OmbudsmanSA

Report (as amended by corrigendum, 9 June 2022)

Full investigation - *Ombudsman Act 1972*

Complainant	Ombudsman 'own initiative' investigation, section 13(2) of the *Ombudsman Act 1972*
Agency	The Health and Community Services Complaints Commissioner
Ombudsman reference	2020/03043
Agency reference	M17/01566
Date investigation commenced	25 September 2021
Issues	1. Whether the Health and Community Services Complaints Commissioner relied on irrelevant considerations in the exercise of his discretion not to publicly release a report for an own motion investigation, and, in doing so, acted in a manner that amounted to error 2. Whether the Health and Community Services Complaints Commissioner failed to seek the views of the complainants regarding the public release of the report, and whether this failure amounted to error 3. Whether the Health and Community Services Complaints Commissioner failed to clearly communicate with the complainants after the commencement of the own motion investigation, and whether this failure amounted to error

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Introduction

Following a report on ABC News on 13 July 2020, I decided to make enquiries and, subsequently, conduct a full investigation of various issues relating to an investigation by the Health and Community Services Complaints Commissioner. In doing so, I exercised my own initiative powers under section 13(2) of the *Ombudsman Act 1972*.

For ease of reference, I shall refer to the Health and Community Services Complaints Commissioner as the Commissioner, and his office as the HCSCC.

On 31 July 2020, the Commissioner released a public summary of an investigation, conducted using the Commissioner's 'own motion' powers under section 43(1)(d) of the *Health and Community Services Complaints Act 2004*, into the provision of health services to people with disabilities by the Department for Health and Wellbeing (**SA Health**) in acute care settings (**the own motion investigation**). The Commissioner's public summary explained that the own motion investigation had considered 'whether the provision of health services to people with disabilities in acute public hospital and care settings by SA Health meets generally acceptable standards'. The summary provided some detail of the Commissioner's reasoning, conclusions, and recommendations, noting that 'sensitive and private information of the complainants' had been protected.

In the interests of their privacy, I have deidentified the complainants, and the people on whose behalf the complaints were made.

It is important to note at the outset that I have not commenced my investigation in order to reinvestigate the issues that the Commissioner considered, nor I do not intend to consider the conclusions reached by the Commissioner in the own motion investigation. Rather, my investigation concerns the public release of information once the own motion investigation was finalised, and the provision of the information to complainants whose complaints had prompted the own motion investigation.

I considered it necessary to conduct an investigation, having regard to:

- a complaint by Ms D to my Office in November 2019. Two of Ms D's complaints to the HCSCC formed part of the own motion investigation and, in November 2019, Ms D complained to my Office that the HCSCC had failed to take action after obtaining an expert opinion to inform the own motion investigation. At the time, I was advised the HCSCC was continuing to implement recommendations from its investigation, and it would inform Ms D of the outcome in due course
- the statutory purpose of complaint handling bodies such as my Office and the HCSCC, as well as the importance of open and transparent complaint management, particularly for complainants who are vulnerable
- ongoing interest and debate around the care for people with disabilities, and Government responses to incidents and complaints when that care is lacking. This issue was the subject of a public hearing of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability in 2021.

My conclusions are detailed below.

Investigation

My investigation has involved:

- seeking an explanation from the HCSCC about the own motion investigation
- obtaining and considering the HCSCC's files for each complaint and the own motion investigation
- seeking a response from each complainant and Ms Colleen Johnson, an expert engaged to assist the own motion investigation
- seeking further information from the HCSCC
- considering:
  - the *Health and Community Services Complaints Act 2004*
  - the *Freedom of Information Act 1991* (**the FOI Act**) and the *Freedom of Information (Exempt Agency) Regulations 2008* (**the FOI Exempt Agency Regulations**)
  - the HCSCC's Policy: Complaints Management
- providing the HCSCC with my provisional report for comment, and considering its response
- providing nine interested parties with my provisional report for comment, and considering their responses
- preparing this report.

Standard of proof

The standard of proof I have applied in my investigation and report is on the balance of probabilities. However, in determining whether that standard has been met, in accordance with the High Court's decision in *Briginshaw v Briginshaw* (1938) 60 CLR 336, I have considered the nature of the assertions made and the consequences if they were to be upheld. That decision recognises that greater care is needed in considering the evidence in some cases.[1] It is best summed up in the decision as follows:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue has been proved … .[2]

[1] This decision was applied more recently in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 110 ALR 449 at pp449-450, per Mason CJ, Brennan, Deane and Gaudron JJ.

[2] *Briginshaw v Briginshaw* at pp361-362, per Dixon J.

Procedural fairness

The following parties provided responses to my provisional report.

The Commissioner

The Commissioner accepted and acknowledged the failings in the HCSCC's communication with complainants in relation to their individual complaints and their subsequent status as informants to the own motion investigation.[3] The Commissioner apologised for the failings in the HCSCC's communication with the complainants. The Commissioner also disagreed with my provisional views on issues one and two, and did not accept the recommendations I foreshadowed in my provisional report. I have carefully considered the Commissioner's submissions and address them, where necessary, in the body of this report. The Commissioner's response did not persuade me to alter my conclusions or recommendations for issues two and three.

However, I have been persuaded to alter my conclusions for issue one – whether the Commissioner relied on irrelevant considerations in the exercise of his discretion not to publicly release his report for the own motion investigation. When I first made enquiries with the Commissioner about how he had exercised his discretion, his response cited certain provisions of the FOI Act and the FOI Exempt Agency Regulations. In my view, the language of the Commissioner's response suggested that he had relied on those provisions, although they were not the only factors in his decision.

In response to my provisional report, the Commissioner disputed this, suggesting instead that he pointed to these provisions to articulate the reasons for his decision. In response to my provisional report, the Commissioner stated that he made the decision not to publish the HCSCC report 'independently and without consideration of the *Freedom of Information Act 1982* [sic] (SA) and the *Freedom of Information (Exempt Agency) Regulations 2008*.'[4]

I have not been able to identify any contemporaneous records of the Commissioner's reasons when he decided not to publish his report, and the Commissioner did not point to any specific evidence to support this submission. As such, I am unable to conclude, to a sufficient standard of proof, that the Commissioner relied on the provisions of the FOI Act and the FOI Exempt Agency Regulations when he exercised his discretion. On this basis, I am now unable to conclude whether or not the Commissioner relied on irrelevant considerations and acted in a manner that amounted to error. I therefore decline to consider this issue further, and make no finding in this regard.

The complainants

Five complainants – Mr A, Ms D, Ms I, Ms K, and Ms M – provided responses to my provisional report, as did Ms Colleen Johnson, the expert engaged by the HCSCC to assist the own motion investigation.

Mr A spoke with my Officer over the telephone, and explained that:

- he had no concerns with how the HCSCC had managed his complaint in 2015 as the matter had been escalated within the relevant local health network and action was taken to resolve issues affecting him
- inaccessible communication methods by the local health network are an ongoing issue for Mr A, and he continues to work to have the issue addressed
- he did not wish to make any submissions regarding my provisional report as he is focused on resolving the barriers to accessible communication.[5]

[3] Letter from the Commissioner to the Ombudsman, 2 November 2021.
[4] Ibid.
[5] Telephone call between Mr A and an Ombudsman SA officer, 21 October 2021.

Ms D provided the following:

> I thank you for your email dated 14 October 2021 and wish to submit the following comments on your provisional views, which were set out in the enclosed report.
>
> I entirely agree with any and all proposed recommendations. I feel that a further investigation into the manner in which the Health and Community Services Complaint Commissioner acted in his investigation into the provision of health services to people with disabilities in acute care settings would be most welcome. The handling of certain procedures during the Commissioner's investigation should certainly be investigated.
>
> I believe that the Commissioner did rely on irrelevant considerations in his decision not to publicly release a report for an own motion investigation. It would appear that the opinion of a single family was one of the deciding factors as to the reason why the Commissioner formed the conclusion not to publish Colleen Johnson's report. I personally, would have welcomed that the report be published.
>
> I was never contacted in order that I could express my opinion or views in regard to any matter or issues to which I felt entitled. I was never provided with full information in regard to my son's issues and many questions remain unanswered. I remain frustrated and upset as I believe I have a right to be advised of the outcomes of my queries and to be provided with appropriate explanations. Therefore, I consider this was a gross misjudgement by the Commissioner. Furthermore, the failure by the Health and Community Services Complaints Commission to notify me of the closure of my son's file, was indeed an enormous shock to me.
>
> Adding to my concerns is the manner in which my son's complaint merely formed part of a Systemic Investigation. I feel this was most inappropriate, unsatisfactory, and lacked transparency. That my complaint was conducted in such a manner has left me (and no doubt other families) with not only unanswered questions but a feeling that we were not entitled to any information concerning our particular loved one. In this light, I feel that the Commissioner has failed (in certain areas) to uphold the rights of people, as set out in the HCSCC Charter of Rights.
>
> In conclusion, it is my opinion that…….
> The manner in which the Commissioner relied on irrelevant considerations in the exercise of his discretion not to publicly release a report for an own motion investigation did amount to error.
>
> The Commissioner did fail to seek the views of the complainants regarding the public release of the report, and this did amount to error.
>
> The HCSCC did fail to communicate clearly with the complainants after the commencement of the Commissioner's own motion investigation and this did amount to error.
>
> I wish to convey my appreciation that Ombudsman SA has made the decision to further investigate the Commissioner's actions on the above matters.[6]

Ms I made submissions in writing and over the telephone. In the latter, Ms I explained to my Officer that:

- she did not know what the HCSCC had found in regard to her son's, Mr J's, care
- she was unhappy with the level of communication by the HCSCC
- she is still angry about the care her son received before his death. She wants to do something about it, but does not know what to do
- she remains concerned about the 'horrific' care her son received, and that similar care continues to be provided to people with disabilities.[7]

[6] Email from Ms D to Ombudsman SA, 31 October 2021.
[7] Telephone call between an Ombudsman SA officer and Ms I, 16 November 2021.

By email, Ms I stated she had contacted the HCSCC 'in a desperate plea to help my son' but that 'nothing was done' and that she feels that her son would be alive if the HCSCC had taken the matter seriously.[8]

Ms K noted one correction and provided the following response to my provisional report:

> Thank you for your investigation into the HCSCC. The death of my sister was traumatic, I also found the complaints process a long confronting ordeal. Having a family member with disabilities is an extremely lonely journey, as is writing and backing up serious complaints regarding the care of a vulnerable group of people who cannot advocate for themselves.
>
> I felt not releasing the full HCSCC report was disappointing since the non-release of the report devalued the complaints which were serious and, for me, prolonged the grieving process.
>
> The communication from the HCSCC was lengthy and not done in a clear manner. It would have been helpful to have a step by step written plan of what the investigation process was and regular updates. It seemed like I was just moving on in the cycle of grief, when I was reminded again, of the event which has made me doubt the respect and care out health system shows towards our most vulnerable.
>
> I would like to know the reasoning and findings of both Ms Johnson's report and the HCSCC report on systemic changes as deemed relevant to my complaint.[9]

Ms M noted some corrections and provided further information about her complaint to the HCSCC, which I have addressed in the body of this report. Ms M also provided the following:

> Thank you for the opportunity to comment on the issues raised in your Provisional Report: Full Investigation - Ombudsman Act 1972, concerning the release of information once the HCSCC 'Own Motion' investigation into the provision of health services to people with disabilities by the Department of Health & Wellbeing (SA Health) in acute care settings.
> …
> To find out from your report that the HCSCC didn't advise me that I was not party to the investigation surprised me considering [a HCSCC officer] thought my complaint warranted inclusion in Mr Tully's 'Own Motion' Investigation.
> …
> I wholeheartedly agree with the excerpt [sic] from Ms Johnson's report, I am certainly jaded by my experience, in particular how my complaint was 'managed' by [a HCSCC officer] and the fact that no adverse findings or recommendations were made in relation to my complaint.
>
> I agree with all of Ms D's responses to your enquiries as listed in point 92 [of my provisional report]. I still have no answers to the questions I raised in each of my Appendices attached to my complaint, and still struggle with the circumstances of my beautiful daughter's death.[10]

While I have made some corrections to my report, I have not altered my conclusions or recommendations as a result of Ms D's, Ms I's, Ms K's, or Ms M's submissions.

Nevertheless, I thank all of the complainants, including those who did not provide a response to my provisional report, for their time and for the information they provided to my Office in the course of this investigation. I recognise that it was, at times, very difficult for them to do so. The information they provided to my Office was invaluable, as it allowed me to gain a clearer understanding of what occurred and how the HCSCC's investigation affected them.

Ms Johnson commended my report and made no further comment regarding its content.[11]

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8 Email from Ms I to Ombudsman SA, 18 November 2021.
9 Email from Ms K to Ombudsman SA, 20 October 2021.
10 Email from Ms M to Ombudsman SA, 11 November 2021.
11 Email from Ms Colleen Johnson to Ombudsman SA, 17 October 2021.

The HCSCC

1. The HCSCC is an independent statutory office established under the *Health and Community Services Complaints Act 2004* (**the HCSC Act**). The HCSCC website provides that:

> The HCSCC helps consumers, carers and service providers – this includes government private and non-government health and community services – to try and resolve complaints.
> - We receive, assess and resolve complaints about health and community services in South Australia.
> - We improve the safety and quality of health and community services in South Australia.
> - We identify, investigate and report on systemic issues of concern in health and community services.
> - We promote good complaint handling.
> - We monitor trends in health and community services complaints and recommend improvements.
> - We provide information, education and advice about
>   - health and community services rights and responsibilities
>   - The HCSCC Charter of Health and Community Services Rights
>   - complaints and good complaint handling
> - We provide assistance to service providers with complaints.[12]

2. Under the HCSC Act, a complaint may be made to the Commissioner on a number of grounds, including where a service provider:
   - acted unreasonably by not providing or discontinuing a service
   - provided a service that was not necessary or was inappropriate
   - acted unreasonably in the manner of providing a service
   - failed to exercise due skill
   - failed to treat a health or community service consumer in an appropriate professional manner
   - failure to respect a consumer's privacy or dignity
   - acted unreasonably by failing to provide a consumer with
     - sufficient information in a manner the consumer could understood, or in order to enable the consumer to make an informed decision
     - a reasonable opportunity to make an informed choice of treatment or service
     - adequate information on the availability of further advice
     - adequate information on the treatment or service
     - with any prognosis that would have been reasonable to provide to the consumer
   - acted unreasonably by
     - denying or restricting a consumer's access to records
     - not making information about the consumer's condition available to them
   - acted unreasonably in disclosing information relating to the consumer to a third party
   - acted unreasonably by not taking proper action in relation to a complaint
   - acted in a manner that is inconsistent with the HCSR Charter
   - acted in a manner that did not conform with generally accepted standards of service delivery.

3. Mr Steve Tully was the Commissioner between March 2012 and February 2018. On 26 February 2018, Associate Professor Grant Davies assumed the role of Commissioner.

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[12] *Health and Community Services Complaints Commissioner,* 'What does the HCSCC do', < https://www.hcscc.sa.gov.au/about/hcscc-role/>, accessed 9 April 2021.

The own motion investigation

Complaints to the HCSCC

9. Between 2014 and 2017, seven complainants raised complaints with the HCSCC about the health services provided to people with disabilities in acute care settings in South Australia. I understand that the HCSCC considered these complaints to be representative of other similar complaints, and that the issues were of a systemic nature.[13]

10. Below, I have briefly described the complaints received by the HCSCC. These summaries do not provide a full account of the people whose care was the subject of complaints to the HCSCC.

Mr A

Mr A has a vision impairment and is unable to personally access information in printed or handwritten formats.

In 2015, Mr A made a complaint about how a health service provider accommodated his vision impairment. Mr A complained that failure to accommodate his impairment undermined his independence and privacy. Mr A had raised these concerns prior to the 2015 complaint but it appears that systemic improvements to client communication had not been achieved.

B, on behalf of Ms C

In December 2015, B made a complaint on behalf of Ms C. Ms C is an Aboriginal woman from the Northern Territory. She has limited English and lives in a remote community. Ms C has an intellectual disability and, in 2014, experienced heart related issues. Ms C was referred to a South Australian hospital and underwent surgery.

The complaint raised concerns about inadequate efforts to obtain consent for the surgery, and the assistance provided to Ms C before and after her admission.

Ms D, on behalf of Mr E, deceased

Ms D made two complaints to the HCSCC on behalf of her son, Mr E. The first was finalised when a mediation agreement was reached in May 2017. Mr E died in August 2017. The second complaint was lodged after Mr E's death.

Mr E had an intellectual disability, vision and hearing impairments, and long standing medical issues, including epilepsy and diabetes. After suffering a stroke in 2015, Mr E was admitted as an inpatient to a South Australian hospital.

Ms D's complaints concerned care and services Mr E had received at the hospital over a two year period. Ms D alleged that Mr E's poor health outcomes and death were the result of his care and treatment. This included disregard of guardianship rights, overmedication, injury due to poor processes, and inadequate care.

[13] Health and Community Services Complaints Commissioner, *Investigation Report pursuant to s54(1) of the Health and Community Services Complaints Act 2004 (SA): Investigations into the provision of health services to people with a disability by SA Health in acute care settings*, 24 July 2020.

Mrs F, on behalf of Mr G

In March 2017, Mrs F made a complaint to the HCSCC about the care provided to her son, Mr G, at a South Australian hospital.

Mr G has an intellectual disability, autism, and mental health issues. He has a history of self-injurious behaviour to his face and eyes, and has difficulty tolerating eye examinations and treatment.

Mrs F's complaint concerned delay in examination and assessment, as well as inaction, discrimination, poor coordination of care, and a reluctance to accommodate dual diagnoses.

Ms I, on behalf of Mr J, deceased

In March 2017, Ms I made a complaint to the HCSCC about the care being provided to her son, Mr J, at a South Australian hospital. Mr J died in March 2017, while an inpatient at the hospital.

Mr J was tetraplegic and had lived independently in his own home.

Ms I's complaint concerned inadequate treatment, delay, neglect, lack of dignity, failure to accommodate Mr J's disability, threats towards Mr J's family, failure to advise of Mr J's deteriorating condition, and admission to palliative care without consultation. In response to my provisional report, Ms I described Mr J's care as horrific.

Ms K, on behalf of Ms L, deceased

In August 2017, Ms K made a complaint to the HCSCC about the care provided to her sister, Ms L, at a South Australian hospital.

Ms L had an intellectual disability, communicated non-verbally, and required physical and social support. Ms L was admitted for surgery at the hospital in June 2017. Ms L died while she was an inpatient in July 2017.

Ms K's complaint included concerns about staff training to care for non-verbal patients, inadequate pain relief for non-verbal patients, failure to accommodate a support worker, and insufficient and insensitive communication.

Ms M, on behalf of Ms N, deceased

In December 2017, Ms M made a complaint to the HCSCC about the care provided to her daughter, Ms N, by two health service providers.

Ms N had an intellectual disability, hypertension, and a heart defect. She lived with Ms M, who was her informal guardian. Ms N was admitted to a South Australian hospital in early December 2015 with pneumonia. Ms N died the next day.

In response to my provisional report, Ms M described her complaint as being about 'a deliberate abuse/misuse of an ammendment [sic] to the Consent Act'.[14] Ms M alleges that the amendment was used to discriminate against and deny Ms N access to acute care.[15]

[14] Above n 10.

[15] In my provisional report, I described Ms M's complaint as concerning incorrect assumption of capacity resulting in delay, disregard for established pathways upon admission, failure to obtain consent, and insufficient regard to medical records.

Commencement of the own motion investigation

11. On 4 September 2017, the former Commissioner, Mr Steve Tully, decided to commence an own motion investigation into the systemic delivery of health services to people with disabilities in acute care settings.[16] In October 2017, the HCSCC notified the Chief Executive of SA Health of this decision.

12. It appears that some of the complainants were advised of the decision in the following manner:
    - Ms D was advised by email on 20 December 2017 that the 'HCSCC has initiated a 'Systemic Investigation' as Mr E's issues are not isolated – we have received other complaints of a similar nature and events.'[17]
    - Mrs F was advised over the telephone on 31 October 2017 that Mr G's case would be included in a systemic investigation.[18] Similar advice was provided by email on 19 February 2018[19]
    - Ms K was advised over the telephone on 30 October 2017 that Ms L's care and treatment would be considered in a systemic investigation alongside other complaints, and that the HCSCC would 'let her know when we have a report to share'[20]
    - Ms M was formally advised, by letter on 25 January 2018, that her complaint about Ms N's care would form part of a systemic investigation, and that the HCSCC would conduct a separate investigation about Ms N's care at the hospital. This appears to be the only instance where formal notification occurred.

13. I have not been able to identify any records of the HCSCC advising Mr A or Ms I that their complaints would form part of the own motion investigation. I understand Ms I was contacted by an independent expert engaged to assist the HCSCC, but there are no records or documents suggesting that Ms I received formal or informal advice from the HCSCC about her complaint's inclusion in the own motion investigation.

14. B was originally advised in December 2015 that an investigation would consider the complaint about Ms C's care, and in January 2017, the HCSCC indicated that the issues were considered to be systemic. However, it does not appear that B was advised that the complaint would form part of the own motion investigation until 14 July 2020, when the HCSCC was preparing to issue a public statement.

15. In October 2017, Mr Tully engaged Ms Colleen Johnson to assist in the own motion investigation and provide an independent expert opinion. Referring to the complaints described above, the HCSCC requested that Ms Johnson:

> …provide your expert opinion on the services provided to [the complainants], by the relevant Hospitals and Care providers and whether or not the services provided to these persons prior to their passing, met the generally accepted standards under the circumstances given their health and disability.
>
> HCSCC seeks your expert opinion in relation to the following questions/list of issues, with specific reference to the background information provided to you regarding these matters:
>
> A. In these particular cases and at a systemic level could the services provided by the Hospitals and Care providers be considered to have breached the generally accepted standards for the provision of services in these circumstances? If so;

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16 In response to my provisional report, the Commissioner requested that I specifically detail the commencement of the own motion investigation. Due to the limited nature of the records provided to my Office, I am unable to detail anything further. In any event, I do not consider this necessary.

17 Email from an HCSCC Officer to Ms D, 20 December 2017.

18 Record of phone call from HCSCC office to Ms F, 31 October 2017.

19 Email from an HCSCC Officer to Ms F, 19 February 2017.

20 File note, 30 October 2017.

- What was the breach?
- How might this breach have been prevented?
- How might this breach be remedied?
- How might this breach be prevented from recurring?

B. Were there any systemic issues or concerns identified? If so;
   a. What were the systemic issues/concerns identified?
   b. What recommendations would you make to address these identified systemic issues/concerns?

C. Have any of the HCSCC Charter of Rights been infringed in these particular cases and at a systemic level?
   a. What was the infringement?
   b. How might this infringement have been prevented?
   c. How might this infringement be remedied?
   d. How might this infringement be prevented from recurring?

D. Any other comments, or further recommendations, you wish to make to the Commissioner regarding these matters?

16. In response to my investigation, Ms Johnson noted that, 'importantly, detailed investigation of each of the seven complaints was to be undertaken by the HCSCC rather than through my investigation process'.[21] This distinction is not clear in the instructions to Ms Johnson, though I understand a meeting was held between the former Commissioner and Ms Johnson before formal instruction was given. I have not been able to locate any records of that meeting in the information provided to my Office.

17. According to Ms Johnson, the HCSCC first advised each of the seven complainants that she had been engaged to assist with the own motion investigation. There are no records of the HCSCC advising Mr A, B, or Ms I of Ms Johnson's appointment. That said, I understand that Ms Johnson spoke with Ms I later.

The expert opinion and the progress of the own motion investigation

18. In response to my investigation, Ms Johnson provided an example of her initial contact with the complainants. The sample email, which refers to a family member of the complainant as the care recipient, provided:

> You may be aware that the HCSCC has asked me to look at a systemic issue in the major Adelaide hospitals that contributed to recent adverse event for a number of people with disabilities. [Your family member] is one of those people.
>
> I have read the documentation you provided to the HCSCC, and I am so sorry to hear of the treatment both [family member] and you were subjected to. It must have been incredibly distressing.

19. The email then provides possible dates and times for Ms Johnson to contact the complainant.

20. Ms Johnson explained to my Office that when she later contacted complainants over the telephone, she explained that their complaint was one of a number received by the HCSCC about the experiences of people with disabilities and their carers in major Metropolitan Adelaide public hospitals. Ms Johnson also noted that she would consider concerns and issues across the health system, while the HCSCC undertook a more

[21] Letter from Ms Colleen Johnson to an Ombudsman SA officer, 19 November 2020.

detailed investigation of the complaints. She advised the complainants that someone from the HCSCC would be in contact with them in that regard.[22]

21. While she could not precisely recall what she advised the complainants in this matter, Ms Johnson explained to my Office that during her contact she informed complainants that:
    - she would interview the parties and prepare a report for the client. In this instance, the client was the HCSCC
    - the client would then contact complainants for subsequent action and feedback.

22. In her response to my Office, Ms Johnson specifically noted that she never advises the parties that they will receive a copy of her report unless she had been advised as such by the client. In this matter, Ms Johnson confirmed that she did not advise any of the complainants of the conclusions reached in her report.

Ms Johnson's report

23. On 12 June 2018, Ms Johnson provided her report to the HCSCC. The report includes considerable detail about each complaint, and the care and services received by Mr A, Ms C, Mr E, Mr G, Mr J, Ms I, and Ms N. In each instance, Ms Johnson formed specific conclusions as to whether the care provided to those people had breached the HCSCC Charter and, in four instances, the provisions of the *South Australian Consent to Medical Treatment and Palliative Care Act 1995*.

24. Broadly speaking, Ms Johnson suggested that each of the cases highlighted multiple breaches of the HCSCC Charter, and that 10 themes had arisen across the complaints in this regard. In concluding, Ms Johnson noted that the cases were 'highly disturbing' and likely represented a 'small proportion of adverse events in the tertiary health service system involving people with disabilities'.[23] Turning to consider possible recommendations, Ms Johnson noted that 'systemic issues of this magnitude require a systemic remedy',[24] and made 12 recommendations.

25. The HCSCC provided Ms Johnson's report and an executive summary to SA Health on 22 August 2018. Neither were provided to any of the complainants for comment. The executive summary provided details of each of the complaints and the issues highlighted in Ms Johnson's report. The Commissioner asked the Chief Executive of SA Health to consider the report and the executive summary, and explain 'the steps being undertaken to prevent and or minimise similar incidents within the health system'.[25]

26. The matter continued between the HCSCC and SA Health for some time after this.

The Commissioner's report

27. In July 2020, the Commissioner completed his report on the own motion investigation (**the HCSCC report**).[26] Like Ms Johnson's report, the HCSCC report provides summaries of each complaint. The facts and allegations for each matter are central to the report and are not de-identified. Turning to consider the issues under investigation, the HCSCC report recounts much of Ms Johnson's reasoning and conclusions. This includes specific reference to the complaints.

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22 Ibid.

23 Johnson, Collen, *Independent Opinion provided to the Health and Community Services Complaints Commissioner (HCSCC), South Australia,* 11 June 2018, 44.

24 Ibid, 45.

25 Letter from the Commissioner to Dr Chris McGowan, 22 August 2018.

26 Health and Community Services Complaints Commissioner, *Investigation Report pursuant to s54(1) of the Health and Community Services Complaints Act 2004; Investigation into the provision of health services to people with a disability by SA Health in acute* settings, 8 July 2020; an erratum was issued on 24 July 2020, incorporating amendments suggested by SA Health.

28. After considering Ms Johnson's conclusions and recommendations, as well as the HCSCC Charter and the responses of SA Health, the Commissioner stated in the HCSCC report:

> On the evidence before me, and on the balance of probabilities, I find the claims raised in the complaints which form the basis for the systemic investigation are substantiated.
>
> Based on the evidence before me, and on the balance of probabilities, I find the systemic delivery of acute services by SA Health hospitals to people with disabilities to be in breach of the HCSCC Charter's five guiding principles and three of the rights, namely Diversity, Decision making capacity and Genuine Partnership.
>
> I am satisfied, based on the historical evidence before me, the systemic delivery of acute services by SA Health hospitals at the time, posed an unacceptable risk to the health or safety of members of the public with disabilities and their families and carers.[27]

29. The Commissioner then recognised the improvements being carried out by SA Health, and, pursuant to section 54(3) of the HCSC Act, recommended that SA Health confirm completion of agreed actions by 4 December 2020. I understand that these actions have now been completed.[28]

Communication and action in response to complaints

30. Having carefully considered each of the complaint files, I summarise the HCSCC's management of each as follows:

Mr A

The HCSCC assisted Mr A to resolve individual instances of inaccessible communication by SA Health. After doing so, the HCSCC indicated that it would close the complaint.

The file was closed more than two years later. Mr A was not advised of this at the time. During this period of time, the HCSCC attempted to find resolution to the systemic issues identified in Mr A's complaint. The own motion investigation was also commenced during this period, but it is unclear if Mr A was advised that his complaint had formed part of that own motion investigation.

B, on behalf of Ms C

On 23 December 2015, the HCSCC wrote to B, advising that an investigation would be undertaken into B's complaint on behalf of Ms C, and that the HCSCC would be in contact in due course to provide an update.[29] On 14 August 2017, the HCSCC advised B that it would conduct a systemic investigation of the complaint.[30] On 29 November 2017, the former Commissioner responded to B's request for an update and gave a clear assurance that B would be provided with a copy of the investigation report once it was available.[31] It is not clear whether this referred to an individual investigation of the matter, or the own motion investigation. In any event, I have been unable to locate any information suggesting that B was advised of the own motion investigation before July 2020. The information that B has provided to my Office suggests that they were not advised of the own motion investigation until after it had been completed.[32]

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27 Ibid.
28 Email from Dr Grant Davies to an Ombudsman SA officer, 6 August 2021.
29 Letter from the HCSCC to B, 23 December 2015.
30 Telephone call from an HCSCC officer to B, 14 August 2017. I have been unable to locate any formal notice of this decision, or a clear explanation of what the systemic investigation would consider.
31 Letter from the former Commissioner to B, 29 November 2017.
32 Email from B to Ombudsman SA, 11 December 2020.

On 21 February 2019, the HCSCC determined to take no further action in response to B's complaint. A file note summarising this decision provides that the relevant local health network had undertaken to review consent processes, particularly for patients from remote and regional areas. The local health network had also employed Aboriginal health practitioners to improve communication with Aboriginal patients, and had commissioned on-site accommodation to provide more options for pre and post treatment care. It does not appear that this resolution had regard to the issues of disability inclusion and access, and it is unclear whether B was ever advised that these issues would be dealt with separately by the HCSCC.

Ms D, on behalf of Mr E, deceased

On 20 December 2017, the HCSCC advised Ms D that her complaint about Mr E's care would form part of the own motion investigation, and that it would likely be completed in March 2018. The HCSCC officer responsible for Ms D's complaint also stated, 'rest assured, you will be contacted no matter what'.[33]

On 23 January 2018, Ms D queried if Mr E's family 'would be provided with any form of address', and explained:

> Whilst we do feel that the systemic investigation would be most beneficial and very much needed in an effort to improve the manner in which disabled patients are cared for… we feel it is unfair that the individual complaints in relation to the patient's care are not addressed.[34]

In reply that day, the HCSCC officer explained that:

> The systemic investigation does involve the investigator going to [the hospital] and interviewing staff and individuals (the only way this can be done legally is via the 'systemic process').
>
> Ultimately, the issues you have raised will be addressed – we just have to tread carefully as there are a LOT of other agencies to which these matters relate or have an interest in.
>
> Sorry to [sic] be answering the specifics, but at this stage I cannot give a definitive answer (other to say all of the issues raised will be considered, investigated and where necessary referred to the appropriate persons).[35]

On 3 September 2018, the complaint file was closed. It is unclear what action was taken by the HCSCC to resolve or finalise Ms D's individual complaint prior to this. I have been unable to locate any record of the HCSCC advising Ms D that the file would be closed. Subsequent contact by Ms D to the HCSCC suggests that she did not become aware of the file closure until 30 January 2020.

Nevertheless, Ms D continued to make contact with the HCSCC, seeking updates on the status of the own motion investigation, and providing further information.

On 27 January 2020, Ms D queried the status of the own motion investigation.[36] An officer replied that 'your complaint formed part of a systemic own motion investigation that [the Commissioner] has undertaken in relation to the allegations you raised. As such, we are unable to share the details of the investigation outcome or report.'[37]

By email on 22 February 2020, Ms D stated:

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33 Email from an HCSCC officer to Ms D, 20 December 2017.
34 Email from Ms D to an HCSCC officer, 23 January 2018.
35 Email from an HCSCC officer to Ms D, 23 January 2018.
36 Email from Ms D to an HCSCC officer, 27 January 2020.
37 Email from an HCSCC officer to Ms D, 30 January 2020.

> Your email also states that this complaint was closed on 3 July 2018. I have never been advised that this complaint was in fact closed, and I would like to learn the reason why I was not informed.
>
> You have advised that my concerns have been dealt with on a systemic basis rather than an individual basis and as such, you would not be able to assist. It would be appreciated if I could be provided with further information as to the exact reason why I am not able to be informed of the outcome of the investigation into my complaint. If the HCSCC has received a satisfactory reply to my questions (relating to my son's care) why am I not permitted to learn of the outcome?
>
> I consider it unjust and unfair, that after months of observing [Mr E's] pain and suffering due to the errors, neglect and mismanagement by hospital staff, and after lodging questions of concern via [the hospital's] Internal Review process, I am advised that I am unable to be informed of the final outcome of answers to my questions.[38]

In reply, the HCSCC apologised that Ms D had not been informed of her complaint's closure, and explained that:

> In an Own Motion investigation there is no singular "complainant" as such – so the investigation does not focus on only one individual service user and their experience, but rather looks at the delivery of services on a systemic basis.
>
> It is for this reason the HCSCC is not required to report back on the own motion systemic investigation to complainants.
>
> As such, I am not at liberty to provide any further information. However, I can let you know that the HCSCC is satisfied with the actions taken by Service Provider to improve their service delivery.[39]

Mrs F, on behalf of Mr G

On 30 October 2017, the HCSCC met with Ms Johnson to discuss her role in the own motion investigation. The next day, the HCSCC officer responsible for the complaint contacted Mrs F to advise that her complaint would be included in the own motion investigation. According to the HCSCC's records, Mrs F was happy to hear this news.[40]

On 19 February 2018, while arranging a meeting between the HCSCC and the relevant hospital, Mrs F referred to the own motion investigation and queried when her complaint would be investigated.[41] Later that day, the HCSCC advised that the investigation was ongoing, an independent investigator had been appointed, and that;

> [Mr G] is one case among a few where there has not been the acute care services to match the need for them. The investigation has a focus on patients with disability in acute care and why they don't get anywhere near the kind of treatment and/or care they need when in hospital and why their outcomes are nowhere near as good. Just this morning I asked the person liaising with the expert to get in touch with her and make a meeting for her to provide us with an update. I will have more information about that investigation after we meet with the investigator again and I can let you know. I really want her to meet with you all so she has a direct picture of the issues from the horses' mouths so to speak.[42]

On 30 April 2018, an internal file note by the HCSCC officer noted that they needed to 'try and get [Ms Johnson] to meet with [Mrs F] for discussion on the issues facing her and [Mr G].'

38 Email from Ms D to an HCSCC officer, 22 February 2020.
39 Email from an HCSCC officer to Ms D, 22 February 2020.
40 Telephone call between an HCSCC officer and Mrs F, 31 October 2017.
41 Email from Mrs F to an HCSCC officer, 19 February 2018.
42 Email from an HCSCC officer to Mrs F, 19 February 2018.

It appears that the HCSCC continued to work with Mrs F and the hospital to reach a resolution for some of the issues raised in Mrs F's complaint. On 12 February 2019, the HCSCC noted that:

> There are no improvements or recommendations resulting form [sic] this complaint. However it is to be noted that there has been a Health Management Plan put in place…'

Mrs F was advised of this decision in a letter from the Commissioner dated 11 February 2019. The Commissioner explained that he had reviewed the complaint and found:

> …there is nothing further the HCSCC can do to assist you with improving [Mr G's] access to the health services he needs. Although there has not been the health services I would like to have seen made available to [Mr G], there has been action taken by [the relevant local health network] staff to address your specific complaint about the response to [Mr G] when he presents to the [emergency department].
>
> I have decided to close your complaint.[43]

The HCSCC's file for the complaint does not include any record of a response by Mrs F. In response to my investigation, Mrs F explained her understanding that the complaint had been closed because of changes to the HCSCC, which 'didn't feel it was worth keeping the case open regardless of ongoing issues not being resolved.'[44]

On 13 March 2019, although the complaint was closed, an HCSCC officer emailed Mrs F in regard to upcoming policy directives, noting that 'it goes a long way to specify that carers and supporters must be involved in the care of the patient and that it is an inclusive relationship.'[45] It is unclear what prompted this email. Nevertheless, Mrs F responded, noting that barriers to appropriate care for [Mr G] continued, and queried 'how this on a practical level is going to make anything difference [sic] to my sons [sic] health outcomes?'[46] There is no record of the HCSCC's response.

There is no record of any further contact between the HCSCC and Mrs F until July 2020.

Ms I, on behalf of Mr J, deceased

After Mr J died in late March 2017, Ms I, explained to the HCSCC that she was unsure about how to proceed with her complaint.[47] On 17 May 2017, she indicated her intention to proceed with the HCSCC's enquiries,[48] but on 2 August 2017, the complaint was suspended until Ms I provided further information. Practically speaking, the HCSCC closed the complaint file. It is unclear whether Ms I was advised of this.

There is no record of any further contact by the HCSCC until July 2020. On 15 July 2020, Ms I called the HCSCC and explained that she was confused by the Commissioner's letter. According to the HCSCC's records, the Commissioner 'explained the process' to Ms I, although it is unclear what the explanation included. Ms I then asked for a copy of the Commissioner's public statement, and Mr J's case notes. The Commissioner directed Ms I to contact the Freedom of Information unit of the relevant local health network.[49]

43 Letter from the Commissioner to Mrs F, 11 February 2019.
44 Email from Mrs F to my Office, 31 October 2020.
45 Email from an HCSCC officer to Mrs F, 13 March 2019.
46 Email from Mrs F to an HCSCC officer, 15 March 2019.
47 Telephone call between Ms I and an HCSCC officer, 20 April 2017.
48 Telephone call between Ms I and an HCSCC officer, 17 May 2017.
49 Telephone call between the Commissioner and Ms I, 15 July 2020.

In response to my investigation, Ms I explained that she had been advised, by telephone before July 2020, that the HCSCC would publish the final report.[50] I have not been able to locate any record of this contact.

Ms K, on behalf of Ms L, deceased

On 30 October 2017, the HCSCC advised Ms K that an investigator had been appointed 'to look into the circumstances of her complaint about her sister, and a number of other similar complaints.' The HCSCC officer also advised that they would 'let her know when [the HCSCC] have a report to share'.[51] On 22 November, Ms K confirmed with the HCSCC that she was open to speaking with Ms Johnson.[52]

In the meantime, the HCSCC continued to work with Ms K and the relevant local health network in regard to the complaint. On 23 February 2018, the parties met, and the local health network explained a number of initiatives that had been put in place to address Ms K's concerns. On 21 August 2018, following an internal meeting about the progress of the broader investigation, the HCSCC officer responsible for Ms K's complaint noted the following on the complaint file:

> …need to follow up and make sure there is some outcome and then provide this outcome to [Ms K] and other complainants (in my case load) who gave information to Colleen Johnson for the report.

On 25 September 2018, Ms K contacted the HCSCC to query the status of her complaint, noting that she had not heard from the HCSCC or the local health network, and 'was wondering if things had been improved or just been forgotten.' The officer replied that they would follow up with the local health network, and that 'the systemic complaints is [sic] still in action.' Separately, the officer noted that the local health network had not followed up on the actions that had been agreed to at the meeting with Ms K.[53]

By 27 November 2018, the HCSCC was still awaiting an update from the local health network, and the responsible HCSCC officer noted that if they did not hear back by the end of the week, the matter would be escalated to the Commissioner. It appears this occurred on 12 February 2019, shortly before the officer left the HCSCC. An internal email for that purpose noted that part of the complaint had been resolved, but other issues were outstanding.[54]

On 4 March 2019, Ms K was provided with a copy of new directives relevant to her complaint, and offered the opportunity to comment. On 24 March 2019, Ms K replied, explaining that she was pleased to see a response to a number of her concerns.[55] However, the complaint was not closed until after the finalisation of the own motion investigation. In response to my enquiries, the Commissioner explained that:

> [Ms K's] complaint was resolved at the finalisation of the own motion investigation. The previous Commissioner decided to incorporate Ms K's complaint into the own motion investigation. That, in my view, was an error. Ms K's complaint ought to have been individually managed to completion, as the others were. However, I note her issues were substantially managed to her satisfaction by 28 March 2019 … which was the last contact with Ms K prior to the finalisation of the own motion report.[56]

I have not been able to locate any record of the HCSCC advising Ms K that her complaint was incorporated in this manner, or that it had been closed.

50 Telephone call between Ms I and my Officer, 18 November 2020.
51 Telephone call between an HCSCC officer and Ms K, 30 October 2017.
52 Email from Ms K to an HCSCC officer, 22 November 2017.
53 Telephone call between Ms K and an HCSCC officer, 25 September 2018.
54 Internal HCSCC email, 12 February 2019.
55 Email from Ms K to an HCSCC officer, 24 March 2019.
56 Letter from the Health and Community Services Complaints Commissioner to Ombudsman SA, 14 August 2020.

Ms M, on behalf of Ms N, deceased

Ms M was first advised of the own motion investigation in a telephone call with the HCSCC officer responsible for her complaint on 25 January 2018. Ms M was later formally advised by letter from the HCSCC officer on 31 January 2018. The letter provided:

> Your complaint will be part of two investigations under s43 of the [HCSC Act]. This is because in one investigation, the HCSCC is investigating allegations you've made about [the hospital] and in the other, your complaint has been included with other complaints in a systemic investigation, under the Commissioner's own motion, which is already underway.[57]

In each contact, the HCSCC officer also noted that the HCSCC had sought a response from the health service providers relevant to Ms M's individual complaint. The degree of overlap between the three approaches is not clear from the record of the phone call or the content of the letter. Having regard to Ms M's response to my provisional report, it appears that the main issue in her complaint was considered in the own motion investigation.

In June 2018, the HCSCC advised Ms M that it would take no further action in response to her complaint about one of the health service providers. On 25 June 2018, Ms M spoke with an HCSCC officer about the decision. During that conversation, Ms M expressed confusion about which complaint had been closed and the progress of the remaining matters. Ms M explained that she had spoken with Ms Johnson about her complaint and asked the responsible officer whether 'she was going to find out what happened with the systemic issues she brought up with Colleen.'[58] The HCSCC officer explained that, as the investigation was focussed on systemic issues, 'the HCSCC doesn't necessarily let people know the outcome'. Nevertheless, the HCSCC officer was able to advise that Ms Johnson's report had been provided to the department and the Minister for Health and Wellbeing for response. Ms M replied that it would be 'gathering dust on the CE's desk' and that she didn't 'hold hope that anything will change.' The HCSCC officer reassured Ms M, and advised that the HCSCC was awaiting a response from the other health service provider.[59]

The HCSCC continued to manage Ms M's individual complaint, and during that time, Ms M asked after the status of the own motion investigation.

On 4 May 2020, the HCSCC provided Ms M with a draft report on its investigation of her complaint. No adverse findings or recommendations were made. By email on 19 June 2020, Ms M explained that she was extremely disappointed and disheartened by the result, and that, in her view, people with intellectual disabilities 'will continue to receive suboptimal care in the event of acute life threating [sic] medical conditions.[60] In response to my provisional report, Ms M reiterated this view, stating that she was 'appalled that no adverse findings or recommendations were made.'[61] The HCSCC maintained its view when it issued its final report for Ms M's complaint on 3 July 2020.

31. On 15 August 2018, Ms Johnson contacted the HCSCC and explained that she had been contacted by Ms D and Ms I.[62] Each complainant had asked after the status of the investigation. Ms Johnson noted that the HCSCC needed to follow up with the complainants, and asked how the HCSCC would do so. The HCSCC officer replied that the HCSCC would contact the relevant complainants. Ms Johnson's contact was later discussed at an internal HCSCC meeting, and the officers with responsibility for the relevant complaints noted that they would provide an update to the complainants. I have not been able to locate records of such contact.

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57 Letter from an HCSCC officer to Ms M, 31 January 2018.
58 Telephone call between Ms M and an HCSCC officer, 25 June 2018.
59 Ibid.
60 Email from Ms M to an HCSCC officer, 19 June 2020.
61 Above n 9.
62 Telephone call between Ms Colleen Johnson and an HCSCC officer, 15 August 2018.

Publication and advice to complainants

32. On 13 July 2020, ABC News aired radio[63] and television reports[64] about the own motion investigation. Ms K and Ms D spoke to the ABC. The television report on the evening of 13 July 2020 noted that:

> The treatment of [Ms L] and [Mr E] were examined by an investigator who looked into a total of seven cases of alleged discrimination against people with disabilities in South Australian public hospitals. The ABC understands that report was handed to the State's Health Complaints Commissioner two years ago, but it has never been made public, and even the families involved are still in the dark.
> …
> While his predecessor planned to release the report, the current Commissioner, Grant Davies, told the ABC: "that's not appropriate, in part because the nature of some of the matters raised are distressing." He has said he will release a summary in the near future.[65]

33. The next day, the Commissioner wrote to each of the complainants and explained:

> I am writing to you in relation to the Own Motion investigation I am conducting which addresses the systemic issues of the care of people with a disability in acute settings.
>
> I am intending to issue a Public Statement summarising the final investigation report on 30 July 2020. As an informant during this process whose individual complaint and participation informed the Own Motion investigation, I would like to offer you the opportunity of receiving a copy of the Public Statement. …
>
> Thank you for your participation in this investigation. Your information, and the information from your finalised complaint, assisted in the findings and recommendations of the Own Motion Investigation Report.

34. In response to my investigation, the Commissioner explained that, after the ABC News reports, the HCSCC contacted Mr H. Mr H is Mr G's father, and Mrs F's spouse. According to the Commissioner, the HCSCC asked whether Mr H consented to the release of Mr G's personal information, and that he 'explicitly asked for his son's matter not to be released'.[66] In response to my initial enquiries, the Commissioner explained that:

> Once one complainant indicated a desire for their information to remain confidential, I determined all personal information should be removed from the report to be published.[67]

35. In my provisional report, I stated that Mr H's view had been determinative in the Commissioner's decision to remove all personal information from the report to be published. The Commissioner rejected this characterisation.[68]

36. Having carefully considered the file for Mrs F's complaint, this action appears to have been the first involvement Mr H had in the matter. When Mrs F completed an HCSCC form, thereby consenting to release of information in the course of the HCSCC's enquiries, she did not include Mr H as a party to the complaint. In response to my investigation, the Commissioner confirmed that Mr H was not a party to Mrs F's

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63 Australian Broadcasting Corporation, 'Health Complaints Commissioner won't release a report into discrimination against people with disabilities' *ABC Radio Adelaide Breakfast*, 13 July 2020; Australian Broadcasting Corporation, 'Discrimination in the healthcare system against people with disabilities' *ABC Radio Adelaide Morning,* 13 July 2020, David Bevan.

64 Australian Broadcasting Corporation, 'Health and Community Services Complaints Commissioner's report into deaths in public hospitals' *ABC News*, 13 July 2020, Leah McLennan.

65 Ibid.

66 Above n 56.

67 Above n 56.

68 Above n 3.

complaint, and that Mrs F had not identified him as a co-complainant at any point prior to the HCSCC's contact with Mr H.[69]

37. The Commissioner has confirmed that he did not contact any of the complainants to seek their view regarding publication of the HCSCC report.[70]

38. The Commissioner's public summary was published on 31 July 2020.

39. When I asked whether the complainants were advised of the outcomes and findings of the own motion investigation, the Commissioner explained:

> On 14 July 2020…, I wrote to all of the complainants who contributed to the own motion investigation that I had concluded the investigation and that I intended to publish a summary of the findings and recommendations on 30 July 2020. I invited them to download the public summary from our website on that day or request a hard copy of the public summary from us. …
>
> As with any own motion investigation, the complainants were not parties to the investigation as they had their own matters managed by the HCSCC on an individual basis, but in this case I considered it important to advise them of its completion.[71]

40. In response to the first recommendation foreshadowed in my provisional report, the Commissioner maintained that;

> The public summary of the own motion investigation contains an exact copy of the rationale and findings in my report. Where the two documents differ is only in the removal of consumer information. Therefore, each of the informants to this own motion have already been provided with a copy of my reasoning, findings and conclusions.[72]

69 Letter from the Commissioner to Ombudsman SA, 2 November 2020.
70 Ibid.
71 Above n 56.
72 Above n 3.

Relevant law and policies

The *Health and Community Services Complaints Act 2004*

41. The HCSC Act provides the following of relevance in this matter:

3—Objects

The objects of this Act are—

(1) to improve the quality and safety of health and community services in South Australia through the provision of a fair and independent means for the assessment, conciliation, investigation and resolution of complaints; and

(2) to provide effective alternative dispute resolution mechanisms for consumers and providers of health or community services to resolve complaints; and

(3) to promote the development and application of principles and practices of the highest standard in the handling of complaints concerning health or community services; and

(4) to provide a scheme that can be used to monitor trends in complaints concerning health or community services; and

(5) to identify, investigate and report on systemic issues concerning the delivery of health or community services.

9—Functions

(1) The Commissioner has the following functions:

(a) to prepare and regularly review the Charter of Health and Community Services Rights under Part 3; and

(b) to identify and review issues arising out of complaints and to make recommendations for improving health and community services and preserving and increasing the rights of people who use those services; and

(c) to review and identify the causes of complaints and to—

(i) recommend ways to remove, resolve or minimise those cases; and

(ii) detect and review trends in the delivery of health or community services; and

…

(e) to receive, assess and resolve complaints; and

(f) to encourage and assist health and community service consumers to resolve complaints directly with the health and community service providers;

…

(h) to inquire into and report on any matter relating to health or community services on the Commissioner's own motion or at the request of the Minister;

…

(2) The Commissioner must, in providing information and advice, and in the assessment and consideration of any complaint, take into account, to such extent as may be appropriate, the position of persons within special needs groups.

(3) For the purposes of subsection (2), ***special needs groups*** are particular classes of persons who, because of the nature of the classes to which they belong, may suffer disadvantage in the provision of services unless their needs are recognised.

42. Upon receipt of a complaint, the Commissioner must assess the matter, and, after doing so, may:
- refer the complaint to a conciliator or undertake informal mediation
- investigate the complaint
- where relevant, refer the complaint to the Australian Health Practitioner Regulation Agency
- refer the matter to another person or body, where the complaint relates to a matter that falls within that person or body's functions
- determine to take no further action.

43. If it is administratively or otherwise appropriate to do so, the Commissioner may split a complaint, or join two or more complaints, and deal with them accordingly.

44. If, in the course of conciliating or informally mediating a complaint, it appears that there is:
- a significant issue of public safety interest or importance, or
- a significant question as to the practice of a health or community service provider,

the conciliation or informal mediation must be brought to an end.

45. Part 6 of the HCSC Act concerns investigations and provides the following:

43—Matters that may be investigated

(1) The Commissioner may investigate—

(a) any matter specified in a written direction given by the Minister; and

(b) a complaint that the Commissioner has determined to investigate under this Act; and

(c) an issue or question arising from a complaint if it appears to the Commissioner—

(i) to be a significant issue of public safety, interest or importance; or

(ii) to be a significant question as to the practice of a health or community service provider; and

(d) on his or her own motion, any other matter relating to the provision of health or community services in South Australia.

...

45—Conduct of investigation

(1) An investigation is to be conducted in such a manner as the Commissioner considers appropriate.

(2) The Commissioner may, in conducting an investigation under this Part, obtain expert advice, or any other advice or support, in order to assist the Commissioner in the investigation.

...

54—Reports

(1) The Commissioner—

(a) may prepare a report of his or her findings and conclusions at any time during an investigation; and

(b) must prepare a report at the conclusion of an investigation.

(2) The Commissioner may provide copies of a report to such persons as the Commissioner thinks fit.

(3) A report may contain information, comments, opinions and recommendations for action.

(4) No action lies against the Commissioner in respect of the contents of a report under this section.

55—Notice of action to providers

(1) If, after investigating a complaint, the Commissioner decides that the complaint is justified but appears to be incapable of being resolved, the Commissioner may—

(a) provide to the health or community service provider a notice of recommended action; and

(b) advise the complainant of the provision of the notice.

(2) A notice must set out—

(a) the particulars of the complaint; and

(b) the reasons for making the decision referred to in subsection (1); and

(c) any action that the Commissioner considers the health or community service provider should take in order to remedy each unresolved grievance disclosed by the complaint.

46. Finally, the HCSC Act's definition of 'confidential', and its confidentiality requirements, are as follows:

4—Interpretation

(1) In this Act, unless the contrary intention appears—

…

confidential information includes—

(a) information about the identity, occupation or whereabouts of a complainant, health or community service consumer or health or community service provider involved in a complaint, investigation or inquiry under this Act;

(b) information disclosed by a complainant, health or community service consumer or a health or community service provider for the purpose of any complaint, investigation or inquiry under this Act;

(c) personal information about a complainant, health or community service consumer or health or community service provider under this Act;

(d) information the release of which would cause personal distress to a person;

(e) information provided on a confidential basis or otherwise affected by a requirement as to confidentiality;

…

75—Preservation of confidentiality

(1) A person must not record, disclose or use confidential information gained by the person through involvement in the administration of this Act, unless the person does so—

(a) when necessary for the purposes of this Act; or

(b) when expressly authorised or required under this or another Act; or

(ba) when necessary for the purpose of a corresponding law; or

(c) when expressly authorised, in writing, by the person to whom it relates; or

(d) when required to do so by a court or tribunal constituted by law; or

(e) when expressly authorised or required under the regulations.

Maximum penalty: $5 000.

(2) For the purposes of this section, the following persons are involved in the administration of this Act:

(a) the Commissioner;

(b) a conciliator;

(c) a professional mentor;

(d) another staff member;

(e) a member of a committee established under this Act.

The *Freedom of Information Act 1991* and *Freedom of Information (Exempt Agency) Regulations 2008*

47. In response to my investigation, the Commissioner referred to the following clauses of the FOI Act, and regulations of the FOI Exempt Agency Regulations, in support of his decision to not release his final report publicly.

Freedom of Information Act 1991

Schedule 1—Exempt documents

6—Documents affecting personal affairs

…

(3a) A document is an exempt document if it contains matter—

(a) consisting of information concerning a person who is presently under the age of 18 years or suffering from mental illness, impairment or infirmity or concerning such a person's family or circumstances, or information of any kind furnished by a person who was under that age or suffering from mental illness, impairment or infirmity when the information was furnished; and

(b) the disclosure of which would be unreasonable having regard to the need to protect that person's welfare.

…

7—Documents affecting business affairs

(1) A document is an exempt document—

…

(c) if it contains matter—

(i) consisting of information (other than trade secrets or information referred to in paragraph (b)) concerning the business, professional, commercial or financial affairs of any agency or any other person; and

(ii) the disclosure of which—

(A) could reasonably be expected to have an adverse effect on those affairs or prejudice the future supply of such information to the Government or to an agency; and

(B) would, on balance, be contrary to the public interest.

Freedom of Information (Exempt Agency) Regulations 2008

4—Exempt agencies

For the purposes of the definition of exempt agency in section 4(1) of the Act, the following agencies are declared to be exempt agencies:

…

(e) each agency established by or under the *Health and Community Services Complaints Act 2004*;

Relevant HCSCC policies

48. Finally, I have had regard to the HCSCC's Policy: Complaints Management (**the complaints management policy**), which provides the following of relevance:

3. Policy Statement

The HCSCC is committed to effective complaints handling by managing complaints in an accountable, transparent, timely and fair manner. Complaints can contribute actively to improving the quality and safety of health and community services in South Australia.

Complaints, enquiries and disclosures may also identify systemic failures or serious one-off incidents requiring further action including regulatory action.

3.1 Principles

The principles of good regulation as contained with the Australian Government Investigation Standards 2011 (the AGIS), that underpin the Charter of Health and Community Services Rights (the Charter) and the Code of Conduct for Unregistered Health Practitioners (the Code of Conduct) are recognised in the complaints management policy.

- **Proportionate** – Enquiries and investigations will be proportionate to the seriousness of the issues raised in the complaint
- **Accountable** – Reasons for decisions will be documented and provided to the parties to the complaint
- **Independent** – Complaints will be managed impartially
- **Consistent** – There will be a consistent approach to dealing with complaints
- **Transparent** – There will be clear and open communication with the parties
- **Flexible** – Complaints may be lodged in a variety of ways to ensure complainants do not experience barriers to making a complaint
- **Targeted** – Handling of complaints will be focused on
    - the core purposes of improving safety and quality of health and community services in South Australia; and
    - providing effective alternative dispute resolution mechanisms for consumers and providers of health or community services to resolve complaints; and
    - promoting the development and application of principles and practices of the highest standard in the handling of complaints about health or community services; and
    - monitoring trends in complaints concerning health or community services; and
    - identifying, investigating and reporting on systemic issues concerning the delivery of health or community services.

4. Service Delivery Commitment

The HCSCC is committed to following complaint management principles and will:

- Provide an accessible complaints management process that adheres to the principles of procedural fairness
- Give appropriate consideration to people with special needs
- Refer complainants to appropriate advocacy and support services to assist them to make a complaint, where appropriate

- Address complaints with integrity and in a fair, objective and unbiased manner
- Treat complainants with respect by handling complaints in a positive, helpful and timely manner
- Provide information about where to lodge a complaint, how to make a complaint and how the complaint will be managed
- Provide information about what can and cannot be achieved by a complaints process
- Allocate complaints that require inquiries[,] further mediation, conciliation or investigative action to a designated staff member within the office of the HCSCC
- Generally not investigate a complaint that is already under investigation by a health or community service provider or another body
- Investigate serious allegations regardless of an investigation by a health or community service provider or another body where a prompt independent investigation is required
- In some instances, place an investigation on hold pending the outcome of another body's investigation
- Accept anonymous complaints. Complainants will be advised, where possible, of the limitations of lodging an anonymous complaint
- Inform parties to the complaint of the progress of the complaint
- Provide complainants with details of the outcome of the complaint and of the options to seek a review or other appeals mechanisms about their health or community service provider
- Advise the complainant as soon as possible if any part of their complaint cannot be dealt with and provide advice about where the matter has or should be redirected (if appropriate)
- Manage conflicts of interest, whether actual, potential or perceived
- Internal reviews of how a complaint was managed will be conducted by a person other than the original decision maker
- If a complainant decides they do not wish to pursue their complaint, the HCSCC may still decide to investigate the complaint
- Ensure all information is collected and handled in accordance with applicant information and privacy laws
- Allow service providers reasonable time and opportunity to respond to inquiries.

49. The complaints management policy was implemented in February 2019. While all of the relevant complaints were lodged before the policy was adopted, the policy's guidance is still relevant to my consideration of issues two and three. The complaints management policy had been implemented by the time the own motion investigation was finalised, and, in my view, the principles detailed above are consistent with good administrative practice. They are also consistent with the principles outlined in the Premier and Cabinet Circular PC 039 – *Complaint Management in the South Australian Public Sector*, which itself draws on the *Australian/New Zealand Standard: Guidelines for Complaint Management in Organizations*.

50. I understand that the HCSCC does not currently have any internal guidelines or policies for the purpose of determining whether to publish a report. According to the Commissioner

> There are no policies or procedures in relation to my unfettered discretion under section 54(2) of the Act. This discretion is exercised on a case by case basis, taking into account all of the matters before me, including the public interest in doing so, what I can reasonably publish in relation to the particulars of the matter, or whether the outcome of doing so will promote systemic change in the sector.[73]

[73] Above n 56.

Consideration

Whether the Commissioner relied on irrelevant considerations in the exercise of his discretion not to publicly release a report for an own motion investigation, and, in doing so, acted in a manner that amounted to error

The scope of this issue

51. The focus of this question is deliberately specific as I have not considered whether the Commissioner's decision not to publish the HCSCC report itself amounted to error. The Commissioner's statutory discretion on publication is broad. In order to confidently conclude that the exercise of that discretion amounted to error, I would need to be satisfied that the decision was unreasonable. The Commissioner provided my investigation with a detailed explanation of his decision. This is provided below from paragraph 59. While I consider that certain elements of the Commissioner's justification were flawed, it does not appear to have been so lacking in evident and intelligible justification[74] to render the decision unreasonable, to the point of error in the exercise of statutory discretion.

52. Instead, my focus is on whether the Commissioner relied on an irrelevant consideration in making his decision, and whether this amounted to error.

53. Before considering this issue, I note that I have not considered whether the Commissioner's decision not to publicly release Ms Johnson's report amounted to error, or was made in a manner that amounted to error. However, I did query this prior to commencing my investigation, and the Commissioner explained:

> Ms Johnson's findings and recommendations form part of the information I was required to consider in making my findings and recommendations at the conclusion of the investigation. In my view, releasing Ms Johnson's expert opinion as a discrete document would give it more weight than is warranted and would have the potential to confuse readers about where it fit into the investigation.[75]

54. I consider it reasonably open for the Commissioner to take this view and, as a result, decide not to publish Ms Johnson's report. On that basis, this issue has not formed part of my investigation.

55. In his public summary, the Commissioner stated:

> There are reports the previous Health and Community Services Complaints Commissioner said he would fully release parts of the report and specifically, the expert opinion. I am also aware of public calls for the release of the expert opinion.

56. In response to my Office's enquiries, the Commissioner clarified that the 'reports' he referred to were:
    - the ABC News reports on 13 July 2020
    - mention of the investigation by Mr Maurice Corcoran, former Principal Community Visitor, in evidence to the Budget and Finance Committee following the death of Ms Ann Marie Smith.[76]

57. While there was expectation in the community that the HCSCC report, and perhaps Ms Johnson's report, would be publicly released, this was ultimately a matter for the

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74 *Minister for Immigration and Citizenship v Li* (2013) 249 CLR 332, Hayne, Kiefel and Bell JJ at [76]; *Stretton v Minister for Immigration and Border Protection (No 2)* (2015) 231 FCR 36.

75 Above n 56.

76 Evidence to the Legislative Council Budget and Finance Committee, Parliament of South Australia, Adelaide, 25 May 2020, 27 (Maurice Corcoran).

Commissioners' discretion. The HCSC Act affords the Commissioner this discretion and does not otherwise require publication.

58. I turn now to consider whether the Commissioner relied on irrelevant considerations in the exercise of his discretion.

The Commissioner's responses

59. In preliminary enquiries prior to commencing my investigation, I asked the Commissioner why he had declined to publicly release the HCSCC report or Ms Johnson's report. In regard to the HCSCC report, the Commissioner referred to the objects of the HCSC Act and explained:

> The HCSCC's primary purpose is the resolution of complaints in relation to health and community services through a variety of mechanisms, including conciliation and investigation. … [Seven] of the individual complaints had been resolved prior to the finalisation of the own motion investigation.[77]

60. The Commissioner then referred to sections 54 and 55 of the HCSC Act. Section 54 requires the Commissioner to prepare a report at the conclusion of an investigation, and permits him to provide copies of a report to such persons as he thinks fit. Section 55 concerns notices of recommended action to health or community service providers, the preparation of a report following the notice, and the provision of that report to such persons as the Commissioner thinks fit. The Commissioner then cited regulation 4 of the FOI Exempt Agency Regulations, which exempts the HCSCC from the application of the FOI Act, and continued:

> The Parliament's intent is for information provided to the HCSCC to remain confidential to the HCSCC. As provided above, the Parliament also intended the Commissioner to have broad discretion about what and to whom to publish. I am required to balance the public interest for public disclosure with keeping confidential information provided by individuals and service providers to the HCSCC.
>
> The investigation contains highly sensitive personal information about the care recipients. That information relates to their disabilities and I believe the release of that information would have been unreasonable with regard to protecting those care recipient's welfare. This is consistent with Section 6(3a) [sic] of the *Freedom of Information Act 1991* (SA). I was also conscious of the distressing nature of the issues under investigation and did not want to cause further distress to the complainant families whose matters were substantially dealt with some time ago.
>
> Out of an abundance of caution, once [Ms D] and [Ms K] publicly released their information, I asked my Senior Media and Communications Advisor to raise with [Mr H], the parent in [Mrs F's complaint], whether he would consent to the release of his son's personal information in a public report. He explicitly asked for his son's matter not to be released. He confirmed that position in a regular meeting on 28 July 2020. I meet with [Mr H] in his professional role [with a disability services organisation]. Once one complainant indicated a desire for their information to remain confidential, I determined all personal information should be removed from the report published. Individuals are able to discuss their personal circumstances should they choose, just as [Ms D and Ms K] have.
>
> I also considered the release of information about service providers would reasonably be expected to prejudice the future supply of information to the HCSCC and was, on balance, contrary to the public interest. That is consistent with Section 7(1)(c) [sic] of the *Freedom of Information Act 1991*.
>
> The complainants who informed the own motion investigation were not parties to the own motion investigation. Their matters were dealt with individually. It is not appropriate to

[77] Above n 56.

> provide the report to individuals who were not parties to the investigation. However, given the public interest in this matter, I was conscious of the need to publish as much as I was able.[78]

61. The Commissioner later clarified what he had considered to be in the public interest in this matter. The Commissioner explained:

> Public interest relates to the disclosure of information on the public record that benefits the public *as a whole*. It has nothing to do with the curiosity of the public as *individuals* such as those expressed in the media or mentioned in the Legislative Council Budget and Finance Committee.
>
> In coming to the view I have, I first determined whether disclosure of information about the findings of the own motion investigation would be in the public interest (ie, a benefit to the public as a whole). Having decided that it was, I sought to weigh up the benefits of disclosure with the potential harms which might be caused. The most obvious potential harm would come from the disclosure of information which might identify individual health consumers or their families. I determined those harms could be managed effectively and the benefit of making information about the own motion investigation available on the public record could be achieved by publishing the findings and recommendations of the own motion report in the manner that I have in the public summary.[79]

62. In my provisional report, I tentatively concluded that the Commissioner had relied on the FOI Act and the FOI Exempt Agency Regulations, based on the Commissioner's responses above. I then tentatively concluded that the FOI Act and its associated regulations had been irrelevant for the following reasons:
    - the FOI Act affords members of the public the right to seek and be given access to documents held by South Australian government agencies. Documents may be released to the public, except where they are exempt under various clauses of the FOI Act. No such applications had been made to prompt consideration or reliance on the exemption clauses
    - moreover, having regard to the long title, objects and principles of the FOI Act, I conclude that Parliament did not intend for the exemption clauses to be so far reaching that they would apply to any documents held by government agencies as a general matter of course, and absent any application for access
    - even if it was the case that the exemption clauses had such general relevance and application, I did not agree with the Commissioner's interpretation of the exemptions clauses
    - in any event, the HCSCC, as the Commissioner has correctly pointed out, is an exempt agency under the FOI Exempt Agency Regulations. It was therefore contradictory to rely on the FOI Act when the HCSCC is exempt from the Act's application

63. In response to my provisional report, the Commissioner stated:

> When making my decision not to release my report, I did not rely on Freedom of Information legislation or the exempt status of my office. Rather, I pointed to these principles to articulate my overarching approach to own motion investigations and the release of sensitive consumer information as a common frame of reference to assist your office to understand my reasoning. My decision not to release these reports was made independently and without consideration of the *Freedom of Information Act 1981* [sic] (SA) and the *Freedom of Information (Exempt Agency) Regulations 2008*.[80]

64. I find it difficult to reconcile this response with the Commissioner's earlier explanation, which was provided within a month of the relevant decision.

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78 Above n 56.
79 Above n 69.
80 Above n 3.

65. While I remain concerned that the Commissioner did rely on the FOI Act and its associated regulations, I am unable to draw on contemporaneous records to resolve the inconsistency. I query whether it would have been prudent to keep a clear record of the Commissioner's reasons at the time the decision was made, given the significant public interest factors that arose in the own motion investigation. Nevertheless, the lack of contemporaneous records presents the possibility that the FOI Act and its associated regulations did not enter into the Commissioner's mind when he determined not to publish the HCSCC report.

66. I am mindful of the standard of proof I adopt in my investigations. As I am unable to resolve the inconsistency in the Commissioner's explanation, I find I am also unable to confidently conclude that the Commissioner relied on the FOI Act and the FOI Exempt Agency Regulations when he determined not to publish the HCSCC report, thereby acting in a manner that amounted to error.

67. While I cannot make a conclusion of error, I maintain that it is irrelevant and misguided to rely on the exemption clauses of the FOI Act, or an agency's exempt status, to generally limit the release of information to the public where an FOI application has not been made.

Opinion

In light of the above, I cannot conclude whether or not the Commissioner took irrelevant considerations into account when exercising his discretion not to publish the HCSCC report, thereby acting in a manner that amounted to error. I decline to consider this issue further.

Whether the Commissioner failed to seek the views of the complainants regarding the public release of the HCSCC report, and whether this failure amounted to error

68. As stated above, the Commissioner has broad discretion in determining whether to publish a report. While it was reasonably open to the Commissioner to take Mr H's views into account, I have considered whether the Commissioner's decision to *only* take Mr H's view into account, and not seek or take into account the views of the seven complainants, amounted to error. I have done so having regard to:
    - the vulnerability of the complainants
    - the seriousness of the complaints
    - the principles outlined in the HCSCC's complaint management policy, which reflect generally accepted standards of complaint management. This includes principles of transparency, consistency, accountability, and fair and equitable access to complaint mechanisms and agencies.

69. The Commissioner rejected how I characterized the effect of Mr H's view in my provisional report; that Mr H's view on the release of Mr G's information was a determinative factor in the Commissioner's decision not to publicly release the HCSCC report. In response to my provisional report, the Commissioner stated:

> Prior to contacting Mr H, I formed the decision not to release my report based on the sensitive nature of its content and the likelihood of vulnerable individuals being easily identified regardless of redaction. Out of an abundance of caution, I contacted the parent of a consumer whose matter had informed the own motion to determine if they shared this view. Mr H was this initial parent. Had Mr H been open to the publication of his son's details, I would have continued to contact other informants. I remain of the opinion that once one informant/guardian opposed the release of sensitive information, my decision had been confirmed.[81]

[81] Above n 3.

70. I again find it difficult reconciling the Commissioner's response to my provisional report with the information provided to my Office at an earlier stage in my investigation.

71. In any event, my characterization of the role of Mr H's view in the Commissioner's decision not to publish the report is not crucial to my consideration of whether the Commissioner failed to seek the views of the complainants. In the circumstances, it was open for the Commissioner to contact Mr H and ask if he, as one of Mr G's parents, consented to the release of information about his son. While Mrs F does not appear to have identified Mr H as a co-complainant at any stage during her contact with the HCSCC, Mrs F advised my Office that she lodged the complaint with her husband's encouragement.[82]

72. In response to my provisional report, the Commissioner also rejected the suggestion that he had contacted Mr H because of an unrelated, preexisting, professional relationship. The Commissioner stated:

> Mr H's identity was not relevant to this process and I maintain my commitment to all members of the public having equitable standing with the HCSCC.[83]

73. When I commenced my investigation, I asked the Commissioner to explain his reasoning for contacting Mr H, rather than Mrs F or any of the other complainants. In response, the Commissioner stated:

> I had an existing relationship with [Mr H] and sought his views about the release of the information about his son. Had he indicated for the release of his son's personal information, I would have sought the original complainant's views as interested parties, not as complainants. As he was adamantly opposed to the release of information, I would not need to contact any other interested parties.[84]

74. I do not accept the Commissioner's recent suggestion that Mr H's identity was not relevant when he was contacted about the release of information about Mr G. I am very concerned about the appropriateness of complaint management practices based on pre-existing relationships with non-complainant interested parties, particularly where no other complainant is afforded the same consideration.

75. In my view, the Commissioner should have sought the views of the complainants after he sought the views of Mr H. The complainants ought to have had equitable access to and standing with the HCSCC, regardless of any preexisting, unrelated professional relationship which might exist with an interested party.

76. Consistency, fairness, transparency and accountability are important principles of complaint management and good administrative practice. They are also included in the HCSCC's complaint management policy, which was in place when the Commissioner turned to consider whether to publicly release the HCSCC report. I have been unable to identify any cogent reason for Mr H's views standing in place for the views of the seven complainants. In all of the circumstances, I consider that the Commissioner erred by failing to seek the views of the other parties once he had sought the views of Mr H.

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82 Email from Mrs F to Ombudsman SA, 31 October 2020.
83 Above n 3.
84 Above n 69.

Opinion and recommendation

In light of the above, I conclude that the Commissioner acted in a manner that amounted to error when, in determining whether to publicly release the HCSCC report, he sought the views of Mr H but failed to seek the views of the complainants.

To remedy this error, I make the following recommendation under section 25(2) of the Ombudsman Act:

1. That the Commissioner reconsider the decision of whether to publicly release the HCSCC report, and in doing so, seek and have regard to the views of the complainants.

In response to my provisional report, the Commissioner stated:

> Based on your perceived error associated with consideration 2, you tentatively recommend I reconsider my decision to release my report of the own motion investigation. I do not accept this recommendation for two reasons:
>
> 1) As you have correctly identified, my decision not to release the report was not in error and is within my statutory discretion; and
>
> 2) The public summary of the own motion investigation contains an exact copy of the rationale and findings in my report. Where the two documents differ is only in in the removal of consumer information. Therefore, each of the informants to this own motion have already been provided with a copy of my reasoning, findings and conclusions.

I am not persuaded to alter my recommendation. I will address each of the Commissioner's reasons in turn.

Firstly, it is not the case that I had concluded that the Commissioner's decision was not in error. I have commented that there appears to be an evident and intelligible justification for the Commissioner's decision but have ultimately declined to consider the issue to the point where I might conclude whether or not there has been error. I have confined my consideration to the manner in which that decision was reached. That is also the focus of my recommendation; that the views of the complainants are appropriately taken into account, as they ought to have been, alongside Mr H's.

The second point of the Commissioner's response appears to be of greater relevance to issue three. I will consider this argument later in my report.

For the sake of completeness however, I have considered it in the context of recommendation one. The precise differences between the public summary and the HCSCC report are not relevant to whether the complainants should have the opportunity to express their views on publication. The provision of outcomes, and the equitable provision of appropriate opportunities for participation in an administrative decision are distinct issues. My recommendation aims to address the latter.

My recommendation remains. It may be the case that, after seeking the views of the complainants, the Commissioner affirms his decision not to publish the report. The purpose of my recommendation is to ensure their views are taken into account in an equitable manner.

Whether the HCSCC failed to communicate clearly with the complainants after the commencement of the Commissioner's own motion investigation, and whether this failure amounted to error

The scope of this issue

77. Before proceeding, it is necessary to clearly distinguish this issue from issues one and two above. As I have explained, the Commissioner has a broad statutory discretion as to whom he provides his investigation reports. I have declined to conclude whether or not the Commissioner's decision itself was in error. Issue one and two have instead focused on the Commissioner's decision-making processes in this matter.

78. In answering the question at hand, I have focused on the broader issue of communication with complainants. In doing so, I have considered communication with the complainants while the own motion investigation was being conducted. This includes communication to advise complainants that:
    - their complaints had formed part of the own motion investigation
    - they were not parties to the own motion investigation
    - their complaints had been closed.

79. I have also considered the HCSCC's communication with the complainants once the own motion investigation was finalised. This includes the level of detail provided to the complainants about the Commissioner's reasoning and findings, and the outcomes of the own motion investigation, in so far as they related to the individual complaints.

The Commissioner's response

80. Before proceeding, I note the Commissioner's response to my provisional consideration of this issue:

> I agree with and accept your opinion regarding our communication with informants to the own motion investigation after its commencement and have taken steps to ensure failings of this nature do not arise again. I apologise for these failings in communication. While I cannot speak to my predecessor's approach to the commencement and subsequent communication of the own motion investigation, I have taken steps to ensure all HCSCC staff have a clear understanding of my approach and expectations in relation to own motion investigations so they can communicate this process with clarity to future informants.[85]

Communication with complainants during the own motion investigation

81. The HCSCC's advice to complainants that their complaints would be considered as part of the own motion investigation was inconsistent.

82. Not all of the complainants were advised of this decision. Mr A and B do not appear to have been advised until after the own motion investigation had been finalized in July 2020. It appears that Ms I was advised of her complaint's inclusion by Ms Johnson, and not by the HCSCC. Where complainants were advised of this decision, the form and level of detail was also inconsistent. The majority of the remaining complainants received informal notice of this decision. It appears only Ms M received a letter from the HCSCC.

83. None of the communication, regardless of how it occurred, included any information to the effect that the complainants were not parties to the own motion investigation. In fact, at times the HCSCC's communication with complainants implied or explicitly stated otherwise:

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[85] Above n 3.

- by email on 20 December 2017, the HCSCC advised Ms D of the own motion investigation, that a report was anticipated by mid-March 2018, and that, 'rest assured, you will be contacted no matter what'.[86] Ms D sought updates on the own motion investigation until 30 January 2020, when she was first advised that she was not a party to the own motion investigation
- by phone call on 30 October 2017, the HCSCC advised Ms K that Ms Johnson had been appointed to 'look into the circumstances of her complaint…and a number of other similar complaints' and that the HCSCC 'will let her know when [it had] a report to share'.[87] Ms K continued to seek updates on the own motion investigation, and expressed concern that the matter would be forgotten. The HCSCC responded but did not advise Ms K that she was not a party to that investigation
- while her individual complaints were progressed, Ms M sought updates on the own motion investigation and expressed concern that Ms Johnson's report would be 'buried'. The HCSCC advised Ms M that the HCSCC doesn't necessarily let people know the outcome'[88] but did not advise Ms M that she was not a party to the investigation.

84. Furthermore, where the HCSCC continued to manage and progress individual complaints, it does not appear that the separation between these matters and the own motion investigation was clearly explained to any of the complainants. In some instances this led to confusion about how the HCSCC was managing the matters, such as in Ms D's complaint. Shortly after the HCSCC advised her that the own motion investigation had commenced, Ms D expressed concern that the systemic investigation would not address or investigate her individual complaint about Mr E's care. In response, the HCSCC reassured Ms D that Ms Johnson would interview all staff and individuals. This was incorrect. In response to my investigation, Ms D explained her understanding that her complaint would form part of the investigation as a whole, and would not be investigated separately.[89]

85. In other instances, the lack of clear separation appears to have resulted in complaint issues being completely absorbed by the own motion investigation. For example, B had raised concerns that Ms C's care had been impacted by inadequate management of cultural and linguistic needs, the needs of patients from remote areas, and the needs of patients with disabilities. The HCSCC's management of B's individual complaint only addressed the first two issues, leaving B without an outcome for the third.

86. Finally, I have been unable to find record of the HCSCC advising two complainants[90] that their individual complaints would be closed, and affording those complainants an opportunity to respond:
- in February 2019, the HCSCC determined to take no further action in response to B's complaint on behalf of Ms C. The HCSCC's file includes a note by the responsible officer that B was advised of this decision, but I have not been able to locate records of any contact with or correspondence to B
- Ms D's complaint about Mr E's care was closed on 3 July 2018. She was not advised of this action, although the HCSCC's file states that this had occurred. Despite further contact by Ms D to the HCSCC, she was not advised of the decision until 18 February 2020.

86 Above n 33.
87 Above n 51.
88 Above n 58.
89 Email from Ms D to Ombudsman SA, 16 November 2020.
90 It also appears that Ms I was not advised when her complaint was closed on 2 August 2017. This predates the commencement of the own motion investigation.

Communication with complainants at the end of the own motion investigation

87. In the course of my investigation, the Commissioner stated that the complainants have been advised of the outcomes of the own motion investigation. The Commissioner restated this view in response to my provisional report, but did not provide any additional evidence or compelling argument to support this. I am not persuaded by the Commissioner's insistence. I remain of the view that this is not a complete and accurate representation of what occurred. It is true that the complainants were advised of the finalisation and general findings of the own motion investigation, in the same manner and with the same level of detail as the general public. They were not, however, advised of the reasoning, conclusions and outcomes of the investigation in relation to their complaints.

88. Ms Johnson's report and the HCSCC report include extensive detail about each of the complaints. Each report forms conclusions about the complaints. I accept that it would be difficult for either report to be redacted or de-identified and remain coherent. I also accept that it would be difficult to provide the reports to each of the complainants without impacting the privacy of the others. Nevertheless, it was open, practically speaking, for the HCSCC to advise each complainant of the reasoning, findings and conclusions of Ms Johnson and, later, of the Commissioner. This information is readily available to the HCSCC given that each report draws specific conclusions in regard to each complaint. It does not appear that any of the complainants in this matter have received advice to this effect.

89. Noting that there appears to be no practical impediment, I consider that it was wrong for the HCSCC not to provide this information to the complainants. I have formed this conclusion based on:
    - how the complainants' expectations were managed
    - accepted principles of complaint management.

90. Although the Commissioner has explained that the complainants are not party to the own motion investigation and therefore are not entitled to this information, this was not consistently communicated to the complainants at an appropriate time, such as at the commencement of the own motion investigation or when some complainants sought updates on the investigation. In some instances, specific assurances to the contrary were given.

91. In conducting my investigation, I sought to understand the complainants' views and expectations of the own motion investigation. Five complainants provided responses as follows:[91]
    - Ms D explained that 'I fully expected that I would be provided with the report, or that it be made available, in order for me to access the final report in its entirety'[92]
    - Ms H explained that while it is 'just a bonus' to 'hear back from any of the various projects/consultancies I have participated in over many years of being a parent to a severely disabled child', she had no expectation of receiving a report from the Commissioner[93]
    - Ms I explained that she was unhappy with the outcome of her complaint; that she knew what had happened to Mr J, but did not know what the HCSCC considered had been wrong in his care[94]
    - Ms K explained that she had expected a report, and hoped she could view it and comment before it was published.[95]

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91 Mr A and B did not provide a response to my enquiries.
92 Above n 63.
93 Email from Mrs F to Ombudsman SA, 31 October 2020.
94 Telephone call between Ms I and an Ombudsman SA officer, 18 November 2020.
95 Email from Ms K to Ombudsman SA, 20 October 2020.

- due to the impact of her daughter's death, Ms M 'had no expectations with regard to the provision of Ms Johnson's report or the HCSCC's final report.'[96]

92. The HCSCC mismanaged the expectations of the complainants and failed to act in accordance with expectations that it had, at times, actively reinforced. In the circumstances it is appropriate for the complainants to know the findings of the own motion investigation in relation to their own complaints.

93. Failing to advise the complainants of the HCSCC's findings is also inconsistent with accepted principles of complaint management such as accountability, consistency, and transparency. These principles are included in the HCSCC's complaints management policy, and reiterated in the policy's service delivery commitments, which require the HCSCC to:
- provide information about where to lodge a complaint, how to make a complaint and how the complaint will be managed
- provide information about what can and cannot be achieved by a complaints process
- inform parties to the complaint of the progress of the complaint
- provide complainants with details of the outcome of the complaint and of the options to seek a review or other appeals mechanisms about their health or community service provider
- advise the complainant as soon as possible if any part of their complaint cannot be dealt with and provide advice about where the matter has or should be redirected (if appropriate).

94. Finally, in all the circumstances, I consider that it was wrong for the complaints not to be advised of the HCSCC's findings in relation to their complaints given:
- the seriousness of the complaints
- the vulnerability of the complainants and the people on whose behalf they had complained
- the purpose of the own motion investigation, and the HCSCC as a complaints handling body.

95. In this regard, I note the following excerpt from Ms Johnson's report, as well as the responses of Ms D and Ms K to my investigation. In her report, Ms Johnson stated:

> Most South Australian residents are likely unaware of the HCSCC's existence, that they can lodge a complaint, or how to lodge a complaint. Other families, carers and/or friends who have experienced adverse events may not have the skills or confidence to lodge a complaint. Others may be jaded by their experiences. Many people with disabilities have no families, carers and/or friends to witness events and complain on their behalf. We can be sure that these seven cases are a small proportion of adverse events in the tertiary health system involving people with disabilities.[97]

96. In response to my enquiries, Ms D stated:

> I believe, that by the investigation taking the form of a "Systemic Investigation", it has deprived the families who submitted their complaints to the HCSCC of receiving an adequate response to their concerns.
>
> I believe that these families fully expected that their complaints would be dealt with separately, on an individual basis. It is my opinion that they, as I, chose to submit their complaints in the first instance, because they wanted answers and explanations as to the reasons why their loved one was treated so poorly and with such unacceptable neglect and abuse.

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96 Email from Ms M to Ombudsman SA, 8 November 2020.
97 Above n 6.

> I feel it is unjust and unfair to conduct an investigation which does not address the concerns of each complaint individually, but rather merges these complaints into one category. It is difficult enough to have to stand by and witness loved ones being treated with such cruelty (even to the point of losing them), and then to be deprived of the reasons why these horrendous events did occur.
>
> I believe, that the families of the seven disabled people who were selected for investigation, expected answers. To my knowledge, answers have not been forthcoming and I would suspect that there remains feelings of immense frustration and disappointment due to the resulting lack of closure.[98]

97. In response to my enquiries, Ms K stated:

> I feel that I fell between the cracks with HCSCC with the retirement of my Complaint Resolution Officer and the resignation of Mr Steve Tully. My fear has been that nothing has changed and people with disabilities who cannot use traditional communication methods, and their families are still discriminated against.
>
> [It] concerns me that it took three years for the edited report to be released and I wonder what has happened to families in the intervening years. I also wonder why the original report was shelved for two years and not released. This reflects so badly on our SA health system and our society and I struggle to accept that we can treat our most vulnerable with such lack of respect.[99]

98. These submissions are powerful. In my view, they speak to the importance of robust and responsive complaints processes, and to the important role that agencies like the HCSCC have. They are persuasive in my consideration of the issue at hand.

99. In all of the circumstances, I consider that by:
    - failing to advise all complainants that their complaints would be considered in the own motion investigation, and the extent to which those complaints would be considered
    - failing to advise the complainants that the HCSCC had determined that they were not party to the own motion investigation
    - failing to advise the complainants of the reasoning, findings and outcomes of the own motion investigation, to the extent that these concerned the individual complaints,

    the HCSCC mismanaged the complainant's expectations, failed to live up to its commitments to the complainants, and failed to act in accordance with its complaints management policy.

Opinion and recommendation

In light of the above, my final view is that the HCSCC failed to clearly communicate with the complainants after the commencement of the own motion investigation, and, in doing so, acted in a manner that amounted to error.

In my provisional report, I foreshadowed making the following recommendation under section 25(2) of the Ombudsman Act:

1. That the HCSCC formally advise each of the complainants in writing of the reasoning and findings of Ms Johnson's report, and the reasoning, findings and outcomes of the HCSCC report, in so far as each are relevant to the complaints.

In response to my provisional report, the Commissioner submitted:

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98 Above n 63.

99 Email from Ms K to Ombudsman SA, 20 October 2020.

> I do not accept your recommendation to formally advise the informants to the own motion investigation of Ms Johnson's report in addition to the reasoning, finding and outcomes of my report.
>
> As I have already identified, all informants have been provided the relevant information from my report in the form of my public summary, which remains accessible on my website.
>
> In relation to Ms Johnson's report, I reiterate my concerns about the content of this report exceeding the scope of her terms of engagement and the unclear provenance of her engagement. It is not and has never been the practise of any Health and Community Services Complaints Commissioner in South Australia to release reports commissioned for the purpose of assessments or investigation of a matter. To my knowledge, my predecessor, Mr Steve Tully, did not ever release his own reports or those of others into the public domain.[100]

I do not consider that all relevant information has been provided to the complainants. The public summary details significant findings by the HCSCC about the care provided by SA Health. Some of the conclusions are very alarming. There is no way for the complainants to identify which conclusion related to them or to the person on whose behalf they made their complaint.

Throughout my investigation, the Commissioner has raised concerns about Ms Johnson's report and whether the assistance she provided the HCSCC exceeded her instructions. I have not considered these concerns in particular detail as:

- on the information provided by the HCSCC, it does not appear that Ms Johnson's engagement and assistance is unclear. Any lack of clarity in this regard appears to arise from the HCSCC's record keeping
- the concerns raised by the Commissioner are not crucial to my consideration of the three issues in my investigation. That is, they are not relevant to whether or not:
    - the Commissioner relied on irrelevant considerations in exercising a statutory discretion
    - the Commissioner failed to seek the views of the complainants equally
    - the HCSCC failed to clearly communicate with the complainants.

In any event, Ms Johnson's assistance and conclusions were relied upon and heavily cited in the HCSCC's report, more than two years later. It is inconsistent for the HCSCC to rely on Ms Johnson's assistance for the purpose of the HCSCC report, but later dismiss that assistance as unreliable or exceeding scope.

I am not persuaded that this should hinder the communication of outcomes to the complainants. My recommendation remains.

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100 Above n 3.

Summary

In light of the above, my final view is that:

1. the Commissioner acted in a manner that amounted to error when, in considering whether to publicly release the HCSCC report, he sought the views of Mr H but failed to seek the views of the complainants

2. the HCSCC failed to clearly communicate with the complainants after the commencement of the own motion investigation, and in doing so, acted in a manner that amounted to error.

As I am unable to confidently conclude whether or not the Commissioner relied on certain exemption clauses of the FOI Act, and the FOI Exempt Agency Regulations, in exercising his discretion not to publish the HCSCC report, I decline to consider the issue further, and make no finding in this regard.

Recommendations

To remedy these errors, I make the following recommendations under section 25(2) of the Ombudsman Act:

1. That the Commissioner reconsider the decision of whether to publicly release the HCSCC report and in doing so, seek and have regard to the views of the complainants.

2. That the HCSCC formally advise each of the complainants in writing of the reasoning and findings of Ms Johnson's report, and the reasoning, findings and outcomes of the HCSCC report, in so far as each are relevant to the complaints.

In the course of this investigation, I have also considered whether it is appropriate to make recommendations for the development and implementation of policies on communication to complainants whose complaints inform own motion investigations. However, in response to my enquiries, the Commissioner explained that:

> - I have instructed staff that own motion investigations are matters which are initiated by me, as the Commissioner, and that there are no complainants to such matters, only informants.
> - I have made it clear exchanges of information during any investigation are not appropriate in the same way that occurs during conciliation. It is up to the HCSCC to come to a view, on balance, whether the allegations have been substantiated or not.
> - I have said to staff they are to provide information about the timelines of actions for the investigation of complaints to complainants about complaint initiated investigations.
> - I have also indicated the way in which matters were rolled into this own motion investigation should not occur again. If individual complaints are the impetus to initiate an own motion investigation, those should be finalised as individual complaints
> - I have also said that we need to make it very clear to complainants of those individual complaints they are not parties to the own motion investigation and will not be engaged as such.
>
> …
> These changes set clear boundaries and expectations in relation to own motion investigations, i.e., they do not have ongoing role in own motion investigations.[101]

While I have refrained from making a recommendation on this point, I am of the view that it would be appropriate for the Commissioner to consider, on a case by case basis, whether any affected parties should be provided with reports in relation to an own motion investigation. I remain concerned that future complainants could be prevented from learning

[101] Above n 69.

the outcome of their complaint, including whether adverse findings had been made, because their complaint had formed part of a broader, systemic response by the HCSCC in an own motion investigation. As a general approach, this appears contrary to the principles of open, transparent and responsive complaint management. It is, in my view, entirely inconsistent with the HCSCC's primary purpose, as detailed in the first and second objects of the HCSC Act:

> (1) to improve the quality and safety of health and community services in South Australia through the provision of a fair and independent means for the assessment, conciliation, investigation and resolution of complaints; and
>
> (2) to provide effective alternative dispute resolution mechanisms for consumers and providers of health or community services to resolve complaints; and

Final comment

In accordance with section 25(4) of the Ombudsman Act, the Commissioner should report to me by 17 August 2022 on what steps have been taken to give effect to the recommendations above; including:

- details of the actions that have been commenced or completed
- relevant dates of the actions taken to implement the recommendations.

In the event that no action has been taken, reasons for the inaction should be provided.

Should the Commissioner maintain his refusal to accept my recommendations, I also note that if appropriate steps are not taken to give effect to them, I may report the matter to Premier, and forward my report to the Speaker of the House of Assembly and the President of the Legislative Council with a request that it be laid before their respective Houses.

I have sent a copy of my report to the Minister for Health and Wellbeing as required by section 25(3) of the *Ombudsman Act 1972*.

Wayne Lines
SA OMBUDSMAN

17 May 2022