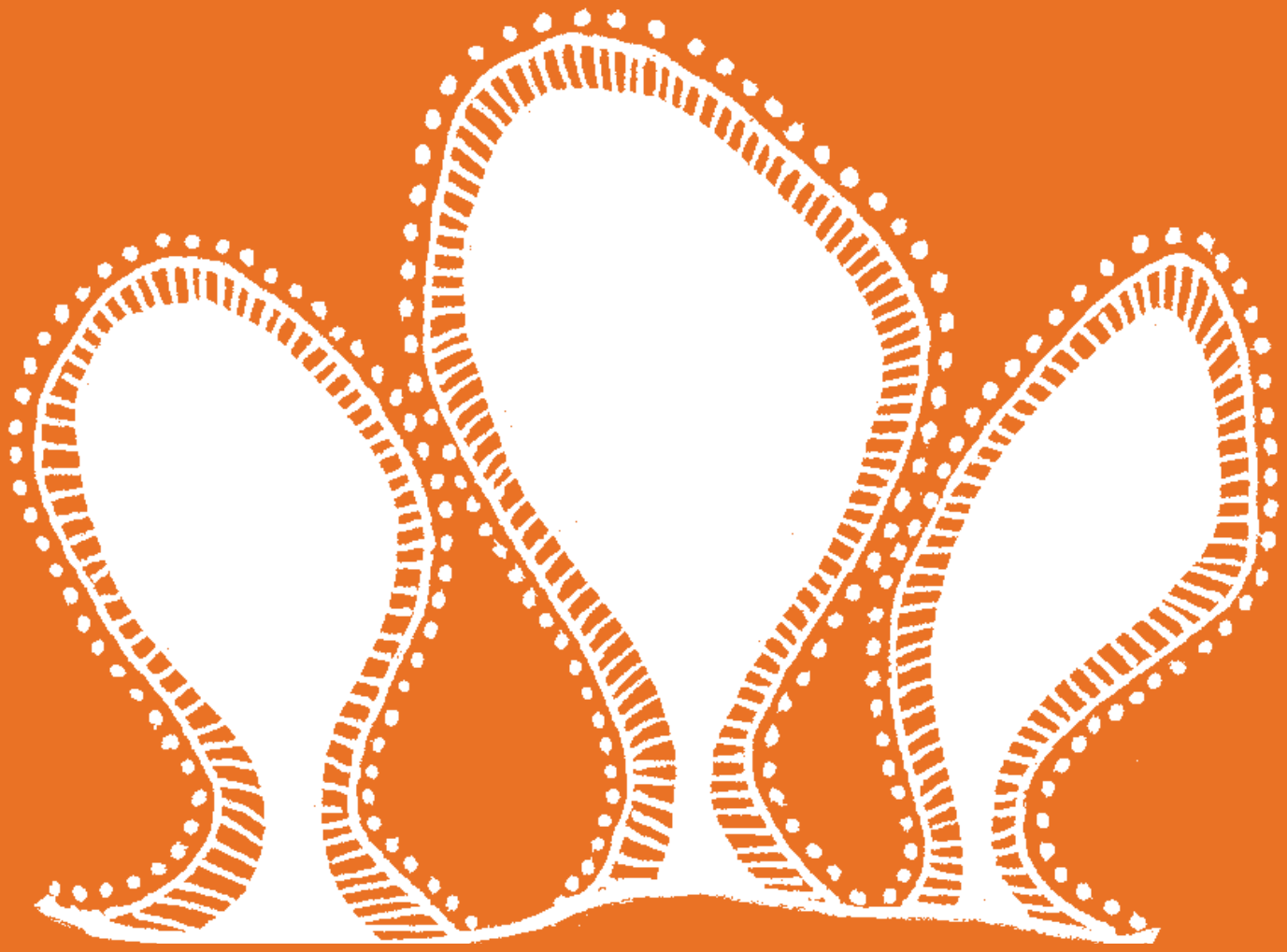


Statutory Functions

The Role of the Commissioner

The OHSC was established in Victoria in 1988 by the HSCRA. The HSC's role is to receive, investigate and resolve complaints from users of health services, to support healthcare services in providing quality healthcare and to assist them in resolving complaints. The legislation also requires that information gained from complaints should be used to improve the standards of health care and prevent breaches of these standards.

The HSCRA states that the HSC is to:

a. Deal with users' complaints; and

b. Suggest ways in which the guiding principles may be carried out and help service providers to improve the quality of health care.

The purposes of the Act include:

a. To provide an independent and accessible complaint mechanism for users of health services; and

b. To provide a means for reviewing and improving the quality of health service provision.

Guiding Principles

The guiding principles of the HSCRA promote:

a. Quality health care, given as promptly as circumstances permit; and

b. Considerate health care; and

c. Respect for the privacy and dignity of persons being given health care; and

d. The provision of adequate information on services provided or treatment available, in terms which are understandable; and

e. Participation in decision making affecting individual health care; and

f. An environment of informed choice in accepting or refusing treatment or participation in education or research programs.

Expectations and Standards

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

Health Records Act

The HSC is also responsible for the administration of the legislation dealing with the privacy of health information and an individual's right to have access to their own information. The *Health Records Act* 2001 (HRA) commenced on 1 July 2002. The purpose of the HRA is to promote fair and responsible handling of health information by:

a. Protecting the privacy of an individual's health information that is held in the public and private sectors; and

b. Providing individuals with a right of access to their health information; and

c. Providing an accessible framework for the resolution of complaints regarding the handling of health information.

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

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

Individuals can complain to the OHSC when their health information has not been managed in accordance with the HRA, or where they have experienced difficulties accessing their health information. The OHSC assesses complaints and, if a complaint is accepted, it may be conciliated, investigated or declined. At each stage the individual has the right to request referral of their complaint to the Victorian Civil and Administrative Appeals Tribunal (VCAT).

Other Statutory Roles

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

Liaison, Training and Promotion

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

The HSC places strong emphasis on promotion and training to improve accessibility of the OHSC to the public and health service providers. During the year under review, the HSC has been represented at many conferences and venues to promote the work of the office. In 2008/09 the HSC gave 111 presentations and 14 lectures; participated in four hypotheticals and nine panel discussions; attended one seminar, two workshops and three forums and gave many media interviews.

.

Public Interest Issues

Unregistered practitioners

The HSC has some serious concerns about alternative health services being provided by some unregistered practitioners. These include treatments for serious illnesses such as cancer, claims of being able to 'cure' conditions such as cerebral palsy and autism, and some counselling services. In the next financial year the HSC will be publishing the outcomes of a formal investigation into one such provider. Consideration is also being given to publicly naming this provider in accordance with section 11(5) of the HSCRA. This power has never been used before; however, the HSC has concerns about public health and safety and has also recommended to the Minister for Health that a negative licensing scheme be introduced in Victoria, as is the case in New South Wales. This would involve the drawing up of a code of conduct for unregistered providers and prosecuting those who fail to comply.

Investigations

Laser and IPL Beauty Therapy

The OHSC received a number of complaints from clients of a beauty therapist who provided laser and intense pulse light (IPL) treatments for cosmetic procedures and hair removal. As the OHSC was unable to resolve the complaints through conciliation and had concerns about the issues raised, the HSC decided to investigate the service.

An audit of the service was conducted using standards developed in the UK. Recommendations were made to improve patient safety, including protocols for the use of lasers and IPLs, annual training for the manager and staff, and six-month audits by a nominee of HSC. Further recommendations were made to improve record keeping and to establish a complaints register and effective complaints process. The provider agreed to implement all the recommendations and is working with the OHSC to ensure this happens.

Occupational Therapist Driving Assessor (OTDA)

As with the earlier Investigation, the OHSC received a number of complaints about an OTDA which could not be resolved in conciliation. Issues were raised about informed financial consent, poor communication skills, inadequate testing of clients and deficient record keeping. The OHSC sought advice from the Occupational Therapists' Association to find an expert to advise in the formulation of recommendations to address these issues.

Recommendations included 12 months supervision of work practices, use of the recommended tests and forms in client assessment, implementation of improved record keeping including informed financial consent processes prior to testing, and improved communication and responses to complaints. The OTDA agreed to the implementation of all recommendations under supervision.

Alternative healer

The OHSC received a complaint about an alternative healer who advertised on their website that they could cure cancers, psychiatric illnesses and other serious conditions. As the complainant's major concern was the healer's promotion of dubious cures, the OHSC held discussions with Consumer Affairs Victoria and the Australian Competition & Consumer Commission (ACCC) and decided to refer the matter to ACCC for Investigation.

Analysis of Complaint Trends

Throughout this Report anecdotal information has been used to illustrate the type of complaints received. Details have been altered to protect confidentiality.

2008/2009 Summary

When complaints are received in writing or by telephone and they appear to be within HSC jurisdiction the details of the complaint are recorded on the database and a file number assigned. These complaints are shown in Table 1 as Complaints lodged.

Complaint forms are then sent to the complainant for completion and return. If these are not returned within one month, the file is closed on the database. These complaints are shown in Table 2 as Single Contact Complaints.

When a complaint form is returned and the matter is within the jurisdiction of this Office the complaint becomes an Accepted Case and is assigned to an assessment officer for management. These complaints are shown in Table 3 as Accepted Cases.

Summary complaint data from the past year is shown in Tables 1, 2 and 3.

	2008/2009		2007/2008	
HSCRA	2167	89%	1799	90%
HRA	261	11%	195	10%
Total	**2428**		**1994**	

Table 1: Complaints lodged
Complaints received complaint forms sent out

	2008/2009		2007/2008	
HSCRA	994	91%	754	90%
HRA	96	9%	99	10%
Total	**1090**		**853**	

Table 2: Single contact complaints
Complaints closed because no complaint form returned

This year we have recorded 2428 complaints, a 22% increase over the previous year and the largest annual total of complaints in the past five years.

In line with the high number of complaints lodged there were 1379 accepted cases for this year, which is a 21% increase over the previous year and the highest number of cases for the past five years.

	2008/2009		2007/2008	
HSCRA	1207	88%	1053	91%
HRA	172	12%	86	9%
Total	**1379**		**1139**	

Table 3: Accepted cases
Complaint forms received and approved for assessment

Enquiries

The OHSC operates a telephone enquiry line which receives complaints and answers general health-related enquiries. Enquiries which are not identified as complaints are recorded against a simple category table. In the past year there were 6273 enquiries recorded.

HRA Issues		Other Issues	
Access to records	11%	Brochure	2%
Brochure	1%	Fees	8%
Fees	3%	Food & environmental health issues	7%
Privacy information	1%	Health insurance	8%
FOI requests	1%	Hospital waiting lists	2%
Presentation to a group	1%	Other	25%
Written enquiry	2%	Referred elsewhere	21%
Telephone enquiry	6%		
Other enquiry	1%		
	27%		**73%**

Table 4: Enquiry types

Who complained

A complainant is most often the user of the health service but could also be the next of kin or legal representative or a person appointed by the service user to complain on his or her behalf. Complaints can be accepted from third parties at the discretion of the Commissioner where a user is unable to complain on their own behalf. The complaints must always be made either by, or on behalf of, a user of a Victorian health service.

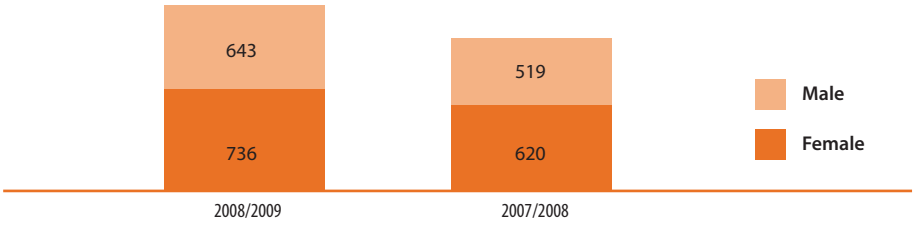


Figure 1: Consumer gender
The OHSC requests and records the gender and age of the service user. There are usually more female consumers reflecting the greater usage of health services by women.

Age Range	Female	Male	Total	
0 - 14	45	83	128	9%
15 - 34	132	81	213	15%
36 - 64	287	179	466	34%
65+	132	137	269	20%
Unknown	140	163	303	22%
Total	**736**	**643**	**1379**	

Table 5: Consumer profile 2008/2009

How Complaints Are Managed

The enquiry telephone line currently operates from 10.00am to 4.00pm, five days a week. At other times messages may be left on the answering machine or with reception. Officers have a broad knowledge of health issues and, where appropriate, can provide referrals to other agencies if the enquiry does not come within the jurisdiction of the HSC.

When enquiries are received by telephone, the Officer advises and encourages callers, where appropriate, to make direct contact with the service provider as the first step in resolving the complaint. It is thought many of the unconfirmed complaints are resolved in this way. The OHSC accepts not everyone is able to do this for him or herself and assists whenever necessary.

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

All potential complaints are recorded on the database as cases. If a complaint is not confirmed in writing, the matter is closed, although complaints identified as serious may be followed up. If a complaint is from a person from a culturally or linguistically diverse background the Officer may use interpreter services and assist the person to make the complaint. Assessment Officers are also available to talk with prospective complainants if they attend the office and appointments can be made by telephoning the Helpline on (03) 8601 5200.

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

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

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

These proceedings are privileged and nothing said or disclosed during the conciliation may be admitted in any court action. The process is entirely voluntary; at any stage in the negotiations either party can decide not to proceed further and this ends the matter in conciliation.

Generally complaints in conciliation fall into two categories. One group requires further explanation as to what happened and a conciliation meeting between the parties may be used for this purpose. The other is a claim for damages, compensation or remedial treatment where there have been allegations or evidence of negligence. Often complaints involve elements of both.

When there is a dispute about a health service provider's liability for a claim, an independent expert opinion can be sought with the agreement of the parties. The conciliator organises this from an expert in the relevant field. Copies of this opinion go to the parties who use it as a basis for further negotiations. The conciliator also assists the parties by obtaining information such as medical records, medical reports and impairment assessments, if required.

If conciliation results in the payment of damages or compensation release documents are prepared and signed and that is the end of the matter. It cannot be pursued further.

When complaints were resolved

A complainant is most often the user of the health service but could also be the next of kin or legal representative or a person appointed by the service user to complain on his or her behalf. Complaints can be accepted from third parties at the discretion of the Commissioner where a user is unable to complain on their own behalf. The complaints must always be made either by, or on behalf of, a user of a Victorian health service.

The stages at which complaints were resolved can be seen in Table 6.

Stage of complaint process	HRA	HSCRA	Total	%
Closed in Assessment	150	974	1124	80%
Closed in Conciliation	32	239	271	20%
Closed in Investigation	1	5	6	0%
Total cases closed	**183**	**1218**	**1401**	

Table 6: Resolution stages

	HRA	HSCRA	Total	
0-3 months	150	974	1124	80%
3-6 months	7	61	68	5%
6-9 months	10	40	50	4%
9-12 months	12	42	54	4%
12-18 months	2	50	52	4%
18-24 months	2	19	21	1%
24 over	0	32	32	2%
Total	**183**	**1218**	**1401**	

Table 7: Time until resolution

Seriousness Rating

All new complaints are given a 'seriousness' rating which depends upon the severity of the outcome for the consumer and the perceived level of risk of the incident. This rating is allocated initially on the basis of the complaint information and may be revised and changed during the course of complaint management as new information emerges.

The rating is as follows:

1. **Low:** A phone call, letter or an explanation should easily resolve the problem. Included in this rating are complaints that are frivolous, vexatious, obviously misconceived or where an investigation is unwarranted.
2. **Medium:** Frequently there has been a misunderstanding. There are issues involving access to records, disputes about costs, discourtesy, diagnostic or treatment errors or differences of opinion without serious consequences.
3. **High:** There may be quality assurance implications, where changes in practice are needed to avoid a recurrence or there is a need for policy development. These also include complaints associated with allegations of negligence leading to personal injury, professional misconduct, unlawful or unethical acts and lack of informed consent with serious adverse outcomes.

The seriousness rating of accepted cases closed in the past year is seen in Table 8.

There has been no variation in the seriousness of complaints over time, with most complaints (88%) rated as low to medium in seriousness.

	2008/2009				
HRA	**Low**	**Medium**	**High**	**Total**	**%**
Access & Correction	63	15	0	78	6%
Collection	1	0	0	1	0%
Data Quality	7	6	1	14	1%
Identifiers	2	0	0	2	0%
Info Available to another HSP	5	3	0	8	1%
Openness	0	1	0	1	0%
Transborder Data Flows	2	0	0	2	0%
Transfer/Closure of HSP	2	1	0	3	0%
Use & Disclosure	49	20	5	74	5%
Total	131	46	6	183	13%
HSCRA	**Low**	**Medium**	**High**	**Total**	**%**
Access	72	48	13	133	9%
Administration	38	16	0	54	4%
Communication	60	55	14	129	9%
Cost	76	26	3	105	7%
Rights	30	23	15	68	5%
Treatment	209	403	117	729	53%
Total	485	571	162	1218	87%
Grand Total	616	617	168	1401	100%
	44%	44%	12%	100%	

Table 8: Seriousness by issue at closure

Assessment Report

There was a significant increase in the number of complaints received this year which impacted on the case loads of the Assessment Team. Discussions with other complaint services indicated there were similar increases in their complaint numbers also. We wait to see if this surge is maintained in the coming year.

The OHSC conducts relatively few Investigations, preferring wherever possible to resolve complaints through mediation and conciliation. This year Investigations were conducted into three health services and these are described in more detail in the Public Interest section of this Report.

	HSC	HRA	Total	%
Apology	79	29	108	8%
Compensation	2	0	2	0%
Declined	340	15	355	27%
Explanation	395	55	450	35%
Fees/Cost waived or reduced	68	1	69	5%
Non-conciliable	0	1	1	0%
Quality change	50	17	67	5%
Referred Out	137	9	146	11%
Service obtained	20	7	27	2%
Withdrawn	27	37	64	5%
HRA - Access to records	0	31	31	2%
HRA - Action/compliance order	0	1	1	0%
HRA - Dismissed	0	5	5	0%
Total	**1118**	**208**	**1326**	**100%**
	84%	16%		

Table 9: Outcomes in Assessment

Note: The above figures represent numbers of outcomes, not numbers of cases.

The most common outcome of complaints resolved in Assessment was that the complainant received a letter from the service with further explanation of the issues. In most cases this was sufficient to resolve the matter.

Approximately one quarter of written complaints are declined each year under the HSCRA and almost half of these are declined because they are not confirmed by the return of a complaint form and signed authority.

HSCRA		
s19 (1) The complaint is frivolous, vexatious or trivial	38	11%
s19 (2) The complaint has been determined elsewhere	69	19%
s19 (3) The incident occurred more than 12 months ago	1	0%
s19 (4) (a) The complaint was not confirmed in writing	148	42%
s19 (4) (b) The complaint contains insufficient detail	24	7%
s19 (4) (c) The complainant or provider is not identifiable	1	0%
s19 (5) Reasonable steps not taken	16	5%
s19 (8) (a) The complaint was rejected (outside jurisdiction)	43	12%
Total	**340**	**96%**

HRA		
s45 (4) Complaint not confirmed in writing	5	1%
s51 (1)(a) Not an interference with the privacy of an individual	3	1%
s51 (1)(c) Complaint not made to respondent by complainant	1	0%
s51 (1)(e) Complaint is frivolous, vexatious, misconceived or lacking in substance	3	1%
s51 (1)(f) Complaint is subject to another enactment, court or tribunal	2	1%
s51 (1)(g) Complaint could be made the subject of another enactment, court or tribunal	1	0%
s51 (1)(h) Respondent dealing/dealt with or hasn't had opportunity to deal with complaint	0	0%
s52 (1) Complaint referred to Registration Board	0	0%
Complaint did not proceed	0	0%
Outside jurisdiction	0	0%
Total	**15**	**4%**

Table 10: Reason given for decline in Assessment

Conciliation Report

Over the past year there has been a significant increase in numbers of complaints, with nearly 400 cases being referred for conciliation. At the same time we have had a reduction in staff numbers. This has inevitably resulted in an increase in the number of complaints on the Conciliation Waiting List – these are files referred to conciliation but waiting to be allocated to conciliators. We continue to monitor these files to ensure any urgent complaints are allocated more quickly.

Our increased workload has made us very conscious of the need to strike a balance between resolving complaints in a timely manner and yet still allowing enough time for the parties to explore the often complex issues fully. The subject matter of the complaints can be deeply personal and some complaints take considerably longer than others to conciliate. Nevertheless, nearly half the complaints referred to conciliation are closed within six months of the referral and 75% are closed within 12 months of referral, as shown in Table 12.

Conciliation procedures are flexible and vary from case to case to suit the needs of the parties and depending on the seriousness and complexity of the complaint. Most of our complaints are resolved with an apology or explanation. Face-to-face conciliation meetings remain a powerful tool for enabling dialogue between health providers and consumers and allowing clarification of issues. Communication problems are a constant thread running through most complaints in conciliation.

We continue to have good working relationships with stakeholders, including medical insurers and solicitors acting for complainants and respondents. There is a high level of co-operation with our processes and there seems to be a general consensus about the benefits of complaint resolution by OHSC without the need for litigation. Another important aspect of conciliation through OHSC is that we can achieve systems changes to improve the quality of healthcare. This is commonly identified by our complainants as one of their main objectives in lodging their complaint.

A man was admitted to a private hospital for surgery to his middle finger. The man identified to nursing staff which finger was to be operated on as their documentation was incorrect. The nurse then changed the documentation to reflect this. However, the surgeon proceeded to operate on the incorrect finger. When the fault was recognised the man was taken back to theatre and a second operation was undertaken on the correct finger. The hospital reviewed their policies and procedures and implemented a 'Marking of the Limb Policy' to ensure the correct surgery site is marked by the surgeon prior to surgery commencing. The man received a financial settlement from the hospital and the surgeon.

A child died in a hospital and the parents requested an autopsy. There was a misunderstanding at the hospital in relation to the parents' wishes and the appropriate paperwork did not accompany the child to the morgue. The child's body was released to the funeral home without autopsy and the error was not discovered until after the cremation. The hospital participated in a conciliation meeting with the family. The hospital agreed to review its policies and procedures and to implement a system change to ensure all relevant paperwork is kept with a body until it is released from the morgue.

Complaints about psychiatric services

The OHSC receives a small number of complaints from users of mental health services. Complainants are often distressed about the circumstances of their admission to high dependency units (HDU). For example:

A suicidal young woman was admitted as an involuntary patient to a HDU of a public hospital. She complained that when she tried to leave she was physically restrained by two male nurses and two security guards. After being sedated she was placed in seclusion for several hours. The woman was bruised severely during attempts to restrain her and she believes the level of force used to restrain her was excessive. The woman also complained that she was physically assaulted by a co-patient. The complainant was heavily sedated at the time. She believes the hospital did not take sufficient care to provide her with a safe environment. The complaint was settled in conciliation and the complainant received a payment of compensation.

The OHSC has also received complaints from women who claim they have been sexually harassed and/or assaulted in HDUs by other patients. When a sexual assault has been alleged the complainants are encouraged to go to the police and to seek support from Victorian Centres Against Sexual Assault (CASA). However, some complainants choose not to do this, preferring instead to have their complaint recorded and to receive assurances from service providers that steps have been taken to ensure that vulnerable patients are protected.

	HSCRA	HRA	Total	%
Apology	108	11	119	26%
Compensation	45	4	49	10%
Explanation	151	4	155	34%
Fees/Cost waived or reduced	15	1	16	3%
Non-conciliable	24	6	30	6%
Quality change	26	4	30	6%
Referred Out	5	4	9	2%
Service obtained	9	1	10	2%
Withdrawn	43	8	51	10%
HRA - Access to records	0	4	4	1%
Grand Total	**426**	**47**	**473**	**100%**
	90%	**10%**		

Table 11: Outcomes in Conciliation

	Total	
0-3 months	62	23%
3-6 months	66	24%
6-9 months	45	17%
9-12 months	33	12%
12-18 months	32	12%
18-24 months	13	5%
24 over	20	7%
Total	**271**	

Table 12: Length of time in Conciliation

Note: The above figures represent numbers of outcomes, not numbers of cases.

Aboriginal Liaison Officer's Report

The Aboriginal Liaison Officer (ALO) performs two important functions:

- Responding to enquiries and complaints received from Aboriginal and Torres Strait Islander (ATSI) consumers about health services; and
- Performing outreach activities promoting the services of this Office within indigenous communities in Victoria.

Complaints

ATSI complaints continue to revolve around issues of communication and access to services.

The ALO can respond to non-complex complaints informally and quickly with the permission of both parties to the dispute and also can resolve more complex complaints in conciliation.

Assistance can be provided in formulating complaints, raising concerns with healthcare providers and arranging meetings between parties with a view to discussing concerns and resolving differences.

The ALO is able to deal with issues in a manner appropriate to indigenous communities which enables a number of them to be resolved informally. The resolution of complaints involves:

- Assisting complainants to formulate their complaints;
- Seeking responses from health providers;
- Seeking medical records, reports and opinions where appropriate;
- Facilitating conciliation meetings between consumers and health providers; and
- Negotiating agreements between parties.

Outreach

The ALO has a key role to play in ensuring this Office is accessible for ATSI consumers. The position fulfils a number of wide-ranging functions including:

- Liaising and creating networks with ATSI communities;
- Increasing awareness of the OHSC;
- Providing policy advice to the HSC on matters pertaining to Indigenous Australians; and
- Attending to enquiries involving ATSI parties.

Brochure

A new brochure was targeted at Indigenous communities, containing a very basic complaint form which will hopefully assist those communities to bring complaints directly to the attention of health providers and this Office.

An Aboriginal man attended the emergency department of a public hospital during a weekend, with a sudden onset of severe flu-like symptoms. He had a history of lung disease and given the context of the swine flu outbreak, he felt he had no other option but to attend the hospital.

The man found triage staff to be abrupt and disparaging and medical staff to be cursory in their investigations. He was advised to visit his medical practitioner the following day, but subsequently became seriously ill requiring hospitalisation in the intensive care unit of another hospital.

A verbal complaint was taken while the man was in hospital and concerns promptly raised with the hospital. All discussions between the parties were facilitated by the ALO.

ATSI Outreach	
Published articles	0
Consultations	42
Presentations	5
Number of people attending presentations	150
Response to questions	4
Review policy documents	0
Total	**201**
ATSI Enquiries	
Enquiries (in person & telephone)	371
Written enquiries	10
ATSI Brochure requests	103
ATSI Poster requests	10
Total	**494**
ATSI Complaints 2008/09	
HRA	
Use & Disclosure	2
HSCRA	
Access	9
Administration	1
Communication	5
Rights	3
Treatment	5
Total	**25**

Table 13: Aboriginal Liaison Officer's activities

Registrar's Report

The OHSC has continued to enjoy a good working relationship with the 12 health registration boards and other agencies, and the interactions between all parties continues to assist us in relation to making decisions about the management of complaints. When complaints about a registered provider are received, consultation takes place between OHSC and the relevant board to determine which organisation should deal with the complaint. Complaints which have the potential to be conciliated are addressed by the OHSC and complaints which concern matters about professional conduct issues are addressed by the registration boards.

Tables 14 and 15 provide detailed information about the complaint exchange activities which have occurred with the registration boards during the year under review.

Again this year, the largest number of complaints received were about medical and dental practitioners. A total of 1152 complaints were discussed between the boards and the OHSC, with 718 of these being about medical practitioners and 212 about dental practitioners. Both these areas saw an increase in complaint numbers in comparison with previous years. There were 222 complaints received about registered practitioners from the remaining ten boards with 72 of these being about pharmacists and 42 about nurses.

Of the complaints discussed, 135 were formally referred between the OHSC and the boards, which is a substantial increase in referrals in comparison with previous years. Of the 473 OHSC complaints discussed, 98 were referred to eight boards for consideration and five boards formally referred 37 complaints for attention by the OHSC.

Organisation	Board complaints discussed with HSC	HSC complaints discussed with boards	HSC complaints formally referred to boards	Board complaints formally referred to HSC
Chinese Medicine Registration Board	12	0	1	0
Chiropractors Registration Board of Victoria	15	6	1	0
Dental Practice Board of Victoria	118	94	28	3
Medical Practitioners Board of Victoria	400	318	54	27
Medical Radiation Practitioners Board of Victoria	1	3	0	1
Nurses Board of Victoria	26	16	2	5
Optometrists Registration Board of Victoria	3	11	4	0
Osteopaths Registration Board of Victoria	6	0	0	0
Pharmacy Board of Victoria	63	9	3	0
Physiotherapists Registration Board of Victoria	5	6	5	1
Podiatrists Registration Board of Victoria	2	1	0	0
Psychologists Registration Board of Victoria	28	9	0	0
Total	**679**	**473**	**98**	**37**

Table 14: Dealings with registration boards

Year	Board notifications discussed with HSC	HSC complaints discussed with boards	HSC complaints formally referred to boards	Board notifications formally referred to HSC
2006	585	365	45	20
2007	695	435	63	20
2008	684	413	58	21
2009	679	473	97	37

Table 15: Comparison of total complaint numbers and those referred in the past four years

The OHSC participated in regular consultation meetings held with the registration boards and DHS in relation to the National Registration and Accreditation Scheme.

During the year under review, the OHSC engaged in interactions with the Disability Services Commissioner, WorkSafe Victoria, the State Coroner, the Office of the Chief Psychiatrist, the Aged Care Complaints Investigations Scheme, Consumer Affairs Victoria, Supported Residential Services, the HACC Programme and Ombudsman Victoria. As with the registration boards, complaints are discussed and formally referred to and from these agencies on a regular basis. The OHSC received nine FOI requests during the year under review; six of these were processed, with the remainder being discontinued by the applicants.

The Registrar's role includes the approval and assessment of complaints, providing advice and support as a member of the assessment team, deputising for the Manager, Assessment and Investigation as required and participating in training activities the Office undertakes for external groups and individuals on an ongoing basis. Meetings are arranged between OHSC staff and staff from registration boards and other agencies. These are useful forums for the exchange of ideas, policy development, education and training, as are the regular meetings with CEOs and Registrars of the boards.

The co-operation of the registration boards and other agencies, with which there is regular dialogue in relation to the work we all undertake, is greatly appreciated.

Health Professions Registration Act and Investigation Review Panels

Following the DHS Review of the Regulation of the Health Professions conducted between 2002 and 2005, the Health Professions Registration Act 2005 (HPRA) was passed by the Victorian Parliament in November 2005 and came into operation on 1 July 2007. It repealed the 11 separate health practitioner registration Acts and section 108AL of the Health Act 1958 relating to medical radiation practitioners. The HPRA covers people who are or will be registered as Chinese medicine practitioners, chiropractors, dental care providers, medical practitioners, medical radiation practitioners, nurses, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists.

The HPRA established a statutory merits review for complainants who are aggrieved by a registration board decision not to investigate their complaint, a decision to close their complaint following investigation, or a decision to forward the complaint to an internal 'professional standards panel' of the board rather than to VCAT for hearing.

The right of review has been framed to respond to concerns of consumers, some of whom do not have confidence in the transparency and fairness of registration board complaints handling. It is designed to provide a better balance between the rights and needs of consumers, and those of practitioners.

When a registration board receives a complaint about a registered health practitioner, the board has powers to appoint an investigator, conduct an investigation and then decide whether disciplinary action is required, and if so, what type and what sanctions should be imposed on the practitioner.

Section 60 of the HPRA provides that a notifier (the term used in the HPRA to describe a person who makes a complaint to a registration board about a registered practitioner) may apply to a responsible board for review of an investigation decision, for example, if the notifier is dissatisfied with the decision. On receipt of such an application, the responsible board is required to establish an Investigation Review Panel (IRP). Schedule 2 of the HPRA sets out the requirements the board must comply with when convening an IRP.

An IRP must be made up of a lawyer (who chairs the panel), a practitioner member, and a nominee of the HSC. The HSC is a statutory officer, with powers established under the HSCRA. The intent is that a nominee of the HSC will bring a level of independent scrutiny to the review of a complaint by a registration board.

As detailed in Section 60 of the HPRA, board decisions that an IRP can review include:

- the decision not to investigate a notification;
- the decision to close a matter following investigation, with no further action; or
- the decision to refer a matter to an internally convened professional standards panel, rather than for external hearing by VCAT.

An IRP has and may exercise all the powers of an investigator under the HPRA. After completing a review of a decision, the panel may:

a. affirm the earlier decision of the responsible board,

b. refer the matter to the board with a request for an investigation,

c. refer the matter back to the board or the investigator for further investigation,

d. in the case of the review of a decision to take no further action, it may substitute its own decision from the range of decisions originally available to the board following an investigation (such as conduct a health or performance assessment or a professional standards or health panel hearing, or refer the matter to an external body), or

e. in the case of the review of a decision to refer the matter to a professional standards panel rather than VCAT, request the board to refer the matter to VCAT for a Tribunal hearing.

Registration Board	
Chinese Medicine Registration Board	0
Chiropractors Registration Board of Victoria	0
Dental Practice Board of Victoria	4
Medical Practitioners Board of Victoria	27
Medical Radiation Practitioners Board of Victoria	0
Nurses Board of Victoria	2
Optometrists Registration Board of Victoria	0
Osteopaths Registration Board of Victoria	0
Pharmacy Board of Victoria	0
Physiotherapists Registration Board of Victoria	3
Podiatrists Registration Board of Victoria	0
Psychologists Registration Board of Victoria	4
Total	**40**

Table 16: Investigation Review Panels held in 2008/2009

Prisoner Complaints

The OHSC receives complaints from prisoners by letter and telephone calls. Complaints are also received from Ombudsman Victoria from prisoners who have telephoned them on their 'prisoner free call service'. The OHSC refers complaints that either directly relate to correctional issues, or cross with correctional issues, to the Ombudsman for attention. The OHSC continues to liaise with, and refer complaints to, the Justice Health Unit at the Correctional Services Commissioner's Office for their information. A poster campaign continues at all prisons.

While complaints from prisoners have risen this reporting period, complaints from female prisoners have dropped dramatically over the reporting period. This may be due to complaints being effectively dealt with and resolved by the prison health service.

Generally the issues of complaint remain the same at each reporting period. Access to services, dissatisfaction with treatment and the provision of medication continue to dominate complaints. Once again a continuing concern for the OHSC, and the frequent subject of complaint from prisoners, is the inconsistency of prescribing by doctors. Prisoners see many different doctors throughout their incarceration and while they may be prescribed a particular medication regime at one prison, this does not mean they will be prescribed the same medication when they are transferred to another location. This is a constant frustration to prisoners who believe they were stable on their medication before it was changed. While medication is a matter of clinical judgement it would assist communication and understanding if health services communicated with each other in these cases.

The co-operative approach by the health service providers helps bring most complaints to a satisfactory resolution. While some prisoners may not be satisfied with the outcome, the responses to their complaints would indicate they are mostly receiving satisfactory services.

A prisoner complains that he has been seeing a doctor at one prison about a lump under his arm near his breast. The doctor did not do any investigations and diagnosed the lump as a cyst. He has now moved to another prison where the lump has been diagnosed as cancer.

Following discussions with a registration board it was decided to refer the complaint to that board for consideration. The prisoner was in agreement for that to occur.

	2009		2008	
HRA				
Access & Correction	2	2%	2	2%
HSCRA				
Access	28	24%	37	32%
Administration	2	2%	2	2%
Communication	4	4%	2	2%
Cost	0	0%	0	0%
Rights	1	1%	1	1%
Treatment	75	67%	69	61%
Total	**112**		**113**	

Table 17: Analysis of prisoner complaints

Reasons For Complaints

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

HSCRA Issue Categories

Access
Availability of services in terms of location, waiting times and other constraints that limit use of the service.

Administration
Support services for providers such as reception, waiting lists, cleaning services, etc.

Treatment
Diagnosis, testing, medication and other therapies provided.

Communication
Manner of communication such as rudeness, lack of interest, quality and quantity of information provided about treatment, risks, outcomes and prognosis.

Cost
Information about costs and fees, discrepancies between advertised and actual costs, charges and rebates.

Rights
Dignity, consent to treatment.

HRA Issue Categories

Access and correction
Right of individuals to access and correct health information held about them, subject to certain criteria.

Anonymity
Right of an individual not to identify him or herself when it is lawful and practicable.

Collection
How and when health information is collected.

Data quality
How accurate, complete, up-to-date and relevant the health information is, having regard to the purpose for which it is held.

Identifiers
The unnecessary use of identifiers, for example, the use of a public sector identifier by a private sector organisation can only occur with the individual's consent or if it is required by law.

Information available to another health service

One health service making information available to another.

Openness
Organisation's policies on the management of health information and steps an individual must take to access their health information.

Transborder data flows
The transfer of an individual's health information outside Victoria.

Transfer/closure of a practice
The process to be followed when a practice or business of a health service provider is sold or closed.

Use and disclosure
How an organisation has used or disclosed an individual's health information.

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

Primary Issues in HSCRA Complaints

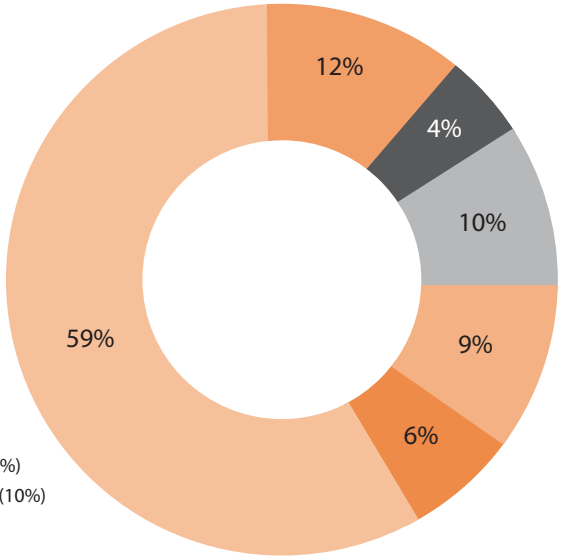


Figure 2: Issues raised

Access

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

Access issues raised in complaints are shown in Table 18.

Access	12%
Communication breakdown	3
Delay in admission	5
Delay in treatment	36
Discharge arrangements	2
Discharge/transfer	6
No/inadequate service	34
Non-attendance	1
Other	39
Refusal to refer	2
Refused admission	4
Transfer unsuitable	1
Transport	1
Waiting list	6
Total	**140**

Table 18: Access

An elderly man admitted to hospital for surgery had been discharged the following day despite the treating doctor saying the patient would be in hospital for at least four days. The family had arranged a carer to stay with the man on discharge but she was not available at the earlier date. The patient had been unwell on arriving at home and had subsequently required readmission to the hospital that night. The hospital responded saying the discharge had not been conducted in accordance with hospital protocol and that all staff had been questioned and counselled about this. The man and his family were satisfied with this outcome.

Administration

Occasionally people complain about the administrative staff and policies of a health service. For example, they might say they found the receptionist rude and uncaring, or that their messages are not passed to the health professionals in a timely manner.

Administration	4%
Advertising	2
Administration	11
Failure to provide certificate	4
Hygiene	4
No/inadequate response	23
Other	5
Policy	2
Total	**51**

Table 19: Administrative issues

A young woman complained she had not received a receipt for her dental treatment one year previously so had been unable to claim the payment against her health insurance. When she telephoned the clinic promises were made that the receipt would be posted but it had never arrived. The OHSC treated this informally by telephone contact with the dentist and the woman received a receipt soon afterwards.

Communication

The sub-issues where communication was named as the primary concern of a complaint can be seen in Table 20; however, experience shows communication is a feature of all complaints.

Communication	10%
Absence of caring	14
Failure to consult	17
Inconsiderate/undignified service	18
Other	10
Poor attitude/discourtesy	38
Wrong/misleading Information	23
Total	**120**

Table 20: Communication

A woman who is the primary carer of her adult son who is being treated for a mental illness complained the hospital psychiatrist refused to communicate with her, even though the patient had consented to the sharing of his health information. The hospital explained the patient was willing for only some aspects of the information to be disclosed to his mother. A meeting was organised between the doctor, the patient and the complainant, and agreement was reached about how the information would be shared in the future.

Cost

People also complain about the overall cost of health services as they believe these should be regulated. The cost issues raised in complaints can be seen in Table 21.

Cost	9%
Amount charged	38
Billing practices	35
Fraud	1
Information on costs	21
Other	9
Over-servicing/ unnecessary treatment	6
Total	**110**

Table 21: Cost

A number of people complained when their local GP practice was sold and the billing policy was changed as a consequence. People with health care cards were no longer bulk-billed and all accounts had to be settled on the day of the consultation. As a result of the complaints the clinic prepared posters explaining the new fee system and inviting patients to discuss any concerns with their doctor. Doctors had the discretion to charge lower fees if they considered this appropriate.

Rights

Complaints about rights are shown in Table 22. If an allegation of unprofessional conduct is made against a provider who is registered by a board, the complaint will often be referred to that board for investigation. Where there is no registration board the OHSC will deal with the complaint. If it is of a serious nature the HSC may decide to conduct a formal investigation.

Rights	6%
Access to records	4
Accuracy of records	7
Assault	11
Discrimination	4
No/insufficient consent	10
Other	5
Privacy/confidentiality	1
Unprofessional conduct	21
Refusal to treat	11
Total	**74**

Table 22: Rights

A man complained a naturopath had behaved in an unprofessional manner when he consulted her about his health problems. He made a follow-up appointment but failed to keep it because of a traffic accident. The naturopath sent him an angry email which included personal comments about his weight and appearance. In response to the complaint she apologised for her behaviour and offered a refund for the initial consultation.

Treatment

Treatment	59%
Inadequate diagnosis	77
Inadequate treatment	281
Medication	75
Negligent treatment	144
Other	26
Rough treatment	21
Unskilful/incompetent treatment	56
Wrong diagnosis	17
Wrong treatment	13
Total	**710**

Table 23: Treatment

A man attended the emergency department of a hospital after falling from a ladder. X-rays showed he had fractured his wrist and ankle and these were treated. He complained of pain in his arm and shoulder but no further investigations were done at the time. One month later he returned to the hospital as he was still in pain and further x-rays showed he had dislocated his shoulder in the fall. The surgeon told him the injury would be more complex to treat after the delay. He had been unable to work for an extended period of time and so the complaint was referred to conciliation in order for him to discuss his claim for loss of income arising from the delay.

Primary Issues in HRA Complaints

Over the past year, there has been an increase from 86 to 172 in the number of accepted HRA cases compared to the previous reporting year. The majority of cases relate to use and disclosure of health information, where the person is complaining that their health information was inappropriately used within the organisation, such as their workplace, or disclosed to another organisation. Use and disclosure complaints increased from 32 to 71 this year. Complaints about access to records are the second most frequent category complained about, with the total being 60 compared to 39 last reporting year.

A typical complaint about access is when the person asks an organisation for a copy of their records, and either access is refused or the incorrect fees are charged. Some health service providers are uncertain about the status of requests for records made by a person's solicitors. In most cases, the OHSC clarifies with organisations their obligations to provide access to records and the fees that can be charged, and the matter is then resolved.

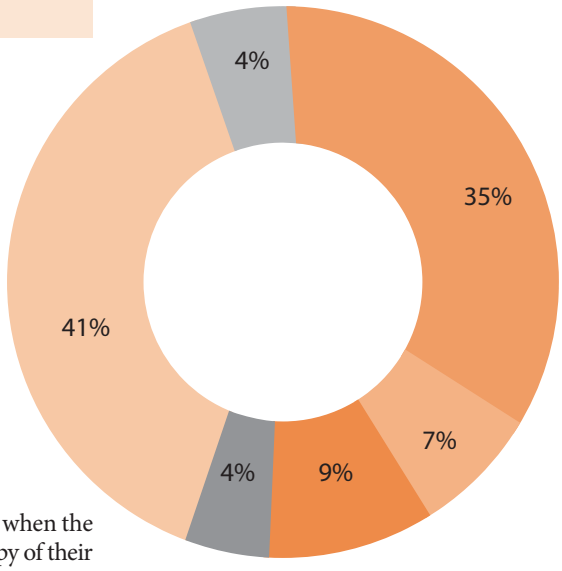


Figure 3: Analysis of issues - HRA

Legend

- Use & disclosure (41%)
- Other (4%)
- Access & correction (35%)
- Collection (7%)
- Data quality (9%)
- Info available to another HSP (4%)

A man had a surgical procedure to his foot performed in 2008, with which he was dissatisfied, and he sought a second opinion from another surgeon. The man discovered the first surgeon had obtained a copy of the reviewing surgeon's letter to the referring GP.

The man advised the OHSC he did not give consent for the first surgeon to know the identity of the reviewing surgeon who had given him the second opinion, or for the reviewing surgeon's letter to be given to the first surgeon. He had initially thought the GP had given the letter to the first surgeon. After making further enquiries, the man discovered that when writing to the referring GP, the reviewing surgeon had copied to the first surgeon his letter to the GP.

Health Privacy Principle 2.1 of the HRA states an organisation is permitted to use and disclose health information for the primary purpose for which it was collected. The information can only be used and disclosed for a different purpose if the individual has consented or if one of the other exceptions set out in HPP 2.2 apply. For example, HPP 2.2(a) permits disclosure for a directly related secondary purpose that the individual would reasonably expect.

In his response to the OHSC, the reviewing surgeon referred to the practice of specialists, when writing to the referring GP, of copying the letter to other practitioners involved in the care of the patient. However the complainant had stated he was in conflict with the first surgeon, and the first surgeon would not be providing further medical care to him. Our office advised the reviewing surgeon that the appropriate course would have been for him to tell the man of his intention to write to the first surgeon. The man would have had the opportunity of advising him he did not want this to occur.

The surgeon accepted that in the future, when providing a second opinion to a patient, he would check with the patient before communicating with the specialist with whom the patient was in dispute. The complaint was resolved and the file was closed.

The major issues in HRA complaints can be seen in Table 24.

Access & Correction	**35%**	**Info available to another HSP**	**4%**
Access refused	45	Information refused	5
Correction refused	5	Unreasonable time in delivery	2
Inaccurate information not concealed	1		7
No written reason for refusal	9	**Use & disclosure**	**41%**
	60	Disclosure - Inadequate consent	56
		Disclosure - Inadequate disclosure	12
		Use - Insufficient information	3
			71
Collection	**7%**	**Data quality**	**9%**
Breach of in-confidence details	8	Data inaccurate, incomplete or out of date	9
Third party collection	1	Unsatisfactory protection	5
Unlawful/Intrusive collection	3	Unlawful/Intrusive collection	2
	12		16
Other	**4%**		
Transborder data flows		**Openness**	
Transborder dataflow unreasonable	1	Policies unavailable, unclear or inadequate	1
	1		1
Transfer/closure of HSP	**1%**	**Identifiers**	**1%**
Unsafe storage of records	2	Misuse	2
	2		2
Anonymity	**0%**		
Refusal of anonymity	0		
	0		
		TOTAL	**172**

Table 24: HRA Issues

Categories of Accepted Complaints Against Health Service Providers

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

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

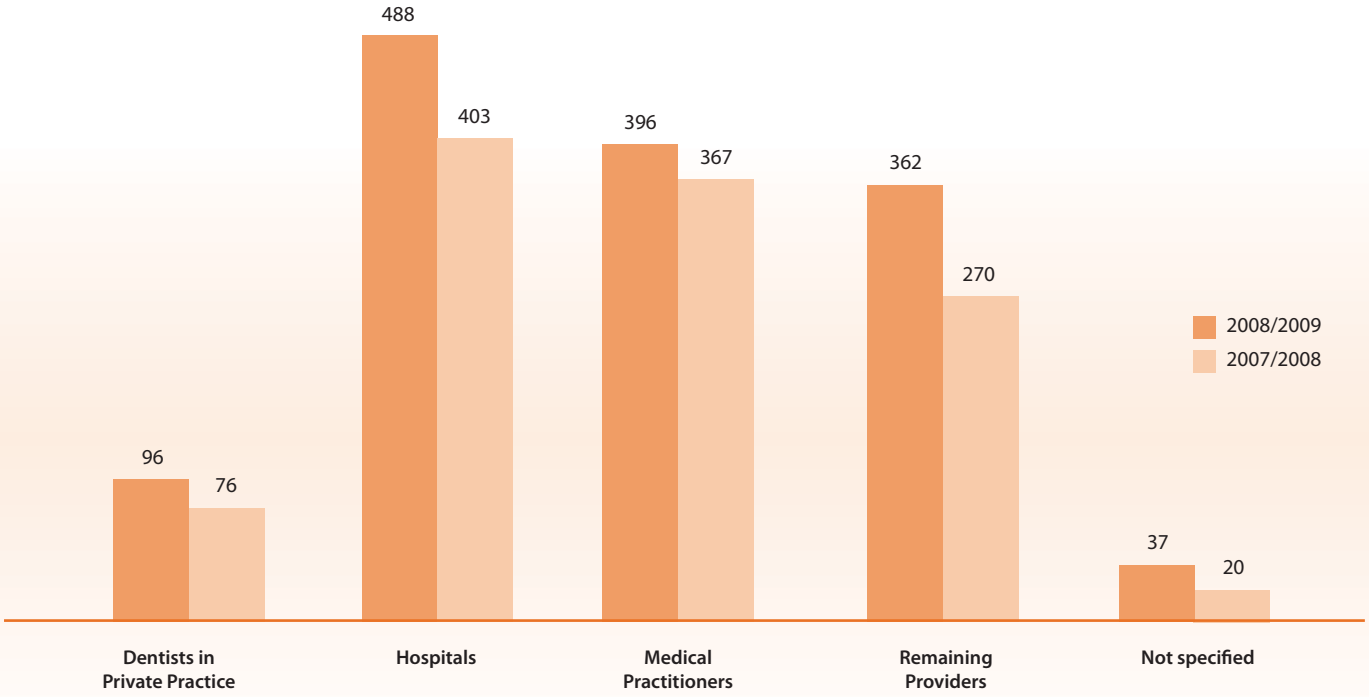


Figure 4: Categories of complaints about health service providers

The increase in the number of complaints against categories of health services is in line with the overall increase in complaints this year (22%), other than for doctors, where complaints increased by only 4%

Medical Practitioners

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

The most frequently named issues in relation to treatment are inadequate treatment and diagnosis, and negligent treatment (70%). These issues are those outlined in the complaint statement and, in reality, there is little to separate 'negligent treatment' from 'inadequate treatment' and they could be viewed as one group. In most of these cases there will be no evidence of negligence found in the complaints process; however, the patient often will believe there was negligence if communication about risks has not been sufficiently communicated or understood.

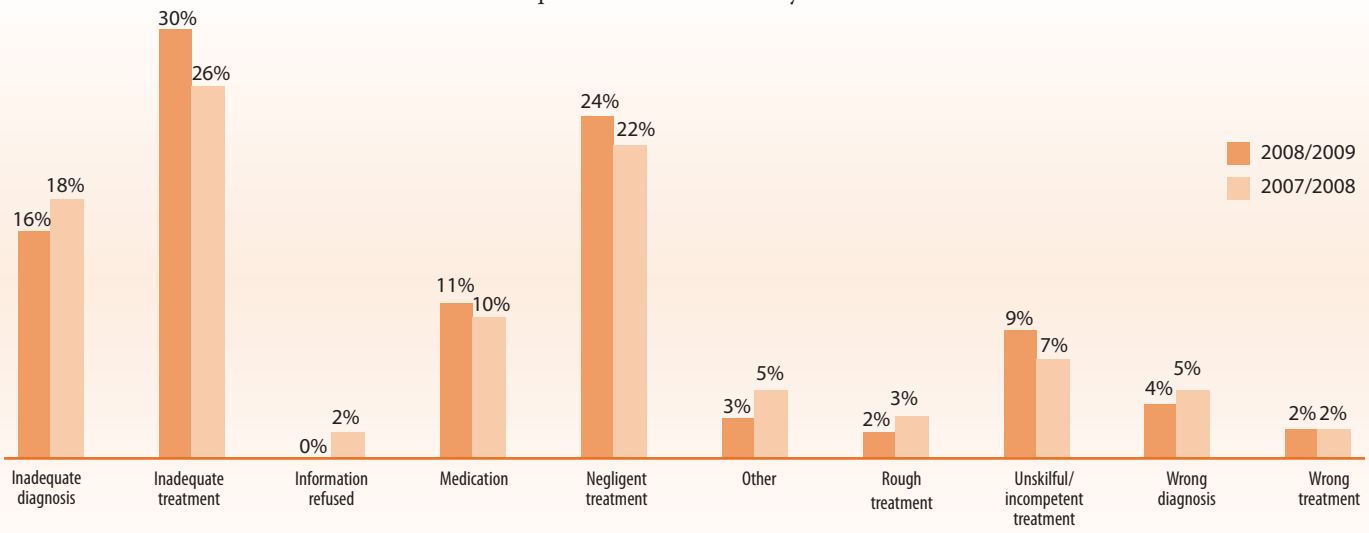


Figure 5: Treatment Issues – Medical Practitioners

General Practitioners

The number of complaints against general practitioners could be seen as quite low in comparison with the number of patient contacts in a year. The relationship between doctors and their patients is very important and mediation can serve to mend this relationship in many cases. Other patients may move frequently from one doctor to another and it can be more difficult to develop the rapport necessary for good communication and to foster trust.

As general practitioners are usually the first service consulted for health issues they see a wide variety of conditions and injuries. There can be an expectation amongst patients that the doctor should know everything in relation to the presenting condition and, although they may be referred to other specialists, patients often believe it is the general practitioner's responsibility to ensure the specialists get it right.

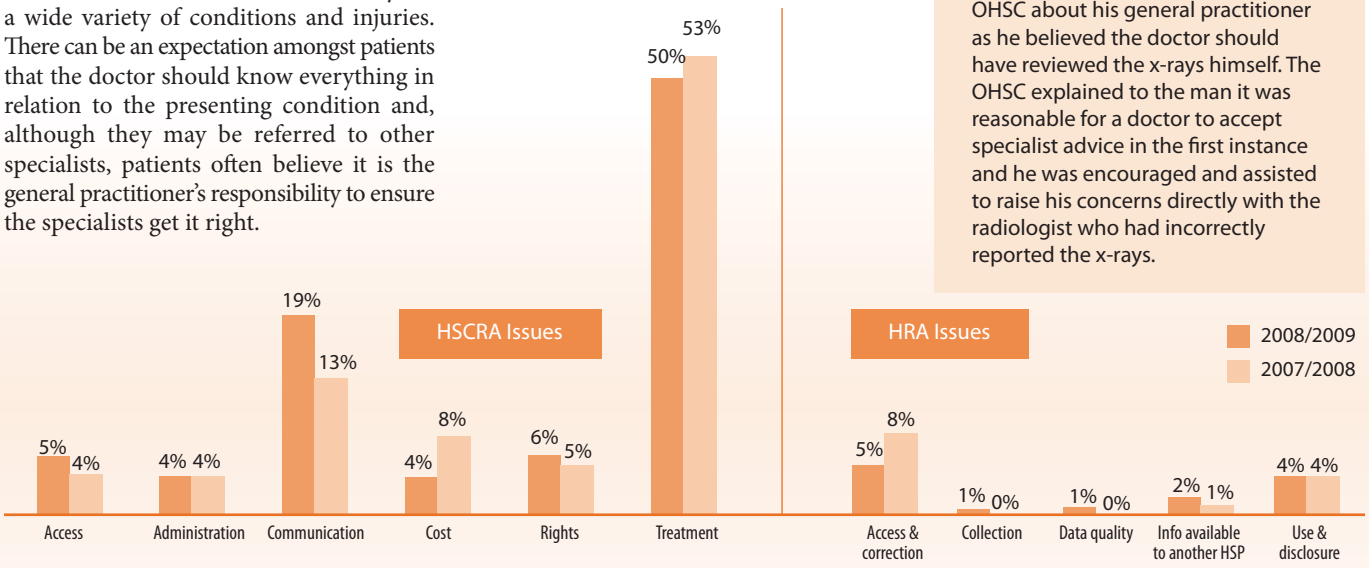
As in previous years, treatment issues outnumber all other issues in complaints about General Practitioners.

Issues in complaints about general practitioners can be seen in Figure 6

Year		%
2007	93	8%
2008	143	13%
2009	132	10%

Table 25: Complaints about GPs as % of all complaints

A man attended his general practitioner following an injury to his hand while gardening. The doctor examined the patient and sent him for an x-ray which was reported as normal. As the hand was tender the doctor bandaged it and advised the patient to rest it for a few days. Over the weekend pain increased and the man attended his local hospital emergency department. The x-rays were obtained and reviewed and it was noted the hand was fractured. The man made a complaint to the OHSC about his general practitioner as he believed the doctor should have reviewed the x-rays himself. The OHSC explained to the man it was reasonable for a doctor to accept specialist advice in the first instance and he was encouraged and assisted to raise his concerns directly with the radiologist who had incorrectly reported the x-rays.



Dentists

Most complaints made about dentists refer to treatment or consent issues. While most dentists advise patients of treatment options, risks and costs, there are still a few complaints each year about lack of adequate informed financial consent for dental procedures. This may in part be due to the complications which can arise in dental treatment which may not have been anticipated when treatment commenced.

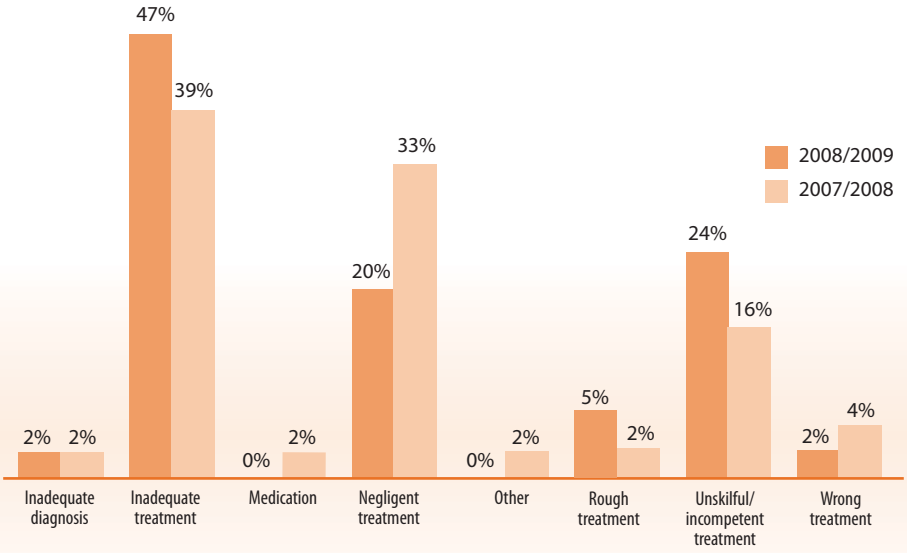


Figure 7: Treatment Issues - Dentists

A woman had been referred to a dentist by her doctor for Medicare-funded treatment. She complained the treatment had not been completed, her dentures were unwearable and there was no money for more treatment so she would need to pay herself if she wanted the work completed. The woman obtained an opinion from another dentist that the dentures were not suited to her and so the dentist agreed to refund that portion of the fees to Medicare so she could have the denture re-made elsewhere.

Hospitals

Public hospitals treat more patients each year than private hospitals do. Complaints about treatment in a private hospital will frequently need to be made against the admitting doctor rather than the hospital. There is a general lack of understanding in the community about the relationships that exist between private specialists and private hospitals and the fact that many smaller private hospitals do not employ their own doctors as staff.

During the year the database was checked to ensure that private hospitals were recorded correctly. This exercise resulted in the correct identification of all private hospitals. The apparent increase in complaints this year is a result of this exercise. The actual increase in complaints against private hospitals (20%) is in line with the overall increase in complaint numbers this year.

The 12% increase in complaints against public hospitals is lower than expected in relation to the overall increase.

Figure 8: Public/Private Hospital Comparisons

Public Hospital Issues

Issues about public hospitals are set out in Figure 9.

A woman complained nursing staff at a public hospital ignored her requests for assistance while she was an inpatient following surgery to her right arm. She said she could not get assistance to go to the bathroom, to eat or to retrieve her items when they fell to the floor. Because of plaster casts and an IV drip she was unable to do these things for herself. She had contacted the hospital's complaints officer who said she would speak to staff but the situation deteriorated. When she contacted the OHSC after discharge the hospital responded explaining there had been a shortage of staff due to illness and apologised for her bad experience. They also gave an undertaking to conduct training for the staff on these communication issues.

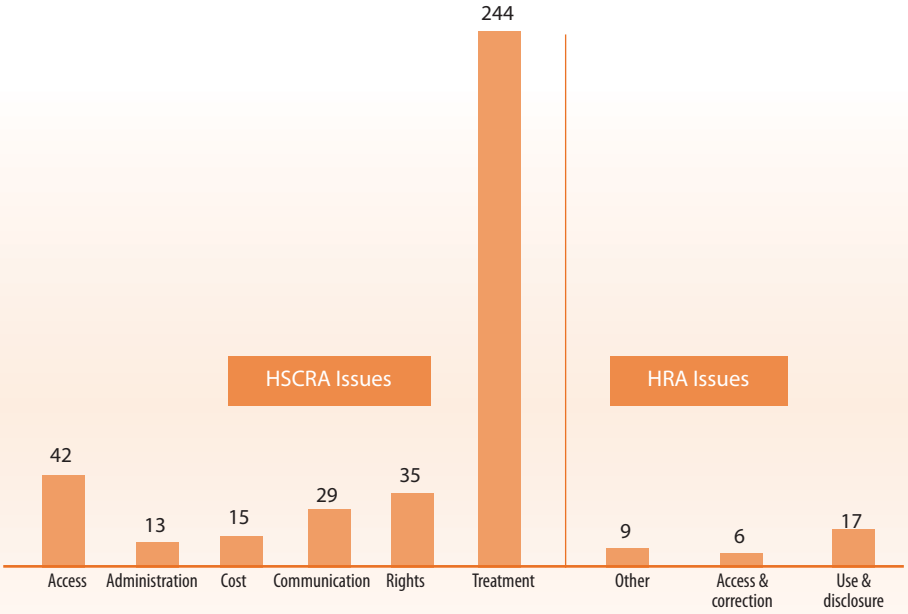


Figure 9: Public Hospital Complaints

Private Hospital Issues

The numbers of complaints against private hospitals are comparatively few as any complaints about treatment decisions and outcomes would usually be made against the admitting doctor rather than the hospital. Complaints might be made against a private hospital for nursing or communication issues.

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

An elderly woman was admitted to a private hospital for surgery. She advised the anaesthetist that she wore an upper denture and he suggested she take it out and leave it in her side table drawer for safe-keeping. When she returned to her room after the surgery she could not find her denture. The hospital responded that she must have left it on the table by mistake where it may have been cleared away with tissues and other rubbish, but the woman was certain she had placed it in the drawer as suggested. After contact from the OHSC the hospital agreed to pay the costs of replacing the denture.

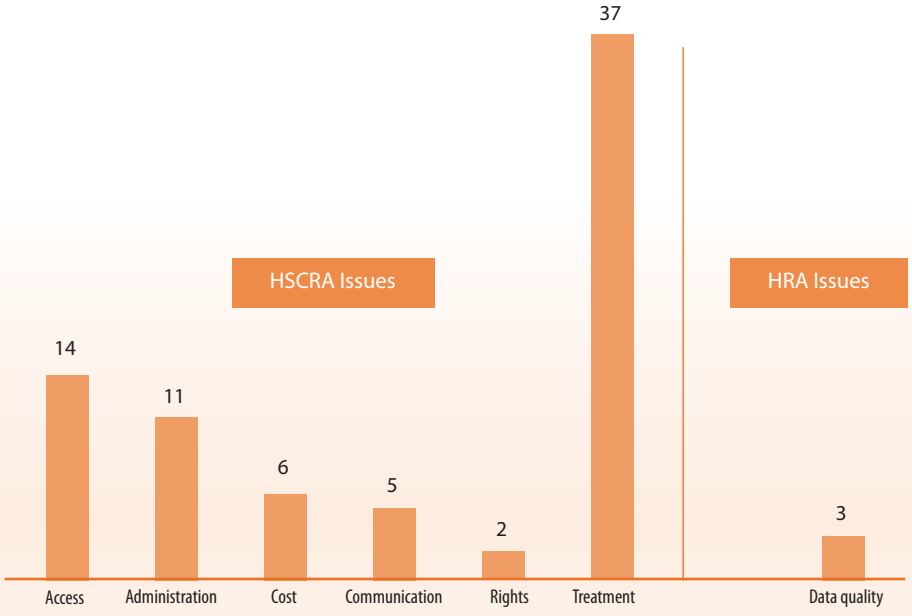


Figure 10: Private Hospital Complaints

Psychiatric Services

There was an 18% increase in the number of complaints involving psychiatric care issues this year in line with the overall increase in complaint numbers. Complaints against medical practitioners in this category decreased slightly from 19% to 16% while complaints against psychiatric health services and public hospitals increased from 62% to 75% of all complaints about psychiatric issues.

	Total	
Medical Practitioner	23	17%
Psychiatric Health Service	25	18%
Public Hospital	71	52%
Remaining Providers	18	13%
Total	**137**	

Table 26: Types of Psychiatric Service

	Total	
Treatment	85	62%
Access/other	44	32%
Assault	5	4%
Health Records Act	3	2%
Total	**137**	

Table 27: Issues in Psychiatric Complaints

A family contacted the OHSC to complain that a young man had absconded from care in a psychiatric hospital although he had been assessed as needing high level care. The hospital explained the young man had requested a cigarette and had been permitted to go out on the upper level terrace to smoke. He then climbed down from the terrace and left the hospital. When he was reported missing some hours later the family were notified and he was soon found. The hospital acknowledged the patient should have been closely monitored while on the terrace and they had reminded staff about their obligations in this matter.