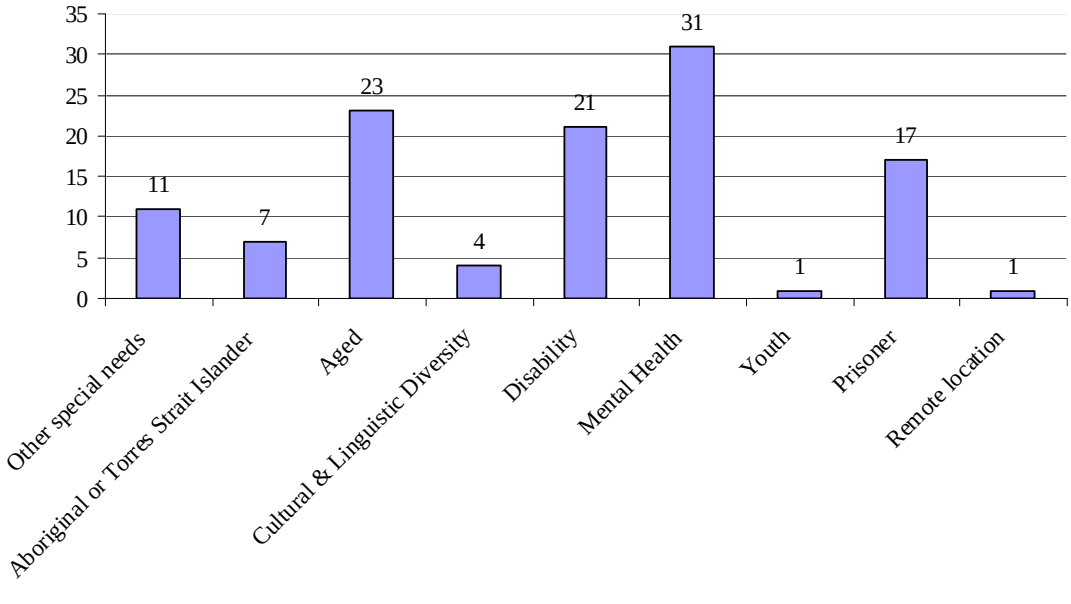
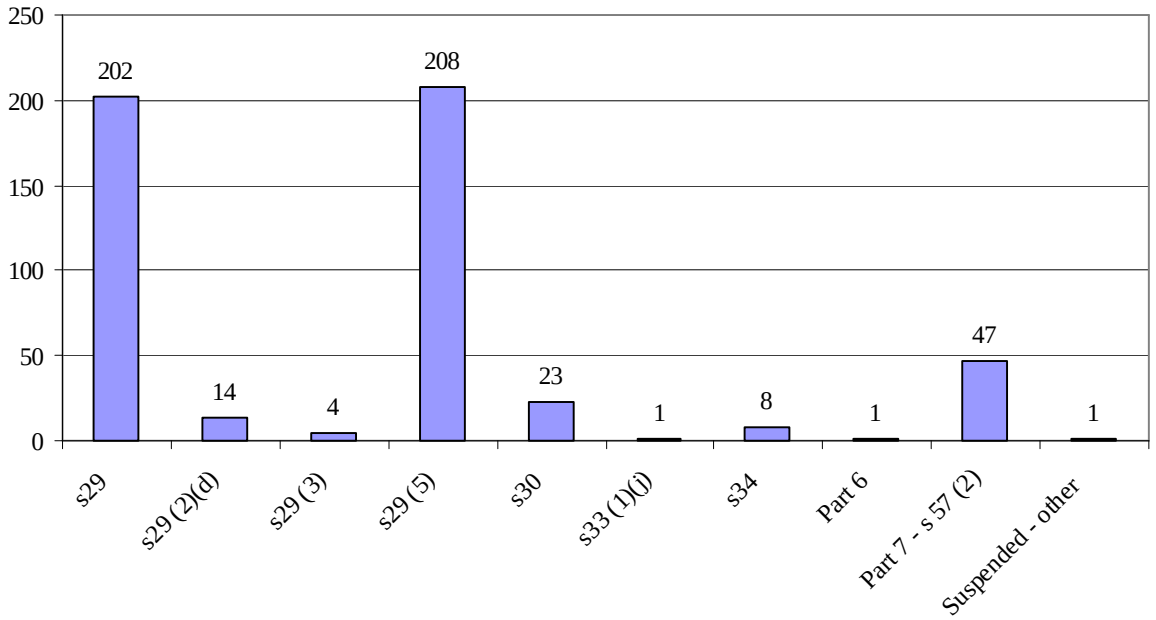
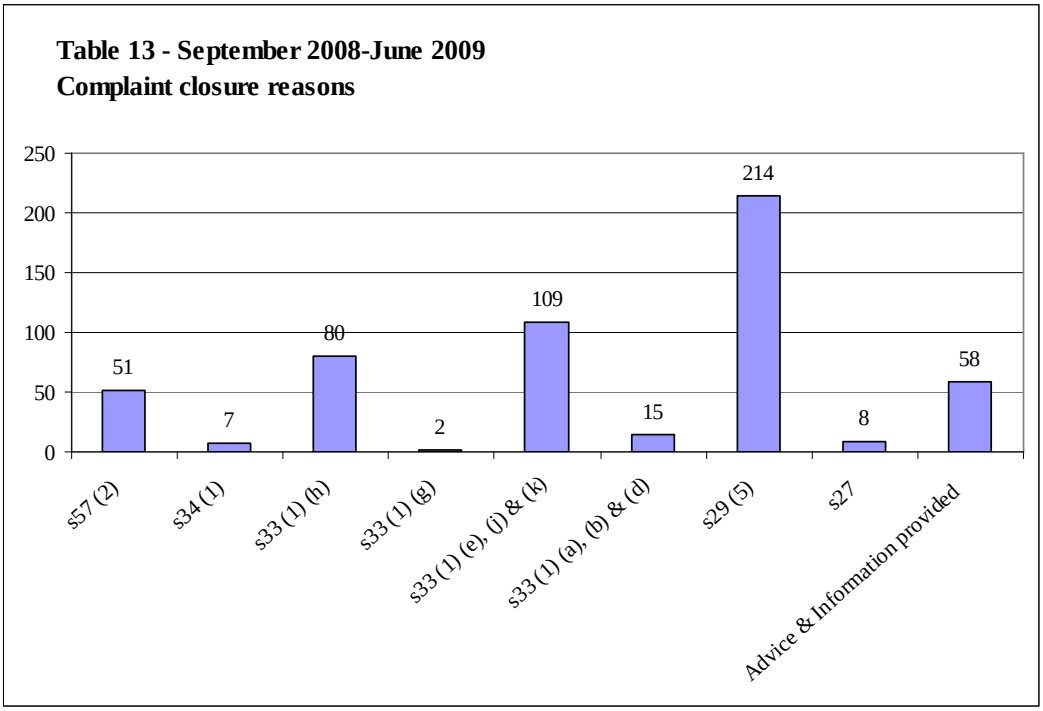


Table 12 - September 2008-June 2009
Main HCSCC action on a complaint



s29	Assessment information provided about HCSCC processes
s29 (2)(d)	Referral to another body
s29 (3)	Referral to Aged Care Complaints Investigation Scheme
s29 (5)	Complainant attempting direct resolution with service
s30	HCSCC conducts preliminary inquiries with the aim to resolve the complaint, to identify issues for investigation, to refer to conciliation, or to identify other actions
s33 (1)(j)	No further action taken as complaint resolved, or abandoned
s34	Withdrawal of complaint
Part 6	Investigations
Part 7 s57(2)	Referral to/from registration authorities.

Table 13 - September 2008-June 2009
Complaint closure reasons



Total finalised complaints: 544.

s57 (2)	referral to/from registration authorities
s34 (1)	withdrawn by complainant
s33 (1)(h)	complainant failed to comply with requirement of Act
s33 (1)(g)	lacks substance
s33 (1)(e)-(t)	reasonable explanation provided
s33 (1)(j)	resolved or abandoned
s33 (1)(k)	reasonable cause
s33 (1)(a)-(d)	not entitled to make a complaint
s33 (1)(b)	doesn't disclose grounds for complaint
s33(1)(c)	determine by legal proceedings
s33 (1)(d)	proceedings have commenced by other eg tribunal
s29 (5)	facilitated direct resolution
s27	outside two year time limit.

HCSCC complaint handling performance standards include:

- 80% closed within 26 weeks
- 95% closed within one year
- no files open more than two years
- <1% of complaints reviewed by the SA Ombudsman.

Of all new complaints received in 2008-09:

- 69% were closed within 21 days
- 26% were closed within 22-44 days
- 4% were open more than 45 days
- 8 systemic files have been open more than two years
- 11 (<1%) of complaints were reviewed by the SA Ombudsman.

Health Services and Complaints Handling - Katie and Gina

Katie is a young woman living with disability. She lives at home with her mum, Gina, with help from support workers. She takes a few medications, including for epilepsy. Gina and the support workers help with this because Katie's disability means she can't take it by herself.

Katie was admitted to hospital. The staff found out what medication Katie needed so they could make sure she still got the medication while she was in hospital. After a few days, Katie's support worker told Gina that Katie did not seem herself. When Gina looked into it, it became clear that Katie was not being given her epilepsy medication. The hospital pharmacy had not provided the epilepsy medication because they didn't have it in stock but they had not told the treating staff, Katie or Gina. Once Gina told the staff they arranged to get the epilepsy medication into the pharmacy.

Gina was also unhappy that the hospital staff had ignored what she had to say about Katie's care. She didn't think she was respected for her experience and knowledge of Katie's needs.

Gina complained to HCSCC about the medication error and about her treatment as a carer. She wanted the hospital to change the way it did things. After contact from HCSCC, the hospital staff met Gina to hear what she had to say. They then sent a letter of apology for the medication error and for their poor communication with her. The hospital changed its practices to make sure the same thing wouldn't happen to others.

As a result of this complaint:

- pharmacy staff now work on the wards for part of the day to make sure each patient's medication is right
- the hospital changed its policy about medications not held in stock
- training has been provided for nursing staff
- Katie and Gina's experience has been discussed at staff meetings so staff can learn from it.

Katie and Gina are happy with the hospital's response and feel that they could use the hospital again if needed.

Disability Services - Carer Recognition, Care Planning and Complaints Handling - Amanda and Nicky

Amanda found out about HCSCC at an outreach presentation. Amanda complained on behalf of her adult daughter, Nicky. Amanda has legal authority to act on Nicky's behalf, due to Nicky's disabilities. Nicky lives in a group home, a supported accommodation facility, in the same country town as Amanda.

Amanda's complaint was about two things:

1. services for Nicky:
    - staff in the group home did not follow Nicky's care plan. As a result, Nicky severely injured herself while involved in a group activity and did not get appropriate medical care for her injuries
    - staff did not recognise Amanda's legal right to accompany Nicky to medical appointments
    - when Amanda insisted, staff limited the flow of information to Nicky's GP and Amanda felt bullied by this.
2. complaints process:
    - when Amanda complained about these issues, it took several months and repeated requests from her, before she received a response
    - when Amanda finally received a response it did not address her concerns.

In HCSCC's assessment, the service did not meet the generally accepted standards for carer recognition and involvement, Nicky's care and complaints handling. The initial response by the service to HCSCC was poor and did not address the issues in the complaint. Local staff were defensive and took excessive time to respond. The complaint was only resolved after HCSCC met senior management. This included providing them with information to illustrate how poorly the local service had responded to Amanda's complaints.

After HCSCC involvement, the main outcomes were that the service:

1. apologised that Nicky's care plan had not been properly implemented and for the delayed response to Amanda's complaint;
2. took steps to prevent a recurrence for Amanda and Nicky and others dependent on their services.

Prison Health Service - Martin

Martin called HCSCC from prison because he was not assessed for methadone treatment under the Prison Opioid Substitution Programme. Martin said he did not have an opioid addiction when he entered prison but had developed an addiction in the last year through illicit use of buprenorphine in prison. Martin said HCSCC could discuss his complaint with Prison Health Services.

Prison Health Services told HCSCC that their assessment when Martin entered prison was that Martin had been an amphetamine user. After HCSCC discussed this with Martin he agreed to let Prison Health Services know that he had been using buprenorphine for a year and wanted to be reassessed for methadone treatment.

Prison Health Services agreed to reassess Martin. They told HCSCC that if Martin tested positive he could be put on the programme based on their harm minimisation approach. HCSCC told Martin that he would be reassessed and asked him to contact HCSCC if he needed to discuss anything after his reassessment. Martin has not contacted HCSCC again.

Private Hospital Overcharging - Kent

Kent needed a gall bladder operation. He did not have private health insurance but chose to have the operation done in a private hospital with a surgeon of his choice, having agreed to pay the full cost of the surgery.

The surgery was successful and Kent made a swift recovery. However, when he received the bill, there were a number of items listed that he was not aware would be used during his surgery. When Kent spoke to the surgeon, the surgeon confirmed that he did not use some of the items for which Kent had been billed. The surgeon and Kent approached the private hospital asking for the bill to be changed so that Kent would only have to pay for items used during the surgery.

The staff in the accounts department stated that all of the items listed on the bill had been used during surgery and Kent would have to pay the bill in full. Kent negotiated a payment plan and began to pay his bill but was concerned that he may be overpaying and called HCSCC.

HCSCC asked the surgeon to put in writing that he did not use a number of the items listed on Kent's bill. The surgeon agreed to do this. HCSCC sent this information to the hospital Chief Executive. Within 24 hours of receiving HCSCC's letter, a senior hospital staff member contacted Kent, confirmed that he had been overcharged and said that his bill would be corrected. Kent was very happy with this outcome but questioned why he had not been able to achieve it without HCSCC.

HCSCC was concerned that the private hospital staff did not properly investigate his complaint initially and also did not refer Kent to HCSCC when he was unhappy with their response.

While the private hospital had a good complaints policy, the staff did not follow it. HCSCC requested that staff be reminded about following the complaints policy, including the option of referral to HCSCC. HCSCC also encouraged the hospital to train staff across the hospital about complaints handling. The hospital agreed to do this.

Conciliation

There were no conciliations completed under Part 5 of the Act during 2008-09. Conciliation and informal mediation under section 30 provide the opportunity for a complainant to discuss their concerns directly with a service provider. Both also often conclude with the complainant and the service provider reaching a confidential agreement about how the complaint can be resolved. The outcomes of both usually include how services can be improved and steps to be taken to prevent a similar complaint happening again. Resolution through informal mediation is quicker and less formal than conciliation.

HCSCC has offered to conciliate several complaints where a complainant seeks financial compensation as a result of preventable harm. The outcome of these complaints will be reported in 2009-10. The *Payment of Financial Compensation arising from Complaints in the Public Health System in South Australia* policy which HCSCC developed with SA Health in 2008 will be reviewed in 2010.

Investigations

Thirteen investigations were underway during 2008-09. Nine of these investigations were started during the year in response to an increased number of complaints that raised a significant public interest issue or a significant question about the practice of a service provider. An investigation under Part 6 of the Act has the potential to result in HCSCC recommendations to reduce the recurrence of any preventable harm identified. HCSCC monitors service provider action on undertakings given and HCSCC recommendations arising from an investigation.

Under the current Act, HCSCC has no powers in the event of unreasonable non-compliance by a service provider. HCSCC identified this shortcoming in the s88 review submission. HCSCC proposed that the Act be amended to give HCSCC comparable powers to other Australian statutory health complaints bodies to name a service provider in the unlikely event of unreasonable non compliance. The government has agreed to amend the Act in 2009-10.

Progress with HCSCC investigations this year included:

1. completing the investigation into a cluster of five adult suicides and one serious attempted suicide
2. suspending the investigation into a cluster of five bowel perforations in people over 70 years of age pending the release of national report - refer bowel perforations below
3. completing a second submission to the SA Parliament Social Development Committee Inquiry into bogus, unregistered and deregistered practitioners based on the investigation of complaints about four unregistered service providers - refer page 11.
4. service provider undertakings to improve the diagnosis and treatment of community acquired pneumonia
5. service provider undertakings to promote compliance with guidelines for the prevention and management of pressure areas
6. service provider undertakings to systematise and improve community services complaints management, including disability services complaints
7. a service provider issued safety alert and other undertakings to ensure access to forensic medical services after an alleged sexual assault
8. work towards identifying the generally accepted standards for the diagnosis and treatment of physical illness in adults living with a mental illness

9. identifying systemic shortcomings in medication management for a group of people with special needs
10. service provider undertakings to revise and promote insulin management guidelines
11. identifying shortcomings in safeguards governing the interstate transfer of people detained under the *Mental Health Act 1993* and the forthcoming *Mental Health Act 2009*
12. monitoring progress with action plan implementation following three substantial service reviews
13. seeking verification of allegations made about poor standards of care for people with special needs in hospital settings.

Investigation into five suicides and one serious attempted suicide

Death by suicide among non indigenous people has been falling since 1997. [2] While this reduction is welcome, there is a risk that people will see further falls in suicide deaths as unlikely or impossible. Every suicide death is a tragedy, for the individual whose pain was unbearable and for their loved ones left with the burden of loss, grief and unanswered questions.

For health care workers a suicide death is a loss too and one that imposes the duty to learn lessons that could prevent the likelihood of recurrence. A commitment to learn after the tragedy of every suicide is essential, fatalism about suicide death has no place in best practice mental health services.

HCSCC received six complaints between September 2005 and February 2006 that related to the assessment and treatment of six adults at risk of suicide. Four of the six people suicided before a complaint was lodged with HCSCC, one person suicided after a complaint was lodged with HCSCC and one person received treatment after a serious attempted suicide before the complaint was lodged with HCSCC. This group of complaints includes the matter referred to HCSCC by the former Minister for Health, Lea Stevens, about the suicide of Mr D Smith in September 2005.

In March 2006 HCSCC started an investigation into these complaints as a group to determine if there were any common features or systemic shortcomings amenable to recommendations to improve the safety or quality of mental health services. The progress of this investigation has been reported in HCSCC annual reports.[3] There were excessive delays by the Commissioner in dealing with this investigation for a range of reasons.

By March 2009, the Coroner had issued findings about the cause of each of the five deaths. The Coroner did not conduct inquests into any of the five deaths.

Based on the information HCSCC obtained about each individual complaint and after a review of the six complaints as a group, HCSCC did not identify systemic shortcomings relating to the assessment and treatment of people at risk of suicide that directly contributed to the five deaths and the serious attempted suicide.

[2] 2007 ABS Suicides, Australia 2005 ABS Catalogue No. 3309.0
[3] 2005-06 pages 6, 14 and 15; 2006-07 pages 29-30; 2007-08 pages 33-35.

However, HCSCC identified four systemic shortcomings common to the six complaints.

1. poor communication and follow up with family members after suicide and serious attempted suicide, leaving families to cope with their grief, guilt and anger, compounded by unanswered questions.

2. variable standards of communication among mental health services and with other service providers

3. confusion and delays due to the overlapping jurisdiction of the Coroner and HCSCC in dealing with complaints about suicide

4. legally protected internal investigations by service providers following a suicide or serious attempted suicide (*Health and Community Services Complaints Act 2004* s82; *Health Care Act 2008* ss 66(3) and 73(3)).

HCSCC is awaiting the response of the Minister for Mental Health and Substance Abuse about improvements in response to recommendations 1 and 2. HCSCC has also requested that SA Health consider the development of a good practice guide to conducting a Root Cause Analysis investigation after a suicide death to promote rigour, consistency and to optimise learning.

HCSCC will not pursue a protocol with the Coroner to address recommendation 3. HCSCC will continue to advise the Coroner if a complaint is received about a notifiable death under the *Coroners Act 2003*.

The Minister for Health has indicated that steps to address recommendation 4 may be considered when this part of the *Health Care Act 2008* is reviewed after two years of operation and after the effects of the comparable Queensland provision on open disclosure can also be evaluated.

Bowel perforations

During 2006-07 HCSCC received five complaints about bowel perforations in people over 72 years of age. Four occurred during, or after, colonoscopy and one occurred during a barium enema. HCSCC grouped these five complaints together to identify any common or systemic features.

During this investigation HCSCC had the benefit of information and advice from Professor James St John AM, Chair of the National Bowel Cancer Screening Program (NBCSP) Quality Working Group (QWG). On the basis of his advice, it became clear that the QWG would deal rigorously and comprehensively with most, if not all, the systemic issues that arose in the HCSCC bowel perforation complaints. In HCSCC's assessment the QWG report is likely to provide a substantial contribution to improving the safety and quality of colonoscopy in Australia.

HCSCC therefore suspended this investigation in May 2008, pending the release of the NBCSP QWG report and the response to the report proposals and recommendations for improving the safety and quality of colonoscopy.

The draft NBCSP QWG report was published in June 2008. The Executive Summary states: 'Currently colonoscopy services are provided in both public and private facilities by practitioners from several specialties. The Bowel Cancer Screening Pilot Program (the Pilot)

conducted between November 2002 and June 2004 raised concerns about a range of issues on the quality of service provision. These issues included the lack of uniform national standards for facilities, inconsistency in reporting requirements for colonoscopy, lack of a national accreditation framework for colonoscopy facilities, the need to introduce a coordinated national approach to the training and maintenance of skills of colonoscopists and the institution of a system for recognition of this training.

These were the key issues that the QWG considered over the 12 months from September 2006 to September 2007. The main proposals from the QWG and suggestions for change include:

- development of a national accreditation scheme for colonoscopy services using uniform national standards
- implementation of the model developed by the QWG for national accreditation standards, with supporting objectives and performance indicators for colonoscopy services, including clinical indicators
- development of a formal process to ensure the ongoing competency of proceduralists through a nationally recognised mandatory certification and eventual re-certification system
- investigation of future training needs and delivery tools for colonoscopy training, especially the practicality and viability of establishing accelerated training programs
- adoption of agreed minimum documentation and electronic reporting systems on procedures and colonoscopy outcomes that link with the accreditation processes, training, and certification processes for proceduralists.'

HCSCC is making inquiries about the response to the draft report, in particular information about the action plan and timetable for the implementation of the report recommendations, nationally and in South Australia. After this information has been obtained, HCSCC will complete this investigation.

Forensic Medical Services after Sexual Assault - Karen

Karen, 15 years old, was on holiday with her family in a country town. While on holiday, Karen was raped by two men. Karen told her family and her parents took her to the local hospital. Although Karen was examined at the hospital, the doctor on duty did not take any samples for forensic evidence.

Karen also reported the rape to the police. In court one man pleaded guilty but the other did not. The lack of forensic evidence meant that the case against this man could not progress.

Karen's parents asked HCSCC to look into the doctor's failure to take forensic evidence when Karen went to the hospital. HCSCC consulted the Medical Board of SA (MBSA) who agreed to investigate the actions of the individual doctor. The MBSA's investigation has been difficult because the doctor no longer works in Australia.

Although the MBSA is investigating the individual doctor, HCSCC identified a serious systemic issue. Metropolitan public health services are generally very responsive to victims of sexual assault. Most victims are referred quickly to Yarrow Place, a specialist forensic sexual assault service. In country South Australia, it is often not possible for victims of sexual assault to travel to Adelaide for a forensic examination but staff can contact Yarrow Place for guidance about how to collect and preserve forensic evidence which can later be used in court.

Although the Yarrow Place consultation service is available, this complaint showed that not all country health staff knew about it. HCSCC is monitoring the implementation of clear guidelines for all country health services to ensure staff know how to respond to sexual assault victims, including ensuring forensic evidence is collected.

Insulin Management in Hospital - Rita and Bradley

Rita called HCSCC about an incident that had happened to her son Bradley, 26. Bradley has diabetes and needs to have insulin regularly. Bradley needs two types of insulin, one of them quite new. Bradley had recently been in hospital for treatment unrelated to his diabetes.

Rita told HCSCC that Bradley thought he had heard the nurses say they would mix both types of insulin and give it to him in one injection. Rita said she was sure that this was not supposed to happen, so she had contacted Diabetes Australia and asked if this was OK. Diabetes Australia said that it was not a good idea to mix different types of insulin.

Rita spoke to Bradley and the nurses looking after him and made sure that Bradley was not getting mixed insulin. Rita then called HCSCC because she was concerned that even though Bradley might be OK, other nurses might not be aware they shouldn't mix different types of insulin and other diabetics in hospital might get mixed insulin.

HCSCC contacted the hospital and asked them about their insulin management guidelines to ensure nursing staff got it right. The hospital told HCSCC that they did not have an up-to-date guideline for insulin. The hospital said the complaint had highlighted a serious risk to patient safety and acted quickly. Training was immediately organised for nurses and a senior clinician was directed to update the insulin guidelines.

Rita and Bradley were happy that their complaint had made it safer for people with diabetes at the hospital. Bradley was particularly happy that he felt safer and did not have to keep checking that the nurses had given him the right insulin.

HCSCC acknowledged that the hospital had taken the issue seriously by making changes to prevent harm to other patients. However, HCSCC wanted to make sure all public hospitals updated their insulin guidelines. HCSCC has raised this with SA Health to ensure all public health services update their insulin guidelines.

HCSCC monitoring service provider responses to HCSCC recommendations and/or issues identified by the service provider as requiring improvement arising from a complaint

From 1 July 2008 HCSCC established a register to monitor service provider undertakings in response to complaints and/or HCSCC recommendations. HCSCC made 16 recommendations to 12 different service providers. Some of the recommendations made by HCSCC related to the service provider:

- not acting reasonably in providing services which met the generally accepted standard
- not meeting reasonable documentation standards
- failing to comply with requirements
- having inadequate policies and procedures
- having unacceptable delays in providing stocked medication
- breaching privacy, confidentiality, dignity and respect
- not providing adequate guidelines and adequate training.

HCSCC required each service provider to provide regular progress and final reports about the implementation of HCSCC recommendations, or improvement actions identified by the service provider, as a result of a complaint.

HCSCC was satisfied that each of the service providers is taking reasonable and timely action on the recommendations.

4.6 Service Evaluation

HCSCC routinely seeks feedback from a sample of complainants using a service evaluation survey.

In response to 40 survey forms sent to complainants, 14 responses (35%) were received. Of the responses received:

- 79% found HCSCC staff courteous and to be good listeners in 2008 and by 2009 all complainants agreed with these statements
- 81% were satisfied with how HCSCC dealt with their complaint
- 71.5% would recommend HCSCC to their family and friends.

In response to the question 'In the end, did you get want you needed?'

- 42% responded yes
- 21% responded partly
- 35% responded no.

Fourteen (35%) of respondents were dissatisfied with the time it took for HCSCC to address their complaint. Timeliness is always a challenge because HCSCC must obtain information or a response from a service provider. Procedural fairness requires that reasonable time must be given to the provider to respond. Service providers often requested additional time to respond which lengthened the process.

4.7 SA Ombudsman Reviews and Complaints about HCSCC

Section 86(c) of the Act enables people to request that the SA Ombudsman reviews HCSCC decisions and actions. Complainants are informed of this right in writing.

This year, the SA Ombudsman reviewed 11 HCSCC complaints. In nine of the complaints reviewed the SA Ombudsman found no HCSCC maladministration. One complaint was abandoned by the complainant and was subsequently closed by the SA Ombudsman. Recommendations about HCSCC determinations were made for one complaint, although the SA Ombudsman noted that HCSCC investigation of the complaint was not unreasonable and the SA Ombudsman's recommendations would not have affected the HCSCC final decision

HCSCC received one complaint in 2008-09. The complaint alleged that a former HCSCC staff member had misled a family about the likely outcome of their complaint and had not been impartial. HCSCC investigated the complaint and then met the family.

HCSCC was unable to substantiate the allegations, as the staff member had left over two years previously. HCSCC acknowledged to the family that their views about the HCSCC staff member had impacted on their trust of HCSCC and other agencies. HCSCC apologised for this added burden.

HCSCC used the complaint to review induction, training and supervision of all staff, reinforce the impartial role of HCSCC in resolving complaints and the need to identify possible conflict of interest when managing complaints.

4.8 Assistance to Service Providers

The majority of requests from service providers fall into two distinct areas:

1. **Development and review of complaints related documents and processes**

   Service providers requesting input from HCSCC into their complaints processes, policies and publications such as booklets and websites. These included:

   - the Optometrists Association of SA
   - Community Accommodation and Respite Agency
   - Child Youth and Women's Health Service - Women's and Children's Hospital.

2. **How to manage specific complaints made directly to the service provider**

   The main request was for assistance to manage difficult behaviours by clients and/or their relatives. In providing assistance HCSCC addresses:

   - procedural fairness
   - safety for clients and staff
   - reasonable complaints processes
   - reasonable limit setting on complainants
   - review options if unable to resolve complaints, including contacting HCSCC.

4.9 Training: *Safer Conversations* and Unreasonably Persistent Complainant Behaviour

Following the *Safer Conversations* pilot project in 2007, HCSCC provided *Safer Conversations* training to another two groups of Country Health SA senior nursing staff in Murray Bridge and Whyalla.

The training provided to 30 senior nursing staff aimed to:

- increase their confidence and skills to respond effectively to consumer and carer complaints
- enable them to raise concerns about the behaviour of colleagues which may place the safety and/or quality of patient care at risk.

These conversations can be crucial because they generally involve strong emotions, high stakes and differences of opinion.

The evaluation of this training showed that:

- 100% of participants said that they would recommend the *Safer Conversations* course to others
- 65% of participants rated the presentations as excellent and the other 35% rated them as good
- 98% of participants said that the *Safer Conversations* course equipped them with skills which will make it easier for them to engage in crucial conversations.

Participant comments:

“I will recognise crucial conversations now and be more confident to have them safely.”

“*Safer Conversations* equipped me with skills and knowledge to engage in conversations which are difficult to have and are crucial to the organisation, individual or patient.”

“I will be able to recognise crucial conversations and be able to manage them in a respectful manner for the best possible outcomes for staff, patients, residents and other stakeholders.”

“I will be able to address complaints and comments in a respectful manner to diffuse situations from getting out of hand from lack of action and disrespect.”

Unusually Persistent Complainant Behaviour training - Ministerial staff

HCSCC has developed an information session about recognising and managing unusually persistent behaviours (UPB) characteristic among a minority of complainants.

HCSCC provided this session to 26 staff from the offices of the Minister for Health, the Minister for Mental Health and Substance Abuse and the Minister for Families and Communities, Ageing and Disability.

Standard approaches to complaint resolution for people demonstrating UPB do not work. Identifying UPB may assist to deal with a complainant more effectively.

Some characteristics identified in people with UPB include that they:

- make frequent contact with the complaints service
- are unclear about what the problem is and what they want to fix it
- feel the damage done to them is much more serious than other people think
- seek personal vindication and/or retribution
- are not satisfied with remedies, like an apology because they seek more severe outcomes, like staff dismissal.

Participants reported that they knew more about recognising and managing people who have UPB after the session. As well as gaining useful tips on how to better manage UPB and complaints generally, participants also learned how to work with HCSCC to resolve complaints. Subject to resources, HCSCC plans to provide UPB training more widely in 2009-10.

5 EXTERNAL RELATIONSHIPS AND COMMUNICATION

5.1 Health Consumers Alliance SA

HCSCC contributions to the Health Consumers Alliance SA (HCA) quarterly newsletter this year focussed on:

- providing timely information to patients and their families after an unexpected healthcare incident (open disclosure), highlighted after cancer treatment errors in three SA Health services
- progress with the section 88 review of the Act
- the HCSCC Aboriginal and Torres Strait Islander outreach project
- the need for the Attorney-General to release two reports about advance care directives to improve end of life care.

Following the appointment of the new HCA Executive Director, Stephanie Miller, in May 2009, HCSCC and HCA re-established regular meetings. In 2009-10, HCSCC and HCA will consider several collaborative initiatives to build the capacity of consumers to raise and resolve complaints.

5.2 Carers SA

HCSCC maintained informal links with Carers SA. Carers SA continued to promote HCSCC throughout their networks, including through their general and mental health newsletters. The ability to collaborate formally with Carers SA to build the capacity of carers to raise and resolve complaints has been constrained by lack of HCSCC resources.

5.3 Service Providers and Peak Organisations

- **HCSCC SA Health Chief Executive Liaison Committee**

HCSCC met the SA Health Chief Executive, Dr Tony Sherbon three times. The main purpose of the Liaison Committee is to address serious, recurrent, or emerging systemic issues identified in HCSCC complaints.

Issues raised by HCSCC in 2008-09 included:

- reviewing consent policy and practice
- complaints management and reporting by non government organisations contracted by SA Health to provide services
- implementing the open disclosure standard
- the SA Cancer Services Review action plan
- delayed discharge from hospital for some people with disabilities
- the implementation plan following the section 88 review of the Act.

- **SA Health Safety and Quality Unit**

The majority of the serious, recurrent and emerging systemic issues identified in HCSCC complaints are linked to the SA Health Safety and Quality Program. In 2009 HCSCC started quarterly meetings with the Executive Director Public Health and Clinical Coordination, Dr Stephen Christley and the Director, Safety and Quality, Michele McKinnon.

In addition to issues referred from the Liaison Committee, issues considered to date have included:

- clinical incident management policy
- pressure area prevention and management guidelines
- SA Health services complaints management and reporting
- medical credentialling
- concerns and complaints about doctors
- the Australian Charter of Healthcare Rights
- SA Patient Safety Survey action plan
- correct site procedures guidelines
- SA Health consumer advisor network.

- **SA Health - Mental Health Unit**

HCSCC met the Director, Mental Health Operations, Derek Wright and the Chief Psychiatrist, Dr Margaret Honeyman twice to monitor the progress of the *Stepping Up* mental health reforms and to deal with serious, recurrent or emerging issues arising from HCSCC complaints about mental health services.

Issues considered included:

- progress with recommendations arising from an HCSCC Supported Residential Facility complaint investigation in 2007-08
- mental health services for people over 65
- interstate transfer of people detained under the *Mental Health Act*
- HCSCC 2008 suicide cluster investigation recommendations
- the Mental Health Bill.

- **SA Health - Country Health SA**

Country Health SA (CHSA) made significant progress towards systematising their complaints management and reporting. The appointment of a Complaints Coordinator and a Director, Safety and Quality in late 2008 improved CHSA responsiveness to HCSCC complaints and action to minimise the recurrence of issues identified in complaints.

- **Department of Families and Communities - Chief Executive**

HCSCC met the former Department of Families and Communities (DFC) Chief Executive, Sue Vardon once and the new Chief Executive, Joslene Mazel three times. The main purpose of these meetings is to address serious, recurrent or emerging systemic issues identified in HCSCC complaints.

Issues raised by HCSCC in 2008-09 included:

- the DFC internal investigation of circumstances surrounding child neglect in two families in the northern suburbs
- DFC management of serious complaints, particularly within Disability SA
- Disability SA complaints management trial
- complaints management and reporting by organisations contracted by DFC to provide services
- monitoring improvements arising from Families SA complaints
- progress with the Commonwealth State and Territory Disability Services Funding Agreement and SA state funding bid to increase funding for disability services

- DFC - HCSCC complaints handling guidelines
- the section 88 review of the Act.

- **Department of Families and Communities - Families SA**

HCSCC met the new Executive Director, Families SA, David Waterford twice. Issues raised by HCSCC included:

- Families SA management of serious complaints
- recommendations and progress following the DFC internal investigation of circumstances surrounding child neglect in two families
- monitoring progress with systemic improvements arising from HCSCC complaints about Families SA.

5.4 Minister for Health

HCSCC met the Minister for Health, John Hill quarterly. In addition to briefing him about matters being dealt with through meetings with SA Health, HCSCC also discussed:

- the increasing number and complexity of HCSCC complaints
- complaints about bogus, unregistered and deregistered providers
- HCSCC funding constraints
- expediting the release of the Advance Care Directives Review reports by the Attorney-General
- the national health professional regulation reforms and the potential implications for HCSCC relationships with health professional registration authorities.

5.5 Minister for Families and Communities and Minister for Mental Health and Substance Abuse

HCSCC had introductory meetings with the Minister for Families and Communities, Jennifer Rankine and the Minister for Mental Health and Substance Abuse, Jane Lomax-Smith. At these meetings HCSCC provided an overview of HCSCC complaints within their portfolio responsibilities and the issues being addressed through the relevant Departmental Chief Executives and senior staff.

5.6 Members of SA Parliament

Members of the SA Parliament infrequently refer complaints directly to HCSCC. The Member for Light, Tony Piccolo, included information about HCSCC in his electorate newsletter.

5.7 The Public Advocate and the President of the Guardianship Board

HCSCC held introductory meetings with the new Public Advocate, Dr John Brayley and the new President of the Guardianship Board, Jeremy Moore. At these meetings, HCSCC provided an overview of HCSCC complaints involving people within their statutory responsibilities. HCSCC also welcomed the continuing cooperation of their staff in referring people to HCSCC.

5.8 Australian Commission for Safety and Quality in Healthcare

The Australian Commission for Safety and Quality in Healthcare (ACSQHC) continued to strengthen its engagement with the Australasian Health Complaints Commissioners

(AHCCs) during 2008-09. ACSQHC-AHCC collaboration included the Australian Charter of Healthcare Rights, implementation of the national Open Disclosure standard and the development of the national Safety and Quality Framework.

5.9 Australasian Health Complaints Commissioners

HCSCC participated in the Australasian Health Complaints Commissioners' (AHCCs) meeting in February 2009. Issues considered by the AHCCs included:

- monitoring and reporting improvements arising from AHCC complaints
- bringing consumer rights in Charters and Codes to life
- consumer advocacy
- AHCC engagement with consumers and people from indigenous backgrounds
- overcoming barriers to open disclosure
- lessons from major statutory inquiries into health care failures.

The highlights of the meeting were:

- a presentation from Professor Michael Ward, Commissioner, Queensland Health Quality and Complaints Commission, about the preliminary findings of a 16 year retrospective analysis of complaints to the Commission about doctors to identify factors indicating that a complaint should be escalated to a higher level of action
- further strengthening AHCC engagement with the Australian Commission for Safety and Quality in Healthcare.

5.10 Private Health and Service Providers

This year HCSCC made no progress with systematically engaging private health service providers, for example bodies representing GPs, medical specialists and private hospitals, or service provider peak bodies.

5.11 Media and Communications

HCSCC issued six media releases and responded to media contacts about the following issues:

- HCSCC's third annual report
- unregistered health practitioners
- providing timely information to patients and their families after an unexpected healthcare incident (open disclosure)
- end of life healthcare planning and advanced directives
- HCSCC disability and aged care outreach
- HCSCC Aboriginal and Torres Strait Islander outreach project.

HCSCC awareness raising information was distributed through the newsletters of the Country Women's Association and the Australian Association of Massage Therapists.

5.12 Demand for HCSCC Resources and Speakers

There were 14 906 unique visitors to the HCSCC website, a 57% increase on the previous year. At least 11 919 consumer pamphlets and 2545 provider pamphlets were distributed.

HCSCC consumer and provider pamphlets were also provided to the:

- Department for Families and Communities College for Learning and Development
- ACH Group workshop
- Onkaparinga Council Disability Forum
- Australian Commission on Safety and Quality in Healthcare Clinical Handover Workshop
- SA Health Aboriginal Health Division 2008 Spirit Festival.

HCSCC provided 36 external presentations to diverse groups and organisations.

6 FUNDING AND EXPENDITURE

Financial performance

HCSCC is funded from the state budget. HCSCC financial transactions are included in the financial statements of SA Health. HCSCC transactions are audited by the Auditor-General, along with those of SA Health.

A summary of 2008-09 funding and expenditure is provided below.

Sources of funding

SA Health - recurrent base as at 01.07.08	$1 126 300
Additional funding for Indigenous Project	$50 000
Budget realignment	$80 000
Additional revenue budget	-$25 000
Revised annual budget as at 30.06.09	**$1 231 300**

Summary of revenue and expenditure

Accommodation cost recovery	$(8 079)
Salaries and wages recoveries	$(34 495)
Training revenue (*Safer Conversations*)	$(11 280)
Total revenue	**$(53 854)**

Salaries & wages	$898 708
Goods & services	$368 813
Internal expense	$1 837
Total expenses	**$1 269 358**
Net operating result	**$1 215 504**

Account payment performance

	Number of accounts paid	Percentage of accounts paid (by number)	Value in $A of accounts paid	Percentage of accounts paid (by value)
Paid by due date	572	83.02%	$322 419	93.22%
Paid late, within 30 days of due date	72	10.45%	$9 450	2.73%
Paid late more than 30 days from due date	45	6.53%	$13 997	4.05%
Total	689	100%	$34 866	100%

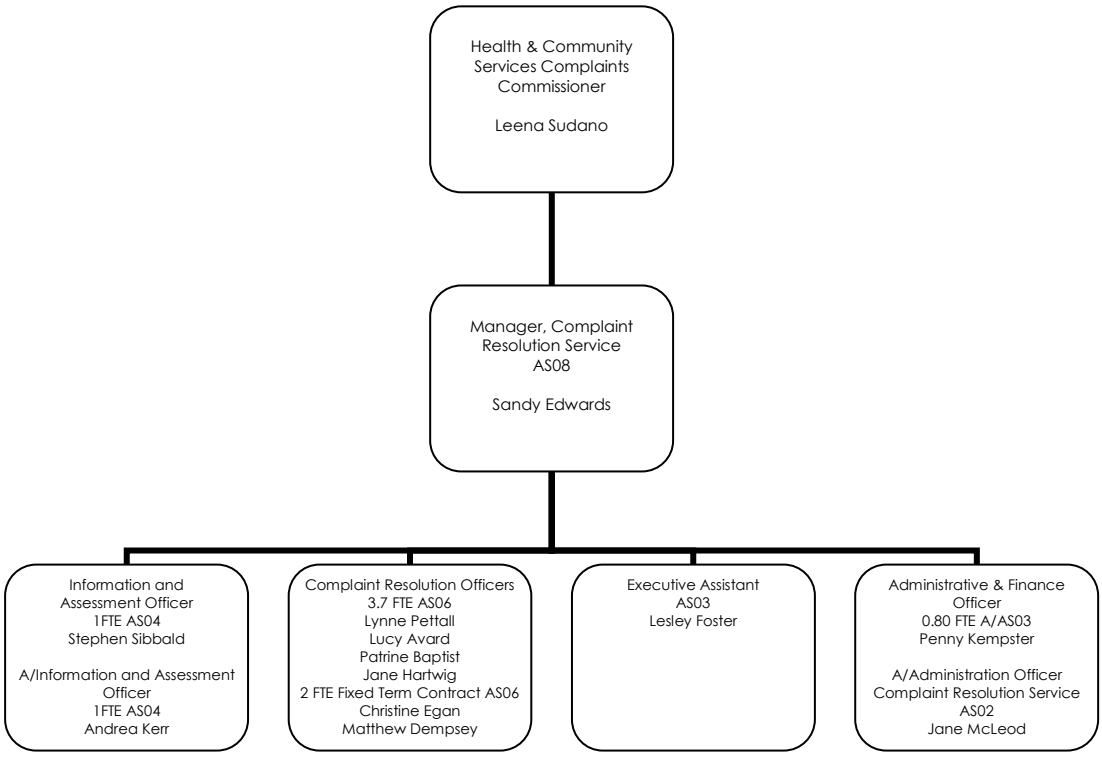
Account payment performance 2007-08 error

There was an error with the 2007-08 account payment performance information provided in the 2007-08 HCSCC annual report. The correct table is detailed below.

	Number of accounts paid	Percentage of accounts paid (by number)	Value in $A of accounts paid	Percentage of accounts paid (by value)
Paid by due date	492	82.41%	$189 674	88.21%
Paid late, within 30 days of due date	86	14.41%	$21 628	10.06%
Paid more than 30 days from due date	19	3.18%	$3 732	1.74%
Total	597	100%	$215 035	100%

7 HUMAN RESOURCES

HCSCC Organisational Chart



Employment

During 2008-09, one person left HCSCC and three were recruited. All vacancies were advertised through the Notice of Vacancies and two vacancies were also advertised in the external press.

Employee numbers, gender and status

Total number of employees		
Persons	12	
FTEs	10.5	
Gender	**% Persons**	**% FTEs**
Male	17%	19%
Female	83%	81%
Number of Persons during the 2008-09 financial year		
Separated from the agency		1
Recruited to the agency		3
Number of Persons at 30.06.09		
Leave without Pay		0

Number of employees by salary bracket

Salary Bracket	Male	Female	Total
$0 - $47 999		1	1
$40 000 - $60 999	1	2	3
$61 000 - $78 199	1	5	6
$78 200 - $98 499		1	1
$98 500 +		1	1
Total	**2**	**10**	**12**

The Health and Community Services Complaints Commissioner is appointed on an untenured 7 year contract until 31 March 2012.

Status of employees in current position by FTE

FTE	Ongoing	Short-Term Contract	Long-Term Contract	Other (Casual)	Total
Male	1.0	1			2.0
Female	6.5	2			8.5
Total	**7.5**	**3**			**10.5**

Status of employees in current position by persons

Persons	Ongoing	Short-Term Contract	Long-Term Contract	Other (Casual)	Total
Male	1	1			2
Female	8	2			10
Total	**9**	**3**			**12**

Executives by gender, classification and status

	Ongoing		Contract Tenured		Contract Untenured		Other (Casual)		Total	
Classification	M	F	M	F	M	F	M	F	M	F
Commissioner						1				
Total						**1**				

Leave management

Average days leave per full time equivalent employee

Leave type	2006-07	2007-08	2008-09
Sick Leave	7.4	7.25	8.06
Family Carers Leave	1.61	1.91	2.19
Miscellaneous Special Leave	0.63	0.96	1.14

Workforce Diversity

HCSCC has 10 female and two male staff. One staff member is Aboriginal: Ngarrindjeri-Ramindjeri; Gurindji.

Number of employees by age bracket and gender

Age Bracket	Male	Female	Total	% of Total	2009 Workforce Benchmark*
15-19					6.5%
20-24					10.3%
25-29					11.1%
30-34					10.7%
35-39	2	2	4	33	11.7%
40-44					11.4%
45-49		2	2	17	11.9%
50-54		3	3	25	10.3%
55-59		3	3	25	8.2%
60-64					5.3%
65+					2.6%
Total	**2**	**10**	**12**	**100%**	

**Source: Australian Bureau of Statistics Australian Demographic Statistics, 6291.0.55.001 Labour Force Status (ST LM8) by sex, age, state and marital status—employed—total from Feb78 Supertable, South Australia at May 2009*

Cultural and linguistic diversity

	Male	Female	Total	% Agency	SA Community*
Number of employees born overseas	1	4	5	42%	20.3%
Number of employees who speak language(s) other than English at home	0	0	0	0%	16.6%

**Benchmarks from ABS Publication Basic Community Profile (SA) Cat No. 2001.0,2006 census.*

Disability

Number of employees with ongoing disabilities requiring workplace adaptation			
Male	Female	Total	% of Agency
0	0	0	0%

Performance Development

HCSCC will use the SA Health Performance Development and Review Policy and resources to provide an annual review for all staff starting in 2009-10.

Documented review of individual performance management

Employees with….	%Total Workforce
A review within the last 12 months	0
A review older than 12 months	0
No review	100%

Leadership and Management Development

Training Expenditure

Training and Development	Total Cost	% of Total Salary Expenditure
Total training and development expenditure	10 836	1.2%
Total leadership and management development expenditure	0	-

Accredited training packages by classification

Classification	Number of accredited training packages
Nil	Nil

Occupational health, safety and injury management

HCSCC occupational health, safety and injury management information is included in the SA Health annual report.

8 FREEDOM OF INFORMATION STATEMENT

Under the *Freedom of Information (Exempt Agency) Regulations 1993*, the Commissioner is exempt from the provisions of the *Freedom of Information Act 1991*. HCSCC follows the SA Health Code of Fair Information Practice as far as possible.