Health Care Complaints Commission
Assessments and Resolution

Assessment Criteria

Complaint Handling

Assessment criteria

It is fundamental to effective complaint handling that complainants feel that their sense of grievance has been acknowledged and taken seriously. Complainants want to know that they will be kept informed of how their complaint will be managed and what they can expect from the process. It is important that this commences at the assessment stage when complaints are first received, recorded and assessed by the Commission. It is equally important that this carries through to the final resolution of the complaint. Appropriate referrals play an important role in reassuring complainants that their complaints are being taken seriously and will be handled sensitively and appropriately.

Where a complaint does require formal investigation by the Commission under section 23 HCCA the assessment process (including consultation) should focus on identifying the method of managing the complaint that is most likely to produce a resolution that is fair and equitable in all the circumstances.

In deciding what form of resolution should be recommended, Assessment Officers should bear in mind:

- the nature of the complaint;
- the personal circumstances of the complainant;
- the outcomes being sought by the complainant;
- the outcomes that are reasonable in the circumstances;
- the ability of the complainant to effectively represent their own interests in dealing with the provider or providers involved;
- the response (if any) received from the provider or providers; and
- the preparedness or otherwise of the provider or providers to address the complainant's concerns.

The assessment criteria outlined here will provide guidance as to what type of further action will generally be appropriate. However, each complaint is different and must be assessed on its particular facts recognising that the circumstances that gave rise to the complaint and the personal situation of the complainant or other affected persons may influence how the complaint will be handled.

Responses to a complaint

There are broadly speaking six types of response available to the Commission in relation to a complaint, see section 20 *Health Care Complaints Act 1993* (HCCA). These are:

1. Investigation
2. Referral to CRO
3. Conciliation
4. Referral to the Director-General of Health
5. Referral to another body
6. Discontinue

1. Investigation

Section 23(1) HCCA provides that the Commission must investigate a complaint where the Commission, *after assessment*, believes that the complaint:

i. raises a significant issue of public health or safety
ii. raises a significant question as to the appropriate care or treatment of a client by a health service provider
iii. if substantiated, would provide grounds for disciplinary action against a health practitioner or
iv. if substantiated, would involve gross negligence on the part of a health practitioner

The Commission will investigate matters involving inappropriate sexual or personal relationships between practitioners and patients/clients. Where a practitioner engages in a sexual relationship with a person with whom the practitioner has or has recently had a therapeutic relationship this will usually provide grounds for disciplinary action against the practitioner on the basis that it amounts to either professional misconduct or unsatisfactory professional conduct.

Other forms of personal relationship – such as attending social engagements with a patient or client, discussing the practitioner's personal affairs with the patient or client, offering to meet the patient or client after hours and/or out of the clinical setting, giving gifts to the patient or client – may also give rise to disciplinary action and, subject to the views of the relevant Board, may be formally investigated by the Commission.

Cases where a practitioner has provided seriously inadequate or inappropriate treatment to a patient or client also warrant investigation. In the first instance the Internal Medical Advisor or Internal Nursing Advisor will generally be able to give advice as to whether care or treatment was so inadequate or inappropriate as to attract criticism. In other cases a peer reviewer or the relevant Board will be able to provide advice as to whether care or treatment was seriously deficient. Disciplinary action is warranted in cases where there was a significant departure from an adequate standard of care by the practitioner. In determining whether there was a significant departure it is necessary to take into account the level of skill and experience of the practitioner.

Criminal convictions, criminal findings and other misconduct by a practitioner that calls into question the person's suitability to hold registration as a practitioner may also give rise to disciplinary action against the practitioner and warrant formal investigation by the Commission. In some cases referrals in relation to criminal or other misconduct will be made by other agencies with the power to carry out investigations such as the Pharmaceutical Services Branch and NSW Police.

The Boards may also refer matters relating to impaired practitioners that require investigation by the Commission.

In addition to section 23(1) there is another instance where a complaint *must* be investigated. The Commission must investigate a complaint where, after consultation with the relevant Board the Board is of the opinion that the complaint should be investigated, see section 13(1) HCCA. This is subject to the complaint being in relation to a matter that is within the jurisdiction of the Commission.

The Commission is obliged to investigate a matter where a practitioner has been suspended or had conditions imposed on their registration by a Registration Board, see for example, section 66B *Medical Practice Act 1992*.

It is only in cases where the Commission decides not to investigate a complaint that consideration should be given to other forms of resolution.

2. Referral of complaints to Complaints Resolution Service

Where a complaint is assessed as not requiring investigation the complaint or part of the complaint may be appropriate for referral to the Complaints Resolution Service (CRS). This is suitable where the complainant may require assistance from a party not connected to the provider [and not directly connected to the health system] to express their concerns and identify what outcomes they would like to achieve as a result of meeting, or otherwise dealing, with the health service provider. CRO involvement can be of particular value where there is high emotional content, complex grief issues, where it is desirable to maintain (or re-establish) the therapeutic relationship, in cases where there has been a breakdown in communication or where the complainant is vulnerable or has special needs.

Identifying complaints by reference to these factors is intended to improve the Commission's ability to provide the best means of resolution.

"High emotional content"

A complaint may indicate that a complainant believes that health care or treatment received by them or by a family member not only failed to properly treat the medical condition with which they presented but may have worsened the condition or caused the death of a family member or friend. Such a belief can be a cause of distress and sometimes hostility. Cases of this kind can be accompanied by high levels of anxiety, anger or hostility on the part of the complainant.

For complaints of this type referral to a CRO is appropriate.

In many of these cases the complaint is resolved by the provider giving more information and fuller explanations to the complainant or family about the nature of the health services provided or the limitations inherent in particular types of care or treatment or the reasons why particular forms of care or treatment were given or not given and the timing of such treatments.

There are many cases where a complainant or family member's distress at what they see as a poor or unexpected outcome feels like a form of betrayal – a feeling that they have been let down by health professionals who could have and should have achieved better results. Cases where complainants and family members want to know "how could they have let this happen?" are appropriate for referral to a CRO.

The high emotional content present in some complaints may be exacerbated by grief, communication breakdown or vulnerability of the complainant – more information about these issues is provided below.

Complex grief issues

In some complaints it appears that the family or companion or carer of a person who died was not aware of the seriousness of the condition of the person in the lead up to their death or did not have an appreciation of the risks associated with the care or treatment provided to the person prior to their death.

Other complaints indicate that family, companions or carers are experiencing significant difficulty accepting the death of the person.

In both these settings the same issues as for high emotional content apply, and may be heightened, because of bereavement. Grief can be overwhelming, indeed almost paralysing, and there are many cases where it is important that family members, companions or carers obtain more complete information about what happened and why. Referral to a CRO is appropriate in such cases.

Where it is desirable to attempt to maintain (or re-establish) the therapeutic relationship

A complainant may want or need to maintain their therapeutic relationship with a particular provider for their ongoing health needs. This can occur in relation to geographic proximity – people in regional, rural or remote locations may have limited choice in respect of health service providers and may not be in a position to travel long distances to seek alternative assistance.

In other cases a person's needs may be so specific that there is a limited number of providers who practice a particular specialism.

A breakdown in the therapeutic relationship because of dissatisfaction by either side with the conduct of the other can have significant adverse consequences for the patient. It is desirable that these matters are resolved quickly and without rancour. CRO involvement can promote resolution on terms that permit the therapeutic relationship to continue.

Cases where the complainant has few choices in relation to where and from whom they access health care are appropriate for referral to a CRO.

Communication breakdown

Some complaints demonstrate that the needs or expectations of one party are not understood or addressed by the other party. In cases where a person's health or wellbeing is directly affected this mismatch of needs and expectations can quickly lead to entrenched and potentially intransigent positions.

Communication breakdown of this kind can lead to anger and hostility and a lack of information or understanding about appropriate forms of care or treatment. Some of these cases will be similar to those involving high emotional content, others will have similarities to cases where it is desirable to

maintain the therapeutic relationship, in other cases the relationship has come to an end but the complainant still needs to know more about the care or treatment provided, or the reasons why particular things were not done, or why the outcome was different to what they had expected.

Complaints where the principal element is ineffective communication between the parties are appropriate for referral to a CRO.

Complainants who are vulnerable or have special needs

An additional layer of complexity can be added in cases where a complainant is vulnerable or has special needs as well as having had difficulties in relation to the provision of health services.

Ill health is, in itself, a cause of distress and even embarrassment for many people. Where this is accompanied by other vulnerabilities – poor language or literacy skills, disability of some kind, societal or cultural factors and the like – it can be difficult for a complainant to identify and pursue the issues that are of concern to them. CROs have extensive experience in these settings and can assist vulnerable complainants to obtain satisfactory resolution of their concerns. This can include making special arrangements for the complainant so that they can access information they need or so that a particular need that the complainant has can be addressed to their satisfaction.

Complainants who identify themselves as having special needs or who we identify as having special needs should be referred to a CRO for assisted resolution.

The following matters may also represent special needs and would generally be referred to CRO for assisted resolution:

- **Transgender Issues**
  Referral to a CRO will generally be appropriate in transgender matters where the conduct complained of relates to the complainant's transgender identity.

  This will include matters where there has been a failure to provide appropriate services which are necessary because of the person's gender reassignment. An example of this might be where a person who now presents as a man still requires gynaecological care.

  In those cases where gender reassignment is not relevant to the complaint it should be assessed like any other complaint.

- **"Difficult" complainants**
  There are cases where it may be difficult to identify with certainty the issues that a complainant wishes the Commission to address. This may be because the person has chronic health problems that affect their ability to articulate their needs or the person may have some form of undiagnosed or untreated mental health condition that reduces their ability to have productive dealings with others.

  In other cases the person may not be suffering from any recognised disorder but may be angry, aggressive, hostile or very strongly focused on the circumstances of their complaint. Some persistent complainants will fall into one of these categories.

  In these cases referral to a CRO will generally be appropriate. The opportunity to be heard and the availability of someone to assist them will afford some, but regrettably not all, difficult complainants a measure of satisfaction.

- **Multi-layered complaints**
  Some complainants will have had many contacts with different parts of the health system over long periods of time. In some cases complainants will raise many diverse issues that require different forms of resolution for each part of the complaint.

  In situations of this kind it is appropriate, providing the issues raised do not require referral for investigation, that the complaint is first referred to a CRO. Initial CRO involvement may assist in identifying those issues that can be resolved by assisted resolution. This may provide an opportunity for issues not suitable for assisted resolution to be given more focus and then referred for other forms of resolution.

- **Drug and alcohol dependency**
  In many, and perhaps most, cases of drug or alcohol dependency the problems that the complainant experiences in respect of their health care are accompanied by other problems in their life.

  Many complainants with such dependencies are not well placed to negotiate unassisted with health service providers and referral to a CRO for assisted resolution is appropriate.

- **Patients needing or undergoing mental health treatment**
  A person who requires or is receiving mental health treatment may face difficulties obtaining information about their condition or their care and treatment. Experience demonstrates that some people in this position have unfounded concerns about their treatment. In these cases referral to a CRO is appropriate.

- **Prisoners**
  Prisoners are generally not well placed to manage the resolution of their complaints without some form of assistance. Referral to a CRO, rather than for conciliation, will generally be appropriate.

Other types of complaint

The areas of complaint outlined above where referral to a CRO is appropriate are not exhaustive. In some cases even where such factors are present some other form of resolution may be more suitable. Other complaints, which do not or do not appear to include any of the factors noted above may still be appropriate for referral to a CRO.

In any case of uncertainty Assessment Officers should seek assistance from the Manager, Complaint Assessment Team or Director, Assessments and Resolution.

3. Conciliation

Conciliation process overview

Conciliation is a more formal and structured process than assisted resolution. In conciliation an independent conciliator, selected from a panel appointed by the Minister, facilitates a meeting of the parties to a complaint in an attempt to achieve an appropriate form of resolution.

The parties to a complaint are not entitled to be legally represented at the conciliation meeting but a complainant is always entitled to have a support person (who is not a lawyer) attend with them. The provider about whom the complaint was made can have a support person present if the Registrar or the conciliator permits it because the provider would be disadvantaged without that person's attendance, see section 50.

An important factor to consider in deciding whether to refer a complaint for conciliation is the ability of the complainant to progress the matter through the conciliation process. The Registrar assists the parties to prepare for the conciliation meeting but the amount of assistance the Registrar can provide to the parties is more limited than that which a CRO can give them during assisted resolution.

Moreover, the Registrar is not present at the conciliation meeting and it is a matter for the parties (particularly the complainant) to articulate their concerns and tell the other side what they want to come away with from the conciliation meeting. While conciliators are skilled at assisting the parties to express themselves, it is still a matter of the complainant being expected to 'do the work' to put their point across.

As with the complaint resolution process, participation in conciliation is **voluntary** and **requires the consent of the parties**. However, unlike the complaint resolution process, conciliation is **confidential** and statements made during and documents made for the purposes of conciliation are not admissible in court, tribunal or Board proceedings unless all of the parties consent to their use, see section 51 HCCA.

The confidentiality of conciliation means that it is a setting where a health service provider about whom a complaint has been made is able to make an **admission of wrongdoing** or give or offer financial or other **compensation** without those things being used against the provider in any subsequent lawsuit. For this reason practitioners may be prepared to engage in conciliation where they might be reluctant to engage in assisted resolution.

Accordingly, in cases where the complainant wants the provider to admit she, he or it acted inappropriately or made a mistake or where the complainant is seeking a refund or financial compensation or additional services at no cost, the complaint should be referred for conciliation.

The Commission's experience indicates that many complainants want an acknowledgement, admission or apology for the wrong they allege was done to them. Complaints where an apology or admission is very important to the complainant may be best suited to conciliation, simply because it may provide the best opportunity for such an outcome to occur.

[NOTE: The Civil Liability Act 2002 provides that an apology or expression of sympathy or regret is not admissible in court proceedings for compensation against a person giving the apology or expressing the sympathy or regret. The protection provided by section 51 HCCA is in addition to that provided by the Civil Liability Act.]

Other features of the different dispute resolution processes that should be considered when making an assessment recommendation are:

- is the complaint capable of being resolved in a single meeting, or does it need several stages of resolution involving different strategies (ie. correspondence, information from a third party, telephone discussions etc);

- are the parties likely to respond well to the more formal and self contained conciliation setting, where the focus is on reaching an agreement at the end of the session;

- are the parties capable of following up to ensure that the terms of any agreement are adhered to, or are they likely to require substantial assistance with this? For example complainants who are assertive are likely to be more able to do this than complainants who are passive or lack confidence. The Registry is not empowered to enforce agreements reached at

conciliation, and can do some limited follow up if they are notified that terms of agreement have not been complied with. However a CRO can remain more actively involved on such follow up and can take a more proactive role than the Registry.

In addition to the nature of the process, the nature of the complaint will also provide some guidance about the appropriate assessment decision.

Provision of Information

As with assisted resolution, conciliation can provide an excellent opportunity for parties to share information, and for the complainant to have their questions answered. The formality of conciliation may encourage more senior members of staff of a health provider to become involved in a complaint, and this may lead to a better outcome for the complainant.

Poor communication

Most complaints that come to conciliation are characterised by a lack of effective communication at some point. As with assisted resolution, conciliation can provide an opportunity to re-establish channels of communication that had been broken or damaged. Conciliation provides a structured environment for doing this, and conciliators are skilled at assisting parties to identify and express their concerns and feelings. Many conciliations include considerable discussion about communication problems and misunderstandings, and apologies for this kind of problem are very common as part of a resolution agreement.

Characteristics of the parties

In some cases factors that would lead the Commission to consider referral of the complaint to a CRO may also be present. As explained above, in cases where a complainant has significant issues such a grief that may interfere with their ability to communicate clearly or the complaint would best be addressed through a multi-stage approach the CRO may be better option. This does not mean that matters involving deep emotions such as grief or anger are not suitable for conciliation. Given the nature of the jurisdiction, strong emotions are a characteristic of many complaints the Commission receives. Where it appears that a complainant is able to articulate their concerns and expectations and it appears that a single conciliation meeting is likely to achieve a good outcome for the parties to a complaint consideration should be given to referring the matter for conciliation.

The Commission is obliged to keep its assessment decision under review while it is dealing with a complaint and to revise the assessment decision where appropriate, see section 20A. Cases which relate to issues identified in Part 2, particularly where there is likely to be a need for ongoing assistance, should generally be referred to a CRO in the first instance. Once those issues have been addressed the complaint can, if necessary, be reassessed for conciliation.

Assessment Officers should be mindful of the nature of the claim for compensation. Where small amounts are being sought – up to a few hundred dollars – it is not likely to be cost effective to refer those matters for conciliation and referral to a CRO may be more appropriate. In other cases complainants have sought large amounts of compensation where there is no basis at law for making such claims and in these cases referral to a CRO might be more appropriate.

In any case of uncertainty Assessment Officers should seek assistance from the Manager, Complaint Assessment Team or Director, Assessments and Resolution.

4. Referral to the Director-General of Health

The Commission is obliged to notify the Director-General where a complaint is received about a **health organisation**, see section 17 HCCA. A 'health organisation' is a health service provider which is not a natural person.

The Commission is obliged to notify the Director-General of a complaint, if after assessment it appears that the complaint involves a breach of any of the Acts set out in section 25 HCCA. The Director-General has administrative and legal functions under those Acts.

Section 25A provides that the Commission may, with the consent of the Director-General, refer a complaint or part of a complaint to the Director-General if the complaint (or part) could be the subject of an inquiry under section 71 of the *Public Health Act 1991* or section 123 of the *Health Services Act 1997*.

Section 71 PHA provides that the DG can conduct an inquiry in relation to the health of the public. Section 123 HSA provides that the Director-General can, subject to some restrictions, conduct an inquiry into the management, administration or services of an organisation that provides a health service.

If a referral is made to the Director-General the Commission must, notwithstanding section 27(3) of the Act, discontinue dealing with the matter. [Section 27(3) says that the Commission must not discontinue dealing with a complaint – even if the requirements of section 27 about discontinuing dealing with a complaint are met – if the complaint involves a significant issue of public health or safety.]

After making a referral to the Director-General under section 25A the Commission may continue to deal with a complaint to the extent that the complaint involves the professional conduct of a practitioner or a health service that affects the clinical care or management of an individual.

5. Referral to another body

Public Health Organisations

The Commission's previous practice of referring complaints to an Area Health Service for their investigation and report back under section 26 HCCA has ceased. Amendments to the HCCA provide that a complaint can be referred to a public health organisation, such as an Area Health Service, for resolution at the local level. The public health organisation must consent to this referral before it is made. It is appropriate to refer matters to an Area Health Service for resolution at the local level where the complaint relates to access to services or the quality of services where the Commission believes there is no need for a CRO to be involved to ensure that the complaint is properly addressed.

Registration Boards

The various Registration Boards have different powers to act in respect of complaints received by them or referred to them by the Commission. Many Boards have **Care Assessment Committees** that are able to make a determination as to the appropriateness of the care or treatment provided to a complainant. Some, such as the Dental Care Assessment Committee (DCAC), are able to direct a practitioner to refund money to a complainant.

Many Boards are able to require a practitioner to attend the Board for counselling. Counselling is appropriate in cases where a practitioner should be subject to some form of less formal intervention to address or correct a deficiency in their practice, such as writing up clinical notes, communicating with patients or clients or in order to make the practitioner understand the importance of good clinical practice.

Some specific arrangements are in place with various Boards in relation to how particular types of complaints should be addressed. An example of this is the Pharmacy Board. The Commission and the Pharmacy Board have an agreement that complaints concerning dispensing errors will be referred to the Board for their investigation.

Some Boards have performance assessment and impairment assessment program. Where a complaint indicates that practitioner may be impaired or have a significant gap in their level of skill or knowledge it may be appropriate to refer them to the relevant Board.

In respect of each Board the following arrangements currently apply:

- **Medical Board**
  The Commission meets with the Board every week to consult on assessment decisions for new complaints. Every month the Commission attends the Board's Conduct Committee to deal with complaints that are subject to investigation or with the Director of Proceedings.

  The Medical Board maintains performance assessment and impairment assessment programs.

  The Medical Board will manage complaints, that do not require investigation under section 23 HCCA, where it appears that deficiencies in the practitioner's skills or abilities have given rise to the complaint or, more likely, a series of complaints.

  The Medical Board only deals with complaints about medical practitioners (they also deal with complaints concerning persons who are 'holding out' that they are medical practitioners). The Board does not deal with complaints about medical centres or non-doctor staff of medical practices.

- **Nurses and Midwives Board**

  The Commission and the Nurses and Midwives Board meet in person once a month to consult on the assessment decision in relation to new complaints. The Commission and the Board also have a teleconference once a month (in the opposite fortnight) to assess new complaints.

  The Board is developing performance assessment and impairment assessment programs.

  The Board has the power to require a nurse or midwife to attend for counselling. Complaints that indicate that a nurse or midwife has a poor understanding of their obligations in respect of good practice, but which are not so serious as to require disciplinary action, are suitable for referral to the Board with a view to counselling the nurse or midwife.

- **Dental Board**
  The Commission meets with the Board every month to consult on assessment decisions for new complaints.

The *Dental Practice Act 2001* establishes a Dental Care Assessment Committee (DCAC). Complaints are suitable for referral to DCAC where there is some physical 'evidence' of the dental work that was carried out by the dentist which can be reviewed and assessed by the Committee (this includes braces, dentures, bridge work and plates). DCAC can direct a dentist to refund fees paid by the complainant.

The Dental Board will accept complaints about dental clinics but will generally only pursue such complaints where a registered dental practitioner can be identified.

The Commission does not retain an Internal Dental Advisor and the Dental Board is able to provide initial advice about the appropriateness of dental care or treatment.

- **Pharmacy Board**

The Commission and the Pharmacy Board meet every month to consult on assessment decisions in relation to new complaints. The Pharmacy Board deals with complaints about pharmacy 'shops' (known as community pharmacies) as well as complaints about pharmacists employed in other settings such as hospital dispensaries.

The Commission and the Pharmacy Board have agreed that complaints relating to **dispensing errors** by pharmacists will be referred to the Board for their investigation.

A dispensing error means an omission in any part of, or an error in any aspect of, the supply of medication by a pharmacist to a member of the public or otherwise through the processing and/or dispensing of a Medical, Dental or other legitimate prescription or request.

A dispensing error occurs when an incident is detected after a patient/agent has taken possession of the medicine. [Where an error is made at some point in the dispensing process but is corrected before the medicine is supplied this is referred to as a 'near miss'.]

Dispensing errors include the following:

Selection errors

- A different drug from that prescribed (disregarding the brand),
- A strength differing from that prescribed,
- A dose form differing from that prescribed,
- A quantity differing from that prescribed (disregarding minor pack size variations),
- The medicine's expiry date has been exceeded.

Clerical errors

- Wrong dose to be taken
- Name of different drug
- Wrong strength
- Wrong directions
- Transposition of two labels
- Wrong person's name

Errors in clinical judgment

- Contraindication
- Dispensing in accordance with the prescription but the dose, frequency or duration is excessive,
- Miscalculation,

- When a drug is combined with another drug that the person is taking, and where the pharmacist knows, or ought to know, that the combination is potentially harmful,
- Inadequate or inappropriate counselling.

The Pharmacy Board has two pharmacy inspectors on staff and in cases of dispensing error complaints (which form the majority of complaints about pharmacists) the Board inspects the pharmacy and conducts a dispensing practice review (DPR).

The Board will deal with complaints about a pharmacy 'shop' as well as complaints about registered pharmacists.

The Commission and the Psychologists Board meet one a month to consult on the assessment decision in relation to new complaints.

- **Psychologists Board**

The *Psychologists Act 2001* establishes the Psychological Care Assessment Committee (PCAC) and matters can be referred to PCAC for their assessment as to the appropriateness of the care or treatment provided.

The Board can require a registered psychologist to attend for counselling.

The Commission does not retain an Internal Psychologist Advisor and the Psychologists Board is able to provide initial advice as to the appropriateness of care or treatment.

It is important to note the following:

A significant number of complaints concerning psychologists relate to medico-legal reports and assessments prepared for use in court cases. Many of the courts cases involve family court custody disputes that can be contentious. The Board's practice in relation to these matters is to advise the complainant that the appropriate place to contest the contents of the psychologists report is in the court for which it was prepared. The Commission supports this approach and in cases where there is no evidence that the psychologist had an improper relationship with one of the parties or engaged in a serious breach of her or his professional obligations the complainant should be advised to contest the report in court.

A significant number of complaints concerning psychologists relate to boundary issues and allegations that an improper sexual or other personal relationship developed between the psychologist and the patient. The Australian Psychological Society (APS) has published a Code of Practice that includes prohibitions against psychologists forming such relationships with patients. Improper sexual or personal relationships between a psychologist and a patient or client will generally give rise to disciplinary action.

- **Physiotherapists Board**

The Commission meets with the Physiotherapists Board once a month to consult in relation to the assessment decision on new complaints.

The *Physiotherapists Act 2001* establishes the Physiotherapy Standards Advisory Committee (PSAC). PSAC can investigate the complaint and encourage the physiotherapist and the complainant to settle the complaint.

- **Optometrists Board**
  The Commission meets with the Optometrists Board as required. The Board has been asked to advise the Commission as to what types of complaints it believes should best be handled by referral to the Board for their management.

- **Dental Technicians Board**
  The Commission meets with the Dental Technicians Board once a month to consult in relation to the assessment decision on new complaints.

  The critical point of distinction between dentists and dental technicians is that dental technicians must only work on a 'healthy mouth'. That is, dental technicians make dental appliances such as dentures and bridges for mouths that have been treated by a dental or medical practitioner. Dental technicians check the fitting of dental appliances but they are not permitted to perform any sort of procedure on a patient's mouth or teeth.

- **Chiropractors Board**
  The Commission meets with the Chiropractors Board once a month.

  The Commission and the Chiropractors Board are in the course of agreeing on matters that are appropriate for referral to the Board for their management.

- **Optical Dispensers Board**
  The Commission meets with the Optical Dispensers Board as required.

- **Osteopaths Board**
  The Commission meets with the Osteopaths Board as required.

- **Podiatrists Board**
  The Commission meets with the Podiatrists Board as required.

6. Discontinue

Some complaints do not warrant investigation or other action by the Commission. Section 27 HCCA outlines some of the circumstances where the Commission can discontinue dealing with a complaint. In addition to the Commission deciding not to deal with a complaint, a complainant can at any time withdraw their complaint by advising the Commission in writing, see section 18 HCCA. [Even where a complainant withdraws the complaint the Commission must continue to deal with the matter if it meets the tests in section 23 HCCA – see Part 1 above.]

The first reason why the Commission may decide not to deal with a complaint (which is not covered in section 27) is because the subject matter of the complaint is not within the jurisdiction of the Commission. This may be because the complaint relates to a matter that occurred outside New South Wales or relates to the provision of services that are not health services for the purposes of the HCCA or because the complaint relates to the actions of a person where that was not engaged in conduct as a practitioner (an example of this might be where a person complains that their landlord, who is a registered physiotherapist, has failed to carry out repairs to the rental property).

Following assessment of a complaint, the Commission may discontinue dealing with it (or any part of a complaint) for any one or more of the following reasons:

- the complaint (or part of a complaint) is frivolous, vexatious or not made in good faith. Frivolous is a legal word for 'silly'. A frivolous complaint is one that is of little or no consequence. Vexatious complaints are those that are made only for the purpose of embarrassing or aggravating the person who is the subject of the complaint where there is no intention to vindicate a genuine grievance. A complaint is "not made in good faith" if the complainant knows that the particulars of the complaint are not accurate or does not believe that the complaint is true (note also section 99 HCCA) or has no intention of participating in a resolution of the complaint;

- the subject-matter of the complaint (or part of the complaint) is trivial;

- the complaint does not warrant investigation or conciliation or the Commission dealing with it under Division 9. If there is no basis on which the Commission can deal with a complaint by investigating it or referring it for assisted resolution or conciliation the Commission can cease dealing with the complaint. Discontinuing a complaint on this basis would be most likely in relation to minor matters with more significant matters being referred to another appropriate body;

- the subject-matter of the complaint (or part) has been or is under investigation by some other competent person or body or has been or is the subject of legal proceedings;

- the complaint (or part) has been referred by the Commission to another person or body for investigation or for consideration of other action (including, for example, performance assessment or impairment assessment under a health registration Act);

- there is or was, in relation to the matter complained of, a satisfactory alternative means of dealing with the matter by the complainant and the complainant does not have a sufficient reason for not pursuing that alternative means;

- the complaint (or part) relates to a matter which occurred more than 5 years before the complaint was made and the complainant does not have a sufficient reason for having delayed the making of the complaint;

- the complainant has failed, without sufficient reason, to provide further particulars of the complaint (or part) within the time specified by the Commission. Section 21 provides that the Commission can seek additional information from a complainant. Section 22 provides that the 60 day time limit to assess a complaint is suspended while additional information is being sought from the complainant. In cases where a complainant has not provided additional information the Assessment Officer should determine if an appropriate assessment decision can be made without that additional information. If an appropriate assessment decision can still be made, even though it was desirable to obtain additional information, then the decision should be made. If an assessment decision cannot be made without the additional information the complaint should be discontinued; or

- the complaint (or part) concerns a matter that falls within the responsibility of the Commonwealth. Examples of this include complaints about the amount of a Medicare rebate or the accreditation of nursing homes or the approval of therapeutic goods.

The Commission must not discontinue dealing with a complaint under this section if it appears to the Commission that the complaint raises a significant issue of public health or safety. Complaints that

raise significant issues of public health or safety warrant investigation pursuant to section 23 HCCA and should be pursued.

In any case of uncertainty Assessment Officers should seek assistance from the Manager, Complaint Assessment Team or Director, Assessments and Resolution.

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Director, Assessments and Resolution

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