From: Moira [redacted] McNeil [redacted]
Sent: Thursday, 3 March 2022 10:39 AM
To: Mental Health Select Committee
Cc: [redacted]
Subject: Submission to the Mental Health Select Committee Inquiry
Attachments: Mental Health Lived Experience_Gold Coast.pdf

Categories: Submission

Moira McNeil
[redacted]

3 March 2022

Mental Health Select Committee

Parliament House George Street BRISBANE QLD 4000

Via email: mhsc@parliament.qld.gov.au

Dear Ministers of the Mental Health Select Committee,

Kindly receive my sincere apologies for being late with this submission, and I hope that you will be able to accept it. With my attention on family I missed the Media Release just prior to Christmas.

My submission is a high level summary of my lived experience, with names redacted as the intent is not to expose or chastise individuals, but rather to demonstrate some challenges faced by users of the Queensland State funded services.

The public are both a part of the system with its interconnectedness with respect to laws depending on the correct identification of relevant issues, as well as being reliant on the effectiveness of the integrated system, with assumed objectivity and apportions to coordinate a balanced approach to useful services.

I would appreciate your consideration of the issues I raise, including highlighting any opportunities to improve future coordination between government services.

With gratitude and hope,

Moira McNeil

Mental Health Lived Experience Gold Coast Queensland

Submission to the Mental Health Select Committee Inquiry into the opportunities to improve mental health outcomes for Queenslanders

2 March 2022

Mental Health Select Committee
Parliament House George Street BRISBANE QLD 4000
Via email: mhsc@parliament.qld.gov.au

Dear Ministers of the Mental Health Select Committee,

Kindly receive my sincere apologies for being late with this submission, and I hope that you will be able to accept it. With my attention on family I missed the Media Release just prior to Christmas.

I am motivated to make a submission based on my personal lived experiences of the difficulties, challenges and complexities linked to laws and multiple agencies involved in mental health services, and concerns for our community. My primary focus is on the need for effective administration of coordinated services coupled with front-line training of staff. Working together in a coordinated manner enables proper diagnoses of the issue and minimises harm. I am hopeful recommendations and rationales to provide policy guidance with that view will be made by the Select Committee.

Delivery of mental health services is a challenging environment, but it is made more difficult for families when the public mental health system is not geared to self-correct or identify opportunities to improve when legitimate concerns are raised. All agencies have a shared 'Duty of Care" with system administrators obligated to enable integrated efficiency, effective and economic services to work. I have continually felt discouraged, frustrated from misinformation, frantic and without hope.

My journey to seek support for my son *Sam (pseudo name) through the Queensland Mental Health (QMH) system spans 6 years including 3 inpatient experiences in Gold Coast Critical Care Mental Health Units with medication the sole focus and very little to no counselling or psychiatric support.

The facilities for mental health counselling or psychiatric support appear to be significantly under resourced and without a clear referral pathway between agencies. My son required critical care. We acted in good faith on advice given to us on multiple dates by the QMH Acute Care team of the Gold Coast Hospital and ended up in Domestic Violence Court twice in a 3 year period, with our personal burden being the unintentional consequences of police action taken.

2015:

1. In 2015 my son Sam distributed disturbing and distressed messages. Emergency services attended and transported him to Robina Hospital Critical Mental Health Unit. Sam was admitted, medicated for 3 weeks then released to our care.

No diagnosis, no further community counselling or psychiatric support was offered.

2017:

2. Sam began to exhibit similar concerning behaviours as he did in 2015. We were instructed by QMH Acute Care clinicians to "*use any excuse*", call 000 advising any attending officer(s)

the actions were the result of Sam being in a mental health crisis requiring immediate medical treatment at hospital to assess, manage the risk and Sam would be transported.

3. Queensland Police Services (QPS) arrived and refused to discuss the risks with QMH staff, transport did not occur for Sam. A Police Protection Notice (PPN) was offered as an option advising that I would be able to speak to a Magistrate who could issue an '*Examination Authority*', to help us with the mental health evaluation process. Redirected to courts, we did not understand a PPN was actually the first step of a Domestic Violence Order (DVO).
4. Based on the extenuating Court circumstances I actively sought legal support from the QMH Acute Care Team; the QMH consulting psychiatrist provided a letter stating "*referring the matter to the Domestic Violence Court was certainly not helpful to* [Sam]*, and if anything it could be considered detrimental"*.
5. Court records show the sitting Magistrate requested the Police Prosecutor to drop the matter, the request was refused by the QPS. With the QPS refusal the Magistrate stated she had no option but to put the Order in force, but she had authority to end the Order within 24 hours or at midnight that night on 15 March 2018. The Magistrate made such an order.
6. The QMH consulting psychiatrist referred Sam into the Community Health program for weekly counselling; Sam was discharged from that service following 7 – 8 visits, labelled as "too well" to continue to receive counselling through the acute care outpatient services.

No diagnosis, no further community counselling or psychiatric support was available.

Services rely on the expertise for each is responsible. In my view a critical point here is that agencies cannot provide directives, information or instructions that are outside their scope of authority. One agency cannot say another agency, or the Court, will act in a particular manner. In our situations both QMH and QPS staff provided me with misleading advice that they had no authority to give.

2019:

7. We received a Facebook message from a Sydney based journalist working on a story in Iceland. The message was the journalist's own son had Schizophrenia. Sam was exhibiting symptoms 'of concern ' and the journalist was certain Sam would require support to get back to Australia. Sam's father, my husband, flew to Reykjavik, brought Sam back and not long after they were home Sam was hospitalised for a second time.

No diagnosis, counselling as an inpatient or continued psychiatric support.

2020:

8. In September Sam felt unwell enough to take himself to the Emergency Department at the Gold Coast Hospital. After more than a 12+ hour wait Sam was interviewed by the Registrar to the consulting psychiatrist of the Acute Care Team. It was after 11:00pm and the Registrar asked me if we were still waiting outside. We were not still on location so we opted for a phone interview. **The Registrar stated he suspected PTSD as a diagnosis**.
9. Sam, as the patient, requested any suitable medication except Lorazepam due to the known side effect of weight gain. The only medication Sam was offered was Lorazepam.
10. In October, a mental deterioration highlighted the need for urgent medical attention.
11. Based solely on advice by QMH Acute Care, and with the confidence there are established partnerships between agencies to provide for a person with mental health issues to be diverted into suitable treatment and care as needed, I called 000 for a welfare check.

12. The welfare check was not actioned. The following morning a Senior Constable stated to me "*If this mental health situation has been ongoing since 2017, - when will this be over, when will* [Sam] *be OK*"? The statement shocked me. It was an example of the ongoing stigma and discrimination experienced by people with mental health issues, and may reflect an inadequate understanding of *Mental Health Act 2016* (Qld) and how the QPS is required to provide a support role to the health authorities in a time of mental health crisis situations.
13. Following that conversation QPS visited Sam. Body cam footage recorded Sam's statements to QPS demonstrating persecutory delusions. QPS failed to recognise the mental health issues or attempt to support Sam with intervention action for an Emergency Examination Authority (EEA). A welfare check was ignored. The sole focus was to serve another PPN.
14. Sam was later admitted as an inpatient at Gold Coast Hospital (GCUH) Critical Mental Health Unit. A stay that raised questions regarding service delivery, please see attached email.

Without support from QMH or the provider GCUH, our family was forced to challenge the QPS decisions and actions i.e. Police Protection Notice (domestic violence). As a family we were forced to request the matter be referred to a Court Hearing for a judicial decision by the sitting Magistrate.

It was an extremely stressful situation to be a member of the community and be faced with no reasonable option but to hire a law firm and openly challenge the QPS PPN decision in Court.

Without considering the personal impact or time demands, the funds required to finance a private solicitor to attend every designated Court Mention, read through QPS submissions, provide advice, file my own Affidavit at the prescribed time and prepare for a Hearing were acquired by increasing the mortgage on our family home. The financial cost is a significant burden to our family finances.

After we filed documents detailing QPS actions with the Court, on 25 June 2021 at final Review Mention prior to a Hearing date being assigned, the QPS withdrew their application to the Court. The Police Protection Notice was withdrawn, and the domestic violence proceedings withdrawn.

In April 2021 and after six years of intermittent episodes under the irregular care of QMH and specifically the Acute Care Team, Sam now has a medical diagnosis. That medical diagnosis is PTSD, from long-term mental and emotional abuse specifically due to the stress and trauma of long-term (10 years) workplace bulling with threats of physical violence.

The recent medical diagnosis through engaging with private sector provides a level of understanding for all of our family and a basis for successful medical intervention and treatment going forward.

Treatments being delivered through private health, private counselling and private psychiatric support, already achieving success with marked improvement and beneficial results for Sam.

My family's suffering and harm could have been prevented if coordination and referral information services between QMH and QPS responded to the mental health issue bought to their attention.

Lived Experience from a Gold Coast Queenslander

[redacted]

ATTACTMENT 'EMAIL', with four (4) written concerns

Subject: FW: Case number: [redacted] - Gold Coast Health, Submitted Concerns [redacted]

From: Reviews [mailto:reviews@oho.qld.gov.au]
Sent: Thursday, 24 February 2022 5:43 PM
To: [redacted]
Subject: RE: Case number: [redacted] - Gold Coast Health, Submitted Concerns [redacted]

Dear [redacted]

I acknowledge receipt of your email below with four attachments, received by the Office of the Health Ombudsman (OHO) today, concerning the review decision relating to your complaint about the Gold Coast University Hospital – Mental Health Services.

The OHO will consider your correspondence and will contact you in due course.

Regards

[redacted]
Senior Review Officer

Reviews Team

Office of the Health Ombudsman
T: 133 646
E: reviews@oho.qld.gov.au
W: www.oho.qld.gov.au
P: PO Box 13281 George Street QLD 4003

OFFICE OF THE HEALTH OMBUDSMAN

The Office of the Health Ombudsman (OHO) acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and emerging.

The OHO embraces workplace flexibility. If you are receiving this email outside of standard work hours, this is in alignment with my working preferences. There is no obligation to respond outside your working hours.

From: [redacted]
Sent: Thursday, 24 February 2022 4:57 PM
To: Reviews <reviews@oho.qld.gov.au>
Cc: [redacted]
Subject: Re: Case number: [redacted] - Gold Coast Health, Submitted Concerns [redacted]

[redacted]

24 February 2022

Office of the Health Ombudsman
PO Box 13281 George Street, Brisbane Qld 4003

Re: Case number: [redacted] **– Gold Coast Health, Submitted Concerns** [redacted]

Dear Office of the Health Ombudsman,

Good afternoon, please see the attached correspondence for your action and decision.
I would appreciate your reply by email to confirm receipt of this email.

Yours sincerely,
[redacted]

[redacted]

24 February 2022

Office of the Health Ombudsman
PO Box 13281 George Street, Brisbane Qld 4003

Re: Case number: [redacted] **– Gold Coast Health, Submitted Issue** [redacted]

Dear Office of the Health Ombudsman,

I acknowledge your letter received on 2 February 2022 with the subject line "*Your complaint to the Office of the Health Ombudsman - outcome of internal review*" with attachment entitled "*Review decision -* [redacted] *Ms_1C7459*" and I write in reply.

Due to its complexity I have reviewed your letter multiple times. I note the reply did not meet the 60-day timeframe set out in OHO's published process, and I accept the suggestion to proceed to the Office of the Queensland Ombudsman. Although I appreciate the time OHO spent to provide me with a detailed summary of my statements and questions, from this letter I am unable to discern any reasoning that addresses each of the subjects I submitted for an internal review on 15 October 2021.

The single letter combines different concerns intentionally submitted separately to Gold Coast University Hospital (GCUH) Patient Liaison Services through the published complaint process. The intent of the separation is to establish facts and ask questions so GCUH could easily identify the underlying causes and resolve the key issue of the concern identified. At no stage did I consent for the issues to be recast from the original context in which I deliberately submitted for resolution.

- Could you please provide me with a statement of reasons supporting your decision for the forth (4) of (4) concerns described in my request for the internal review with numbered and separate headings entitled [redacted] Patient Complaint 1'?

It is concerning that the letter from OHO dated 2 February 2021 accepts and quotes a reply from [redacted] on behalf of GCUH that contradicts mandatory requirements in the *Mental Health Act 2016*.

For inpatients transferring to treatment in the community the *Mental Health Act 2016 Act s220 (1 - 4)* clearly mandates the authorised doctor ***must*** provide written notice of a patient's treatment and care in the community, and the patient's obligations while receiving treatment and care in the community. https://www.legislation.qld.gov.au/view/html/inforce/current/act-2016-005#sec.220

Instead of meeting statutory requirements, it is concerning the Queensland State health regulatory authority would accept and quote directions to lodge a Right to Information access application, a process that could take 28 days, as a reasonable process to receive the discharge instructions when it is unlawful to have discharged a patient for community care without written instructions.

OHO email of 25 November 2021 appears to be a fact check as OHO requested further information to support my statement that the issuing of 'discharge summaries' as a systemic challenge to Gold Coast Health as it has been highlighted by others, including by a Gold Coast GP in 2019. The GP's concerns were made public through the Royal Australian College of General Practitioners (RACGP).

The GP spoke out about the experience in seeking clinical information relating to an acutely unwell patient who had been discharged from an acute psychiatric admission at GCUH.

OHO acknowledged my reply on 29 November 2021, noted OHO's intent to review and further discuss the information but I am unable to decern any considered response in OHO's reply letter.

The OHO Resolution Team was involved in facilitating a meeting with the GCUH, held at 10:00am on Tuesday 27 July 2021. I attended as a support person for [redacted] and on 1 August 2021 I provided a written meeting summary to OHO that [redacted] and I compiled based on from our meeting notes from the discussion and the mutually agreed facts by the meeting's attendees.

As noted in a letter on 25 July 2021 to [redacted] Team Leader, Continuing Care Team Mental Health and Specialist Services, and Cc to OHO Resolution Team, the main question to be answered was: "**Question 3:** *Why (How) was I discharged with only verbal instructions*?"

In dealing with [redacted] personal and private medical information, under the *Information Privacy Act 2009,* [redacted] response must adhere to the mandatory privacy principles. Queensland Health policies dictate compliance when dealing with personal information in the course of administering a customer complaint, and to only collecting personal information ***necessary*** to the administration of the complaint. In an apparent breach of [redacted] privacy, the lengthy medical history of [redacted] hospital admissions was not required to address the main Question 3 as stated above.

The GCUH provided a submission to OHO dated 9 August 2021 and signed by [redacted] Executive Director Mental Health and Specialist Services. Although lengthy, [redacted] submission contains numerous emotive statements expressing concerns without clinical diagnosis, is inaccurate in some points and fails to address substantive issues, is misleading by containing details that conflict with emails I have archived and seeks to discredit and mask the relevance of the matters raised.

The final paragraphs on pages 14 and 15 of the GCUH submission refer to the meeting discussion held at 10:00am on Tuesday 27 July 2021.

It is noted there was an open discussion about the process to ensure there is a discharge summary completed within 24 to 72 hours post discharge or at discharge, if possible. The meeting summary [redacted] and I submitted to OHO on 1 August 2021 captured notes to the same effect on page 2.

At that meeting [redacted] Medical Director asked [redacted] what resolution was sought, and [redacted] replied: "I don't want this [a lack of a discharge summary, causing confusion with medication] to happen to anyone else".

Following his discharge as an inpatient [redacted] attended a single appointment in community care. The medication the team insisted [redacted] was to receive differed from the verbal discharge instructions he could remember so [redacted] refused the medication until someone could check the medication instructions with the discharge doctor and provide him with a copy.

That action was within his medical rights. In response [redacted] was asked by community health to attend the GCUH Emergency Unit a particular evening, and when he arrived he found he was not expected. [redacted] was assigned a room known as 'The Pod' with 8 other people and 3 beds. No meals were provided, he was dirty from working all day and not allowed to shower and following a more than 24 hour wait [redacted] was readmitted under the provisions that he had a 'relapse'.

The critical importance to provide discharge instructions with a clear transition care plan in simple language, highlighting information about medication, cannot be overstated. This is particularly important for vulnerable patients whom are likely to have received anti-psychotic medication at the time of discharge. Poor discharge records can guarantee that a health plan does not deliver results.

The passing from one care setting to another, particularly for patients with complex and chronic care needs, opens the potential for mistakes, oversights and misunderstandings and, far too often, a marked absence of information that **must** flow from a hospital to the patient and receiving carer.

If all parties identified and agreed at the meeting the underlying cause as an unlawful lack of a discharge instructions or summary, and all parties noted in the same discussion and recognised the need for a confirmed process to rectify the identified problem, then the agreed process was the resolution as detailed on page 14, the final paragraph of the GCUH submission OHO dated 9 August 2021 and signed by [redacted] Executive Director Mental Health and Specialist Services.

- Could you please provide a copy of OHO's request to GCHHS for additional information, sent on 7 January 2022, and the response from [redacted] Deputy Executive Director Medical Services, Clinical Governance and Research, GCHHS, received on 21 January 2022?
- It is a misrepresentation for the GCUH to state there was no resolution when in fact there are lawful regulatory responsibilities resulting from the concern and I am seeking support from OHO to have the record corrected.

Under authority of regulatory oversight, there is a public interest basis for OHO to investigate the discharge process from the Gold Coast Hospital Mental Health Services Acute Care wards.

Yours in appreciation,

[redacted]

[redacted]

24 February 2022

Office of the Health Ombudsman
PO Box 13281 George Street, Brisbane Qld 4003

Re: Case number: [redacted] – Gold Coast Health, Submitted Concern [redacted]

Dear Office of the Health Ombudsman,

I acknowledge OHO's letter received on 2 February 2022 with the subject line "*Your complaint to the Office of the Health Ombudsman - outcome of internal review*" with attachment entitled "*Review decision - [redacted] Ms_1C7459*" and I write in reply.

Due to its complexity I have reviewed the letter multiple times. I note OHO's reply did not meet the 60-day timeframe set out in OHO's published process, and I accept OHO's suggestion to proceed to the Office of the Queensland Ombudsman. Although I appreciate the time OHO spent to provide me with a detailed summary of my statements and questions, from the letter I can't discern OHO's reasoning that addresses each of the subjects I submitted for an internal review on 15 October 2021.

The single letter combines concerns intentionally submitted separately to Gold Coast University Hospital (GCUH) Patient Liaison Services through the published complaint process. The intent of the separation is to establish facts and ask questions so GCUH could easily identify the underlying causes and resolve the key issue of the concern presented. At no stage did I consent for the issues to being recast from the original context in which I deliberately submitted for resolution.

- Could OHO please provide me with a statement of reasons supporting OHO's decision for the second (2) of the four (4) concerns described in my request for the internal review with numbered and separate headings entitled 'Mental Health Services function?

It is concerning to note the communication from OHO dated 17 September 2021 contains information that is not factually correct.

To be clear I have not received a communication or response that references, discusses, or addresses my written concerns and questions submitted on 11 April 2021 to the Patient Liaison Service of Gold Coast University Hospital (GCUH) entitled "Mental Health Services function" and subsequently submitted to OHO on 17 June 2021.

Without a discussion to understand the concern it is difficult to arrive at a resolution. The subject has not been discussed with me by GCUH and all questions and issues remain unanswered.

The OHO Resolution Team arranged a meeting through the Patient Liaison Service of GCUH held on 27 July 2021. OHO received the meeting agenda as submitted by GCUH for the meeting. The listed subject of the meeting were the concerns my son [redacted] raised on 29 March 2021 regarding the services he obtained from GCUH. I provided a summary of the responses [redacted] and I recorded from the meeting to the OHO Resolution Team on 1 August 2021.

- Perhaps I have missed some content so could OHO please highlight where my concern entitled "Mental Health Services function" is discussed within: the 26 July 2021 meeting agenda prepared and submitted by [redacted] Team Leader Continuing Care Team Mental Health and Specialist Services Gold Coast Health, my meeting summary provided to OHO on 1 August 2021, or the GCUH response OHO provided to me on 17 September 2021 signed by [redacted] Executive Director Mental Health and Specialist Services GCUH?

Please reference the concern "Mental Health Services function" submitted to OHO on 17 June 2021 and please address a critical question repeated here:

- Question 2: Could OHO please confirm "*the priority was more towards treating the psychotic episode, and once stable move towards counselling through private providers*" is the documented process supporting the policies of the Queensland Mental Health Services?

On 31 March 2021 I was advised number of psychology professionals available to provide counselling services through the public health system supported by GCUH was limited to two (2), and there would be an extended wait time for my son to receive services. This fact suggests it's not objectives or policy that is guiding the availability of services offered and raises further questions as to fair and equable service distribution with assumed objectivity and apportions to coordinate a balanced approach to useful services.

- What is the basis for clients to be added to the waiting list, and if [redacted] was under the care of a Consultant Psychiatrist, Mental Health & Specialist Services from October 2020 – March 2021 why was he not already on the waiting list for psychotherapy? It appears psychotherapy would be included in a properly documented treatment plan.

I refer to my emails to the OHO office dated 17 June and 15 October 2021 as I continue to seek OHO support, as the responsibility agency, to fully investigate my concerns on systemic issues, the policies that govern mental health services, how GCUH is servicing local mental health needs and community expectations, and how GCUH plan and use suitable performance measures and metrics to improve their health services into the future.

Yours in appreciation,

[redacted]

[redacted]

24 February 2022

Office of the Health Ombudsman
PO Box 13281 George Street, Brisbane Qld 4003

Re: Case number: [redacted] – Gold Coast Health, Submitted Concern [redacted]

Dear Office of the Health Ombudsman,

I acknowledge OHO's letter received on 2 February 2022 with the subject line "*Your complaint to the Office of the Health Ombudsman - outcome of internal review*" with attachment named "*Review decision -* [redacted] *Ms_1C7459*" and I write in reply.

Due to its complexity I have reviewed OHO's letter multiple times. I note the reply did not meet the 60-day timeframe set out OHO's published process, and I accept OHO's suggestion to proceed to the Office of the Queensland Ombudsman. Although I appreciate the time OHO spent to provide me with a detailed summary of my statements and questions, from letter I can't discern any of OHO's reasoning that addresses each of the subjects I submitted for an internal review on 15 October 2021.

The single OHO letter combines concerns intentionally submitted separately to Gold Coast University Hospital (GCUH) Patient Liaison Services through the published complaint process. The intent of the separation is to establish facts and ask questions so GCUH could easily identify the underlying causes and resolve the key issue of the concern presented. At no stage did I consent for the issues to being recast from the original context in which I deliberately submitted for resolution.

- Could OHO please provide me with a statement of reasons supporting OHO's decision for the third (3) of the four (4) concerns described in my request for the internal review with numbered and separate headings entitled 'Complaint?

It is concerning to note the OHO letter dated 2 February 2022 contains information that is not factually correct.

To be clear and correct GCUH staff did not contact police as stated on page 2, it was GCUH staff who provided me with instructions to call police for support of a known medical requirement.

Directions or advice on how another authority will act or consider a particular situation has no lawful basis, is unreasonable, and I consider the advice to be contrary to *[s] 4.1 (c) of the Code of Conduct*

for the Queensland public service, [as public servants, we will]: exercise our lawful powers and authority with care and for the purpose for which these were granted (2011, page 12).

For our family to have faced and fought in the Magistrates Court a Police Protection Order that was put in place following a request for a welfare check, the request made specifically under the directions of GCUH Acute Care Team, leaves us distressed and again utterly fractured as a family.

It appears GCUH Acute Care team are unaware of the Memorandum of Understanding made on 15 June 2017, a replacement of a 2016 agreement, by the Queensland Government acting through Queensland Health and the Queensland Police Service. The agreement between agencies stipulates and pledges cooperation when actioning mental health support and the need for urgent medical attention. GCUH appears to be unaware of this Queensland State-wide agreement and GCUH are lacking a proper policy with procedures or supporting measures to put the agreement into action.

Implementation of a step-by-step process based on the pledged and necessary cooperation between agencies when actioning mental health support for vulnerable people who have the need for urgent medical attention.

OHO email of 25 November 2021 appears to be a fact check as OHO requested clarification of a statement in the submission to OHO dated 9 August 2021 signed by [redacted] Executive Director, Mental Health and Specialist Services, Gold Coast University Hospital (GCUH).

OHO acknowledged my reply that the identified statement OHO questioned was false and misleading on 29 November 2021 and replied of OHO's intent to review and discuss the information.

As the Regulator responsible for health matters, could OHO please provide a response?

Outside of statements to deflect the third of my 3 suggested reasonable and workable resolutions sent to [redacted] on 8 August 2021, no person has acknowledged, addressed, or discussed my initial concerns and questions submitted on 11 April 2021 to the Patient Liaison Service of Gold Coast University Hospital (GCUH) entitled "Complaint".

Without a discussion to understand the concern or my suggested resolutions submitted to GCUH on 8 August 2021 it is difficult to arrive at an agreed set of actions. The subject has not been discussed with me by GCUH and all questions remain unanswered.

I wrote to OHO on 15 October 2021 further to my written concerns about GCUH entitled "Complaint" submitted to OHO on 17 June 2021. Unsatisfactory conduct by a health professional includes a lack of knowledge of or proper application of procedures to coordinate support services.

On 26 July 2021 I discussed the proposed 27 July 2021 meeting itinerary, with [redacted] Team Leader, Continuing Care Team, Mental Health and Specialist Services, GCUH as the submitter of the meeting agenda. [redacted] agreed it was unreasonable to include [redacted] in discussions that referenced my concerns about GCUH advice for action that begat police action.

It has been inferred that the stated subject matter was included in the 27 July 2021 meeting, which is untrue and cannot be substantiated by any of the participants. The subject matter is recorded as 'no resolution' in the resulting submission to OHO dated 9 August 2021 signed by [redacted] Executive Director, Mental Health and Specialist Services, GCUH without a discussion with me.

Although the Queensland Government was in caretaker mode, on 10 November 2020 I raised my concerns of GCUH advice outside of authority, highlighting the lack of coordination between agencies, and the inconsistencies of how services are delivered with the Departmental Liaison Officer to the Minister for Health. Following that conversation [redacted], Medical Director, Adult and Older Person Mental Health – Community contacted me confirming receipt of a Ministerial communication.

[redacted] stated "all agencies have a duty of care", and "agencies are responsible for actions but also responsible for omission of actions". [redacted] indicated the subject actions provided a "potential for learning", learning that he would certainly facilitate.

My questions submitted to GCUH remain unanswered:

Question 1: Has Gold Coast Health has put the resources into comprehensive training, so GCH public servants fully understand and internalise the intent of the agreement, then adopt, and utilise the agreement in daily operations? Procedural processes are necessary.

Question 2: Exactly what learnings, training, and amendments to policies and procedures, to eliminate the same risk to others have occurred since my discussion with [redacted] on Wednesday 11 November 2020?

With regards to this matter, I could not decern the reasons for the OHO delegate's decision in the decision notice dated 17 September 2021 or on 2 February 2022.

I am seeking OHO support, as the responsibility agency, to fully investigate my concerns on systemic issues, the lawful policies that regulate mental health services, and how GCUH is servicing local mental health needs and community expectations, and how GCUH plan and use suitable performance measures and metrics to improve their health services into the future.

Yours in appreciation,
[redacted]

[redacted]

22 February 2022

Office of the Health Ombudsman
PO Box 13281 George Street, Brisbane Qld 4003

Re: Case number: [redacted] – Gold Coast Health, Submitted Concern [redacted]

Dear Office of the Health Ombudsman,

I acknowledge your letter received on 2 February 2022 with the subject line "*Your complaint to the Office of the Health Ombudsman - outcome of internal review*" with attachment named "*Review decision - [redacted] Ms_1C7459*" and I write in reply.

Due to its complexity I have reviewed letter multiple times. I note the reply did not meet the 60-day timeframe set out in in OHO's published process, and I accept OHO's suggestion to proceed to the Office of the Queensland Ombudsman. Although I appreciate the time OHO spent to provide me with a detailed summary of my statements and questions, from OHO's letter I can't discern any reasoning that addresses each of the subjects I submitted for an internal review on 15 October 2021.

The single letter combines concerns intentionally submitted separately to Gold Coast University Hospital (GCUH) Patient Liaison Services through the published complaint process. The intent of the separation is to establish facts and ask questions so GCUH could easily identify the underlying causes and resolve the key issue of the concern presented. At no stage did I consent for the issues to being recast from the original context in which I deliberately submitted for resolution. I am unable to decern the reasons for the decision.

- Could OHO please provide me with a statement of reasons supporting the decision for the first (1) of (4) concerns described in my request for the internal review with numbered and separate headings entitled 'Gold Coast Health Published Complaints Management Policy'?
- Could OHO address the unanswered questions submitted to OHO on 15 October 2021?

Question 1: If OHO is unable to compel the Queensland Government public health service provider to share their complaint management policy with supporting procedures and process, then who is?

Question 2: Is my only option to initiate a Right to Information access application with a financial element involved for me? If I must submit an RTI access application, could OHO please provide advice for the textural descriptions or details I should include ensuring I receive the information I am seeking and that my application is not declined?

On 9 June 2021 I telephoned OHO seeking advice on the GCUH complaint management policy so I could understand how the GCUH assessed the information I provided, as well as the GCUH processes to identify and resolve the key issues of my concern. I have not obtained a copy so it appeared the GCUH complaint management policy, which would provide a definition of a customer complaint and the guiding principles for handling customer complaints was and is not publicly available.

- If the complaint management policy is not published, and won't be released, how can the public understand the process that a Queensland Government funded public health service is operating under?

Public expectations of a state funded health service rely on the basic requirements of transparency, responsibility and accountability. The public must understand how complaint or grievance details are identified, assessed, measured, and what basis is utilized as a driver to motivate continuous improvement of services to promote change within the hospital to improve patients' experiences.

The examination of complaints for quality improvement and understanding the delivery of care has become more commonplace. People with a complaint about health care services want to be treated with dignity and be assured that their complaint will be treated respectfully and seriously.

The *Hospital and Health Boards Act 2011*, Part 1 Division 4 [s 13] states:

> (g) *information about the delivery of public sector health services should be provided to the community in an open and transparent way*.

The *Department of Health, Standard QH-IMP-450-1:2017, Customer complaint management* published by Queensland Health:

> [s] 3.2.3 "*The Customer Complaints Management Guideline (the Guideline) is considered the default process.* ***Local processes must be documented, if they deviate from the Guideline and be readily available and easily accessible***"[emphasis added].

To ensure compliance agencies must comply with current Australian Standard about handling customer complaints (ISO 10002:2018). Routine monitoring and review of the service's complaints system is necessary to check that the system works in the way the complaints policy intended.

I refer to my email to the OHO dated 1 August 2021 with an attachment entitled "Gold Coast Health published standard" and the OHO replies dated 17 September 2021 and 2 February 2022 as I continue to seek OHO's support to locate the Gold Coast health complaint management framework. I am unable to separate or decern the reasons for the delegate's decision in the decision notice dated 17 September 2021 or 2 February 2022.

In the public interest in our community based on principles of integrity, transparency, accountability and participation in decision making I'd like to thank you for your time in considering this matter.

Yours in appreciation,

[redacted]